Prescribing Element of the Enhanced Primary Care Contract 2019-20
Supporting Information

The prescribing element of the Enhanced Primary Care Contract focuses on controlling prescribing expenditure and achieving a number of quality-related targets. Achievement of these elements enables practices to qualify for payment. Financial pressures mean that a savings target will be built into each practice’s prescribing budget.

Medicines Management will publish and circulate key prescribing areas that practices can work on in order to optimise medicines, change prescribing practice and realise savings. A number of searches will be available to run on SystmOne to support this work.

Additionally, OptimiseRx generates savings, best practice and safety messages. Your Practice Link Pharmacist can provide tailored OptimiseRx data to help improve acceptance rates.

The Practice Link Pharmacists will continue to utilise Eclipse to identify savings opportunities for individual practices. Practices can obtain their own log-in if desired.

Quality Indicators (C)

Up to 50% of the reward for the scheme is available for achievement of the five quality indicators: 8% per practice per indicator, with a further 2% per indicator if all of the practices in the network achieve their target*.

Achievement of quality indicators 1,2,3 and 4 will be measured over 6 months, from 1st July 2019 to 31st December 2019 (Quarters 2-3) using ePACT data. Achievement of quality indicator 5 will be measured by submission of Appendix 3 by the 31st December 2019. (Note: practices may be asked for evidence/random checks may be undertaken by the Medicines Management team).

Practices will have the opportunity to submit an appeal, the details and process of which will be sent out by the Primary Care Team for the Enhanced Primary Care Contract.

SystmOne search reports will be written to assist practices in reviewing their own prescribing and performance. Baseline data and monthly progress trackers will also be provided. Further advice can be sought from their Practice Link Pharmacist.

See Appendix 1 for an overview of prescribing analysis terms.

* The payment structure may be reviewed as Networks are still to be determined.
The following five indicators have been selected by the CCG in consultation with the Hammersmith and Fulham (H&F) Prescribing Steering Group to ensure practices continue to focus on these important areas of prescribing. The scheme has been approved by the relevant CCG committees.

1. Reducing inappropriate prescribing of broad spectrum antibiotics in primary care

<table>
<thead>
<tr>
<th>Quality Indicator 1</th>
<th>8% payment if this threshold is achieved (Additional 2% payment if the threshold is achieved by all practices in the network)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduction in the prescribing of broad spectrum antibiotics (co-amoxiclav, cephalosporins and quinolones) in primary care.</td>
<td>≤ 40 items per 1000 antibiotic STAR PU</td>
</tr>
</tbody>
</table>

**Useful Information:**

Antimicrobial resistance (AMR) is a key focus area within the CCG Improvement and Assessment Framework\(^1\). The purpose of this indicator is to encourage appropriate antibiotic prescribing in primary care, particularly in relation to broad spectrum antibiotics.

Public Health England (PHE) released a patient safety alert which states “AMR has risen alarmingly over the last 40 years, with evidence suggesting that the overuse and inappropriate prescribing of antibiotics is a key driver. From 2010 to 2013, total antibiotic prescribing in England increased by 6%. The consequences of AMR include increased treatment failure for common infections and decreased treatment options where antibiotics are vital. If not addressed, this will have a direct impact on patient safety and the quality of patient care.”\(^2\)

Antimicrobial stewardship is core to combatting AMR and is an important element of the UK Five Year Antimicrobial Resistance Strategy\(^3\). Antimicrobial stewardship embodies an organisational and system-wide approach to promoting and monitoring the judicious use of antimicrobials by\(^2\):

- Optimising therapy for individual patients
- Preventing overuse and misuse
- Minimising the development of resistance at patient and community levels

Overall, reducing the inappropriate use of antibiotics will delay the development of AMR and consequently reduce the onset of infections that are harder to treat, more costly to treat and are often associated with greater patient harm. This initiative will also result in more patients being protected from healthcare acquired infections such as Clostridium difficile (C.diff)\(^3,4\).

Furthermore, broad spectrum antibiotics (i.e. co-amoxiclav, cephalosporins and quinolones), should be prescribed in line with national guidelines or local microbiology advice. This indicator is in line with the CCG improvement and assessment framework for 2017\(^4\).

**NOTE:** A leaflet for patients on SystmOne called “How to treat your infection” is also available.

See page 3 for references.
2. Improving appropriateness of antibiotic prescribing per 1000 antibiotic STAR- PU

| Quality Indicator 2 | 8% payment if this threshold is achieved  
(Additional 2% payment if the threshold is achieved by all practices in the network)* |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Reducing the quantity of antibiotics prescribed per 1000 antibiotic STAR PU.</td>
<td>≤ 350 items per 1000 antibiotic STAR PU</td>
</tr>
</tbody>
</table>

**Useful Information:**
This continues to be a focus in the NHS England (NHS E) Quality Premium guidance 2017-19.
Antibiotic items per STAR-PU in the guidance must be equal to or below England 2013/14 mean performance value of 1.161 items per STAR-PU (Note this includes data for a full year and non-practice budgets). A local threshold has been agreed. Practices will be measured on the quantity of antibiotics they prescribe.

**Useful Links:**
- NHS antibiotic awareness resources: [https://www.gov.uk/government/collections/european-antibiotic-awareness-day-resources](https://www.gov.uk/government/collections/european-antibiotic-awareness-day-resources)
- NICE Antimicrobial stewardship: systems and processes for effective antimicrobial medicine use: [https://www.nice.org.uk/guidance/NG15/chapter/1-Recommendations](https://www.nice.org.uk/guidance/NG15/chapter/1-Recommendations)

**References:**
3. Reducing inappropriate prescribing of hypnotics in primary care

<table>
<thead>
<tr>
<th>Quality Indicator 3</th>
<th>8% payment if this threshold is achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reducing the prescribing of hypnotics in primary care (flunitrazepam, flurazepam</td>
<td></td>
</tr>
<tr>
<td>hydrochloride, loprazolam mesilate, lormetazepam, nitrazepam, temazepam, triazolam,</td>
<td></td>
</tr>
<tr>
<td>zaleplon, zolpidem tartrate, zopiclone).</td>
<td>(Additional 2% payment if the threshold is achieved by all practices in the network)*</td>
</tr>
<tr>
<td>5% reduction in ADQ per STAR PU</td>
<td></td>
</tr>
</tbody>
</table>

Useful Information

Patients taking benzodiazepines, Z drugs and even melatonin are at risk of falls, cognitive impairment, dependence and withdrawal symptoms and an increased risk of dementia¹.

Despite the well-recognised risks, the prescribing in H&F is higher than the national average and 7th highest in London.

Hypnotics should not be used first line for insomnia, non-drug methods such as sleep hygiene, stimulant avoidance and the use of cognitive behavioural therapy are more appropriate¹.

Hypnotics should only be used when it is absolutely necessary for severe insomnia, at the lowest dose which controls symptoms, for the shortest period of time¹,²,³.

If prescribed, hypnotics should be issued on an acute prescription and the duration should not continue for longer than two weeks. Occasional use for four weeks may be required but only after re-assessment at two weeks.

Hypnotics should only be used for a maximum of four weeks²,⁴.

It is very important that the patient is informed of the reasons why further prescriptions of hypnotics are not given⁴. See Appendix 2 a) for an example patient letter and b) Information leaflet and sleep guide.

If insomnia persists despite initial management then the patient should be referred to a sleep clinic⁴.

The MHRA reinforced the issues about addiction to benzodiazepines in the July 2011 edition of Drug Safety Update. Various approaches to reducing hypnotic prescribing can achieve significant success. See NICE's clinical knowledge summary on benzodiazepine and Z-drug withdrawal for advice on assessing a person who is being prescribed long-term benzodiazepines or 'Z drugs', and on managing withdrawal of treatment.

A new offence of driving with certain controlled drugs above specified limits in the blood came into force in March 2015. See the July 2014 edition of Drug Safety Update and the drugs and driving: the law government webpage for more details.

Review and, if appropriate, optimise prescribing of hypnotics to ensure that it is in line with national guidance.

Useful Links:
- CKS: Management of Insomnia: [https://cks.nice.org.uk/insomnia#Imanagement](https://cks.nice.org.uk/insomnia#Imanagement)
- NHS: Sleep and tiredness. Sleep diary can be accessed via this site:
https://www.nhs.uk/live-well/sleep-and-tiredness/how-to-get-to-sleep/

- Royal College of Psychiatrists. Sleeping well guide: https://www.rcpsych.ac.uk/mental-health/problems-disorders/sleeping-well

References:
3. BNF 76, Sept 18: Hypnotics and anxiolytics
4. NICE CKS: Managing long-term insomnia (> 4 weeks) https://cks.nice.org.uk/insomnia#!scenario:1

3. Promoting self-care

<table>
<thead>
<tr>
<th>Quality Indicator 4</th>
<th>8% payment if this threshold is achieved (Additional 2% payment if the threshold is achieved by all practices in the network)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reducing prescribing of emollients and bath emollients, in line with Prescribing Wisely (PW) &amp; NHS E guidance on conditions for which over the counter (OTC) items should not routinely be prescribed in primary care. Exclusions may apply.</td>
<td>10% reduction in spend from baseline.</td>
</tr>
</tbody>
</table>

Useful Information:
From June 2016–June 2017 the NHS spent approximately £569m on items available OTC. If there is a reduction in spend on treating conditions that are self-limiting or which lend themselves to self-care, or on items where there is little evidence of clinical effectiveness, resources can be used for other higher priority areas that have a greater impact for patients, support improvements in services and/or deliver transformation that will ensure the long-term sustainability of the NHS1.

Emollients and bath emollients have been identified as areas of high spend which could be reduced. Little impact has been seen following introduction of the PW programme across North West London in October 2017.

NHS E recommends that prescriptions for emollients and bath emollients for the treatment of dry skin or contact dermatitis should not routinely be offered in primary care as the condition is appropriate for self-care.

Examples of exceptions include patients with psoriasis and eczema where the prescribing of emollients is required in the management of these conditions3,4.

Useful Links:
- NWL CCG Conditions for which over the counter items should not routinely be prescribed in primary care. Aligning the North West London Prescribing Wisely list to the NHSE guidance: https://www.healthiernorthwestlondon.nhs.uk/sites/nhsnwlonfond/files/uploadedfiles/SarahA/files/Aligning%20NWL%20CCG%20Prescribing%20Wisely%20Over%20The%20Counter%20(OTC)%20list%20to%20NHSE%20(OTC)%20guidance.pdf
• Approximate retail price of OTC products:  

• OTC leaflet for patients:  

References:

1. NHS England Guidance: ‘Conditions for which over the counter items should not routinely be prescribed in primary care: Guidance for CCGs’  

2. North West London CCG: Prescribing Wisely  
   https://www.healthiernorthwestlondon.nhs.uk/bettercare/thevision/prescribingwisely/withoutprescription

3. NICE CKS. Eczema – atopic, management.  
   (https://cks.nice.org.uk/eczema-atopic#!scenario:1)

4. NICE CKS. Psoriasis, prescribing information, emollients.  
   (https://cks.nice.org.uk/psoriasis#!prescribingInfoSub)
5. Reviewing and de-prescribing Proton-pump inhibitors (PPIs)

<table>
<thead>
<tr>
<th>Quality Indicator 5</th>
<th>8% payment if this threshold is achieved (Additional 2% payment if the threshold is achieved by all practices in the network)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reviewing and de-prescribing PPIs on repeat prescriptions in ≥ 65 years.</td>
<td>Submission of the completed declaration form and data collection form (see Appendix 3).</td>
</tr>
</tbody>
</table>

PPIs are commonly issued in primary care however they are often prescribed without an appropriate indication, dose and continued indefinitely without review. Although PPIs are generally considered safe, over-prescribing has numerous adverse effects particularly with long term use such as C.diff infections, increased risk of bone fractures, acute interstitial nephritis, hypomagnesaemia, rebound acid hypersecretion syndrome and hyponatraemia.

PPIs should be initiated only where clearly indicated and for the shortest duration that is appropriate, in order to minimise adverse effects. Those on long term PPIs should have an annual review of their condition, encouraging them to try stepping down or stopping treatment.

PPIs should be discontinued if they are no longer indicated by gradual tapering of the dose. This is to reduce the risk of rebound hyperacidity and the need to reinstate. Studies in healthy volunteers have shown reflux-like symptoms within two weeks of PPI withdrawal, and for at least four weeks after. To minimise the risk of rebound acid hypersecretion and improve success of PPI withdrawal/dosage reduction a suitable alginate-containing antacid may be recommended.

There are exceptions where the benefits of long term PPIs do outweigh the risks. Examples of exceptions for de-prescribing PPIs include: Barrett’s oesophagus, severe oesophagitis – grade 3 & 4, history of bleeding GI ulcer, ongoing uncontrolled GORD, gastro-protection if co-prescribed a potentially ulcerogenic medicine such as antiplatelets, anticoagulants, corticosteroids, selective serotonin reuptake inhibitors and non-steroidal anti-inflammatory drugs.

References
2. BNF 76, Sept 18
7. WeMeRec Bulletin: Proton pump inhibitors. Nov 2015
Useful Links:

Expenditure thresholds (D)

Up to 30% of the reward for the prescribing element of the Enhanced Primary Care Contract is available for achieving expenditure thresholds, as outlined in the table below.

<table>
<thead>
<tr>
<th>Expenditure thresholds</th>
<th>Maximum % of scheme reward depending on level of performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>i) Practice’s 2019/20 prescribing expenditure is &gt; practice’s budget allocation for 2019/20</td>
<td>0%</td>
</tr>
<tr>
<td>ii) Practice’s 2019/20 prescribing expenditure is ≤ practice’s budget allocation for 2019/20</td>
<td>25%</td>
</tr>
<tr>
<td>iii) Practice’s 2019/20 prescribing expenditure is &lt; practice’s budget allocation for 2019/20 by greater than 0.5%</td>
<td>Max 30%</td>
</tr>
</tbody>
</table>

Prescribing expenditure will be adjusted in-year for changes in prescribing of a defined list of expensive drugs and changes in weighted practice population.

Summary of Payment Schedule

<table>
<thead>
<tr>
<th>Quality (C)</th>
<th>Percentage Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality Indicators (8% for practice achievement and 2% for network achievement per indicator)*</td>
<td>50%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Expenditure (D)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice’s 2019/20 prescribing expenditure is &gt; practice’s budget allocation for 2019/20.</td>
<td>0%</td>
</tr>
<tr>
<td>Practice’s 2019/20 prescribing expenditure is ≤ practice’s budget allocation for 2019/20.</td>
<td>25%</td>
</tr>
<tr>
<td>Practice’s 2019/20 prescribing expenditure is &lt; practice’s budget allocation for 2019/20 by greater than 0.5%.</td>
<td>30%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Top up payment (E)</th>
<th></th>
</tr>
</thead>
</table>
Subject to (C) being 40% or greater and (D) being 25% or greater the practice would then be eligible for a 20% top up payment.

<table>
<thead>
<tr>
<th>Practice payment calculation</th>
<th>20%</th>
</tr>
</thead>
<tbody>
<tr>
<td>( B \times (C + D + \text{[if eligible] } 20%) )</td>
<td></td>
</tr>
<tr>
<td>( B = \text{practice maximum payment based on (total investment/CCG weighted population) x practice weighted list size} )</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 1 - Guide to prescribing analysis terms

Denominators provide a method of comparing behaviour between different groups of prescribers. The various denominators have developed over time as knowledge of what affects prescribing patterns is gained or the ability to manipulate the information is available.

(a) ASO (13) PUs – Age and Sex Originated Prescribing Units

Developed by the National Prescribing Research Unit in 1993, ASTRO PUs were designed to weight practice populations for age, sex and temporary residents. Following a number of reviews, the weightings were updated in 2013; where temporary resident data is no longer collected (practices are reimbursed by a different method). ASTRO PUs were devised from the total of all drug costs and so should not be used for making comparisons within therapeutic groups. There are differences in the age and sex of patients for whom drugs in specific therapeutic groups are usually prescribed.

If you would like a copy of the ASTRO (2013) PU weighting table, please contact your practice link pharmacist.

(b) STAR PUs - Specific Therapeutic group Age-sex Related Prescribing Units

STAR PUs have been developed based on costs for the eight leading therapeutic groups (gastrointestinal, cardiovascular, respiratory, central nervous system, infection, endocrine, musculoskeletal and skin) which together account for 85% of prescribing in England. STAR PU weightings were also updated in 2013.

(c) ADQs - Average Daily Quantities

An ADQ is based on prescribing behaviour within England. It represents the assumed average maintenance dose per day, for a drug used for its main indication, in adults. An ADQ is an analytical unit, which can be used to compare treatment activity and not a recommended dose.

ADQs are a more accurate measure of prescribing activity compared to the number of items. This indicator measures the total volume prescribed for each drug strength, for a given time period and calculates the total quantity of daily doses e.g. one ADQ for ibuprofen is 1.2g.

To reduce the ADQ, practices can work on reducing the strength, quantity and dosage.

For further information see the Health and Social Care Information Centre website
Appendix 2a: Example patient letter to reduce use of hypnotics to be customised

Dear [Title] [Surname]

Re: Hypnotic tablets (Sleeping tablets)

We have recently been reviewing our prescribing of sleeping tablets and note that you are currently prescribed [add tablet name] tablets to help you sleep.

Current national guidance states that this medication should only be used for short periods of time and prescriptions should be reviewed regularly.

The reasons for this are:

- The body can get used to the tablets so they no longer work properly.
- You can become dependent on them so that you feel that you cannot sleep without them.
- The tablets can cause balance problems and make you more likely to fall. You may also experience a “hangover” effect the next day which may impair your ability to drive or operate machinery.
- They can cause daytime drowsiness and confusion as well as adversely affect memory/energy.
- Long term use can make depression and anxiety worse.

If you have been taking the tablets regularly for a long time, stopping them suddenly can cause you to become unwell so it is important to reduce the amount of tablets you take gradually under the direction of your doctor.

[Select option]

- We would be grateful if you could make an appointment to discuss your tablets with the GP/nurse/pharmacist. Until you have this appointment your sleeping tablets have been removed from the repeat medication systems.

- We would like you to consider only taking the tablets when absolutely necessary to reduce the number of tablets you currently use. The practice is setting up a clinic for patients to discuss the long term use of sleeping tablets. [Add name] will be running the clinic and I have made an appointment for you to see them on the [add date] at [add time]. If this is inconvenient please telephone the practice to re-arrange your appointment.

- We would like you to make an appointment to see your usual GP.

- To support you to reduce the amount of tablets, we have produced a “reducing dose regimen,” which we would like you to follow. This initial reducing regime will be for 14 days and will be
attached to your next prescription. Before the end of the 14 day period, can you then make an appointment to see your GP/nurse/pharmacist/attend clinic

- We note from our records that you have not requested a supply since [add date]. We will be removing these tablets from your repeat prescription list.

We have enclosed a sleep guide and an information leaflet. If you would like further help or advice, please contact the practice.

Yours sincerely,

Appendix 2b: Example of patient information leaflet & sleep guide

Patient information leaflet & sleep guide - Sleeping tablets (Benzodiazepines and Z-drugs)

This advice is for people who are prescribed benzodiazepines (e.g. temazepam, nitrazepam) and Z-drugs (e.g. zolpidem and zopiclone).

Why are doctors reluctant to prescribe sleeping tablets?

Sleeping tablets may cause significant problems, which include:

- **Drowsiness and clumsiness**
  People taking sleeping tablets are known to have more accidents (e.g. falls and car-related incidents), therefore it may not be safe to drive or operate machinery. Older people taking sleeping tablets have an increased risk of falling and sustaining bone fractures (e.g. hip injury).

- **Mood and mental changes**
  Some people can become aggressive, confused, forgetful or depressed. In older people, there may also be a link to dementia.

- **Dependence and tolerance**
  Your body may quickly get used to the effect of sleeping tablets so they may stop helping if you keep taking them. Some people may become addicted to sleeping tablets (i.e. dependence problems), and this means that they may experience withdrawal symptoms if the drug is stopped suddenly. Typical withdrawal symptoms include anxiety, panic attacks, sweating, headaches and shaking. Other symptoms may include the inability to sleep, sickness or being oversensitive to light and sound.

What is the alternative to sleeping tablets?

Your doctor, nurse or pharmacist can advise you on how to tackle poor sleep without drug intervention. Advice includes:

- Establishing fixed times for going to bed and waking up.
- Creating a relaxing bedtime routine.
- Only going to bed when you feel tired.
- Maintaining a comfortable sleeping environment that's not too hot, cold, noisy or bright.
• Not napping during the day.
• Avoiding caffeine, nicotine and alcohol in the evenings or late at night.
• Avoiding eating a heavy meal or exercising vigorously late at night.

Further information about sleep

Good sleep hygiene: [http://www.nhs.uk/Conditions/Insomnia/Pages/Prevention.aspx](http://www.nhs.uk/Conditions/Insomnia/Pages/Prevention.aspx)
Sleeping well leaflet: [www.rcpsych.ac.uk/healthadvice/problemsdisorders/sleepingwell.aspx](http://www.rcpsych.ac.uk/healthadvice/problemsdisorders/sleepingwell.aspx)

Advice if a sleeping tablet is prescribed

Sleeping tablet prescriptions will usually only last for a short amount of time (a week or so). For additional support you can self-refer to IAPT.

If you feel drowsy the next day, do not drive or operate machinery.
The DVLA is responsible for deciding if a person is medically unfit to drive. It is the responsibility of the licence holder to inform the DVLA of any medical condition or tablets that may affect safe driving - see [www.gov.uk/drug-driving-law](http://www.gov.uk/drug-driving-law)

• Avoid alcohol.
• Never give your sleeping tablets to anyone and always keep them in a safe place (locked cupboard).

What if you have been taking sleeping tablets regularly for some time?

• As a rule, you should consider reducing or stopping taking sleeping pills with advice from your doctor.
• Do it gradually; cut down the dose a little at a time.
• Pick a good time to do it; it is best to wait until your stress levels are as low as possible. Consider stopping the tablets whilst on holiday or when you have less pressure from work or family pressures etc.
• Remember to anticipate and accept that you are likely to have worse sleep when undertaking a tablet reduction regime. This is normal and will pass. However, most people who reduce or stop sleeping tablets say they feel much better mentally and physically. There are leaflets available from your practice or pharmacy to help you with coping strategies, and tips on how to naturally improve your sleep pattern.
• Use the “good sleep guide”

Copies are available from your GP practice and include helpful advice on how to get a good night’s sleep. Good sleep patterns can take weeks to establish, but be confident and you will get there in the end!
• Look for possible causes of sleep interference such as pain, indigestion, breathlessness or itching. They can often be treated without sleeping tablets.
• Check with your doctor or pharmacist whether any other medicines you are taking are likely to cause sleep problems.

**IMPORTANT.** Do not stop your sleeping tablet medication suddenly, as this may cause problems. You should discuss your case in detail with your doctor first.

**Further information**

Benzodiazepines: [https://www.rcpsych.ac.uk/mental-health/treatments-and-wellbeing/benzodiazepines?searchTerms=benzodiazepines](https://www.rcpsych.ac.uk/mental-health/treatments-and-wellbeing/benzodiazepines?searchTerms=benzodiazepines)


Battle against tranquillisers: [http://bataid.org](http://bataid.org)

Adapted from PrescQIPP Bulletin 175: Hypnotics
Appendix 3: Reviewing and deprescribing patients on PPIs Declaration form

Practice Name: ………………………………………… Practice Code: ………………… List size …………………

List of PPIs (generic/brand) to include in search:

<table>
<thead>
<tr>
<th>Generic Names</th>
<th>Brand Names</th>
<th>Brand Names</th>
<th>Brand Names</th>
</tr>
</thead>
<tbody>
<tr>
<td>Esomeprazole</td>
<td>Nexium</td>
<td>Nexium Control</td>
<td>Ventra</td>
</tr>
<tr>
<td></td>
<td>Emozul</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Vimovo (contains naproxen)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lansoprazole</td>
<td>Zoton</td>
<td>Zoton fastabs</td>
<td></td>
</tr>
<tr>
<td>Omeprazole</td>
<td>Losec</td>
<td>Losec Mups</td>
<td>Mepradec</td>
</tr>
<tr>
<td></td>
<td>Boots Acid reflux GR tablets</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mezzopram</td>
<td></td>
<td>Zanprol</td>
</tr>
<tr>
<td></td>
<td>Axorid (contains ketoprofen)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pantoprazole</td>
<td>Protium</td>
<td>Pantoloc control</td>
<td></td>
</tr>
<tr>
<td>Rabeprazole Sodium</td>
<td>Pariet</td>
<td></td>
<td></td>
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</tbody>
</table>

Table below shows the number of patients to review per practice list size

<table>
<thead>
<tr>
<th>Practice List Size</th>
<th>Minimum number of total patients to review</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-5000</td>
<td>30</td>
</tr>
<tr>
<td>5000-10,000</td>
<td>40</td>
</tr>
<tr>
<td>10,000-15,000</td>
<td>50</td>
</tr>
<tr>
<td>15,000 &amp; above</td>
<td>60</td>
</tr>
</tbody>
</table>

Data collection

<table>
<thead>
<tr>
<th>Number</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of patients ≥ 65 years currently on a repeat PPI prescription</td>
<td></td>
</tr>
<tr>
<td>Number of repeat PPI prescriptions reviewed</td>
<td></td>
</tr>
<tr>
<td>Number of repeat PPI prescriptions changed</td>
<td></td>
</tr>
<tr>
<td>Number of repeat PPI prescriptions stopped</td>
<td></td>
</tr>
</tbody>
</table>

Action plan for improving the way in which long term PPIs are prescribed and reviewed

<table>
<thead>
<tr>
<th>Post review actions</th>
<th>Responsible GP</th>
<th>Date of completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I declare that our practice has reviewed and implemented the necessary actions for these patients.

Name:…………………………………… Signature……………………………… Date……………………
Submit this declaration with the data collection form provided (DO NOT SUBMIT PATIENT IDENTIFIABLE DATA) to the Medicines Management team by 31st December 2019.
Data collection form to be submitted (WITHOUT PATIENT IDENTIFIABLE DATA (PID)):
Note: Practices may be asked for evidence/random checks may be undertaken by the Medicines Management Team, so please retain a copy with PID

Data collection form: Reviewing and de-prescribing PPIs on repeat prescriptions in ≥ 65 years (Indicator 5).

DO NOT SUBMIT WITH PATIENT IDENTIFIABLE DATA

<table>
<thead>
<tr>
<th>Patient No.</th>
<th>Current PPI (name, dose, strength)</th>
<th>Indication</th>
<th>Action taken (e.g. dose reduced, stopped, reviewed no change re-review in 6 months)</th>
<th>Notes/Additional information</th>
<th>Date actioned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example</td>
<td>Omeprazole 20mg caps 1 bd</td>
<td>Treated GORD 4-8 weeks, oesophagitis healed, symptoms controlled</td>
<td>Taper to a lower dose-please specify</td>
<td>Switched to 20mg OD</td>
<td>1.5.19</td>
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