

Frequently
Asked
Questions
related to the
Medicines
Optimisation
Prototype
Dashboard



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Frequently asked questions related to the Medicines Optimisation prototype dashboard

1. How frequently will the dashboard be updated and how can I comment on this and future versions?

We are conducting an evaluation of how the dashboard is used by CCGs and of its usefulness in delivering improvements in medicines optimisation. Until that is complete there are no firm decisions about the future of the dashboard. However, there is a generic email address that we will use to receive your suggestions for improvement England.MODashboard@nhs.net

It is likely that we will use some of the feedback from the emails that we receive as part of the evaluation.

The evaluation of the contribution of this dashboard, combined with our understanding of medicines optimisation from the patients' perspective gained via our patient engagement work will inform the direction and development of the NHS England Medicines Optimisation work.

2. Why doesn't the dashboard use the ONS Clusters that are being used by NHS England to allow CCGs to compare themselves to similar CCG areas?

We appreciate that as well as having the option to choose which CCGs you can compare your data to, it would be helpful for the dashboard to "autopopulate" with your ONS cluster CCGs. We intend to address this in any future versions that are developed.

3. Why does the QIPP antibiotic prescribing comparator not include co-amoxiclav alongside cephalosporins and quinolones to discourage the inappropriate use of broad spectrum antibiotics?

The QIPP prescribing comparators are developed by collaboration between BSA, NHS England, DH, and the HSCIC and are currently being updated following comments received following a recent consultation on proposals to retain, amend or retire the current QIPP prescribing comparators. There is an agreed process for changes, which includes the link to the NICE key therapeutic topics - Medicines management options for local implementation materials. The medicines optimisation dashboard will be updated to reflect any changes to this comparator.

4. Does the trust data include mental health trusts?

At present, the medicine reconciliation data includes mental health and community trusts if they report their data to the patient safety thermometer.

5. Why did you include data on the uptake of novel oral anticoagulants?

The dashboard is aiming to start to make the links between good care and improved patient outcomes. This indicator was chosen to highlight areas where despite NICE guidance stating that these medicines should be an option in the management of Atrial Fibrillation (AF), there is significant variation in their use. In time, we would hope to highlight how many patients with a diagnosis of AF are not receiving any anticoagulation (via the NHS IQ GRASP-AF tool) www.primis.nottingham.ac.uk

NICE guidance on AF will be published soon and we expect to reflect any changes in any future versions of the dashboard.

6. The QOF indicators don't include exception reporting. Doesn't that make comparisons difficult?

We recognise that exception reporting, where significant, can affect comparisons using QOF data. We will consider including the exception reporting in future.

Exception data is reported in the QOF data tables available via the Health & Social Care Information Centre website <http://www.hscic.gov.uk/catalogue/PUB12262>

An explanation of exception reporting is available via the above link.

There are a number of the QOF indicators that include or relate to medicines and which provide a link to the management of a condition, patient outcome or an indication of medicine optimisation e.g. monitoring the safety or effectiveness of a medicine. The QoF indicators included in the dashboard were selected to highlight areas where there is significant variation in outcomes for certain patients with long term conditions. Good achievement would indicate that patients in these groups are supported to adhere to their medication regimes and or are monitored frequently to reduce safety issues.

For more detail on the rationale and description of each metric, please see the specification included within the document "Supporting information for the Medicines Optimisation prototype dashboard."

7. How does Medicines Optimisation link to the Pharmaceutical Price Regulation Scheme? (PPRS)

As the NHS has become more focussed on patient experience, patient outcomes and inefficiencies, the focus on medicines has remained largely around cost and not value or outcomes or most importantly how well a patient was able to use their medicine.

The four Medicines Optimisation principles relate to a patient centred approach to getting better outcomes and value from medicines. This will also be important in developing a joint approach to working in partnership with the pharmaceutical industry, giving us a set of common goals. It will also inform how schemes such as the PPRS are implemented.

The Pharmaceutical Price Regulation Scheme (PPRS) is a voluntary scheme covering all the key issues that underpin the pricing of the majority of NHS branded medicines. It runs for 5 years, and the most recent agreement was put in place on 1st January 2014. The PPRS is designed to strike a balance through promoting the common interests of patients, the NHS, the industry and the taxpayer. The agreement can be found here.

<https://www.gov.uk/government/publications/pharmaceutical-price-regulation-scheme-2014>.

For further information on PPRS see

<http://www.england.nhs.uk/wp-content/uploads/2014/05/pharm-price-reg-qa.pdf>

8. Why are the total number of practice lists different for PINCER metric, QOF metric and EPS metric?

The QOF metric measures data from 2013 to 2014 which is different to the time periods for PINCER and the EPS data. In addition, EPS has included both open and dormant practices, whereas, PINCER has not.

Practices are defined as dormant in agreement with HSCIC as a temporary arrangement where practices are in transition towards closing. Dormant practices have been included in the EPS metric as prescribing has taken place from those organisations during the reported period.