

# Prescribing & Medicines Workstream<sub>v0\_6</sub>

To maximise the clinical and cost effective purchase  
& use of medicines in the East Midlands without  
adverse impact on quality and safety

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# Case for change

Prescribing costs are rising, prescribing expenditure is increasing, medicines waste is still an issue, and we have an ageing demography

- Prescribing is one of the most common interventions in healthcare. In 2009, it accounted for 12% (£12.3bn) of the total NHS budget
- NHSEM expenditure on medicines in 2009 was £935m
  - £226m in hospitals, an increase of 15.1%
  - £693m in Primary Care, an increase of 2.6%
- Costs of medicines increased by 5.6%
  - 13.2% in hospitals, and 2.6% in Primary Care



# Case for change II

- Unused prescription medicines cost the NHS East Midlands ~£30m every year, 40-50% of this is avoidable.
- Pts aged >65 years account for 45% of the NHS drug dispensing (18% of the population), and this age group is increasing
- Up to 50% of patients do not take their prescribed medicines as intended (NICE CG76. Medicines Adherence )
- In 2008/9 over 542,000 bed days in England and Wales were attributed to adverse events caused by medicines (HES Online – external causes for admission),
- Doing nothing is not an option. The following suggestions require implementing to reduce the impact of these inefficiencies and increases



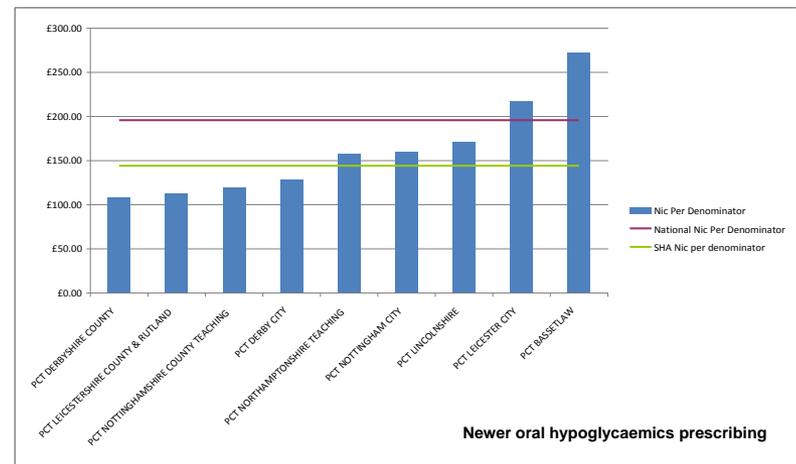
# The Challenge

- The aim of this presentation is by highlighting opportunity and variation, to get the following solutions into commissioning contracts and SOPs:
  - Efficient prescribing against Better Care Better Value (BCBV) indicators
  - Cost-effective drug switches and disinvestments, in-line with NICE guidance
  - Effective management of high cost and limited-clinical-value drugs
  - Improved compliance and reduced waste through patient engagement
  - Contractually oblige organisations to prescribe within NICE guidelines, and monitor through regional CQUINs

# Variation & Opportunity

- There is a wide, and often unnecessary variation in prescribing practice and use of medicines across NHS East Midlands

- e.g. Newer oral hypoglycaemics (for type II diabetes)
- If Derby County PCT prescribing was at the same level as Bassetlaw PCT, Derby would spend £1.2 million per year more than they do now on these drugs

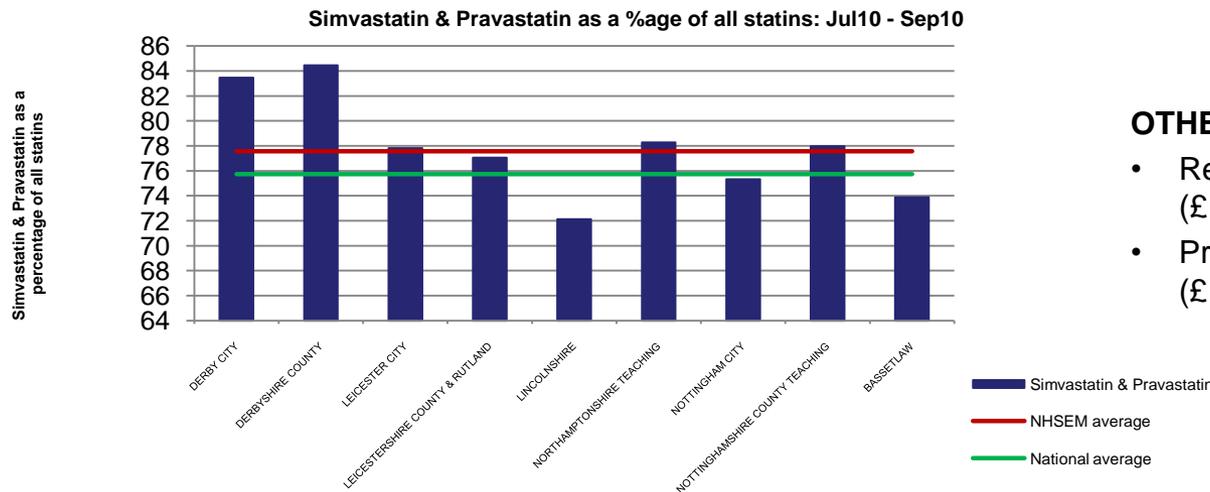


Spending variation

- Organisations have already made savings of ~£20m in 2010/11 (compared to baseline), with PCT SOPs highlighting a potential £90m over the next 3yrs years.
  - These savings however are greatly absorbed due to budgets, and increasing costs & quantities of prescribing

# Efficient Prescribing

- Better Care Better Value (BCBV) – Increasing low cost statin prescribing
  - Recommendation – to review and, where appropriate, revise prescribing of high-cost statins to ensure it complies with NICE guidance
  - The number of prescriptions for statins is continuing to increase by ~20% a year
  - In 2009/10, NHSEM prescribed 4.96 million statins, 23% of these being high cost branded statins
    - Atorvastatin 20mg, 40mg & 10mg are 1<sup>st</sup>, 3<sup>rd</sup> & 12<sup>th</sup> highest prescribed drug in NHSEM primary care by total cost - Apr-Dec 2010
  - A course of branded statin is 6x more costly than a generic statin
  - There's a £2.6m opportunity if all NHSEM PCTs worked towards getting into the top quartile (generics above 79% of all statins) of the country



## OTHER BCBV INDICATORS

- Renin Angiotensin drugs / low cost ACEIs (£1.4m opportunity for 74%)
- Proton Pump Inhibitors (£1.38m opportunity for 91%)

# Cost effective switches

- E.g. Felodipine (anti-hypertensive )
  - If prescribing practice switches from reducing suggested black-list Felodipine to amlodipine by 75%, it could save NHSEM ~£2.1m
    - With a 75% switch, savings range from ~£33K for Bassetlaw PCT, to ~£611K for Lincolnshire PCT
    - Switching by 100% could save NHSEM ~£2.8m

Switching prescribing of Felodipine to Amlodipine



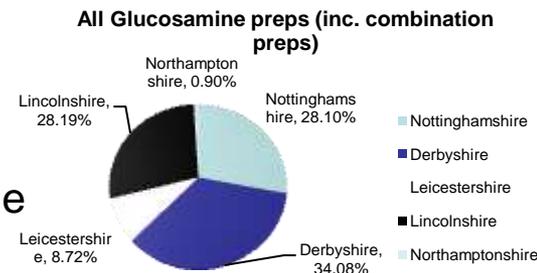


# Disinvestments

- The ideal of a regional formulary and/or a regional black list has been challenging. Following the appropriate evidence and guidelines, percentage target disinvestments are more realistic, by either:
  - Stopping a medication (replacing with nothing)
  - Swapping a medication (replacing with something else)

- E.g. Glucosamine

- Used for symptomatic relief of mild to moderate osteoarthritis of the knee
- Lack of evidence to support it's use or benefits
- In most cases, no need to replace with a different medicine
- NHEM annually spending ~£2.9m (90% in Derby, Nottm & Lincs combined)



- A list of medicines that can be regionally black listed, or regionally 'disinvested from' in NHSEM is currently being produced

# Limited clinical value

E.g. Prednisolone.

- In 2010, 60% of all prednisolone items prescribed in NHSEM were enteric coated, yet accounted for 85% of total prednisolone expenditure
  - There is no good evidence that using enteric coated prednisolone reduces the risk of causing peptic ulcers compared with plain prednisolone.
  - NHSEM is spending £4.5m overall on prednisolone.
  - Reducing prescribing of enteric coated prednisolone by half (to 30%) would save £1.4m. Reducing to 20% would save £1.9m



# Case studies

- We are compiling LOCAL case studies from NHSEM organisations, and 'QIPP Detail Aids with regional Medicines Information Service
- These will be published as a compendium of good practice examples and activities, to support the objectives of the workstream
  - Case studies will be added to the Medicines & Prescribing section of the Towards Excellence website  
<http://www.excellence.eastmidlands.nhs.uk/welcome/improving-care/cross-cutting-areas-for-improvement/improving-prescribing-and-medicines-management/>
  - Medicines Information centre and Medicines Management leads are producing
    - 1-siders for busy GP
    - Links to further evidence for those who require 'convincing'



eg QIPP Detail Aid





# What we recommend

All organisations are already making progress with developing or improving at-least three of the below

	<b>Provider</b>	<b>Commissioner</b>
<b>Procurement</b>	Utilise procurement opportunities through the procurement hub to maximise cost-effective procurement	Ensure organisations are collaboratively procuring new and expensive medication through procurement hub
<b>Cost effective switches</b>	Enable cost effective prescribing in line with NICE guidance and locally commissioned policy	Encourage cost-effective drug switches that are in line with NICE guidance
<b>Disinvest in high cost drugs</b>	Disinvest in use of high cost drugs of limited clinical value	Set a target for the reduction of high-cost and limited clinical value drugs
<b>Pt engagement programme to reduce medicines waste</b>	Develop and implement a patient engagement programme across primary and secondary care, to encourage concordance and reduce waste	Commission a service that encourages use of patients' own medicines within hospitals and use of the 'green medicines bag'
<b>Prescribe within NICE/National Guidelines</b>	Prescribe in line with NICE/National Guidance	Contractually oblige organisations to prescribe within NICE guidelines, and monitor through regional CQUINs

Benefits to delivering the above can be found in the attached



Benefits

# Additional opportunities

- Workstream is working with other clinical networks (e.g. Stroke, COPD) and other NHSEM QIPP workstreams (e.g. Falls & Bone Health, Dementia) to support their aims & objectives
- Other local groups are undertaking Meds & Prescribing initiatives
  - Medicines & Procurement Workstream,
  - Productive Notts,
  - Joint Area Prescribing Committees
  - EMSCG producing additional prescribing CQUINs
- National work is supporting the workstream
  - National Prescribing QIPP indicators being produced, and adding 11 to the Prescribing Toolkit
  - New national BCBV indicators being produced
  - National Prescribing Centre (NPC) produced National therapeutic guidelines, adding to them in March 2011, and producing 'local decision making' guides
  - Nationally producing a 'best practice guidance on commissioning secondary care prescribing services' (Spring 2011).

# Summary & questions

## To summarise:

- As prescribing costs and expenditure increase, there's a constant need to review prescribing practices, maintain quality, and reduce variance and costs
- Initial 'solutions' to commission are:
  - Efficient prescribing against indicators
  - Cost-effective drug switches and disinvestments,
  - Effective management of high cost and limited-clinical-value drugs
  - Improved compliance and reduced waste through patient engagement
  - Contractually oblige organisations to prescribe within NICE guidelines,

## Questions to ask:

- Is there something you need between now and the end of March 2011?
- How can we sustain regional momentum post March 2011?
- What other information do you need?
- What will convince you to implement these objectives?



Challenges



Key Contacts