Public Accounts Committee

Report on Primary Care Prescribing

Together with the Minutes of Proceeding of the Committee relating to the Report and the Minutes of Evidence

Ordered by the Public Accounts Committee to be printed on 3 February 2015

Mandate 2011/16 **Twenty Seventh Report: NIA 230/11-16**

Membership and Powers

The Public Accounts Committee is a Standing Committee established in accordance with Standing Orders under Section 60(3) of the Northern Ireland Act 1998. It is the statutory function of the Public Accounts Committee to consider the accounts, and reports on accounts laid before the Assembly.

The Public Accounts Committee is appointed under Assembly Standing Order No. 56 of the Standing Orders for the Northern Ireland Assembly. It has the power to send for persons, papers and records and to report from time to time. Neither the Chairperson nor Deputy Chairperson of the Committee shall be a member of the same political party as the Minister of Finance and Personnel or of any junior minister appointed to the Department of Finance and Personnel.

The Committee has 11 members including a Chairperson and Deputy Chairperson and a quorum of 5.

The membership of the Committee since 23 May 2011 has been as follows:

Ms Michaela Boyle [3] (Chairperson)
Mr John Dallat [5] (Deputy Chairperson)

Mr Roy Beggs[14]	Mr Trevor Clarke[8]
Mr Alex Easton[12]	Mr Phil Flanagan[13]
Mr Paul Girvan	Mr Ross Hussey
Mr Daithí McKay[7]	Mr Adrian McQuillan[1]
Mr Seán Rogers[6]	

1 With effect from 24 October 2011 Mr Adrian McQuillan replaced Mr Paul Frew
2 With effect from 23 January 2012 Mr Conor Murphy replaced Ms Jennifer McCann
3 With effect from 02 July 2012 Ms Michaela Boyle replaced Mr Paul Maskey as Chairperson
4 With effect from 02 July 2012 Mr Conor Murphy is no longer a Member and his replacement on this committee has not yet been announced
5 With effect from 07 September 2012 Mr John Dallat replaced Mr Joe Byrne as Deputy Chairperson.
6 With effect from 10 September 2012 Mr Sean Rogers was appointed as a Member
7 With effect from 10 September 2012 Mr Daithí McKay was appointed as a Member
8 With effect from 01 October 2012 Mr Trevor Clarke replaced Mr Alex Easton
9 With effect from 11 February 2013 Mr Sammy Douglas replaced Mr Sydney Anderson
10 With effect from 15 April 2013 Mr Chris Hazzard replaced Mr Mitchel McLaughlin
11 With effect from 07 May 2013 Mr David McIlveen replaced Mr Sammy Douglas
12 With effect from 16 September 2013 Mr Alex Easton replaced Mr David McIlveen
13 With effect from 06 October 2014 Mr Phil Flanagan replaced Mr Chris Hazzard
14 With effect from 06 October 2014 Mr Roy Beggs replaced Mr Michael Copeland

List of Abbreviations Used in the Report

the Committee	Public Accounts Committee (PAC)
C&AG	Comptroller and Auditor General
NI	Northern Ireland
the Department	Department of Health, Social Services and Public Safety
HSC	Health and Social Care
UK	United Kingdom
GPs	General Practitioners
NIPU	NI Prescribing Units
QOF	Quality Outcomes Framework
MMAs	Medicine Management Advisers
PERT	Prescribing Efficiency Review Team

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Executive Summary

1. Primary care prescribing costs £460 million each year - around 10 per cent of all health and social care expenditure. Responsibility for managing the Northern Ireland (NI) General Pharmaceutical Services budget was devolved from the Department of Health, Social Services and Public Safety (the Department) to the Health and Social Care (HSC) Board on 1 July 2010.

2. The overall volume of items prescribed has been increasing across all United Kingdom (UK) countries over recent years. By 2013, almost 39 million items prescribed by General Practitioners (GPs), were dispensed by NI community pharmacy contractors (contractors or CPCs). Despite the rise in volume, prescribing costs per head of population fell in England, Scotland and Wales over the seven year period to 31 March 2014. By contrast the prescribing costs per head of population in NI were slightly higher in 2013 than in 2007.

3. The Committee acknowledges that, working with the HSC Board, GP practices have achieved savings in prescribing costs over the last four years. A key element in this performance has been a substantial increase in the prescribing of lower cost, generic versions of drugs, rather than more expensive brand name drugs. However, the Committee believes that there is scope to generate significant further savings without compromising patient care through GPs prescribing, where suitable, more lower cost versions of generic drugs.

4. The Committee does not understand the Department's reluctance to accept the validity of cost comparisons either locally (between GP practices) or with other UK regions. It was disheartening that the Department expended considerable energy finding flaws in the use of comparative data and refused to accept that it was possible to use the comparators to estimate the potential for generating savings.

5. Taking account of local data and information on the prescribing costs of other UK countries, the Department, in conjunction with the HSC Board, should undertake an exercise to establish the level of potential savings which more cost effective generic prescribing could generate. This could then be used to set a target prescribing cost for individual GP practices against which to benchmark prescribing performance and to identify areas where further improvement is necessary.

6. In the Committee's view, GPs have little incentive to consider the cost of their prescribing decisions since the cost falls to the HSC Board. The challenge for the HSC Board is to continue to: develop close working relationships with GPs in order to promote better prescribing; use benchmarking data to help GPs peer-review their prescribing practices; and encourage GPs to more fully explain their decision to prescribe a particular medication to patients.

7. In terms of factors which may impact on prescribing levels and costs, the Committee acknowledges the extensive body of research which indicates that the health needs of the population in NI exceed those in the rest of the UK. However, it notes, too, the data presented in the NIAO report which suggests that the volume and costs of prescribing does not neatly match variations in indicators of clinical need, such as local disease prevalence data collected by GP practices and that NI has a lower proportion of older people than other UK regions. It is important that, as part of the benchmarking process, such data is used in conjunction with that on prescribing costs and volumes to investigate the reasons for any anomalies.

8. It is unacceptable that the Department and community pharmacists have failed to reach agreement on the terms of a revised reimbursement contract. This must be resolved as a matter of urgency. Had the Department been successful in agreeing implementation of the new contract (which is in place elsewhere in the UK) in 2006, £46 million would have been released to provide additional, patient-focused pharmaceutical services in the community.

Conclusions

9. **The Health service here could make significant savings, without affecting patient care, if GPs consistently prescribed lower cost, but equally effective, medicines.** A comparison of prescribing costs per head of population across the UK suggests that if NI prescribing costs had been in line with those in Wales in 2013, overall costs could have been reduced by £73 million. NIAO's examination of GP prescribing patterns in three (out of 15) therapeutic areas clearly showed that GPs here tended to prescribe more expensive generic versions of drugs compared to their UK counterparts. More cost effective prescribing in these areas could have saved the health service here £8.9 million in 2012 and £5.1 million in 2013. NIAO also identified that reducing local prescribing levels of the most frequently dispensed drug in NI (Pregabalin[1]) to those elsewhere in the UK would have released over £8.5 million in 2012 and £9.7 million in 2013.

10. **Prescribing costs vary greatly between GP practices – over a 100 per cent difference between the lowest and highest cost GP practices.** The Department uses standardised costs (NI '*prescribing units*' which adjust prescribing costs for, among other things, social class and age distribution) to assess the relative prescribing performance of individual GP practices. The HSC Board has had success in reducing the variation in standardised prescribing costs over the period from 2010 to 2013. However, by reducing the average standardised cost by 10 per cent over a three year period, the NIAO have calculated that further savings of £54 million could be generated.

11. **The full extent of possible savings on the prescribing budget will need to be quantified if the Department is to demonstrate that annual targets are sufficiently challenging.** Insufficient steps have been taken to quantify the potential for generating savings. In the absence of this information, the Department cannot demonstrate the value for money they are getting from prescribing nor whether the savings targets which have been set to date have been sufficiently challenging.

12. **GPs prescribing choices have only recently been bound by an agreed "formulary" of cost effective drugs.** A higher proportion of more expensive drugs were being prescribed in NI because of the delay in introducing the NI Formulary and a '*Managed Entry*' process. Prior to April 2014, unlike Scotland and Wales, in NI there was no body which specified what medicines ought to be (or ought not to be) prescribed.

13. **Generic prescribing is not economical if the patient fails to take the medicine or is convinced that it is less effective.** While campaigns, such as '*Go Generic*', have been successful in reassuring patients of the effectiveness of generic, rather than branded, drugs, patients, particularly elderly patients, can become confused where they are repeatedly prescribed different, generic drugs. This confusion may mean that patients take their drugs wrongly or not at all. More must be done to ensure that patients are more fully informed of the rationale (clinical and cost) supporting GP prescribing decisions.

14. **While prescription drugs work and save many lives, alternative treatments and/or behaviour change can lead to equivalent or better and more cost-effective outcomes.** The Department considers that the absence of appropriate treatment facilities and/or therapies (to treat, for example, mental health or to manage pain) results in additional prescribing costs. Short-term decisions to prescribe (rather than provide access to more appropriate treatments/therapies) lead to ineffective long-term treatment of patients.

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1 Pregablin is a medicine used to treat epilepsy, neuropathic pain and generalised anxiety disorder. As an analgesic it works by reducing the volume of pain signals sent to the brain from damaged nerves. It can have a euphoric effect on patients and cases of abuse and misuse have been reported.

15. **The system for reimbursing pharmacists for dispensing drugs is vulnerable to fraud.** The decision on which drug to prescribe rests solely with the GP, however, the controls currently in place may not be sufficient to ensure due regularity and propriety: for instance, in cases where a pharmacist, against the GP's instructions, dispenses a generic rather than a branded drug. Such potentially fraudulent behaviour not only results in additional costs but may pose patient safety risks. It is not sufficient for the Department and HSC Board to rely on the public to identify such potentially fraudulent behaviour among pharmacists.

16. **The Department, HSC Board the NI pharmaceutical contractors need to reach agreement on reimbursement arrangements.** In 2010, a judicial review concluded that by continuing to apply the Scottish Drug Tariff in NI in the absence of an agreed contract, the Department had failed to meet its statutory duty to provide fair and reasonable remuneration to community pharmacists. A subsequent judicial review also found in favour of community pharmacists. The Judicial Review process cost the Department £550,000. As a result of the Department's failure to agree the new pharmaceutical contract, £46 million (which could have been released to provide additional, patient-focused pharmaceutical services in the community) had to be repaid to pharmacists.

Summary of Recommendations

Recommendation 1

The Committee is concerned that large variations between GP practice prescribing costs have little impact on the financial envelope GPs receive through the General Medical Services contract. As this contract is negotiated on a UK-wide basis, the Committee recommends that the Department examines, in conjunction with its UK counterparts, how the GMS contract can be strengthened to ensure that GPs improve all aspects of their performance, including prescribing.

Recommendation 2

Since the cost of the drugs prescribed in primary care falls to the HSC Board, GPs have limited incentive to prescribe more efficiently. To improve accountability, the Committee recommends that the Department establishes benchmarks for GP practices to compare against each other and identify areas where improvement is needed. The Committee also recommends that this benchmarking data is published periodically on the basis that sharing data is a necessary part of a drive to improve efficiency.

Recommendation 3

The Committee recommends that the HSC Board takes a more proactive approach to examining prescribing patterns in each of the remaining 12 therapeutic areas in order to establish the potential for generating savings.

Recommendation 4

The Committee recommends that the HSC Board establishes a long-term plan outlining the timescale within which savings will be achieved and shares this with the Committee.

Recommendation 5

The Committee recommends that the Department takes steps to investigate the relationship between health need and prescribing.

Recommendation 6

While the Committee recognises the benefits of minimising bureaucracy, it is essential that proper systems and controls are in place to prevent and detect fraud. The Committee recommends that the HSC Board considers and introduces appropriate internal controls/ sanctions to detect any instances where community pharmacists, contrary to GP instructions, dispense a generic rather than branded drug.

Recommendation 7

The Committee recommends that the Department explores with the pharmaceutical industry the scope to achieve greater consistency of appearance, labelling and/or packaging of the more common drugs supplied to the health service.

Recommendation 8

The Committee recommends that the HSC Board further develops public awareness initiatives to equip patients with more information on the use and cost of medicines, in particular to ensure that patients are better educated on the efficacy of less-expensive generic products. Further the Committee recommends that GPs are reminded of the need to fully inform patients of the rationale for their prescribing decisions.

Recommendation 9

The Department's decision not to use its reserved powers to obtain information from contractors was flawed. The Committee notes that the Department is currently undertaking a Cost of Service Investigation and is now producing annual Margins Surveys but considers that the continued failure to agree a way forward is unacceptable. The Committee recommends that a suitable solution is reached between the parties as a matter of urgency.

Introduction

1. The Public Accounts Committee (the Committee) met on 3 December 2014 to consider the Comptroller and Auditor General's report "*Primary Care Prescribing*". The main witnesses were:

   - **Mr Richard Pengelly**, Accounting Officer, Department of Health, Social Services and Public Safety;
   - **Dr Mark Timoney**, Chief Pharmaceutical Officer, Department of Health, Social Services and Public Safety;
   - **Mr Joe Brogan**, Head of Pharmacy and Medicines Management, Health and Social Care Board;
   - **Mr Kieran Donnelly**, Comptroller and Auditor General; and
   - **Mr Jack Layberry**, Treasury Officer of Accounts.

2. Responsibility for managing the Northern Ireland (NI) General Pharmaceutical Services budget was devolved from the Department to the HSC Board on 1 July 2010.

3. In 2013, almost 39 million items prescribed by General Practitioners (GPs), were dispensed by NI community pharmacy contractors (contractors or CPCs). That year, contractors received £460 million for providing community pharmaceutical services on behalf of the Health and Social Care (HSC) Board. This represents approximately 10 per cent of the total spend on healthcare in Northern Ireland.

4. The overall volume of items prescribed has been increasing across all UK countries over recent years. Despite the rise in volume, prescribing costs per head of population fell in England, Scotland and Wales over the seven year period to 31 March 2014. By contrast, the prescribing costs per head of population in NI were higher in 2013 than in 2007.

5. The HSC Board has achieved savings in the four years since the General Pharmaceutical Budget was devolved from the Department. Since 2010, while the volume of items prescribed has continued to increase (by almost 5 per cent to 2012), the overall cost of dispensing items has decreased by just over 7 per cent.

6. The Comptroller and Auditor General's report identified that, while progress has been made in controlling NI prescribing costs, there is scope to generate significant further savings without compromising patient care.

7. In taking evidence, the Committee explored four key areas, as follows:

   - The likely level of additional prescribing savings which can be generated without adversely affecting patient care;
   - The extent to which closer working with GP practices could generate savings;
   - The importance of tailoring treatments and medication in order to secure the best outcomes for patients; and
   - The efforts made by the Department and NI pharmaceutical contractors to reach agreement on the arrangements for reimbursing the cost of the most frequently prescribed and dispensed generic medicines.

The health service can make substantial savings on the prescribing budget without affecting patient care

8. The Committee and the Department agree that good management of prescribing is about much more than simply containing costs. To be truly effective, patients must receive the most suitable treatment for their condition and that treatment must be secured at the best possible price.

9. The primary care prescribing budget is significant at £460 million - 10 per cent of the entire health and social care spend each year. While the Committee commends the HSC Board for generating savings since July 2010, it considers that there is scope for generating significant further savings without adversely affecting patient care.

On comparisons of the prescribing cost per head across the UK

10. It is clear that prescribing costs in Northern Ireland are not in line with the rest of the UK. If the prescribing costs per head of population in NI in 2013 had been in line with those in Wales, overall prescribing costs could have been reduced by £73 million.

11. The Department acknowledges that published data on UK prescribing costs shows that prescribing here is more expensive than in England, Scotland and Wales. While the Committee accepts that there may be differences, it questions whether the regional service delivery differences outlined by the Department fully explain the extent of the cost differential.

12. The Committee considers that, at the very least, such high level comparators indicate there is scope to generate significant savings against the NI prescribing budget. Given that NI is the only UK region which incurred higher costs per head of population in 2013 than in 2007, the Committee concludes that NI has been much slower in achieving savings than other parts of the UK.

On prescribing cost comparisons between GP practices

13. The Committee accepts that variations in GP practice caseloads will result in variations in prescribing costs. It therefore welcomes the use of NI '*prescribing units*' (NIPU) which normalise prescribing data by adjusting for, among other things, social class and age distribution. The Committee acknowledges that the use of standardised costs offers an opportunity for the Department to assess the relative prescribing performance of individual GP practices.

14. The Committee welcomes the success in reducing the variation in standardised prescribing costs over the period from 2010 to 2013 but notes that, in 2013, there was over 100% variation between the GP practice with the lowest cost prescribing rate and that of the highest cost practice. The Committee also notes that the Comptroller and Auditor General in his 2014 report calculated that by reducing the average cost per 1,000 NIPU by 10 per cent over a three year period, savings of £54 million could be generated.

Recommendations 1 and 2

15. **The Committee is concerned that large variations between GP practice prescribing costs have little impact on the financial envelope GPs receive through the General Medical Services contract. As this contract is negotiated on a UK-wide basis, the Committee recommends that the Department examines, in conjunction with its UK counterparts, how the GMS contract can be strengthened to ensure that GPs improve all aspects of their performance, including prescribing.**

16. **Since the cost of the drugs prescribed in primary care falls to the HSC Board, GPs have limited incentive to prescribe more efficiently. To improve accountability, the Committee recommends that the Department establishes benchmarks for GP practices to compare**

against each other and identify areas where improvement is needed. The Committee also recommends that this benchmarking data is published periodically on the basis that sharing data is a necessary part of a drive to improve efficiency.

17. In the Committee's view, a higher proportion of more expensive drugs were being prescribed in NI because of the delay in introducing the NI Formulary and a '*Managed Entry*' process. Prior to April 2014, unlike Scotland and Wales, in NI there was no body which specified what medicines ought to be (or ought not to be) prescribed. The Committee acknowledges that such a body is now in place.

18. The NIAO's examination of prescribing patterns in three (out of 15) therapeutic areas illustrated how improved prescribing decisions could generate significant savings. The Department accepts that the failure to switch from an expensive generic version of a drug to a less expensive generic version resulted in additional costs of £8.9 million in 2012 and £5.1 million in 2013. Further, it accepts that reducing NI prescribing levels for the most frequently dispensed drug in NI, to levels elsewhere in the UK would have released over £8.5 million in 2012 and £9.7 million in 2013.

19. The HSC Board told the Committee that it was aware of inefficiencies in stomach acid treatment prescribing prior to theNIAO's work. If this is the case, it is unacceptable that appropriate action was not taken to avoid incurring unnecessary costs.

Recommendation 3

20. **The Committee recommends that the HSC Board takes a more proactive approach to examining prescribing patterns in each of the remaining 12 therapeutic areas in order to establish the potential for generating savings.**

On the adequacy of annual savings targets

21. Given the Department's acknowledgment that there may be scope to save *"tens of millions of pounds"*, the Committee is disappointed that steps have not been taken to quantify the potential savings that could be generated by more cost effective prescribing. In the absence of this information, the Committee is unconvinced that the Department's annual savings targets have been sufficiently challenging.

Recommendation 4

22. **The Committee recommends that the HSC Board establishes a long-term plan outlining the timescale within which savings will be achieved and shares this with the Committee.**

On the impact of varying healthcare needs of the NI population

23. The Committee notes the extensive body of research, commissioned by the Department, which indicates that the health needs of the population in Northern Ireland exceed those in the rest of the UK. However against this, Northern Ireland has a lower proportion of older people than other UK regions, a lower prevalence of many diseases (according to the Department's own GP payment tool (the Quality Outcomes Framework (QOF)), and has had a lower volume of prescribing than that in Wales, for example, in each of the past seven years.

24. While the Department was dismissive of the use of data from the Quality and Outcomes Framework (QOF) to measure relative health needs, the Committee considers that the disparity in the information sources suggests that either the relationship between health need and prescribing is not as straightforward as may be expected or that there may be some problem with the information produced on disease prevalence.

Recommendation 5

25. **The Committee recommends that the Department takes steps to investigate the relationship between health need and prescribing.**

The HSC Board must continue to work closely with GPs to secure better value for money from prescribing

On the role and numbers of Medicine Management Advisers (MMAs)

26. Savings have been achieved through the greater use, and availability, of generic drugs and the work of the Prescribing Efficiency Review Team (PERT). PERT (through its Medicines Management Advisers (MMAs)) monitors prescribing spend at individual GP practice level and sets regional targets for reducing expenditure on specific drugs and therapeutic areas.

27. The Committee acknowledges that efforts to reduce prescribing costs have achieved real savings over the past four years. The Committee accepts that there is no recognised 'correct' ratio of MMAs but notes that in other UK regions additional resources are made available for MMA or other pharmaceutical support to GPs. MMAs play a significant role in generating efficiencies within GP practices. The Department told the Committee that it is currently preparing a business case to identify the optimal number of MMAs (or other pharmaceutical support) required in NI. The Committee expects to have sight of the final business case.

On the vulnerability to fraud

28. The Committee asked the Department to outline the controls it has in place to identify instances where a pharmacist dispenses a generic drug when the GP's prescription is for a branded drug. Such potentially fraudulent behaviour not only results in additional costs but may pose patient safety risks.

29. The Department told the Committee that it relies on the public to identify and report any instances of potentially fraudulent behaviour among pharmacists.

Recommendation 6

30. **While the Committee recognises the benefits of minimising bureaucracy, it is essential that proper systems and controls are in place to prevent and detect fraud. The Committee recommends that the HSC Board considers and introduces appropriate internal controls/ sanctions to detect any instances where community pharmacists, contrary to GP instructions, dispense a generic rather than branded drug.**

On the relationship between GPs and consultants in secondary care

31. In some cases, hospital consultants prescribe a drug which is not regularly used in primary care or which is normally prescribed by a GP in a cheaper, but clinically equivalent, alternative form. In such a scenario, the GP is expected to follow the recommendation of the secondary care consultant.

32. The Committee believes that patient safety and the overall quality of care depends upon appropriate mechanisms being in place to facilitate the exchange of views on prescribing practice between GPs in primary care and their secondary care counterparts. The Committee requests that the Department provides it with an update on the current arrangements in place to ensure that proper consideration can be given to the consequences of secondary care decisions on primary care prescribing.

It is important that patients are treated in the most effective way and provided with appropriate advice on prescribing decisions

On the consideration of alternatives to prescribing drugs

33. Patient care and safety is of paramount importance in providing health and social care services. An important consideration in this is ensuring that patients receive the appropriate treatment for their condition.

34. The Department told the Committee that the absence of appropriate treatment facilities and/or therapies (to treat, for example, mental health or to manage pain) results in additional prescribing costs. The Committee considers that short-term decisions to prescribe lead to ineffective long-term treatment of patients. The Committee considers that, to treat patients effectively, the full range of possible treatments must be fully evaluated. Such evaluation would consider the cost and likely long-term success of conventional prescribing against available alternative therapies.

On fully informing patients of the clinical and cost implications of prescribing decisions

35. The Committee acknowledges the success of campaigns, such as '*Go Generic*', in reassuring patients of the effectiveness of generic, rather than branded, drugs. However, the Committee is not convinced that sufficient work has been done to reassure patients that, for many conditions, one of several generic versions will be clinically appropriate to treat their condition.

36. The Committee is concerned that, patients, particularly elderly patients, may become confused where they are repeatedly prescribed a different, generic drug. This confusion may mean that patients take their drugs wrongly or not at all. In the Committee's view, GPs must do more to ensure that patients are more fully informed of the rationale (clinical and cost) supporting their prescribing decisions.

Recommendations 7 and 8

37. **The Committee recommends that the Department explores with the pharmaceutical industry the scope to achieve greater consistency of appearance, labelling and/or packaging of the more common drugs supplied to the health service.**

38. **The Committee recommends that the HSC Board further develops public awareness initiatives to equip patients with more information on the use and cost of medicines, in particular to ensure that patients are better educated on the efficacy of less-expensive generic products. Further the Committee recommends that GPs are reminded of the need to fully inform patients of the rationale for their prescribing decisions.**

The Department, HSC Board and the NI pharmaceutical contractors need to reach agreement on reimbursement arrangements

39. Having undertaken research on community pharmacist procurement profit levels, in 2006, the Department of Health in England introduced a new community pharmacy contract in England and Wales. Scotland phased the contract in during 2007.

40. The revised arrangements introduced a new UK Drug Tariff category (Category M) covering almost half of all items reimbursed each year. Under the revised contractual arrangements, reimbursement rates for Category M items moved closer to actual purchase prices paid by community pharmacists. Funding released was then made available to community pharmacists who could demonstrate they were providing additional patient-focussed pharmaceutical services in the community setting.

41. Community pharmacists in NI refused to provide information to allow the Department to quantify local procurement profit levels and subsequently refused to accept the terms of the revised contract. Despite this, the Department continued to rely on the Scottish Drug Tariff and effectively introduced the revised contractual arrangements in NI.

42. The Department's actions were challenged by community pharmacists in two separate judicial reviews. Both judicial reviews found in favour of the community pharmacists concluding that although the Department had reserved powers to ensure that community pharmacists provided the required information it had failed to use these powers and had unlawfully continued to apply the UK Drug Tariff in the absence of an agreed contract.

43. The situation remains unresolved and, seven years after the revised contract became effective in England and Wales, it is still not in place in NI. The Judicial Review process cost the Department £550,000. In addition, as a result of Department's failure to agree the new pharmaceutical contract a total of £46 million had to be repaid to pharmacists.

Recommendation 9

44. **The Department's decision not to use its reserved powers to obtain information from contractors was flawed. The Committee notes that the Department is currently undertaking a Cost of Service Investigation and is now producing annual Margins Surveys but considers that the continued failure to agree a way forward is unacceptable. The Committee recommends that a suitable solution is reached between the parties as a matter of urgency.**

Northern Ireland Assembly

Appendix 1

Minutes of Proceedings of the Committee Relating to the Report

Wednesday, 19 November 2014
Room 29, Parliament Buildings

Present: Ms Michaela Boyle (Chairperson)
Mr John Dallat (Deputy Chairperson)
Mr Roy Beggs
Mr Alex Easton
Mr Paul Girvan
Mr Ross Hussey
Mr Adrian McQuillan

In Attendance: Ms Lucia Wilson (Assembly Clerk)
Mr Jack Peel (Assistant Assembly Clerk)
Mrs Danielle Saunders (Clerical Supervisor)
Mr Darren Weir (Clerical Officer)

Apologies: Mr Trevor Clarke
Mr Phil Flanagan

2.09pm The meeting began in public session

2.17pm The meeting went into closed session

5. Inquiry into Primary Care Prescribing

2.19pm Alex Easton declared an interest as Assembly Private Secretary to the Health Minister.

2.19pm Alex Easton left the meeting.

The Committee received briefing from the C&AG and NIAO Officials on the Inquiry into Primary Care Prescribing.

3.00pm Mr Hussey left the meeting.

The Committee lost its decision-making quorum. In the absence of a decision-making quorum proceedings continued in line with Standing Order 49(5).

3.05pm Mr Hussey re-joined the meeting

Mr Dallat joined the meeting

3.10pm Mr McQuillan left the meeting

Agreed: The Committee agreed to seek further evidence to support the Inquiry from the medical field.

3.20pm Mr McQuillan re-joined the meeting

3.22pm Mr McQuillan left the meeting

3.26pm Mr McQuillan re-joined the meeting

[EXTRACT]

Wednesday, 26 November 2014
Room 29, Parliament Buildings

Present: Ms Michaela Boyle (Chairperson)
Mr Roy Beggs
Mr Trevor Clarke
Mr Phil Flanagan
Mr Paul Girvan
Mr Adrian McQuillan

In Attendance: Ms Lucia Wilson (Assembly Clerk)
Mr Jack Peel (Assistant Assembly Clerk)
Mrs Danielle Saunders (Clerical Supervisor)
Mr Darren Weir (Clerical Officer)

Apologies: Mr John Dallat (Deputy Chairperson)
Mr Ross Hussey
Mr Alex Easton

2.22pm The meeting began in public session

2.24pm Meeting went into closed session

6. Inquiry into Primary Care Prescribing – Preparation Session

The Committee received briefing from the C&AG and NIAO Officials on the Inquiry into Primary Care Prescribing.

Agreed: Members discussed areas of questioning for the evidence session to be held on 3rd December. Members agreed those areas which they wanted to focus their questioning on.

2.50pm Mr Girvan left the meeting

2.56pm Mr McQuillan left the meeting

The Committee lost its decision-making quorum. In the absence of a decision-making quorum proceedings continued in line with Standing Order 49(5).

[EXTRACT]

Wednesday, 3 December 2014
Senate Chamber, Parliament Buildings

Present: Ms Michaela Boyle (Chairperson)
Mr Roy Beggs
Mr Trevor Clarke
Mr John Dallat (Deputy Chairperson)
Mr Alex Easton
Mr Phil Flanagan
Mr Paul Girvan
Mr Sean Rogers

In Attendance: Ms Lucia Wilson (Assembly Clerk)
Mr Jack Peel (Assistant Assembly Clerk)
Mrs Danielle Saunders (Clerical Supervisor)
Mr Darren Weir (Clerical Officer)

Apologies: Mr Ross Hussey
Mr Adrian McQuillan
Mr Daithi McKay

2.12pm The meeting began in public session

5. Inquiry into Primary Care Prescribing – Evidence Session

2.13pm Mr Easton declared an interest as Assembly Private Secretary to the Health Minister and left the meeting.

2.14pm Mr Clarke joined the meeting

2.14pm Mr Girvan left the meeting

2.15pm Mr Girvan re-joined the meeting

2.20pm Mr Dallat left the meeting

2.21pm Mr Clarke left the meeting

2.24pm Mr Dallat re-joined the meeting

2.26pm Mr Clarke re-joined the meeting

The Committee took oral evidence on the above inquiry from:

Mr Richard Pengelly, Accounting Officer, Department of Health, Social Services and Public Safety

Dr Mark Timoney, Chief Pharmaceutical Officer for the Department of Health, Social Services and Public Safety

Mr Joe Brogan, Head of Pharmacy and Medicines Management, Health and Social Care Board

The witnesses answered a number of questions put by the Committee and agreed to provide additional information in writing.

3.21pm Mr Beggs left the meeting

3.22pm Mr Beggs re-joined the meeting

3.29pm Mr Clarke left the meeting

3.45pm Mr Flanagan left the meeting

3.46pm Mr Dallat left the meeting – The Committee lost its decision-making quorum.

In the absence of a decision-making quorum proceedings continued in line with Standing Order 49(5).

3.58pm Mr Dallat re-joined the meeting – decision making quorum returned.

3.59pm Mr Girvan left the meeting - The Committee lost its decision-making quorum. In the absence of a decision-making quorum proceedings continued in line with Standing Order 49(5).

4.00pm Mr Girvan re-joined the meeting – decision making quorum returned

4.28pm Mr Rogers left the meeting – The Committee lost its decision-making quorum. In the absence of a decision-making quorum proceedings continued in line with Standing Order 49(5).

4.32pm Mr Rogers re-joined the meeting – decision making quorum returned

4.52pm Mr Dallat left the meeting - The Committee lost its decision-making quorum. In the absence of a decision-making quorum proceedings continued in line with Standing Order 49(5).

6. Inquiry into Primary Care Prescribing – Discussion with NIAO Officials

The Committee discussed the evidence session with NIAO Officials

4.57pm The meeting went into closed session

[EXTRACT]

Wednesday, 10 December 2014
Room 29, Parliament Buildings

Present: Ms Michaela Boyle (Chairperson)
Mr Roy Beggs
Mr John Dallat (Deputy Chairperson)
Mr Phil Flanagan
Mr Paul Girvan
Mr Ross Hussey
Mr Adrian McQuillan
Mr Sean Rogers

In Attendance: Ms Lucia Wilson (Assembly Clerk)
Mr Jack Peel (Assistant Assembly Clerk)
Mrs Danielle Saunders (Clerical Supervisor)
Mr Darren Weir (Clerical Officer)

Apologies: Mr Trevor Clarke
Mr Daithi McKay

2.10pm The meeting began in public session

2.17pm Mr Hussey left the meeting

2.32pm The meeting moved into closed session.

2.34pm Mr Hussey re-joined the meeting

2.39pm Mr Dallat joined the meeting

2.39pm The meeting was suspended.

2.42pm The meeting re-commenced

7. Inquiry into Primary Care Prescribing – Consideration of Issues Paper

The Committee received briefing on the issues paper from the C&AG, Sean McKay and Richard Emerson.

2.45pm Mr Hussey left the meeting

2.58pm Mr Dallat left the meeting

3.02pm Mr Dallat re-joined the meeting

3.09pm Mr Girvan left the meeting

3.13pm Mr Flanagan left the meeting

Agreed: The Committee agreed that NIAO to produce first draft of report based on issues paper.

Agreed: The Committee agreed that the Chairperson, Deputy Chairperson and Mr Hussey would meet Dr Brendan O'Hare at his surgery in Castlederg on 8th January 2015 to gather more information on this inquiry.

[EXTRACT]

Wednesday, 21 January 2015
Room 29, Parliament Buildings

Present: Ms Michaela Boyle (Chairperson)
Mr Roy Beggs
Mr Trevor Clarke
Mr Alex Easton
Mr Paul Girvan
Mr Ross Hussey
Mr Daithi McKay
Mr Adrian McQuillan
Mr Sean Rogers

In Attendance: Ms Lucia Wilson (Assembly Clerk)
Mr Jack Peel (Assistant Assembly Clerk)
Mrs Danielle Saunders (Clerical Supervisor)
Mr Darren Weir (Clerical Officer)

Apologies: Mr John Dallat (Deputy Chairperson)

2.10pm Mr. Clarke joined the meeting

2.27pm Mr. McQuillan left the meeting

2.31pm Mr. McQuillan re-joined the meeting

2.35pm The meeting moved into closed session

7. Inquiry into Primary Care Prescribing

2.35pm Mr Easton declared an interest as Assembly Private Secretary to the Minister for Health and left the meeting.

2.41pm Mr McKay joined the meeting

2.43pm Mr McKay left the meeting

2.51pm Mr McKay re-joined the meeting

2.57pm Mr Hussey left the meeting

3.02pm Mr McKay left the meeting

Agreed: The Committee agreed to note the correspondence from Mr Richard Pengelly.

Agreed: The Committee agreed to note the contents of the Clerk's report on the Chair and Mr Hussey's meeting with Dr Brendan O'Hare.

[EXTRACT]

Tuesday, 3 February 2015
Room 21, Parliament Buildings

Present: Ms Michaela Boyle (Chairperson)
Mr John Dallat (Deputy Chairperson)
Mr Roy Beggs
Mr Trevor Clarke
Mr Alex Easton
Mr Phil Flanagan
Mr Paul Girvan
Mr Daithi McKay
Mr Adrian McQuillan
Mr Sean Rogers

In Attendance: Ms Lucia Wilson (Assembly Clerk)
Mr Jack Peel (Assistant Assembly Clerk)
Mrs Danielle Saunders (Clerical Supervisor)
Mr Darren Weir (Clerical Officer)

Apologies Mr Ross Hussey

12.49pm The meeting began in public session

12.56pm Mr Rodgers joined the meeting

12.57pm Mr Clarke and Mr McQuillan joined the meeting

1.19pm Mr Girvan left the meeting

1.26pm Mr Girvan re-joined the meeting

1.29pm Mr Rodgers left the meeting

5. Inquiry into Primary Care Prescribing – Consideration of Draft Report

1.35pm Mr Easton declared an interest as Assembly Private Secretary to the Minister for Health and left the meeting.

Agreed: The Committee considered its draft report on the above inquiry.

Main Body of Report:

Paragraphs 11-17	Read and Agreed
Paragraphs 18-20	Read and Agreed
Paragraph 21	Read, Amended and Agreed
Paragraph 22	Read and Agreed
Recommendation 1	Deleted
Paragraphs 24-25	Read and Agreed
Recommendations 2&3	Read, Amended and Agreed
Paragraphs 28-30	Read and Agreed
Recommendation 4	Read and Agreed
Paragraph 32	Read and Agreed
Recommendation 5	Read, Amended and Agreed
Paragraph 34-35	Read, Amended and Agreed

Recommendation 6	Read and Agreed
Paragraphs 37-40	Read and Agreed
Recommendation 7	Read and Agreed
Paragraphs 42-47	Read and Agreed
Recommendations 8&9	Read, Amended and Agreed
Paragraphs 50-54	Read and Agreed
Recommendation 10	Read and Agreed

Executive Summary:

Paragraphs 1-3	Read and Agreed
Paragraph 4	Read, Amended and Agreed
Paragraphs 5-8	Read and Agreed

Conclusions:

Paragraphs 9-16	Read and Agreed

Summary of Recommendations:

Recommendation 1	Deleted
Recommendations 2-10	Read and Agreed

Agreed: The Committee agreed the minutes, minutes of evidence and correspondence to be included as appendices to the report.

Agreed: The Committee ordered the report to be printed

Agreed: The Committee agreed the report to be launched on Wednesday 25th February 2015 and for a press release to be brought before the Committee on Wednesday 18th February 2015.

1.49pm Mr Flanagan joined the meeting

1.51pm Mr Beggs left the meeting

1.53pm Mr Rodgers re-joined the meeting

1.54pm Mr McKay and Mr Clarke left the meeting

1.56pm Mr Dallat left the meeting

2.09pm Mr Dallat re-joined the meeting

2.15pm Mr Flanagan left the meeting

2.31pm Mr McQuillan left the meeting. The Committee lost its decision-making quorum. In the absence of a decision-making quorum proceedings continued in line with Standing Order 49(5).

2.36pm Mr McQuillan re-joined the meeting. Decision-making quorum returned.

2.38pm Mr Girvan left the meeting. The Committee lost its decision-making quorum. In the absence of a decision-making quorum proceedings continued in line with Standing Order 49(5).

2.40pm Mr Girvan re-joined the meeting. Decision-making quorum returned.

[EXTRACT]

Appendix 2

Minutes of Evidence

3 December 2014

Members present for all or part of the proceedings:

Ms Michaela Boyle (Chairperson)
Mr John Dallat (Deputy Chairperson)
Mr Roy Beggs
Mr Trevor Clarke
Mr Alex Easton
Mr Phil Flanagan
Mr Paul Girvan
Mr Seán Rogers

Witnesses:

Mr Jack Layberry	*Department of Finance and Personnel*
Mr Richard Pengelly Dr Mark Timoney	*Department of Health, Social Services and Public Safety*
Mr Joe Brogan	*Health and Social Care Board*
Mr Kieran Donnelly	*Northern Ireland Audit Office*

1. **The Chairperson (Ms Boyle)**: With us are Mr Richard Pengelly, accounting officer from the Department of Health, Social Services and Public Safety (DHSSPS); Dr Mark Timoney, the chief pharmaceutical officer for the Department of Health, Social Services and Public Safety; and Mr Joe Brogan, the head of pharmacy and medicines management for the Health and Social Care Board (HSCB). We also have Mr Kieran Donnelly, the Comptroller and Auditor General (C&AG), and Mr Jack Layberry, the Treasury Officer of Accounts for the Department of Finance and Personnel (DFP). I thank the witnesses for joining us. You are all very welcome. I will move into my line of questioning to Mr Pengelly.

2. Mr Pengelly, expenditure on primary care prescribing is significant, at £460 million. That represents 10% of the entire Health and Social Care (HSC) spend each year. Whilst the Committee acknowledges that progress has been made in GP prescribing efficiency savings, the Audit Office report points out that there is scope for further improvement in that area.

3. I would like to take you to figure 2 on page 11 of the report, which gives a comparison of prescribing costs from 2007 and 2013, showing that spend here was higher. There was a bit of a rise and a slight dip over that period. Figure 2 shows that the spend per head here is higher in comparison with England and particularly with Scotland, where it is £40 per head cheaper. There seems to be a bigger issue that we need to get to grips with, Mr Pengelly, or Mr Brogan whoever wants to take that question.

4. **Mr Richard Pengelly (Department of Health, Social Services and Public Safety)**: I will start, and my colleagues may want to come in with some of the detail. I absolutely acknowledge your point, and the figures clearly do not mask that we are more expensive than England, Scotland and Wales. We certainly do not claim to be delivering the service at the cost that we would like to.

5. I would like to make a couple of points. It is important, as the report acknowledges, to reflect the journey that we have been on for about the last 10 years. We have made very significant progress in the shift from branded to generic medicine, and we have gone from a 41% use of generic medicines to 71% in 10 years. Over the past six years, we have reduced the cost by 18% in real terms.

6. The point that I want to convey to the Committee — it may want to explore this in more detail — has two dimensions. From a fairly poor starting position about 10 years ago, I think that we have made some very good progress. Having said that, more remains to be done, and we are committed to doing that. That is the issue that I would like to explore and explain today. We feel that we can get better. The one caveat that I would

add to that, particularly as regards comparisons with elsewhere, is that primary care physicians are, in many ways, the gatekeepers to health and social care in Northern Ireland, and the actions and interventions they perform have a very significant influence on the pathway that follows. At one extreme, it is possible to go for what you could pejoratively term as "cheap and nasty prescribing", which means going very cheap. That would bring primary costs down. As you said, that is about 10% of the total cost. However, secondary care is very expensive.

7. One of the interesting statistics that I would lay alongside our performance in managing the cost of primary care are our hospital inpatient rates, which are in many ways fundamentally impacted by what happened in primary care. The Nuffield Foundation report from earlier this year compared England, Scotland, Wales and Northern Ireland. It found that, of the four areas, we have the lowest hospital inpatient rates per thousand of the population. I read that as a very strong endorsement of the quality of our primary care. The reality is that you sometimes pay a price in primary care for that quality, but there is a very significant payback in better health outcomes for the individual and reduced costs in secondary care.

8. That said, we cannot rest on our laurels, and we must seek to drive forward, particularly on moving from branded to generic prescribing. Section 4 of the report also brings out the possibility of switching therapies that are of equal and equivalent clinical value.

9. In summary, I think that we have done well. There is more to do, and we remain focused on doing it.

10. **Dr Mark Timoney (Department of Health, Social Services and Public Safety)**: If I could maybe make a remark about the journey that we have been on. Richard talked about the rise in generic prescribing and dispensing rates in Northern Ireland over quite some time. That was first brought to our attention back in 2005, when we had a very low generic rate. We have put a number of initiatives in place over that time to focus on the quality and safety of prescribing in the first instance, rather than looking at the cost first off. We believe that in engaging with clinicians and ensuring that the public understand that we are looking at transparent and defensible initiatives we can make cost very important in the agenda. However, we are looking to quality and safety to drive the health gain that will deliver those efficiencies in the programme.

11. We took a number of approaches over that period. As we began those, we saw generic rates increasing by 4% year-on-year to their current rate of 71%. We note that we are now travelling at a faster rate than some of the other UK countries in reducing costs per head and cost per item that we have identified.

12. There has been a lot of activity. It has been very focused on patients' needs and has demonstrated some changes in trends that we feel have resulted in a reduction of at least 18% in real terms in the cost of medicines for our population in the past six to seven years.

13. **The Chairperson (Ms Boyle)**: OK. Dr Timoney, with respect, the quality and safety aspect of prescribing is paramount, but was there not a lost opportunity at that time for looking at costs?

14. **Mr Pengelly**: I think the point that we are making is that you cannot separate the two: you must look at cost and quality together. In retrospective mode, I am told that one of the mistakes that we made prior to 2004 was to focus purely on cost and to not bring in the qualitative dimension.Against that, I might say that, prior to 2004, we did not seem to be terribly good at cost. So, I question how good we were.

15. **Mr Joe Brogan (Health and Social Care Board)**: Chair, can I come in on that? Ultimately, it is the GPs whom we have to influence in prescribing. GPs will have an interaction with a patient. They will see the patient in front of them, and their focus is on how to make that patient better. Cost is not necessarily

paramount in their clinical decision-making. So, in that influence, we provide guidance that is quality- and safety-focused but that inevitably also address cost. In that way, it is a sweeter pill for the GP to take, in that we are focusing not just on a cost argument. I am a pharmacist. They will respond to me as a clinician, and, if I go to them with an argument about quality and safety knowing full well that there is also a cost efficiency at the back of that, they will be much more accepting of that advice.

16. **The Chairperson (Ms Boyle)**: But will you agree that, in switching from generic to less expensive generics, there was room for savings?

17. **Mr Brogan**: Absolutely. We accept that. Mr Pengelly mentioned that we have made really good progress. There is more to do, and we continue to work hard to yield as much efficiency as we possibly can, ultimately for patients' benefit.

18. **Mr Girvan**: [Inaudible.] — it was the safety aspect. I am eager to find out why, if drugs have the same chemical make-up, the same strength and everything else, there would be a safety issue associated with prescribing a generic drug as opposed to a branded drug. If that drug is deemed to be exactly the same chemical and to have the same strength and everything else, why would there be a safety issue?

19. **Dr Timoney**: One reason that patients flagged up to us on a regular basis throughout this campaign is that, when generic medicines are presented to patients, they are often presented with a different appearance. They may be a different colour, may be in a different box and may have other elements that lead the patient to believe that it may not be the same drug that they had the previous month. Multiply that for a patient that is on four, five, six or 10 medicines and you can maybe see where a lot of confusion can arise. Add a vulnerable patient into that picture and you will then find perhaps that the patient's ability to take the medicine — what we call adherence to the prescription — may be impaired. If the patient stops taking medicine that is designed to improve some long-term condition that they are being treated for, the chances are that that condition will deteriorate and the patient may need to seek an additional service or, indeed, hospital.

20. **Mr Girvan**: Does that not lead back to a point where the GP, as the gatekeeper responsible for informing a patient, will say, "By the way, I am going to prescribe a certain drug to you. It is different from the previous one, but it does exactly the same job and I want you to take it"? You can either tell the patient or whoever administers their drugs that because some people are not even doing that for themselves. They are maybe on antidepressants and suchlike and so might not necessarily be in control of giving themselves the medication. Does that not fall back on the GP, who should ultimately be up to speed with what he is supposed to be doing?

21. **Mr Pengelly**: Absolutely. The GP is the decision-maker for the drug therapy for the individual. The point that GPs make — we all acknowledge this — is that primary care is under intense pressure through the volume of patients and the time allocation. It has to be said that human nature comes into play at times. When a GP is facing a patient and the patient is particularly uncomfortable with the change in shape or colour of a pill that is chemically identical to another — that is the point that you made — GPs sometimes feel that they do not have sufficient time to do that. I am not offering a value judgement on whether that is right or wrong.

22. **Mr Girvan**: That brings me back to what Mr Brogan said.

23. **Mr Pengelly**: The point that Joe is focusing on through the work of the board and the medicines management advisers (MMAs) is about dialogue with and education of GPs and other projects that we are doing to educate the public. You made a point about generic and branded, and I accept that, in the vast majority of cases, there is zero

difference. I have two experts either side of me. The caveat is that, with some compounds, the simple fact is that the tablet may be a different colour and, although the colour itself is inert and neutral, it can have a reaction with the chemicals, and that can make it perform less effectively for some patients.

24. **Mr Brogan**: Perhaps I could expand a little bit. I will draw the Committee's attention to paragraph 4.1, which talks about the two kinds of interventions that we want GPs to make. What various members are talking about is the straightforward branded medicine to a generic equivalent. There should not really be any issue in the vast majority of cases.

25. The other element to note in the second bullet point of paragraph 4.1 is that that is probably where we are at, because we have expanded mainly our generic prescribing reasonably satisfactorily, although we have a few percentages to go. The other key area of efficiency that we are really going after is shifting the actual drug name to a different drug. It will be a different drug that will be available in generic form; it will be moving from a different drug that is a branded form and is not available in the generic. We are shifting it to an equivalent medicine that does reasonably the same job but is generic. Detailing that is a more difficult engagement for the GP to have with the patient. We try to provide support for the GPs and information for the patients. We talk to the patients, and we encourage the reception staff and the community pharmacists to support that change where it is clinically appropriate to do so. That is the real challenge moving forward. We have kind of cracked the generic dispensing issue, although we have a few percentage points to go on that, and we are now moving to focus on moving branded products that do not have a generic equivalent into a different medicine.

26. **The Chairperson (Ms Boyle)**: Thank you. Mr Pengelly, you talked about what was going on in 2004. Obviously, there is a lot of room for improvement. Do you agree that there has not been such an improvement and that, compared with England, Scotland and Wales, there is a significant difference between the cost per head in 2004 and that now?

27. **Mr Pengelly**: A difference remains, and we would like to eliminate that gap, if appropriate. There are two comments in your point to consider. I genuinely feel that we have performed very well since 2004 in improving what was a very poor position, particularly in the level of generic prescribing. I think that we have done well. Is there room to do more? Absolutely, and we want to drive on and do that. I do not want to undermine the progress that has been made over the last 10 years, Chair. However, I do not want that to come across as saying that we have done a great job and that we should sit back and rest on our laurels.

28. **The Chairperson (Ms Boyle)**: OK. Thank you.

29. **Mr Girvan**: The report states that GPs could have saved £73 million if they had followed the same line that was used in Wales. There are times when we tend to use regions as comparisons, and there are times when we set that aside. We seem to hang on to it only when it suits us, but that is for another day. Paragraph 4.6 acknowledges that prescribing per head of population is still much higher than it should be. Do you agree that it could be reduced to £73 million in line with Wales? By how much do you think we could reduce it, and what is the timescale for achieving that?

30. **Mr Pengelly**: There are two points. Do I believe that there is scope for us to reduce our costs to closer to the Welsh position? Absolutely and unconditionally. Do I believe the gap of £73 million? Equally, absolutely and unconditionally, no, I think that it is a very simplistic analysis. There are fundamental structural differences between prescribing in Northern Ireland and Wales. One of those is acknowledged in the report, and it is the impact that secondary care clinicians have. Typically in Northern Ireland, as you leave hospital, the consultant gives you a note to take to your GP, who dispenses your drugs, whereas in Wales, the drugs

are given to you from the hospital at a cost to secondary care. There are other elements, such as oxygen and some others, that are handled separately that account for a figure approaching £10 million. The National Audit Office's 2012 report stated that there was a 4% need differential between Northern Ireland and Wales.We do not have a precise figure for that secondary impact as a result of the structural issues between Northern Ireland and Wales. It could be as much as £30 million of a difference. The other fundamental point that I mentioned to the Chair is that

31. **Mr Girvan**: So, £30 million

32. **Mr Pengelly**: Of the £73 million.

33. **Mr Girvan**: Is that a £43 million saving?

34. **Mr Pengelly**: It could be. Plus the 4% need would account for about £13 million. The other issues would account for £6 million or £7 million, so there is a range of issues. It is useful to make a comparison with Wales at a high level to ask whether we are better or worse. Clearly, we are worse than Wales. By how much is, I think, irrelevant. You can then use that figure as the basis for getting into what happens on a monthly basis, with the MMAs looking at the detail of what happens in an individual GP practice and at its prescribing habits.

35. That is where the rubber should hit the road on this, because the big comparison just says that there is an issue.

36. **Mr Girvan**: I think that some will maybe focus on the MMA support and advice that is going out to surgeries, but within —

37. **Mr Pengelly**: Sorry for interrupting, but the big point that I mentioned to the Chair is hospital inpatient admissions, which are a fundamental indicator of the quality of primary care. In Wales, the figure is 144 per 1,000 of the population; in Northern Ireland, it is 131 per 1,000. That suggests to me that better care is given in primary care in Northern Ireland compared with Wales. Sometimes —

38. **Mr Girvan**: That argument fits OK whenever you want to make that case, but whenever you want to make a case on A&E — I am using that just as an example, because those are A&E admissions you are talking about —

39. **Mr Pengelly**: No, these are hospital inpatient admissions.

40. **Mr Girvan**: Inpatient admissions.

41. **Mr Pengelly**: So, the pathway for that is that you will visit your primary care physician and get some treatment. If that is unsuccessful, you continue on the pathway through to a consultant with an outpatient appointment.

42. **Mr Girvan**: Would that not then bear out figure 10 of the report, where we made reference to having probably better underlying health than maybe some of those other regions that you are talking about? I know that that is beside the point, because I know we make the point that we are a lot worse than everywhere else, yet we have suffered this, that and the other. We will deal with that too when we come to it.

43. **Mr Pengelly**: All I would say at this stage is that this is unique. This is the first place where I or any of my colleagues in the health system have ever heard it said that Northern Ireland has lower health need than the rest of the UK.

44. **Mr Girvan**: I know, but we are always good at sounding as though we are always poor and down in the mouth about everything. We blame everything that happened in the last 40 years on the Troubles and say that, as a consequence of that, we need to be dealt with as a special case in every area, never mind just in health. I am making a point here.

45. I want to move to paragraph 1·14. We have made relatively slow progress in going from branded to generic drugs. There seems to be some more flexibility with new medications, in that we are sometimes using new medications that are a lot more expensive to prescribe. That is higher than in other regions of the United Kingdom.

46. **Mr Pengelly**: Joe will come in with some detail on that. I am not sure that we are, as it states in the report, much quicker off the mark than the rest of the UK. I think that the pharmaceutical industry made that assertion. We are very much plugged in to what happens on a UK level. Joe can talk about the detail of that.

47. This goes to the quality issue. New drugs are developed at huge cost to the industry, tested and brought to market because they are demonstrably clinically more effective than the old drugs. Yes, new drugs tend to be dearer, particularly because they are under brand and could be replacing a generic alternative, but by and large and almost wholly and exclusively, they are much more clinically effective. Sometimes it is the right thing to do to pay a bit more for a treatment.

48. **Mr Girvan**: But you would agree that we prescribe more new drugs than any other region of the United Kingdom.

49. **Mr Pengelly**: No, I would not. Joe will deal with that point.

50. **Mr Brogan**: I do not think we can make that assertion. There are certainly trends in practice historically where a new drug came to market and, because of its clinical effectiveness, a GP may have taken it on more rapidly. That is an individual clinical assessment with the patient. In the past couple of years, we have tried to develop a system of managed entry in which we bring forward a clinical and cost-effectiveness test on all new drugs that come to market. From April, we been running that managed entry process and have partnered with Scotland. It has a health technology appraisal system called the Scottish Medicines Consortium (SMC). In the absence of the National Institute for Health and Care Excellence (NICE), we use the SMC to give us advice about whether a drug is clinically and cost-effective for our population, and we then provide guidance to general practitioners.

51. Through the introduction of that managed entry arrangement, we manage the new drugs that are really good, cost-effective and clinically appropriate for our population — that is a good thing to do — but we also manage where there is less of an argument or an evidence base for new drugs when, frankly, there are sufficient generic or branded medicines on the market. That allows us to say that they do not need to use that drug in a Northern Ireland setting. So, we have progressed by creating a formal managed entry process. That is important to emphasise.

52. **Mr Girvan**: The second part of the paragraph deals with secondary care prescribing and the impact on GPs here as opposed to those in the rest of the United Kingdom. You obviously did not agree with that point.

53. **Mr Pengelly**: That is absolutely a factor in GP prescribing, but our position is that we do not think that it is more of a factor in Northern Ireland than anywhere else in the UK. Through their dialogue with GPs, our MMAs make the point that there is sometimes a frustration among GPs that patients come out of hospital having been prescribed a certain drug therapy, and it is very difficult for GPs to say to them that they have been prescribed one drug but that there is maybe an alternative generic version or an alternative therapy that would be equally efficient. The view of the patient tends to be that they have been in hospital and have been treated by a highly experienced consultant who has given them that drug. In our view, that is UK-wide issue, and it is the focus of that MMA/GP debate across the UK. It is not more of an issue in Northern Ireland than anywhere else.

54. **Mr Brogan**: To emphasise, we have no evidence that that has a bigger impact in Northern Ireland than in other parts of the UK. We know that approximately 60% of GPs' prescribing choices are influenced by secondary care. We try to manage the whole system and to engage with hospital clinicians in secondary care and GPs to formulate what the right decision is for the vast majority of patients. That is why we have established the 'Northern Ireland Formulary', which contains a list of all the first- and second-line choices

that have been agreed by primary and secondary care. That means that we are all on the same page with the treatment and pathways for individual patients.

55. **Mr Girvan**: I appreciate where you are coming from on that point, but, from what I can see, I am of a clear understanding that we are missing out on tens of millions of pounds of savings. Whether it is £70 million or £50 million, it is tens of millions of pounds of savings that could be used effectively in the health service.

56. "Efficiency" is a very broad term, and I do not see much in the line of efficiency in the report. I will go through the report in much detail, and it probably gives far more information about what is going on in the health service than I believed was possible. There is abuse going on in one area or the other. However, that has nothing to do with prescribing, and I want to focus on —

57. **Mr Pengelly**: I absolutely accept your point. There are millions, if not tens of millions, of savings in the prescribing budget. There is clear evidence of that. One of the things that I am working on at the moment is our financial plan for 2015-16, in which we need to make in the region of £160 million of savings. At this stage, we are planning for something in the region of £20 million of that to come from prescribing. Clearly, if we are putting that in, it is on the basis that it is achievable and we feel that it is there.

58. For us, the issue is the pace at which we get there. Fundamentally, the thing that drives the prescribing bill in Northern Ireland is GPs' clinical behaviour. They can rightly say to us, "If you are not in the room when I'm facing the patient, you do not know the whole dialogue and you don't know the circumstances".That is an education process, but we need to respect the clinical judgement of GPs.

59. **Mr Girvan**: We are allowed to question it.

60. **Mr Pengelly**: You cannot question it after the event. We cannot say to GPs that they have a budget of x to prescribe this year and, once they hit that budget, they cannot write any more prescriptions. However, it is absolutely challenged.

61. **Mr Clarke**: You might not be fit to say it retrospectively, but the challenge from the Department could come beforehand and suggest a more generic approach. I do not necessarily accept what you say, Richard, about none of us being in the GP's surgery and looking at the client. Many of us have been in that surgery when doctors prescribe. Well, I have certainly heard stories about doctors prescribing a particular drug. There is a chance that the client may have to go back if that drug does not work, but they have gone for an alternative. There seems to be a direction with GPs that they go with specific drugs first and, if they do not work, they go with a different one. Surely, if they went with the best and most efficient one at the start, they could cut out the other one. I know that you are new in this post, but I think that you have a role to change that culture.

62. **Mr Pengelly**: I absolutely accept that point, but my point is that we discharge that responsibility every month.

63. **Mr Clarke**: How? The financial evidence is not there.

64. **Mr Pengelly**: I would say that the evidence is there. We have reduced costs by over 18% in the last six years. That has to be an indication of some progress.

65. **Mr Clarke**: Sorry, Chairperson, I hope you do not mind if I continue.

66. Are we saying that GPs in London are different from GPs in Northern Ireland? Are we saying that, in their prescribing methods, GPs in London have got it wrong and GPs in Northern Ireland have got it right? If you look at the trend and the comparison between the two regions, you see that London is at £169 per head of population and Northern Ireland is at £244. Even if you take the 18% away from the £244, it still leaves us in somewhat of a catch-up position in relation to London.

67. **Mr Pengelly**: There are a whole lot of factors at play. Outside the individual

behaviour of GPs, there is the nature of the patient, and that touches on our concerns about the QOF data. Aside from a patient's particular illness, their age, their socio-economic background and the level of deprivation they have to endure all influence prescribing behaviour.

68. The important bit is that our MMAs look every month at the actual prescribing behaviour of GPs. They look at their trends, their average costs and the percentage of certain types of drug therapies. They question that and speak to GPs. That happens.

69. **Mr Brogan**: It does. We absolutely challenge GPs. We challenge them on a monthly basis and seek an explanation when there is variation that is beyond expected norms. We expect that there will be action from that.

70. I have brought graphs along that show the kind of things we do. It you are an outlier, we expect that there will be activity and we will reduce the amount of variance. I know that will probably come up later on. We will be there. We cannot be in with the patient and the GP — that is a sacrosanct interaction. However, we want to influence GP prescribing behaviours so that we get quality, safety and cost-effectiveness.

71. You are absolutely right: there are millions of pounds worth of opportunities that we need to yield and reinvest in the service.

72. **Mr Clarke**: That is where I fundamentally disagree. You may be trying. I have done a quick calculation, but there is a 69% difference. I accept the point that the two areas are different and that the types of things that are presented may be different, but the general illnesses will be very similar and, whatever seems to happen there, we seem to follow behind that. You said that, through your model, you have driven 18% of efficiencies, but that still leaves you another 50% to try to catch up on.

73. **Mr Pengelly**: But the point, and I will not repeat —

74. **Mr Clarke**: You did. There is nothing to back up the point that you made at the start. You are talking about outcomes, and I think that you talked about the outcomes in primary care. It is easy to do that for statistical purposes, but you cannot directly relate that to that figure.

75. **Mr Pengelly**: It is easy to do the bit I have done. It is easier to make a very trite comparison between Northern Ireland and England, as has been done in this report. We had fundamental concerns about this.

76. I made the point to Mr Girvan about the comparison with Wales and why we believe that it is not entirely valid. That is more so with England. More of the primary care budget, in comparison with England, takes place in secondary care. So, the £30 million figure would be a lot more significant in comparison with England.

77. **Mr Clarke**: Do you believe that the Minister got it wrong in 2011 when he agreed with the comparative nature of the figures? It is on record in the House.

78. **Mr Brogan**: Could I draw your attention to —

79. **Mr Clarke**: Sorry, no; just stick to that one first.

80. **Mr Pengelly**: I am not aware of what the Minister said.

81. **Mr Clarke**: It was the Minister's quotation. He recognised that Northern Ireland was not London. The English model and the prescribing costs were read into the record. However, with regard to cost comparison, the Minister is on record answering a question on rural pharmacies on 11 October. So, he is on the record accepting those figures, and he is on the record accepting that there is a parallel to be drawn between them, and there actually is a discrepancy. What has changed between 2011 and 2014?

82. **Mr Pengelly**: Just to be clear: what I am saying, and what I hope to have made clear, is that I feel that the absolute comparison is flawed. The general

nature of the comparison, as all three of us said, is that, on a reasonable comparison, we are above the cost of our colleagues across the UK and there is work to be done to reduce that. However, the point that we were debating was the extent of that gap. I do not believe that it is as wide as suggested.

83. **Mr Clarke**: So, you do not accept that it is 69%, but you accept that there is a lot of work to be done.

84. **Mr Pengelly**: Yes.

85. **Mr Clarke**: Because of the difficulties and the complexities of the Department and everyone, how quickly are you going to get to a comparative figure that we can all agree?

86. **Mr Pengelly**: The more important issue is what GPs are doing day and daily in Northern Ireland and whether that is clinically and financially effective. The comparison with England, Scotland and Wales is interesting, and it gives us the sense of whether we are worst in class or best in class. However, we will effect change in the dialogue with what is happening in GP surgeries, and we are doing that.

87. With regard to the difficulty about the pace at which we fix it, it is necessarily not as quick as we would like, because it has to be done through education. If we were to change it immediately, every GP should see a patient, write out a script and send it to the board for approval before it is dispensed so that we can question whether it is clinically appropriate and financially effective. We simply cannot do that; we cannot delay treatment. So, the only option open to us is the examination of prescribing patterns and behaviour and a process of education, and we are doing that.

88. I assume that we will come to the number and extent of our MMAs later. I think that there is an issue there, and that we could intensify our investment in MMAs to allow more of that dialogue with GPs. I think that that would help our pace a bit, but it is fundamentally an education process.

89. **Mr Girvan**: I appreciate the line that has been taken there. I understand the benefit of having MMAs to inform about the new drugs that are coming through, the new drugs that are coming on to the list as generic, and making sure that they are aware of them and that they do not necessarily have to prescribe the branded on. However, we are dealing with people who are learned and should, at least, realise that we are trying to deliver on our budgets. They should be trying to achieve savings as well.

90. I want to talk about the savings that could have been made across three areas, and the illnesses are the same in England as here. For example, in areas such as hypertension, where the medication is the same and where generic drugs are available, savings of £8·3 million could have been made in 2012 and a saving of £6·5 million could have been made in 2013. That is in part 4 of the report. A fairly reasonable saving of nearly £15 million could have been made across three therapeutic areas if a little bit of concentration had been applied. It always leaves it open for people to think, and I am only just floating this in. In the past, you have heard people say that they are going away with one of the big pharmaceutical companies that is running an information programme for doctors or fund managers in health centres and that it is being held in Bermuda or whatever. To be honest, it leaves itself open for those sorts of questions to be asked.

91. Why would somebody prescribe a drug that costs £35 a month when he could have got away with prescribing something that costs £2·53 and does exactly the same thing? Is there an alternative? Is there an ulterior motive in some of those guys doing that? Yes, they are supposed to be there to look after the patient and to make the patient better was that the term you used? Yes. Some of us think that it is just about getting them out the door. They just reach for the pad and say, “Away you go. You have your prescription. We do not care what medication you are on, but that is what you are getting anyway”. I

am just saying that there is a perception that that goes on, we are not focusing in on those areas. We could have one health centre in a demographic area dealing with a number of patients and another one four miles down the road with a similar type of background yet it could have twice the prescribing rate.

92. **Mr Pengelly**: I absolutely take the point and absolutely accept that there could be a perception out there about those external influences on prescribing behaviour. One drug costs £30-something and another drug costs a couple of pounds, and the view is that they may both be fit for purpose. Equally, in some cases, they may not both be fit for purpose. There may be clinical reasons. The point that I made about not being there when the prescribing decision

93. **Mr Girvan**: I accept that, but it would not be 70% of a difference. I could understand 1% or 2% of people maybe having a reaction but not 70%.

94. **Mr Pengelly**: Absolutely. That is the reason why we are focused on that area and why we want to drive it down. The issue is fundamentally about which of those patients we can do that with, because, for some of them, that differential is appropriate and, for many of them, it is not appropriate.

95. **Mr Girvan**: You do not know until you try it.

96. **Mr Pengelly**: We cannot inject ourselves into the room beside every GP when they make every prescribing decision. We do a process of education. I am not sure, Chair, that you will want to get into the granularity of this today. It might be helpful if we produce a note to set out what happens on a monthly basis in terms of the interrogation.

97. **Mr Girvan**: Yes, that would be helpful.

98. **The Chairperson (Ms Boyle)**: You could send that evidence to us.

99. **Mr Pengelly**: Yes, we can. It will illustrate that. We look at practices that are more than two standard deviations away from the mean. We look at where there is a high percentage of certain types of drug and comparisons with GPs in the same area, where you assume there is a broadly similar population cohort. So, we can set that out and give a sense of —

100. **Mr Clarke**: I hope that I am not taking someone else's area, but look at figure 17. Richard, why have you not picked up on that? I suppose that I will probably have to try to pronounce that word.

101. **Mr Brogan**: Esomeprazole and omeprazole.

102. **Mr Clarke**: Do you want to say it?

103. **Mr Brogan**: Omeprazole is available generically. Esomeprazole was brought to market and was branded until very recently. There is now a generic of esomeprazole available. It is still two to three times more expensive per month than omeprazole.

104. **Mr Clarke**: I think that it is worth reading into the record that esomeprazole costs £17·03 and the other one costs £2·27. If you look at the pattern across the UK, it seems that our GPs have got carried away with the one at £17 as opposed to the one at £2. Why is the work that you are talking about, Richard, not picking that up?

105. **Mr Pengelly**: I will read into the record that we knew about that long before the chart was produced for this report.

106. **Mr Clarke**: So, what have you done about it? Those are last year's figures.

107. **Mr Pengelly**: There is ongoing dialogue with GPs. I am sorry for repeating, but, until we put ourselves beside the GP and say, "We are taking your pen off you because you are not writing a script for that drug", they will continue to do it. We will continue to examine their prescribing behaviour, visit them, sit down opposite them, talk about their prescribing patterns, educate them and talk about the difference in the drugs.

108. **Mr Brogan**: Just to go over that: esomeprazole and omeprazole is one project area that we have been working at for the past three or four years.

You will say, "Well, why have you not delivered on it?"

109. **Mr Clarke**: Are you reading my mind, Joe?

110. **Mr Brogan**: When I go into a GP surgery, I lift all their pens. If it says "esomeprazole", I replace it with an omeprazole pen. You are right to say that we are using more of that more expensive drug and ask why we are not using omeprazole.

111. **Mr Clarke**: That one switch would save £2·7 million.

112. **Mr Brogan**: It cannot be done overnight. It is about individual patient review on an annual basis and moving them over from one drug to the other. If you have ever suffered from heartburn, you might know that this is the drug that is used in severe heartburn right through to Barrett's oesophagus. The GP will want to assess the individual clinical responses to moving from one to the other. He does not want to upset somebody who is already on a stable drug. We —

113. **Mr Clarke**: If I was the Minister and I saw that, I would have had heartburn.

114. **The Chairperson (Ms Boyle)**: I want to bring in a couple of other members.

115. **Mr Beggs**: It is inappropriate that the dear drug is allowed to be promoted and advertised on a pen on a GP's desk that you are so keen to have removed. It should not be there is the first place.

116. Are there other structural process differences between GP operations in Northern Ireland and in England that puts real pressure on them to make the right decisions for the benefit of our National Health Service? What differences are there other than GP prescribing? Are there other pressures on GPs from the health system in England, Scotland and Wales that mean that they do things differently from you?

117. **Mr Pengelly**: On the issue of the pen, I respect what you say, but I do not think there is a way I can stop a GP from using a pen of his or her choice, as much as I would like to.

118. **Mr Beggs**: Yes, but it is a symptom of the success of the billion pound advertising of pharmaceutical companies.

119. **Mr Pengelly**: I absolutely accept the sentiment of that. Our issue is that we want to stop that from having an undue influence on prescribing behaviour. However, we need to remember that, fundamentally, GPs are independent contractors. They are not employees of the health service.

120. **Mr Beggs**: And you can set the contract for them.

121. **Mr Pengelly**: We have been trying to negotiate a contract with them since about 2006. I think that is a point we will explore later.

122. **Mr Clarke**: But somebody else is picking up the tab for this, Richard.

123. **Mr Pengelly**: It is not something that I am comfortable with.

124. **Mr Beggs**: Can we deal with the issue of the process? Are different processes and pressures coming from the health service in England, Scotland and Wales that are getting a different result from what we are getting?

125. **Mr Pengelly**: Joe or Mark will say something on the detail of that. The fundamental answer is no. These are GPs who are licensed to operate on a UK basis. We have, by and large, the same set of clinical prescribing tools. We operate within the BMA with NICE guidance.

126. **Mr Beggs**: Have you asked your English colleagues why we are getting a different result from that in England, Scotland and Wales?

127. **Mr Pengelly**: That dialogue will happen on an ongoing and regular basis, and Joe or Mark will say a bit more about that. We need to focus our energy and attention on what our GPs are doing to make sure that they are making the right clinical and financial decisions about prescribing patterns.

128. **Mr Clarke**: But they are not.

129. **Mr Pengelly**: When they are not, we educate them, highlight the differences and push them —

130. **Mr Beggs**: But it is not working.

131. **Mr Pengelly**: We cannot direct a GP on how to prescribe. I cannot say to a GP, "I do not like the drug you've prescribed".

132. **Mr Clarke**: England, Scotland and Wales definitely seem to be getting the message on the cost of the two drugs. There is a big switch there. Wales, in particular, has done exceptionally well, albeit they are using it to a lesser degree. The other three regions are using it to a lesser degree. You are the paymaster here, Richard. Take that as one example, where one drug is £17 and the equivalent is £2·27. Can you not say, "We are taking that off the list. We are not going to fund that drug any more"?

133. **Mr Pengelly**: No is the short answer.

134. **Mr Clarke**: I will take the long version as well in a minute, because that is obviously —

135. **Mr Pengelly**: Joe will expand on that.

136. **Mr Brogan**: We cannot say no currently. We cannot say no to esomeprazole, whose branded form is Nexium, because it is clinically available and licensed. We would have to go through a particular process —

137. **Mr Girvan**: It is too dear.

138. **Mr Brogan**: It is appropriate in a small proportion of cases. It is being used in a percentage of patients throughout the UK. Would you want us to say no to people with extreme disease such as Barrett's oesophagus, which is a pre-cancerous condition? Would we wish to go down that route? I would argue probably not because that is not clinically appropriate. So, we have to influence what is clinically appropriate.

139. Mr Beggs asked about structural differences. It is the same GMS GP contract across the four nations, so the levers that are available in other parts of the UK are available to us in Northern Ireland. You will make the argument as to why we are not doing the same as other parts of the UK, and I accept the point. We have not done as well as other parts of the UK, but we have made good progress over the past number of years to set that right.

140. In the graph at figure 16, the £4·14 is the cost per head of population for that group of medicines. Compare that with Scotland, where it is now £3·85. If you want to go down the route of comparing populations, which is arguable anyway, you see that we are starting to deliver efficiencies here through the work of my staff, who have been absolutely brilliant.

141. **Mr Clarke**: I would say that they are not. You could look at the graph in a different way and say that the population in those other regions are much higher, so the efficiencies should be greater.

142. **Mr Pengelly**: The cost per drug per patient will be the cost per patient regardless of the population size.

143. **Mr Clarke**: Yes, but the higher percentage of numbers affects that figure as well, does it not?

144. **Mr Pengelly**: No, because it is the cost of the drug. It is the unit cost of the drug going by how many patients are on it.

145. **Mr Beggs**: You have not given an explanation for figure 17. As highlighted by Trevor, what that shows is quite stark.

146. **Mr Pengelly**: Figure 17 absolutely underpins the point that we still have some distance to travel to get to the place we want to be. The issue, to the understandable frustration of members, is the pace at which we get to that. We are not saying that we are in a perfect place. However, beyond our approach of routinely, regularly and ruthlessly monitoring GP prescribing and educating GPs, talking to them and highlighting differences, I cannot envisage what else we could do at this stage.

147. **Dr Timoney**: We have talked about the need to be in the room and to

be present at the point at which the clinical decision is reached. It might be suggested that we need to build on that capacity and have the medication review that has been discussed more figuratively delivered at the patients who are being retained on those medicines to determine whether they are still cost-effective and clinically effective for their condition.

148. **Mr Clarke**: There is something else that the figure does not say that I would be intrigued to know. Richard has told us that you knew about that before the Audit Office brought it to his attention. Did you do any work or analysis in those areas? It is like everything where a handful of GP surgeries make up the highest percentage of that. As you are familiar with it and will have looked at it in detail, is there is a geographical problem in Northern Ireland on top of that?

149. **Mr Pengelly**: There will be a detailed analysis of that by each of the 351 GP practices in Northern Ireland.

150. **Mr Clarke**: So, we know who the offenders are.

151. **Mr Pengelly**: Yes.

152. **Mr Clarke**: The picture is not as stark, because I assume that there is a minority of cases.

153. **Mr Pengelly**: To be clear: we know where the high prescribing costs are. We do not know where the offenders are. Some high prescribing costs are clinically justified. My GP colleagues would not forgive me if I did not put in that caveat.

154. **The Chairperson (Ms Boyle)**: You talk about offenders, but you know who is making savings in the areas. You are well aware of Dr Brendan O'Hare in my constituency and the savings he has made. Have you talked to him about how he does it?

155. **Mr Brogan**: Certainly. I know Brendan and I know the practice very well. I was their first prescribing adviser in 1996, so I hope that some of my influence has been brought to bear within that practice. Brendan made significant inroads in 2011 and 2012. Forgive me if I am speaking for Brendan, but I know what he would say, which is that it is an ongoing issue. Brendan's practice is practice 616 — I know the numbers off the top of my head. It had higher costs and has a particular higher need as it covers a rural population in Castlederg and beyond. They made significant efficiencies, but have slipped in certain areas and know that they need to continue to work at it. It is an ongoing issue, and our medicines management adviser goes in every couple of months and tells him that he needs to do this, this and this. One of the drugs that is listed in the report, rosuvastatin, is a target for that practice. They will know that and work very closely with our medicines management advisers to identify what they need to address to move it on. Maybe, at the end of it all —

156. **The Chairperson (Ms Boyle)**: He is a GP who recognised that it is a work in progress. He has identified savings and has made the initial move to make those savings. Would it not be excellent if all our surgeries were doing the same?

157. **Mr Clarke**: You will have no problem getting an appointment the next time you want one.

158. **The Chairperson (Ms Boyle)**: He is not my doctor.

159. Before I bring in the Deputy Chairperson, who is anxiously waiting, that brings me on to something else. Mr Brogan, in paragraph 3.13, you recognised that the medicines management advisers — for anyone listening, that is the MMAs — play a central part in influencing the prescribing behaviour of the GPs. Given the importance of that role, it is surprising that, proportionally, there are considerably fewer MMAs in post here than in Scotland. Do you accept that the number of MMAs here is too low, with one per 130,000 of the population compared with up to six per 100,000 of the population in Scotland?What assurances can you offer that the number of MMAs whom we have in place here is appropriate?

160. **Mr Brogan**: The report describes how we deploy MMAs. We have roughly 25 practices per MMA, and they go to each general practice on an ongoing basis, provide detailed information, look at the outlying behaviour, identify how we address that and develop action plans. That number came from an Audit Scotland report a number of years ago, and one issue identified was how we enable practices to make changes. In Scottish general practice, GPs have some pharmacist time to help them to make the changes. We are keen to explore with GPs the commissioning of additional prescribing support through pharmacists being embedded in practices. Mark mentioned — it has come up — having a pharmacist in the room with the general practitioner and the patient. It is not quite the same. It is embedded in the practice staff to support and enable the change, deal with the issues of managing patients moving from one drug to another, look at reviews and so on. That is work in progress. I accept the point that has been raised in the Audit Office report. It identifies that we probably need to do more, but that needs to done in a context —

161. **The Chairperson (Ms Boyle)**: Do you think that more MMAs are needed?

162. **Mr Pengelly**: Chair, it is a resounding yes to the substance behind your point. GPs need more support for their prescribing behaviour, but the only slight reservation we have is that we are still not sure — we are doing work on it — whether the right place for that is through MMAs employed in the board who review the performance of GPs or through pharmacists employed directly by GP surgeries. If you speak to the likes of Tom Black from the BMA, he will say that the association is very enthusiastic about the GP federation model, and part of its plans for that, I understand, will be that each federation employs at least one pharmacist to support the GPs in that area. We are doing that, but we absolutely agree with you on the need for more support.

163. **Mr Dallat**: Is there a thought that generic drugs have somehow become rebranded and are no longer the tea and the sugar and the tea out of the big container but, in fact, have taken on their own advertising and promotion?

164. **Mr Pengelly**: Sorry, I am not sure that I follow your question.

165. **Mr Dallat**: I take this seriously, and I brought along this heartburn thing. Omeprazole is £2·27 and is prescribed all over the place at £17. There are different packages for the product. Have you unwittingly got yourselves back into the marketing situation that generic drugs were supposed to take us out of?

166. **Mr Pengelly**: No. With the comparison of £17, I think that it is a different drug.

167. **Mr Brogan**: It is a different drug.

168. **Mr Dallat**: There is a liquid version of this one, which your GPs are prescribing at £10. Does a better class of patient get the £10 one?

169. **Mr Pengelly**: As I understand it, stroke victims' capacity to swallow can be severely constrained, so they cannot take tablets, which is why GPs routinely prescribe the liquid form of tablet.

170. **Mr Dallat**: If that is the case, I accept that. Are you sure that that is right?

171. **Mr Pengelly**: I am advised by clinicians that that is the case.

172. **Mr Brogan**: With liquid preparations, the vast majority of medicines available in tablet or capsule form will be swallowed normally. Some individuals will have difficulties in swallowing.

173. **Mr Dallat**: I am striving to get to the bottom of why the average amount of money spent on drugs varies so widely from area to area and from health centre to health centre. I will certainly put in a plug for my own and say that you will not get one extra tablet in Kilrea — not for love nor money — if you are not entitled to it, but that clearly does not apply across the board. The report, which I believe that we are supposed to take

seriously, is riddled with many questions that have not been answered.

174. **Mr Pengelly**: We agree with that, Mr Dallat. In terms of variability, I think that you are referring to the graph on page 43, which shows the average cost per thousand prescribing units. There are a couple of very interesting things about that. This is 2013; if you looked at the same graph for 2010, you would see that, instead of the mean being £41,004, at that stage it was 14% higher. In three years, therefore, we have reduced the mean and significantly reduced the level of variability between practices. However, the graph shows us that there is still differential prescribing. If you take the mean point as the middle of the graph, it is easy to focus all our energy and attention on those practices on the right-hand side of the graph, which have a higher than average cost. I think that we should be equally concerned about those GP practices on the left-hand side, because we need to ask whether their prescribing is clinically effective. It is at a lower cost, but we must always balance cost with clinical effectiveness not only because of the obvious impact that that has on the individuals being treated but because it can lead to some very significant secondary care costs if we do not treat issues properly and appropriately first time in primary care. We need, therefore, to look at both sides, and we continue to work on that.

175. The paper that we promised to bring to you, Chair, will show that we examine, as a matter of routine, any practice that is more than two standard deviations away from the mean point, so there is a focus on anyone who is not quite close to the mean figure. As I said, we will set out all the other areas that we look at. Variability is an issue that we look at.

176. **Mr Dallat**: Chairperson, I am trying to get my head round this. Is Mr Pengelly suggesting that the people who are registered with a practice where the average spend per head is £26,303 are in pain and dying earlier or are in some way more disadvantaged than those who happen to be registered at the practice that is spending £55,501 per head of population?

177. **Mr Pengelly**: I hope that I am not suggesting anything, Mr Dallat. I am saying that, if we examine GP prescribing behaviour, we must look at both cost and quality. I am saying that it would be inappropriate just to look at everyone on the right-hand side of the mean point and say that their costs were too high and that they needed to be reduced. When costs are high, they need to be reduced, but we also want to make sure that prescribing is clinically effective. Sometimes that means that the discussion between an MMA and a GP may be, "You have used drug x at a cost of £3, and, in the circumstances, maybe drug y at £15 would have been more clinically appropriate and would have prevented the patient ultimately needing to be referred on to secondary care".

178. **Mr Girvan**: Are GPs made aware of the variance of drug costs?

179. **Mr Pengelly**: Yes.

180. **Mr Brogan**: Every month.

181. **Mr Girvan**: In what form do they receive that information?

182. **Mr Brogan**: This is the quarterly statement from COMPASS. It is very detailed and has lots of indicators. We provide a monthly statement of the cost. We allocate an indicative budget to every general practitioner. Roughly, we say that an average GP practice will indicatively have £1 million for a prescribing budget. We do not actually give them the cash. We give them the indicative budget, and then we measure their performance monthly on the budget spend. If there are issues of variance at the end of each month, our adviser will be on the phone. Equally, the practice manager will be on the phone to our adviser saying, "What have we done? What can we do right, and how do we move on?"

183. **Mr Girvan**: Does that not lead into the point that Trevor made? You go in with a chest problem, for example, and the first prescription that they give you is a certain strength of Amoxil. You finish

that course and go back in a week's time to find that your chest problem has not improved. All of a sudden, the GP suggests trying doxycycline, which is fairly strong, as a second prescription, and you end up taking it. That is the cost of two drugs, whereas it should have been knocked on the head the first time with a proper good strong antibiotic. If the doctor sounds your chest and finds that you have a fairly nasty infection that needs to be dealt with, he prescribes amoxycillin. Probably half the infections out there are immune to it, because it has been prescribed so often.

184. **Mr Pengelly**: That is fundamentally an issue of the clinical quality of the behaviour of the GP. It is not an issue about how we control the prescribing budget. At the end of the day —

185. **Mr Girvan**: That comes back to the manager.

186. **Mr Pengelly**: It does, but we dispense the cost of the drugs prescribed by general practitioners based on their experience and clinical judgement.

187. **Mr Girvan**: How many GPs read about the cost of the drug to them?

188. **Mr Brogan**: Every general practitioner will be expected to read and acknowledge the COMPASS report, because we meet general practitioners annually and go through the COMPASS report in detail.

189. I will come back to your example, and I cannot help myself. You mentioned Amoxil, but we say that amoxycillin is the generic. That is the one you would go for first if it was clinically appropriate. In Castlederg, for instance — this is not to deride Castlederg — the antibiotic prescribing frequency is somewhat higher. If I were to speak to Brendan O'Hare, I would say, "This is a healthy adult with a chest infection, just leave them alone". The GP gives advice to the patient, and, if they come back and it is clinically significant, then it would be amoxycillin. Then they would be left alone, and then perhaps another one. There is a step-wise progression, and we produce clinical guidelines, offer support and give advice to general practitioners. We give advice on information for patients on looking after themselves and avoiding the need for antibiotics, because antibiotic resistance is a wider issue.

190. **Dr Timoney**: There are regional guidelines for antibiotic prescribing, and the report indicates how well that practice is identified. The indicators in that practice have been agreed with the BMA as good or poor prescribing, or necessary volume.

191. **The Chairperson (Ms Boyle)**: We talked among ourselves about scores on the doors, which councils do for health ratings for takeaways and so on. It would be in GPs' best interests to have that on their doors to show that the practice is highly efficient in what it is prescribing.

192. **Mr Pengelly**: Would patients naturally gravitate towards a more expensive GP? I do not know.

193. **The Chairperson (Ms Boyle)**: I do not know. I am not the expert, but I do not think so.

194. **Mr Pengelly**: If we could come up with a score like the council score for catering establishments that combined cost and quality, we would be comfortable with putting that into the public domain.

195. **Mr Brogan**: We put all information on prescribing by general practitioners on the Business Services Organisation website. There is a lot of data to work through, but it is important that we put it up there.

196. **The Chairperson (Ms Boyle)**: Mr Girvan mentioned this — I do not know whether it is myth or fact — but it is in the public domain that GPs maybe have allegiances to some pharmaceutical companies, and that would help to dispel those myths.

197. **Mr Clarke**: I am wondering about the trend. I am looking at page 16 again — I am not trying to tramp on anybody's foot — but is part of the problem, Richard, the very fact that we have free prescriptions? There is obviously a cost to free prescriptions. Is the cost

the prescription or is it handing in the prescription?

198. **Mr Pengelly**: The interesting point is that the number of prescription items per person in Wales is higher than in Northern Ireland. I think that there is a graph that shows that. Since the introduction of free prescriptions in Northern Ireland, our volume has gone up by 5%, but our cost has come down 7%.

199. **Mr Clarke**: That is good.

200. **Mr Pengelly**: We cannot attribute our position to free prescriptions. Even if you look at the trend, England is the only part of the UK that continues with prescription charges. There is no fundamental difference in patterns in trend lines between England, Scotland, Wales and Northern Ireland.

201. **Mr Clarke**: I was just curious about the cost and the patterns of prescribing.

202. **The Chairperson (Ms Boyle)**: We will move on because I am conscious of the time. We have Mr Flanagan next.

203. **Mr Flanagan**: I thought that we were still on Trevor. I did not think that he had even started his questions.

204. **Mr Clarke**: I filtered mine in.

205. **Mr Flanagan**: That is good team work. With reference to paragraph 4.8, when you take account of population factors such as age and social deprivation, the data on prescribing units shows a wide range of variation in the costs of different practices, as we discussed. The Audit Office used your information to estimate the scope for generating savings. At paragraph 4.11, it calculated that £54 million could be saved. Paragraph 4.10 states that the prescribing unit:

"system normalises prescribing data to enable a more balanced comparison within prescribing".

206. Will you outline what NI PUs are and what they can be used for, given that you appear to disagree with their use in this context in your response to the report?

207. **Mr Pengelly**: To be clear: I do not disagree with the use of PUs for that important analysis. The bit that I am uncomfortable with is saying that, in any data series in which points run from low to high, if you strike the arithmetical average and if everyone above it constrains themselves to the average, you will save money. To me, that is a statement of mathematics rather than an evidence-based statement about how we effect savings in the prescribing budget. My issue is that, if you do that once, your average moves down, so you continue to do it because everything will then tend to zero. The logical consequence of that argument is that prescribing costs should be zero. We do not disagree with the use of the prescribing unit. I think that it is a very useful piece of analysis. Prescribing units, rather than just going on a pure per capita basis —

208. **Mr Girvan**: You believe in logic.

209. **Mr Pengelly**: Yes. I am an accountant.

210. **Mr Girvan**: Exactly.

211. **Mr Pengelly**: It is recognising that different cohorts of the population require differential levels of prescribing — for example, the very young and the very elderly. It is about trying to give a weighted adjustment. We could get a much more sophisticated explanation, but it is about trying to reflect the prescribing needs of the population rather than just being a numbers game.

212. **Mr Brogan**: An individual over the age of 65, for example, will be expected to consume considerably more medicines than somebody under 65. So, there is an age/sex curve. As you grow older, you will consume more medicines. The female population uses more medicine in a younger age group than males and then gradually catches up.

213. **Mr Flanagan**: What does "younger" mean?

214. **Mr Brogan**: There is a 10-year differential. You will see an age/sex curve, and we can provide that to the Committee. As females grow older, once

they hit 35 or 40, they start to use more medicines than males.

215. **Mr Flanagan**: At that stage of their life, some of them might have been through an awful lot.

216. **The Chairperson (Ms Boyle)**: I declare that I am not on any medication.

217. **Mr Pengelly**: We are absolutely not offering a critique or a validation; we are just saying that the empirical evidence is that that group of the population consumes more medicines —

218. **Mr Brogan**: — at a particular age line. You can see the parallels. We try to standardise populations so that, if you have predominantly more younger females or younger males in the population, you can start to compare practices with other practices. So we can flatten out the differences in population up to a point. It is important to remember that it is only up to a point. A needs index is also built into this, which looks at deprivation and other measures of social deprivation. That is really important because of the health outcomes linked to social deprivation.

219. **Mr Flanagan**: So you are happy enough to use the prescribing unit data to compare practice with practice, but paragraph 4.11 states that the estimated savings of £54 million is crude. What is the logic behind that?

220. **Mr Pengelly**: It is saying that, if you reduce your cost by £54 million, you will save £54 million.

221. **Mr Flanagan**: That is a good enough statement for an accountant, is it not?

222. **Mr Pengelly**: I cannot argue with its factual accuracy, but I am not sure about the scope to save £54 million, because, if you reduce any number by an amount, you will save that amount. The suggestion clearly is that we should be saving £54 million. We want to look at the evidence of prescribing behaviour in GP surgeries as the basis for saving. If we can drive that saving beyond £54 million, of course we will want to do that, but this is not a statement on what we feel is readily achievable. It is just a statement of mathematics.

223. **Mr Flanagan**: You say that you want to look at it. Will you do that?

224. **Mr Pengelly**: We have spent some time on it. We look at what GPs do every month, and detailed reports are provided to them. That has been happening for some time.

225. **Mr Flanagan**: Paragraph 4.11 states that the estimate does not take into account other factors such as access to other services, the impact of cross-border services, private health care and things like that. You say that you do not accept the figure of £54 million without further robust analysis. So what steps will you take to undertake further analysis to build on that work? What are you doing? You cannot simply say, "We do not accept your figure". You come up with a figure then.

226. **Mr Pengelly**: This is a generic analysis based on weighted prescribing units to try to get a like-for-like comparison so that it will red-flag any areas where we feel that prescribing patterns are out of the norm. It will be people who are more than two standard deviations above the mean or areas where there are particular patterns. We do that on an actual basis. This is flagging up statistically where you might want to focus attention. We are focusing attention on every single GP practice in Northern Ireland. We are saying that, for this to be valid, you will need to invest more time and energy. We think that a separate piece of work that we are doing is of more value and gives us a better insight into —

227. **Mr Flanagan**: What useful work are you doing to see how much savings can be made?

228. **Mr Pengelly**: We are not trying to quantify how much savings can be made. We are trying to drive the cost down to its lowest possible level. We simply do not know. The drug bill will always fluctuate considerably, because people contract illnesses. There is a whole host of reasons, and you will

never get stability. However, we need to make sure that we educate and work with our GPs so that, every time that they are faced with a prescribing decision, they make something that is clinically appropriate and financially responsible.

229. **Mr Flanagan**: How much are you trying to do on preventative health-care policy? How much of the £100 million that was spent last year on antidepressants could have been sorted out if access to counselling services was far easier, and you did not have to wait nine months to get it?

230. **Mr Brogan**: I will give an example of what we have tried to do. We have generated prescribing efficiencies and real cash savings. Last year, we managed to reinvest additional money into Belfast £1·4 million. It is now investing that into primary care talking therapies and primary care hubs, and it has just initiated that process. We are trying to reduce the amount spent on antidepressants. If you look at the numbers, you will ask why we are investing there. We have to invest in counselling and psychological therapies absolutely but we do not have a limitless supply of funding, so we have to reduce on the antidepressant side and reinvest whatever efficiencies we have into those sorts of services.

231. **Mr Flanagan**: The expenditure on antidepressants is not going down, because GPs realise that there are lengthy waiting times to see a counsellor. They have no option, therefore, other than to give a patient antidepressants, even though neither the patient nor the doctor wants them.

232. **Mr Brogan**: We have yielded out efficiencies and other elements of the prescribing budget to invest in that area. In the Belfast local commissioning group, we expect to see a shift in activity on antidepressants and patients getting the benefit of talking therapies.

233. **Mr Pengelly**: Your point is well made, and it is absolutely correct. Again, when it comes to a comparison between Northern Ireland and other regions, particularly in mental health and pain management, there are two areas in which GPs have said that their understanding is that a similar GP in some part of GB has the option to refer a patient to another clinic for some counselling rather than a medical intervention. GPs feel that that option is not open to them here, because the waiting time to access it is so long that they have no choice but to prescribe. That is a component of our higher cost. It is also a simple factor of the financial pressure; we cannot offer every type of clinic and immediate access to those clinics. That is the balancing act that we are trying to drive forward.

234. **Mr Flanagan**: If we are serious about tackling the high cost of primary care prescribing, it is not simply talking about generic drugs. We need to sort out the fact that people in the Western Trust area have to wait nearly two years for a hip operation and nine months for basic counselling services. Those things have a knock-on effect on the amount of medication that GPs have to prescribe needlessly, when there is a solution that people should have access to.

235. **Mr Pengelly**: Absolutely. The issue of investment goes beyond primary care; it goes well into secondary care. The sort of interventions that you talked about through the Public Health Agency and health promotion can make a very significant contribution to the generality of health. However, the specific point is that quicker access to secondary care can take people off medication more quickly.

236. **Mr Flanagan**: Have you done any economic modelling that looks at how investment in counselling services would have a knock-in effect on reduced expenditure on antidepressants?

237. **Mr Brogan**: We have. As part of that Belfast LCG model, it has developed a business case to reinvest the funding into the psychological —

238. **Mr Flanagan**: I think that you said that you had expended £1·4 million on counselling services and things

like that. How much will that save on antidepressant prescribing?

239. **Mr Brogan**: I could not give you the figure. I would have to get the business case.

240. **Mr Flanagan**: There is a figure, but you do not have it.

241. **Mr Brogan**: There is an estimate about the impact, and that takes four or five years to run through. However, we can certainly get that information for you.

242. **Mr Flanagan**: Mark, do you agree that the Health and Social Care Board and the BSO need to undertake further work to compare and investigate the reasons for variations in prescribing units between GP practices to get to the bottom of this?

243. **Dr Timoney**: I think that they have gone a long way in getting to that analysis through the COMPASS reports that we discussed. There are absolutely clear comparisons between neighbouring GP practices in areas on a regional basis and at a high level on the range of prescribing indicators agreed with the BMA that we discussed — the levels of overprescribing, the examples of good prescribing and examples when prescribing is less than desirable. A lot of work has been done. It is about ensuring that appropriate clinical choices are made to make sure that patients' issues are addressed about the current prescription and how they can get the best treatment available to them cost-effectively on the basis of that analysis for an individual practice and its population.

244. **Mr Flanagan**: We are here to make sure that public money is spent wisely. Are you confident that there are no GPs compromised by their links with some pharmaceutical companies, or are you still fearful that that exists?

245. **Dr Timoney**: There are rules of engagement. The industry has come a long way in its responsible promotion of its material. I do not think that the risk is as high now as it was 10 years ago. The industry does deploy a lot of its resource in marketing, and that is bound to have an influence. Our medicines management advisers tell us that that influence is there. However, with our formulary, NICE guidance and various other guidance, there is ample evidence to counterbalance erroneous influence.

246. **Mr Flanagan**: How compliant are those in the primary-care sector now with the formulary list?

247. **Dr Timoney**: Compliance is at 83%.

248. **Mr Flanagan**: How does that compare with previous years? Is it increasing?

249. **Dr Timoney**: When we set the formulary we said that it would contain a list of drugs that were suitable for initiating and maintaining patients for 70% of the population. That allows a measure of clinical freedom for those patients who do not respond to first- and second-line choices. The doctor is then free clinically to decide to take another drug in place.

250. We felt that 70% would afford a margin of clinical freedom. However, when we analyse the implementation of the strategy, it tells us that 83% are compliant with those first- and second-line choices.

251. **Mr Flanagan**: Have you any idea how that compares with secondary-care prescribing?

252. **Dr Timoney**: Secondary-care patients are of a different nature. They probably find themselves in secondary care because the first and second choices afforded to manage their condition may, in some cases, not have worked. Although the same formulary and list of drugs apply, compliance may be somewhat less. We address the formulary with secondary-care clinicians and ensure that they take it into account.

253. **Mr Flanagan**: Is the figure lower, or do you not know?

254. **Dr Timoney**: I have not seen an analysis of the secondary-care figures.

255. **Mr Flanagan**: Richard, I want to draw your attention to the PEDU review in December 2011. You will be well aware

of it. It critically assessed the plans of the Department of Health to deliver savings, drawing on the findings of the McKinsey and Appleby reviews, as well as the application of best practice from Britain.

256. The review acknowledged the McKinsey calculation on prescription and prescribing savings. Michaela calculated that there is about a 40% gap in costs between here and England. My understanding is that the PEDU review concluded that there may need to be a monetary approach to prescribing protocols and generic prescribing if the overall cost with England does not narrow.

257. Now that you are in this role compared with your previous one, what steps do you intend to take to meet the expectations set by PEDU?

258. **Mr Pengelly**: The PEDU report reviewed the McKinsey work. McKinsey, I think, identified potential savings in primary-care prescribing of between £148 million and £177 million if Northern Ireland was able to move to the top-of-class English performance. That was a valid approach for the McKinsey review, which was trying to set an aspirational target to save money in Northern Ireland.

259. We need to recognise that top-of-class performance in England terms is never practically achievable across Northern Ireland; prescribing patterns in the affluent south-east of England will never be achievable. That said, they set a figure of £148 million to £177 million. Since 2010, we have delivered savings of £132 million. Allowing for the differential of not achieving top-of-class performance, the Department has delivered well against a very aspirational target.

260. In moving forward with things like mandatory formulae, those discussions have, coincidentally, started in the Department since my arrival, as Mark reminds me, so it is an issue that we want to pursue. The point is that I have not left behind that exposure to some of these issues that I encountered when in PEDU.

261. **Mr Flanagan**: Has the overall cost gap with England narrowed significantly since this review?

262. **Mr Pengelly**: It has narrowed. As for "significantly", the table at the front still shows quite a significant gap.

263. **Dr Timoney**: Cost per head is at a 5% reduction rate in Northern Ireland and 3·5% in England, whereas cost per item is reducing in Northern Ireland at 10% and the English rate is reducing at about 8·5%. We are, as I said, moving faster.

264. **Mr Pengelly**: However, not as fast as we want.

265. **Mr Flanagan**: So, are we looking at cost per item or cost per head?

266. **Dr Timoney**: It was to offer two measures of performance.

267. **Mr Flanagan**: When we are talking about the potential introduction of a mandatory approach to protocols and generic prescribing, are we talking about cost per item or cost per head?

268. **Mr Pengelly**: It would influence both. They are two subtly different measures of the same broad performance.

269. **Dr Timoney**: We use two measures. One is cost and one is volume. You try to attract the volume on one hand and you try to get the best safety nets, given other quality and safety factors.

270. **Mr Flanagan**: Can you tell us what progress has been made on the initiatives outlined in the McKinsey review?

271. **Mr Pengelly**: The McKinsey review largely set an envelope for what could be achieved if we moved towards performance in England. The £132 million that has been saved has been through prescribing, particularly since 2010, the responsibility transferred to Joe's area in the board. There is a huge amount of detail in the initiatives. Joe, do you have a couple of headline points on that?

272. **Mr Brogan**: I am trying to recall. I was trying to dig into the McKinsey review. It highlighted some therapeutic areas,

and we have made some progress, albeit we accept that we have more progress to make. McKinsey also talks about procurement efficiencies. We have attempted to do more procurement in primary and secondary care, and efficiencies have come out of that. The general point is that we have done some things; we have yielded efficiencies of £132 million. We have more to do and we accept that.

273. Part 1 of the Audit Office report talks about English hospital prescribing, which came up earlier. It is important to look at the entire system. If you add English hospital prescribing to English primary-care prescribing and then compare with Northern Ireland, there is not a lot of difference when you add in the two elements of our care. So, it is important to consider all that in the round but accept that there is more to do to get the efficiencies that we need.

274. **Dr Timoney**: McKinsey pointed out that, in 2010-11, there had been significant work done in Northern Ireland to achieve those efficiencies. As a result, the Department's response to McKinsey was to drive the 2010-11 targets higher. In fact, we tried to achieve in the comprehensive spending review period in one year what we set out to achieve for the whole three-year period. That was at the point when the work transferred to the board, and that formed the basis of the board's efficiency plan. Those efficiencies have been achieved to the extent that Mr Pengelly has pointed out, which is in the region of £132 million over those three years.

275. **Mr Brogan**: I am sorry, can I come back to you, Mr Flanagan? I have just pulled up the McKinsey report so that I can refresh my memory. We set a prescribing efficiency target annually, and we manage that through a prescribing multidisciplinary efficiency review team of accountants, who are very important to us, doctors and pharmacists. We review 25 projects in all different types of therapeutic areas.

276. **Mr Flanagan**: What about the patients? Do you talk to them at all?

277. **Mr Brogan**: We do. If we identify that there is a potential for efficiency, we engage with patient groups to understand —

278. **Mr Flanagan**: So, patients are an afterthought?

279. **Mr Brogan**: No. First, we have to scope out what is potential and, as we develop our plans, we will engage with patients to understand whether it is a reasonable thing to do and how would we manage that, fully aware of the changes that we would be expecting to make with patients.

280. **Mr Flanagan**: Mark, my final question is for you, and it relates to the drive for value for money and efficiency through the prescribing of generic medication. I am concerned that one of the results of that is that when people are regularly prescribed antidepressant medication, they go to the doctor for a repeat prescription, and every time they go to the chemist to pick up the medication, they are given a different brand of generic medication. The side effects change every time, which means that somebody with mental-health problems or suicidal ideations is being given a different type of medication with a different coating on it, which causes different side effects every time they get a new prescription. As part of the drive to save money, what are you doing to ensure that patients are not being negatively impacted because of the change in their medication?

281. **Dr Timoney**: We recognise that medicines optimisation is key to our work over the next numbers of years; that is why we are launching a medicines optimisation quality framework at the start of the new year to look at the patient experience through their medicines review and to address quality, safety and the patient experience. We want to make more use of our pharmacists' clinical skills and the time that they take when dispensing to reassure patients that the drug is equivalent so that, when the patient experiences a problem with the drugs, they can discuss the side effects

with them to ensure that there is no detrimental effect.

282. **Mr Flanagan**: If a doctor is prescribing medication that is the exact same as the branded product, why does the same pharmacy give out a different brand of unbranded medication every time?

283. **Dr Timoney**: Because that is how they procure medicine. They are free to procure medicines from whatever source —

284. **Mr Flanagan**: Does it make sense?

285. **Mr Pengelly**: The alternative is that we only prescribe branded medicine and quadruple our cost.

286. **Mr Flanagan**: The alternative is that a pharmacy has an agreement that it keeps the same brand of non-branded medication, particularly for antidepressants and for people who have suicidal ideations.

287. **Mr Pengelly**: The concept behind the move from branded to generic — the point was made earlier by one or two members — is that branded and generic drugs are chemically identical. We acknowledge that, in some very limited cases, there can be a limited therapeutic index that can cause difficulties, but the concept is that they are the same. So, let the market deliver generic drugs at the cheapest possible price so that the chemical compound is delivered in an effective but financially responsible way. We could turn that on its head — that is doable — but it would drive significant cost growth with, I suspect, pretty limited clinical effectiveness. There are issues about making sure that people put their hand up. One of the reasons that we will give separate money to pharmacists is that people should acknowledge that their pharmacist is an expert source of advice.

288. **Mr Flanagan**: In some of the stories that I have read, Richard, it is too late for people to put their hands up because they are dead because their antidepressant has been changed repeatedly every month and they have gone through the side effects every month and cannot cope and kill themselves. That is what is going on. I do not know whether you are aware of it or not, but that is happening with generic antidepressants because people's medication is being changed every month.

289. **Mr Pengelly**: We obviously do not know the detail of individual cases. However, I have heard from professionals that the instances where different types of a generic formulation would have a meaningful impact are exceptionally limited.

290. **Mr Brogan**: If there are instances, we would certainly be interested to follow up on them. The generality is that community pharmacies will stick with whatever is available through their named wholesaler. There is a commercial arrangement on what generic medicines they will buy in at any given time. Largely, they will try to stay to the same one, but we have no control because that is a market issue. So, inevitably there will be changes. If there are changes, particularly where individuals have particular needs, we have asked pharmacists to talk to the patient from a professional perspective about the change so that they manage that. If that has not occurred, I will be interested to find out and understand what has happened because, ultimately, we want to make sure that patients get the right medicines and consume them appropriately. If we do not achieve that, it does not really matter whether we are prescribing branded or generic. We need to keep patients well.

291. **Mr Flanagan**: I am happy to follow that up with you if you are happy to hear that. Thanks.

292. **Mr Beggs**: Thanks for the information to date. I hope to draw some more information out so that we can improve our system. I would like to focus on the drug Pregabalin, which I understand, based on the cumulative amount, is the most expensive drug prescribed by GPs and cost some £17 million in 2013. Hopefully, in looking at how you have managed it and looking at the record, we can see how effective the process has been. Figure 25 in the Audit Office

report shows a steep rise in the volume of Pregabalin prescribed in Northern Ireland, from about 140,000 items to 250,000 items in a four-year period. It did not quite double in quantity. Can you explain the dramatic increase in the prescribing of that drug?

293. **Mr Brogan**: There are three licence indications for Pregabalin. One is neuropathic pain, and that is largely the volume that we are related to here. Neuropathic pain is a specific type of pain. Diabetic patients who have had an amputation get neuropathic pain. You have a particular nerve pain. It is also licensed in two other indications — epilepsy and generalised anxiety disorder. Largely, the rise is to do with pain and dealing with intractable pain issues. In 2010, NICE issued clinical guidelines saying that Pregabalin is a very good, clinically effective, useful intervention. There are other drugs, including Amitriptyline, which is unlicensed. It is an old — I use that word advisedly — antidepressant, but it has been used for that kind of pain disorder.

294. In the past, GPs would have used Amitriptyline as their default drug, but it is unlicensed; it also has a negative effect, particularly on older people who have cardiac problems. Therefore, GPs have tended to use a mixture; they will still use Amitriptyline, but they have used Pregabalin more so . With neuropathic and intractable pain, they will also seek advice from specialist pain clinicians. Indeed, we have seen that much of the rise is due to the fact that pain specialists in secondary care have used that drug and welcome it. There are another couple of drugs that are used as well: Gabapentin and Duloxetine. Those are the four main drugs used in that field.

295. We are quite happy that the Audit Office identified that particular area. We do think that we are probably using too much of that particular drug, but we also know that the other drugs that are used in that condition area — Amitriptyline and Gabapentin — are not used to the same level as other parts of the UK. Therefore, there is a bit of an issue —

296. **Mr Beggs**: Are they used to a higher or lower level?

297. **Mr Brogan**: Scotland, for example, will use maybe two or three times as much Gabapentin as Northern Ireland. Therefore, there is something about the mix and the clinical decision-making around whether you use Pregabalin, Gabapentin, Amitriptyline or Duloxetine. Having said all that, and looking at the numbers and the potential for efficiencies, I think that we probably use too much. With regard to the interventions that we have tried to develop to deal with that, the issue that we are talking about is intractable pain, so we have to develop services and alternatives to manage that, such as Mr Flanagan talked about earlier — psychosocial support in managing chronic intractable pain. We have developed a toolkit in conjunction with pain specialists, particularly in the South Eastern Trust, that is really helpful for patients. We are trying to advise that, yes, they may need medicine, but that there are other means of trying to manage intractable neuropathic pain.

298. **Mr Beggs**: Richard, have you looked at the cost of all that medication as opposed to the cost of providing additional methods of treatment and avoiding medication? Have you looked at the cost savings that could be made by providing appropriate services to counselling and support in different mechanisms?

299. **Mr Pengelly**: That will be looked at in the board as part of its commissioning role. GPs regularly say that one of the reasons why they are accused of over-prescribing — to use that phrase — is because of the lack of availability of some pain clinics. Earlier this year, the Patient Client Council produced a report, 'The Painful Truth', where it interviewed patients who were suffering chronic pain. One of its findings was that the view of patients was that sometimes GPs were too quick to prescribe rather than explore alternative interventions. There is a combination of factors, but those costs are explored by the

board and evaluated as part of the commissioning decision.

300. **Mr Beggs**: I am getting confused. Joe said that the pain clinics were prescribing this and that that was the cause of the rise. Can we have clarity: is it the GPs or is it the pain clinics that are prescribing specialist drugs? In one sense, we have the permanent secretary saying that GPs indicate that they are prescribing them due to the lack of pain clinics to provide alternatives, and then we have a representative of the board telling us that they are being prescribed by the pain clinics. Can you clarify what is going on?

301. **Mr Pengelly**: Sorry, we are both saying exactly the same thing. The point that Joe was making goes back the point about the influence of secondary care on primary care prescribing. The patient suffering chronic pain in a secondary-care environment will tend to be prescribed this very expensive drug. That influences primary-care behaviour.

302. Pain clinics are part of secondary care; they not part of the primary-care prescribing issue that we are looking at in this narrow context.

303. **Mr Brogan**: I will give you a little more detail, Mr Beggs, if you bear with me. We do audits in primary care and in hospital land looking at the primary prescriber of Pregabalin. That was done in the South Eastern Health and Social Care Trust are. That showed a 60:40 split, so 40% of initiations were GP land and 60% in secondary care. That has changed over the years as GPs have got more used to that drug.

304. It is a bit of both and, coming back to your point, it is important to look at whether there are alternatives. We have had some success in providing alternatives to patients. Having said that, there will always be a need for medicines to deal with some of these issues.

305. **Mr Beggs**: Again looking at this almost doubling in four years, during that period NICE originally recommended Pregabalin at a first-line treatment. It then withdrew the early guidance and advised that it was one of three drugs for treatment, so it almost doubled despite the removal of the NICE guidance and a clear indication that there were three drugs. Has the new guidance got down to the coalface?

306. **Mr Brogan**: What we do with NICE guidance, where it is appropriate to do so, is develop an implementation tool. Following the first NICE guidance in 2010, there was NICE guidance in 2006 or 2007 for diabetes because that dealt with the neuropathic pain. That guidance mentioned Pregabalin. One could argue that our GPs and specialists used the first NICE guidance some years before that and started to use Pregabalin earlier.

307. In 2010, the key guidance came out. We looked at it and started to inform GPs that there were alternatives and to use Pregabalin judiciously. When the new guidance came out, we redeveloped our guidance to GPs working with secondary and primary care so that, alongside our formulary, they were singing off the same hymn sheet, as it were, so that we are completely clear about the right treatment modalities, what we would expect a GP to do in particular situations, and then how we refer on to secondary care.

308. **Mr Beggs**: Have the alternatives also doubled during this period?

309. **Mr Brogan**: No.

310. **Mr Beggs**: Essentially, they are not listening to what you are telling them.

311. **Mr Brogan**: The doubling of Pregabalin is in the number of prescriptions. The cost per head moved from £8·20 or so to £9·43. The number of prescriptions may have gone up because we asked GPs to reduce the number of items on them. Instead of prescribing 56 days, move to 28 days. That will increase the number of prescriptions, and that might be because they want to see the patient more frequently.

312. **Mr Beggs**: The cumulative cost at figure 26 shows that the equivalent of £9·43 for every person in Northern Ireland

has been spent on this drug. That is almost £10 per head of population, yet in England, Scotland and Wales it is less than half that. Does that not sound alarm bells?

313. We were told earlier about monthly reports with any movement off standard deviation and that there is analysis. We are way off the mark compared to other parts of the United Kingdom. What is happening? What are they doing wrong or what are we doing wrong?

314. **Mr Pengelly**: There is a sense that we are doing something wrong; the issue is about the extent of it. This is a perfect illustration of the debate that we had earlier with Mr Girvan. We get the detailed reports, which are subject to dialogue between MMAs and GPs. The reality is that, in many cases, prescription of this drug at primary care is the appropriate clinical intervention. The difficulty is, as part of that dialogue, finding out those cases where it is not the appropriate intervention, and there are cases. However, that is a constant process of dialogue.

315. You mentioned a specific focus on the number of times that this is prescribed, so it is part of that debate with each of the practices where this is happening. I share the Committee's frustration that we cannot make more rapid progress in bringing the cost down, but it has to be driven by that dialogue.

316. **Mr Beggs**: Given its higher cost per person and greater use here, is there any particular underlying health issue with epilepsy, general anxiety or neuropathic pain in Northern Ireland compared to other parts? Is there a medical issue with the population that is more common and has resulted in the increased prescribing of the drug?

317. **Mr Brogan**: There is a general need. I cannot not give you any evidence around what the difference is in Northern Ireland. Essentially, you are asking whether there is a difference in need with this specific issue across the four countries. I cannot give you that comparison.

318. **Mr Pengelly**: The general articulation of needs differences between Northern Ireland and the UK would not explain the differential. There are accepted higher levels of need. I think that Appleby talked about 9%; the National Audit Office report, which used Deloitte, talked about it being as high as 26%. That would not explain the degree of variability with other parts of the UK.

319. **Mr Beggs**: When I look at figure 10, that is my impression. Your quality outcomes framework (QOF) figures indicate in the areas mentioned that we are only very slightly out of kilter with other parts of the United Kingdom for levels of epilepsy and, perhaps, depression. Would it be about 0·3% of a difference as opposed to 100% of a difference?

320. **Mr Pengelly**: This issue has shown the specific disease prevalence, but it is like anything: the devil is in the detail. This high-level summary masks that.

321. **Mr Brogan**: This is QOF data. QOF is developed, essentially, as a payment tool for GPs. There are a number of disease registers that we contract GPs to maintain. They are listed, and that is fine; it shows the overall incidence. The Audit Office report has taken the Northern Ireland numbers and compared them with the other UK countries. That is not necessarily the way to compare disease prevalence. We need to investigate it in a different way and to seek other data sources.

322. **Mr Beggs**: One of my colleagues will perhaps pursue the issue of QOF data later, so I will not delve into it. It has been estimated that if we had reduced our prescribing of that drug to UK levels, about £9·7 million could have been saved in 2013. Given that that drug costs our GPs the most to prescribe £17 million what actions have you taken to bring improvement in that area?

323. **Mr Pengelly**: The detail of the reports that we will send the Committee indicate that that is a key metric of GP behaviour. It is part of the dialogue. That will come to the Committee. Your time —

324. **Mr Beggs**: OK. I look forward to receiving them. What action do you take when a GP ignores all the data and information that you provide them?

325. **Mr Brogan**: The contract gives us a vehicle whereby a GP or practice is deemed to be excessively prescribing, and we agreed with the BMA a definition of excessive prescribing. We have agreed seven indicators that demonstrate where there is excessiveness beyond the average. Again, it comes down to the control charts —

326. **Mr Beggs**: Will you provide us with those indicators?

327. **Mr Brogan**: We will provide you with all that. There is an accountability mechanism for the outliers.

328. Needless to say, it is outliers, so it is at the two to three standard deviations and beyond. We are talking about the minority of practices that we identify as potentially excessive. Our requirement is for them to move towards the mean, where there is a little bit of variation.

329. **Mr Beggs**: I see that you have given yourself a target of reducing costs by £1 million as opposed to the £9·7 million. Is that challenging enough?

330. **Mr Brogan**: I accept that. We will produce the history of the past four years and our attempts to try to develop and get efficiencies out of this area. Unfortunately, the current programme shows that we are not necessarily going to achieve that £1 million target, but we will continue to progress against that towards the end of the year.

331. **Mr Beggs**: My local minor injuries unit has closed down over hundreds of thousands of pounds, yet this area could save millions of pounds. If you are not even going to hit your £1 million target, does that not tell you that there is something wrong with our system and that we need to do something more fundamental?

332. **Mr Pengelly**: I think it is telling us that it is not merely a case of wishing our problems away on this. We have identified by this high-level analysis, potentially, the scope for making savings. You only effect those savings by making individual changes at the point of prescription. That is fundamentally about education. Moving to the point where we pre-approve every prescription is not realistic, so we have to continually highlight prescribing patterns that are outwith the norm and educate GPs about alternative interventions, alternative drugs and what options might be available to them to squeeze this down. We work continually with them to do that. We want to make more rapid progress. I accept that the pace that we are moving at is frustrating, but we cannot just flick a switch and capture these savings.

333. **Mr Beggs**: You are certain that we have all the tools that health authorities have in other parts of the United Kingdom? Is it just that we are not getting the message across?

334. **Mr Pengelly**: No. We acknowledged earlier, and the Chair raised with me, the need for additional pharmacy support for GPs. The issue is about whether that would be in the form of additional MMAs or additional pharmacists embedded within GPs. We need to do that, but that in itself brings a resourcing problem. That is an issue that we are looking at going forward into the 2015-16 financial year.

335. **Mr Beggs**: Is it a cost-effective resourcing problem that saves money?

336. **Mr Pengelly**: It is, but there is an issue. There are two tiers of challenge facing the health service —

337. **Mr Beggs**: Sorry, does this save money by investing —

338. **Mr Pengelly**: There are two tiers of challenge facing the health service: one is meeting statutory obligations about which we have no discretion, and the other is with discretionary funding and making it available on a prioritised basis. This would be a priority intervention. If we were able to secure unlimited funding from the Executive, this would unquestionably

be a priority intervention. However, it is a discretionary spend, and, at the moment, we are facing a significant challenge to continue to meet our statutory obligations.

339. **Mr Beggs**: I think one of my colleagues will delve further into that.

340. **The Chairperson (Ms Boyle)**: Following on from that, there are no sanctions for doctors who overprescribe, obviously. So, in reality, what can be done beyond the work that the MMAs do in educating GPs? Do you intend to look at what any other jurisdictions are doing?

341. **Mr Brogan**: We do look at the other jurisdictions, and we try to identify best practice and implement that in Northern Ireland. There is a sanction within the GMS contract. We can invoke the contract for that excessive prescribing element. Where there is no justification for that excessiveness, we can invoke the contract and, ultimately, we can remove the contract from the general practitioner.

342. **Mr Beggs**: How often have you invoked it?

343. **Mr Brogan**: It has been done very infrequently, but it has been done.

344. **Mr Beggs**: How often?

345. **Mr Brogan**: It has been done at least once in the past three years.

346. **Mr Rogers**: Gentlemen, you are welcome —

347. **Mr Girvan**: Sorry, before you move on, from 2000 to 2013 there was an increase in the prescribing of drugs by 70%.

348. **Mr Pengelly**: Yes, but since 2010 there has been an increase in prescription numbers by 5% but a decrease in cost by 7%, so there is a generality of better prescribing behaviour. The reality is that we have a growing population.

349. **Mr Girvan**: I am not talking about 7%; I am talking about a 70% increase in the number of prescriptions issued from 2000 to 2013.

350. **Mr Pengelly**: There are a number of factors there. We have a growing population.

351. **Mr Girvan**: We have not grown that much. We have gone from 1·68 million to 1·8 million.

352. **Mr Pengelly**: The point that Joe made is that, in many cases, to encourage better prescribing behaviour, GPs are being advised to prescribe shorter courses of treatment. That will have an influence. If I prescribe you a year's worth of drugs, that is one item on a prescription. If I break that down into 52 instalments so that you come back to me on a regular basis —

353. **Mr Girvan**: That is 52 prescriptions for the one.

354. **Mr Pengelly**: That is an extreme example.

355. **Mr Girvan**: I understand. What interrogation goes on into repeat prescriptions for somebody who ends up in hospital, and when the pharmacist in the hospital — you maybe have some experience of this — goes to check on the drug regime that the patient is on, he finds that they are on 24 tablets a day and does not know why they are on that? They might ask, "How long have you been on that?", and the patient might reply, "I have been on that for seven years on a repeat prescription". The pharmacist might say, "You should have only been on one course of that for a maximum of three months", yet they are in with a kidney problem caused by the medication that they have been on and are still on because they had been on it for seven years on a repeat prescription.

356. **Dr Timoney**: We have attempted to put a service in place over the years to look at and track that. We have integrated medicines management pharmacists, as they are described, who are picking up those patients coming out of hospitals, reconciling those medicines for their appropriateness when they arrive in the hospital, and ensuring that, during the patient's stay, medicines are changed and that those 24 medicines are reduced to an appropriate number —

357. **Mr Girvan**: Four, and the person said that they had never felt better in all their life.

358. **Dr Timoney**: Then, in advance of them being discharged from hospital, that information is communicated back to primary care so that, when the patient goes home, it stays with them. When that was tested and researched, it showed that there was a reduced length of stay in hospital and reduced readmission rates, that the medicine's appropriateness improved, and that every £1 invested in that service

359. **Mr Girvan**: If they had not appeared in through A&E, they would still have been receiving 24 tablets a day and would have been sitting like a zombie in their living room, unable to function in their daily life, while their GP was quite happy to dish that out to them.

360. **Mr Brogan**: Absolutely. We see cases all the time of patients being on medicines, and, when it comes to review, they did not actually need them or we could have optimised that. We want to learn from those experiences, and we have just commissioned pharmacist support in GP practices to undertake the medication review. Another element of that is particularly around care homes. Patients in a care home setting, who are usually old and have lots of medicines, need to have ongoing reviews. As part of our commissioning arrangements with GPs, we will ask the pharmacists to go into care homes to undertake the medication review, reduce the medicines that they do not need and optimise to make sure that they do not get the side effects but get the right treatment outcomes.

361. **The Chairperson (Ms Boyle)**: In my area, my own GP practice has changed its methodology in how you access repeat prescriptions. You can no longer just phone in and get your repeat prescription; you have to either go online or walk in and order your prescription. The facility to just phone up for a repeat prescription no longer exists. Is that across the board, or is it just down to the discretion of the GP practices? Is that maybe a way of trying to make savings, or is it a way of making sure that the quality and safety of things is done right? Has that been done by the board right across?

362. **Mr Pengelly**: There are two issues, Chair, and I will let Joe speak to the second one. The first issue is how you access a request for a repeat prescription; at the moment, that is particular to individual GP practices. One of the separate issues that I want to drive forward is that, across Northern Ireland, we can get that automated so that everyone has the ability to go online and order. That will reduce administrative costs in the GP practice and make it easier for people, because it can sometimes be difficult to get through to your practice when people are trying to access appointments. That is separate from the point about review and whether you can continue to call on a repeat prescription, which is the clinical point.

363. **Mr Brogan**: It is up the individual GP practice how it manages that repeat request line. Some have a telephone request, and it will be a number of hours. As you say, some will have the online facility, where it is appropriate to do so. For certain individuals it is great, but for others it may not necessarily be so. We advise GP practices that they have to listen to their patients in terms of what the needs are, but there ultimately needs to be scrutiny of the requirement. An individual may literally be on 20 different medicines. When a request comes in, we ask the practice — particularly the practice staff, who we do a lot of work with — to scrutinise the request. It is not simply saying, "I need all my repeat prescriptions"; it is, "Do I need medicine 1, 2, 3 and 4? Do I need that paracetamol? It's just when required. Do I need this particular tablet? I only use it now and again." That scrutiny is really important. We try to make sure that the practice staff are well trained and ask the right questions of the patients. Ultimately, it is to get the right amount of medicine supplied in good time for patients.

364. **The Chairperson (Ms Boyle)**: It may work in towns and urban areas, but it

would not work in some of the areas I represent, such as Aughabrack or Aghyaran. We have broadband issues.

365. **Mr Rogers**: I am very interested, Richard, in your statistics and what people say about statistics and so on. You talked about figure 14 and the mean etc. There is an over-reliance on statistics. You talk about the mean and two standard deviations from the mean. That is fine if the mean is not skewed. However, if you take something like the drug that Trevor mentioned earlier, the generic alternative is roughly £2·20, and the other one is £17. Look at Northern Ireland in figure 17: they used a large percentage of the £17 drug. My reading of figure 14 is that the mean is really skewed. It would be very interesting to look at the mean across England, Scotland, Wales and Northern Ireland to see where it lies.

366. **Mr Pengelly**: The point we are making is that these are of some use in terms of giving you a limited sense of relative performance across a large population sample. The reality is that, whilst the use of prescribing units is a good way of standardising, it is entirely possible to get two practices side by side that have such a fundamental difference in the makeup of their population that even that attribution would give you a skewed result. It is giving the generality of performance. Sorry for repeating myself, but all paths point to the actual prescribing behaviour. All this material does is throw up a series of red flags where we want to pay particular attention. There is a whole range of areas — as I said, we will put this in the pack that we will forward to the Committee — that we examine in detail for each practice. Issues like this, where there is a massive differential between broadly similar therapies, are areas of particular focus.

367. **Mr Rogers**: We are looking only at that mean and saying that there are a few above and a few below it, but that mean does not truly reflect where we should be in terms of costs. Are those targets reasonable?

368. **Mr Pengelly**: The use of the mean is really to highlight areas for specific attention. Attention is paid every month to looking at the prescribing pattern of the GP practice in the context of its actual population. The use of the mean and the prescribing units is only useful in trying to get a sense of how practices compare with each other. Where we effect change is what happens within a practice, where we use actual data and population numbers.

369. **Mr Brogan**: We have 350-odd practices. I mentioned earlier that each practice is allocated a budget of roughly £1 million. The performance of the individual practice is a much better way of understanding whether it is prescribing cost-effectively for that population. We then look at the overspending practices. We expect to work out what the variables are along a whole range of indicator sets, and we will then have a discussion about what the individual practice need is and what its access to other services is. We will then try to attempt to reduce prescribing back towards where we think the budget ought to be in terms of its spend.

370. **Mr Pengelly**: The real value of figure 14 from our perspective is much more about monitoring trends, as opposed to a particular point in time. That is one of the issues and, to be frank, one of our frustrations with our colleagues in the Audit Office: it would have been very helpful, to understand this, to put in the positions as at 2010 and 2013, because it would have showed a reduction in both the variability and the mean cost. That is where that information is particularly important, because it shows you the direction of travel you are making, the movements in variability and the movements in average cost, as opposed to using it as a vehicle to actually understand what is happening in any individual practice.

371. **Mr Brogan**: In terms of the variability, we have moved from over five practices beyond three standard deviations to just two. So the variability is starting to flatten, and the mean has actually come down over the past number of years.

372. **Mr Pengelly**: By 14% in three years.

373. **Mr Rogers**: I take your point. It would also be useful to see the trends in Scotland and England and so on.

374. On a similar point in terms of statins, on page 48 the report states:

"By moving from branded to generic statins, the HSC Board has managed to reduce unit costs".

375. So, the HSC Board is taking a bit of credit. However, when you look at the graph in figure 18, the number of prescriptions for statins has gone from 1·65 million to 1·95 million. There are 300,000 more prescriptions. Surely, if you buy more drugs you will get them cheaper, so the unit cost will be cheaper anyway.

376. **Mr Pengelly**: No. The total cost is £14·64 million. Again, the upward trajectory of the number goes to the prescribing habits; there are more scripts containing fewer days of treatment.

377. **Mr Brogan**: Perhaps, and the other side of it is that in terms of cardiovascular need, this drug is for cholesterol lowering, so the drive from a therapeutic perspective is to reduce cholesterol as low as possible. We have seen more and more patients going on to therapy, so I would expect the number of prescriptions to go up because that is where the need is going and that is where the evidence points to as being the right thing to do. We have tried to reduce the amount of cost that it takes to manage that demand, and we have succeeded.

378. On your point about buying more reducing the unit price, unfortunately we are part of a worldwide market and the price is fixed for the branded medicines. In generic medicines, there is market competition, and we will follow the market price. However, for the brands, the price is set at a UK level; we have no ability to manage that.

379. **Mr Rogers**: Similarly to what everybody else has been asking, and still on the issue of statins, the Audit Office illustrates that GPs in Northern Ireland continue to prescribe a higher proportion of a more expensive brand of statins, whilst NICE guidelines recommend the use of generic alternatives. The NICE recommendations were published in 2006, and Scotland moved in 2011, as did Wales. However, on page 51, the report states:

"Until April 2014, in Northern Ireland there was no body specifying what medicines ought to be or not be prescribed resulting in a higher proportion of the more expensive drugs being prescribed."

380. **Mr Brogan**: I accept that point. We did not have a body to assess how clinically effective and cost-effective the medicines that were coming into the market were and make that judgement. We have that body now, which will help us. I accept that.

381. **Mr Rogers**: Why did it take until 2014 to get there, when across the Irish Sea it was happening in 2011?

382. **Mr Brogan**: We have been following NICE clinical guidance throughout. It does say "in 2006", and we have been following that. It also mentions two other elements: the Scottish Medicines Consortium and the All Wales Medicines Strategy Group. We simply did not have those bodies in place in Northern Ireland. It took us a number of years to get there, but we put that in place from 1 April 2014.

383. **Mr Rogers**: Who took their eye off the ball?

384. **Mr Brogan**: It is not necessarily a case of taking your eye off the ball; it is a case of looking at what is right for the population in Northern Ireland, what the other systems are in other parts of the UK, interrogating those systems and understanding whether they are correct for Northern Ireland, alongside NICE clinical guidelines. From our perspective, we have to follow NICE. We then developed a framework where we have NICE but we also have an additional element, which is aligned with the Scottish Medicines Consortium.

385. **Mr Rogers**: Why did this not happen?

386. **Mr Brogan**: We already had NICE guidance, so this was adding to NICE.

England does not have an SMC or the All Wales Medicines Strategy Group. They just have NICE. We have added to that and said, "Right, we have NICE plus this other body." We recognised that more could be done and we put in a system where we can have that, without necessarily any challenge from other parties, to make sure that we have a good framework for making clinically effective and cost-effective medicines available.

387. **Mr Rogers**: Was it in April 2014 when you recognised that more needed to be done, or was it back in 2011?

388. **Mr Brogan**: No, it has taken just over 18 months or two years for us to be able to put that framework in place by 1 April and to get that arrangement developed.

389. **Mr Pengelly**: Whilst there were those additional arrangements in Scotland and Wales, they were not in place in England, and England is still performing much better than us on a cost basis. The work that we are dong to help our performance is, to some extent, aided by this, but I would not want to point this out as being a panacea for all our issues if it is not there in England and they are achieving better performance.

390. **Mr Rogers**: OK, I accept your point. Joe, you said that costs were not paramount in the decision-making in terms of GPs. We understand that the patient comes first and whatever else, but where were costs and value for money on the list? You said that there have been improvements since April this year, and I acknowledge that, but what is being done here proactively to ensure that we have value for money?

391. **Mr Brogan**: Proactively, we address this issue on a monthly basis with individual GPs and practice staff. Value for money is absolutely there, alongside the other elements of safety and quality. I would not say that one is necessarily more important than any other in the round. They all have to be taken together, and it comes down to the interaction with the patient. It is a question of what is best for the patient who is in front of the GP but also what is best for the wider health service as well.

392. We remind and educate GPs. We provide them with tools and support for their staff in terms of the changes. We provide advice right across primary care, community pharmacy, GPs, health visitors and district nurses in terms of what is the right thing to do for individual patients and the wider HSC.

393. **Mr Rogers**: What if they do not take that advice?

394. **Mr Brogan**: We have already mentioned that we have the GMS contract, which gives us an element of leverage. Ultimately, there is a professional sanction where, if there are examples of excessiveness or issues, we will take professional sanction as well as contractual sanction.

395. **Mr Rogers**: Without going into detail, have there been any cases of professional sanction?

396. **Mr Brogan**: We have certainly raised issues from a professional perspective where those issues have caused us concern.

397. **Mr Dallat**: I have this heard this story from both sides. I have had local pharmacists complaining to me that they were reimbursed at less than the cost price. Is that true?

398. **Mr Pengelly**: I think that can be the case in some cases.

399. **Mr Dallat**: Can you explain that?

400. **Mr Pengelly**: It is a fairly complex model.

401. **Mr Brogan**: We pay community pharmacies for the drugs that they dispense. There is a range of drugs; there are the branded medicines and the generic medicines. We know that on the generic medicines side they earn additional profit. They may buy a drug from the wholesaler for £10, but the reimbursement drug tariff price may be £11, so they are getting a 10% profit. We apply a clawback, which equalises the amount of profit earned on the

branded and the generic. Typically, on the branded medicine side, they do not earn that level of profit. So what we have attempted to do is to modulate it across the piece. With branded medicines they may appear not to necessarily be getting the full reimbursement price, but that is equalised because the generic medicines are actually getting additional profit. When you balance it out, there will be additional profit, and there is a profit margin that we have factored into the remuneration, the target being £16·5 million on an annual basis.

402. **Mr Dallat**: Just for our report, can you give us a breakdown of the percentage of the £460 million which was received by the small independent pharmacists, for whom I have a lot of time, the Northern Ireland-based pharmacy chains, the UK-based chains and the global chains.

403. **Mr Brogan**: Yes, we will provide that.

404. **Mr Dallat**: OK. I suppose that the question I really should have asked is: why have your Department and the pharmaceutical contractors failed to agree on the arrangements for reimbursing the cost of the most frequently prescribed and dispensed generic drugs? Are the contractors too powerful? Why is there no agreement?

405. **Mr Pengelly**: This goes right back to the basic contract that started in 2006. The key point at the moment, to be fair to both sides, is that the 2010 judicial review clarified the statutory duty on us to provide "fair and reasonable" remuneration to pharmacists. So, the devil is in the detail about what is fair and reasonable remuneration. You can understand that their view and ours may be somewhat at odds. At the moment, we are starting work on a cost-of-service inquiry, which will try to clarify what is the actual cost of providing a community pharmacy service in Northern Ireland. Aligned to that, there will be an assessment and a margins survey about the state of the market, the price at which they are accessing largely generic drugs from the wholesale market and what is a reasonable level of retained profit. That will allow both sides to engage in detailed discussion about what is a reasonable level of remuneration and underpin what will, hopefully, be an agreed contractual position.

406. **Mr Dallat**: Tell me, Richard: why have the community pharmacy contractors in Northern Ireland refused to participate in the UK-wide study to establish profit margins for pharmacists on generic drugs?

407. **Mr Pengelly**: I suppose that the short answer would be that that is a question that we would like them to answer in detail.

408. **Mr Dallat**: You are funding them.

409. **Mr Pengelly**: We need a community pharmacy service and, to be fair, we have our differences with community pharmacists on this aspect, but I do not want that to detract from the fact that they are a fundamentally important piece of health and social care provision in Northern Ireland.

410. **Mr Dallat**: Absolutely. I could not agree more. All the more reason why I should ask you the question: why have you no power to compel them?

411. **Mr Brogan**: Maybe, Mr Dallat, I could come back on that. Was the question around the margins survey and why they were not participating in that?

412. **Mr Dallat**: Yes.

413. **Mr Brogan**: They are participating in the margins survey. They are collaborating very well in identifying what level of profit margin —

414. **Mr Pengelly**: They did not participate in the costing survey previously, way back, which predated the first judicial review.

415. **Mr Brogan**: Are we talking about the current position or a historic one?

416. **Mr Dallat**: We are talking about the UK-wide study to establish profit margins. Maybe, if there is confusion, I can ask the Comptroller and Auditor General to clarify that.

417. **Mr Kieran Donnelly (Northern Ireland Audit Office)**: Chair, I think we are talking about the previous arrangements, where there was a lack of participation at the earlier stage.

418. **Mr Pengelly**: This predated the judicial review.

419. **Mr Dallat**: How do they manage this in other jurisdictions? Did you find out why they were successful and you were not?

420. **Mr Brogan**: In 2004-05, the Department initiated investigations on a collaborative basis alongside community pharmacy. There are two big elements to that: the cost of service investigation and undertaking the margins survey. Equally, in the other countries, that was the course of travel. I cannot get into the detail of why the wheels came off in Northern Ireland, because I was not party, necessarily, to those discussions. Needless to say, with the judicial review, we ended up in a place where none of us wanted to get to. We were compelled to provide fair and reasonable remuneration, which is absolutely right, and now we need to learn from those mistakes and do the investigations, one of which is the cost of service investigation. It should be noted that the margins survey is on track, and we are collaborating really well with community pharmacy colleagues to understand the level of margin.That gives us the clarity around the profit that is earned in respect of generics and proprietary. Once we have the cost investigation complete — it comes back to Mr Pengelly's point — we will be in a better place to have the negotiation associated with the contract.

421. **Mr Dallat**: Surely there must be some blame somewhere for bringing about a situation where there were two judicial reviews, costing £550,000, because you insisted on applying the Scottish drug tariff without any agreement whatsoever. Was that your darkest time in the whole thing?

422. **Mr Pengelly**: The application of the new tariff in 2006 was a consequence of the Department of Health in England having material concerns, which were underpinned by an evidence base, that there were significant figures of retained profit within the community pharmaceutical sector. As a consequence of the new tariff that was implemented then I think that the latest figures were up to 2008 or 2009 over £3 billion was saved from the drugs bill in England. Given that we were following that tariff, if we apply a pro rata approach, it has saved over £100 million in Northern Ireland.

423. The problem was that, in England, it was implemented in line with a new contract, which allowed for some of the savings generated by the new category M element of the tariff to be recycled to pharmacists for providing additional services in the community, but because we could not agree the contract with the pharmacists here, there was no mechanism to recycle those savings. So, in the first year, as the report acknowledges in respect of 2006-07, there was a £6 million payment to recognise the fact that those savings were not being recycled. That payment was not made automatically by us. That was part of a negotiated process. For as long as we made that payment without it being formally underpinned by additional services, the pharmacists would not have any incentive to enter into contract negotiations, so we did not make the payment in order that we could secure the traction to try to get a contract dialogue going.

424. **Mr Dallat**: Have you reached agreement with the contractors now?

425. **Mr Pengelly**: No, we have not, because the work of the cost of service inquiry is ongoing. To be fair to both sides, neither side will enter into material contract negotiations until we understand the cost of service. We are due to finish that work, hopefully, by the end of this financial year. That will form the basis of what we hope will be a meaningful and positive dialogue for getting to a new contract.

426. **Mr Dallat**: Is that not a very depressing situation that we are in?

427. **Mr Pengelly**: It is frustrating that we do not have a contract, but it takes two to tango.

428. **Mr Dallat**: Millions and millions of pounds are dispensed every year, and you have no contract.

429. **Mr Pengelly**: It is dispensed in line with a tariff that is based on firm empirical evidence. The intention is that the new contract will not fundamentally alter the price. The major component of primary care prescribing costs is the ingredient cost of the drugs dispensed. This is not to go to that. It is fundamentally looking at how savings from future changes to drug prices can be recycled and how we can incentivise community pharmacists to do that bit of work that they do tremendously well when the public go to them. We need to incentivise the public to make better use of pharmacists too, so that that is their first port of call for advice on minor injuries and ailments.

430. **Mr Dallat**: I am asking this question as much in defence of the local pharmacists as of the taxpayer. The local pharmacist is the heart of many small communities. It is important for me to understand. When the crisis happened in 2006, I knew nothing about it, and it took a lifetime to find out what was going on. It would have been nice had those issues perhaps been channelled through the Assembly and the Committees. Then at least we might have known what was going on. Perhaps that is a good example of how the Department should not embark on doing something on its own without some kind of consultation.

431. The pharmaceutical side, of course, is extremely powerful. There was some reference at the beginning of the meeting to pens: I have an SDLP one here. I do not think that it would influence anybody. In terms of sponsorship, are there conflicts of interest, and is there a code of conduct to ensure that those giant organisations are not influencing what happens?

432. **Mr Pengelly**: There is a code of conduct in place. Mark touched on that earlier.

433. **Dr Timoney**: That is right. The industry has taken responsibility to ensure that the code of conduct has been developed by a consortium of all the representative members of the industry, and it has broadly promoted it to its members and to health care professionals who engage with the Department. The rules of engagement are clear: let us have the patient first and the interests of Health and Social Care second, and let us protect the intelligent property. Very good positions for agreement have been established through those mechanisms.

434. **Mr Dallat**: So, Dr Timoney, you would not be terrible happy if a new health clinic official opening was sponsored by a drug company.

435. **Dr Timoney**: Provided that the rules of engagement were upheld and it is in patients' interests, I think —

436. **Mr Dallat**: I think that we have both made the point that there needs to be some kind of code of conduct. We are handling millions and millions of pounds of public money, and there are all sorts of ways of influencing how that money is spent. The questions that have been asked today bear out the need for a great deal more work to be done before the taxpayer, the patient and the local pharmacy can be absolutely sure that the tail is not wagging the dog.

437. **Mr Pengelly**: That is a fair comment, Mr Dallat. We have a code of conduct, but the difficulty is in policing it and making sure that it is applied day and daily and within the spirit in which it is intended. That will be a challenge for us, and we need to continue to monitor it.

438. **Mr Dallat**: Sometimes the Committee is accused of not being fair. As you have, we should recognise the health clinics and doctors who are applying the thing across the board and to the fairness of everyone. The Audit Office report obviously suggests that a great deal more work needs to be done. Hopefully, when our report is completed, there will be a clearer understanding of where we are and where we are going.

439. **Mr Girvan**: I want to come back on a point about the pharmacies. It could probably work both ways, but a doctor could, instead of writing a prescription for a generic drug, write it for a branded drug. The patient then would go to the pharmacy, hand in their prescription, and the pharmacist could say that the chain does not carry that drug but that he has another one that is exactly the same medication and give that to the patient. It is a generic drug and is exactly the same as the one that was prescribed, only the doctor prescribed the branded medication. The branded drug may be £17, and the pharmacist handed out the £2·53 drug. On occasions, it might work the other way round.

440. **Mr Dallat**: Yes, it does at times.

441. **Mr Girvan**: I use the example of a very large pharmacy that has a very large chain, not only here but in the rest of the UK. Tracing where it purchases its drugs, as a private company, is virtually impossible; and, to be honest, it does not have to furnish you with that information. They could well have dispensed the generic drug, and you were paying out on a prescription for a branded drug. They could have dispensed a drug that is up to seven times the price of the generic one plus the profit.

442. **Mr Brogan**: If it is prescribed in the generic form and a generic is available, they can only claim for the generic. They cannot claim for the branded drug. If they do so —

443. **Mr Girvan**: You have said that if branded drugs are prescribed by doctors, there may be a very good case for why it has to be that branded drug. They do not have to make that case. They just have to say that the doctor prescribed it.

444. **Mr Brogan**: If a doctor has prescribed a brand, the pharmacist must follow the brand. They cannot deviate from that and substitute a generic. If they have done that, I would be interested in understanding that example, because —

445. **Mr Girvan**: I am sure that it happens.

446. **Mr Brogan**: — that is a breach in their terms, and I would be interested in that.

447. **Mr Girvan**: I am using an example.

448. **Mr Pengelly**: To put it in lay terms: a branded prescription must be dispensed in branded form and will be remunerated on that basis. A generic prescription can be dispensed in either generic or branded form depending on availability but will be remunerated in generic form only.

449. **Mr Girvan**: I am sure that, of those in the room who have received prescriptions, a number have gone to a pharmacy that did not have the variety of drug on the prescription. I am one in particular, because I get a repeat prescription. Levothroxine is quite a common medicine, but there is another generic form of the same medication, and they will give you that. If they do not have the variety that you are on, they will dish out the other one. I do not care. I am happy. I have got my medication, and I am away and will take it in my usual form.

450. **Mr Pengelly**: But you will go back to your GP and ask him to dispense your medication in generic form in future rather than in branded form.

451. **Mr Girvan**: Of course I do, but what I am saying — where I am coming from — and you have to understand —

452. **Mr Pengelly**: The point that Joe made was that if the GP writes the prescription in branded form —

453. **Mr Girvan**: Which he does.

454. **Mr Pengelly**: — the community pharmacist should either dispense it in branded form or should not dispense it. It is his or her job to secure the branded form, and he or she should not — that is an issue of compliance for us that we need —

455. **Mr Girvan**: It is about policing that. How do you police it? There is no mechanism to police it.

456. **Mr Pengelly**: We need members of the public to put their hand up and advise us.

We can only reasonably expect them to do that if we better educate the public that that should not happen. I suspect that your point is about which members of the public would understand that a pharmacist should not dispense generic —

457. **Mr Girvan**: Most people will have got their medication and be away.

458. **Dr Timoney**: There are a small number of medicines that should always be prescribed by brand. It is because their toxic levels are very close to the therapeutic levels or where there is a risk that not taking enough of the drug could offset the patient's condition. Northern Ireland has been applauded for putting together a list of those medicines. You mentioned thyroxine, and it could be that a challenge has arisen in relation to those medicines. Just bear in mind that —

459. **Mr Girvan**: I understand that.

460. **Dr Timoney**: — there are certain clinical conditions for which generic medicines are not always appropriate. However, in the majority of cases —

461. **Mr Girvan**: There have been occasions — I am sure that it happens on many occasions — when somebody goes in with a generic prescription and the pharmacy does not have that drug but might have the branded drug.

462. **Mr Pengelly**: They will only be recouped at the generic cost.

463. **Mr Girvan**: I understand that, and that they might do that at a cost to themselves. But I have seen it the other way. I have experienced it myself, and I am sure that many around the table have experienced the same. It goes on, even if you are stating that it is a breach. Pharmacists tell patients that it is exactly the same medication and that they can have confidence that they are taking something that will not cause them any more difficultly. When they do their paperwork at the end of the month or whenever, they will not remember that they prescribed a statin to a particular lady.

464. **Mr Brogan**: One of the questions you asked was about the assurance. We have assurance mechanisms in the payment agency, which will pick up on missed codes. We ask community pharmacists to code what they have dispensed. If it is a generic on the prescription, we expect them to code for that generic, and if they code for a branded medication, that will be challenged. On the other side, we run checking clinics to check whether generic medicines have been dispensed when branded medicines have been prescribed. We invite members of the public to come along with their medicines, and we look at the prescriptions and at what has been dispensed. Of course —

465. **Mr Girvan**: How often does that happen?

466. **Mr Brogan**: That happens every month.

467. **Mr Girvan**: How many would take up that opportunity?

468. **Mr Brogan**: It is a very small population base. We dispense 38 million or 39 million prescription items, and we only sample across the region. On occasion, we have identified where there appear to be issues and have gone back to the community pharmacy to address those issues. If there are individual issues and patients are receiving a generic when a brand has been prescribed, we would certainly wish to hear about those and to follow them up.

469. **The Chairperson (Ms Boyle)**: Thank you, gentlemen. To wrap up, I have one or two questions. I want to go back to the QOF data. It is generally accepted that we have a health need here that is higher than in other regions — England, Scotland and Wales.That, of course, is acknowledged in paragraph 3.22. However, it gives rise to concern that, in paragraph 3.25, data on disease prevalence produced in QOF do not generally support that perception. In fact, according to QOF figures, we have a lower prevalence of many of the main diseases here than in other parts of the UK. Paragraph 3.24 highlights your

concerns about using the QOF data in that way. However, in paragraph 3.23, we read that the HSC Board does not share those concerns. How can the Department and the HSC Board hold such divergent views on that?

470. **Mr Pengelly**: The key issue here is that the Department and the board do not hold divergent views. The board feels that its views are not properly reflected in this, and it agrees with the Department's view. In fact, the board led the dialogue to say that the use of the QOF data in that way was inappropriate.

471. **The Chairperson (Ms Boyle)**: Following on from that, you have explained your objections to the use of data from QOF and various other sources. What work have you done to quantify health-care needs here relative to those elsewhere in the UK? What specific piece of work has been done?

472. **Mr Pengelly**: The most recent piece of work was the Appleby review, which gave a figure of 9% and pointed out that some areas could range up to 17%. After that, there was the 2012 work by the National Audit Office that utilised Deloitte, which had it ranging up to 26%.

473. The concept of health need is important in understanding some of the different costs between Northern Ireland and other places. The issue about providing health care does not require an absolute articulation of the number attached. The reality is that health need will be different across a whole range of disciplines, both horizontally and vertically. Different speciality areas will have different levels of need, as will the primary care sector against the secondary care sector. It tends to be a number that is most used in the debate between this Department and the Finance Department. We tend to use it as a way of saying that our costs are being driven by a higher level of need. It is not of particular relevance for planning the delivery of care in Northern Ireland. We tend to work on a trend basis in Northern Ireland.

474. I want to be clear that it is not that the QOF material is not important and valuable in its own right; our point is that we feel, as do our professional statistical colleagues and the health and social care information centre in England that produce QOF data, that it is not appropriate to be used to understand the drivers of primary care prescribing costs. That is the subtlety. It is used as a measure of activity and to drive clinical activity in primary care. It is not complete in terms of all disease spectrums, and, typically, it is completely silent on social and economic factors and the big issue of co-morbidity, which is a very significant factor in prescribing costs.

475. **The Chairperson (Ms Boyle)**: Finally, figure 11 on page 38 seems to dispel another myth that here has a relatively smaller share of older people than GB, and that that trend is likely to continue until at least 2030. Do you accept that health-care needs may be greater in areas with a larger number of older people?

476. **Mr Pengelly**: I absolutely accept that a greater proportion of elderly people is a significant driver of cost, but it is only one driver. There is a whole range of other issues like, as I have just mentioned, co-morbidity and social and economic factors. I accept that the graph is absolutely correct in what it portrays, but the issue for us is that our proportion of the elderly population is increasing at a faster rate than other places in the UK. So, from this point on, as we do year-on-year comparisons, that will make it difficult for us to match year-on-year changes in England, Scotland and Wales. It is a significant component, but only one component of driving overall need and cost.

477. **The Chairperson (Ms Boyle)**: Whilst we as a Committee acknowledge the efforts of the Health and Social Care Board that have generated the savings, it seems that much more can be done, and we remain of the view that some form of comparison must be possible on the basis of the report and what we have heard today. Further analysis needs to be done — you have accepted that —

on the primary care prescribing budget, and that has to be done in the most cost-effective manner. Obviously, what is coming out of here today is that you must set challenging savings targets for the future, so that valuable resources can be released back into our health-care sector. It ain't rocket science. Mr Girvan and I sit on the Finance and Personnel Committee, and we heard this morning about how our innovation labs can assist with solutions.

478. **Mr Pengelly**: The Finance Minister is with our Minister at the South Eastern Trust's innovation lab this afternoon seeing the good work that is happening within health and social care.

479. **Mr Girvan**: We will not tell you what I said.

480. **The Chairperson (Ms Boyle)**: It is in Hansard.

481. **Mr Girvan**: I hope that it is not another talking shop for them to have another series of meetings and deal with stuff. It has to have results that are customer-led, and there has to be definite evidence of that. Progress has to be made. There is plenty of opportunity, because we are always holding carrots out, but I have yet to see some mechanism for a stick to be used. I come from the private sector, and the stick would work very well here. I would like to see some form of sanction being taken against those who refuse to go down that route, so that we had some way of dealing with it. I appreciate that those doctors might well feel that they have their own contract. What we have from the BMA, negotiated as a national contract, is sacrosanct and cannot be touched, but, because we are commissioning them to deliver a service, there has to be some way of ensuring that they do it effectively and efficiently.

482. **Mr Pengelly**: On your point about real innovation as opposed to talking about innovation, I note that Northern Ireland is one of a very limited number of regions across the EU that has been awarded three-star reference site status because of some of the innovative work that we have been doing in medicines management. We actually chair a cross-EU reference site collaborative network, with other regions looking to the work that we are doing here. That is some external recognition of the progress that we have made.

483. **Mr Beggs**: I want to push a little bit more on medicine management advisers. What is the break-even point? How long does it take for them to recoup the money by bringing in the savings through good practice by GPs? You are reticent to employ more of them because of the limited budget, but how soon would they actually save the money in the medicines budget and therefore pay for themselves?

484. **Mr Pengelly**: That is the key question.

485. **Mr Beggs**: Do you not have an answer to that?

486. **Mr Pengelly**: I am trying to explain the answer to it. We are doing a business case at the moment. The point of it is to identify the cost of more MMAs, what the potential saving would be from each of those MMAs and what time period we would secure that in. The issue is whether we need to go to the Scottish position or beyond that. Where does the law of diminishing returns kick in? There is also the point that I mentioned earlier — that we absolutely need more pharmacy support for GPs, but the question is whether it should be MMAs or pharmacies in the GP practice. The advantage there is that MMAs will spend a lot of time talking to GPs. Pharmacies are part of that care package. They are there, based in the pharmacy every day.

487. The business case that Joe and colleagues in the Health and Social Care Board are preparing at the moment deals with all the points you mention; it is looking at the cost, the associated savings and the payback time. That will come to us to make decisions. I personally think — I think that this is the point you are getting to, Mr Beggs — that it is not beyond us to assume that the cost of an additional MMA will be recouped in the year that the cost is incurred. I think that there is that

possibility. So, it is not the traditional invest-to-save, where the concern is that you spend a lot of money this year to save money next year. I think that it can be neutral year-on-year. We are very positive about where we go with it.

488. **Mr Brogan**: I can give you a real example, Mr Beggs. We embarked on a project this year looking not just at pharmacists but at dieticians. We invested £350,000 in a range of dieticians, who went into GP practices, did assessments of dietetic requirements and improved the clinical care. The upshot of that was that we returned £1·1 million of efficiencies. So, that is a one-in-three efficiency saving for that investment. That project won an award at the Northern Ireland Allied Health Professions conference last month. Those are the kinds of examples we want to explore as part of this business case, because it is a mix. Certainly, our MMAs have done a brilliant job, and we pay tribute to them, but we need to think about what is the mix in effecting the change within general practice.

489. **Mr Beggs**: Given the millions of pounds that can be saved, I urge you to come to a decision and allow those savings to be made.

490. **The Chairperson (Ms Boyle)**: OK, members, we have all had the opportunity to ask questions of our witnesses, so I believe that there are no final issues that could be arising from today's session. Mr Brogan, I am certainly not looking forward to getting older and the cost that I will be to the health service. I am not looking forward to taking all those drugs.

491. Mr Layberry, do you have anything to add or are you content?

492. **Mr Jack Layberry (Department of Finance and Personnel)**: No, thank you.

493. **The Chairperson (Ms Boyle)**: OK. Mr Donnelly, is there anything you want to add?

494. **Mr Donnelly**: Just a comment on a point that Mr Pengelly made about figure 14, which looks at the variation in GP practices. Our objective with that graph was simple, which was to demonstrate that, at a point in time — 2013 — there was a substantial degree of variation. I think that Richard said that he would have liked to see another graph going back to 2010. Fair enough. That would have shown even more variability. So in a sense there is less variability now, but there is still enormous variability, and that needs to be looked at.

495. **The Chairperson (Ms Boyle)**: OK, thank you, Mr Donnelly. I am content with that.

496. I thank you all for your attendance before the Committee. It has been extremely useful. As we develop our report, we will certainly take on board the information that you provided.

497. **Mr Pengelly**: Thank you, Chair.

Appendix 3

Correspondence

Correspondence of 25 November 2014 from DHSSPS

From the Permanent Secretary
and HSC Chief Executive

Department of
Health, Social Services
and Public Safety

Mr Kieran Donnelly
Comptroller and Auditor General
NIAO
106 University Street
BELFAST
BT7 1EU

PUBLIC ACCOUNTS
26 NOV 2014
COMMITTEE

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Castle Buildings
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BELFAST, BT4 3SQ
Tel: 02890520662
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Email :richard.pengelly@dhsspsni.gov.uk

Our Ref: RP161
SECCOR/128/2014

Date: 25 November 2014

Dear Kieran

NIAO DRAFT REPORT: PRIMARY CARE PRESCRIBING

Further to my letter to you dated 14 November, I had indicated that, as the report had not been agreed before publication, I would write to you in relation to those areas of particular concern to us. As I also stated then, while I see this as a significant issue of principle, the number of actual issues where we have a residual difficulty is small in number. These are set out below:

- Para 1.11 – the Report states, as regards the comparison with Wales, that our view is simply that "the statistics do not compare jurisdictions on a like for like basis". The actual position is much stronger than that - we consider the calculation by NIAO of a differential in NI prescribing costs when compared with Wales, and simplistic presentation as a measure of relative efficiency, as being grossly misleading.

- Para 1.14 – the text states that we do not accept the final two bullet points, yet is silent as to why.

- Para 4.10 - the Department provided NIAO with more up to date information for the financial year 2013/14 which demonstrates that £15m could have been realised if all GPs achieved the prescribing profile of an average practice and not the £19m figure that NIAO reported in relation to the 2013 calendar year.

- Para 4.6 - the report fails to properly report that the range of variation in prescribing costs between GP practices has significantly reduced between 2010 and 2013. Material submitted, including narrative and tables, to NIAO by the Department clearly indicating this trend should have been included in the body of the report as had been requested and a more balanced position presented.

- Para 3.19 - the Department repeatedly requested that NIAO rephrase the section on 'the use of an "unclassified" category...' on a point of clarification and to place the NIAO commentary in perspective.

While the above issues relate to the extent to which the Department's view has been reflected, of separate concern are those areas of simple factual inaccuracy. These include:

- Executive Summary, paragraph 2 – the Report states that GP's decisions are "highly regulated and controlled". The reality is that such decisions are not "controlled" (as properly reflected in paragraph 8 of the Executive Summary).

- Para 2.2 – the text states that NI "has a lower average population per service provider than England and Wales", yet figure 4 shows the actual figures as being 3,291 for NI, 3,024 for England and 2,905 for Wales – i.e. we are higher.

I am copying this to Jack Layberry, Treasury Officer of Accounts.

Yours sincerely

RICHARD PENGELLY

Correspondence of 5 December 2014 to DHSSPS

Public Accounts Committee

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Parliament Buildings
Ballymiscaw
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5 December 2014

Richard Pengelly
Accounting Officer
Department for Health, Social Services and
Public Safety
Castle Buildings
Stormont Estate
Belfast
BT4 3SQ

Dear Richard,

Public Accounts Committee Evidence Session – Primary Care Prescribing Inquiry

Thank you for your participation in the Committee's evidence session on this inquiry on 3 December.

The Committee agreed at this evidence session that it would ask you to provide some additional information to assist them with their inquiry. Could you therefore please provide us with the following information?

- A breakdown of the £460million in dispensing funding provided to Community Pharmacy Contractors by:
  - Local independent pharmacies
  - Local chains
  - UK chains
  - Global Chains
- A breakdown by each GP surgery in NI of their average prescribing cost per patient based upon the BSO standardised figures produced using NI PU's.
- The monthly variation report of GP prescribing costs

I would request a response on the above issues by 19 December 2014.

Yours sincerely,

Michaela Boyle

Michaela Boyle
Chairperson
Public Accounts Committee

Correspondence of 17 December 2014 from DHSSPS

From the Permanent Secretary and HSC Chief Executive

Department of Health, Social Services and Public Safety
www.dhsspsni.gov.uk

Michaela Boyle
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Richard.pengelly@dhsspsni.gov.uk

Our Ref: RP179

Date: 17 December 2014

Dear Michaela

PAC SESSION ON PRESCRIBING

I refer to your letter of 5 December and the request for additional information. This is now attached at Annex 1.

I hope this is helpful.

Yours sincerely

RICHARD PENGELLY

cc: Mark Timoney
Paul Gibson

Working for a Healthier People

INVESTORS IN PEOPLE

ANNEX 1

Breakdown of the £460million in dispensing funding provided to Community Pharmacy Contractors

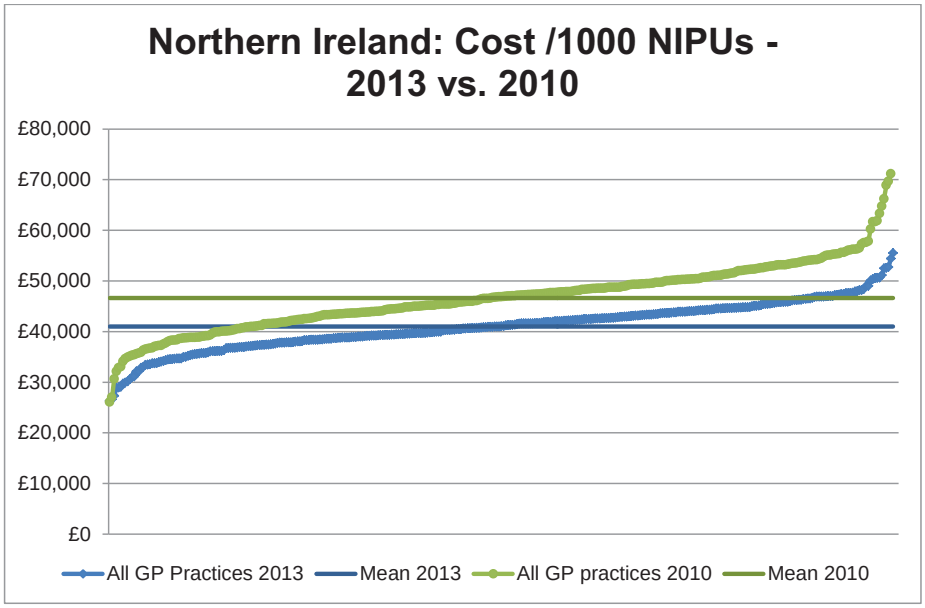
The payments are as follows:

- Local Independent Pharmacies £218.0m
- Local Chains £140.8m
- UK Chains £19.0m
- Global Chains £67.8m
- Other Payments (including payments to Appliance Suppliers, Dispensing Doctors, etc) £13.5m

Breakdown by each GP surgery in NI of their average prescribing cost per patient based upon the BSO standardised figures produced using NI PU's

Each GP practice prescribing cost per 1000 NIPU is set out in **Appendix A**:

The following graphs demonstrate the reduction in variation and the overall reduction in costs that have occurred over the 3 year timescale:



Monthly variation report of GP prescribing costs

Monthly Reports

- Each GP practice is set an indicative prescribing budget which is set based on the capitation calculation (NI PU)
- Prescribing costs are reported on a monthly basis (**Monthly Prescribing Statements)**
- Each GP practice will receive a report on a monthly basis setting out the spend, the projected spend, performance against budget and performance against peers

Examples of 5 GP practice statements are provided at **Appendix B**, one practice from each LCG:

- Each Local Commissioning Group receives a summary report which sets out the overall performance comparing each of the 5 LCGs
- Regular meetings are held with all LCG chairs and commissioning leads to discuss trends

An example of a LCG Monthly Prescribing Statement is provided at **Appendix C**.

Quarterly Reports

On a quarterly basis, each GP practice receives the **COMPASS report.** COMPASS is a regional prescribing support service that provides GPs with feedback on their prescribing and how they compare to their peers both locally and regionally. The COMPASS report is a prescribing feedback report that provides an in depth analysis of prescribing within general practice and provides a tool to monitor cost-effective prescribing. The report provides an overview of prescribing, identifies potentially high cost areas, encourages generic prescribing, discourages over-prescribing of specific medications e.g. benzodiazepines and demonstrates potential financial savings. Examples of areas that are monitored include:

- Overall prescribing in terms of cost/volume
- Cost effective choices: generic and therapeutic switches
- Controlled drugs
- High risk drugs e.g. red list drugs, methotrexate
- 50 indicators looking at a wide range of therapeutic areas e.g. pain indicators include prescribing of NSAIDs, lidocaine plasters, pregabalin and opioid analgesics

Reports are produced on a quarterly basis at HSCB, LCG and GP practice level. A HSCB COMPASS Report is at **Appendix D.** A sample of the report for each LCG area is at **Appendix E** and a sample of a GP practice report from each LCG area is at **Appendix F.**

Examples of other reports used by HSCB Medicines Management Advisers (MMAs) to monitor prescribing

1. **'Basket of Indicators' Control Charts**
   A specific set of indicators has been agreed with the BMA which are used to monitor whether a practice could be prescribing "excessively" as set out within the terms of the GMS contract. Two standard deviations from the mean is beyond expected norms requiring at least justification and possibly review and improvement. Three standard deviations is an unacceptable position requiring work to remedy the situation. The process is set out in **Appendix G**.

   The indicators are:
   - Items/1000 NIPUs
   - Proportion of PPIs prescribed as lansoprazole or omeprazole as % of all PPIs
   - Proportion of simvastatin, pravastatin or atorvastatin as a % of all statins
   - Frequency (DDD/1000 NIPUs) of benzodiazepines and Z drugs

- Proportion of citalopram, fluoxetine and sertraline items as a % of SSRIs
- Frequency (DDD/1000 NIPUs) of NSAIDs
- Frequency (items /1000 NIPUs) of antibiotics

A sample of each control chart is attached at **Appendix H**. The control charts show prescribing information for all GP practices in Northern Ireland and highlight which practices are 2 or 3SDs from the mean.

2. Control Charts Database

A control chart for each indicator is prepared which identifies outlying prescribing behaviour (those practices more than 2 standard deviations and 3 standard deviations from the mean).Control charts are presented for overall controlled drug prescribing, strong analgesics, hypnotic and anxiolytics. Separate reports are produced for patient prescribing and stock prescribing. The database enables MMAs to compare a practice with their LCG area and view two year trend charts at drug group and individual drug level. A sample report from the strong analgesics patient prescribing control chart is attached at **Appendix I**.

Appendix A

Breakdown by each GP surgery of their average prescribing cost in 2013

Year	Practice	Cost /1000 NIPUs 2013
2013	144	£26,303
2013	618	£26,611
2013	1	£27,311
2013	585	£28,924
2013	581	£28,955
2013	157	£29,070
2013	146	£29,740
2013	10	£29,910
2013	528	£30,167
2013	395	£30,587
2013	517	£30,998
2013	16	£31,100
2013	477	£32,131
2013	104	£32,145
2013	386	£32,866
2013	551	£33,015
2013	350	£33,428
2013	85	£33,461
2013	601	£33,531
2013	279	£33,715
2013	74	£33,717
2013	514	£33,749
2013	542	£33,969
2013	579	£34,029
2013	147	£34,213
2013	498	£34,337
2013	232	£34,459
2013	14	£34,519
2013	310	£34,535
2013	552	£34,625
2013	534	£34,666
2013	83	£34,693
2013	311	£34,693
2013	622	£34,977
2013	554	£35,009
2013	114	£35,188
2013	13	£35,325

2013	63	£35,442
2013	253	£35,554
2013	194	£35,573
2013	33	£35,650
2013	497	£35,719
2013	105	£35,724
2013	19	£35,799
2013	433	£35,866
2013	610	£36,094
2013	546	£36,124
2013	547	£36,130
2013	321	£36,147
2013	556	£36,169
2013	506	£36,184
2013	600	£36,332
2013	159	£36,712
2013	145	£36,728
2013	509	£36,773
2013	73	£36,788
2013	461	£36,794
2013	62	£36,858
2013	463	£36,929
2013	66	£36,935
2013	6	£36,956
2013	621	£37,038
2013	360	£37,097
2013	652	£37,107
2013	51	£37,163
2013	223	£37,236
2013	563	£37,273
2013	382	£37,331
2013	623	£37,353
2013	55	£37,380
2013	576	£37,398
2013	226	£37,432
2013	234	£37,455
2013	583	£37,542
2013	153	£37,623
2013	620	£37,758
2013	31	£37,803
2013	627	£37,815

2013	154	£37,822
2013	605	£37,829
2013	358	£37,845
2013	86	£37,869
2013	561	£37,909
2013	568	£37,986
2013	29	£38,021
2013	420	£38,029
2013	195	£38,082
2013	79	£38,272
2013	553	£38,301
2013	281	£38,347
2013	604	£38,363
2013	495	£38,366
2013	543	£38,382
2013	352	£38,382
2013	499	£38,441
2013	431	£38,451
2013	537	£38,537
2013	282	£38,552
2013	464	£38,562
2013	60	£38,577
2013	96	£38,669
2013	346	£38,691
2013	70	£38,754
2013	302	£38,785
2013	344	£38,796
2013	336	£38,799
2013	345	£38,820
2013	38	£38,829
2013	539	£38,851
2013	92	£38,890
2013	562	£38,891
2013	258	£38,989
2013	460	£38,994
2013	166	£39,005
2013	71	£39,099
2013	502	£39,165
2013	328	£39,169
2013	626	£39,182
2013	493	£39,186

2013	664	£39,213
2013	606	£39,234
2013	53	£39,288
2013	314	£39,307
2013	507	£39,324
2013	116	£39,356
2013	545	£39,362
2013	227	£39,393
2013	229	£39,399
2013	81	£39,417
2013	401	£39,428
2013	64	£39,478
2013	532	£39,478
2013	453	£39,520
2013	132	£39,562
2013	207	£39,586
2013	28	£39,626
2013	111	£39,660
2013	526	£39,678
2013	68	£39,687
2013	369	£39,689
2013	655	£39,715
2013	598	£39,730
2013	473	£39,787
2013	662	£39,803
2013	17	£39,858
2013	58	£39,933
2013	80	£39,949
2013	20	£39,978
2013	608	£39,981
2013	5	£40,217
2013	191	£40,266
2013	393	£40,313
2013	516	£40,325
2013	529	£40,344
2013	615	£40,356
2013	616	£40,427
2013	434	£40,473
2013	412	£40,478
2013	323	£40,584
2013	417	£40,601

2013	462	£40,629
2013	501	£40,662
2013	355	£40,672
2013	202	£40,688
2013	333	£40,720
2013	474	£40,740
2013	95	£40,785
2013	584	£40,815
2013	582	£40,843
2013	228	£40,936
2013	103	£40,940
2013	467	£40,952
2013	471	£40,962
2013	304	£40,977
2013	233	£40,985
2013	491	£41,017
2013	15	£41,071
2013	284	£41,227
2013	326	£41,254
2013	614	£41,255
2013	224	£41,326
2013	136	£41,347
2013	438	£41,444
2013	319	£41,572
2013	276	£41,593
2013	201	£41,597
2013	205	£41,603
2013	151	£41,609
2013	356	£41,614
2013	72	£41,622
2013	231	£41,631
2013	440	£41,635
2013	602	£41,704
2013	52	£41,772
2013	283	£41,854
2013	384	£41,862
2013	566	£41,898
2013	36	£41,899
2013	260	£41,945
2013	267	£42,024
2013	256	£42,037

2013	9	£42,049
2013	93	£42,088
2013	500	£42,136
2013	278	£42,157
2013	505	£42,197
2013	75	£42,198
2013	98	£42,233
2013	406	£42,297
2013	390	£42,330
2013	261	£42,350
2013	24	£42,359
2013	458	£42,448
2013	198	£42,481
2013	479	£42,484
2013	515	£42,487
2013	3	£42,518
2013	388	£42,561
2013	465	£42,574
2013	651	£42,583
2013	519	£42,594
2013	143	£42,632
2013	404	£42,651
2013	617	£42,676
2013	280	£42,709
2013	472	£42,725
2013	660	£42,754
2013	140	£42,797
2013	257	£42,884
2013	165	£42,926
2013	308	£42,963
2013	533	£42,966
2013	625	£43,011
2013	476	£43,056
2013	481	£43,121
2013	504	£43,139
2013	254	£43,167
2013	23	£43,202
2013	325	£43,227
2013	596	£43,302
2013	32	£43,316
2013	305	£43,320

2013	222	£43,326
2013	57	£43,368
2013	508	£43,453
2013	536	£43,465
2013	156	£43,557
2013	84	£43,617
2013	391	£43,654
2013	535	£43,667
2013	61	£43,686
2013	221	£43,709
2013	494	£43,767
2013	624	£43,790
2013	255	£43,906
2013	482	£43,906
2013	37	£43,907
2013	544	£43,922
2013	385	£43,978
2013	307	£43,992
2013	329	£44,001
2013	337	£44,034
2013	357	£44,117
2013	609	£44,159
2013	407	£44,204
2013	457	£44,215
2013	271	£44,228
2013	654	£44,282
2013	549	£44,317
2013	351	£44,335
2013	230	£44,397
2013	164	£44,534
2013	366	£44,534
2013	317	£44,550
2013	569	£44,585
2013	18	£44,608
2013	419	£44,623
2013	303	£44,623
2013	367	£44,658
2013	334	£44,679
2013	530	£44,692
2013	285	£44,752
2013	454	£44,756

2013	196	£44,762
2013	661	£44,783
2013	629	£44,787
2013	619	£44,817
2013	331	£44,978
2013	396	£45,072
2013	368	£45,092
2013	193	£45,120
2013	274	£45,196
2013	252	£45,419
2013	597	£45,441
2013	361	£45,474
2013	571	£45,510
2013	148	£45,601
2013	341	£45,650
2013	555	£45,747
2013	455	£45,785
2013	389	£45,817
2013	574	£45,848
2013	387	£45,879
2013	503	£45,899
2013	275	£45,982
2013	657	£46,150
2013	315	£46,204
2013	418	£46,206
2013	113	£46,253
2013	540	£46,263
2013	470	£46,436
2013	263	£46,445
2013	512	£46,522
2013	101	£46,522
2013	206	£46,660
2013	265	£46,862
2013	478	£46,883
2013	531	£46,917
2013	192	£46,917
2013	312	£46,920
2013	413	£46,951
2013	603	£46,995
2013	327	£47,002
2013	469	£47,008

2013	313	£47,201
2013	69	£47,245
2013	405	£47,282
2013	475	£47,405
2013	272	£47,425
2013	578	£47,577
2013	541	£47,594
2013	273	£47,633
2013	402	£47,657
2013	349	£47,928
2013	330	£47,980
2013	94	£48,152
2013	410	£48,214
2013	599	£48,403
2013	354	£48,945
2013	30	£49,031
2013	204	£50,061
2013	466	£50,369
2013	564	£50,534
2013	264	£50,628
2013	394	£50,649
2013	586	£51,139
2013	259	£52,481
2013	451	£52,574
2013	409	£52,723
2013	663	£54,428
2013	162	£55,501

HSC Indicative Prescribing Scheme

Monthly Prescribing Statement - September 2014

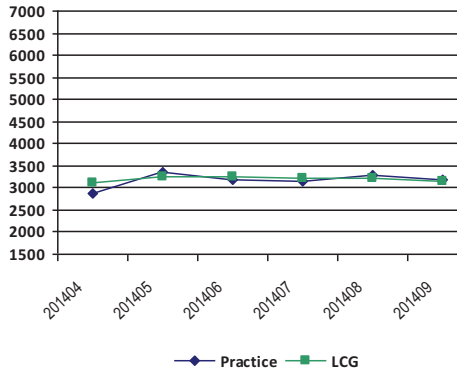
Belfast LCG Practice Number X

Annual Indicative Amount	**365,324**
Number of Patients	**1,255**
Number of Northern Ireland Prescribing Units (NIPUs)	**9,123**
Current Month Spend *	**28,905**
Cost Per 1000 NIPUs *	**3,168**
Cumulative Spend Year to Date *	**172,652**
Cumulative Cost Per 1000 NIPUs Year to Date *	**19,016**
Projected Annual Spend *	**346,167**
Projected Over/Under Spend	**-19,157**
Projected % Over/Under Spend**	**-5.24%**

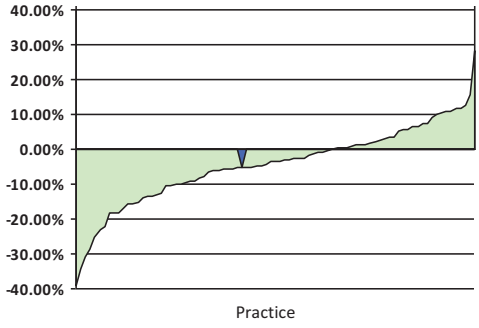
****If your % projected over/under spend is within -1% to 1% it will not display on the graph below**

NIPUs: In measuring prescribing, differences between practices are taken into account in order to make valid comparisons with local and national averages. NIPUs standardise for differences between practices in terms of patient list size, age/sex structure and additional needs.

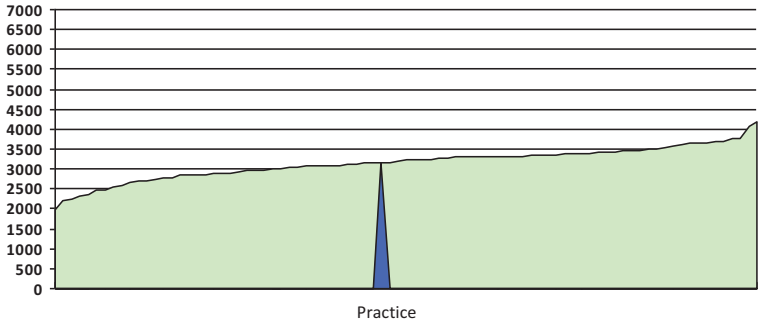
***Ingredient Cost per 1000 NIPU**



****Percentage Over/Under Spend for LCG Practices**



***Current Month Cost per 1000 NIPU for LCG Practices**



*** Excluding Expensive Drugs**

If you have any queries relating to this statement please contact your MMA

Providing Support to Health and Social Care

HSC Indicative Prescribing Scheme

Monthly Prescribing Statement - September 2014

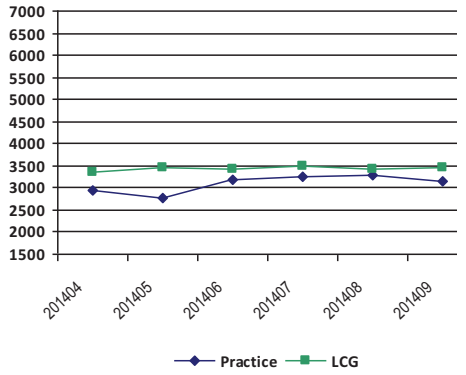
South Eastern LCG Practice Number Z

Annual Indicative Amount	**425,989**
Number of Patients	**1,704**
Number of Northern Ireland Prescribing Units (NIPUs)	**10,381**
Current Month Spend *	**32,668**
Cost Per 1000 NIPUs *	**3,147**
Cumulative Spend Year to Date *	**193,502**
Cumulative Cost Per 1000 NIPUs Year to Date *	**18,560**
Projected Annual Spend *	**374,189**
Projected Over/Under Spend	**-51,800**
Projected % Over/Under Spend**	**-12.16%**

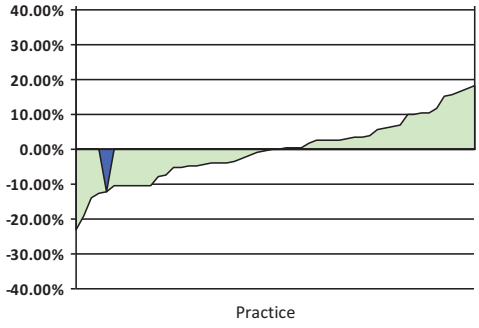
****If your % projected over/under spend is within -1% to 1% it will not display on the graph below**

NIPUs: In measuring prescribing, differences between practices are taken into account in order to make valid comparisons with local and national averages. NIPUs standardise for differences between practices in terms of patient list size, age/sex structure and additional needs.

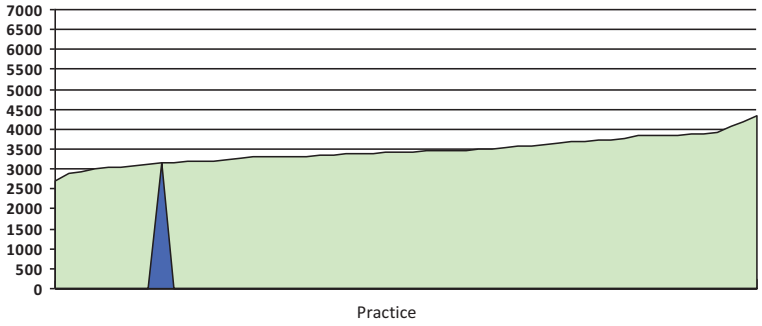
***Ingredient Cost per 1000 NIPU**



****Percentage Over/Under Spend for LCG Practices**



***Current Month Cost per 1000 NIPU for LCG Practices**



*** Excluding Expensive Drugs**

If you have any queries relating to this statement please contact your MMA

Providing Support to Health and Social Care

HSC Indicative Prescribing Scheme

Monthly Prescribing Statement - September 2014

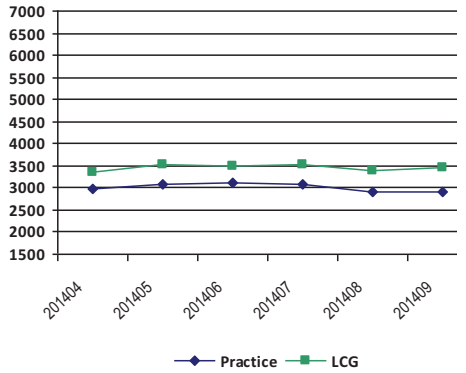
Northern LCG Practice Number Y

Annual Indicative Amount	**905,903**
Number of Patients	**4,067**
Number of Northern Ireland Prescribing Units (NIPUs)	**21,971**
Current Month Spend *	**63,761**
Cost Per 1000 NIPUs *	**2,902**
Cumulative Spend Year to Date *	**395,964**
Cumulative Cost Per 1000 NIPUs Year to Date *	**18,093**
Projected Annual Spend *	**783,198**
Projected Over/Under Spend	**-122,704**
Projected % Over/Under Spend**	**-13.54%**

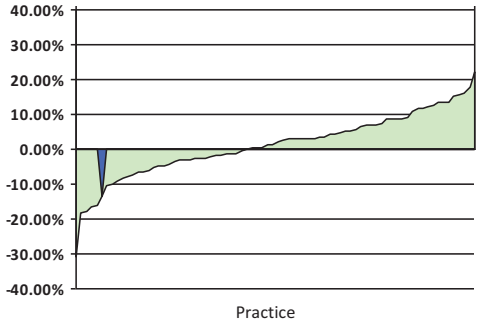
****If your % projected over/under spend is within -1% to 1% it will not display on the graph below**

NIPUs: In measuring prescribing, differences between practices are taken into account in order to make valid comparisons with local and national averages. NIPUs standardise for differences between practices in terms of patient list size, age/sex structure and additional needs.

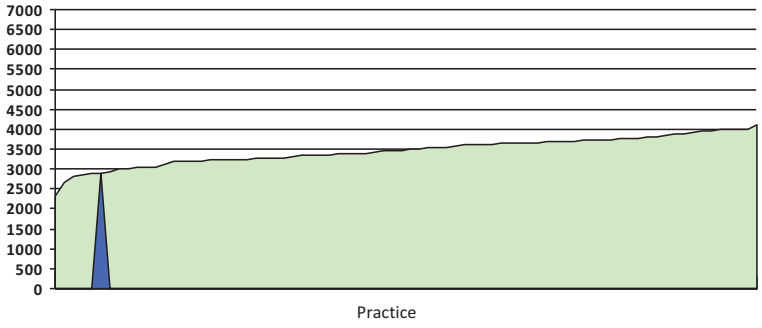
***Ingredient Cost per 1000 NIPU**



****Percentage Over/Under Spend for LCG Practices**



***Current Month Cost per 1000 NIPU for LCG Practices**



*** Excluding Expensive Drugs**

If you have any queries relating to this statement please contact your MMA

Providing Support to Health and Social Care

HSC Indicative Prescribing Scheme

Monthly Prescribing Statement - September 2014

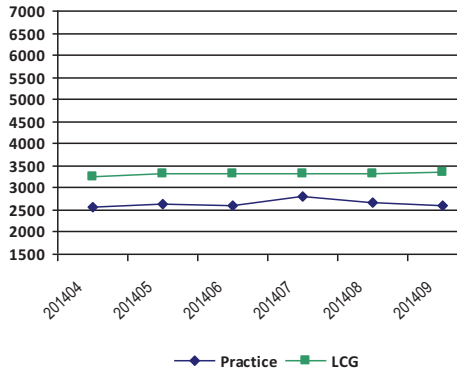
Southern LCG Practice Number AA

Annual Indicative Amount	**922,205**
Number of Patients	**4,759**
Number of Northern Ireland Prescribing Units (NIPUs)	**23,627**
Current Month Spend *	**61,549**
Cost Per 1000 NIPUs *	**2,605**
Cumulative Spend Year to Date *	**375,981**
Cumulative Cost Per 1000 NIPUs Year to Date *	**15,882**
Projected Annual Spend *	**762,319**
Projected Over/Under Spend	**-159,886**
Projected % Over/Under Spend**	**-17.34%**

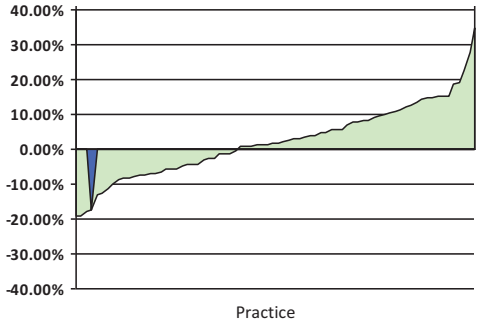
****If your % projected over/under spend is within -1% to 1% it will not display on the graph below**

NIPUs: In measuring prescribing, differences between practices are taken into account in order to make valid comparisons with local and national averages. NIPUs standardise for differences between practices in terms of patient list size, age/sex structure and additional needs.

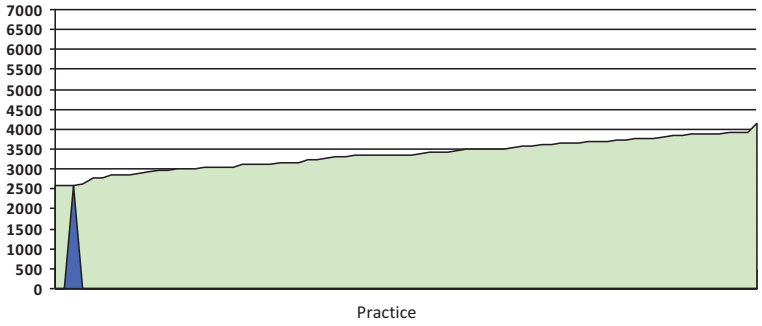
***Ingredient Cost per 1000 NIPU**



****Percentage Over/Under Spend for LCG Practices**



***Current Month Cost per 1000 NIPU for LCG Practices**



*** Excluding Expensive Drugs**

If you have any queries relating to this statement please contact your MMA

Providing Support to Health and Social Care

HSC Indicative Prescribing Scheme

Monthly Prescribing Statement - September 2014

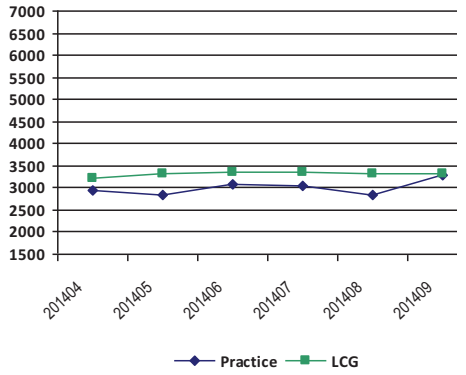
Western LCG Practice Number A

Annual Indicative Amount	**597,340**
Number of Patients	**2,972**
Number of Northern Ireland Prescribing Units (NIPUs)	**15,119**
Current Month Spend *	**49,486**
Cost Per 1000 NIPUs *	**3,273**
Cumulative Spend Year to Date *	**271,005**
Cumulative Cost Per 1000 NIPUs Year to Date *	**18,001**
Projected Annual Spend *	**547,830**
Projected Over/Under Spend	**-49,510**
Projected % Over/Under Spend**	**-8.29%**

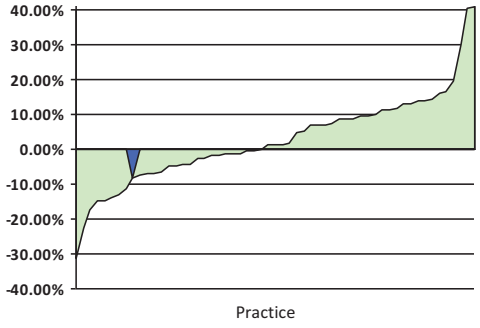
****If your % projected over/under spend is within -1% to 1% it will not display on the graph below**

NIPUs: In measuring prescribing, differences between practices are taken into account in order to make valid comparisons with local and national averages. NIPUs standardise for differences between practices in terms of patient list size, age/sex structure and additional needs.

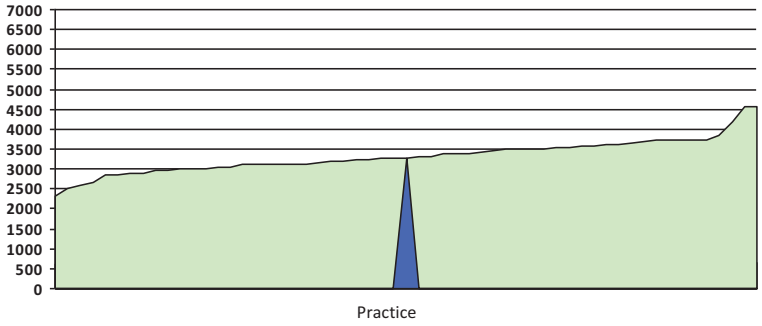
***Ingredient Cost per 1000 NIPU**



****Percentage Over/Under Spend for LCG Practices**



***Current Month Cost per 1000 NIPU for LCG Practices**



*** Excluding Expensive Drugs**

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Providing Support to Health and Social Care

HSC Indicative Prescribing Scheme

LCG Monthly Prescribing - September 2014

BELFAST	
Annual Indicative Amount	98,652,810
Number of Patients	432,160
Number of Northern Ireland Prescribing Units (NIPUs)	2,366,750
Current Month Total Spend (Including Expensive Drugs, OOH's and NMP's)	7,835,166
Cost Per 1000 NIPUs	3,311
Cumulative Spend Year to Date	47,867,332
Projected Annual Spend	94,976,310
Projected Over/Under Spend	-3,676,500
Projected % Over/Under Spend	-3.73%
NORTHERN	
Annual Indicative Amount	100,086,168
Number of Patients	455,629
Number of Northern Ireland Prescribing Units (NIPUs)	2,401,395
Current Month Total Spend (Including Expensive Drugs, OOH's and NMP's)	8,400,027
Cost Per 1000 NIPUs	3,498
Cumulative Spend Year to Date	50,417,087
Projected Annual Spend	100,508,030
Projected Over/Under Spend	421,862
Projected % Over/Under Spend	0.42%
SOUTH EASTERN	
Annual Indicative Amount	72,382,111
Number of Patients	317,851
Number of Northern Ireland Prescribing Units (NIPUs)	1,736,211
Current Month Total Spend (Including Expensive Drugs, OOH's and NMP's)	6,111,347
Cost Per 1000 NIPUs	3,520
Cumulative Spend Year to Date	36,345,680
Projected Annual Spend	72,468,905
Projected Over/Under Spend	86,794
Projected % Over/Under Spend	0.12%

NIPUs: In measuring prescribing, differences between practices need to be taken into account in order to make valid comparisons with local and national averages. NIPUs standardise for differences between practices in terms of patient list size, age/sex structure and additional needs.

Providing Support to Health and Social Care

HSC

HSC Indicative Prescribing Scheme
LCG Monthly Prescribing - September 2014

SOUTHERN

Annual Indicative Amount	76,083,806
Number of Patients	399,475
Number of Northern Ireland Prescribing Units (NIPUs)	1,825,298
Current Month Total Spend (Including Expensive Drugs, OOH's and NMP's)	6,565,180
Cost Per 1000 NIPUs	3,597
Cumulative Spend Year to Date	38,862,392
Projected Annual Spend	77,901,208
Projected Over/Under Spend	1,817,402
Projected % Over/Under Spend	2.39%

WESTERN

Annual Indicative Amount	65,349,453
Number of Patients	324,187
Number of Northern Ireland Prescribing Units (NIPUs)	1,567,935
Current Month Total Spend (Including Expensive Drugs, OOH's and NMP's)	5,568,945
Cost Per 1000 NIPUs	3,552
Cumulative Spend Year to Date	33,577,973
Projected Annual Spend	67,468,520
Projected Over/Under Spend	2,119,067
Projected % Over/Under Spend	3.24%

NIPUs: In measuring prescribing, differences between practices need to be taken into account in order to make valid comparisons with local and national averages. NIPUs standardise for differences between practices in terms of patient list size, age/sex structure and additional needs.

Providing Support to Health and Social Care

Health and Social Care Board (HSCB) COMPASS Report

HSCB

April-June 2014

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Quarter last year: Apr-Jun 13

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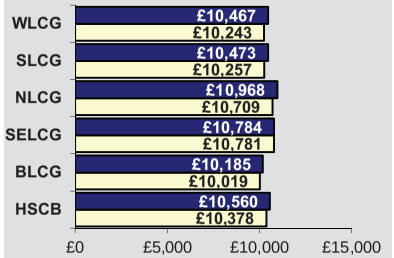
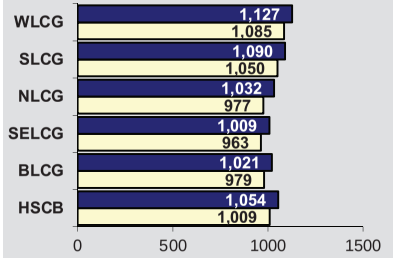
BLCG
SELCG
NLCG
SLCG
WLCG

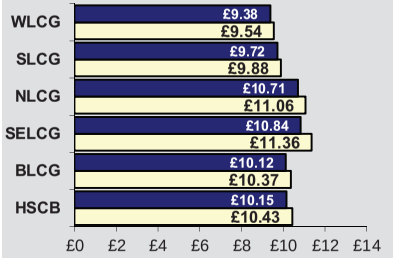
Cost /1000 NIPUs



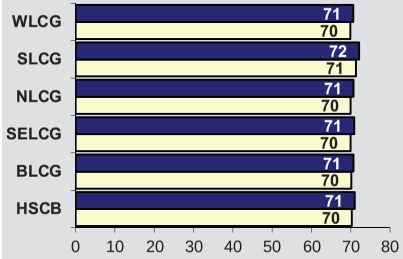
Items /1000 NIPUs



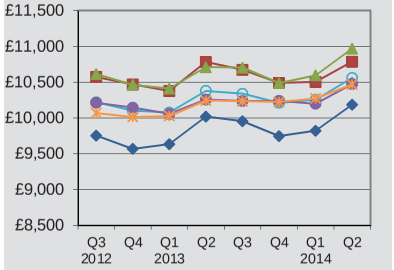
Cost /Item



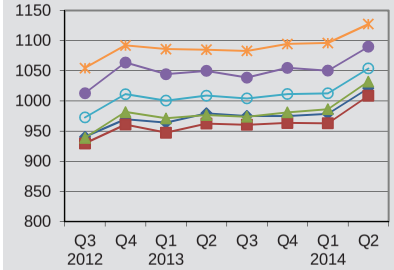
Generic dispensing rate (%)



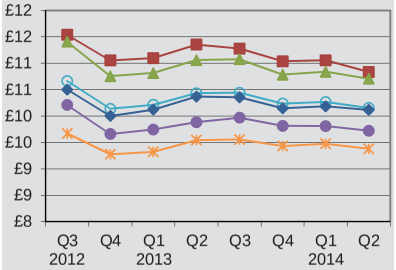
Cost /1000 NIPUs



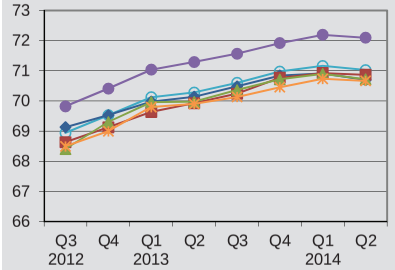
Items /1000 NIPUs



Cost /Item



Generic dispensing rate (%)



COMPASS Unit, Operations Directorate, FPS, BSO, 2 Franklin Street, Belfast BT2 8DQ Web site: http://www.hscbusiness.hscni.net/services.htm Tel: 028 9053 5661 Fax: 028 9053 2963

Top 40 : Forty most costly drugs in the HSCB

HSCB

	Drug Name	Cost (£)	No of Items	Quantity	Cost (£) /Item	% of NI Total Cost	Change from last year
1	TIOTROPIUM BROMIDE (DT) 18MICROGRAM [INHALATION	1,127,526	26,048	1,009,724	43.29	1.10	0.06
2	SERETIDE WITH COUNTER 250MCG/25 [EVOHALER]	1,011,576	13,676	17,007	73.97	0.99	-0.06
3	PREGABALIN (DT) 75MG [CAPSULE]	975,972	14,553	848,671	67.06	0.95	0.05
4	PREGABALIN (DT) 150MG [CAPSULE]	881,827	12,713	766,806	69.36	0.86	0.08
5	TEMAZEPAM (DT) 10MG [TABLET]	873,650	45,808	1,190,302	19.07	0.85	-0.37
6	SYMBICORT 200/6 [TURBOHALER]	870,884	17,572	22,918	49.56	0.85	0.01
7	FLUTICASONE 250MICROGRAMS/DOSE / SALMETEROL 25M	851,337	11,209	14,313	75.95	0.83	0.08
8	INSULIN LANTUS SOLOSTAR 3ML [PRE-FILLED PEN]	697,001	13,033	83,976	53.48	0.68	0.02
9	PREGABALIN (DT) 300MG [CAPSULE]	670,266	9,979	582,840	67.17	0.65	0.07
10	BUDESONIDE 200MICROGRAMS/DOSE / FORMOTEROL 6MI	664,202	13,045	17,479	50.92	0.65	0.03
11	EZETIMIBE (DT) 10MG [TABLET]	634,775	15,051	675,549	42.17	0.62	-0.03
12	AVIVA [REAGENT]	619,306	18,878	1,986,229	32.81	0.61	0.02
13	VICTOZA 3ML [PRE-FILLED INJECTION PEN]	583,891	5,714	14,880	102.19	0.57	-0.04
14	PREGABALIN (DT) 50MG [CAPSULE]	579,939	8,564	504,295	67.72	0.57	0.07
15	VERSATIS [MEDICATED PLASTER]	557,844	9,140	231,153	61.03	0.55	0.04
16	DULOXETINE (DT) 60MG [GASTRO-RESISTANT CAPSULE]	551,689	14,796	557,262	37.29	0.54	0.08
17	ROSUVASTATIN (DT) 10MG [TABLET]	547,424	18,904	850,130	28.96	0.53	-0.02
18	INSULIN NOVORAPID FLEXPEN 3ML [PRE-FILLED PEN]	542,336	11,903	88,617	45.56	0.53	0.01
19	NEBIVOLOL (DT) 2.5MG [TABLET]	511,185	5,374	205,130	95.12	0.50	0.08
20	INSULIN NOVOMIX 30 FLEXPEN 3ML [INJECTION DEVICE]	502,212	10,462	84,010	48.00	0.49	0.01
21	PREGABALIN (DT) 100MG [CAPSULE]	495,670	7,088	431,017	69.93	0.48	0.06
22	CO-CODAMOL (DT) 30MG/500MG [TABLET]	486,950	140,327	11,067,069	3.47	0.48	-0.01
23	SOLIFENACIN (DT) 5MG [TABLET]	480,677	13,525	522,085	35.54	0.47	0.01
24	ROSUVASTATIN (DT) 20MG [TABLET]	438,416	10,857	471,777	40.38	0.43	0.02
25	OMEPRAZOLE (DT) 20MG [GASTRO-RESISTANT CAPSULE]	435,588	237,019	10,605,961	1.84	0.43	-0.03
26	FORTISIP COMPACT 125ML [BOTTLE]	406,545	6,382	201,260	63.70	0.40	0.03
27	PREGABALIN (DT) 25MG [CAPSULE]	398,687	6,178	346,684	64.53	0.39	0.06
28	HYDROCORTISONE (DT) 10MG [TABLET]	398,467	2,308	194,108	172.65	0.39	0.08
29	SITAGLIPTIN (DT) 100MG [TABLET]	391,716	7,913	329,767	49.50	0.38	0.02
30	SYMBICORT 400/12 [TURBOHALER]	371,754	7,201	9,783	51.63	0.36	0.02
31	BUTRANS 20MCG/HR [TRANSDERMAL PATCH]	360,763	5,802	25,114	62.18	0.35	0.02
32	SERETIDE WITH COUNTER 125MCG/25 [EVOHALER]	346,150	7,925	9,890	43.68	0.34	-0.03
33	LAMICTAL 100MG [TABLET]	344,660	4,302	314,005	80.12	0.34	0.04
34	SPIRIVA REFILL 18MCG [CAPSULE]	340,276	8,117	304,725	41.92	0.33	-0.01
35	ONE TOUCH ULTRA TEST STRIP [REAGENT]	330,605	12,525	1,378,670	26.40	0.32	-0.14
36	CO-CODAMOL (DT) 15MG/500MG [TABLET]	329,082	54,735	3,988,200	6.01	0.32	0.03
37	SOLIFENACIN (DT) 10MG [TABLET]	327,226	7,183	273,365	45.56	0.32	0.01
38	NUTRAMIGEN AA 400G [POWDER]	325,012	2,409	12,372	134.92	0.32	0.07
39	PREGABALIN (DT) 200MG [CAPSULE]	322,738	4,594	280,642	70.25	0.32	0.06
40	FLUTICASONE 125MICROGRAMS/DOSE / SALMETEROL 25M	318,780	7,091	9,108	44.96	0.31	0.03
	TOTAL	**21,904,605**	**849,903**			**21.40**	

G: Generic form available

Top 20 generic switches by cost

HSCB

	Proprietary Drug	Number of Items	Cost (£)	Generic equivalent	Potential Savings for the quarter (£)
1	NEXIUM 40MG [TABLET]	1,568	71,542	ESOMEPRAZOLE 40MG [GASTRO-RESISTANT TABLET]	£56,120
2	LOSEC 20MG [CAPSULE]	1,365	38,278	OMEPRAZOLE 20MG [GASTRO-RESISTANT CAPSULE]	£34,813
3	NEXIUM 20MG [TABLET]	1,311	46,406	ESOMEPRAZOLE 20MG [GASTRO-RESISTANT TABLET]	£34,315
4	XALATAN 2.5ML [EYE DROP]	2,044	39,487	LATANOPROST 50MICROGRAMS/ML [EYE DROP]	£33,190
5	ARIMIDEX 1MG [TABLET]	304	33,362	ANASTROZOLE 1MG [TABLET]	£32,423
6	SINGULAIR 10MG [TABLET]	890	34,334	MONTELUKAST 10MG [TABLET]	£31,126
7	PLAVIX 75MG [TABLET]	487	26,364	CLOPIDOGREL 75MG [TABLET]	£24,985
8	ARICEPT 10MG [TABLET]	180	18,135	DONEPEZIL 10MG [TABLET]	£17,766
9	LIPITOR 20MG [TABLET]	358	16,361	ATORVASTATIN 20MG [TABLET]	£15,425
10	BONDRONAT 50MG [TABLET]	68	15,063	IBANDRONIC ACID 50MG [TABLET]	£13,788
11	ACTONEL ONCE A WEEK 35MG [TABLET]	480	13,814	RISEDRONATE 35MG [TABLET]	£12,976
12	LIPITOR 40MG [TABLET]	291	12,911	ATORVASTATIN 40MG [TABLET]	£12,057
13	BONVIVA F/C 150MG [TABLET]	362	14,058	IBANDRONIC ACID 150MG [TABLET]	£11,751
14	SINGULAIR PAEDIATRIC CHEWABLE 5MG [TABLET]	371	12,913	MONTELUKAST SF 5MG [CHEWABLE TABLET]	£11,722
15	SEROQUEL 25MG [TABLET]	293	12,055	QUETIAPINE 25MG [TABLET]	£11,576
16	IMIGRAN 100MG [TABLET]	135	12,055	SUMATRIPTAN 100MG [TABLET]	£11,557
17	APROVEL 150MG [TABLET]	606	12,549	IRBESARTAN 150MG [TABLET]	£10,779
18	SINGULAIR PAEDIATRIC CHEWABLE 4MG [TABLET]	359	11,373	MONTELUKAST SF 4MG [CHEWABLE TABLET]	£10,395
19	XALACOM 2.5ML [EYE DROP]	707	15,065	LATANOPROST/TIMOLOL 50MICROGRAMS/ML / 5MG/ML [EYE DROP]	£9,678
20	EBIXA 20MG [TABLET]	311	24,208	MEMANTINE 20MG [TABLET]	£9,380
	Total	**12,490**	**480,331**		**£405,822**

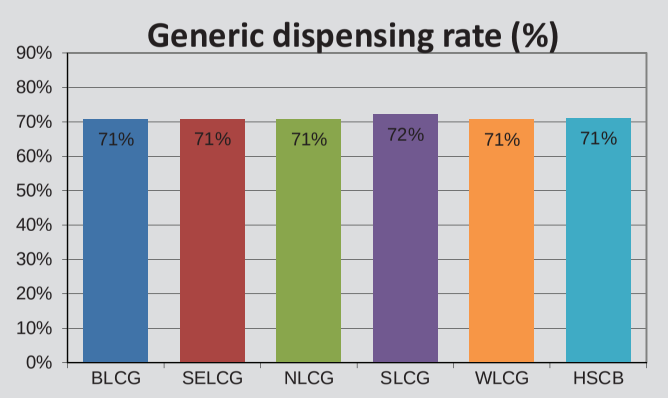
Potential savings per annum = £1,623,286

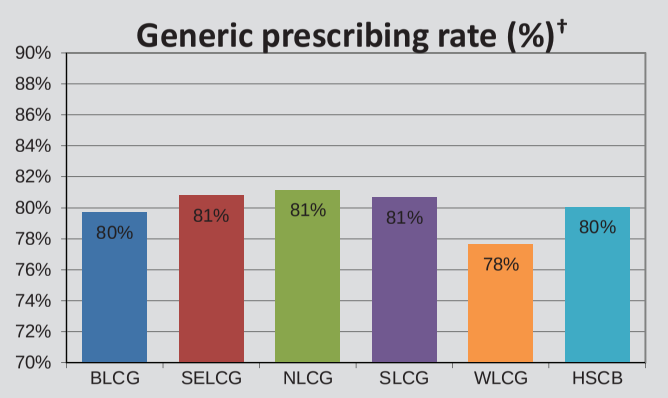
Top cost effective switches

HSCB

	Drug name	Number of Items	Spend	Cost effective choice	Potential Savings for the quarter
1	SOLIFENACIN (DT) 5MG [TABLET]	13,525	£480,677	TOLTERODINE (DT) 2MG [TABLET]	£430,703
2	SOLIFENACIN (DT) 10MG [TABLET]	7,183	£327,226	TOLTERODINE (DT) 2MG [TABLET]	£301,059
3	FESOTERODINE (DT) 4MG [MODIFIED-RELEASE TABLET]	3,966	£133,841	TOLTERODINE (DT) 2MG [TABLET]	£119,927
4	DOXAZOSIN (DT) 8MG [MODIFIED-RELEASE TABLET]	6,638	£113,622	DOXAZOSIN (DT) 4MG [TABLET]	£101,894
5	MOMETASONE NASAL (DT) 50MICROGRAMS/DOSE [SPRAY]	19,604	£162,944	BECLOMETASONE NASAL (DT) 50MCG [SPRAY]	£99,411
6	FESOTERODINE (DT) 8MG [MODIFIED-RELEASE TABLET]	2,266	£77,451	TOLTERODINE (DT) 2MG [TABLET]	£69,399
7	VESICARE FILM COATED 5MG [TABLET]	2,120	£74,965	TOLTERODINE (DT) 2MG [TABLET]	£67,171
8	FLUTICASONE PROPIONATE (DT) 50MICROGRAMS/DOSE [NASAL SPRAY]	6,985	£86,847	BECLOMETASONE NASAL (DT) 50MCG [SPRAY]	£61,763
9	AZITHROMYCIN (DT) 250MG [CAPSULE]	1,884	£71,356	AZITHROMYCIN (DT) 250MG [TABLET]	£55,710
10	DOXAZOSIN (DT) 4MG [MODIFIED-RELEASE TABLET]	7,653	£66,886	DOXAZOSIN (DT) 2MG [TABLET]	£55,383
11	NYSTATIN (DT) 100,000UNITS/ML [ORAL SUSPENSION]	4,595	£101,542	MICONAZOLE SUGAR FREE (DT) 20MG/G [OROMUCOSAL GEL]	£51,364
12	SALINE STERI-NEB [AMPOULE]	2,290	£135,822	STERIPOULES SODIUM CHLORIDE 2.5ML [AMPOULE]	£51,324
13	VESICARE FILM COATED 10MG [TABLET]	1,097	£50,032	TOLTERODINE (DT) 2MG [TABLET]	£46,032
14	OMEPRAZOLE (DT) 40MG [GASTRO-RESISTANT CAPSULE]	9,994	£65,713	OMEPRAZOLE (DT) 20MG [GASTRO-RESISTANT CAPSULE]	£31,978
15	PARACETAMOL 500MG SOLUBLE TABLETS (DT) 500MG [EFFERVESCENT TAB LET]	6,654	£44,613	PARACETAMOL (DT) 500MG [TABLET]	£30,540
16	TOVIAZ 4MG [TABLET]	1,028	£33,659	TOLTERODINE (DT) 2MG [TABLET]	£30,160
17	NITROFURANTOIN (DT) 50MG [TABLET]	2,031	£54,013	NITROFURANTOIN (DT) 50MG [CAPSULE]	£25,194
18	CO-CODAMOL (DT) 8MG/500MG [EFFERVESCENT TABLET]	7,971	£48,199	CO-CODAMOL (DT) 8MG/500MG [TABLET]	£24,992
19	IBUPROFEN (DT) 10% [GEL]	9,846	£56,866	KETOPROFEN (DT) 2.5% [GEL]	£24,653
20	AVAMYS NASAL 120 DOSE [SPRAY]	5,896	£40,675	BECLOMETASONE NASAL (DT) 50MCG [SPRAY]	£24,607
21	DICLOFENAC (DT) 1% [GEL]	9,298	£57,836	KETOPROFEN (DT) 2.5% [GEL]	£24,141
22	REGURIN XL 60MG [CAPSULE]	911	£26,158	TOLTERODINE (DT) 2MG [TABLET]	£23,117
23	LEVOCETIRIZINE (DT) 5MG [TABLET]	5,575	£31,492	CETIRIZINE (DT) 10MG [TABLET]	£23,015
24	OMEPRAZOLE DISPERSIBLE (DT) 20MG [GASTRO-RESISTANT TABLET]	1,810	£28,946	LANSOPRAZOLE (DT) 15MG [ORODISPERSIBLE TABLET]	£21,211
25	MOVICOL POWDER [SACHET]	10,220	£103,961	LAXIDO ORANGE SUGAR FREE [ORAL POWDER SACHET]	£20,906
	Total	**151,040**	**£2,475,346**		**£1,815,655**

Overall Generic Dispensing — *HSCB*





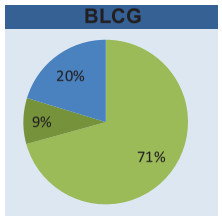
The range of generic drugs listed within Part I of the NI drug tariff increased in April 2011. This change may have increased the generic dispensing rate.

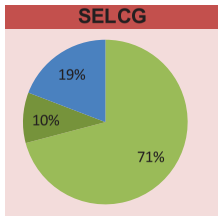
Prescribed and dispensed generically
Prescribed generically and dispensed by brand as no generic is currently available
Presribed and dispensed by brand

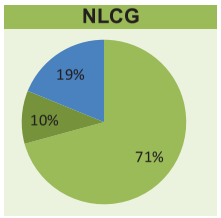
†The generic **prescribing** rates chart is new. This chart reports GP prescribing of generics. This will include drugs that, although prescribed generically, will have been dispensed by brand as no generic is currently available.

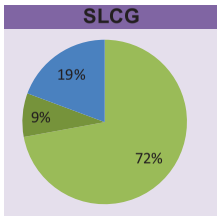
NB 100% generic prescribing rate is not achievable or desired as there are a number of items unsuitable for generic prescribing. See link below:

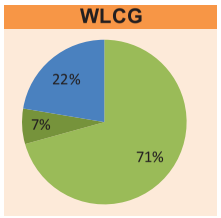
http://www.hscboard.hscni.net/medicinesmanagement/Prescribing%20Guidance/index.html

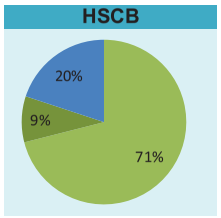






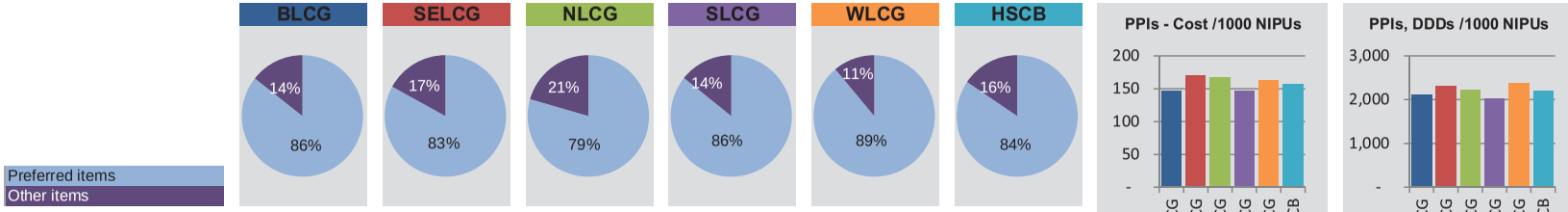


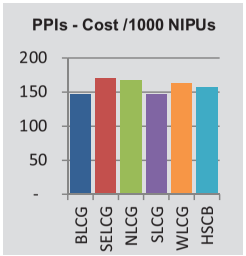


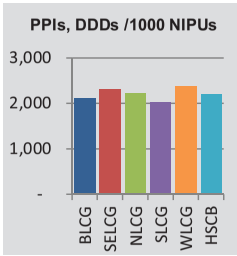


Proton Pump Inhibitors (PPIs)

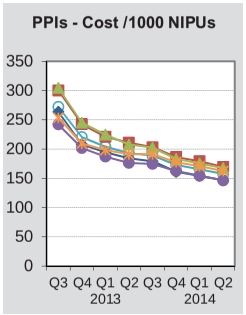
HSCB

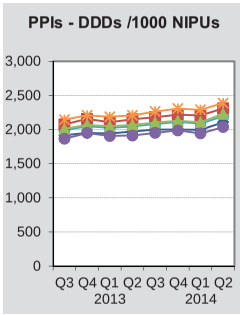


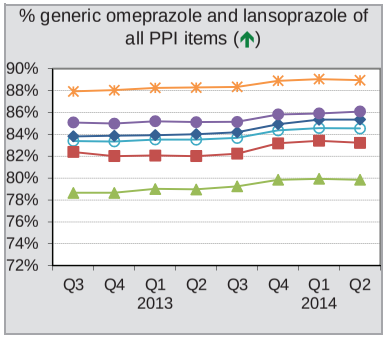


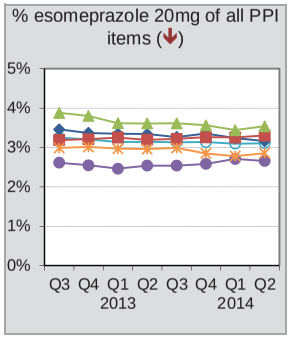


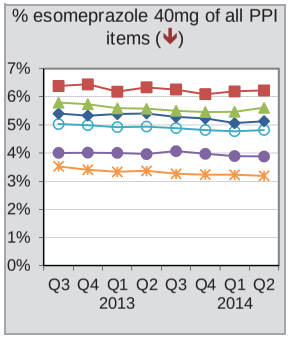
Drug name	Items	%	Items	%	Items	%	Items	%	Items	%	Items	%
Lansoprazole	36084	31.14%	26308	31.22%	34755	30.85%	40902	42.06%	20504	21.11%	158553	31.26%
Omeprazole	63116	54.47%	43643	51.78%	54781	48.63%	42461	43.67%	65883	67.82%	269884	53.21%
Pantoprazole	5641	4.87%	4927	5.85%	10431	9.26%	6210	6.39%	3082	3.17%	30291	5.97%
Losec	264	0.23%	210	0.25%	350	0.31%	396	0.41%	381	0.39%	1611	0.32%
Protium	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%
Esomeprazole (tablets)	8931	7.71%	7688	9.12%	9890	8.78%	5838	6.00%	5496	5.66%	37843	7.46%
Lansoprazole orodispersible†	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%
Omeprazole dispersible†	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%
Rabeprazole	488	0.42%	406	0.48%	926	0.82%	353	0.36%	241	0.25%	2414	0.48%
Emozul (capsules)	29	0.03%	30	0.04%	2	0.00%	16	0.02%	18	0.02%	95	0.02%
Nexium (tablets)	523	0.45%	512	0.61%	775	0.69%	413	0.42%	660	0.68%	2883	0.57%
Pariet	43	0.04%	43	0.05%	76	0.07%	61	0.06%	58	0.06%	281	0.06%
Losec MUPS†	428	0.37%	295	0.35%	318	0.28%	324	0.33%	519	0.53%	1884	0.37%
Zoton FasTab†	330	0.28%	217	0.26%	341	0.30%	266	0.27%	305	0.31%	1459	0.29%









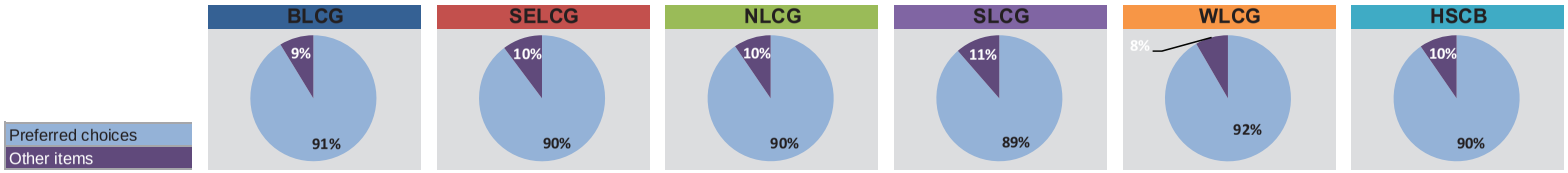


Q1 = Jan/Mar

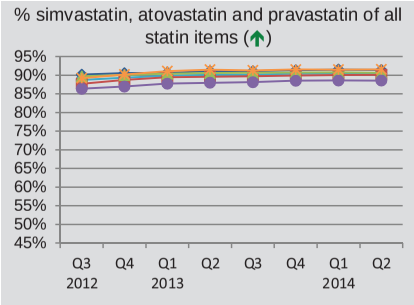
Upward trend preferable ↑

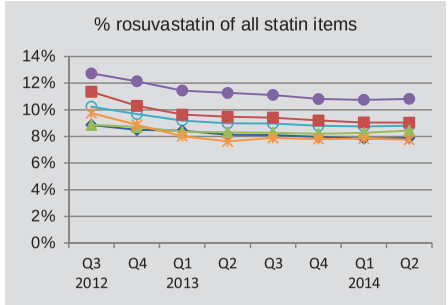
Downward trend preferable ↓

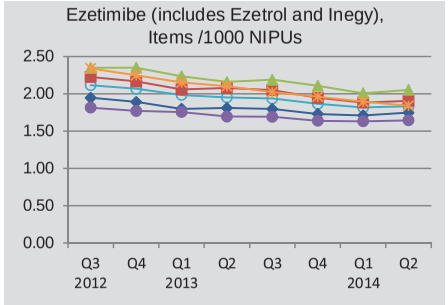
Lipid lowering drugs — *HSCB*



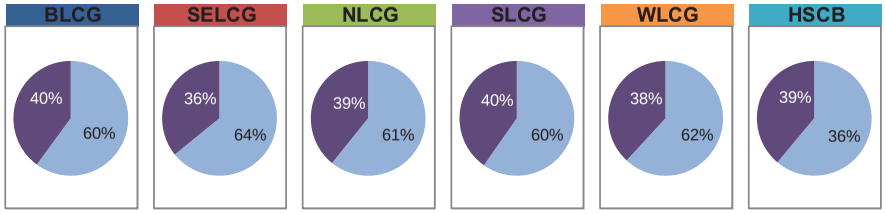
Drug name	BLCG Items	BLCG %	SELCG Items	SELCG %	NLCG Items	NLCG %	SLCG Items	SLCG %	WLCG Items	WLCG %	HSCB Items	HSCB %
Simvastatin 10mg	2144	2.11%	2192	2.84%	2054	2.09%	1450	1.58%	1344	1.48%	9184	2.00%
Simvastatin 20mg	12503	12.30%	7893	10.24%	9574	9.76%	8376	9.14%	10462	11.51%	48808	10.62%
Simvastatin 40mg	33785	33.23%	26269	34.09%	28458	29.00%	33912	37.01%	30818	33.89%	153242	33.35%
Simvastatin 80mg	50	0.05%	146	0.19%	81	0.08%	76	0.08%	62	0.07%	415	0.09%
Simvastatin 20mg/5ml	28	0.03%	23	0.03%	31	0.03%	17	0.02%	42	0.05%	141	0.03%
Simvastatin 40mg/5ml	53	0.05%	77	0.10%	49	0.05%	51	0.06%	39	0.04%	269	0.06%
Atorvastatin 10mg	8943	8.80%	7316	9.49%	8771	8.94%	5472	5.97%	6951	7.64%	37453	8.15%
Atorvastatin 20mg	12793	12.58%	8142	10.56%	13787	14.05%	8031	8.76%	11232	12.35%	53985	11.75%
Atorvastatin 40mg	16661	16.39%	11845	15.37%	16812	17.13%	18386	20.06%	16903	18.59%	80607	17.54%
Atorvastatin 80mg	1388	1.37%	1238	1.61%	1066	1.09%	1086	1.19%	2053	2.26%	6831	1.49%
Pravastatin	4442	4.37%	4048	5.25%	8088	8.24%	4319	4.71%	3380	3.72%	24277	5.28%
Fluvastatin	277	0.27%	218	0.28%	253	0.26%	210	0.23%	143	0.16%	1101	0.24%
Rosuvastatin	7587	7.46%	6918	8.98%	7943	8.09%	8721	9.52%	6015	6.62%	37184	8.09%
Simvastatin + Ezetimibe	95	0.09%	82	0.11%	117	0.12%	75	0.08%	58	0.06%	427	0.09%
Lescol /other brands	16	0.02%	6	0.01%	20	0.02%	19	0.02%	12	0.01%	73	0.02%
Lipostat	15	0.01%	27	0.04%	34	0.03%	11	0.01%	27	0.03%	114	0.02%
Zocor	29	0.03%	13	0.02%	20	0.02%	24	0.03%	16	0.02%	102	0.02%
Crestor	648	0.64%	413	0.54%	605	0.62%	1162	1.27%	1085	1.19%	3913	0.85%
Inegy	52	0.05%	23	0.03%	56	0.06%	56	0.06%	29	0.03%	216	0.05%
Lipitor 10mg	52	0.05%	71	0.09%	113	0.12%	61	0.07%	121	0.13%	418	0.09%
Lipitor 20mg	66	0.06%	45	0.06%	133	0.14%	49	0.05%	71	0.08%	364	0.08%
Lipitor 40mg	44	0.04%	53	0.07%	70	0.07%	71	0.08%	53	0.06%	291	0.06%
Lipitor 80mg	5	0.00%	8	0.01%	9	0.01%	1	0.00%	7	0.01%	30	0.01%



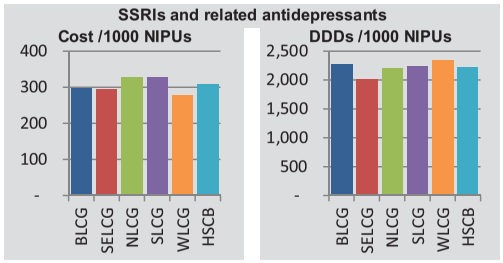


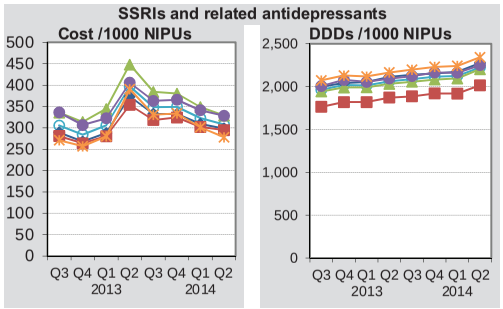


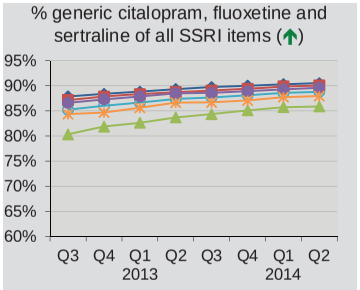
SSRIs and related antidepressant drugs

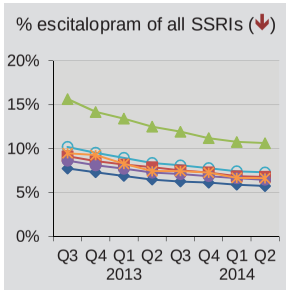


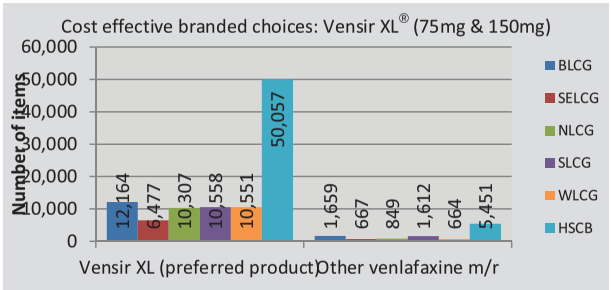
Drug name	BLCG Items	BLCG %	SELCG Items	SELCG %	NLCG Items	NLCG %	SLCG Items	SLCG %	WLCG Items	WLCG %	HSCB Items	HSCB %
Citalopram	32292	25.18%	23424	30.11%	26867	23.31%	24780	24.59%	22006	23.17%	129369	25.02%
Fluoxetine	23958	18.68%	14973	19.25%	18813	16.32%	19116	18.97%	17671	18.60%	94531	18.28%
Sertraline	20807	16.23%	11505	14.79%	24395	21.17%	16278	16.15%	19086	20.09%	92071	17.81%
Duloxetine	5098	3.98%	4425	5.69%	5448	4.73%	4015	3.98%	2906	3.06%	21892	4.23%
Escitalopram	4717	3.68%	3675	4.72%	7648	6.64%	3889	3.86%	3512	3.70%	23441	4.53%
Flupentixol	22	0.02%	117	0.15%	101	0.09%	105	0.10%	44	0.05%	389	0.08%
Fluvoxamine	51	0.04%	30	0.04%	72	0.06%	25	0.02%	32	0.03%	210	0.04%
Mirtazapine	18805	14.67%	7994	10.28%	13935	12.09%	13140	13.04%	10722	11.29%	64596	12.49%
Paroxetine	2596	2.02%	1442	1.85%	2329	2.02%	2309	2.29%	3088	3.25%	11764	2.28%
Reboxetine	79	0.06%	102	0.13%	136	0.12%	70	0.07%	43	0.05%	430	0.08%
Venlafaxine (incl. XL)	2956	2.31%	1366	1.76%	2323	2.02%	2960	2.94%	1236	1.30%	10841	2.10%
Cipramil	80	0.06%	45	0.06%	49	0.04%	40	0.04%	68	0.07%	282	0.05%
Efexor /XL /other brands	14500	11.31%	7473	9.61%	11512	9.99%	12266	12.17%	12587	13.25%	58338	11.28%
Faverin	3	0.00%	8	0.01%	6	0.01%	8	0.01%	5	0.01%	30	0.01%
Lustral	78	0.06%	47	0.06%	120	0.10%	105	0.10%	86	0.09%	436	0.08%
Prozac	79	0.06%	46	0.06%	45	0.04%	72	0.07%	83	0.09%	325	0.06%
Seroxat	118	0.09%	35	0.04%	85	0.07%	90	0.09%	60	0.06%	388	0.08%
Cipralex	396	0.31%	189	0.24%	529	0.46%	545	0.54%	672	0.71%	2331	0.45%
Cymbalta	1417	1.11%	809	1.04%	728	0.63%	772	0.77%	866	0.91%	4592	0.89%
Edronax	35	0.03%	20	0.03%	20	0.02%	43	0.04%	19	0.02%	137	0.03%
Fluanxol	62	0.05%	27	0.03%	51	0.04%	115	0.11%	116	0.12%	371	0.07%
Optimax	0	0.00%	1	0.00%	0	0.00%	9	0.01%	2	0.00%	12	0.00%
Zispin SolTab	76	0.06%	29	0.04%	36	0.03%	31	0.03%	86	0.09%	258	0.05%

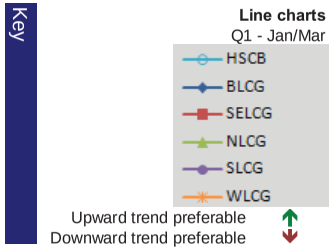


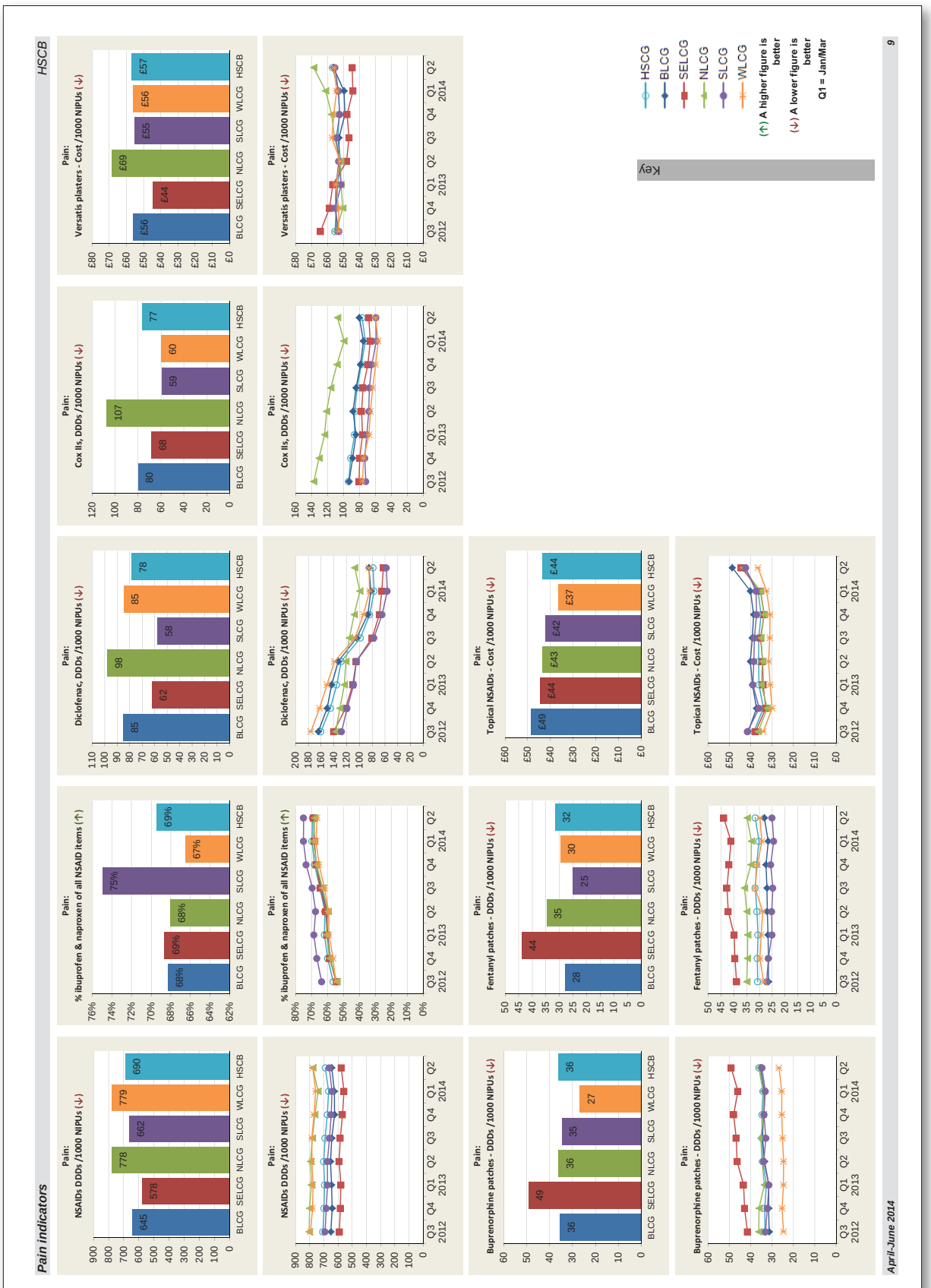











HSCB
Pain indicators
Pain:
NSAIDs DDDs /1000 NIPUs (↓)
BLCG 645
SELCG 578
NLCG 778
SLCG 662
WLCG 779
HSCB 690
Pain:
% ibuprofen & naproxen of all NSAID items (↑)
BLCG 68%
SELCG 69%
NLCG 68%
SLCG 75%
WLCG 67%
HSCB 69%
Pain:
Diclofenac, DDDs /1000 NIPUs (↓)
BLCG 85
SELCG 62
NLCG 98
SLCG 58
WLCG 85
HSCB 78
Pain:
Cox IIs, DDDs /1000 NIPUs (↓)
BLCG 80
SELCG 68
NLCG 107
SLCG 59
WLCG 60
HSCB 77
Pain:
Versatis plasters - Cost /1000 NIPUs (↓)
BLCG £56
SELCG £44
NLCG £69
SLCG £55
WLCG £56
HSCB £57
Pain:
Buprenorphine patches - DDDs /1000 NIPUs (↓)
BLCG 36
SELCG 49
NLCG 36
SLCG 35
WLCG 27
HSCB 36
Pain:
Fentanyl patches - DDDs /1000 NIPUs (↓)
BLCG 28
SELCG 44
NLCG 35
SLCG 25
WLCG 30
HSCB 32
Pain:
Topical NSAIDs - Cost /1000 NIPUs (↓)
BLCG £49
SELCG £44
NLCG £43
SLCG £42
WLCG £37
HSCB £44
Key
HSCG
BLCG
SELCG
NLCG
SLCG
WLCG
(↑) A higher figure is better
(↓) A lower figure is better
Q1 = Jan/Mar
April-June 2014
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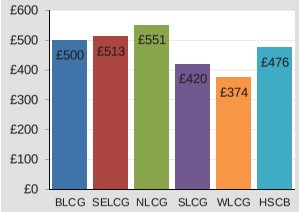
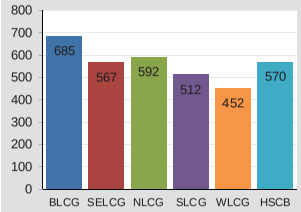
Pain indicators

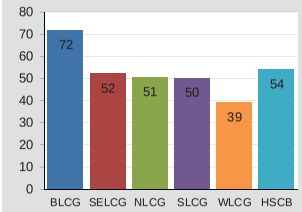
Pregabalin, Cost /1000 NIPUs (↓)



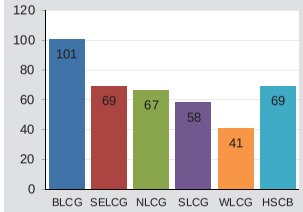
Paracetamol-opioid compound analgesics, DDDs /1000 NIPUs



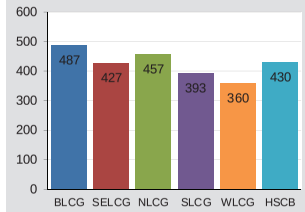
Co-codamol 8/500, DDDs /1000 NIPUs



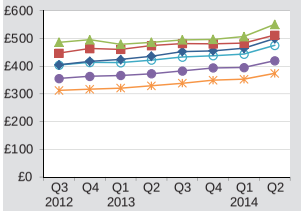
Co-codamol 15/500, DDDs /1000 NIPUs



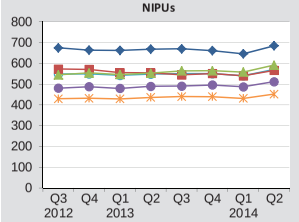
Co-codamol 30/500, DDDs /1000 NIPUs



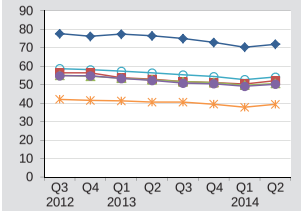
Pregabalin, Cost /1000 NIPUs (↓)



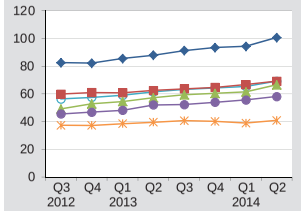
Paracetamol-opioid compound analgesics, DDDs /1000 NIPUs



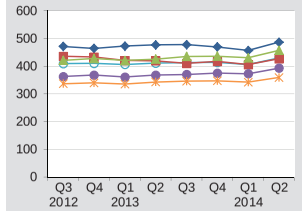
Co-codamol 8/500, DDDs /1000 NIPUs



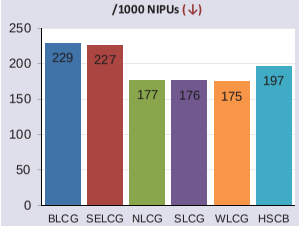
Co-codamol 15/500, DDDs /1000 NIPUs



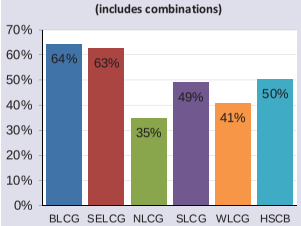
Co-codamol 30/500, DDDs /1000 NIPUs



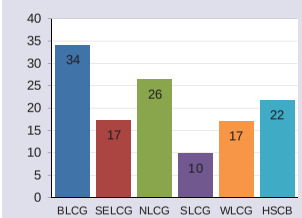
Tramadol/ tramadol-containing preparations, DDDs /1000 NIPUs (↓)



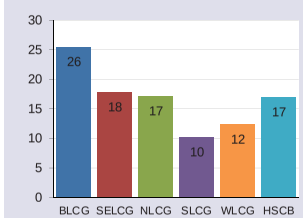
Tramadol MR items as a % of all tramadol items (↑) (includes combinations)



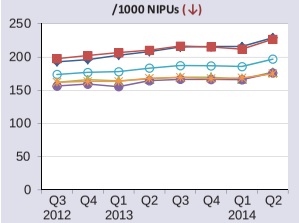
Dihydrocodeine, DDDs /1000 NIPUs (↓)



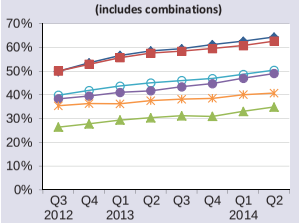
Co-dydramol, DDDs /1000 NIPUs



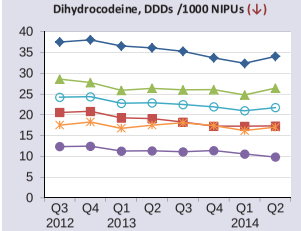
Tramadol/ tramadol-containing preparations, DDDs /1000 NIPUs (↓)



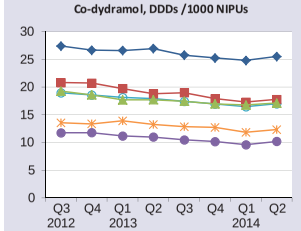
Tramadol MR items as a % of all tramadol items (↑) (includes combinations)

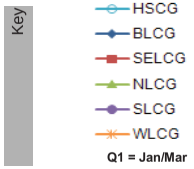


Dihydrocodeine, DDDs /1000 NIPUs (↓)



Co-dydramol, DDDs /1000 NIPUs

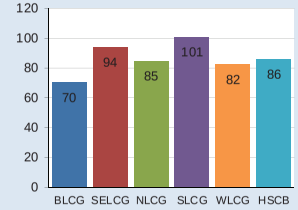




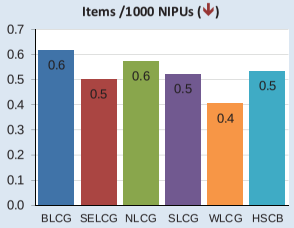
Other Indicators

Respiratory: Combination Inhalers
Cost per asthma/COPD patient (↓)

Respiratory:
Leukotriene receptor antagonists, DDDs /1000 NIPUs (↓)

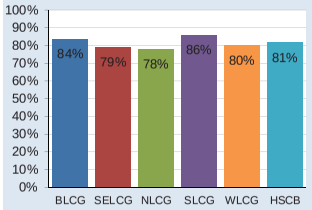


Orlistat:
Items /1000 NIPUs (↓)

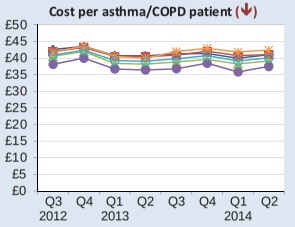


Endocrine:
Blood glucose monitoring, cost /1000 NIPUs (↓)

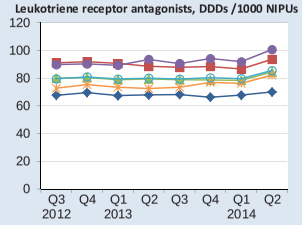
Endocrine:
% metformin & sulphonylureas (↑)



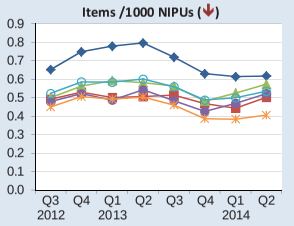
Respiratory: Combination Inhalers
Cost per asthma/COPD patient (↓)



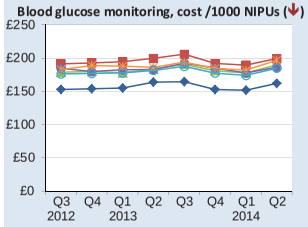
Respiratory:
Leukotriene receptor antagonists, DDDs /1000 NIPUs (↓)



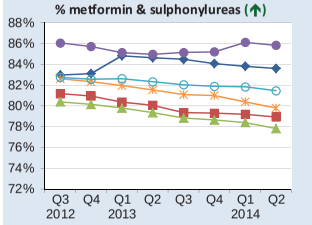
Orlistat:
Items /1000 NIPUs (↓)



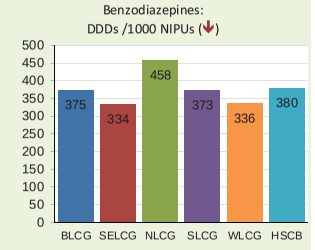
Endocrine:
Blood glucose monitoring, cost /1000 NIPUs (↓)



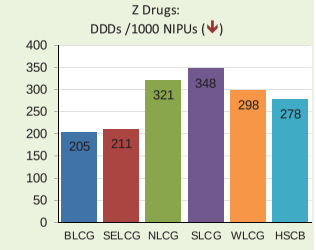
Endocrine:
% metformin & sulphonylureas (↑)



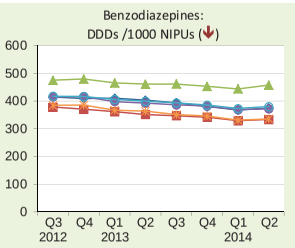
Benzodiazepines:
DDDs /1000 NIPUs (↓)



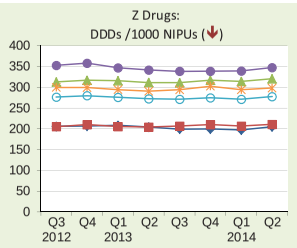
Z Drugs:
DDDs /1000 NIPUs (↓)



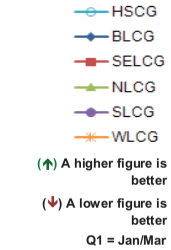
Benzodiazepines:
DDDs /1000 NIPUs (↓)



Z Drugs:
DDDs /1000 NIPUs (↓)



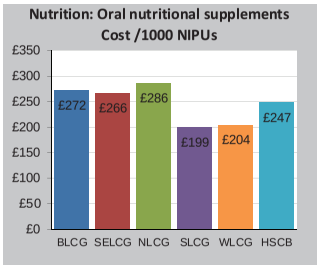
Key



(↑) A higher figure is better

(↓) A lower figure is better

Q1 = Jan/Mar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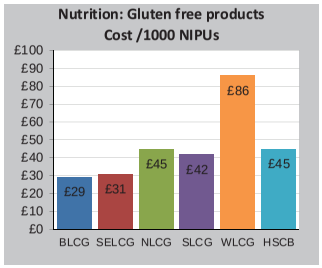
£350
£300
£250
£200
£150
£100
£50
£0
£272
£266
£286
£199
£204
£247
BLCG SELCG NLCG SLCG WLCG HSCB


Nutrition: Gluten free products
Cost /1000 NIPUs
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£90
£80
£70
£60
£50
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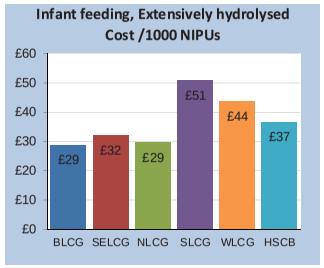
£10
£0
£29
£31
£45
£42
£86
£45
BLCG SELCG NLCG SLCG WLCG HSCB


Infant feeding, Extensively hydrolysed
Cost /1000 NIPUs
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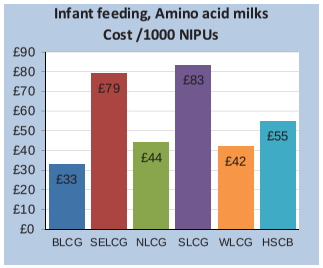
£50
£40
£30
£20
£10
£0
£29
£32
£29
£51
£44
£37
BLCG SELCG NLCG SLCG WLCG HSCB


Infant feeding, Amino acid milks
Cost /1000 NIPUs
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£80
£70
£60
£50
£40
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£20
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£33
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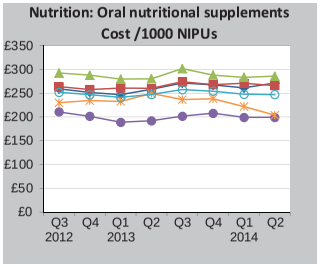
£44
£83
£42
£55
BLCG SELCG NLCG SLCG WLCG HSCB


Nutrition: Oral nutritional supplements
Cost /1000 NIPUs
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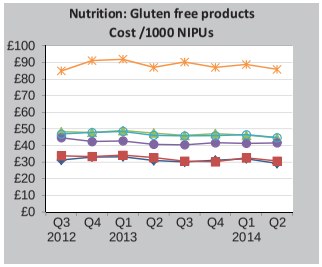
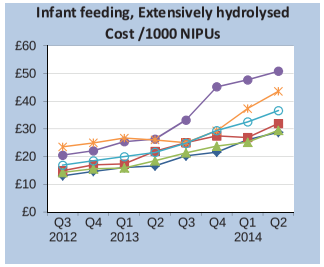
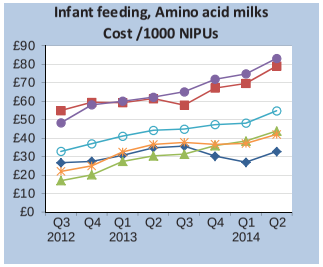
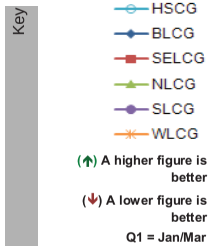
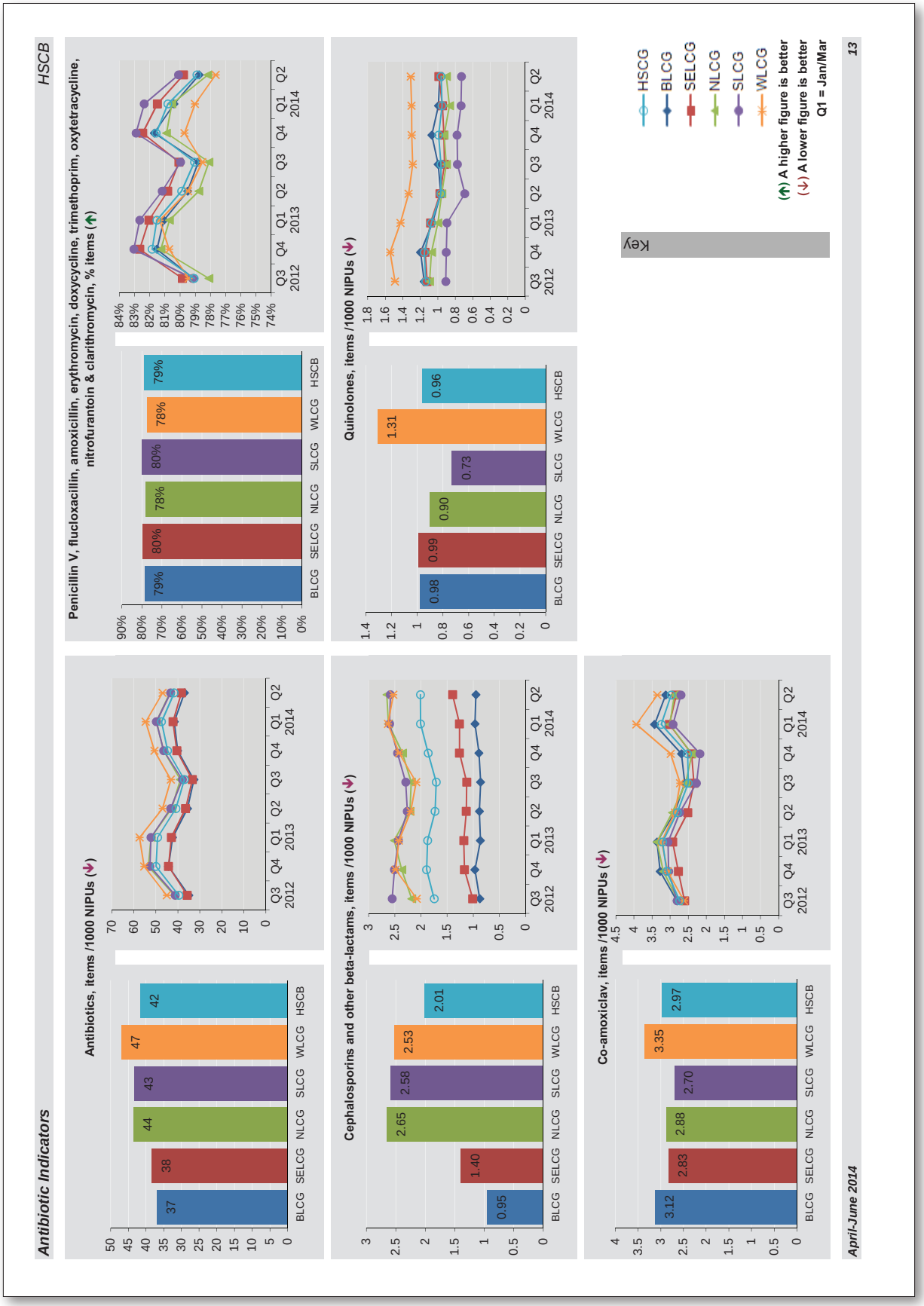
£300
£250
£200
£150
£100
£50
£0
Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2
2012 2013 2014


Nutrition: Gluten free products
Cost /1000 NIPUs
£100
£90
£80
£70
£60
£50
£40
£30
£20
£10
£0
Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2
2012 2013 2014


Infant feeding, Extensively hydrolysed
Cost /1000 NIPUs
£60
£50
£40
£30
£20
£10
£0
Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2
2012 2013 2014


Infant feeding, Amino acid milks
Cost /1000 NIPUs
£90
£80
£70
£60
£50
£40
£30
£20
£10
£0
Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2
2012 2013 2014


Key
HSCG
BLCG
SELCG
NLCG
SLCG
WLCG
(↑) A higher figure is better
(↓) A lower figure is better
Q1 = Jan/Mar


HSCB
Antibiotic Indicators
Antibiotics, items /1000 NIPUs (↓)
Penicillin V, flucloxacillin, amoxicillin, erythromycin, doxycycline, trimethoprim, oxytetracycline, nitrofurantoin & clarithromycin, % items (↑)
Quinolones, items /1000 NIPUs (↓)
Cephalosporins and other beta-lactams, items /1000 NIPUs (↓)
Co-amoxiclav, items /1000 NIPUs (↓)
BLCG SELCG NLCG SLCG WLCG HSCB
Q3 2012 Q4 Q1 2013 Q2 Q3 Q4 Q1 2014 Q2
Key
HSCG
BLCG
SELCG
NLCG
SLCG
WLCG
(↑) A higher figure is better
(↓) A lower figure is better
Q1 = Jan/Mar
April-June 2014
13

High Risk Drugs

Drug name/group	Items	Quantity
Warfarin 0.5mg	17	579
Warfarin 5mg	44	2,741
Methotrexate 10mg	17	362
Red List drugs	62	N/A

IV antibiotics: patient prescribing

Drug name	Items	Quantity
Amoxicillin 1g powder for solution for injection vials	1	1
Amoxil 1g powder for solution for injection vials	2	22
Augmentin Intravenous 1.2g powder for solution for injection vials	13	169
Augmentin Intravenous 600mg powder for solution for injection vials	6	131
Azactam 2g powder for solution for injection vials	1	5
Benzylpenicillin 600mg powder for solution for injection vials	1	15
Bramitob 300mg/4ml nebuliser solution 4ml ampoules	1	56
Ceftriaxone 1g powder for solution for injection vials	24	119
Ceftriaxone 250mg powder for solution for injection vials	1	2
Ceftriaxone 2g powder for solution for injection vials	12	65
Cidomycin Adult Injectable 80mg/2ml solution for injection ampoules	2	30
Cidomycin Adult Injectable 80mg/2ml solution for injection vials	3	20
Clarithromycin 500mg powder for solution for infusion vials	1	14
Crystapen 1.2g powder for solution for injection vials	3	79
Crystapen 600mg powder for solution for injection vials	3	6
Fortum 1g powder for solution for injection vials	2	14
Fortum 2g powder for solution for injection vials	1	42
Fortum 500mg powder for solution for injection vials	1	10
Genticin Injectable 80mg/2ml solution for injection ampoules	13	458
Kefadim 2g powder for solution for injection vials	2	3
Magnapen 500mg powder for solution for injection vials	1	5
Meronem 1g powder for solution for injection vials	5	59
Meronem 500mg powder for solution for injection vials	3	29
Piperacillin 2g / Tazobactam 250mg powder for solution for injection vials	1	30
Rocephin 1g powder for solution for injection vials	10	58
Rocephin 2g powder for solution for injection vials	2	9
Targocid 200mg powder and solvent for solution for injection vials	1	12
Targocid 400mg powder and solvent for solution for injection vials	2	17
Tavanic 500mg/100ml solution for infusion vials	1	3
Tazocin 2.25g powder for solution for injection vials	1	1
Tazocin 4.5g powder for solution for injection vials	11	219
Tobramycin 80mg/2ml solution for injection vials	1	0
Tygacil 50mg powder for solution for infusion vials	1	10
Vancocin 1g powder for solution for infusion vials	1	2
Zinacef 1.5g powder for injection vials	2	15
Zinacef 250mg powder for injection vials	1	40
Zinacef 750mg powder for injection vials	14	385
Totals	**151**	

Top 15 Stock items by cost (excluding dressings & appliances)

	Drug name	Cost (£)	Items	Quantity
1	Nexplanon 68mg implant	£20,898	43	263
2	Mirena 20micrograms/24hours intrauterine device	£13,024	33	148
3	Depo-Medrone 40mg/1ml suspension for injection vials	£10,152	181	2974
4	ViATIM vaccine suspension for injection 1ml pre-filled syringes	£10,132	31	340
5	Revaxis vaccine suspension for injection 0.5ml pre-filled syringes	£8,834	141	1359
6	Depo-Medrone with Lidocaine suspension for injection 1ml vials	£8,529	108	2191
7	EpiPen 300micrograms/0.3ml (1 in 1,000) solution for injection auto-injectors	£6,798	149	257
8	Chlorphenamine 10mg/1ml solution for injection ampoules	£6,777	377	2303
9	EpiPen Jr. 150micrograms/0.3ml (1 in 2,000) solution for injection auto-injectors	£6,110	127	231
10	Pneumovax II vaccine solution for injection 0.5ml vials	£6,107	64	734
11	Sodium chloride 0.9% irrigation solution 20ml Steripod unit dose	£5,301	160	16904
12	Depo-Medrone 80mg/2ml suspension for injection vials	£4,531	52	736
13	Kenalog Intra-articular / Intramuscular 40mg/1ml suspension for injection vials	£3,625	170	2433
14	Twinrix Adult vaccine suspension for injection 1ml pre-filled syringes	£3,553	10	120
15	Prednisolone 5mg soluble tablets	£3,518	73	2467
	Total	**£117,889**	**1,719**	
	Total of all Stock (including dressings and appliances)	**£876,931**	**27,136**	

Top 15 CDs (schedules 2, 3, 4 and 5)

	Drug name	Cost (£)	Items	Quantity
1	Buccolam 10mg/2ml oromucosal solution pre-filled oral syringes	£1,510	15	66
2	Midazolam 10mg/2ml oromucosal solution pre-filled oral syringes	£572	8	25
3	Cyclimorph 10 solution for injection 1ml ampoules	£535	56	305
4	Diamorphine 5mg powder for solution for injection ampoules	£491	36	216
5	Midazolam 5mg/1ml oromucosal solution pre-filled oral syringes	£470	3	22
6	Buccolam 5mg/1ml oromucosal solution pre-filled oral syringes	£428	5	20
7	Diamorphine 10mg powder for solution for injection ampoules	£339	26	132
8	Diazepam 5mg/2.5ml rectal solution tube	£215	41	197
9	Diazepam 10mg/2ml solution for injection ampoules	£189	45	421
10	Diazemuls 10mg/2ml emulsion for injection ampoules	£189	19	209
11	Buccolam 7.5mg/1.5ml oromucosal solution pre-filled oral syringes	£178	2	8
12	Nebido 1000mg/4ml solution for injection ampoules	£160	1	2
13	Chlordiazepoxide 10mg capsules	£151	20	1686
14	Cyclimorph 15 solution for injection 1ml ampoules	£119	12	65
15	Co-codamol 30mg/500mg tablets	£113	41	2576
	Total	**£5,659**	**330**	

Appendix: COMPASS Explanatory Notes

Glossary			
ICPs	Integrated Care Partnerships	NIPUs	Northern Ireland Prescribing Units
LCG	Local Commissioning Group		
HSCB	Health and Social Care Board		

Quarter: Information in the COMPASS report is based on three months of prescribing data, i.e. one quarter.

ICP average: Figures refer to the average of all practices within the respective ICP.

LCG average: Figures refer to the average of all practices within the respective LCG.

HSCB average: Figures refer to the average of all practices within the HSCB, i.e. all practices in NI.

Cost (£): Net ingredient cost, equivalent to England's Net Ingredient Cost (NIC). Cost is useful in terms of monitoring the overall drugs bill, checking spend within prescribing budgets and calculating savings made or potential savings. Cost is less useful as a measure of drug consumption because of the differences in cost of alternative preparations and changes in prices.

Items: Number of prescription items. Count of items is a reasonable measure of the number of courses of treatments for vaccinations and acute treatments such as short courses of antibiotics. For other treatments it is less useful because of the wide variation in duration of supply per item.

NIPUs: In measuring prescribing, differences between practices need to be taken account of in order to make valid comparisons with local and national averages. NIPUs standardise for differences between practices in terms of patient list size, age/sex structure and additional needs.

Quantity: Number of physical units, i.e. tablets, capsules, patches, mLs, inhalers, vials etc. Quantity is a useful measure of prescribing when looking at individual preparations, e.g. methotrexate 10mg or warfarin 0.5mg and 5mg.

Change from Last Year: The actual change from the same quarter in the previous year.

Defined Daily Dose (DDD): The DDD is a unit of measurement based on the assumed average maintenance dose per day used for its main indication in adults. The World Health Organisation (WHO) developed the DDD as a method to compare drugs of different chemical structures and potencies. The DDD methodology standardises quantities prescribed into number of daily doses. See worked example below. The number of DDDs is calculated as follows:

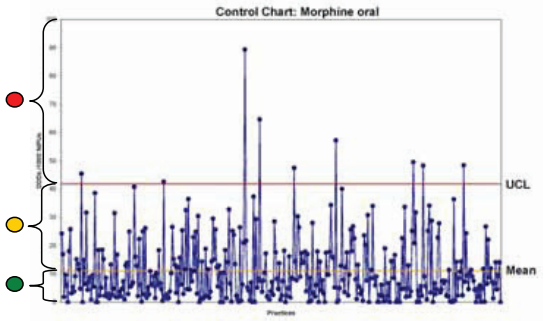
$$\text{Number of DDDs} = \frac{\text{Strength (mg) x quantity}}{\text{DDD (mg)}}$$

Worked example	Quantity (no. of tabs /caps)	DDD (mg)	No. of DDDs
Ibuprofen 200mg 2 caps 3 times a day	168	1200	$\frac{200 \times 168}{1200} = 28$
Ranitidine 150mg 1 tablet twice a day	56	300	$\frac{150 \times 56}{300} = 28$
Lansoprazole 30mg 1 capsule once a day	28	30	$\frac{30 \times 28}{30} = 28$

Prescribing Indicators listed throughout the report give some indication of prescribing quality but are not quantitative measures of good prescribing. Arrows indicate whether a larger figure or a smaller figure suggests 'better' prescribing. Values are given for the practice, locality average, LCG average and HSCB average. They are, therefore, useful in identifying outliers i.e. practice's whose prescribing differs substantially from other practices and to highlight areas for further analysis.

Red List Drugs: The Red list is an advisory list where it is considered by the Regional Group on Specialist Medicines, that responsibility for prescribing should remain with the consultant or specialist clinician. It is recommended that the supply of these specialist medicines should be organised via the hospital pharmacy.

Controlled Drugs (CDs): On the patient and stock prescribing pages there are red, orange and green dots. Each dot represents where a practice is on a control chart in relation to the Upper Control Limit (UCL) and the mean for all practices in NI (see chart below). The UCL is the mean + 3 standard deviations. A green dot represents a practice at the mean or below. An orange dot represents a practice above the mean but below the UCL. A red dot represents a practice above the UCL.



LCG COMPASS Report

Belfast LCG

April-June 2014

Contents

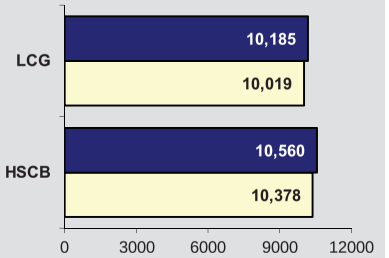
Contents cont'd

Key

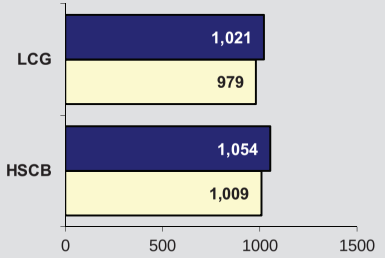
Quarter this year Apr-Jun 14
Quarter last year Apr-Jun 13

LCG
HSCB

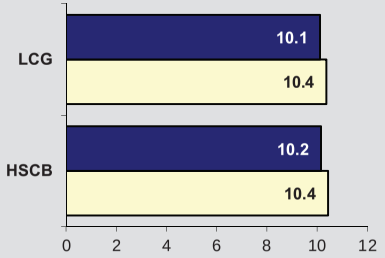
Cost (£) /1000 NIPUs



Items /1000 NIPUs



Cost (£) /Item



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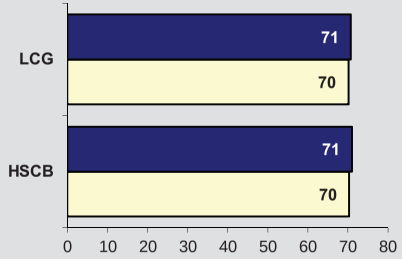
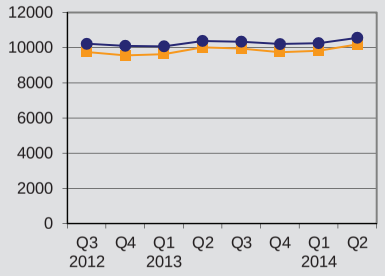
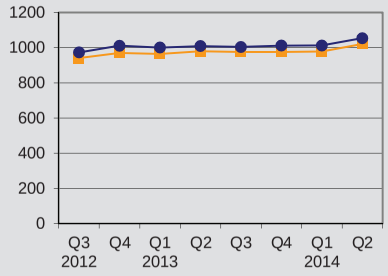


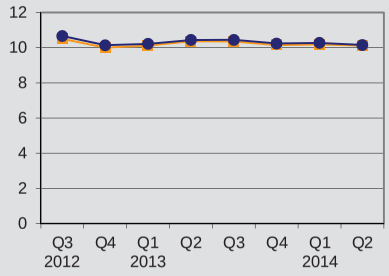
Cost (£) /1000 NIPUs



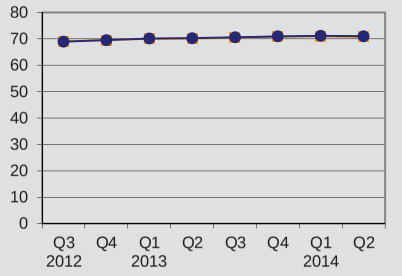
Items /1000 NIPUs



Cost (£) /Item



Generic dispensing rate (%)



COMPASS Unit, Operations Directorate, FPS, BSO, 2 Franklin Street, Belfast BT2 8DQ Web site: http://www.hscbusiness.hscni.net/services.htm Tel: 028 9053 5661 Fax: 028 9053 2963

Top 40 : Forty most costly drugs in your LCG

Belfast LCG

	Drug Name	Drug's position in HSCB's most costly drugs*	Cost (£)	No of Items	Quantity	Cost (£) /Item	% of Board Total Cost	Change from last year
1	TIOTROPIUM BROMIDE (DT) 18MICROGRAM [INHALATION	1	362,057	8,938	324,230	40.51	1.52	0.05
2	FLUTICASONE 250MICROGRAMS/DOSE / SALMETEROL 25M	7	265,638	3,510	4,466	75.68	1.11	0.10
3	PREGABALIN (DT) 75MG [CAPSULE]	3	232,076	3,555	201,805	65.28	0.97	0.03
4	PREGABALIN (DT) 150MG [CAPSULE]	4	223,466	3,296	194,318	67.80	0.94	0.11
5	TEMAZEPAM (DT) 10MG [TABLET]	5	205,659	11,779	280,196	17.46	0.86	-0.45
6	SYMBICORT 200/6 [TURBOHALER]	6	193,268	3,840	5,086	50.33	0.81	-0.02
7	PREGABALIN (DT) 300MG [CAPSULE]	9	175,013	2,610	152,185	67.05	0.73	0.09
8	BUDESONIDE 200MICROGRAMS/DOSE / FORMOTEROL 6MI	10	174,078	3,586	4,581	48.54	0.73	0.05
9	SERETIDE WITH COUNTER 250MCG/25 [EVOHALER]	2	171,124	2,252	2,877	75.99	0.72	-0.13
10	INSULIN LANTUS SOLOSTAR 3ML [PRE-FILLED PEN]	8	157,576	2,913	18,985	54.09	0.66	0.05
11	EZETIMIBE (DT) 10MG [TABLET]	11	145,267	3,557	154,598	40.84	0.61	-0.02
12	VICTOZA 3ML [PRE-FILLED INJECTION PEN]	13	138,243	1,295	3,523	106.75	0.58	-0.02
13	NEBIVOLOL (DT) 2.5MG [TABLET]	19	137,154	1,483	55,036	92.48	0.58	0.15
14	PREGABALIN (DT) 50MG [CAPSULE]	14	134,617	2,012	117,058	66.91	0.56	0.05
15	PREGABALIN (DT) 100MG [CAPSULE]	21	131,675	1,924	114,500	68.44	0.55	0.08
16	INSULIN NOVORAPID FLEXPEN 3ML [PRE-FILLED PEN]	18	131,500	2,721	21,487	48.33	0.55	0.02
17	CO-CODAMOL (DT) 30MG/500MG [TABLET]	22	128,127	35,053	2,911,948	3.66	0.54	-0.03
18	INSULIN NOVOMIX 30 FLEXPEN 3ML [INJECTION DEVICE]	20	126,578	2,535	21,174	49.93	0.53	0.02
19	VERSATIS [MEDICATED PLASTER]	15	126,520	2,073	52,426	61.03	0.53	0.00
20	DULOXETINE (DT) 60MG [GASTRO-RESISTANT CAPSULE]	16	126,514	3,484	127,792	36.31	0.53	0.09
21	SOLIFENACIN (DT) 5MG [TABLET]	23	122,952	3,591	133,544	34.24	0.52	0.04
22	AVIVA [REAGENT]	12	120,782	3,732	387,371	32.36	0.51	-0.01
23	CO-CODAMOL (DT) 15MG/500MG [TABLET]	36	114,059	18,243	1,382,340	6.25	0.48	0.05
24	ROSUVASTATIN (DT) 10MG [TABLET]	17	112,616	3,927	174,889	28.68	0.47	-0.01
25	OMEPRAZOLE (DT) 20MG [GASTRO-RESISTANT CAPSULE]	25	102,133	55,698	2,486,810	1.83	0.43	-0.03
26	FORTISIP COMPACT 125ML [BOTTLE]	26	100,760	1,531	49,881	65.81	0.42	0.13
27	PREGABALIN (DT) 25MG [CAPSULE]	27	100,558	1,566	87,442	64.21	0.42	0.07
28	FLUTICASONE 125MICROGRAMS/DOSE / SALMETEROL 25M	40	95,970	2,228	2,742	43.07	0.40	0.07
29	PROPRANOLOL (DT) 80MG [MODIFIED-RELEASE CAPSULE]	46	94,523	10,665	379,172	8.86	0.40	0.04
30	BUDESONIDE 400MICROGRAMS/DOSE / FORMOTEROL 12M	55	93,936	1,857	2,472	50.58	0.39	0.03
31	PREGABALIN (DT) 200MG [CAPSULE]	39	89,646	1,310	77,953	68.43	0.38	0.07
32	ROSUVASTATIN (DT) 20MG [TABLET]	24	89,132	2,272	95,915	39.23	0.37	0.02
33	MAXITRAM SR 100MG [CAPSULE]	57	87,870	7,173	434,282	12.25	0.37	0.06
34	SOLIFENACIN (DT) 10MG [TABLET]	37	86,535	1,954	72,291	44.29	0.36	0.03
35	MEMANTINE (DT) 20MG [TABLET]	54	85,762	2,760	83,235	31.07	0.36	-0.34
36	BUTRANS 20MCG/HR [TRANSDERMAL PATCH]	31	85,314	1,371	5,939	62.23	0.36	0.00
37	FORTISIP 200ML [BOTTLE]	42	81,467	1,868	39,547	43.61	0.34	-0.06
38	SALBUTAMOL CFC FREE (DT) 100MICROGRAMS/DOSE [PR	48	81,267	37,943	54,178	2.14	0.34	0.02
39	SITAGLIPTIN (DT) 100MG [TABLET]	29	80,980	1,695	68,173	47.78	0.34	0.03
40	RISPERDAL CONSTA 50MG [INJECTION]	95	80,374	296	563	271.53	0.34	-0.05
	TOTAL		**5,392,783**	**264,096**			**22.62**	

G: Generic form available

*This is the drug's position in the HSCB's most costly drugs. For example, the LCG's 40th most costly drug is RISPERDAL CONSTA 50MG [INJECTION]. This drug is number 95 in HSCB's most costly drugs.

Top 20 generic switches by cost

Belfast LCG

	Proprietary Drug	Number of Items	Cost (£)	Generic equivalent	Potential Savings for the quarter (£)
1	XALATAN 2.5ML [EYE DROP]	619	12,734	LATANOPROST 50MICROGRAMS/ML [EYE DROP]	£10,703
2	NEXIUM 40MG [TABLET]	273	13,011	ESOMEPRAZOLE 40MG [GASTRO-RESISTANT TABLET]	£10,206
3	ARIMIDEX 1MG [TABLET]	90	9,290	ANASTROZOLE 1MG [TABLET]	£9,028
4	NEXIUM 20MG [TABLET]	249	10,335	ESOMEPRAZOLE 20MG [GASTRO-RESISTANT TABLET]	£7,642
5	SINGULAIR 10MG [TABLET]	191	8,089	MONTELUKAST 10MG [TABLET]	£7,333
6	LOSEC 20MG [CAPSULE]	233	6,218	OMEPRAZOLE 20MG [GASTRO-RESISTANT CAPSULE]	£5,655
7	ARICEPT 10MG [TABLET]	53	5,198	DONEPEZIL 10MG [TABLET]	£5,092
8	PLAVIX 75MG [TABLET]	90	4,973	CLOPIDOGREL 75MG [TABLET]	£4,713
9	ACTONEL ONCE A WEEK 35MG [TABLET]	159	4,321	RISEDRONATE 35MG [TABLET]	£4,059
10	BONDRONAT 50MG [TABLET]	19	4,409	IBANDRONIC ACID 50MG [TABLET]	£4,036
11	SEROQUEL 25MG [TABLET]	93	3,776	QUETIAPINE 25MG [TABLET]	£3,626
12	SEROQUEL 100MG [TABLET]	40	3,680	QUETIAPINE 100MG [TABLET]	£3,593
13	NARAMIG 2.5MG [TABLET]	71	3,155	NARATRIPTAN 2.5MG [TABLET]	£2,914
14	LIPITOR 20MG [TABLET]	63	2,957	ATORVASTATIN 20MG [TABLET]	£2,788
15	BONVIVA F/C 150MG [TABLET]	78	2,999	IBANDRONIC ACID 150MG [TABLET]	£2,507
16	FOSAMAX ONCE WEEKLY 70MG [TABLET]	67	2,582	ALENDRONIC ACID 70MG [TABLET]	£2,480
17	IMIGRAN 100MG [TABLET]	24	2,523	SUMATRIPTAN 100MG [TABLET]	£2,418
18	NEOCLARITYN 5MG [TABLET]	319	3,150	DESLORATADINE 5MG [TABLET]	£2,345
19	SINGULAIR PAEDIATRIC CHEWABLE 5MG [TABLET]	68	2,543	MONTELUKAST SF 5MG [CHEWABLE TABLET]	£2,309
20	XALACOM 2.5ML [EYE DROP]	145	3,580	LATANOPROST/TIMOLOL 50MICROGRAMS/ML / 5MG/M	£2,300
	Total	**2,944**	**109,521**		**£95,748**

Potential savings per annum = £382,991

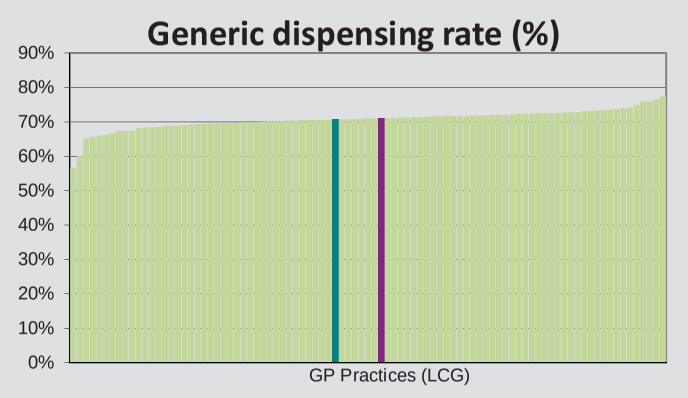
Top cost effective switches

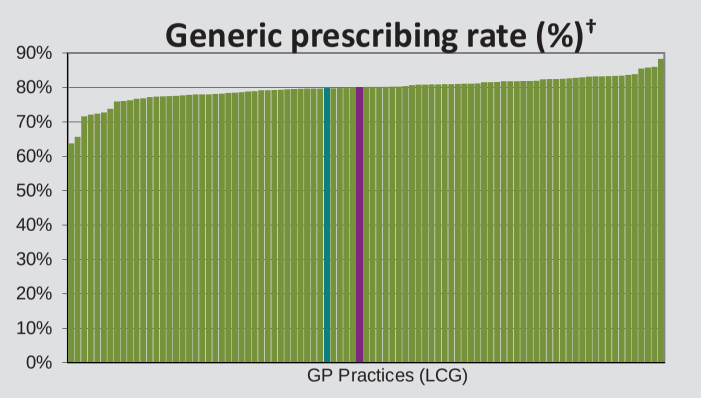
Belfast LCG

	Drug name	Number of Items	Spend	Cost effective choice	Potential Savings for the quarter
1	SOLIFENACIN (DT) 5MG [TABLET]	3,591	£122,952	TOLTERODINE (DT) 2MG [TABLET]	£110,169
2	SOLIFENACIN (DT) 10MG [TABLET]	1,954	£86,535	TOLTERODINE (DT) 2MG [TABLET]	£79,615
3	MOMETASONE NASAL (DT) 50MICROGRAMS/DOSE [SPRAY]	4,016	£33,992	BECLOMETASONE NASAL (DT) 50MCG [SPRAY]	£20,737
4	DOXAZOSIN (DT) 8MG [MODIFIED-RELEASE TABLET]	1,153	£21,097	DOXAZOSIN (DT) 4MG [TABLET]	£18,919
5	AZITHROMYCIN (DT) 250MG [CAPSULE]	566	£23,431	AZITHROMYCIN (DT) 250MG [TABLET]	£18,293
6	VESICARE FILM COATED 5MG [TABLET]	502	£17,803	TOLTERODINE (DT) 2MG [TABLET]	£15,952
7	FESOTERODINE (DT) 4MG [MODIFIED-RELEASE TABLET]	533	£17,544	TOLTERODINE (DT) 2MG [TABLET]	£15,720
8	FLUTICASONE PROPIONATE (DT) 50MICROGRAMS/DOSE [NASAL SPRAY]	1,646	£20,754	BECLOMETASONE NASAL (DT) 50MCG [SPRAY]	£14,760
9	NYSTATIN (DT) 100,000UNITS/ML [ORAL SUSPENSION]	1,167	£25,700	MICONAZOLE SUGAR FREE (DT) 20MG/G [OROMUCOSAL GEL]	£13,000
10	SALINE STERI-NEB [AMPOULE]	514	£34,324	STERIPOULES SODIUM CHLORIDE 2.5ML [AMPOULE]	£12,970
11	VESICARE FILM COATED 10MG [TABLET]	294	£13,094	TOLTERODINE (DT) 2MG [TABLET]	£12,047
12	DOXAZOSIN (DT) 4MG [MODIFIED-RELEASE TABLET]	1,484	£13,503	DOXAZOSIN (DT) 2MG [TABLET]	£11,181
13	FESOTERODINE (DT) 8MG [MODIFIED-RELEASE TABLET]	356	£12,322	TOLTERODINE (DT) 2MG [TABLET]	£11,041
14	PARACETAMOL 500MG SOLUBLE TABLETS (DT) 500MG [EFFERVESCENT TAB LET]	2,143	£15,155	PARACETAMOL (DT) 500MG [TABLET]	£10,375
15	CO-CODAMOL (DT) 8MG/500MG [EFFERVESCENT TABLET]	2,898	£17,875	CO-CODAMOL (DT) 8MG/500MG [TABLET]	£9,268
16	OMEPRAZOLE (DT) 40MG [GASTRO-RESISTANT CAPSULE]	2,921	£18,996	OMEPRAZOLE (DT) 20MG [GASTRO-RESISTANT CAPSULE]	£9,244
17	DICLOFENAC (DT) 1% [GEL]	2,984	£18,287	KETOPROFEN (DT) 2.5% [GEL]	£7,633
18	REGURIN XL 60MG [CAPSULE]	270	£7,890	TOLTERODINE (DT) 2MG [TABLET]	£6,972
19	LEVOCETIRIZINE (DT) 5MG [TABLET]	1,471	£8,366	CETIRIZINE (DT) 10MG [TABLET]	£6,114
20	NITROFURANTOIN (DT) 50MG [TABLET]	427	£12,188	NITROFURANTOIN (DT) 50MG [CAPSULE]	£5,685
21	AVAMYS NASAL 120 DOSE [SPRAY]	1,274	£9,261	BECLOMETASONE NASAL (DT) 50MCG [SPRAY]	£5,602
22	IBUPROFEN (DT) 10% [GEL]	2,127	£12,653	KETOPROFEN (DT) 2.5% [GEL]	£5,485
23	MOVICOL POWDER [SACHET]	2,555	£26,639	LAXIDO ORANGE SUGAR FREE [ORAL POWDER SACHET]	£5,357
24	OMEPRAZOLE DISPERSIBLE (DT) 20MG [GASTRO-RESISTANT TABLET]	417	£6,895	LANSOPRAZOLE (DT) 15MG [ORODISPERSIBLE TABLET]	£5,052
25	CO-CODAMOL (DT) 30MG/500MG [EFFERVESCENT TABLET]	1,354	£10,266	CO-CODAMOL (DT) 30MG/500MG [TABLET]	£4,750
	Total	**38,617**	**£607,522**		**£435,945**

Overall Generic Dispensing

Belfast LCG





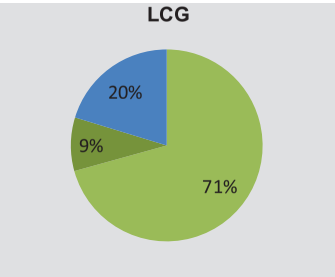
The range of generic drugs listed within Part I of the NI drug tariff increased in April 2011. This change may have increased the generic dispensing rate.

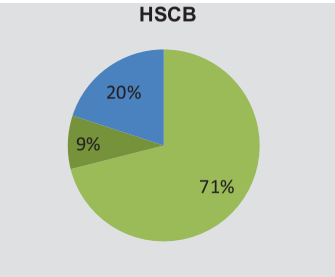
LCG Average | HSCB Average

Prescribed and dispensed generically
Prescribed generically and dispensed by brand as no generic is currently available
Presribed and dispensed by brand

†The generic **prescribing** rates chart is new. This chart reports GP prescribing of generics. This will include drugs that, although prescribed generically, will have been dispensed by brand as no generic is currently available.

NB 100% generic prescribing rate is not achievable or desired as there are a number of items unsuitable for generic prescribing. See link below:
http://www.hscboard.hscni.net/medicinesmanagement/Prescribing%20Guidance/index.html

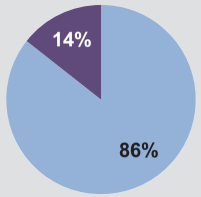




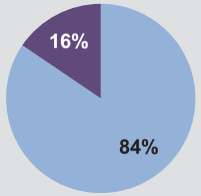
Proton Pump Inhibitors (PPIs)

Belfast LCG

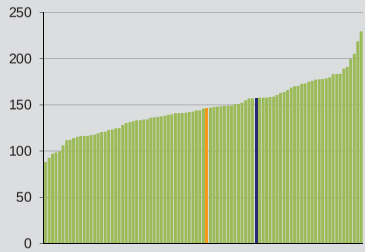
LCG



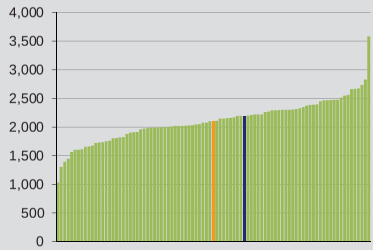
HSCB



PPIs - Cost /1000 NPUs



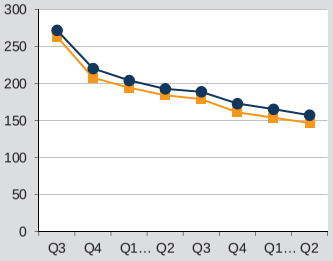
PPIs - DDDs /1000 NIPUs



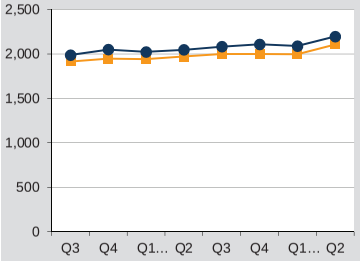
Drug name	Items	%
Lansoprazole	36084	31.14%
Omeprazole	63116	54.47%
Pantoprazole	5641	4.87%
Losec	264	0.23%
Protium	0	0.00%
Esomeprazole (tablets)	8931	7.71%
Lansoprazole orodispersible†	0	0.00%
Omeprazole dispersible†	0	0.00%
Rabeprazole	488	0.42%
Emozul (capsules)	29	0.03%
Nexium (tablets)	523	0.45%
Pariet	43	0.04%
Losec MUPS†	428	0.37%
Zoton FasTab†	330	0.28%

Drug name	Items	%
Lansoprazole	158553	31.26%
Omeprazole	269884	53.21%
Pantoprazole	30291	5.97%
Losec	1611	0.32%
Protium	0	0.00%
Esomeprazole (tablets)	37843	7.46%
Lansoprazole orodispersible†	0	0.00%
Omeprazole dispersible†	0	0.00%
Rabeprazole	2414	0.48%
Emozul (capsules)	95	0.02%
Nexium (tablets)	2883	0.57%
Pariet	281	0.06%
Losec MUPS†	1884	0.37%
Zoton FasTab†	1459	0.29%

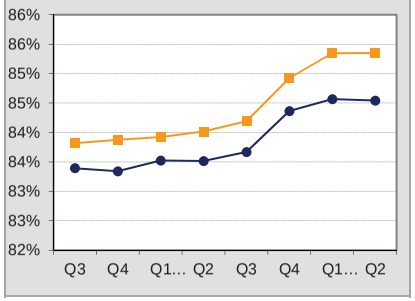
PPIs - Cost /1000 NIPUs



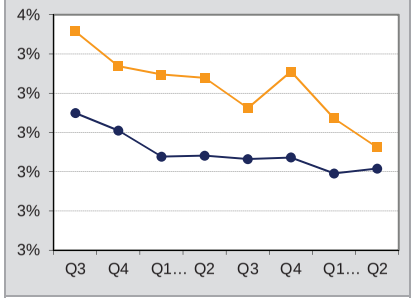
PPIs - DDDs /1000 NIPUs



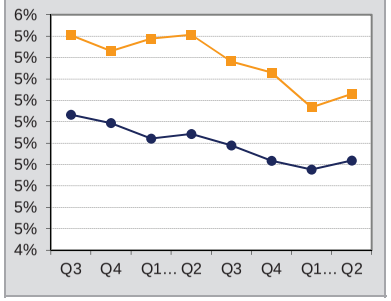
% generic omeprazole and lansoprazole of all PPI items (↑)



% esomeprazole 20mg of all PPI items (↓)



% esomeprazole 40mg of all PPI items (↓)



Key

Pie charts

Preferred choices

Other items

† If patients do not have swallowing difficulties, they could be switched to omeprazole or lansoprazole capsules.

Line charts

Q1 = Jan/Mar

LCG

HSCB

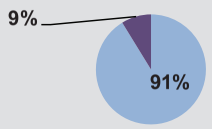
Upward trend preferable ↑

Downward trend preferable ↓

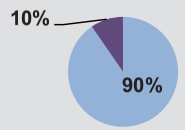
Lipid lowering drugs

Belfast LCG

LCG



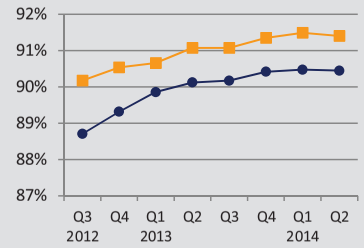
HSCB



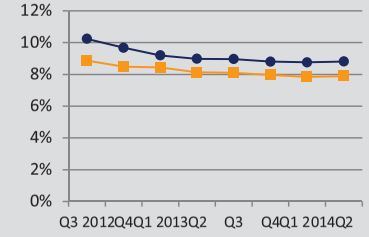
Drug name	Items	%
Simvastatin 10mg	2144	2.11%
Simvastatin 20mg	12503	12.30%
Simvastatin 40mg	33785	33.23%
Simvastatin 80mg	50	0.05%
Simvastatin 20mg/5ml	28	0.03%
Simvastatin 40mg/5ml	53	0.05%
Atorvastatin 10mg	8943	8.80%
Atorvastatin 20mg	12793	12.58%
Atorvastatin 40mg	16661	16.39%
Atorvastatin 80mg	1388	1.37%
Pravastatin	4442	4.37%
Fluvastatin	277	0.27%
Rosuvastatin	7587	7.46%
Simvastatin + Ezetimibe	95	0.09%
Lescol /other brands	16	0.02%
Lipostat	15	0.01%
Zocor	29	0.03%
Crestor	648	0.64%
Inegy	52	0.05%
Lipitor 10mg	52	0.05%
Lipitor 20mg	66	0.06%
Lipitor 40mg	44	0.04%
Lipitor 80mg	5	0.00%

Drug name	Items	%
Simvastatin 10mg	9184	2.00%
Simvastatin 20mg	48808	10.62%
Simvastatin 40mg	153242	33.35%
Simvastatin 80mg	415	0.09%
Simvastatin 20mg/5ml	141	0.03%
Simvastatin 40mg/5ml	269	0.06%
Atorvastatin 10mg	37453	8.15%
Atorvastatin 20mg	53985	11.75%
Atorvastatin 40mg	80607	17.54%
Atorvastatin 80mg	6831	1.49%
Pravastatin	24277	5.28%
Fluvastatin	1101	0.24%
Rosuvastatin	37184	8.09%
Simvastatin + Ezetimibe	427	0.09%
Lescol /other brands	73	0.02%
Lipostat	114	0.02%
Zocor	102	0.02%
Crestor	3913	0.85%
Inegy	216	0.05%
Lipitor 10mg	418	0.09%
Lipitor 20mg	364	0.08%
Lipitor 40mg	291	0.06%
Lipitor 80mg	30	0.01%

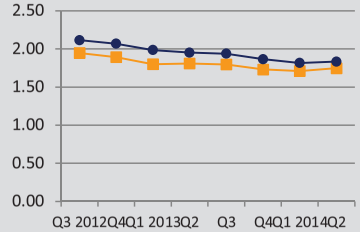
% simvastatin, atorvastatin and pravastatin of all statin items (↑)



% rosuvastatin of all statin items (↓)



Ezetimibe, Items /1000 NIPUs (↓)
(includes Ezetrol and Inegy)



Key

Pie charts

Preferred choices

Other items

Line charts

Q1 = Jan/Mar

LCG

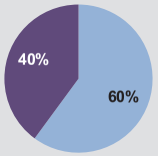
HSCB

Upward trend preferable ↑

SSRIs and related antidepressant drugs

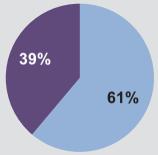
Belfast LCG

LCG



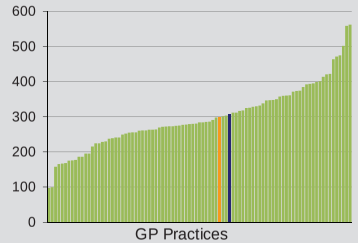
Drug name	Items	%
Citalopram	32292	25.18%
Fluoxetine	23958	18.68%
Sertraline	20807	16.23%
Duloxetine	5098	3.98%
Escitalopram	4717	3.68%
Flupentixol	22	0.02%
Fluvoxamine	51	0.04%
Mirtazapine	18805	14.67%
Paroxetine	2596	2.02%
Reboxetine	79	0.06%
Venlafaxine (incl. XL)	2956	2.31%
Cipramil	80	0.06%
Efexor /XL /other brands	14500	11.31%
Faverin	3	0.00%
Lustral	78	0.06%
Prozac	79	0.06%
Seroxat	118	0.09%
Cipralex	396	0.31%
Cymbalta	1417	1.11%
Edronax	35	0.03%
Fluanxol	62	0.05%
Optimax	0	0.00%
Zispin SolTab	76	0.06%

HSCB

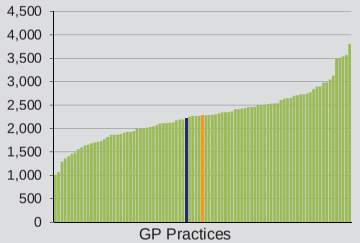


Drug name	Items	%
Citalopram	129369	25.02%
Fluoxetine	94531	18.28%
Sertraline	92071	17.81%
Duloxetine	21892	4.23%
Escitalopram	23441	4.53%
Flupentixol	389	0.08%
Fluvoxamine	210	0.04%
Mirtazapine	64596	12.49%
Paroxetine	11764	2.28%
Reboxetine	430	0.08%
Venlafaxine (incl. XL)	10841	2.10%
Cipramil	282	0.05%
Efexor /XL /other brands	58338	11.28%
Faverin	30	0.01%
Lustral	436	0.08%
Prozac	325	0.06%
Seroxat	388	0.08%
Cipralex	2331	0.45%
Cymbalta	4592	0.89%
Edronax	137	0.03%
Fluanxol	371	0.07%
Optimax	12	0.00%
Zispin SolTab	258	0.05%

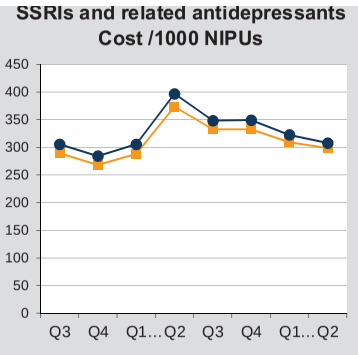
SSRIs and related antidepressants Cost /1000 NIPUs



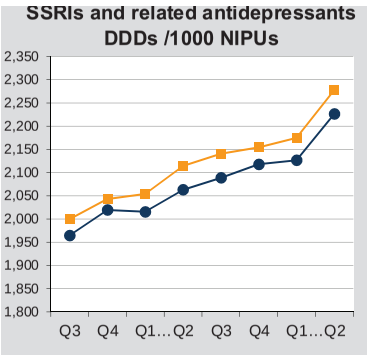
SSRIs and related antidepressants DDDs /1000 NIPUs



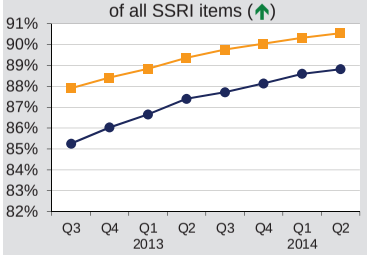
SSRIs and related antidepressants Cost /1000 NIPUs



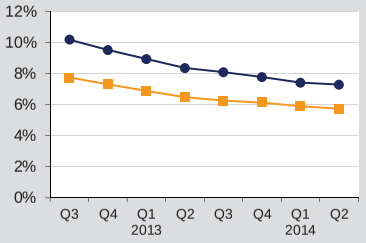
SSRIs and related antidepressants DDDs /1000 NIPUs

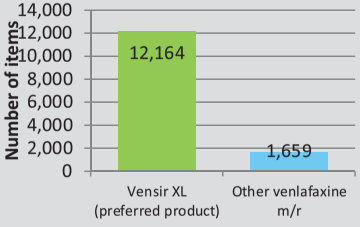


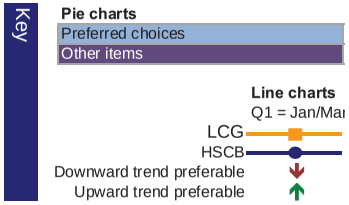
% generic citalopram, fluoxetine and sertraline of all SSRI items (↑)

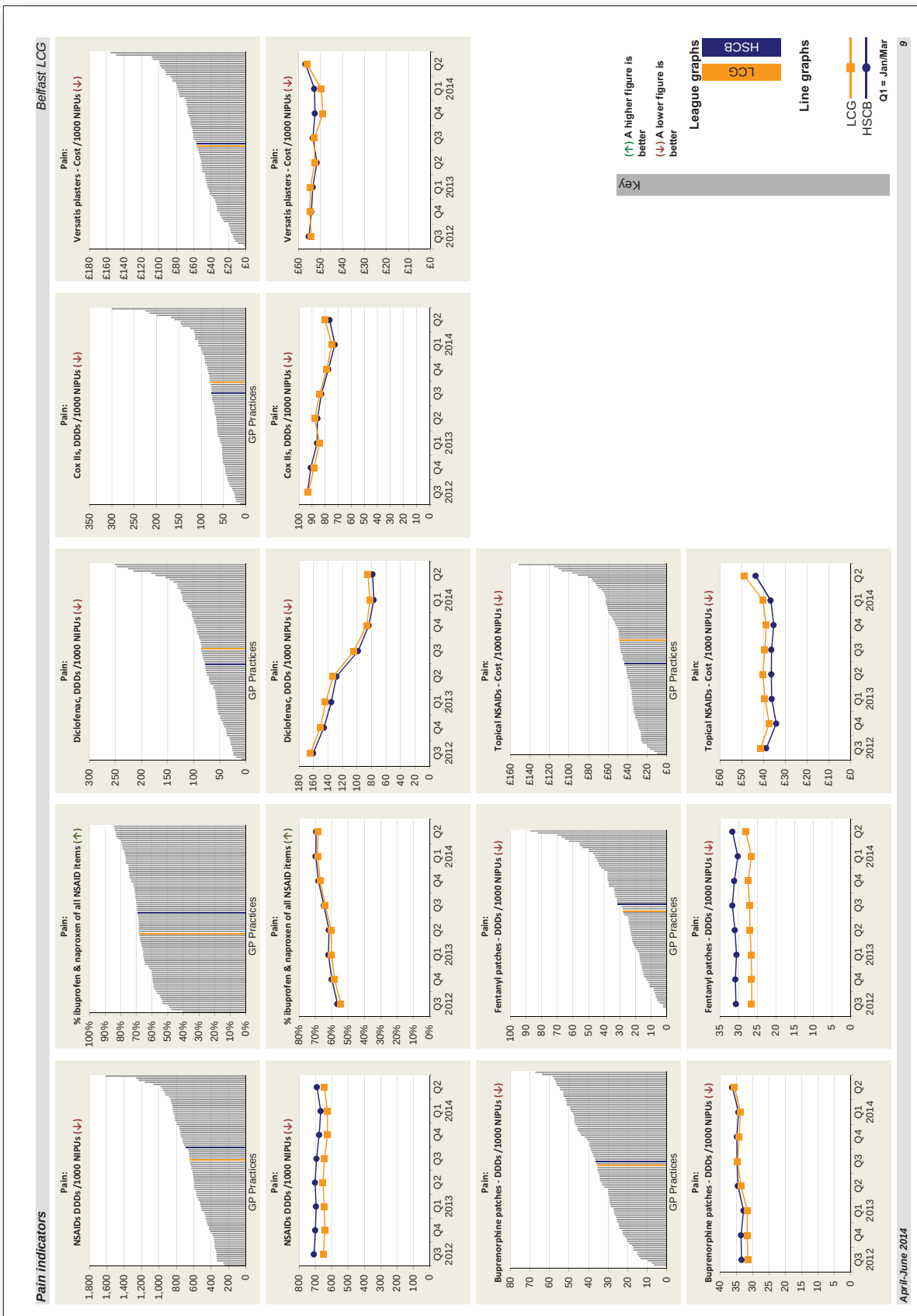


% escitalopram of all SSRIs (↓)








Belfast LCG
Pain indicators
Pain:
NSAIDs DDDs /1000 NIPUs (↓)
Pain:
Cox IIs, DDDs /1000 NIPUs (↓)
Pain:
Versatis plasters - Cost /1000 NIPUs (↓)
Pain:
Diclofenac, DDDs /1000 NIPUs (↓)
Pain:
% ibuprofen & naproxen of all NSAID items (↑)
Pain:
Fentanyl patches - DDDs /1000 NIPUs (↓)
Pain:
Topical NSAIDs - Cost /1000 NIPUs (↓)
Pain:
Buprenorphine patches - DDDs /1000 NIPUs (↓)
GP Practices
Q3 2012
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Key
(↑) A higher figure is better
(↓) A lower figure is better
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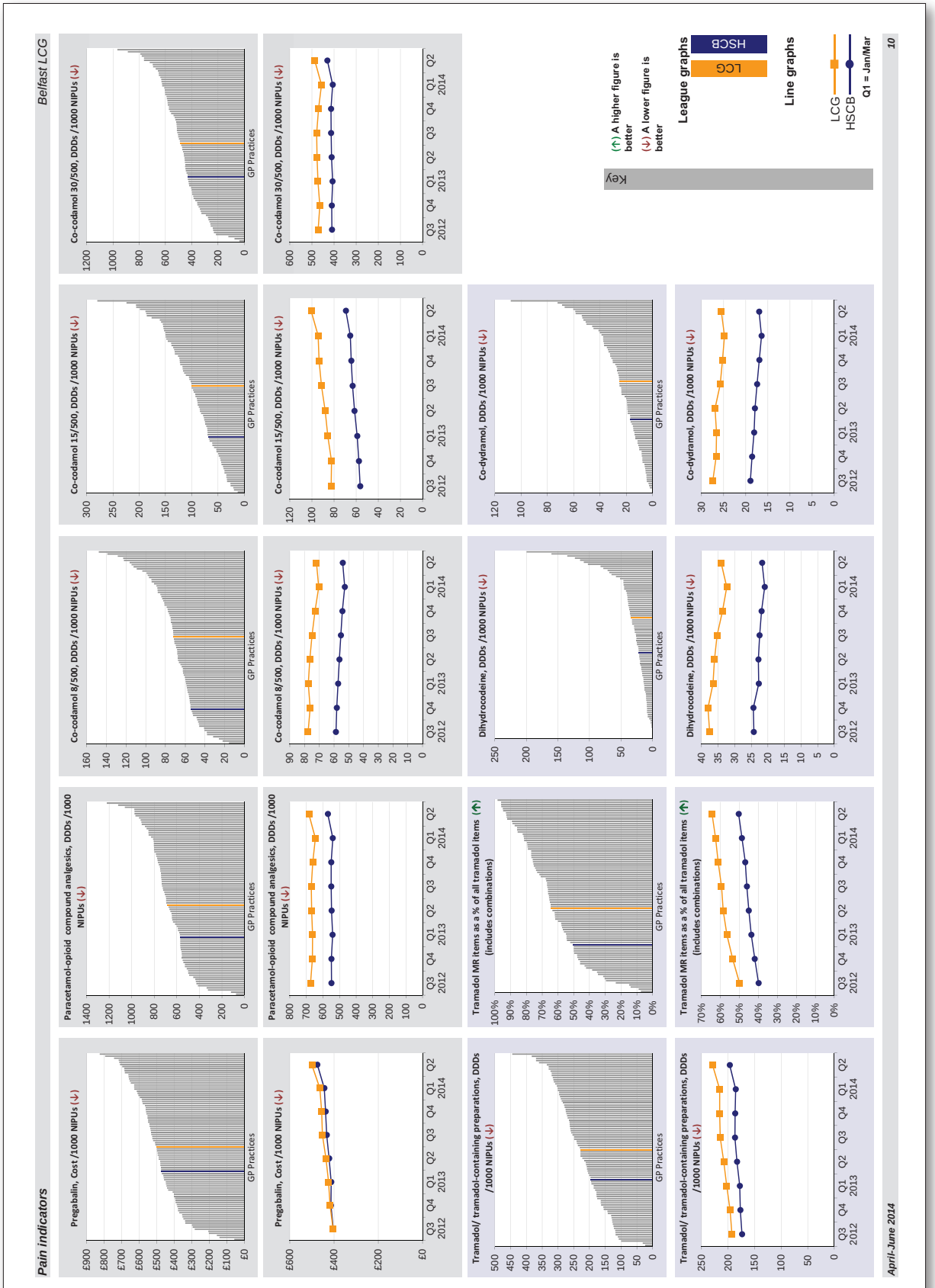
Belfast LCG
Pain indicators
Co-codamol 30/500, DDDs /1000 NIPUs (↓)
Co-codamol 15/500, DDDs /1000 NIPUs (↓)
Co-codamol 8/500, DDDs /1000 NIPUs (↓)
Co-dydramol, DDDs /1000 NIPUs (↓)
Paracetamol-opioid compound analgesics, DDDs /1000 NIPUs (↓)
Dihydrocodeine, DDDs /1000 NIPUs (↓)
Pregabalin, Cost /1000 NIPUs (↓)
Tramadol MR items as a % of all tramadol items (↑) (includes combinations)
Tramadol/ tramadol-containing preparations, DDDs /1000 NIPUs (↓)
GP Practices
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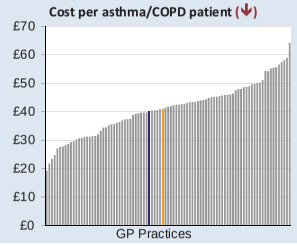
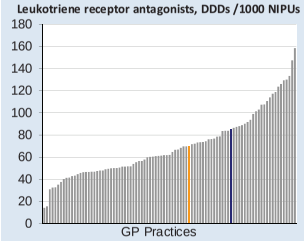
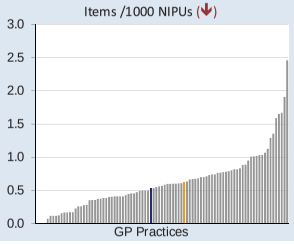
Respiratory: Combination Inhalers
Cost per asthma/COPD patient (↓)



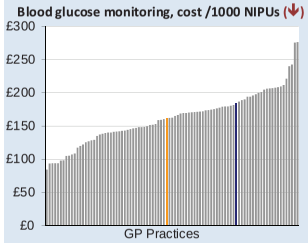
Respiratory: (↓)
Leukotriene receptor antagonists, DDDs /1000 NIPUs



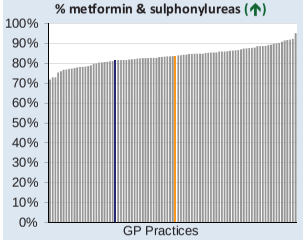
Orlistat:
Items /1000 NIPUs (↓)



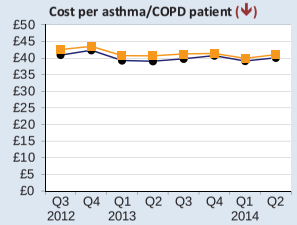
Endocrine:
Blood glucose monitoring, cost /1000 NIPUs (↓)



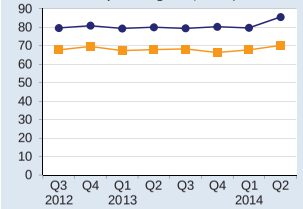
Endocrine:
% metformin & sulphonylureas (↑)



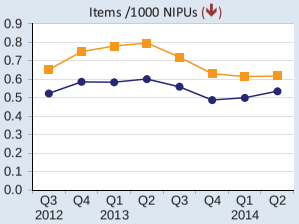
Respiratory: Combination Inhalers
Cost per asthma/COPD patient (↓)



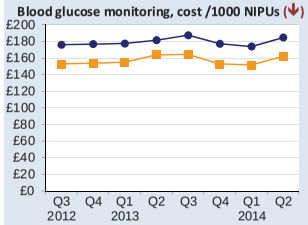
Respiratory: (↓)
Leukotriene receptor antagonists, DDDs /1000 NIPUs



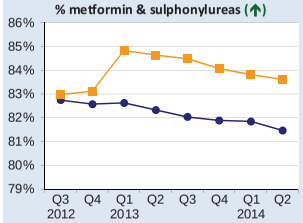
Orlistat:
Items /1000 NIPUs (↓)



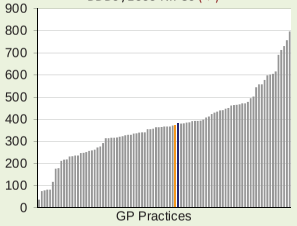
Endocrine:
Blood glucose monitoring, cost /1000 NIPUs (↓)



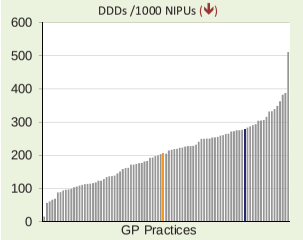
Endocrine:
% metformin & sulphonylureas (↑)



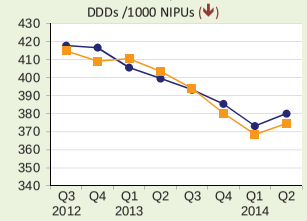
Benzodiazepines:
DDDs /1000 NIPUs (↓)



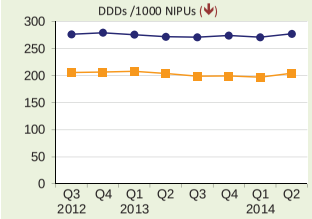
Z Drugs:
DDDs /1000 NIPUs (↓)



Benzodiazepines:
DDDs /1000 NIPUs (↓)



Z Drugs:
DDDs /1000 NIPUs (↓)



Key

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League graphs

LCG HSCB

Line graphs

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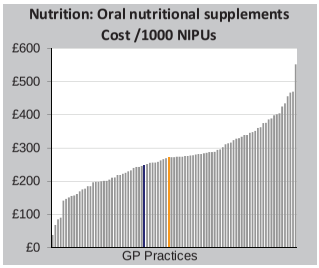
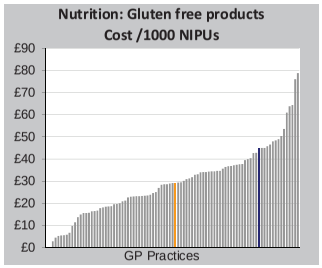
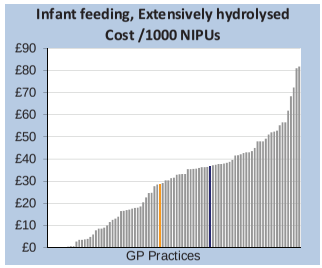
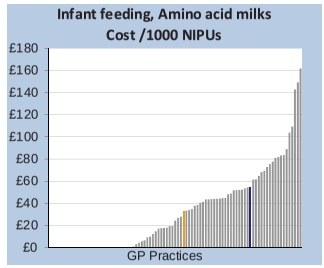
HSCB

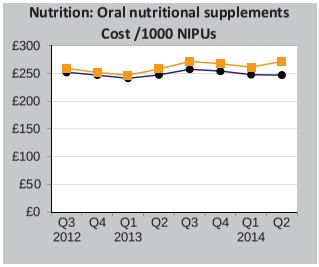
Q1 = Jan/Mar

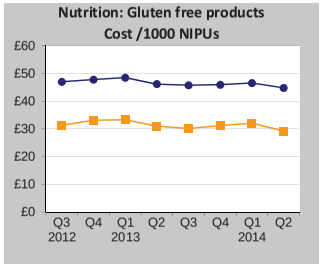


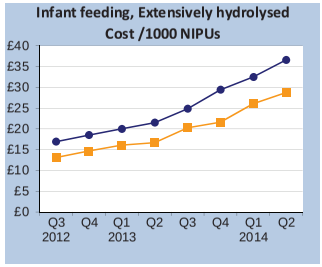


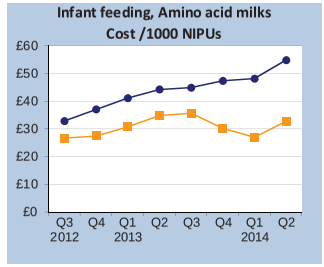












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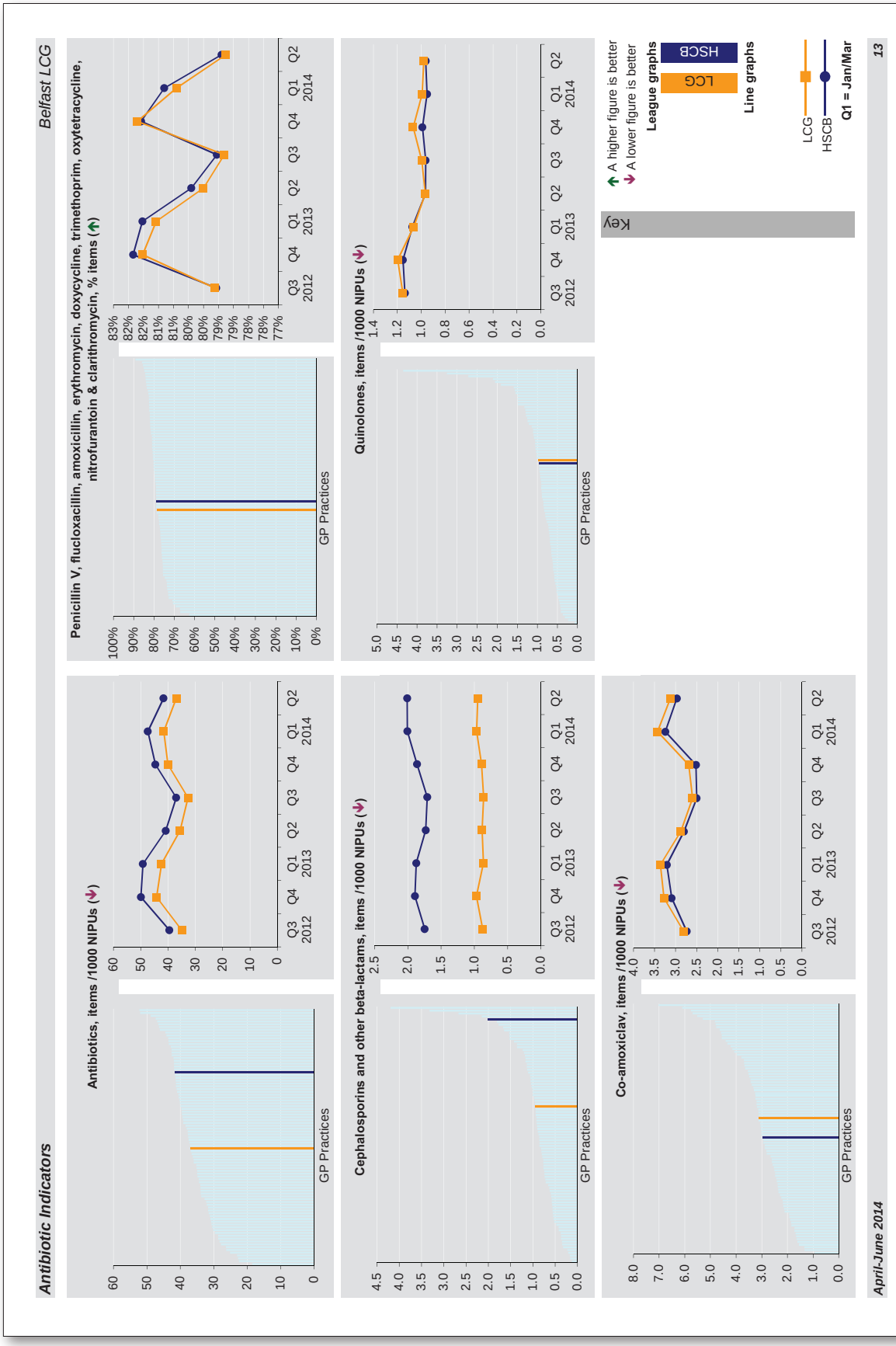
Antibiotic Indicators
Belfast LCG
Penicillin V, flucloxacillin, amoxicillin, erythromycin, doxycycline, trimethoprim, oxytetracycline, nitrofurantoin & clarithromycin, % items (↑)
Quinolones, items /1000 NIPUs (↓)
Antibiotics, items /1000 NIPUs (↓)
Cephalosporins and other beta-lactams, items /1000 NIPUs (↓)
Co-amoxiclav, items /1000 NIPUs (↓)
GP Practices
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Stock Prescribing

High Risk Drugs

Drug name/group	Items	Quantity
Warfarin 0.5mg	5	217
Warfarin 5mg	10	619
Methotrexate 10mg	4	82
Red List drugs	21	N/A

IV antibiotics: patient prescribing

Drug name	Items	Quantity
Amoxicillin 1g powder for solution for injection vials	1	1
Augmentin Intravenous 600mg powder for solution for injection vials	2	34
Azactam 2g powder for solution for injection vials	1	5
Ceftriaxone 250mg powder for solution for injection vials	1	2
Crystapen 600mg powder for solution for injection vials	1	1
Genticin Injectable 80mg/2ml solution for injection ampoules	9	408
Meronem 1g powder for solution for injection vials	2	6
Rocephin 2g powder for solution for injection vials	1	4
Tazocin 4.5g powder for solution for injection vials	2	35
Tygacil 50mg powder for solution for infusion vials	1	10
Zinacef 750mg powder for injection vials	3	88
Totals	**24**	

Top 15 Stock Items by Cost (excluding dressings & appliances)

	Drug name	Cost (£)	Items	Quantity
1	ViATIM vaccine suspension for injection 1ml pre-filled syringes	£5,453	15	183
2	Revaxis vaccine suspension for injection 0.5ml pre-filled syringes	£3,075	47	473
3	Depo-Medrone 40mg/1ml suspension for injection vials	£2,503	40	732
4	Twinrix Adult vaccine suspension for injection 1ml pre-filled syringes	£1,777	6	60
5	Pneumovax II vaccine solution for injection 0.5ml vials	£1,614	16	194
6	Sodium chloride 0.9% irrigation solution 20ml Steripod unit dose	£1,599	50	5100
7	Depo-Medrone 80mg/2ml suspension for injection vials	£1,373	13	223
8	Chlorphenamine 10mg/1ml solution for injection ampoules	£1,364	75	470
9	Helicobacter Test INFAI breath test kit	£1,286	11	67
10	Nexplanon 68mg implant	£1,192	4	15
11	EpiPen 300micrograms/0.3ml (1 in 1,000) solution for injection auto-injectors	£1,084	20	41
12	EpiPen Jr. 150micrograms/0.3ml (1 in 2,000) solution for injection auto-injectors	£1,058	18	40
13	Depo-Medrone with Lidocaine suspension for injection 1ml vials	£817	12	210
14	Avaxim vaccine suspension for injection 0.5ml pre-filled syringes	£724	3	40
15	Minims tropicamide 1% eye drops 0.5ml unit dose	£722	18	1400
	Total	**£25,641**	**348**	
	Total of all Stock (including dressings and appliances)	**£140,843**	**4,962**	

Top 15 CDs (schedules 2, 3, 4 and 5)

	Drug name	Cost (£)	Items	Quantity
1	Midazolam 5mg/1ml oromucosal solution pre-filled oral syringes	£86	1	4
2	Diazepam 5mg/2.5ml rectal solution tube	£71	15	65
3	Midazolam 10mg/2ml oromucosal solution pre-filled oral syringes	£69	1	3
4	Diamorphine 5mg powder for solution for injection ampoules	£57	5	25
5	Buccolam 10mg/2ml oromucosal solution pre-filled oral syringes	£46	1	2
6	Cyclimorph 10 solution for injection 1ml ampoules	£44	5	25
7	Co-codamol 30mg/500mg tablets	£39	12	888
8	Diazepam 2.5mg RecTubes	£31	6	27
9	Morphine sulphate 10mg/1ml solution for injection ampoules	£26	4	28
10	Diamorphine 10mg powder for solution for injection ampoules	£26	2	10
11	Diazepam 10mg/2.5ml rectal solution tube	£25	5	18
12	Diazemuls 10mg/2ml emulsion for injection ampoules	£20	3	22
13	Diazepam 10mg/2ml solution for injection ampoules	£18	4	40
14	Chlordiazepoxide 10mg capsules	£18	2	200
15	Hypnovel 10mg/2ml solution for injection ampoules	£14	2	20
	Total	**£588**	**68**	

Appendix: COMPASS Explanatory Notes

Glossary			
ICPs	Integrated Care Partnerships	NIPUs	Northern Ireland Prescribing Units
LCG	Local Commissioning Group		
HSCB	Health and Social Care Board		

Quarter: Information in the COMPASS report is based on three months of prescribing data, i.e. one quarter.

ICP average: Figures refer to the average of all practices within the respective ICP.

LCG average: Figures refer to the average of all practices within the respective LCG.

HSCB average: Figures refer to the average of all practices within the HSCB, i.e. all practices in NI.

Cost (£): Net ingredient cost, equivalent to England's Net Ingredient Cost (NIC). Cost is useful in terms of monitoring the overall drugs bill, checking spend within prescribing budgets and calculating savings made or potential savings. Cost is less useful as a measure of drug consumption because of the differences in cost of alternative preparations and changes in prices.

Items: Number of prescription items. Count of items is a reasonable measure of the number of courses of treatments for vaccinations and acute treatments such as short courses of antibiotics. For other treatments it is less useful because of the wide variation in duration of supply per item.

NIPUs: In measuring prescribing, differences between practices need to be taken account of in order to make valid comparisons with local and national averages. NIPUs standardise for differences between practices in terms of patient list size, age/sex structure and additional needs.

Quantity: Number of physical units, i.e. tablets, capsules, patches, mLs, inhalers, vials etc. Quantity is a useful measure of prescribing when looking at individual preparations, e.g. methotrexate 10mg or warfarin 0.5mg and 5mg.

Change from Last Year: The actual change from the same quarter in the previous year.

Defined Daily Dose (DDD): The DDD is a unit of measurement based on the assumed average maintenance dose per day used for its main indication in adults. The World Health Organisation (WHO) developed the DDD as a method to compare drugs of different chemical structures and potencies. The DDD methodology standardises quantities prescribed into number of daily doses. See worked example below. The number of DDDs is calculated as follows:

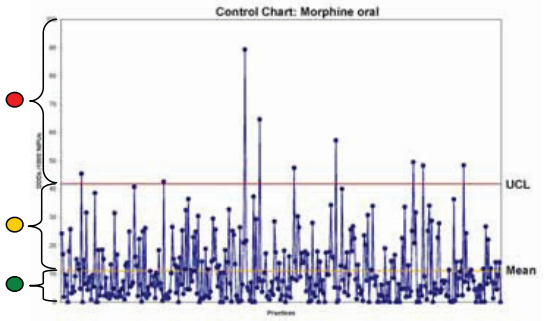
$$\text{Number of DDDs} = \frac{\text{Strength (mg) x quantity}}{\text{DDD (mg)}}$$

Worked example	Quantity (no. of tabs /caps)	DDD (mg)	No. of DDDs
Ibuprofen 200mg 2 caps 3 times a day	168	1200	$\frac{200 \times 168}{1200} = 28$
Ranitidine 150mg 1 tablet twice a day	56	300	$\frac{150 \times 56}{300} = 28$
Lansoprazole 30mg 1 capsule once a day	28	30	$\frac{30 \times 28}{30} = 28$

Prescribing Indicators listed throughout the report give some indication of prescribing quality but are not quantitative measures of good prescribing. Arrows indicate whether a larger figure or a smaller figure suggests 'better' prescribing. Values are given for the practice, locality average, LCG average and HSCB average. They are, therefore, useful in identifying outliers i.e. practice's whose prescribing differs substantially from other practices and to highlight areas for further analysis.

Red List Drugs: The Red list is an advisory list where it is considered by the Regional Group on Specialist Medicines, that responsibility for prescribing should remain with the consultant or specialist clinician. It is recommended that the supply of these specialist medicines should be organised via the hospital pharmacy.

Controlled Drugs (CDs): On the patient and stock prescribing pages there are red, orange and green dots. Each dot represents where a practice is on a control chart in relation to the Upper Control Limit (UCL) and the mean for all practices in NI (see chart below). The UCL is the mean + 3 standard deviations. A green dot represents a practice at the mean or below. An orange dot represents a practice above the mean but below the UCL. A red dot represents a practice above the UCL.



LCG COMPASS Report

South Eastern LCG

April-June 2014

Contents

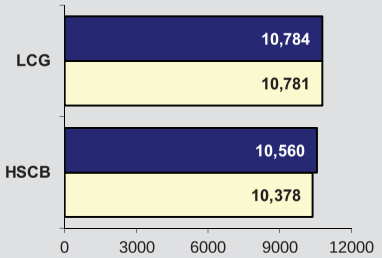
Contents cont'd

Key

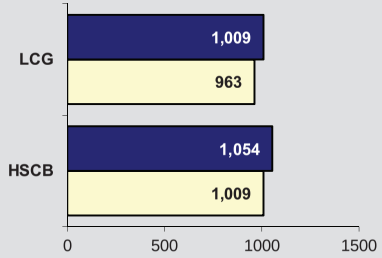
Quarter this year Apr-Jun 14
Quarter last year Apr-Jun 13

LCG
HSCB

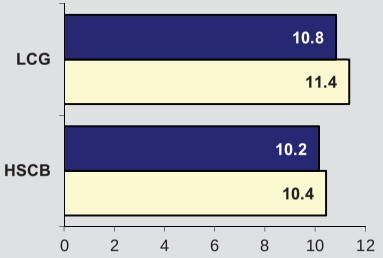
Cost (£) /1000 NIPUs



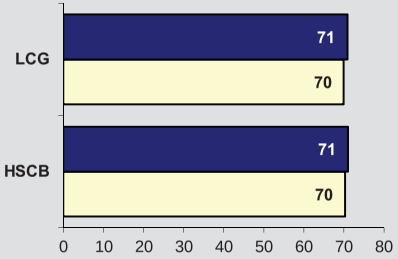
Items /1000 NIPUs



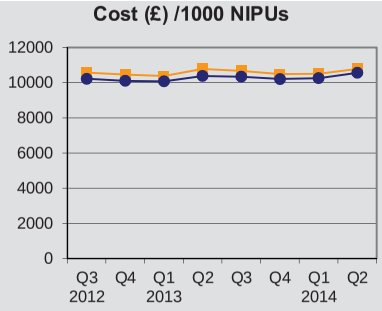
Cost (£) /Item



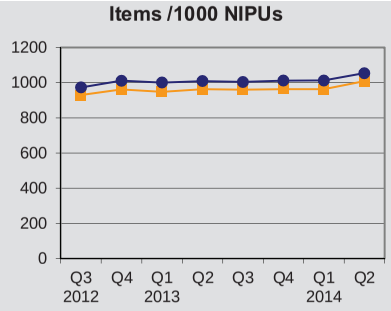
Generic dispensing rate (%)



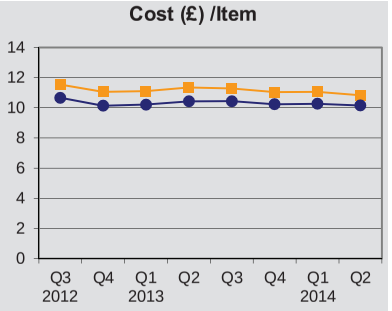
Cost (£) /1000 NIPUs



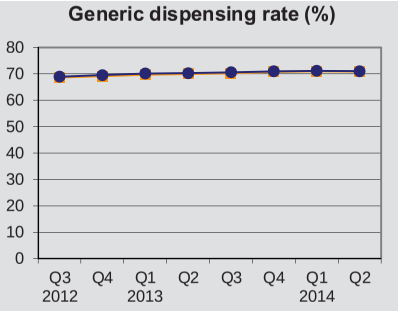
Items /1000 NIPUs



Cost (£) /Item



Generic dispensing rate (%)



COMPASS Unit, Operations Directorate, FPS, BSO, 2 Franklin Street, Belfast BT2 8DQ Web site: http://www.hscbusiness.hscni.net/services.htm Tel: 028 9053 5661 Fax: 028 9053 2963

Top 40 : Forty most costly drugs in your LCG

South Eastern LCG

	Drug Name	Drug's position in HSCB's most costly drugs*	Cost (£)	No of Items	Quantity	Cost (£) /Item	% of Board Total Cost	Change from last year
1	BUDESONIDE 200MICROGRAMS/DOSE / FORMOTEROL 6MI	10	196,726	3,611	5,177	54.48	1.10	0.03
2	FLUTICASONE 250MICROGRAMS/DOSE / SALMETEROL 25M	7	187,719	2,367	3,156	79.31	1.05	0.07
3	INSULIN LANTUS SOLOSTAR 3ML [PRE-FILLED PEN]	8	174,474	2,976	21,021	58.63	0.98	-0.01
4	PREGABALIN (DT) 150MG [CAPSULE]	4	174,243	2,431	151,516	71.68	0.98	0.09
5	PREGABALIN (DT) 75MG [CAPSULE]	3	169,165	2,413	147,100	70.11	0.95	0.00
6	TIOTROPIUM BROMIDE (DT) 18MICROGRAM [INHALATION	1	167,508	3,613	150,007	46.36	0.94	0.00
7	TEMAZEPAM (DT) 10MG [TABLET]	5	145,814	7,166	198,665	20.35	0.82	-0.33
8	PREGABALIN (DT) 300MG [CAPSULE]	9	135,770	1,941	118,061	69.95	0.76	0.08
9	SERETIDE WITH COUNTER 250MCG/25 [EVOHALER]	2	120,625	1,631	2,028	73.96	0.68	-0.05
10	DULOXETINE (DT) 60MG [GASTRO-RESISTANT CAPSULE]	16	114,357	3,044	115,512	37.57	0.64	0.13
11	ROSUVASTATIN (DT) 10MG [TABLET]	17	110,529	3,561	171,647	31.04	0.62	-0.03
12	AVIVA [REAGENT]	12	110,426	3,268	354,155	33.79	0.62	0.03
13	EZETIMIBE (DT) 10MG [TABLET]	11	110,006	2,572	117,072	42.77	0.62	-0.04
14	PREGABALIN (DT) 50MG [CAPSULE]	14	100,547	1,448	87,432	69.44	0.56	0.02
15	VICTOZA 3ML [PRE-FILLED INJECTION PEN]	13	99,984	936	2,548	106.82	0.56	0.00
16	SYMBICORT 200/6 [TURBOHALER]	6	98,648	1,897	2,596	52.00	0.55	0.00
17	INSULIN NOVORAPID FLEXPEN 3ML [PRE-FILLED PEN]	18	98,299	2,160	16,062	45.51	0.55	0.00
18	NUTRAMIGEN AA 400G [POWDER]	38	94,808	669	3,609	141.72	0.53	0.16
19	NEBIVOLOL (DT) 2.5MG [TABLET]	19	92,932	970	37,296	95.81	0.52	0.04
20	DUTASTERIDE (DT) 500MICROGRAM [CAPSULE]	41	91,014	2,118	91,715	42.97	0.51	0.00
21	PREGABALIN (DT) 100MG [CAPSULE]	21	87,583	1,192	76,159	73.48	0.49	0.02
22	CO-CODAMOL (DT) 30MG/500MG [TABLET]	22	86,686	23,238	1,970,129	3.73	0.49	-0.01
23	FLUTICASONE 125MICROGRAMS/DOSE / SALMETEROL 25M	40	82,810	1,801	2,366	45.98	0.46	0.05
24	BUTRANS 20MCG/HR [TRANSDERMAL PATCH]	31	82,800	1,317	5,764	62.87	0.46	0.05
25	ROSUVASTATIN (DT) 20MG [TABLET]	24	81,967	1,925	88,204	42.58	0.46	0.00
26	MEMANTINE (DT) 20MG [TABLET]	54	80,375	2,613	78,007	30.76	0.45	-0.42
27	FORTISIP COMPACT 125ML [BOTTLE]	26	80,176	1,136	39,691	70.58	0.45	0.10
28	SITAGLIPTIN (DT) 100MG [TABLET]	29	79,515	1,537	66,940	51.73	0.45	0.05
29	VERSATIS [MEDICATED PLASTER]	15	75,302	1,216	31,203	61.93	0.42	-0.03
30	PREGABALIN (DT) 25MG [CAPSULE]	27	74,043	1,133	64,385	65.35	0.42	0.02
31	OMEPRAZOLE (DT) 20MG [GASTRO-RESISTANT CAPSULE]	25	72,822	37,653	1,773,087	1.93	0.41	-0.03
32	HYDROCORTISONE (DT) 10MG [TABLET]	28	71,194	416	34,702	171.14	0.40	0.09
33	PREGABALIN (DT) 200MG [CAPSULE]	39	67,729	907	58,895	74.67	0.38	0.06
34	SOLIFENACIN (DT) 5MG [TABLET]	23	66,650	1,881	72,392	35.43	0.37	-0.09
35	ENSURE PLUS MILKSHAKE 220ML [BOTTLE]	76	66,383	1,326	32,863	50.06	0.37	-0.02
36	BUTRANS 10MCG/HR [TRANSDERMAL PATCH]	45	65,096	1,956	8,253	33.28	0.37	0.02
37	ONE TOUCH ULTRA TEST STRIP [REAGENT]	35	62,980	2,284	262,636	27.57	0.35	-0.14
38	INSULIN NOVOMIX 30 FLEXPEN 3ML [INJECTION DEVICE]	20	61,926	1,277	10,359	48.49	0.35	0.03
39	BUPRENORPHINE ES (DT) 20MICROGRAMS/HOUR [TRANS	64	60,520	962	4,213	62.91	0.34	-0.01
40	MAXITRAM SR 100MG [CAPSULE]	57	60,198	4,655	297,521	12.93	0.34	0.06
	TOTAL		**4,060,350**	**141,217**			**22.79**	

G: Generic form available

*This is the drug's position in the HSCB's most costly drugs. For example, the LCG's 40th most costly drug is MAXITRAM SR 100MG [CAPSULE]. This drug is number 57 in HSCB's most costly drugs.

Top 20 generic switches by cost

South Eastern LCG

	Proprietary Drug	Number of Items	Cost (£)	Generic equivalent	Potential Savings for the quarter (£)
1	NEXIUM 40MG [TABLET]	323	16,095	ESOMEPRAZOLE 40MG [GASTRO-RESISTANT TABLET]	£12,625
2	ARIMIDEX 1MG [TABLET]	63	7,816	ANASTROZOLE 1MG [TABLET]	£7,596
3	LOSEC 20MG [CAPSULE]	194	6,570	OMEPRAZOLE 20MG [GASTRO-RESISTANT CAPSULE]	£5,976
4	PLAVIX 75MG [TABLET]	108	6,201	CLOPIDOGREL 75MG [TABLET]	£5,877
5	NEXIUM 20MG [TABLET]	187	7,104	ESOMEPRAZOLE 20MG [GASTRO-RESISTANT TABLET]	£5,253
6	XALATAN 2.5ML [EYE DROP]	260	5,400	LATANOPROST 50MICROGRAMS/ML [EYE DROP]	£4,539
7	IMIGRAN 100MG [TABLET]	29	2,969	SUMATRIPTAN 100MG [TABLET]	£2,845
8	SEROQUEL 25MG [TABLET]	53	2,927	QUETIAPINE 25MG [TABLET]	£2,810
9	SINGULAIR 10MG [TABLET]	73	3,023	MONTELUKAST 10MG [TABLET]	£2,740
10	LIPITOR 40MG [TABLET]	53	2,341	ATORVASTATIN 40MG [TABLET]	£2,186
11	LIPITOR 20MG [TABLET]	44	2,144	ATORVASTATIN 20MG [TABLET]	£2,021
12	ARICEPT 10MG [TABLET]	14	1,929	DONEPEZIL 10MG [TABLET]	£1,890
13	BONVIVA F/C 150MG [TABLET]	43	2,116	IBANDRONIC ACID 150MG [TABLET]	£1,769
14	ACTONEL ONCE A WEEK 35MG [TABLET]	59	1,759	RISEDRONATE 35MG [TABLET]	£1,652
15	ARAVA 20MG [TABLET]	32	2,430	LEFLUNOMIDE 20MG [TABLET]	£1,611
16	LIPITOR 10MG [TABLET]	71	1,729	ATROVASTATIN 10MG [TABLET]	£1,579
17	MIRAPEXIN 0.7MG [TABLET]	7	1,616	PRAMIPEXOLE 700MICROGRAM [TABLET]	£1,552
18	BONDRONAT 50MG [TABLET]	8	1,653	IBANDRONIC ACID 50MG [TABLET]	£1,513
19	FOSAMAX ONCE WEEKLY 70MG [TABLET]	46	1,505	ALENDRONIC ACID 70MG [TABLET]	£1,445
20	IMIGRAN 50 50MG [TABLET]	37	1,486	SUMATRIPTAN 50MG [TABLET]	£1,405
	Total	**1,704**	**78,812**		**£68,885**

Potential savings per annum = £275,539

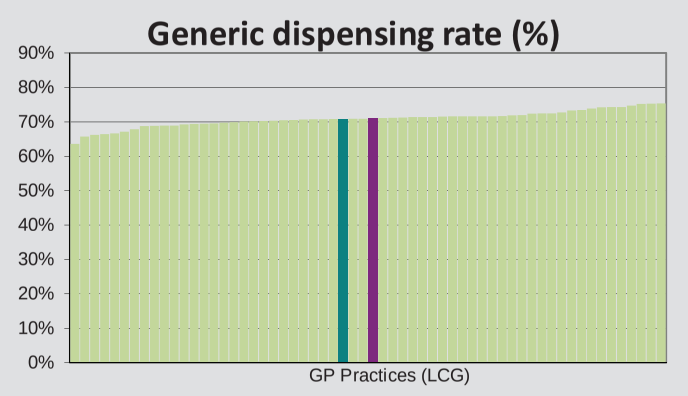
Top cost effective switches

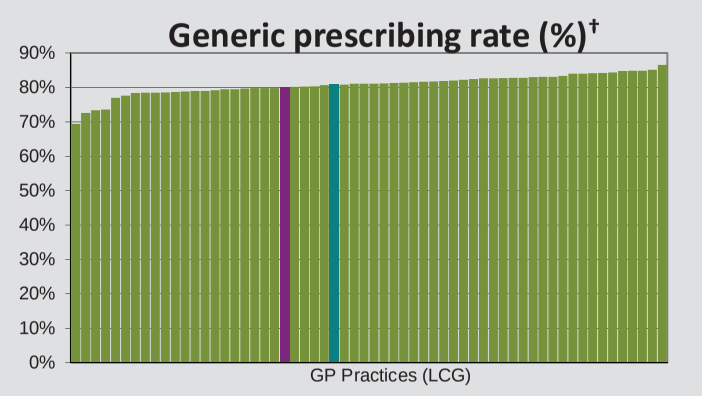
South Eastern LCG

	Drug name	Number of Items	Spend	Cost effective choice	Potential Savings for the quarter
1	SOLIFENACIN (DT) 5MG [TABLET]	1,881	£66,650	TOLTERODINE (DT) 2MG [TABLET]	£59,721
2	SOLIFENACIN (DT) 10MG [TABLET]	974	£44,461	TOLTERODINE (DT) 2MG [TABLET]	£40,906
3	DOXAZOSIN (DT) 8MG [MODIFIED-RELEASE TABLET]	1,312	£22,995	DOXAZOSIN (DT) 4MG [TABLET]	£20,622
4	FESOTERODINE (DT) 4MG [MODIFIED-RELEASE TABLET]	507	£19,157	TOLTERODINE (DT) 2MG [TABLET]	£17,166
5	MOMETASONE NASAL (DT) 50MICROGRAMS/DOSE [SPRAY]	2,932	£24,585	BECLOMETASONE NASAL (DT) 50MCG [SPRAY]	£15,001
6	DOXAZOSIN (DT) 4MG [MODIFIED-RELEASE TABLET]	1,611	£14,353	DOXAZOSIN (DT) 2MG [TABLET]	£11,885
7	FLUTICASONE PROPIONATE (DT) 50MICROGRAMS/DOSE [NASAL SPRAY]	1,278	£15,799	BECLOMETASONE NASAL (DT) 50MCG [SPRAY]	£11,236
8	SALINE STERI-NEB [AMPOULE]	389	£24,874	STERIPOULES SODIUM CHLORIDE 2.5ML [AMPOULE]	£9,399
9	AZITHROMYCIN (DT) 250MG [CAPSULE]	260	£11,598	AZITHROMYCIN (DT) 250MG [TABLET]	£9,055
10	FESOTERODINE (DT) 8MG [MODIFIED-RELEASE TABLET]	269	£9,938	TOLTERODINE (DT) 2MG [TABLET]	£8,905
11	OMEPRAZOLE (DT) 40MG [GASTRO-RESISTANT CAPSULE]	2,482	£16,416	OMEPRAZOLE (DT) 20MG [GASTRO-RESISTANT CAPSULE]	£7,988
12	NYSTATIN (DT) 100,000UNITS/ML [ORAL SUSPENSION]	696	£15,492	MICONAZOLE SUGAR FREE (DT) 20MG/G [OROMUCOSAL GEL]	£7,837
13	VESICARE FILM COATED 5MG [TABLET]	220	£7,278	TOLTERODINE (DT) 2MG [TABLET]	£6,521
14	PARACETAMOL 500MG SOLUBLE TABLETS (DT) 500MG [EFFERVESCENT TAB LET]	1,153	£8,252	PARACETAMOL (DT) 500MG [TABLET]	£5,649
15	OMEPRAZOLE DISPERSIBLE (DT) 20MG [GASTRO-RESISTANT TABLET]	406	£6,812	LANSOPRAZOLE (DT) 15MG [ORODISPERSIBLE TABLET]	£4,991
16	LEVOCETIRIZINE (DT) 5MG [TABLET]	1,133	£6,746	CETIRIZINE (DT) 10MG [TABLET]	£4,930
17	IBUPROFEN (DT) 10% [GEL]	1,984	£11,280	KETOPROFEN (DT) 2.5% [GEL]	£4,890
	Total	**19,487**	**£326,686**		**£246,701**

Overall Generic Dispensing

South Eastern LCG





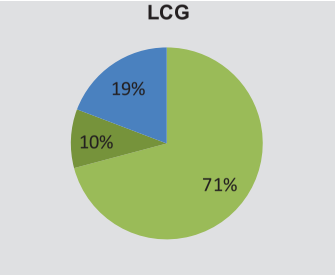
The range of generic drugs listed within Part I of the NI drug tariff increased in April 2011. This change may have increased the generic dispensing rate.

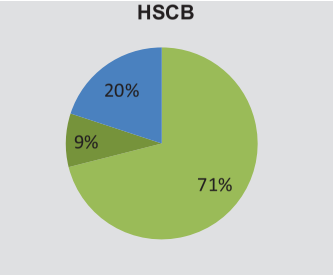
LCG Average | HSCB Average

Prescribed and dispensed generically
Prescribed generically and dispensed by brand as no generic is currently available
Presribed and dispensed by brand

†The generic **prescribing** rates chart is new. This chart reports GP prescribing of generics. This will include drugs that, although prescribed generically, will have been dispensed by brand as no generic is currently available.

NB 100% generic prescribing rate is not achievable or desired as there are a number of items unsuitable for generic prescribing. See link below:
http://www.hscboard.hscni.net/medicinesmanagement/Prescribing%20Guidance/index.html

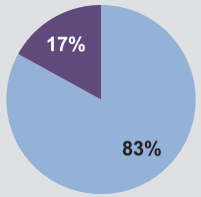




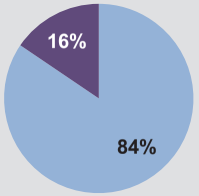
Proton Pump Inhibitors (PPIs)

South Eastern LCG

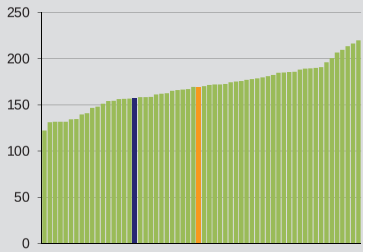
LCG



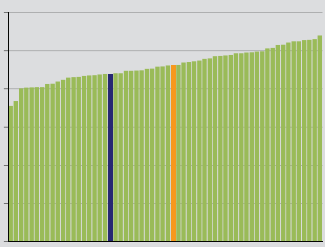
HSCB



PPIs - Cost /1000 NPUs



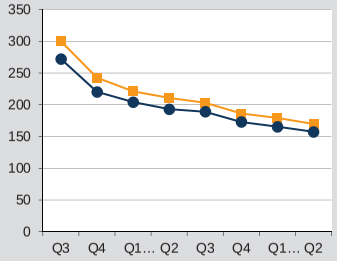
PPIs - DDDs /1000 NIPUs



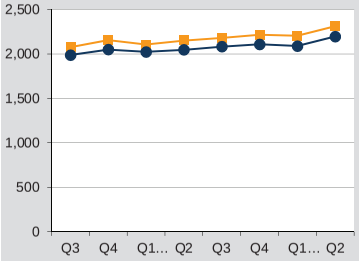
Drug name	Items	%
Lansoprazole	26308	31.22%
Omeprazole	43643	51.78%
Pantoprazole	4927	5.85%
Losec	210	0.25%
Protium	0	0.00%
Esomeprazole (tablets)	7688	9.12%
Lansoprazole orodispersible†	0	0.00%
Omeprazole dispersible†	0	0.00%
Rabeprazole	406	0.48%
Emozul (capsules)	30	0.04%
Nexium (tablets)	512	0.61%
Pariet	43	0.05%
Losec MUPS†	295	0.35%
Zoton FasTab†	217	0.26%

Drug name	Items	%
Lansoprazole	158553	31.26%
Omeprazole	269884	53.21%
Pantoprazole	30291	5.97%
Losec	1611	0.32%
Protium	0	0.00%
Esomeprazole (tablets)	37843	7.46%
Lansoprazole orodispersible†	0	0.00%
Omeprazole dispersible†	0	0.00%
Rabeprazole	2414	0.48%
Emozul (capsules)	95	0.02%
Nexium (tablets)	2883	0.57%
Pariet	281	0.06%
Losec MUPS†	1884	0.37%
Zoton FasTab†	1459	0.29%

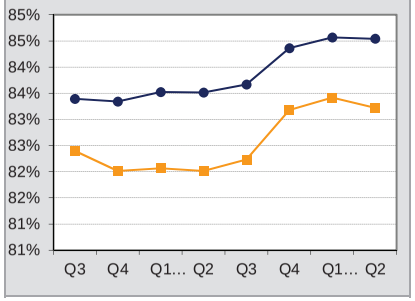
PPIs - Cost /1000 NIPUs



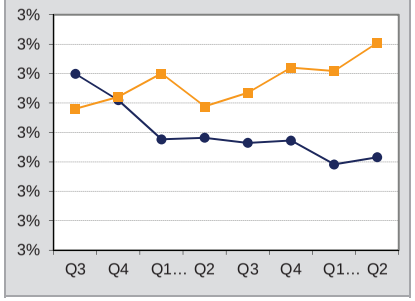
PPIs - DDDs /1000 NIPUs



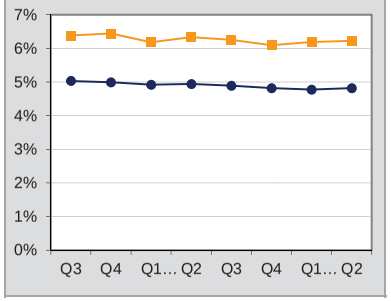
% generic omeprazole and lansoprazole of all PPI items (↑)



% esomeprazole 20mg of all PPI items (↓)



% esomeprazole 40mg of all PPI items (↓)



Key

Pie charts

Preferred choices

Other items

† If patients do not have swallowing difficulties, they could be switched to omeprazole or lansoprazole capsules.

Line charts

Q1 = Jan/Mar

LCG

HSCB

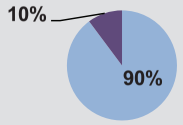
Upward trend preferable ↑

Downward trend preferable ↓

Lipid lowering drugs

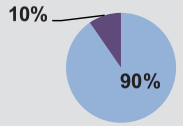
South Eastern LCG

LCG



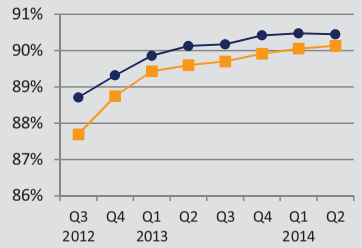
Drug name	Items	%
Simvastatin 10mg	2192	2.84%
Simvastatin 20mg	7893	10.24%
Simvastatin 40mg	26269	34.09%
Simvastatin 80mg	146	0.19%
Simvastatin 20mg/5ml	23	0.03%
Simvastatin 40mg/5ml	77	0.10%
Atorvastatin 10mg	7316	9.49%
Atorvastatin 20mg	8142	10.56%
Atorvastatin 40mg	11845	15.37%
Atorvastatin 80mg	1238	1.61%
Pravastatin	4048	5.25%
Fluvastatin	218	0.28%
Rosuvastatin	6918	8.98%
Simvastatin + Ezetimibe	82	0.11%
Lescol /other brands	6	0.01%
Lipostat	27	0.04%
Zocor	13	0.02%
Crestor	413	0.54%
Inegy	23	0.03%
Lipitor 10mg	71	0.09%
Lipitor 20mg	45	0.06%
Lipitor 40mg	53	0.07%
Lipitor 80mg	8	0.01%

HSCB

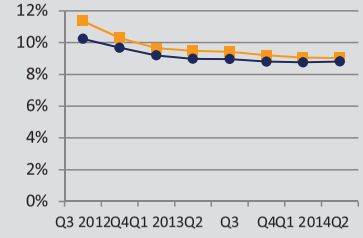


Drug name	Items	%
Simvastatin 10mg	9184	2.00%
Simvastatin 20mg	48808	10.62%
Simvastatin 40mg	153242	33.35%
Simvastatin 80mg	415	0.09%
Simvastatin 20mg/5ml	141	0.03%
Simvastatin 40mg/5ml	269	0.06%
Atorvastatin 10mg	37453	8.15%
Atorvastatin 20mg	53985	11.75%
Atorvastatin 40mg	80607	17.54%
Atorvastatin 80mg	6831	1.49%
Pravastatin	24277	5.28%
Fluvastatin	1101	0.24%
Rosuvastatin	37184	8.09%
Simvastatin + Ezetimibe	427	0.09%
Lescol /other brands	73	0.02%
Lipostat	114	0.02%
Zocor	102	0.02%
Crestor	3913	0.85%
Inegy	216	0.05%
Lipitor 10mg	418	0.09%
Lipitor 20mg	364	0.08%
Lipitor 40mg	291	0.06%
Lipitor 80mg	30	0.01%

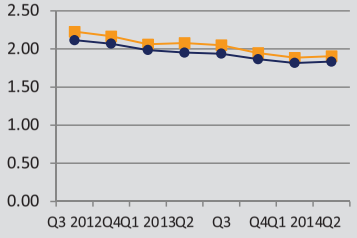
% simvastatin, atorvastatin and pravastatin of all statin items (↑)



% rosuvastatin of all statin items (↓)



Ezetimibe, Items /1000 NIPUs (↓)
(includes Ezetrol and Inegy)



Key

Pie charts

Preferred choices

Other items

Line charts

Q1 = Jan/Mar

LCG

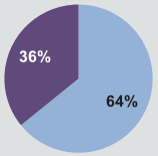
HSCB

Upward trend preferable ↑

SSRIs and related antidepressant drugs

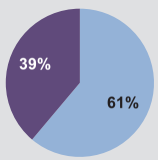
South Eastern LCG

LCG



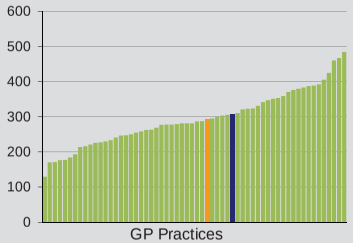
Drug name	Items	%
Citalopram	23424	30.11%
Fluoxetine	14973	19.25%
Sertraline	11505	14.79%
Duloxetine	4425	5.69%
Escitalopram	3675	4.72%
Flupentixol	117	0.15%
Fluvoxamine	30	0.04%
Mirtazapine	7994	10.28%
Paroxetine	1442	1.85%
Reboxetine	102	0.13%
Venlafaxine (incl. XL)	1366	1.76%
Cipramil	45	0.06%
Efexor /XL /other brands	7473	9.61%
Faverin	8	0.01%
Lustral	47	0.06%
Prozac	46	0.06%
Seroxat	35	0.04%
Cipralex	189	0.24%
Cymbalta	809	1.04%
Edronax	20	0.03%
Fluanxol	27	0.03%
Optimax	1	0.00%
Zispin SolTab	29	0.04%

HSCB

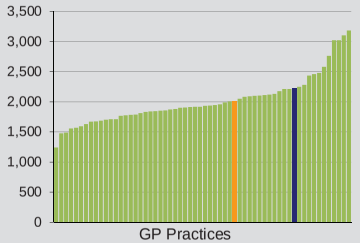


Drug name	Items	%
Citalopram	129369	25.02%
Fluoxetine	94531	18.28%
Sertraline	92071	17.81%
Duloxetine	21892	4.23%
Escitalopram	23441	4.53%
Flupentixol	389	0.08%
Fluvoxamine	210	0.04%
Mirtazapine	64596	12.49%
Paroxetine	11764	2.28%
Reboxetine	430	0.08%
Venlafaxine (incl. XL)	10841	2.10%
Cipramil	282	0.05%
Efexor /XL /other brands	58338	11.28%
Faverin	30	0.01%
Lustral	436	0.08%
Prozac	325	0.06%
Seroxat	388	0.08%
Cipralex	2331	0.45%
Cymbalta	4592	0.89%
Edronax	137	0.03%
Fluanxol	371	0.07%
Optimax	12	0.00%
Zispin SolTab	258	0.05%

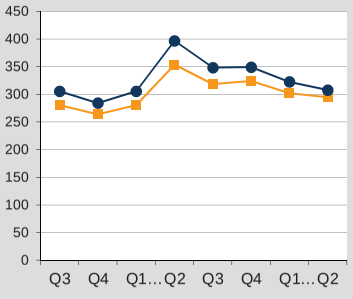
SSRIs and related antidepressants Cost /1000 NIPUs



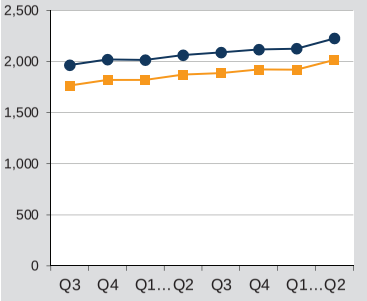
SSRIs and related antidepressants DDDs /1000 NIPUs



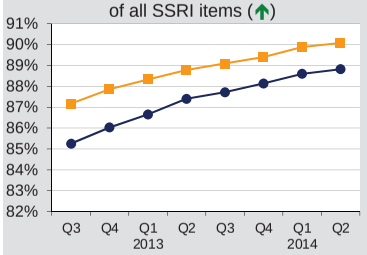
SSRIs and related antidepressants Cost /1000 NIPUs



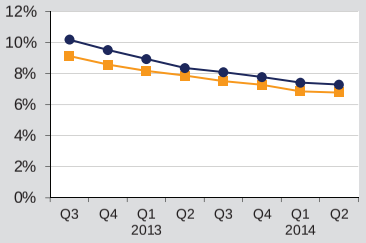
SSRIs and related antidepressants DDDs /1000 NIPUs

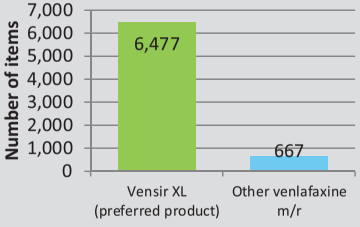


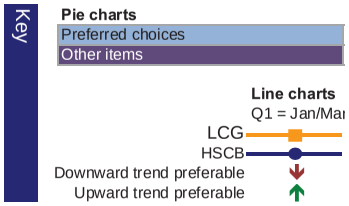
% generic citalopram, fluoxetine and sertraline of all SSRI items (↑)

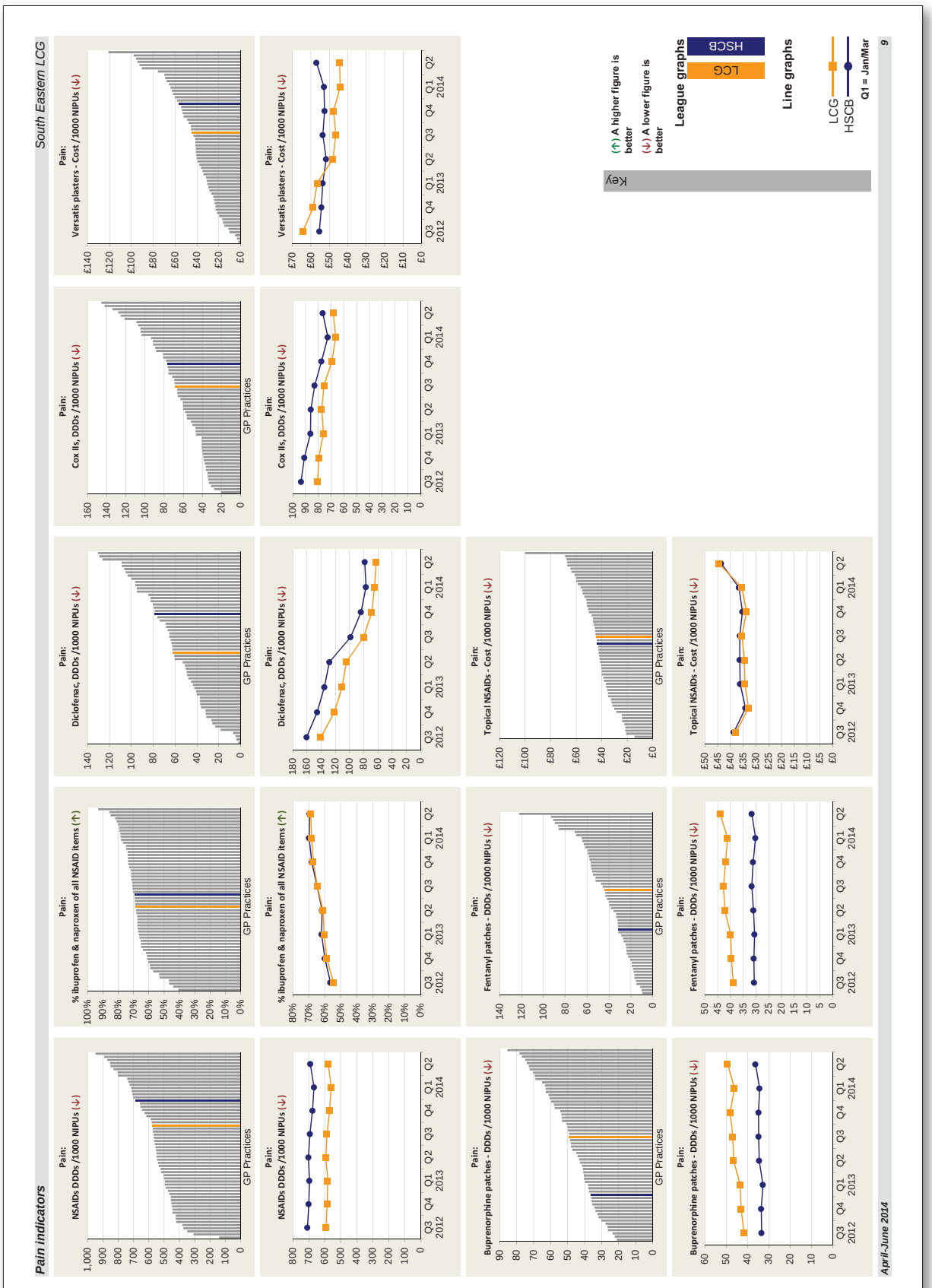


% escitalopram of all SSRIs (↓)





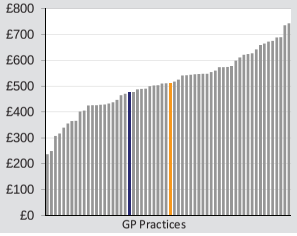



Pain indicators
South Eastern LCG
Pain:
NSAIDs DDDs /1000 NIPUs (↓)
Pain:
Cox IIs, DDDs /1000 NIPUs (↓)
Pain:
Diclofenac, DDDs /1000 NIPUs (↓)
Pain:
% ibuprofen & naproxen of all NSAID items (↑)
Pain:
Buprenorphine patches - DDDs /1000 NIPUs (↓)
Pain:
Fentanyl patches - DDDs /1000 NIPUs (↓)
Pain:
Topical NSAIDs - Cost /1000 NIPUs (↓)
Pain:
Versatis plasters - Cost /1000 NIPUs (↓)
GP Practices
Q3 2012
Q4
Q1 2013
Q2
Q3
Q4
Q1 2014
Q2
Key
(↑) A higher figure is better
(↓) A lower figure is better
League graphs
LCG
HSCB
Line graphs
LCG
HSCB
Q1 = Jan/Mar
April-June 2014
9

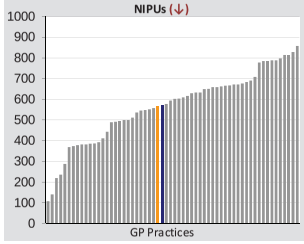
Pain indicators

South Eastern LCG

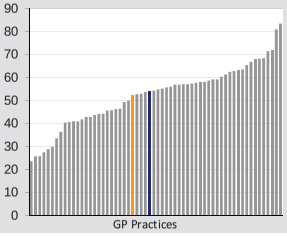
Pregabalin, Cost /1000 NIPUs (↓)



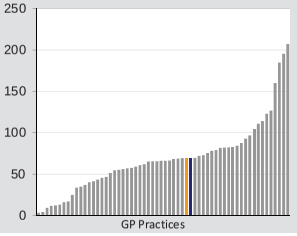
Paracetamol-opioid compound analgesics, DDDs /1000 NIPUs (↓)



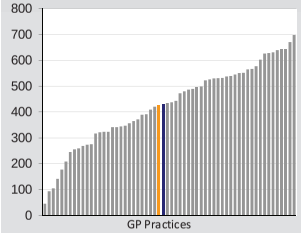
Co-codamol 8/500, DDDs /1000 NIPUs (↓)



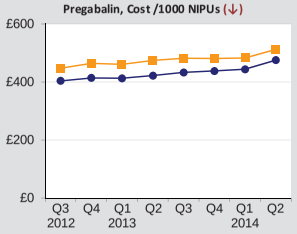
Co-codamol 15/500, DDDs /1000 NIPUs (↓)



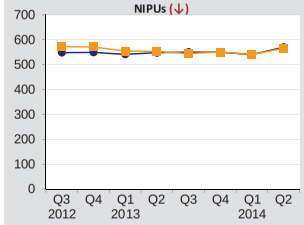
Co-codamol 30/500, DDDs /1000 NIPUs (↓)



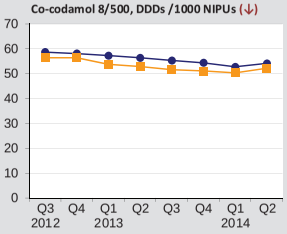
Pregabalin, Cost /1000 NIPUs (↓)



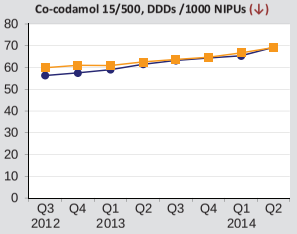
Paracetamol-opioid compound analgesics, DDDs /1000 NIPUs (↓)



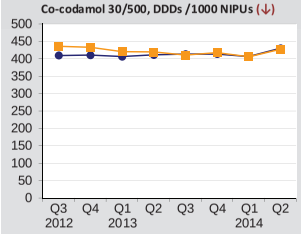
Co-codamol 8/500, DDDs /1000 NIPUs (↓)



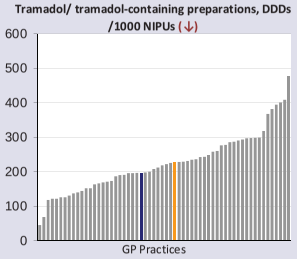
Co-codamol 15/500, DDDs /1000 NIPUs (↓)



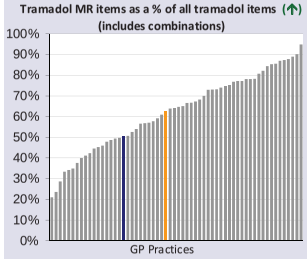
Co-codamol 30/500, DDDs /1000 NIPUs (↓)



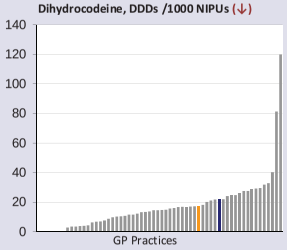
Tramadol/ tramadol-containing preparations, DDDs /1000 NIPUs (↓)



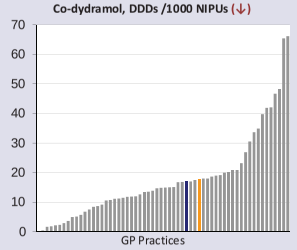
Tramadol MR items as a % of all tramadol items (↑) (includes combinations)



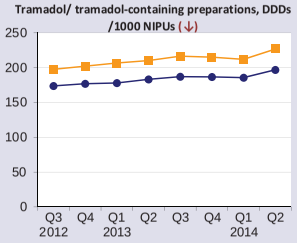
Dihydrocodeine, DDDs /1000 NIPUs (↓)



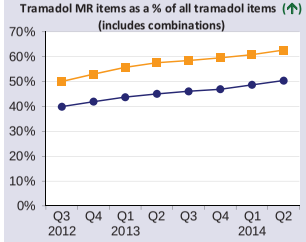
Co-dydramol, DDDs /1000 NIPUs (↓)



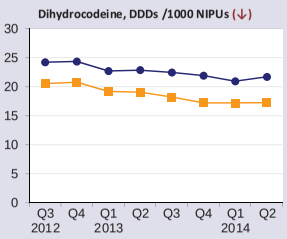
Tramadol/ tramadol-containing preparations, DDDs /1000 NIPUs (↓)



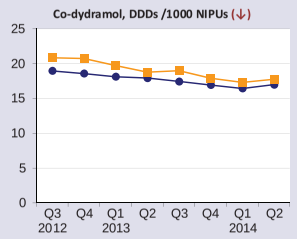
Tramadol MR items as a % of all tramadol items (↑) (includes combinations)



Dihydrocodeine, DDDs /1000 NIPUs (↓)



Co-dydramol, DDDs /1000 NIPUs (↓)



Key

(↑) A higher figure is better

(↓) A lower figure is better

League graphs

LCG

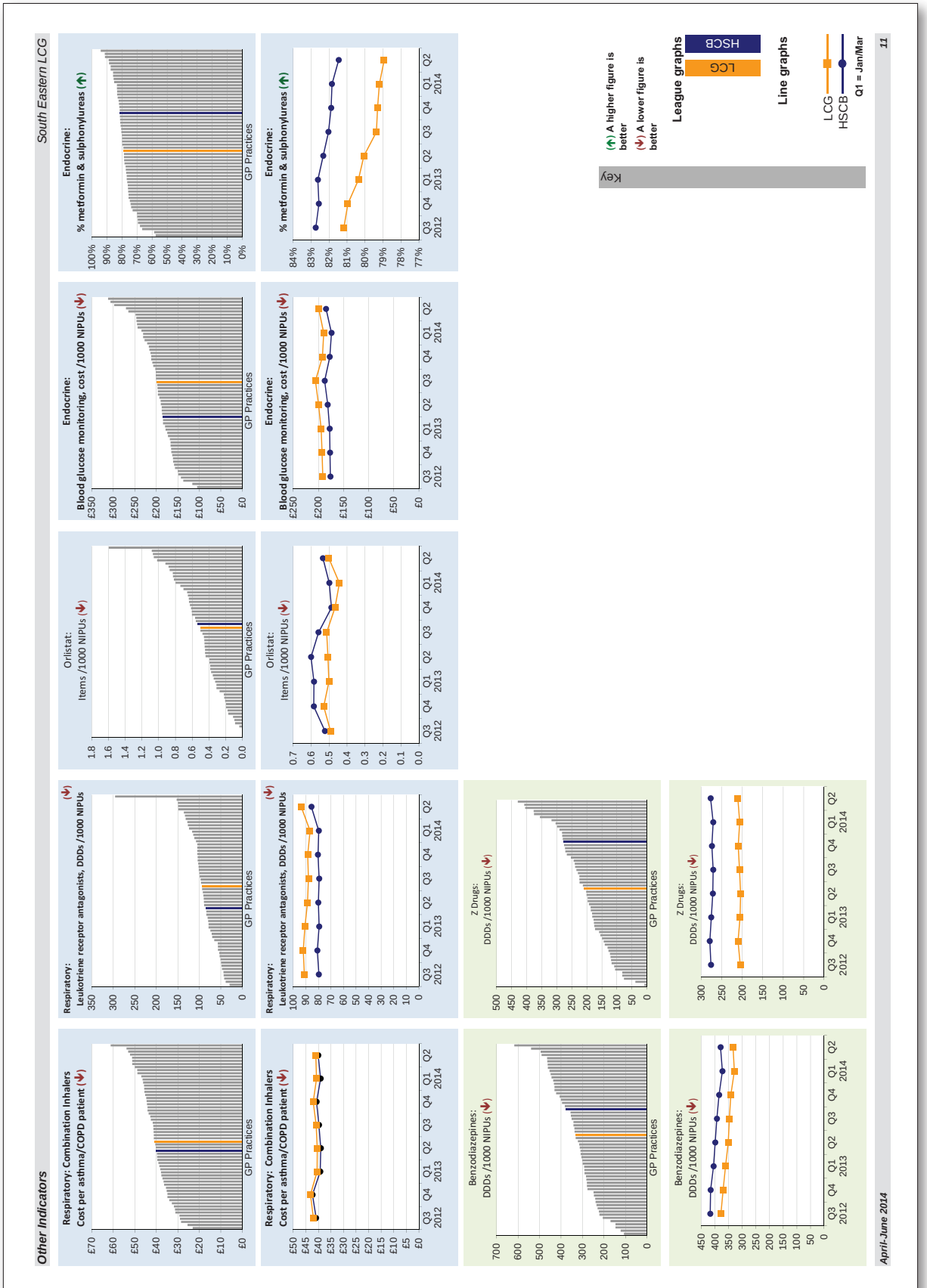
HSCB

Line graphs

LCG

HSCB

Q1 = Jan/Mar


South Eastern LCG
Other Indicators
Endocrine: % metformin & sulphonylureas (↑)
Endocrine: Blood glucose monitoring, cost /1000 NIPUs (↓)
Orlistat: Items /1000 NIPUs (↓)
Respiratory: Leukotriene receptor antagonists, DDDs /1000 NIPUs (↓)
Z Drugs: DDDs /1000 NIPUs (↓)
Respiratory: Combination Inhalers Cost per asthma/COPD patient (↓)
Benzodiazepines: DDDs /1000 NIPUs (↓)
GP Practices
Q3 2012
Q4
Q1 2013
Q2
Q3
Q4
Q1 2014
Q2
Key
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League graphs
LCG
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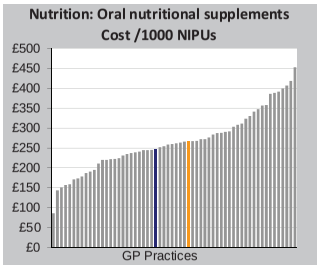
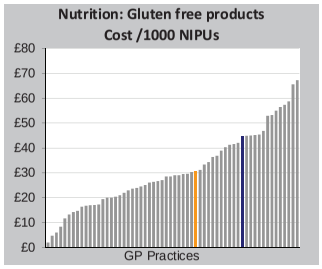
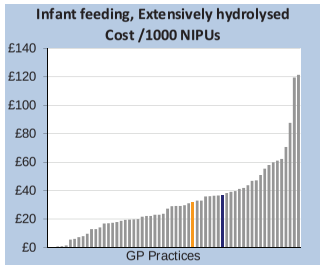
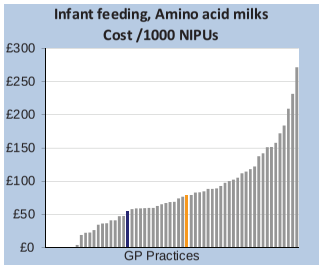
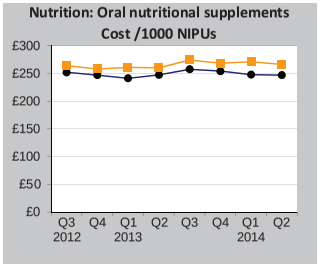
Line graphs
LCG
HSCB
Q1 = Jan/Mar
April-June 2014
11

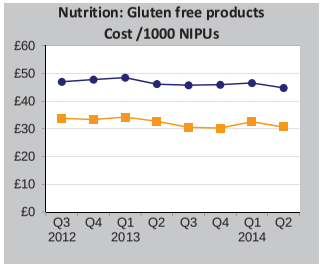


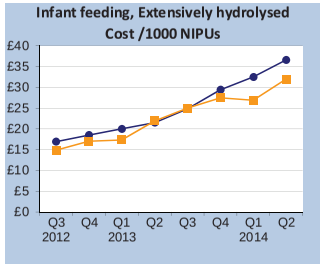


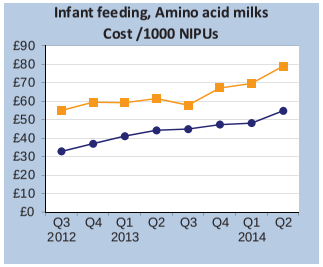












Key

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(↓) A lower figure is better

League graphs

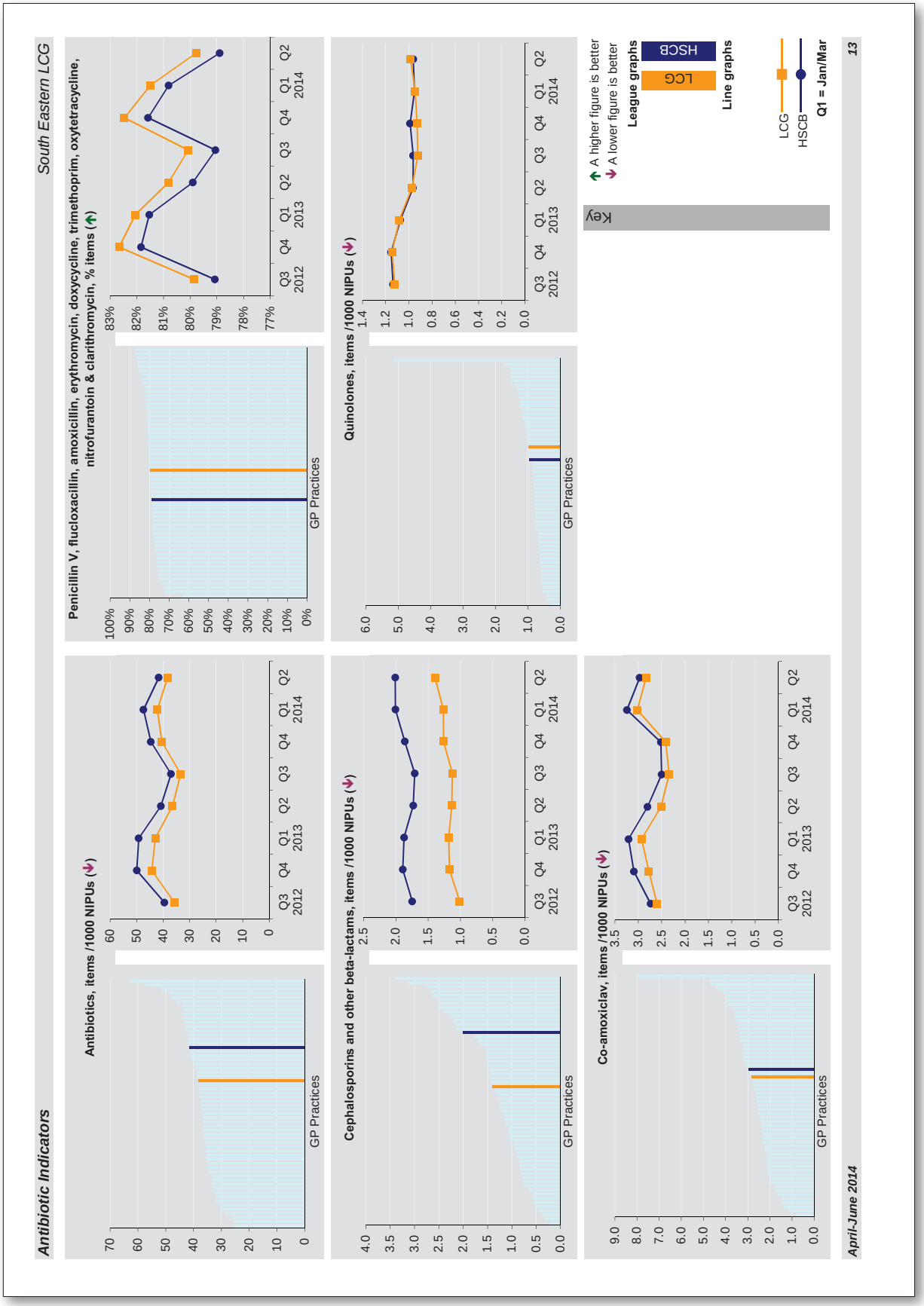
LCG HSCB

Line graphs

LCG

HSCB

Q1 = Jan/Mar


Antibiotic Indicators
South Eastern LCG
Penicillin V, flucloxacillin, amoxicillin, erythromycin, doxycycline, trimethoprim, oxytetracycline, nitrofurantoin & clarithromycin, % items (↑)
Quinolones, items /1000 NIPUs (↓)
Antibiotics, items /1000 NIPUs (↓)
Cephalosporins and other beta-lactams, items /1000 NIPUs (↓)
Co-amoxiclav, items /1000 NIPUs (↓)
GP Practices
Q3 2012
Q4
Q1 2013
Q2
Q3
Q4
Q1 2014
Q2
Key
A higher figure is better
A lower figure is better
League graphs
HSCB
LCG
Line graphs
LCG
HSCB
Q1 = Jan/Mar
April-June 2014
13

Stock Prescribing

High Risk Drugs

Drug name/group	Items	Quantity
Warfarin 0.5mg	-	-
Warfarin 5mg	18	970
Methotrexate 10mg	4	28
Red List drugs	8	N/A

IV antibiotics: patient prescribing

Drug name	Items	Quantity
Augmentin Intravenous 1.2g powder for solution for injection vials	1	2
Augmentin Intravenous 600mg powder for solution for injection vials	2	76
Bramitob 300mg/4ml nebuliser solution 4ml ampoules	1	56
Ceftriaxone 1g powder for solution for injection vials	5	21
Ceftriaxone 2g powder for solution for injection vials	1	1
Crystapen 1.2g powder for solution for injection vials	1	50
Genticin Injectable 80mg/2ml solution for injection ampoules	1	5
Meronem 500mg powder for solution for injection vials	2	15
Rocephin 1g powder for solution for injection vials	3	15
Tavanic 500mg/100ml solution for infusion vials	1	3
Tazocin 4.5g powder for solution for injection vials	2	29
Zinacef 1.5g powder for injection vials	1	10
Zinacef 250mg powder for injection vials	1	40
Zinacef 750mg powder for injection vials	5	150
Totals	**27**	

Top 15 Stock Items by Cost (excluding dressings & appliances)

	Drug name	Cost (£)	Items	Quantity
1	Mirena 20micrograms/24hours intrauterine device	£2,992	8	34
2	Nexplanon 68mg implant	£2,066	6	26
3	Depo-Medrone 40mg/1ml suspension for injection vials	£1,907	23	559
4	Depo-Medrone with Lidocaine suspension for injection 1ml vials	£1,385	22	356
5	ViATIM vaccine suspension for injection 1ml pre-filled syringes	£1,132	5	38
6	Depo-Medrone with Lidocaine suspension for injection 2ml vials	£1,054	10	150
7	Depo-Medrone 80mg/2ml suspension for injection vials	£1,052	10	171
8	Depo-Medrone 120mg/3ml suspension for injection vials	£1,039	6	117
9	Chlorphenamine 10mg/1ml solution for injection ampoules	£996	58	345
10	EpiPen Jr. 150micrograms/0.3ml (1 in 2,000) solution for injection auto-injectors	£952	20	36
11	EpiPen 300micrograms/0.3ml (1 in 1,000) solution for injection auto-injectors	£952	20	36
12	Pneumovax II vaccine solution for injection 0.5ml vials	£849	7	102
13	Prednisolone 5mg soluble tablets	£779	14	546
14	Sodium chloride 0.9% irrigation solution 20ml Steripod unit dose	£643	25	2050
15	Kenalog Intra-articular / Intramuscular 40mg/1ml suspension for injection vials	£595	28	399
	Total	**£18,394**	**262**	
	Total of all Stock (including dressings and appliances)	**£142,537**	**4,341**	

Top 15 CDs (schedules 2, 3, 4 and 5)

	Drug name	Cost (£)	Items	Quantity
1	Buccolam 10mg/2ml oromucosal solution pre-filled oral syringes	£549	5	24
2	Buccolam 5mg/1ml oromucosal solution pre-filled oral syringes	£171	2	8
3	Diamorphine 5mg powder for solution for injection ampoules	£114	7	50
4	Cyclimorph 10 solution for injection 1ml ampoules	£96	10	55
5	Midazolam 10mg/2ml oromucosal solution pre-filled oral syringes	£92	1	4
6	Buccolam 7.5mg/1.5ml oromucosal solution pre-filled oral syringes	£89	1	4
7	Buccolam 2.5mg/0.5ml oromucosal solution pre-filled oral syringes	£82	1	4
8	Diamorphine 10mg powder for solution for injection ampoules	£64	5	25
9	Cyclimorph 15 solution for injection 1ml ampoules	£36	3	20
10	Diazemuls 10mg/2ml emulsion for injection ampoules	£27	3	30
11	Stesolid 5mg rectal tube	£26	4	19
12	Diazepam 10mg/2ml solution for injection ampoules	£25	8	56
13	Co-codamol 15mg/500mg tablets	£25	3	300
14	Co-codamol 8mg/500mg effervescent tablets	£21	2	300
15	Diazepam 5mg tablets	£19	15	647
	Total	**£1,437**	**70**	

Appendix: COMPASS Explanatory Notes

Glossary			
ICPs	Integrated Care Partnerships	NIPUs	Northern Ireland Prescribing Units
LCG	Local Commissioning Group		
HSCB	Health and Social Care Board		

Quarter: Information in the COMPASS report is based on three months of prescribing data, i.e. one quarter.

ICP average: Figures refer to the average of all practices within the respective ICP.

LCG average: Figures refer to the average of all practices within the respective LCG.

HSCB average: Figures refer to the average of all practices within the HSCB, i.e. all practices in NI.

Cost (£): Net ingredient cost, equivalent to England's Net Ingredient Cost (NIC). Cost is useful in terms of monitoring the overall drugs bill, checking spend within prescribing budgets and calculating savings made or potential savings. Cost is less useful as a measure of drug consumption because of the differences in cost of alternative preparations and changes in prices.

Items: Number of prescription items. Count of items is a reasonable measure of the number of courses of treatments for vaccinations and acute treatments such as short courses of antibiotics. For other treatments it is less useful because of the wide variation in duration of supply per item.

NIPUs: In measuring prescribing, differences between practices need to be taken account of in order to make valid comparisons with local and national averages. NIPUs standardise for differences between practices in terms of patient list size, age/sex structure and additional needs.

Quantity: Number of physical units, i.e. tablets, capsules, patches, mLs, inhalers, vials etc. Quantity is a useful measure of prescribing when looking at individual preparations, e.g. methotrexate 10mg or warfarin 0.5mg and 5mg.

Change from Last Year: The actual change from the same quarter in the previous year.

Defined Daily Dose (DDD): The DDD is a unit of measurement based on the assumed average maintenance dose per day used for its main indication in adults. The World Health Organisation (WHO) developed the DDD as a method to compare drugs of different chemical structures and potencies. The DDD methodology standardises quantities prescribed into number of daily doses. See worked example below. The number of DDDs is calculated as follows:

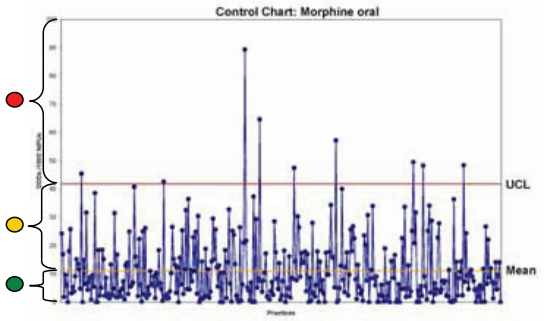
$$\text{Number of DDDs} = \frac{\text{Strength (mg) x quantity}}{\text{DDD (mg)}}$$

Worked example	Quantity (no. of tabs /caps)	DDD (mg)	No. of DDDs
Ibuprofen 200mg 2 caps 3 times a day	168	1200	$\frac{200 \times 168}{1200} = 28$
Ranitidine 150mg 1 tablet twice a day	56	300	$\frac{150 \times 56}{300} = 28$
Lansoprazole 30mg 1 capsule once a day	28	30	$\frac{30 \times 28}{30} = 28$

Prescribing Indicators listed throughout the report give some indication of prescribing quality but are not quantitative measures of good prescribing. Arrows indicate whether a larger figure or a smaller figure suggests 'better' prescribing. Values are given for the practice, locality average, LCG average and HSCB average. They are, therefore, useful in identifying outliers i.e. practice's whose prescribing differs substantially from other practices and to highlight areas for further analysis.

Red List Drugs: The Red list is an advisory list where it is considered by the Regional Group on Specialist Medicines, that responsibility for prescribing should remain with the consultant or specialist clinician. It is recommended that the supply of these specialist medicines should be organised via the hospital pharmacy.

Controlled Drugs (CDs): On the patient and stock prescribing pages there are red, orange and green dots. Each dot represents where a practice is on a control chart in relation to the Upper Control Limit (UCL) and the mean for all practices in NI (see chart below). The UCL is the mean + 3 standard deviations. A green dot represents a practice at the mean or below. An orange dot represents a practice above the mean but below the UCL. A red dot represents a practice above the UCL.



LCG COMPASS Report

Northern LCG

April-June 2014

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Key

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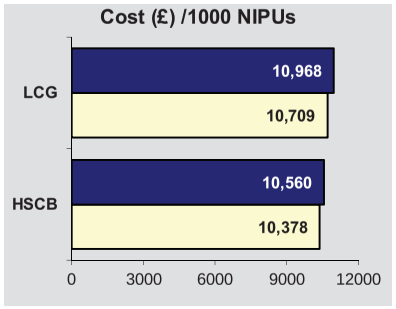
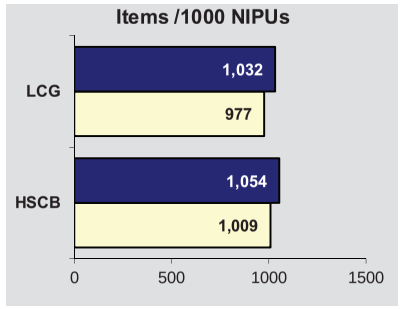
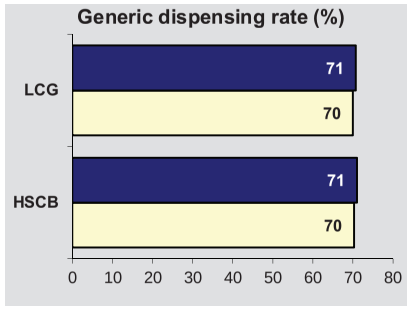
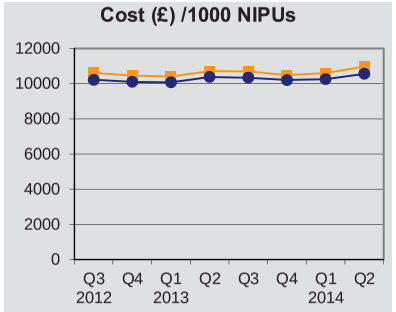
Quarter last year Apr-Jun 13

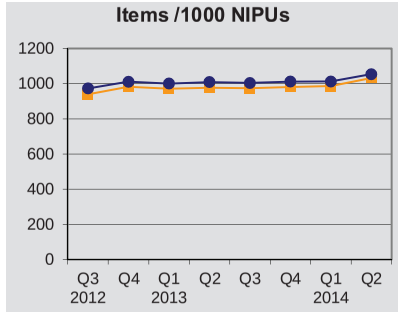
LCG
HSCB

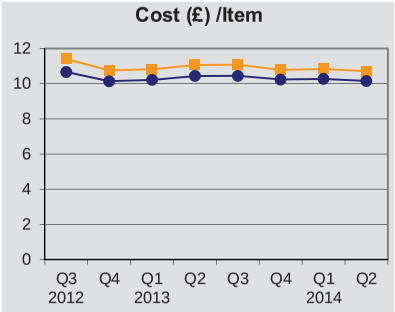


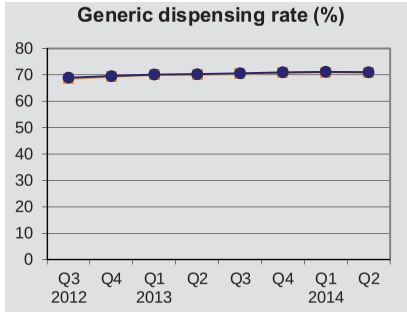












COMPASS Unit, Operations Directorate, FPS, BSO, 2 Franklin Street, Belfast BT2 8DQ Web site: http://www.hscbusiness.hscni.net/services.htm Tel: 028 9053 5661 Fax: 028 9053 2963

Top 40 : Forty most costly drugs in your LCG

Northern LCG

	Drug Name	Drug's position in HSCB's most costly drugs*	Cost (£)	No of Items	Quantity	Cost (£) /Item	% of Board Total Cost	Change from last year
1	TIOTROPIUM BROMIDE (DT) 18MICROGRAM [INHALATION	1	313,007	6,142	280,305	50.96	1.25	0.03
2	PREGABALIN (DT) 75MG [CAPSULE]	3	276,996	4,061	240,866	68.21	1.11	0.08
3	SERETIDE WITH COUNTER 250MCG/25 [EVOHALER]	2	264,270	3,313	4,443	79.77	1.06	0.04
4	PREGABALIN (DT) 150MG [CAPSULE]	4	234,267	3,244	203,710	72.22	0.94	0.08
5	TEMAZEPAM (DT) 10MG [TABLET]	5	223,623	11,740	304,672	19.05	0.89	-0.32
6	FLUTICASONE 250MICROGRAMS/DOSE / SALMETEROL 25M	7	199,793	2,455	3,359	81.38	0.80	-0.02
7	EZETIMIBE (DT) 10MG [TABLET]	11	190,899	4,020	203,161	47.49	0.76	-0.05
8	PREGABALIN (DT) 300MG [CAPSULE]	9	185,464	2,685	161,273	69.07	0.74	0.08
9	SYMBICORT 200/6 [TURBOHALER]	6	181,032	3,413	4,764	53.04	0.72	0.03
10	PREGABALIN (DT) 50MG [CAPSULE]	14	165,652	2,452	144,045	67.56	0.66	0.08
11	AVIVA [REAGENT]	12	158,484	5,307	508,287	29.86	0.63	0.02
12	SOLIFENACIN (DT) 5MG [TABLET]	23	155,018	3,959	168,372	39.16	0.62	0.04
13	VERSATIS [MEDICATED PLASTER]	15	153,684	2,697	63,682	56.98	0.61	0.14
14	VICTOZA 3ML [PRE-FILLED INJECTION PEN]	13	146,679	1,436	3,738	102.14	0.59	-0.11
15	BUDESONIDE 200MICROGRAMS/DOSE / FORMOTEROL 6MI	10	141,094	2,577	3,713	54.75	0.56	0.02
16	PREGABALIN (DT) 100MG [CAPSULE]	21	139,006	1,976	120,875	70.35	0.56	0.09
17	DULOXETINE (DT) 60MG [GASTRO-RESISTANT CAPSULE]	16	134,681	3,522	136,041	38.24	0.54	0.05
18	ROSUVASTATIN (DT) 10MG [TABLET]	17	131,347	4,030	203,977	32.59	0.52	-0.03
19	CO-CODAMOL (DT) 30MG/500MG [TABLET]	22	122,653	36,876	2,787,601	3.33	0.49	0.00
20	INSULIN NOVORAPID FLEXPEN 3ML [PRE-FILLED PEN]	18	122,229	2,768	19,972	44.16	0.49	0.00
21	FORTISIP COMPACT 125ML [BOTTLE]	26	119,608	2,107	59,212	56.77	0.48	0.00
22	INSULIN LANTUS SOLOSTAR 3ML [PRE-FILLED PEN]	8	119,005	2,384	14,338	49.92	0.48	-0.01
23	SITAGLIPTIN (DT) 100MG [TABLET]	29	117,698	2,094	99,084	56.21	0.47	0.01
24	NEBIVOLOL (DT) 2.5MG [TABLET]	19	114,705	1,029	46,029	111.47	0.46	0.07
25	PREGABALIN (DT) 25MG [CAPSULE]	27	113,721	1,747	98,888	65.10	0.45	0.07
26	INSULIN NOVOMIX 30 FLEXPEN 3ML [INJECTION DEVICE]	20	103,049	2,281	17,238	45.18	0.41	-0.01
27	SOLIFENACIN (DT) 10MG [TABLET]	37	100,773	1,952	84,187	51.63	0.40	0.03
28	OMEPRAZOLE (DT) 20MG [GASTRO-RESISTANT CAPSULE]	25	96,287	46,916	2,344,442	2.05	0.38	-0.02
29	HYDROCORTISONE (DT) 10MG [TABLET]	28	95,109	500	46,331	190.22	0.38	0.08
30	ROSUVASTATIN (DT) 20MG [TABLET]	24	93,520	2,019	100,636	46.32	0.37	0.03
31	FORTISIP 200ML [BOTTLE]	42	92,677	2,489	44,989	37.23	0.37	-0.03
32	ESCITALOPRAM (DT) 20MG [TABLET]	51	91,254	2,746	101,393	33.23	0.36	-0.04
33	INSULIN LEVEMIR 100U/ML 3ML [FLEXPEN]	50	91,157	1,704	10,852	53.50	0.36	0.00
34	PREGABALIN (DT) 200MG [CAPSULE]	39	86,347	1,241	75,084	69.58	0.34	0.06
35	BUTRANS 20MCG/HR [TRANSDERMAL PATCH]	31	85,615	1,341	5,960	63.84	0.34	0.01
36	FORTICREME COMPLETE 125G [DESSERT]	47	81,603	1,696	41,634	48.11	0.33	0.01
37	SERETIDE WITH COUNTER 125MCG/25 [EVOHALER]	32	81,445	1,791	2,327	45.47	0.33	0.00
38	LEVOTHYROXINE SODIUM (DT) 25MICROGRAM [TABLET]	53	81,082	16,322	879,977	4.97	0.32	-0.01
39	ONE TOUCH ULTRA TEST STRIP [REAGENT]	35	79,872	3,145	333,077	25.40	0.32	-0.13
40	TEMAZEPAM (DT) 20MG [TABLET]	44	79,794	3,899	113,759	20.47	0.32	-0.10
	TOTAL		**5,564,196**	**208,076**			**22.22**	

G: Generic form available

*This is the drug's position in the HSCB's most costly drugs. For example, the LCG's 40th most costly drug is TEMAZEPAM (DT) 20MG [TABLET]. This drug is number 44 in HSCB's most costly drugs.

Top 20 generic switches by cost

Northern LCG

	Proprietary Drug	*Number of Items*	*Cost (£)*	*Generic equivalent*	*Potential Savings for the quarter (£)*
1	NEXIUM 40MG [TABLET]	455	21,565	ESOMEPRAZOLE 40MG [GASTRO-RESISTANT TABLET]	£16,917
2	NEXIUM 20MG [TABLET]	319	11,812	ESOMEPRAZOLE 20MG [GASTRO-RESISTANT TABLET]	£8,735
3	LOSEC 20MG [CAPSULE]	284	8,553	OMEPRAZOLE 20MG [GASTRO-RESISTANT CAPSULE]	£7,779
4	ARIMIDEX 1MG [TABLET]	64	7,473	ANASTROZOLE 1MG [TABLET]	£7,263
5	PLAVIX 75MG [TABLET]	127	7,475	CLOPIDOGREL 75MG [TABLET]	£7,084
6	XALATAN 2.5ML [EYE DROP]	405	7,488	LATANOPROST 50MICROGRAMS/ML [EYE DROP]	£6,294
7	LIPITOR 20MG [TABLET]	133	6,480	ATORVASTATIN 20MG [TABLET]	£6,109
8	SINGULAIR 10MG [TABLET]	138	5,704	MONTELUKAST 10MG [TABLET]	£5,171
9	APROVEL 150MG [TABLET]	175	4,052	IRBESARTAN 150MG [TABLET]	£3,480
10	IMIGRAN 50 50MG [TABLET]	76	3,546	SUMATRIPTAN 50MG [TABLET]	£3,352
11	SINGULAIR PAEDIATRIC CHEWABLE 4MG [TABLET]	96	3,417	MONTELUKAST SF 4MG [CHEWABLE TABLET]	£3,123
12	LIPITOR 40MG [TABLET]	70	3,326	ATORVASTATIN 40MG [TABLET]	£3,106
13	BONDRONAT 50MG [TABLET]	15	3,306	IBANDRONIC ACID 50MG [TABLET]	£3,027
14	ACTONEL ONCE A WEEK 35MG [TABLET]	97	3,021	RISEDRONATE 35MG [TABLET]	£2,838
15	CASODEX 50MG [TABLET]	21	2,896	BICALUTAMIDE 50MG [TABLET]	£2,834
16	ARICEPT 10MG [TABLET]	28	2,852	DONEPEZIL 10MG [TABLET]	£2,794
17	REQUIP 2MG [TABLET]	10	2,830	ROPINIROLE 2MG [TABLET]	£2,610
18	IMIGRAN 100MG [TABLET]	39	2,720	SUMATRIPTAN 100MG [TABLET]	£2,608
19	LIPITOR 10MG [TABLET]	109	2,770	ATROVASTATIN 10MG [TABLET]	£2,529
20	SEROQUEL 25MG [TABLET]	64	2,498	QUETIAPINE 25MG [TABLET]	£2,398
	Total	**2,725**	**113,785**		**£100,050**

Potential savings per annum = £400,201

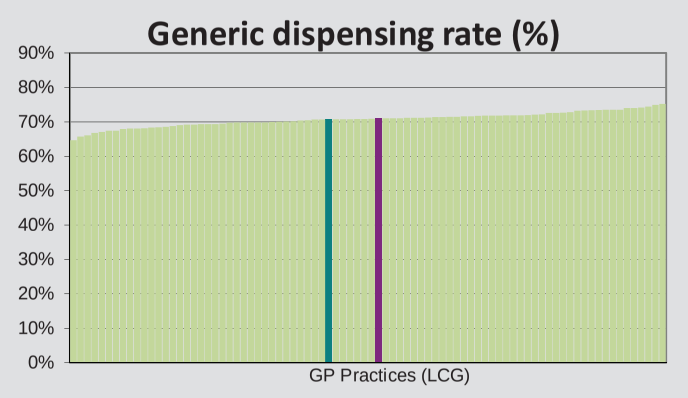
Top cost effective switches

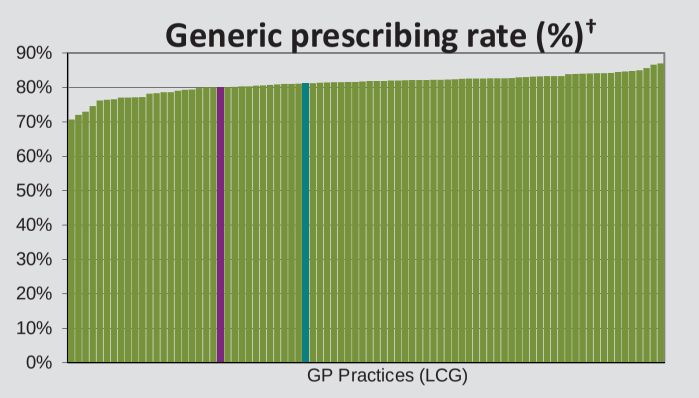
Northern LCG

	Drug name	Number of Items	Spend	Cost effective choice	Potential Savings for the quarter
1	SOLIFENACIN (DT) 5MG [TABLET]	3,959	£155,018	TOLTERODINE (DT) 2MG [TABLET]	£138,901
2	SOLIFENACIN (DT) 10MG [TABLET]	1,952	£100,773	TOLTERODINE (DT) 2MG [TABLET]	£92,715
3	FESOTERODINE (DT) 4MG [MODIFIED-RELEASE TABLET]	1,075	£37,897	TOLTERODINE (DT) 2MG [TABLET]	£33,957
4	MOMETASONE NASAL (DT) 50MICROGRAMS/DOSE [SPRAY]	5,564	£46,715	BECLOMETASONE NASAL (DT) 50MCG [SPRAY]	£28,500
5	DOXAZOSIN (DT) 8MG [MODIFIED-RELEASE TABLET]	1,294	£24,425	DOXAZOSIN (DT) 4MG [TABLET]	£21,904
6	FESOTERODINE (DT) 8MG [MODIFIED-RELEASE TABLET]	650	£23,636	TOLTERODINE (DT) 2MG [TABLET]	£21,178
7	FLUTICASONE PROPIONATE (DT) 50MICROGRAMS/DOSE [NASAL SPRAY]	1,910	£24,519	BECLOMETASONE NASAL (DT) 50MCG [SPRAY]	£17,437
8	NYSTATIN (DT) 100,000UNITS/ML [ORAL SUSPENSION]	1,211	£27,199	MICONAZOLE SUGAR FREE (DT) 20MG/G [OROMUCOSAL GEL]	£13,758
9	VESICARE FILM COATED 5MG [TABLET]	387	£14,480	TOLTERODINE (DT) 2MG [TABLET]	£12,974
10	DOXAZOSIN (DT) 4MG [MODIFIED-RELEASE TABLET]	1,444	£13,931	DOXAZOSIN (DT) 2MG [TABLET]	£11,535
11	AZITHROMYCIN (DT) 250MG [CAPSULE]	373	£13,581	AZITHROMYCIN (DT) 250MG [TABLET]	£10,603
12	SALINE STERI-NEB [AMPOULE]	501	£26,368	STERIPOULES SODIUM CHLORIDE 2.5ML [AMPOULE]	£9,964
13	VESICARE FILM COATED 10MG [TABLET]	188	£9,198	TOLTERODINE (DT) 2MG [TABLET]	£8,462
14	OMEPRAZOLE (DT) 40MG [GASTRO-RESISTANT CAPSULE]	2,445	£16,824	OMEPRAZOLE (DT) 20MG [GASTRO-RESISTANT CAPSULE]	£8,187
15	NITROFURANTOIN (DT) 50MG [TABLET]	484	£12,902	NITROFURANTOIN (DT) 50MG [CAPSULE]	£6,018
16	CO-CODAMOL (DT) 8MG/500MG [EFFERVESCENT TABLET]	1,929	£11,340	CO-CODAMOL (DT) 8MG/500MG [TABLET]	£5,880
17	TOVIAZ 4MG [TABLET]	177	£6,469	TOLTERODINE (DT) 2MG [TABLET]	£5,796
18	PARACETAMOL 500MG SOLUBLE TABLETS (DT) 500MG [EFFERVESCENT TAB LET]	1,342	£8,429	PARACETAMOL (DT) 500MG [TABLET]	£5,770
19	IBUPROFEN (DT) 10% [GEL]	2,286	£13,024	KETOPROFEN (DT) 2.5% [GEL]	£5,646
20	DICLOFENAC (DT) 1% [GEL]	2,037	£12,966	KETOPROFEN (DT) 2.5% [GEL]	£5,412
21	LEVOCETIRIZINE (DT) 5MG [TABLET]	1,150	£6,810	CETIRIZINE (DT) 10MG [TABLET]	£4,977
22	AVAMYS NASAL 120 DOSE [SPRAY]	1,187	£8,018	BECLOMETASONE NASAL (DT) 50MCG [SPRAY]	£4,851
23	PREDNISOLONE (DT) 5MG [GASTRO-RESISTANT TABLET]	3,870	£15,767	PREDNISOLONE (DT) 5MG [TABLET]	£4,840
	Total	**37,415**	**£630,286**		**£479,267**

Overall Generic Dispensing

Northern LCG





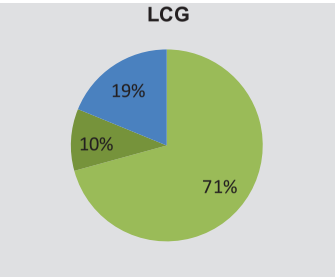
The range of generic drugs listed within Part I of the NI drug tariff increased in April 2011. This change may have increased the generic dispensing rate.

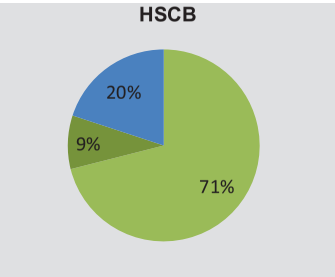
LCG Average | HSCB Average

Prescribed and dispensed generically
Prescribed generically and dispensed by brand as no generic is currently available
Presribed and dispensed by brand

†The generic **prescribing** rates chart is new. This chart reports GP prescribing of generics. This will include drugs that, although prescribed generically, will have been dispensed by brand as no generic is currently available.

NB 100% generic prescribing rate is not achievable or desired as there are a number of items unsuitable for generic prescribing. See link below:
http://www.hscboard.hscni.net/medicinesmanagement/Prescribing%20Guidance/index.html

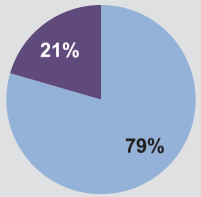




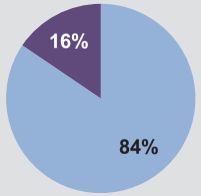
Proton Pump Inhibitors (PPIs)

Northern LCG

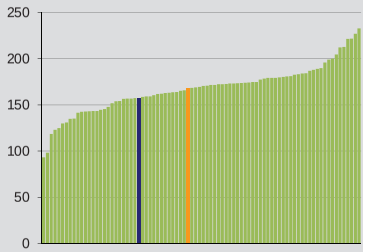
LCG



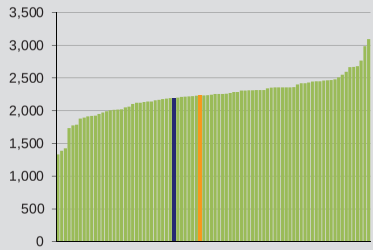
HSCB



PPIs - Cost /1000 NPUs



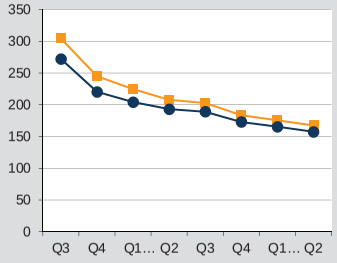
PPIs - DDDs /1000 NIPUs



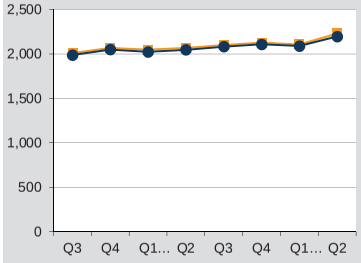
Drug name	Items	%
Lansoprazole	34755	30.85%
Omeprazole	54781	48.63%
Pantoprazole	10431	9.26%
Losec	356	0.32%
Protium	0	0.00%
Esomeprazole (tablets)	9890	8.78%
Lansoprazole orodispersible†	0	0.00%
Omeprazole dispersible†	0	0.00%
Rabeprazole	926	0.82%
Emozul (capsules)	2	0.00%
Nexium (tablets)	775	0.69%
Pariet	76	0.07%
Losec MUPS†	318	0.28%
Zoton FasTab†	341	0.30%

Drug name	Items	%
Lansoprazole	158553	31.26%
Omeprazole	269884	53.21%
Pantoprazole	30291	5.97%
Losec	1611	0.32%
Protium	0	0.00%
Esomeprazole (tablets)	37843	7.46%
Lansoprazole orodispersible†	0	0.00%
Omeprazole dispersible†	0	0.00%
Rabeprazole	2414	0.48%
Emozul (capsules)	95	0.02%
Nexium (tablets)	2883	0.57%
Pariet	281	0.06%
Losec MUPS†	1884	0.37%
Zoton FasTab†	1459	0.29%

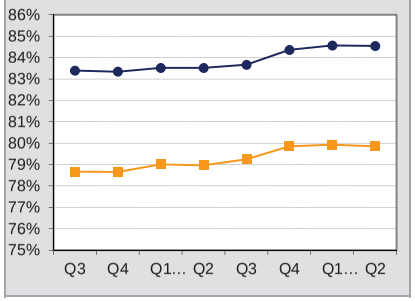
PPIs - Cost /1000 NIPUs



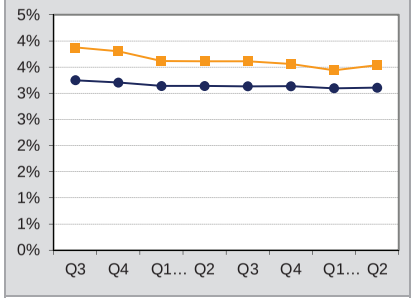
PPIs - DDDs /1000 NIPUs



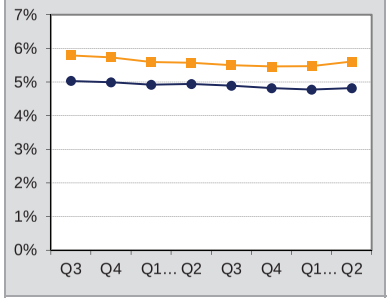
% generic omeprazole and lansoprazole of all PPI items (↑)



% esomeprazole 20mg of all PPI items (↓)



% esomeprazole 40mg of all PPI items (↓)



Key

Pie charts

Preferred choices

Other items

† If patients do not have swallowing difficulties, they could be switched to omeprazole or lansoprazole capsules.

Line charts

Q1 = Jan/Mar

LCG

HSCB

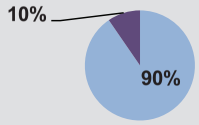
Upward trend preferable ↑

Downward trend preferable ↓

Lipid lowering drugs

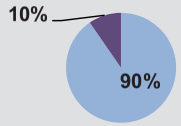
Northern LCG

LCG



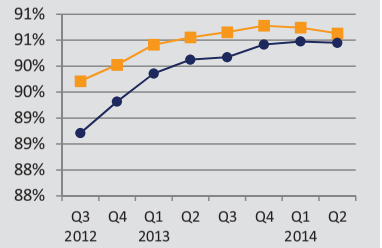
Drug name	Items	%
Simvastatin 10mg	2054	2.09%
Simvastatin 20mg	9574	9.76%
Simvastatin 40mg	28458	29.00%
Simvastatin 80mg	81	0.08%
Simvastatin 20mg/5ml	31	0.03%
Simvastatin 40mg/5ml	49	0.05%
Atorvastatin 10mg	8771	8.94%
Atorvastatin 20mg	13787	14.05%
Atorvastatin 40mg	16812	17.13%
Atorvastatin 80mg	1066	1.09%
Pravastatin	8088	8.24%
Fluvastatin	253	0.26%
Rosuvastatin	7943	8.09%
Simvastatin + Ezetimibe	117	0.12%
Lescol /other brands	20	0.02%
Lipostat	34	0.03%
Zocor	20	0.02%
Crestor	605	0.62%
Inegy	56	0.06%
Lipitor 10mg	113	0.12%
Lipitor 20mg	133	0.14%
Lipitor 40mg	70	0.07%
Lipitor 80mg	9	0.01%

HSCB

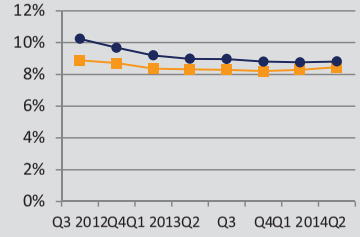


Drug name	Items	%
Simvastatin 10mg	9184	2.00%
Simvastatin 20mg	48808	10.62%
Simvastatin 40mg	153242	33.35%
Simvastatin 80mg	415	0.09%
Simvastatin 20mg/5ml	141	0.03%
Simvastatin 40mg/5ml	269	0.06%
Atorvastatin 10mg	37453	8.15%
Atorvastatin 20mg	53985	11.75%
Atorvastatin 40mg	80607	17.54%
Atorvastatin 80mg	6831	1.49%
Pravastatin	24277	5.28%
Fluvastatin	1101	0.24%
Rosuvastatin	37184	8.09%
Simvastatin + Ezetimibe	427	0.09%
Lescol /other brands	73	0.02%
Lipostat	114	0.02%
Zocor	102	0.02%
Crestor	3913	0.85%
Inegy	216	0.05%
Lipitor 10mg	418	0.09%
Lipitor 20mg	364	0.08%
Lipitor 40mg	291	0.06%
Lipitor 80mg	30	0.01%

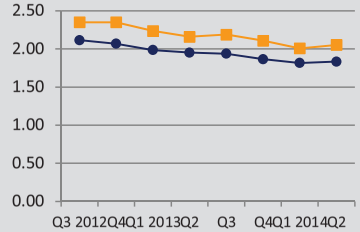
% simvastatin, atorvastatin and pravastatin of all statin items (↑)



% rosuvastatin of all statin items (↓)



Ezetimibe, Items /1000 NIPUs (↓)
(includes Ezetrol and Inegy)



Key

Pie charts

Preferred choices

Other items

Line charts

Q1 = Jan/Mar

LCG

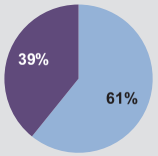
HSCB

Upward trend preferable ↑

SSRIs and related antidepressant drugs

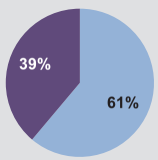
Northern LCG

LCG



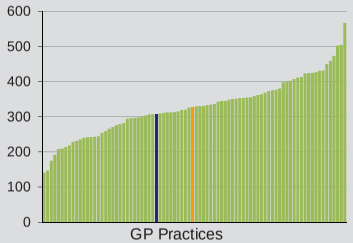
Drug name	Items	%
Citalopram	26867	23.31%
Fluoxetine	18813	16.32%
Sertraline	24395	21.17%
Duloxetine	5448	4.73%
Escitalopram	7648	6.64%
Flupentixol	101	0.09%
Fluvoxamine	72	0.06%
Mirtazapine	13935	12.09%
Paroxetine	2329	2.02%
Reboxetine	136	0.12%
Venlafaxine (incl. XL)	2323	2.02%
Cipramil	49	0.04%
Efexor /XL /other brands	11512	9.99%
Faverin	6	0.01%
Lustral	120	0.10%
Prozac	45	0.04%
Seroxat	85	0.07%
Cipralex	529	0.46%
Cymbalta	728	0.63%
Edronax	20	0.02%
Fluanxol	51	0.04%
Optimax	0	0.00%
Zispin SolTab	36	0.03%

HSCB

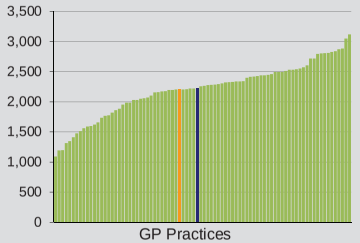


Drug name	Items	%
Citalopram	129369	25.02%
Fluoxetine	94531	18.28%
Sertraline	92071	17.81%
Duloxetine	21892	4.23%
Escitalopram	23441	4.53%
Flupentixol	389	0.08%
Fluvoxamine	210	0.04%
Mirtazapine	64596	12.49%
Paroxetine	11764	2.28%
Reboxetine	430	0.08%
Venlafaxine (incl. XL)	10841	2.10%
Cipramil	282	0.05%
Efexor /XL /other brands	58338	11.28%
Faverin	30	0.01%
Lustral	436	0.08%
Prozac	325	0.06%
Seroxat	388	0.08%
Cipralex	2331	0.45%
Cymbalta	4592	0.89%
Edronax	137	0.03%
Fluanxol	371	0.07%
Optimax	12	0.00%
Zispin SolTab	258	0.05%

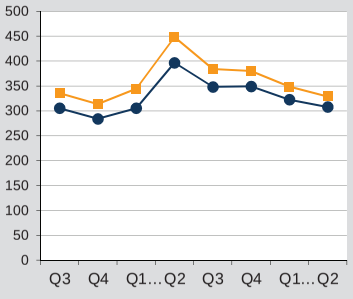
SSRIs and related antidepressants Cost /1000 NIPUs



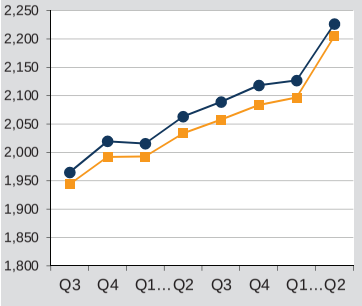
SSRIs and related antidepressants DDDs /1000 NIPUs



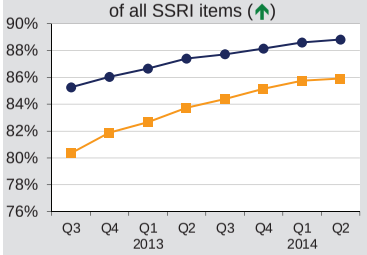
SSRIs and related antidepressants Cost /1000 NIPUs



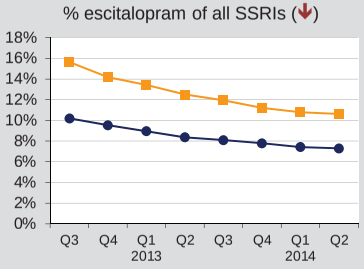
SSRIs and related antidepressants DDDs /1000 NIPUs

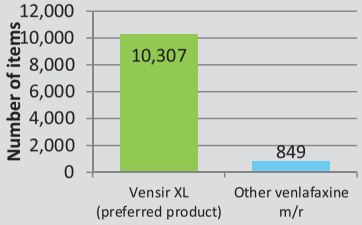


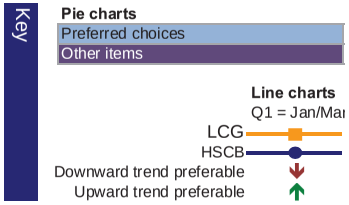
% generic citalopram, fluoxetine and sertraline of all SSRI items (↑)

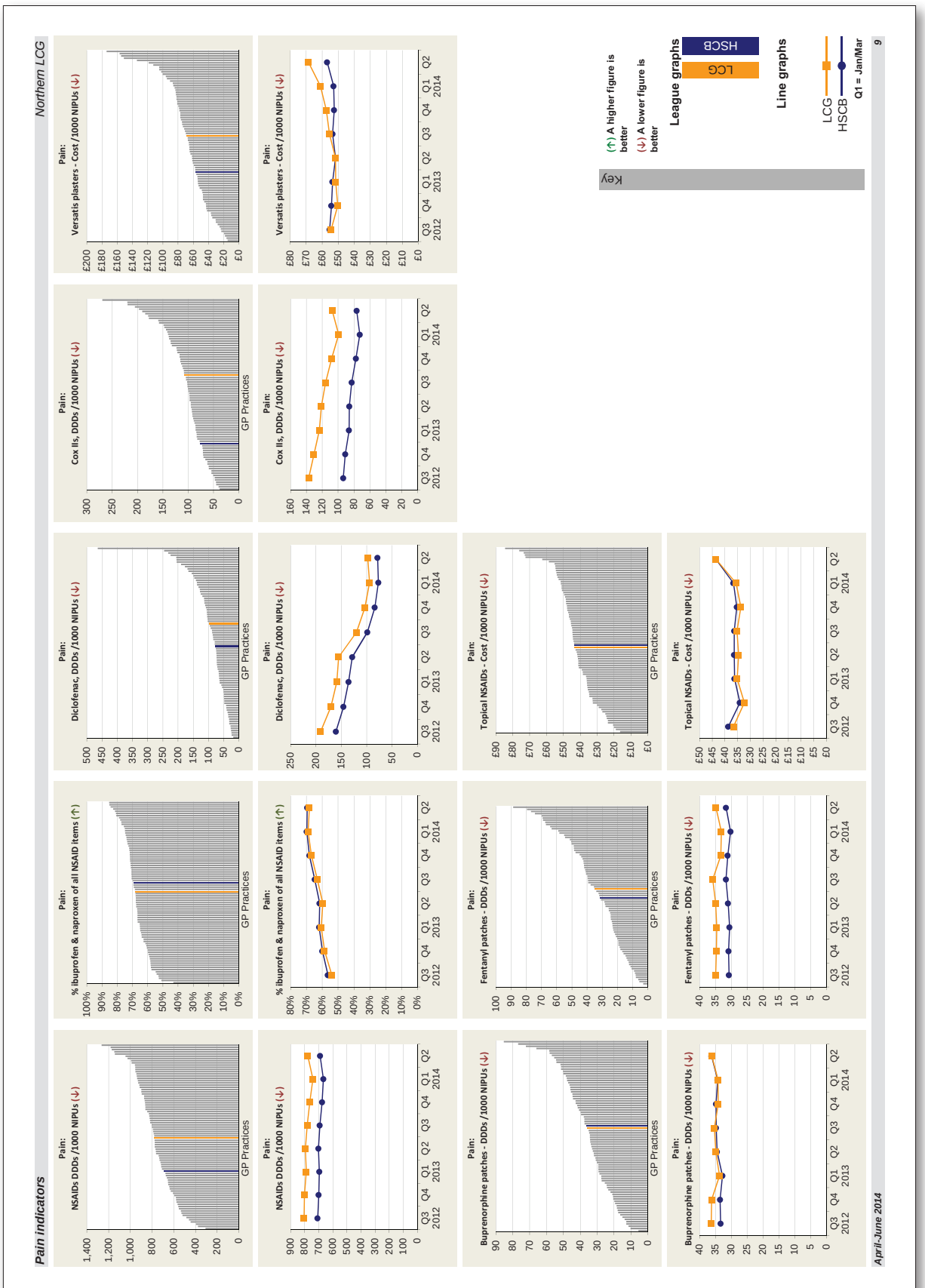


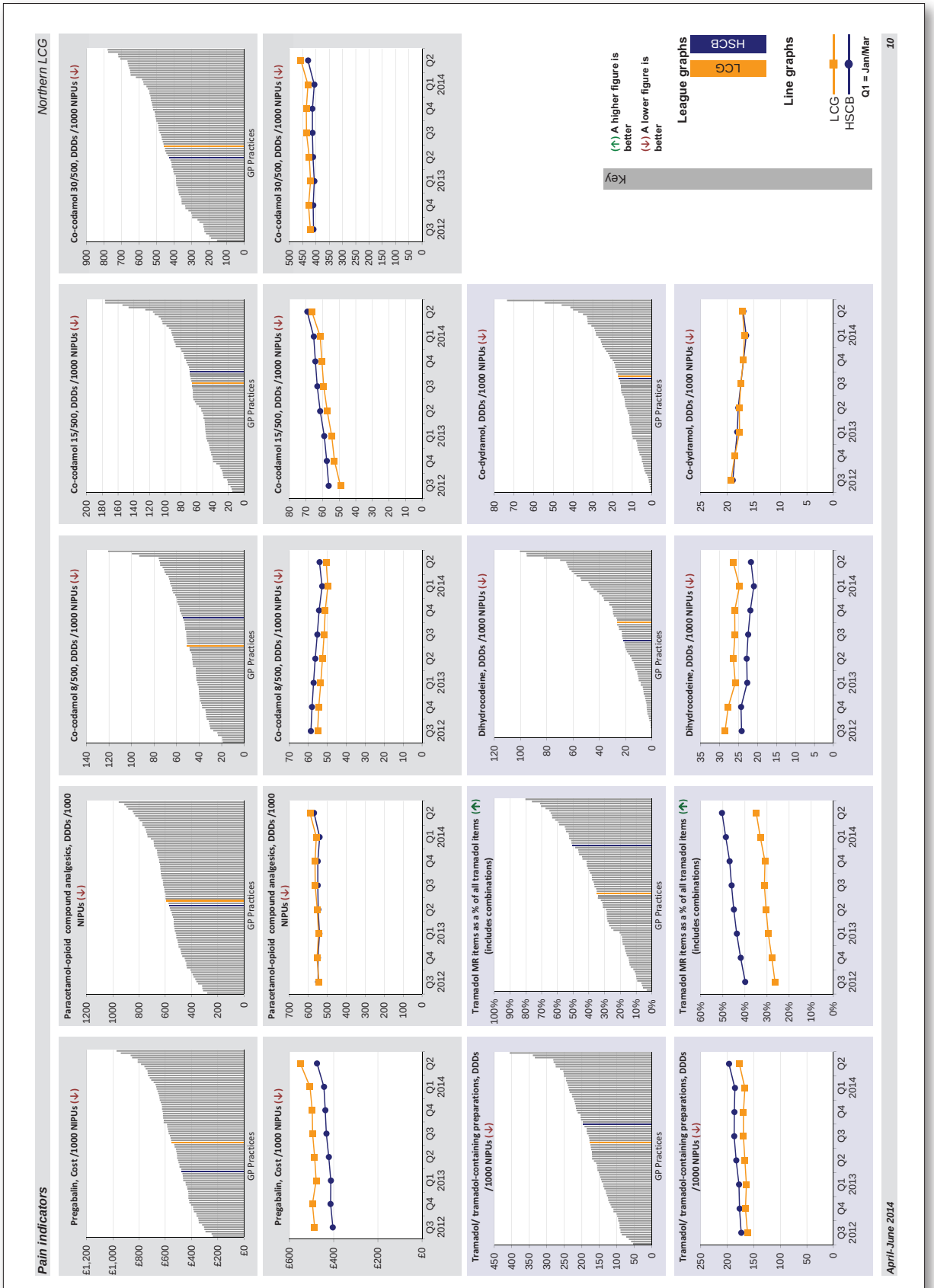
% escitalopram of all SSRIs (↓)

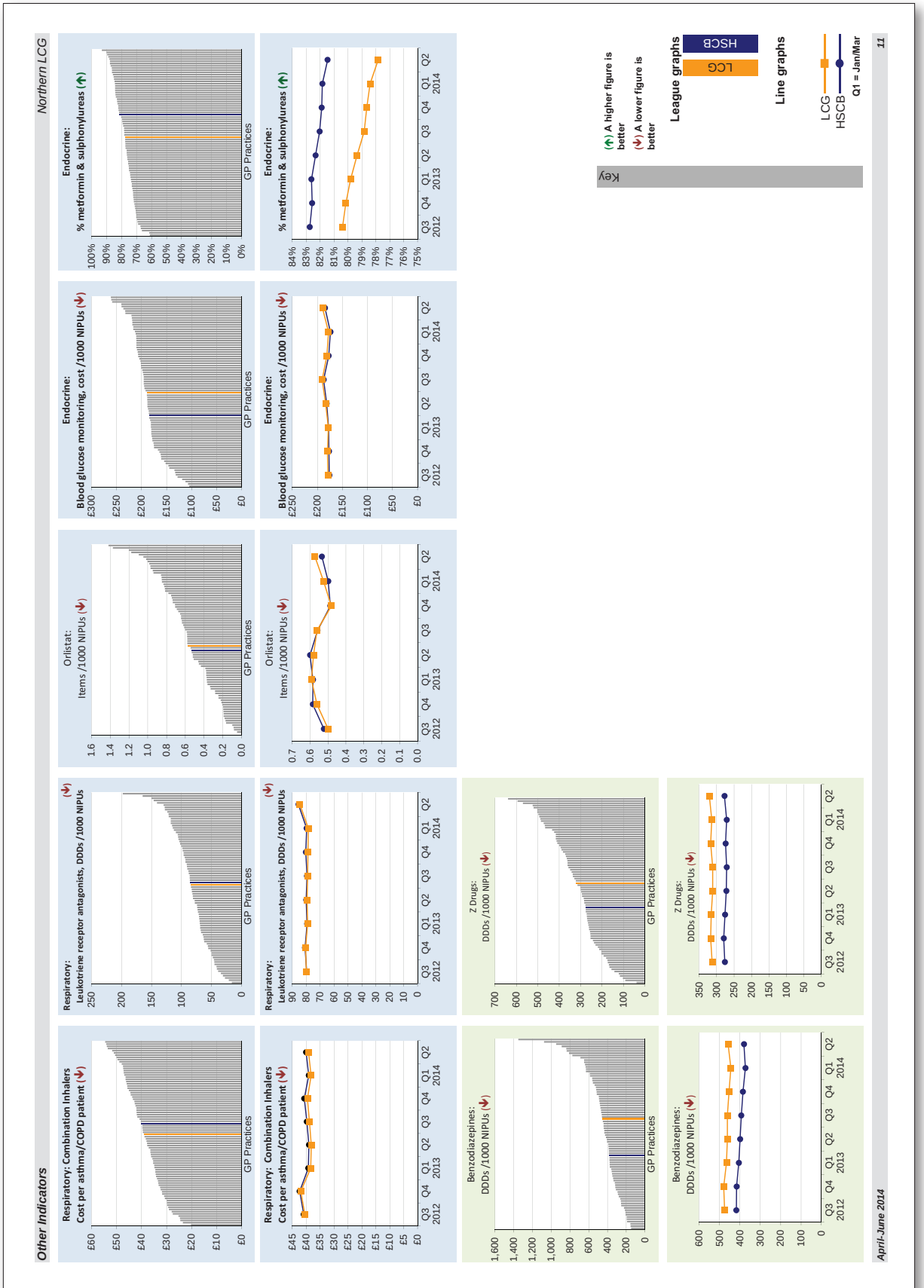







Pain indicators
Northern LCG
Pain: NSAIDs DDDs /1000 NIPUs (↓)
Pain: % ibuprofen & naproxen of all NSAID items (↑)
Pain: Diclofenac, DDDs /1000 NIPUs (↓)
Pain: Cox IIs, DDDs /1000 NIPUs (↓)
Pain: Versatis plasters - Cost /1000 NIPUs (↓)
Pain: Buprenorphine patches - DDDs /1000 NIPUs (↓)
Pain: Fentanyl patches - DDDs /1000 NIPUs (↓)
Pain: Topical NSAIDs - Cost /1000 NIPUs (↓)
GP Practices
Key
(↑) A higher figure is better
(↓) A lower figure is better
League graphs
LCG
HSCB
Line graphs
LCG
HSCB
Q1 = Jan/Mar
April-June 2014
9


Pain indicators
Northern LCG
Co-codamol 30/500, DDDs /1000 NIPUs (↓)
Co-codamol 15/500, DDDs /1000 NIPUs (↓)
Co-dydramol, DDDs /1000 NIPUs (↓)
Co-codamol 8/500, DDDs /1000 NIPUs (↓)
Dihydrocodeine, DDDs /1000 NIPUs (↓)
Paracetamol-opioid compound analgesics, DDDs /1000 NIPUs (↓)
Tramadol MR items as a % of all tramadol items (↑) (includes combinations)
Pregabalin, Cost /1000 NIPUs (↓)
Tramadol/ tramadol-containing preparations, DDDs /1000 NIPUs (↓)
GP Practices
Q3 2012
Q4
Q1 2013
Q2
Q3
Q4
Q1 2014
Q2
Key
(↑) A higher figure is better
(↓) A lower figure is better
League graphs
LCG
HSCB
Line graphs
LCG
HSCB
Q1 = Jan/Mar
April-June 2014
10


Other Indicators
Northern LCG
Respiratory: Combination Inhalers Cost per asthma/COPD patient (↓)
Respiratory: Leukotriene receptor antagonists, DDDs /1000 NIPUs (↓)
Orlistat: Items /1000 NIPUs (↓)
Endocrine: Blood glucose monitoring, cost /1000 NIPUs (↓)
Endocrine: % metformin & sulphonylureas (↑)
Benzodiazepines: DDDs /1000 NIPUs (↓)
Z Drugs: DDDs /1000 NIPUs (↓)
GP Practices
Q3 2012
Q4 2012
Q1 2013
Q2 2013
Q3 2013
Q4 2013
Q1 2014
Q2 2014
Key
(↑) A higher figure is better
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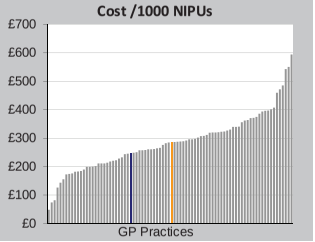
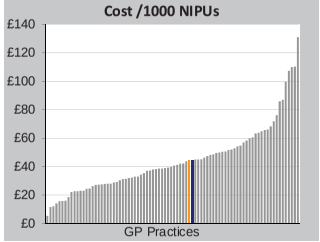
League graphs
LCG
HSCB
Line graphs
LCG
HSCB
Q1 = Jan/Mar
April-June 2014
11

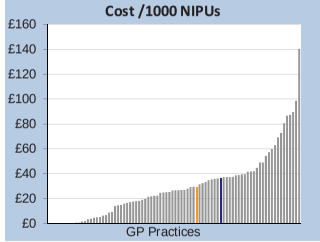
Nutrition: Oral nutritional supplements
Cost /1000 NIPUs



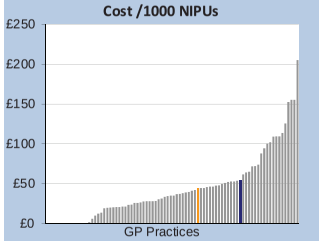
Nutrition: Gluten free products
Cost /1000 NIPUs



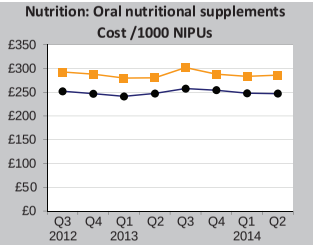
Infant feeding, Extensively hydrolysed
Cost /1000 NIPUs



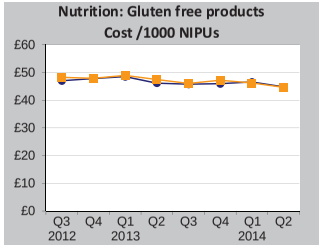
Infant feeding, Amino acid milks
Cost /1000 NIPUs



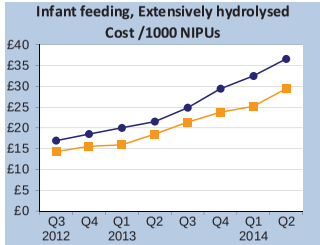
Nutrition: Oral nutritional supplements
Cost /1000 NIPUs



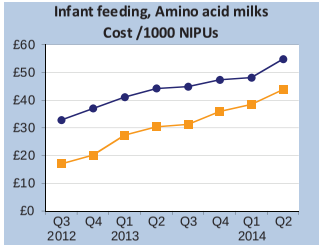
Nutrition: Gluten free products
Cost /1000 NIPUs



Infant feeding, Extensively hydrolysed
Cost /1000 NIPUs



Infant feeding, Amino acid milks
Cost /1000 NIPUs



Key

(↑) A higher figure is better

(↓) A lower figure is better

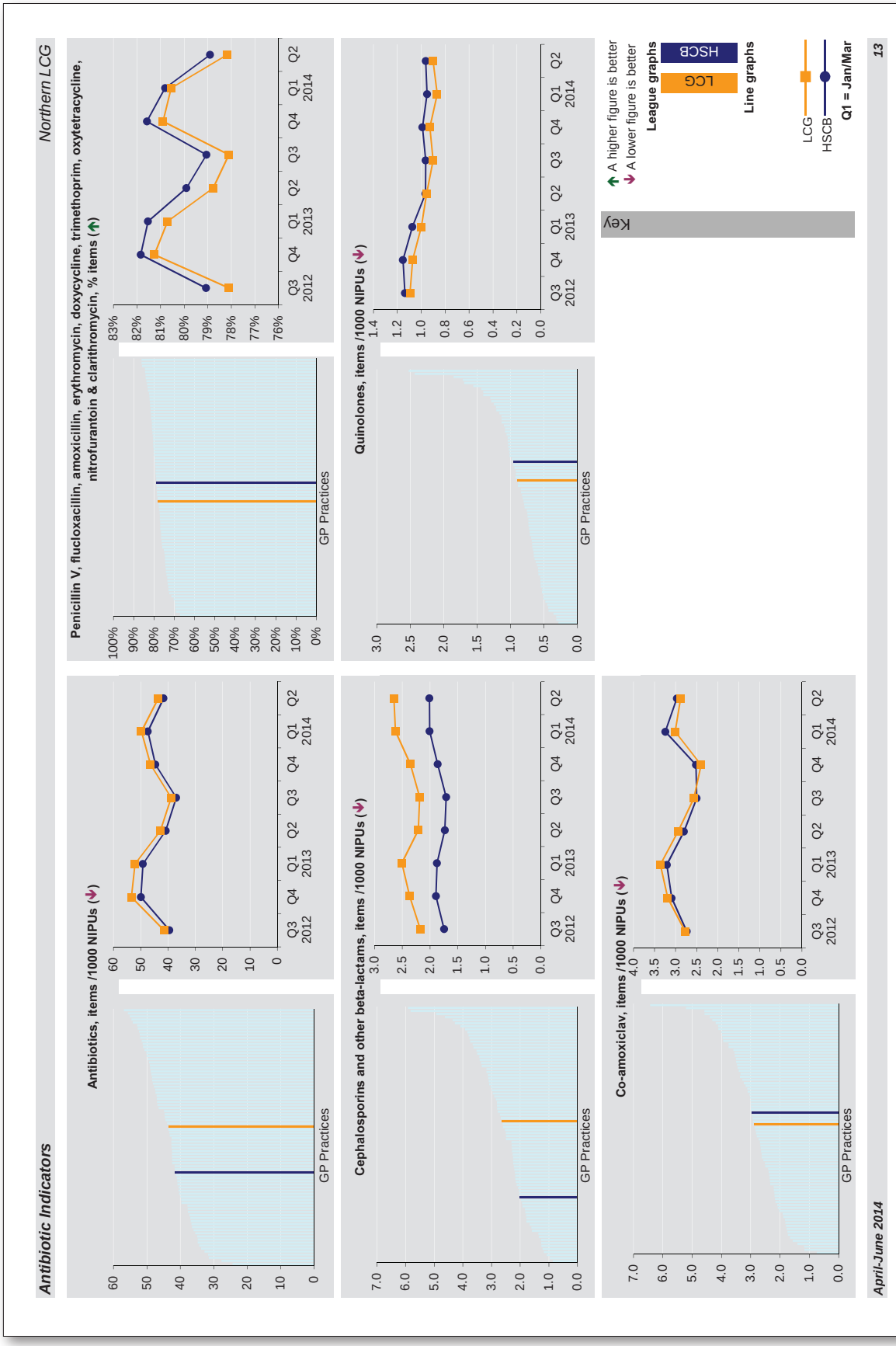
League graphs

LCG HSCB

Line graphs

LCG
HSCB

Q1 = Jan/Mar


Antibiotic Indicators
Northern LCG
Penicillin V, flucloxacillin, amoxicillin, erythromycin, doxycycline, trimethoprim, oxytetracycline, nitrofurantoin & clarithromycin, % items (↑)
Quinolones, items /1000 NIPUs (↓)
Antibiotics, items /1000 NIPUs (↓)
Cephalosporins and other beta-lactams, items /1000 NIPUs (↓)
Co-amoxiclav, items /1000 NIPUs (↓)
GP Practices
Q3 2012
Q4
Q1 2013
Q2
Q3
Q4
Q1 2014
Q2
Key
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HSCB
LCG
Line graphs
LCG
HSCB
Q1 = Jan/Mar
April-June 2014
13

Stock Prescribing

High Risk Drugs

Drug name/group	Items	Quantity
Warfarin 0.5mg	3	99
Warfarin 5mg	4	400
Methotrexate 10mg	-	-
Red List drugs	7	N/A

IV antibiotics: patient prescribing

Drug name	Items	Quantity
Amoxil 1g powder for solution for injection vials	2	22
Augmentin Intravenous 1.2g powder for solution for injection vials	6	82
Augmentin Intravenous 600mg powder for solution for injection vials	1	6
Ceftriaxone 1g powder for solution for injection vials	4	17
Cidomycin Adult Injectable 80mg/2ml solution for injection ampoules	1	5
Cidomycin Adult Injectable 80mg/2ml solution for injection vials	1	5
Crystapen 1.2g powder for solution for injection vials	1	1
Crystapen 600mg powder for solution for injection vials	1	4
Fortum 500mg powder for solution for injection vials	1	10
Genticin Injectable 80mg/2ml solution for injection ampoules	1	5
Magnapen 500mg powder for solution for injection vials	1	5
Piperacillin 2g / Tazobactam 250mg powder for solution for injection vials	1	30
Rocephin 1g powder for solution for injection vials	4	26
Targocid 400mg powder and solvent for solution for injection vials	1	5
Tazocin 2.25g powder for solution for injection vials	1	1
Tazocin 4.5g powder for solution for injection vials	5	92
Tobramycin 80mg/2ml solution for injection vials	1	0
Vancocin 1g powder for solution for infusion vials	1	2
Zinacef 750mg powder for injection vials	1	30
Totals	**35**	

Top 15 Stock Items by Cost (excluding dressings & appliances)

	Drug name	Cost (£)	Items	Quantity
1	Depo-Medrone with Lidocaine suspension for injection 1ml vials	£4,024	45	1033
2	Nexplanon 68mg implant	£3,178	9	40
3	Depo-Medrone 40mg/1ml suspension for injection vials	£2,295	58	673
4	EpiPen 300micrograms/0.3ml (1 in 1,000) solution for injection auto-injectors	£2,248	50	85
5	Chlorphenamine 10mg/1ml solution for injection ampoules	£1,864	101	630
6	Revaxis vaccine suspension for injection 0.5ml pre-filled syringes	£1,658	30	255
7	Pneumovax II vaccine solution for injection 0.5ml vials	£1,647	22	198
8	Mirena 20micrograms/24hours intrauterine device	£1,496	3	17
9	EpiPen Jr. 150micrograms/0.3ml (1 in 2,000) solution for injection auto-injectors	£1,481	35	56
10	ViATIM vaccine suspension for injection 1ml pre-filled syringes	£1,460	4	49
11	Sodium chloride 0.9% irrigation solution 20ml Steripod unit dose	£1,414	41	4508
12	Minims tropicamide 1% eye drops 0.5ml unit dose	£1,291	30	2501
13	Iodoflex paste dressing	£1,114	29	277
14	Kenalog Intra-articular / Intramuscular 40mg/1ml suspension for injection vials	£931	43	625
15	Emla 5% cream	£901	62	2003
	Total	**£27,001**	**562**	
	Total of all Stock (including dressings and appliances)	**£228,015**	**7,959**	

Top 15 CDs (schedules 2, 3, 4 and 5)

	Drug name	Cost (£)	Items	Quantity
1	Midazolam 5mg/1ml oromucosal solution pre-filled oral syringes	£385	2	18
2	Buccolam 10mg/2ml oromucosal solution pre-filled oral syringes	£275	3	12
3	Cyclimorph 10 solution for injection 1ml ampoules	£167	19	95
4	Nebido 1000mg/4ml solution for injection ampoules	£160	1	2
5	Buccolam 7.5mg/1.5ml oromucosal solution pre-filled oral syringes	£89	1	4
6	Buccolam 5mg/1ml oromucosal solution pre-filled oral syringes	£86	1	4
7	Diamorphine 5mg powder for solution for injection ampoules	£84	7	37
8	Diazemuls 10mg/2ml emulsion for injection ampoules	£74	7	82
9	Diamorphine 10mg powder for solution for injection ampoules	£51	4	20
10	Diazepam 10mg/2.5ml rectal solution tube	£48	6	35
11	Diazepam 10mg/2ml solution for injection ampoules	£47	11	105
12	Cyclimorph 15 solution for injection 1ml ampoules	£36	4	20
13	Co-codamol 8mg/500mg tablets	£33	11	964
14	Sustanon 250mg/1ml solution for injection ampoules	£29	2	12
15	Pethidine 50mg/1ml solution for injection ampoules	£26	6	55
	Total	**£1,590**	**85**	

Appendix: COMPASS Explanatory Notes

Glossary			
ICPs	Integrated Care Partnerships	NIPUs	Northern Ireland Prescribing Units
LCG	Local Commissioning Group		
HSCB	Health and Social Care Board		

Quarter: Information in the COMPASS report is based on three months of prescribing data, i.e. one quarter.

ICP average: Figures refer to the average of all practices within the respective ICP.

LCG average: Figures refer to the average of all practices within the respective LCG.

HSCB average: Figures refer to the average of all practices within the HSCB, i.e. all practices in NI.

Cost (£): Net ingredient cost, equivalent to England's Net Ingredient Cost (NIC). Cost is useful in terms of monitoring the overall drugs bill, checking spend within prescribing budgets and calculating savings made or potential savings. Cost is less useful as a measure of drug consumption because of the differences in cost of alternative preparations and changes in prices.

Items: Number of prescription items. Count of items is a reasonable measure of the number of courses of treatments for vaccinations and acute treatments such as short courses of antibiotics. For other treatments it is less useful because of the wide variation in duration of supply per item.

NIPUs: In measuring prescribing, differences between practices need to be taken account of in order to make valid comparisons with local and national averages. NIPUs standardise for differences between practices in terms of patient list size, age/sex structure and additional needs.

Quantity: Number of physical units, i.e. tablets, capsules, patches, mLs, inhalers, vials etc. Quantity is a useful measure of prescribing when looking at individual preparations, e.g. methotrexate 10mg or warfarin 0.5mg and 5mg.

Change from Last Year: The actual change from the same quarter in the previous year.

Defined Daily Dose (DDD): The DDD is a unit of measurement based on the assumed average maintenance dose per day used for its main indication in adults. The World Health Organisation (WHO) developed the DDD as a method to compare drugs of different chemical structures and potencies. The DDD methodology standardises quantities prescribed into number of daily doses. See worked example below. The number of DDDs is calculated as follows:

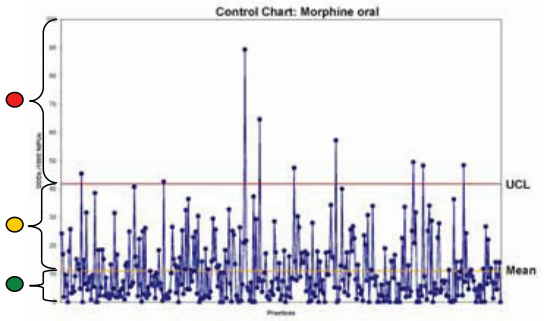
$$\text{Number of DDDs} = \frac{\text{Strength (mg) x quantity}}{\text{DDD (mg)}}$$

Worked example	Quantity (no. of tabs /caps)	DDD (mg)	No. of DDDs
Ibuprofen 200mg 2 caps 3 times a day	168	1200	$\frac{200 \times 168}{1200} = 28$
Ranitidine 150mg 1 tablet twice a day	56	300	$\frac{150 \times 56}{300} = 28$
Lansoprazole 30mg 1 capsule once a day	28	30	$\frac{30 \times 28}{30} = 28$

Prescribing Indicators listed throughout the report give some indication of prescribing quality but are not quantitative measures of good prescribing. Arrows indicate whether a larger figure or a smaller figure suggests 'better' prescribing. Values are given for the practice, locality average, LCG average and HSCB average. They are, therefore, useful in identifying outliers i.e. practice's whose prescribing differs substantially from other practices and to highlight areas for further analysis.

Red List Drugs: The Red list is an advisory list where it is considered by the Regional Group on Specialist Medicines, that responsibility for prescribing should remain with the consultant or specialist clinician. It is recommended that the supply of these specialist medicines should be organised via the hospital pharmacy.

Controlled Drugs (CDs): On the patient and stock prescribing pages there are red, orange and green dots. Each dot represents where a practice is on a control chart in relation to the Upper Control Limit (UCL) and the mean for all practices in NI (see chart below). The UCL is the mean + 3 standard deviations. A green dot represents a practice at the mean or below. An orange dot represents a practice above the mean but below the UCL. A red dot represents a practice above the UCL.



LCG COMPASS Report

Southern LCG

April-June 2014

Contents

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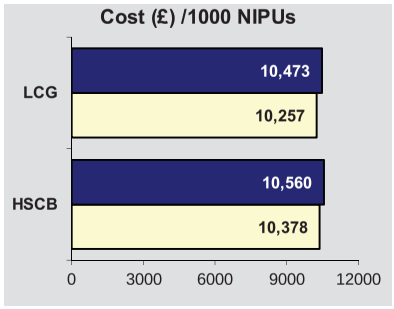
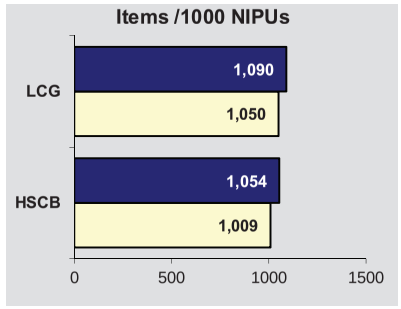
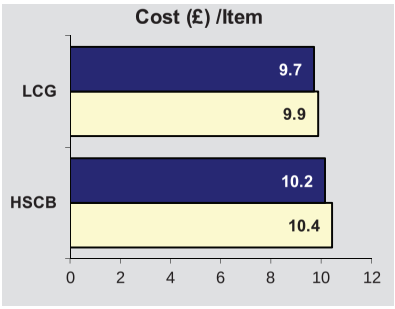
Key

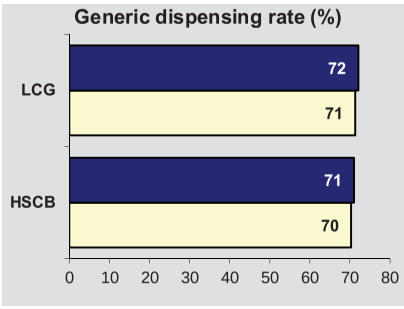
Quarter this year: Apr-Jun 14
Quarter last year: Apr-Jun 13

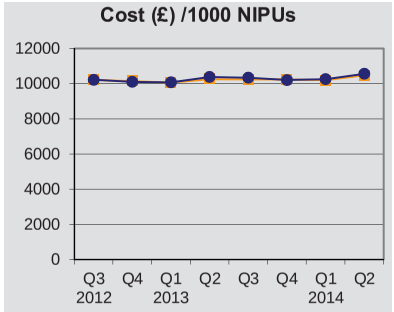
LCG
HSCB

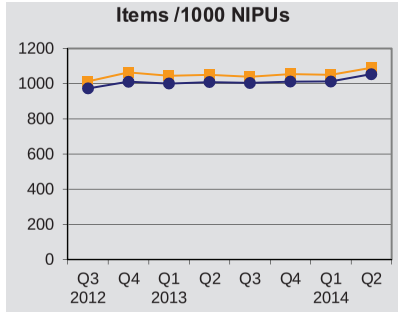


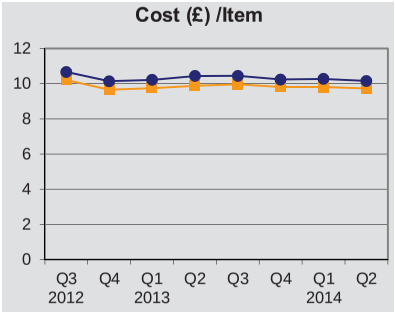


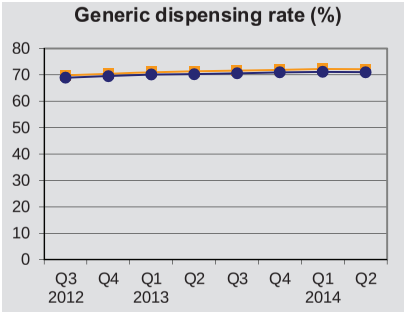












COMPASS Unit, Operations Directorate, FPS, BSO, 2 Franklin Street, Belfast BT2 8DQ Web site: http://www.hscbusiness.hscni.net/services.htm Tel: 028 9053 5661 Fax: 028 9053 2963

Top 40 : Forty most costly drugs in your LCG

Southern LCG

	Drug Name	Drug's position in HSCB's most costly drugs*	Cost (£)	No of Items	Quantity	Cost (£) /Item	% of Board Total Cost	Change from last year
1	SERETIDE WITH COUNTER 250MCG/25 [EVOHALER]	2	213,831	2,860	3,595	74.77	1.12	-0.13
2	TEMAZEPAM (DT) 10MG [TABLET]	5	177,968	9,153	242,473	19.44	0.93	-0.36
3	SYMBICORT 200/6 [TURBOHALER]	6	173,318	3,444	4,561	50.32	0.91	0.00
4	PREGABALIN (DT) 75MG [CAPSULE]	3	171,226	2,571	148,892	66.60	0.89	0.10
5	INSULIN LANTUS SOLOSTAR 3ML [PRE-FILLED PEN]	8	146,271	2,705	17,623	54.07	0.76	0.03
6	FLUTICASONE 250MICROGRAMS/DOSE / SALMETEROL 25M	7	140,849	2,025	2,368	69.55	0.74	0.22
7	TIOTROPIUM BROMIDE (DT) 18MICROGRAM [INHALATION	1	135,874	3,256	121,678	41.73	0.71	0.11
8	PREGABALIN (DT) 150MG [CAPSULE]	4	133,883	1,972	116,420	67.89	0.70	0.06
9	ROSUVASTATIN (DT) 10MG [TABLET]	17	124,369	4,622	193,141	26.91	0.65	-0.04
10	INSULIN NOVOMIX 30 FLEXPEN 3ML [INJECTION DEVICE]	20	122,071	2,432	20,420	50.19	0.64	0.02
11	AVIVA [REAGENT]	12	116,855	3,239	374,776	36.08	0.61	0.04
12	INSULIN NOVORAPID FLEXPEN 3ML [PRE-FILLED PEN]	18	113,777	2,295	18,591	49.58	0.59	0.02
13	VERSATIS [MEDICATED PLASTER]	15	108,515	1,726	44,965	62.87	0.57	0.03
14	DULOXETINE (DT) 60MG [GASTRO-RESISTANT CAPSULE]	16	104,871	2,756	105,930	38.05	0.55	0.08
15	PREGABALIN (DT) 50MG [CAPSULE]	14	103,207	1,522	89,745	67.81	0.54	0.07
16	ROSUVASTATIN (DT) 20MG [TABLET]	24	102,814	2,608	110,638	39.42	0.54	0.00
17	NEBIVOLOL (DT) 2.5MG [TABLET]	19	98,759	1,071	39,628	92.21	0.52	0.12
18	BUDESONIDE 200MICROGRAMS/DOSE / FORMOTEROL 6MI	10	98,040	2,017	2,580	48.61	0.51	0.02
19	EZETIMIBE (DT) 10MG [TABLET]	11	97,837	2,385	104,122	41.02	0.51	-0.01
20	NUTRAMIGEN AA 400G [POWDER]	38	89,660	665	3,413	134.83	0.47	0.16
21	PREGABALIN (DT) 300MG [CAPSULE]	9	86,866	1,331	75,536	65.26	0.45	0.03
22	SOLIFENACIN (DT) 5MG [TABLET]	23	83,178	2,384	90,343	34.89	0.43	0.02
23	VICTOZA 3ML [PRE-FILLED INJECTION PEN]	13	82,443	810	2,101	101.78	0.43	-0.01
24	CO-CODAMOL (DT) 30MG/500MG [TABLET]	22	82,391	24,446	1,872,580	3.37	0.43	-0.01
25	HYDROCORTISONE (DT) 10MG [TABLET]	28	81,131	488	39,554	166.25	0.42	0.08
26	FORTISIP 200ML [BOTTLE]	42	78,375	1,824	38,046	42.97	0.41	-0.03
27	PREGABALIN (DT) 100MG [CAPSULE]	21	73,211	1,058	63,662	69.20	0.38	0.04
28	DUTASTERIDE (DT) 500MICROGRAM [CAPSULE]	41	72,835	1,756	73,395	41.48	0.38	0.02
29	SERETIDE WITH COUNTER 125MCG/25 [EVOHALER]	32	72,380	1,583	2,068	45.72	0.38	-0.06
30	TEMAZEPAM (DT) 20MG [TABLET]	44	68,976	3,203	98,337	21.53	0.36	-0.15
31	QUETIAPINE (DT) 300MG [MODIFIED-RELEASE TABLET]	52	66,164	605	23,352	109.36	0.35	0.05
32	SITAGLIPTIN (DT) 100MG [TABLET]	29	64,762	1,369	54,520	47.31	0.34	0.01
33	NAPROXEN (DT) 500MG [GASTRO-RESISTANT TABLET]	56	64,296	5,784	272,612	11.12	0.34	0.23
34	PREGABALIN (DT) 25MG [CAPSULE]	27	63,513	991	55,229	64.09	0.33	0.04
35	PARACETAMOL (DT) 500MG [TABLET]	49	62,966	26,211	2,394,348	2.40	0.33	-0.02
36	FORTISIP COMPACT 125ML [BOTTLE]	26	62,955	974	31,166	64.64	0.33	0.03
37	ONE TOUCH ULTRA TEST STRIP [REAGENT]	35	61,789	2,033	257,667	30.39	0.32	-0.14
38	OMEPRAZOLE (DT) 20MG [GASTRO-RESISTANT CAPSULE]	25	61,690	36,238	1,502,102	1.70	0.32	-0.03
39	SYMBICORT 400/12 [TURBOHALER]	30	61,294	1,160	1,613	52.84	0.32	-0.01
40	SPIRIVA REFILL 18MCG [CAPSULE]	34	60,581	1,483	54,252	40.85	0.32	-0.03
	TOTAL		**3,985,790**	**171,055**			**20.83**	

G: Generic form available

*This is the drug's position in the HSCB's most costly drugs. For example, the LCG's 40th most costly drug is SPIRIVA REFILL 18MCG [CAPSULE]. This drug is number 34 in HSCB's most costly drugs.

Top 20 generic switches by cost

Southern LCG

	Proprietary Drug	Number of Items	Cost (£)	Generic equivalent	Potential Savings for the quarter (£)
1	LOSEC 20MG [CAPSULE]	339	8,605	OMEPRAZOLE 20MG [GASTRO-RESISTANT CAPSULE]	£7,826
2	NEXIUM 40MG [TABLET]	224	9,446	ESOMEPRAZOLE 40MG [GASTRO-RESISTANT TABLET]	£7,410
3	SINGULAIR 10MG [TABLET]	187	7,249	MONTELUKAST 10MG [TABLET]	£6,572
4	XALATAN 2.5ML [EYE DROP]	372	7,188	LATANOPROST 50MICROGRAMS/ML [EYE DROP]	£6,042
5	NEXIUM 20MG [TABLET]	189	6,406	ESOMEPRAZOLE 20MG [GASTRO-RESISTANT TABLET]	£4,737
6	ARICEPT 10MG [TABLET]	49	4,716	DONEPEZIL 10MG [TABLET]	£4,620
7	ARIMIDEX 1MG [TABLET]	40	4,327	ANASTROZOLE 1MG [TABLET]	£4,205
8	BONDRONAT 50MG [TABLET]	20	3,858	IBANDRONIC ACID 50MG [TABLET]	£3,531
9	PLAVIX 75MG [TABLET]	76	3,678	CLOPIDOGREL 75MG [TABLET]	£3,486
10	LIPITOR 40MG [TABLET]	71	2,858	ATORVASTATIN 40MG [TABLET]	£2,669
11	BONVIVA F/C 150MG [TABLET]	87	3,018	IBANDRONIC ACID 150MG [TABLET]	£2,522
12	SINGULAIR PAEDIATRIC CHEWABLE 5MG [TABLET]	74	2,692	MONTELUKAST SF 5MG [CHEWABLE TABLET]	£2,444
13	EBIXA 20MG [TABLET]	75	6,226	MEMANTINE 20MG [TABLET]	£2,412
14	LUSTRAL 100MG [TABLET]	58	2,935	SERTRALINE 100MG [TABLET]	£2,353
15	EBIXA 10MG [TABLET]	60	3,475	MEMANTINE 10MG [TABLET]	£2,223
16	APROVEL 150MG [TABLET]	107	2,401	IRBESARTAN 150MG [TABLET]	£2,062
17	IMIGRAN 100MG [TABLET]	22	2,136	SUMATRIPTAN 100MG [TABLET]	£2,049
18	ACTONEL ONCE A WEEK 35MG [TABLET]	63	2,132	RISEDRONATE 35MG [TABLET]	£2,003
19	LIPITOR 20MG [TABLET]	48	2,119	ATORVASTATIN 20MG [TABLET]	£1,998
20	XALACOM 2.5ML [EYE DROP]	144	2,859	LATANOPROST/TIMOLOL 50MICROGRAMS/ML / 5MG/M	£1,837
	Total	**2,305**	**88,324**		**£73,001**

Potential savings per annum = £292,002

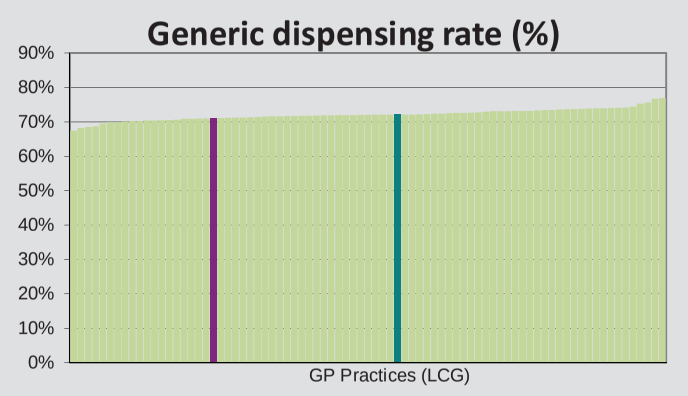
Top cost effective switches

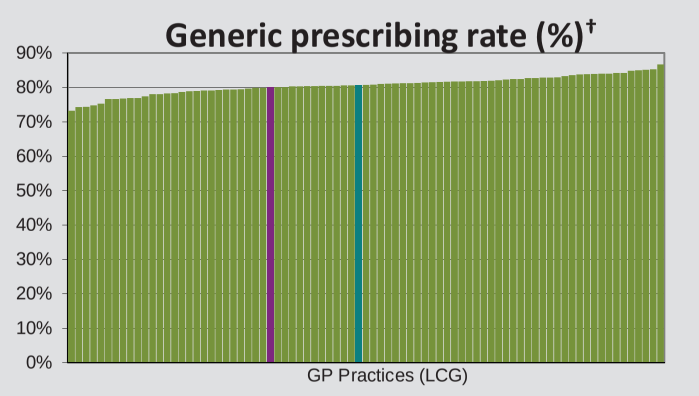
Southern LCG

	Drug name	Number of Items	Spend	Cost effective choice	Potential Savings for the quarter
1	SOLIFENACIN (DT) 5MG [TABLET]	2,384	£83,178	TOLTERODINE (DT) 2MG [TABLET]	£74,530
2	SOLIFENACIN (DT) 10MG [TABLET]	1,352	£57,839	TOLTERODINE (DT) 2MG [TABLET]	£53,214
3	FESOTERODINE (DT) 4MG [MODIFIED-RELEASE TABLET]	875	£30,157	TOLTERODINE (DT) 2MG [TABLET]	£27,022
4	MOMETASONE NASAL (DT) 50MICROGRAMS/DOSE [SPRAY]	4,275	£35,538	BECLOMETASONE NASAL (DT) 50MCG [SPRAY]	£21,678
5	DOXAZOSIN (DT) 8MG [MODIFIED-RELEASE TABLET]	1,349	£22,113	DOXAZOSIN (DT) 4MG [TABLET]	£19,831
6	VESICARE FILM COATED 5MG [TABLET]	479	£17,603	TOLTERODINE (DT) 2MG [TABLET]	£15,773
7	FLUTICASONE PROPIONATE (DT) 50MICROGRAMS/DOSE [NASAL SPRAY]	1,605	£19,400	BECLOMETASONE NASAL (DT) 50MCG [SPRAY]	£13,796
8	FESOTERODINE (DT) 8MG [MODIFIED-RELEASE TABLET]	397	£13,709	TOLTERODINE (DT) 2MG [TABLET]	£12,284
9	VESICARE FILM COATED 10MG [TABLET]	271	£11,968	TOLTERODINE (DT) 2MG [TABLET]	£11,011
10	DOXAZOSIN (DT) 4MG [MODIFIED-RELEASE TABLET]	1,560	£13,112	DOXAZOSIN (DT) 2MG [TABLET]	£10,857
11	NYSTATIN (DT) 100,000UNITS/ML [ORAL SUSPENSION]	995	£21,172	MICONAZOLE SUGAR FREE (DT) 20MG/G [OROMUCOSAL GEL]	£10,710
12	SALINE STERI-NEB [AMPOULE]	468	£25,989	STERIPOULES SODIUM CHLORIDE 2.5ML [AMPOULE]	£9,821
13	IBUPROFEN (DT) 10% [GEL]	2,411	£13,982	KETOPROFEN (DT) 2.5% [GEL]	£6,062
14	TOVIAZ 4MG [TABLET]	220	£6,749	TOLTERODINE (DT) 2MG [TABLET]	£6,047
15	NITROFURANTOIN (DT) 50MG [TABLET]	474	£12,879	NITROFURANTOIN (DT) 50MG [CAPSULE]	£6,008
16	CARDURA XL 8MG [TABLET]	371	£6,426	DOXAZOSIN (DT) 4MG [TABLET]	£5,763
17	AZITHROMYCIN (DT) 250MG [CAPSULE]	231	£7,340	AZITHROMYCIN (DT) 250MG [TABLET]	£5,730
18	AVAMYS NASAL 120 DOSE [SPRAY]	1,234	£8,449	BECLOMETASONE NASAL (DT) 50MCG [SPRAY]	£5,112
19	LEVOCETIRIZINE (DT) 5MG [TABLET]	1,228	£6,609	CETIRIZINE (DT) 10MG [TABLET]	£4,830
20	DICLOFENAC (DT) 1% [GEL]	1,767	£11,031	KETOPROFEN (DT) 2.5% [GEL]	£4,605
	Total	**23,946**	**£425,244**		**£324,681**

Overall Generic Dispensing

Southern LCG





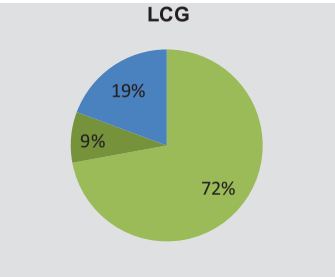
The range of generic drugs listed within Part I of the NI drug tariff increased in April 2011. This change may have increased the generic dispensing rate.

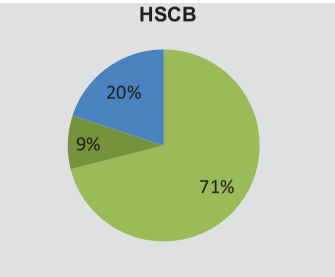
LCG Average | HSCB Average

Prescribed and dispensed generically
Prescribed generically and dispensed by brand as no generic is currently available
Presribed and dispensed by brand

†The generic **prescribing** rates chart is new. This chart reports GP prescribing of generics. This will include drugs that, although prescribed generically, will have been dispensed by brand as no generic is currently available.

NB 100% generic prescribing rate is not achievable or desired as there are a number of items unsuitable for generic prescribing. See link below:
http://www.hscboard.hscni.net/medicinesmanagement/Prescribing%20Guidance/index.html

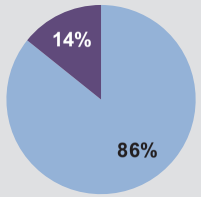




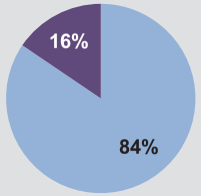
Proton Pump Inhibitors (PPIs)

Southern LCG

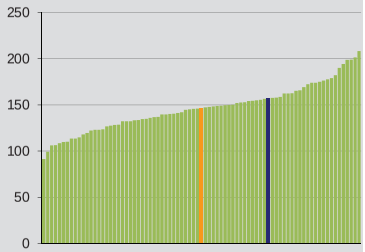
LCG



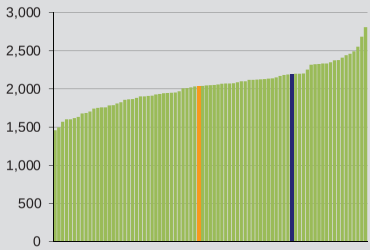
HSCB



PPIs - Cost /1000 NPUs



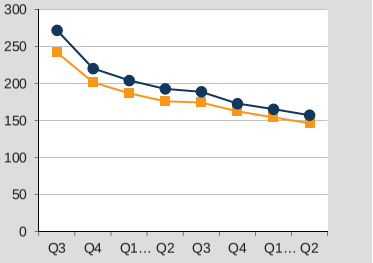
PPIs - DDDs /1000 NIPUs



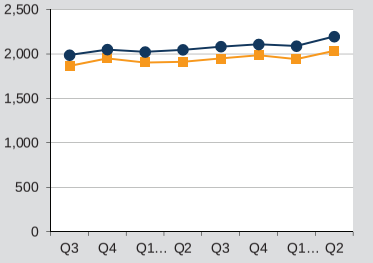
Drug name	Items	%
Lansoprazole	40902	42.06%
Omeprazole	42461	43.67%
Pantoprazole	6210	6.39%
Losec	397	0.41%
Protium	0	0.00%
Esomeprazole (tablets)	5838	6.00%
Lansoprazole orodispersible†	0	0.00%
Omeprazole dispersible†	0	0.00%
Rabeprazole	353	0.36%
Emozul (capsules)	16	0.02%
Nexium (tablets)	413	0.42%
Pariet	61	0.06%
Losec MUPS†	324	0.33%
Zoton FasTab†	266	0.27%

Drug name	Items	%
Lansoprazole	158553	31.26%
Omeprazole	269884	53.21%
Pantoprazole	30291	5.97%
Losec	1611	0.32%
Protium	0	0.00%
Esomeprazole (tablets)	37843	7.46%
Lansoprazole orodispersible†	0	0.00%
Omeprazole dispersible†	0	0.00%
Rabeprazole	2414	0.48%
Emozul (capsules)	95	0.02%
Nexium (tablets)	2883	0.57%
Pariet	281	0.06%
Losec MUPS†	1884	0.37%
Zoton FasTab†	1459	0.29%

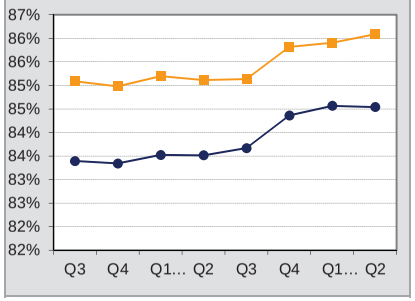
PPIs - Cost /1000 NIPUs



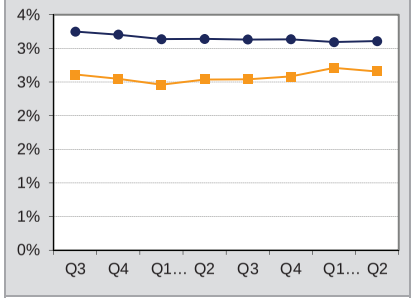
PPIs - DDDs /1000 NIPUs



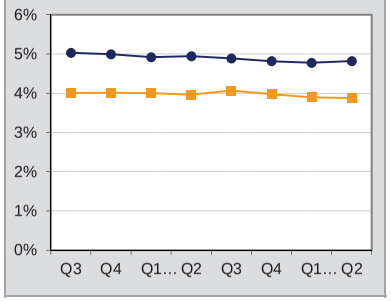
% generic omeprazole and lansoprazole of all PPI items (↑)



% esomeprazole 20mg of all PPI items (↓)



% esomeprazole 40mg of all PPI items (↓)



Key

Pie charts

Preferred choices

Other items

† If patients do not have swallowing difficulties, they could be switched to omeprazole or lansoprazole capsules.

Line charts

Q1 = Jan/Mar

LCG

HSCB

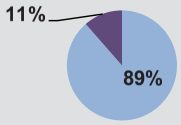
Upward trend preferable ↑

Downward trend preferable ↓

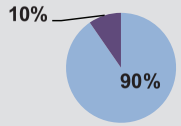
Lipid lowering drugs

Southern LCG

LCG



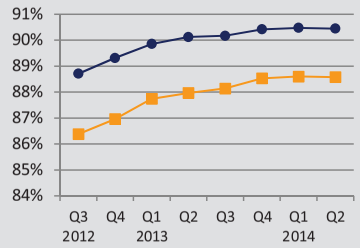
HSCB



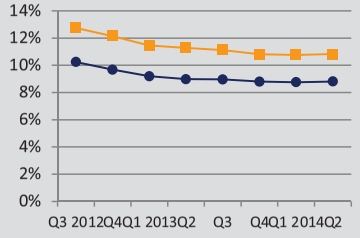
Drug name	Items	%
Simvastatin 10mg	1450	1.58%
Simvastatin 20mg	8376	9.14%
Simvastatin 40mg	33912	37.01%
Simvastatin 80mg	76	0.08%
Simvastatin 20mg/5ml	17	0.02%
Simvastatin 40mg/5ml	51	0.06%
Atorvastatin 10mg	5472	5.97%
Atorvastatin 20mg	8031	8.76%
Atorvastatin 40mg	18386	20.06%
Atorvastatin 80mg	1086	1.19%
Pravastatin	4319	4.71%
Fluvastatin	210	0.23%
Rosuvastatin	8721	9.52%
Simvastatin + Ezetimibe	75	0.08%
Lescol /other brands	19	0.02%
Lipostat	11	0.01%
Zocor	24	0.03%
Crestor	1162	1.27%
Inegy	56	0.06%
Lipitor 10mg	61	0.07%
Lipitor 20mg	49	0.05%
Lipitor 40mg	71	0.08%
Lipitor 80mg	1	0.00%

Drug name	Items	%
Simvastatin 10mg	9184	2.00%
Simvastatin 20mg	48808	10.62%
Simvastatin 40mg	153242	33.35%
Simvastatin 80mg	415	0.09%
Simvastatin 20mg/5ml	141	0.03%
Simvastatin 40mg/5ml	269	0.06%
Atorvastatin 10mg	37453	8.15%
Atorvastatin 20mg	53985	11.75%
Atorvastatin 40mg	80607	17.54%
Atorvastatin 80mg	6831	1.49%
Pravastatin	24277	5.28%
Fluvastatin	1101	0.24%
Rosuvastatin	37184	8.09%
Simvastatin + Ezetimibe	427	0.09%
Lescol /other brands	73	0.02%
Lipostat	114	0.02%
Zocor	102	0.02%
Crestor	3913	0.85%
Inegy	216	0.05%
Lipitor 10mg	418	0.09%
Lipitor 20mg	364	0.08%
Lipitor 40mg	291	0.06%
Lipitor 80mg	30	0.01%

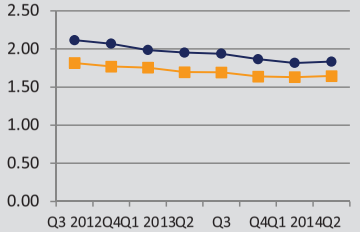
% simvastatin, atorvastatin and pravastatin of all statin items (↑)



% rosuvastatin of all statin items (↓)



Ezetimibe, Items /1000 NIPUs (↓)
(includes Ezetrol and Inegy)



Key

Pie charts

Preferred choices

Other items

Line charts

Q1 = Jan/Mar

LCG

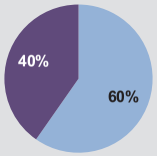
HSCB

Upward trend preferable ↑

SSRIs and related antidepressant drugs

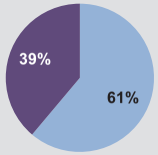
Southern LCG

LCG



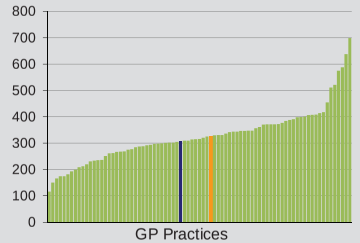
Drug name	Items	%
Citalopram	24780	24.59%
Fluoxetine	19116	18.97%
Sertraline	16278	16.15%
Duloxetine	4015	3.98%
Escitalopram	3889	3.86%
Flupentixol	105	0.10%
Fluvoxamine	25	0.02%
Mirtazapine	13140	13.04%
Paroxetine	2309	2.29%
Reboxetine	70	0.07%
Venlafaxine (incl. XL)	2960	2.94%
Cipramil	40	0.04%
Efexor /XL /other brands	12266	12.17%
Faverin	8	0.01%
Lustral	105	0.10%
Prozac	72	0.07%
Seroxat	90	0.09%
Cipralex	545	0.54%
Cymbalta	772	0.77%
Edronax	43	0.04%
Fluanxol	115	0.11%
Optimax	9	0.01%
Zispin SolTab	31	0.03%

HSCB

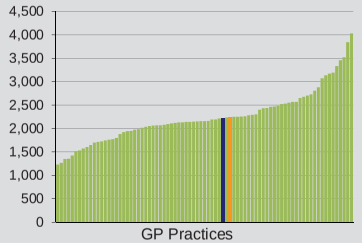


Drug name	Items	%
Citalopram	129369	25.02%
Fluoxetine	94531	18.28%
Sertraline	92071	17.81%
Duloxetine	21892	4.23%
Escitalopram	23441	4.53%
Flupentixol	389	0.08%
Fluvoxamine	210	0.04%
Mirtazapine	64596	12.49%
Paroxetine	11764	2.28%
Reboxetine	430	0.08%
Venlafaxine (incl. XL)	10841	2.10%
Cipramil	282	0.05%
Efexor /XL /other brands	58338	11.28%
Faverin	30	0.01%
Lustral	436	0.08%
Prozac	325	0.06%
Seroxat	388	0.08%
Cipralex	2331	0.45%
Cymbalta	4592	0.89%
Edronax	137	0.03%
Fluanxol	371	0.07%
Optimax	12	0.00%
Zispin SolTab	258	0.05%

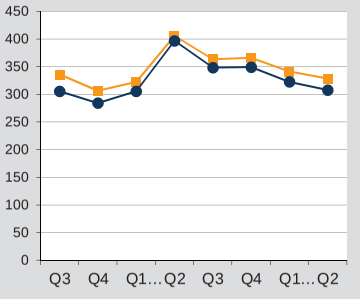
SSRIs and related antidepressants Cost /1000 NIPUs



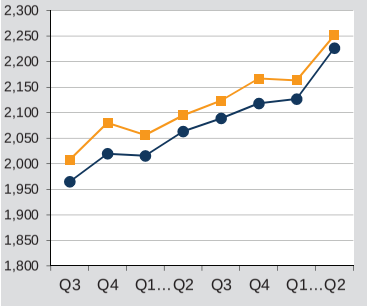
SSRIs and related antidepressants DDDs /1000 NIPUs



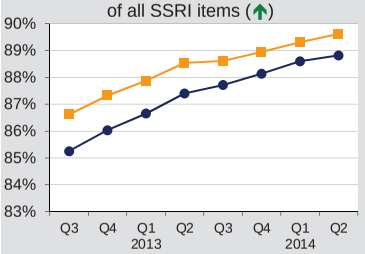
SSRIs and related antidepressants Cost /1000 NIPUs



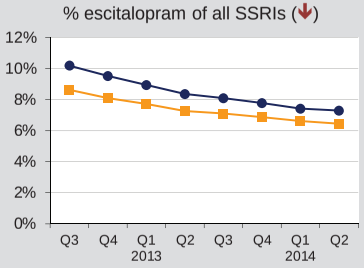
SSRIs and related antidepressants DDDs /1000 NIPUs

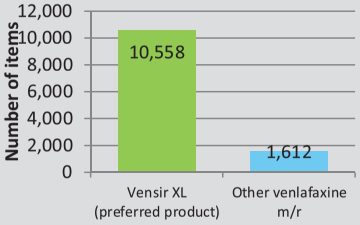


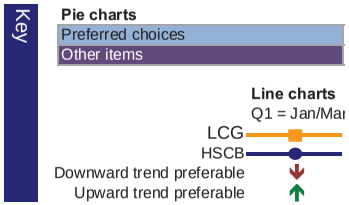
% generic citalopram, fluoxetine and sertraline of all SSRI items (↑)

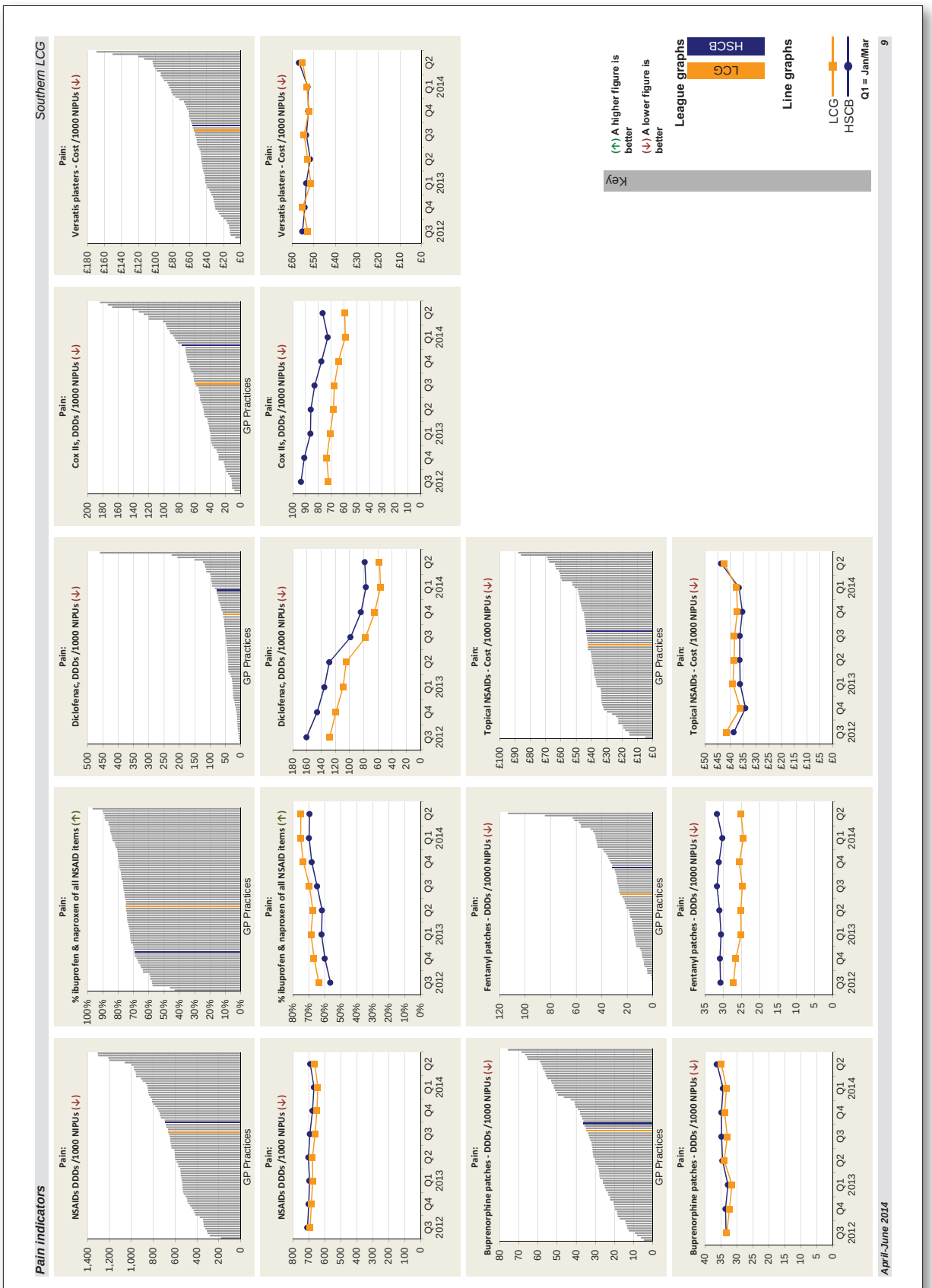


% escitalopram of all SSRIs (↓)





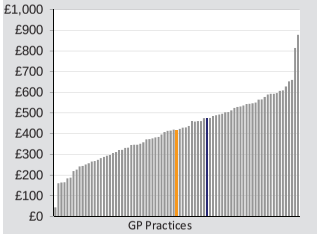



Pain indicators
Southern LCG
Pain: NSAIDs DDDs /1000 NIPUs (↓)
Pain: % ibuprofen & naproxen of all NSAID items (↑)
Pain: Diclofenac, DDDs /1000 NIPUs (↓)
Pain: Cox IIs, DDDs /1000 NIPUs (↓)
Pain: Versatis plasters - Cost /1000 NIPUs (↓)
GP Practices
Pain: Buprenorphine patches - DDDs /1000 NIPUs (↓)
Pain: Fentanyl patches - DDDs /1000 NIPUs (↓)
Pain: Topical NSAIDs - Cost /1000 NIPUs (↓)
Q3 2012
Q4
Q1 2013
Q2
Q3
Q4
Q1 2014
Q2
Key
(↑) A higher figure is better
(↓) A lower figure is better
League graphs
LCG
HSCB
Line graphs
LCG
HSCB
Q1 = Jan/Mar
April-June 2014
9

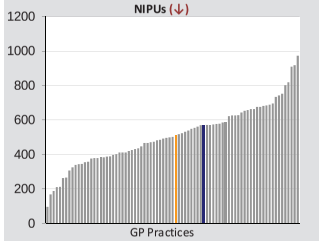
Pain indicators

Southern LCG

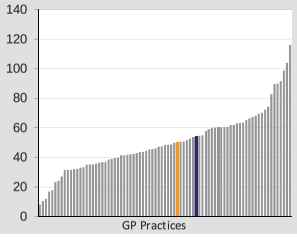
Pregabalin, Cost /1000 NIPUs (↓)



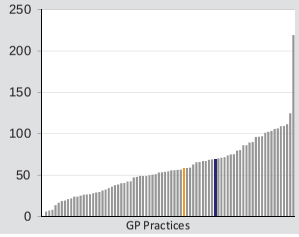
Paracetamol-opioid compound analgesics, DDDs /1000 NIPUs (↓)



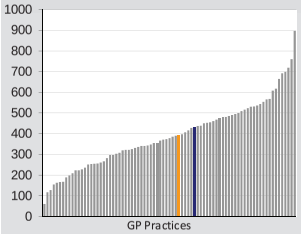
Co-codamol 8/500, DDDs /1000 NIPUs (↓)



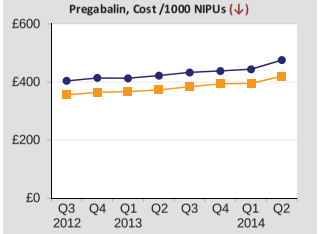
Co-codamol 15/500, DDDs /1000 NIPUs (↓)



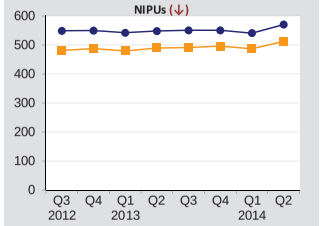
Co-codamol 30/500, DDDs /1000 NIPUs (↓)



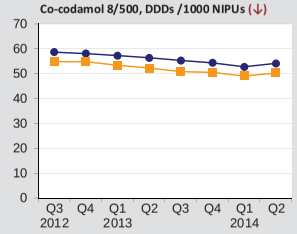
Pregabalin, Cost /1000 NIPUs (↓)



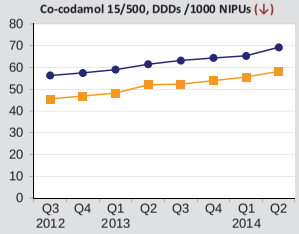
Paracetamol-opioid compound analgesics, DDDs /1000 NIPUs (↓)



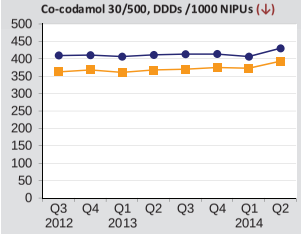
Co-codamol 8/500, DDDs /1000 NIPUs (↓)



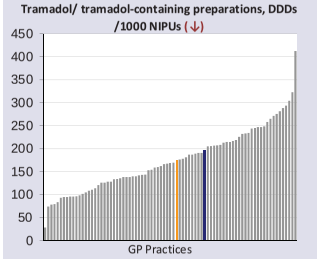
Co-codamol 15/500, DDDs /1000 NIPUs (↓)



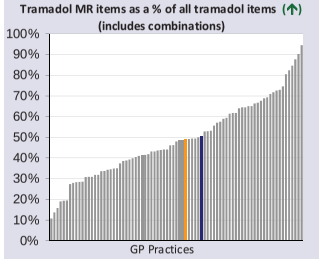
Co-codamol 30/500, DDDs /1000 NIPUs (↓)



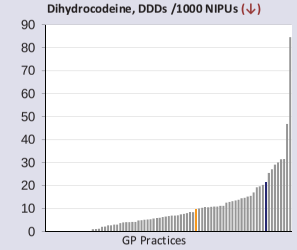
Tramadol/ tramadol-containing preparations, DDDs /1000 NIPUs (↓)



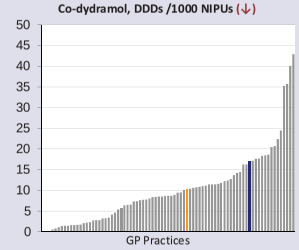
Tramadol MR items as a % of all tramadol items (↑) (includes combinations)



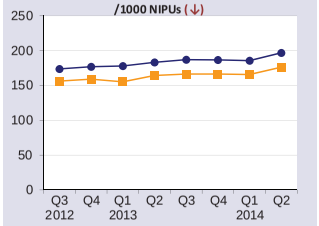
Dihydrocodeine, DDDs /1000 NIPUs (↓)



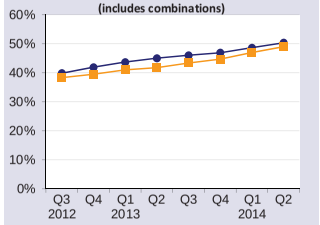
Co-dydramol, DDDs /1000 NIPUs (↓)



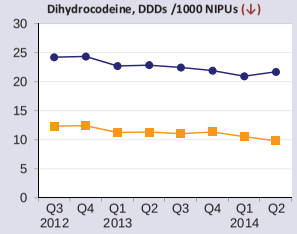
Tramadol/ tramadol-containing preparations, DDDs /1000 NIPUs (↓)



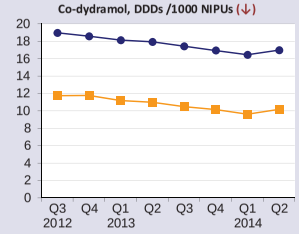
Tramadol MR items as a % of all tramadol items (↑) (includes combinations)



Dihydrocodeine, DDDs /1000 NIPUs (↓)



Co-dydramol, DDDs /1000 NIPUs (↓)



Key

(↑) A higher figure is better

(↓) A lower figure is better

League graphs

LCG

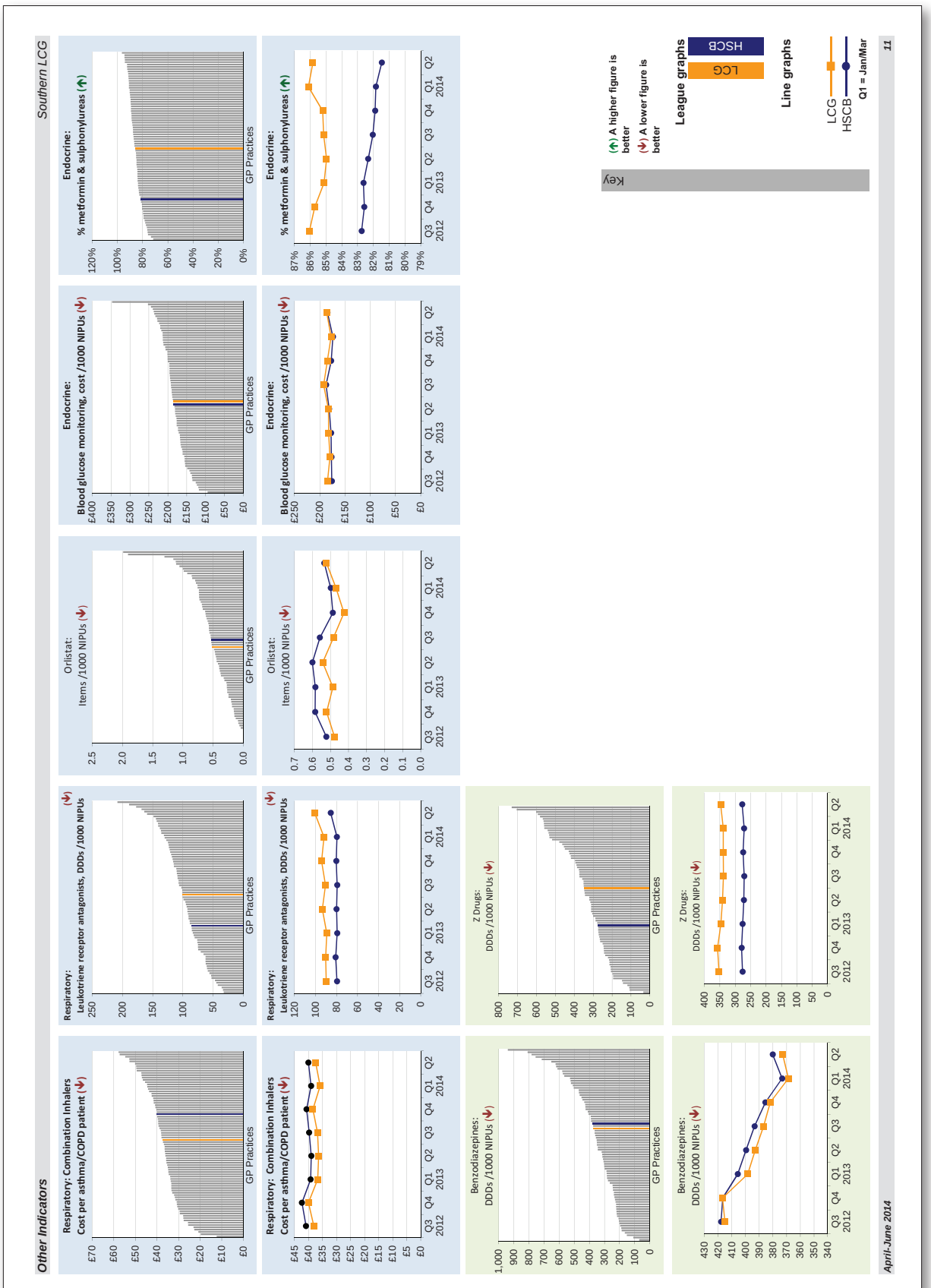
HSCB

Line graphs

LCG

HSCB

Q1 = Jan/Mar


Southern LCG
Other Indicators
Respiratory: Combination Inhalers Cost per asthma/COPD patient (↓)
Respiratory: Leukotriene receptor antagonists, DDDs /1000 NIPUs (↓)
Orlistat: Items /1000 NIPUs (↓)
Endocrine: Blood glucose monitoring, cost /1000 NIPUs (↓)
Endocrine: % metformin & sulphonylureas (↑)
Benzodiazepines: DDDs /1000 NIPUs (↓)
Z Drugs: DDDs /1000 NIPUs (↓)
GP Practices
Q3 2012
Q4 2012
Q1 2013
Q2 2013
Q3 2013
Q4 2013
Q1 2014
Q2 2014
Key
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League graphs
LCG
HSCB
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LCG
HSCB
Q1 = Jan/Mar
April-June 2014
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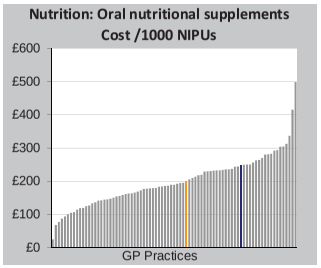

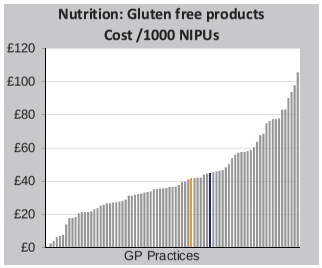

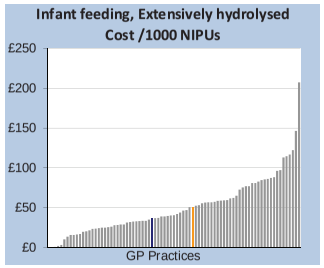

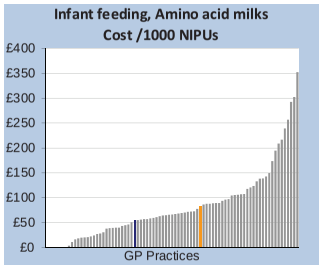

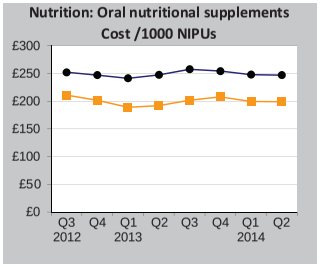

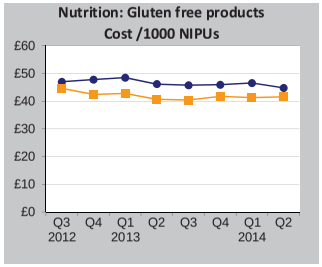

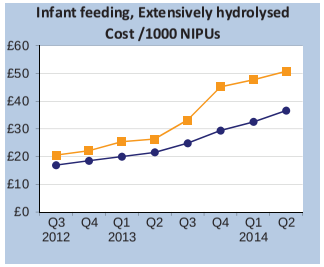

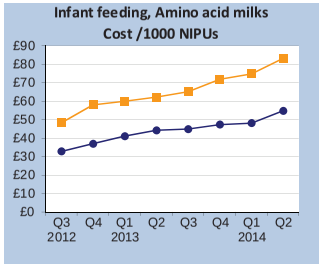

Key

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League graphs

LCG HSCB

Line graphs

LCG

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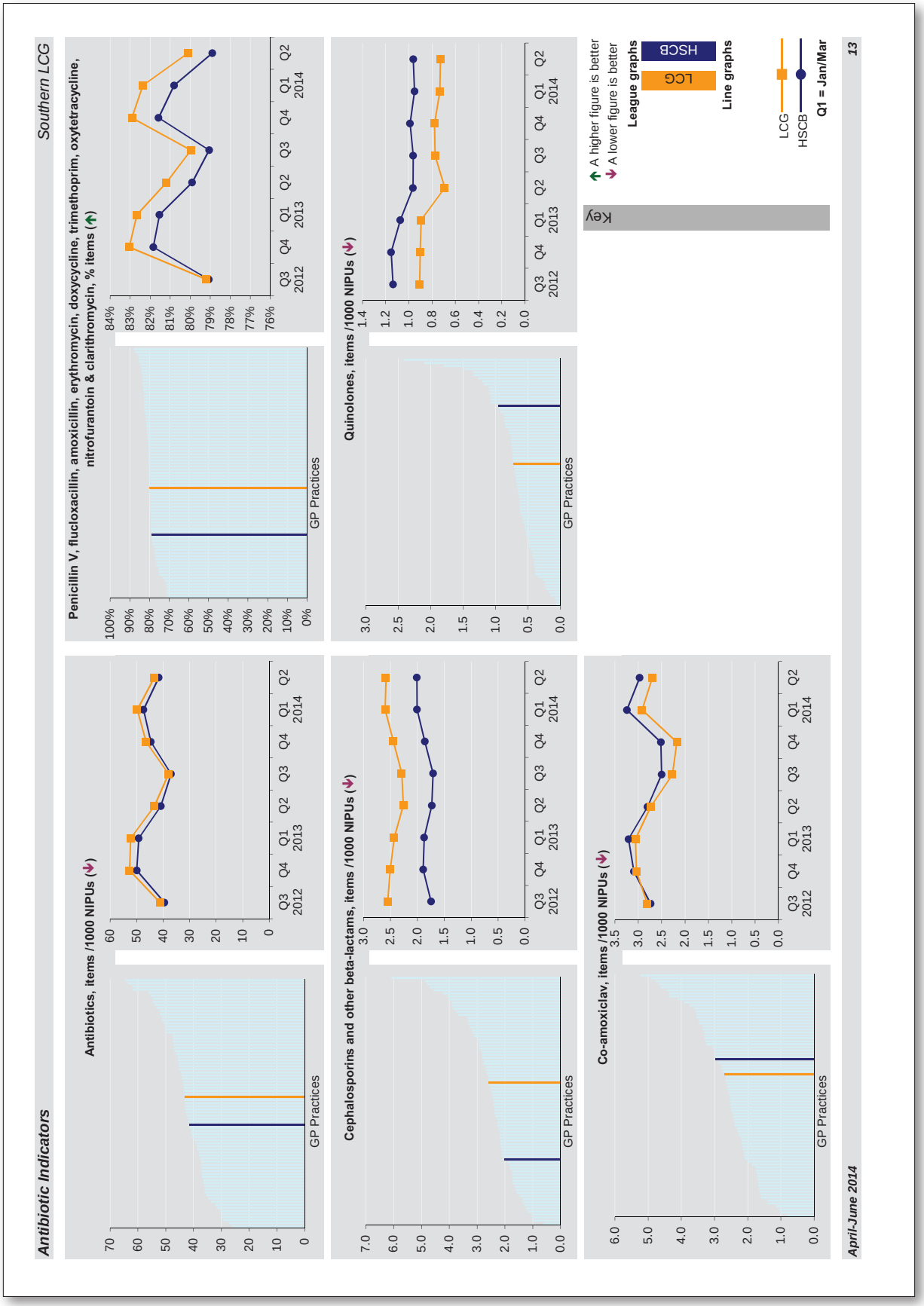
Q1 = Jan/Mar


Antibiotic Indicators
Southern LCG
Penicillin V, flucloxacillin, amoxicillin, erythromycin, doxycycline, trimethoprim, oxytetracycline, nitrofurantoin & clarithromycin, % items (↑)
Quinolones, items /1000 NIPUs (↓)
Antibiotics, items /1000 NIPUs (↓)
Cephalosporins and other beta-lactams, items /1000 NIPUs (↓)
Co-amoxiclav, items /1000 NIPUs (↓)
GP Practices
Q3 2012
Q4
Q1 2013
Q2
Q3
Q4
Q1 2014
Q2
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High Risk Drugs

Drug name/group	Items	Quantity
Warfarin 0.5mg	3	66
Warfarin 5mg	8	454
Methotrexate 10mg	2	16
Red List drugs	15	N/A

IV antibiotics: patient prescribing

Drug name	Items	Quantity
Augmentin Intravenous 1.2g powder for solution for injection vials	1	10
Benzylpenicillin 600mg powder for solution for injection vials	1	15
Kefadim 2g powder for solution for injection vials	2	3
Zinacef 1.5g powder for injection vials	1	5
Zinacef 750mg powder for injection vials	2	31
Totals	**7**	

Top 15 Stock Items by Cost (excluding dressings & appliances)

	Drug name	Cost (£)	Items	Quantity
1	Mirena 20micrograms/24hours intrauterine device	£3,432	12	39
2	Depo-Medrone 40mg/1ml suspension for injection vials	£2,806	44	822
3	Revaxis vaccine suspension for injection 0.5ml pre-filled syringes	£2,763	42	425
4	ViATIM vaccine suspension for injection 1ml pre-filled syringes	£2,086	7	70
5	Nexplanon 68mg implant	£1,669	8	21
6	Chlorphenamine 10mg/1ml solution for injection ampoules	£1,599	91	540
7	EpiPen 300micrograms/0.3ml (1 in 1,000) solution for injection auto-injectors	£1,561	36	59
8	Twinrix Adult vaccine suspension for injection 1ml pre-filled syringes	£1,499	3	50
9	EpiPen Jr. 150micrograms/0.3ml (1 in 2,000) solution for injection auto-injectors	£1,455	27	55
10	Pneumovax II vaccine solution for injection 0.5ml vials	£1,240	11	149
11	Depo-Medrone with Lidocaine suspension for injection 1ml vials	£1,205	13	310
12	Helicobacter Test INFAI breath test kit	£1,133	5	59
13	Kenalog Intra-articular / Intramuscular 40mg/1ml suspension for injection vials	£1,097	49	736
14	Prednisolone 5mg soluble tablets	£995	21	698
15	GlucaGen Hypokit 1mg powder and solvent for solution for injection	£772	29	67
	Total	**£25,309**	**398**	
	Total of all Stock (including dressings and appliances)	**£202,163**	**5,451**	

Top 15 CDs (schedules 2, 3, 4 and 5)

	Drug name	Cost (£)	Items	Quantity
1	Buccolam 10mg/2ml oromucosal solution pre-filled oral syringes	£549	5	24
2	Midazolam 10mg/2ml oromucosal solution pre-filled oral syringes	£275	3	12
3	Cyclimorph 10 solution for injection 1ml ampoules	£140	14	80
4	Diamorphine 10mg powder for solution for injection ampoules	£129	10	50
5	Chlordiazepoxide 10mg capsules	£122	14	1356
6	Medikinet XL 40mg capsules	£92	1	48
7	Buccolam 5mg/1ml oromucosal solution pre-filled oral syringes	£86	1	4
8	Diamorphine 5mg powder for solution for injection ampoules	£79	6	35
9	Diazepam 10mg/2ml solution for injection ampoules	£65	14	145
10	Diazepam 5mg/2.5ml rectal solution tube	£59	10	54
11	Diazemuls 10mg/2ml emulsion for injection ampoules	£50	4	55
12	Co-codamol 30mg/500mg tablets	£42	15	960
13	Cyclimorph 15 solution for injection 1ml ampoules	£36	4	20
14	Stesolid 5mg rectal tube	£28	2	20
15	Morphine sulphate 10mg/1ml solution for injection ampoules	£26	3	28
	Total	**£1,778**	**106**	

Appendix: COMPASS Explanatory Notes

Glossary			
ICPs	Integrated Care Partnerships	NIPUs	Northern Ireland Prescribing Units
LCG	Local Commissioning Group		
HSCB	Health and Social Care Board		

Quarter: Information in the COMPASS report is based on three months of prescribing data, i.e. one quarter.

ICP average: Figures refer to the average of all practices within the respective ICP.

LCG average: Figures refer to the average of all practices within the respective LCG.

HSCB average: Figures refer to the average of all practices within the HSCB, i.e. all practices in NI.

Cost (£): Net ingredient cost, equivalent to England's Net Ingredient Cost (NIC). Cost is useful in terms of monitoring the overall drugs bill, checking spend within prescribing budgets and calculating savings made or potential savings. Cost is less useful as a measure of drug consumption because of the differences in cost of alternative preparations and changes in prices.

Items: Number of prescription items. Count of items is a reasonable measure of the number of courses of treatments for vaccinations and acute treatments such as short courses of antibiotics. For other treatments it is less useful because of the wide variation in duration of supply per item.

NIPUs: In measuring prescribing, differences between practices need to be taken account of in order to make valid comparisons with local and national averages. NIPUs standardise for differences between practices in terms of patient list size, age/sex structure and additional needs.

Quantity: Number of physical units, i.e. tablets, capsules, patches, mLs, inhalers, vials etc. Quantity is a useful measure of prescribing when looking at individual preparations, e.g. methotrexate 10mg or warfarin 0.5mg and 5mg.

Change from Last Year: The actual change from the same quarter in the previous year.

Defined Daily Dose (DDD): The DDD is a unit of measurement based on the assumed average maintenance dose per day used for its main indication in adults. The World Health Organisation (WHO) developed the DDD as a method to compare drugs of different chemical structures and potencies. The DDD methodology standardises quantities prescribed into number of daily doses. See worked example below. The number of DDDs is calculated as follows:

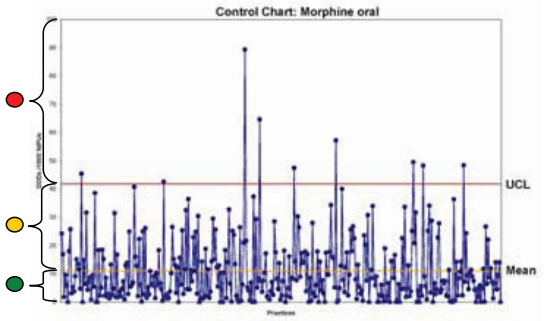
$$\text{Number of DDDs} = \frac{\text{Strength (mg) x quantity}}{\text{DDD (mg)}}$$

Worked example	Quantity (no. of tabs /caps)	DDD (mg)	No. of DDDs
Ibuprofen 200mg 2 caps 3 times a day	168	1200	$\frac{200 \times 168}{1200} = 28$
Ranitidine 150mg 1 tablet twice a day	56	300	$\frac{150 \times 56}{300} = 28$
Lansoprazole 30mg 1 capsule once a day	28	30	$\frac{30 \times 28}{30} = 28$

Prescribing Indicators listed throughout the report give some indication of prescribing quality but are not quantitative measures of good prescribing. Arrows indicate whether a larger figure or a smaller figure suggests 'better' prescribing. Values are given for the practice, locality average, LCG average and HSCB average. They are, therefore, useful in identifying outliers i.e. practice's whose prescribing differs substantially from other practices and to highlight areas for further analysis.

Red List Drugs: The Red list is an advisory list where it is considered by the Regional Group on Specialist Medicines, that responsibility for prescribing should remain with the consultant or specialist clinician. It is recommended that the supply of these specialist medicines should be organised via the hospital pharmacy.

Controlled Drugs (CDs): On the patient and stock prescribing pages there are red, orange and green dots. Each dot represents where a practice is on a control chart in relation to the Upper Control Limit (UCL) and the mean for all practices in NI (see chart below). The UCL is the mean + 3 standard deviations. A green dot represents a practice at the mean or below. An orange dot represents a practice above the mean but below the UCL. A red dot represents a practice above the UCL.



LCG COMPASS Report

Western LCG

April-June 2014

Contents

Contents cont'd

Key

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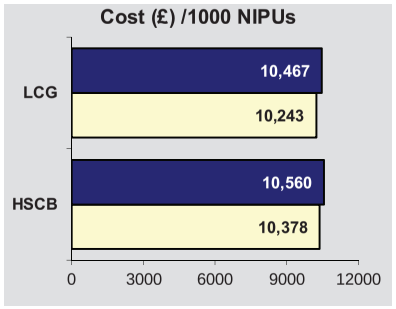
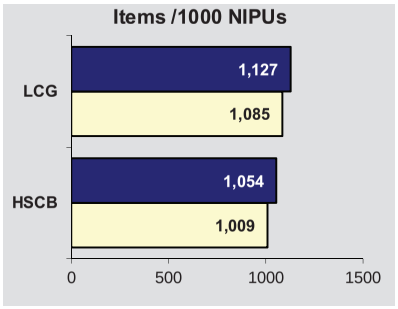
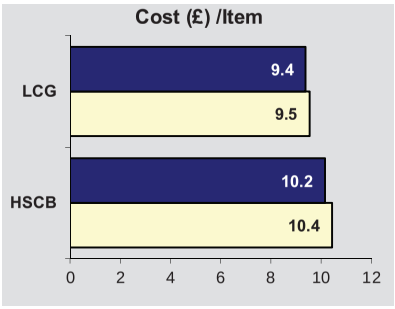
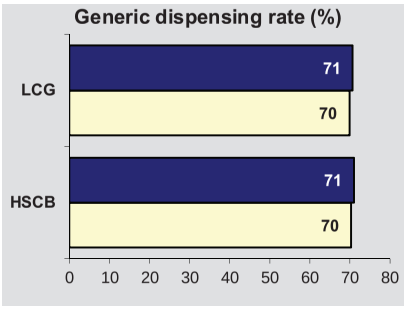
Quarter last year Apr-Jun 13

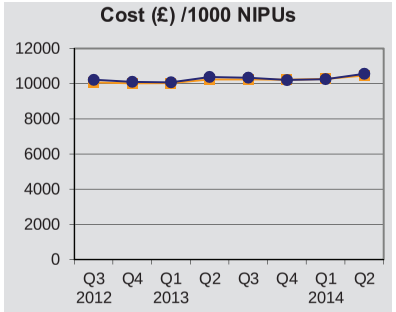
LCG
HSCB

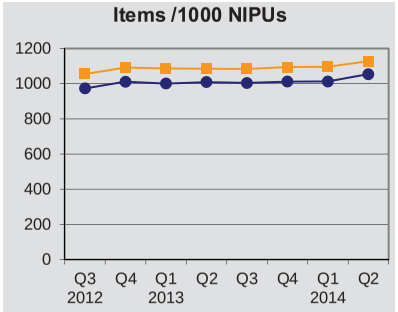


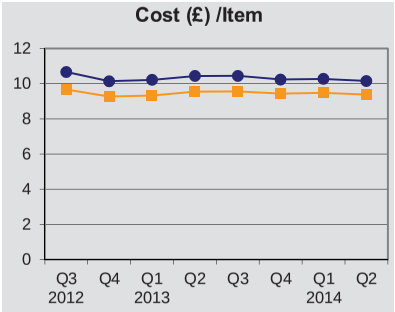


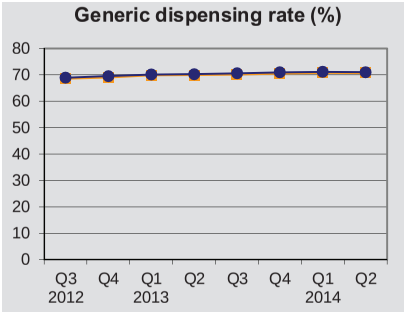












COMPASS Unit, Operations Directorate, FPS, BSO, 2 Franklin Street, Belfast BT2 8DQ Web site: http://www.hscbusiness.hscni.net/services.htm Tel: 028 9053 5661 Fax: 028 9053 2963

Top 40 : Forty most costly drugs in your LCG

Western LCG

	Drug Name	Drug's position in HSCB's most costly drugs*	Cost (£)	No of Items	Quantity	Cost (£) /Item	% of Board Total Cost	Change from last year
1	SERETIDE WITH COUNTER 250MCG/25 [EVOHALER]	2	241,727	3,620	4,064	66.78	1.46	-0.03
2	SYMBICORT 200/6 [TURBOHALER]	6	224,618	4,978	5,911	45.12	1.36	0.04
3	TIOTROPIUM BROMIDE (DT) 18MICROGRAM [INHALATION	1	149,080	4,099	133,504	36.37	0.90	0.10
4	PREGABALIN (DT) 75MG [CAPSULE]	3	126,509	1,953	110,008	64.78	0.77	0.04
5	SYMBICORT 400/12 [TURBOHALER]	30	122,626	2,619	3,227	46.82	0.74	0.06
6	SPIRIVA REFILL 18MCG [CAPSULE]	34	122,168	3,258	109,404	37.50	0.74	-0.01
7	TEMAZEPAM (DT) 10MG [TABLET]	5	120,587	5,970	164,296	20.20	0.73	-0.40
8	VICTOZA 3ML [PRE-FILLED INJECTION PEN]	13	116,543	1,237	2,970	94.21	0.71	-0.06
9	PREGABALIN (DT) 150MG [CAPSULE]	4	115,968	1,770	100,842	65.52	0.70	0.06
10	AVIVA [REAGENT]	12	112,759	3,332	361,640	33.84	0.68	0.05
11	OMEPRAZOLE (DT) 20MG [GASTRO-RESISTANT CAPSULE]	25	102,656	60,514	2,499,520	1.70	0.62	-0.05
12	INSULIN LANTUS SOLOSTAR 3ML [PRE-FILLED PEN]	8	99,675	2,055	12,009	48.50	0.60	0.02
13	VERSATIS [MEDICATED PLASTER]	15	93,823	1,428	38,877	65.70	0.57	0.04
14	SERETIDE 60 DOSE 500MCG [ACCUHALER]	61	92,847	2,066	2,269	44.94	0.56	0.02
15	LAMICTAL 100MG [TABLET]	33	90,831	1,395	82,667	65.11	0.55	0.06
16	EZETIMIBE (DT) 10MG [TABLET]	11	90,766	2,517	96,596	36.06	0.55	-0.06
17	INSULIN NOVOMIX 30 FLEXPEN 3ML [INJECTION DEVICE]	20	88,588	1,937	14,819	45.73	0.54	-0.02
18	PREGABALIN (DT) 300MG [CAPSULE]	9	87,153	1,412	75,785	61.72	0.53	0.07
19	SERETIDE WITH COUNTER 125MCG/25 [EVOHALER]	32	77,770	2,019	2,222	38.52	0.47	-0.01
20	HYDROCORTISONE (DT) 10MG [TABLET]	28	77,211	489	37,516	157.90	0.47	0.08
21	INSULIN NOVORAPID FLEXPEN 3ML [PRE-FILLED PEN]	18	76,531	1,959	12,505	39.07	0.46	-0.01
22	PREGABALIN (DT) 50MG [CAPSULE]	14	75,917	1,130	66,015	67.18	0.46	0.12
23	RIVAROXABAN (DT) 20MG [TABLET]	71	74,430	1,151	35,443	64.67	0.45	0.38
24	DULOXETINE (DT) 60MG [GASTRO-RESISTANT CAPSULE]	16	71,267	1,990	71,987	35.81	0.43	0.06
25	ROSUVASTATIN (DT) 20MG [TABLET]	24	70,983	2,033	76,384	34.92	0.43	0.03
26	TEMAZEPAM (DT) 20MG [TABLET]	44	68,581	3,437	97,774	19.95	0.42	-0.18
27	ROSUVASTATIN (DT) 10MG [TABLET]	17	68,563	2,764	106,476	24.81	0.42	0.00
28	NEBIVOLOL (DT) 2.5MG [TABLET]	19	67,636	821	27,141	82.38	0.41	0.01
29	CO-CODAMOL (DT) 30MG/500MG [TABLET]	22	67,093	20,714	1,524,811	3.24	0.41	-0.01
30	OXYGEN CD (BOC) 460L [CYLINDER]	58	65,010	724	2,829	89.79	0.39	-0.01
31	LAMICTAL 200MG [TABLET]	70	64,796	670	34,898	96.71	0.39	0.05
32	PREGABALIN (DT) 100MG [CAPSULE]	21	64,194	938	55,821	68.44	0.39	0.07
33	PROGRAF 1MG [CAPSULE]	43	62,277	375	38,790	166.07	0.38	0.06
34	ONE TOUCH ULTRA TEST STRIP [REAGENT]	35	59,543	2,565	248,301	23.21	0.36	-0.17
35	DOVOBET [GEL]	80	57,989	1,225	105,958	47.34	0.35	0.10
36	FLUTICASONE 250MICROGRAMS/DOSE / SALMETEROL 25M	7	57,339	852	964	67.30	0.35	0.07
37	SERETIDE 60 DOSE 250MCG [ACCUHALER]	63	56,175	1,359	1,605	41.34	0.34	-0.03
38	QUETIAPINE (DT) 300MG [MODIFIED-RELEASE TABLET]	52	55,026	520	19,421	105.82	0.33	0.07
39	BUDESONIDE 200MICROGRAMS/DOSE / FORMOTEROL 6MI	10	54,264	1,254	1,428	43.27	0.33	0.04
40	SOLIFENACIN (DT) 5MG [TABLET]	23	52,879	1,710	57,434	30.92	0.32	0.04
	TOTAL		**3,644,396**	**156,859**			**22.08**	

G: Generic form available

*This is the drug's position in the HSCB's most costly drugs. For example, the LCG's 40th most costly drug is SOLIFENACIN (DT) 5MG [TABLET]. This drug is number 23 in HSCB's most costly drugs.

Top 20 generic switches by cost

Western LCG

	Proprietary Drug	Number of Items	Cost (£)	Generic equivalent	Potential Savings for the quarter (£)
1	SINGULAIR 10MG [TABLET]	301	10,269	MONTELUKAST 10MG [TABLET]	£9,309
2	NEXIUM 40MG [TABLET]	293	11,425	ESOMEPRAZOLE 40MG [GASTRO-RESISTANT TABLET]	£8,963
3	NEXIUM 20MG [TABLET]	367	10,748	ESOMEPRAZOLE 20MG [GASTRO-RESISTANT TABLET]	£7,948
4	LOSEC 20MG [CAPSULE]	315	8,331	OMEPRAZOLE 20MG [GASTRO-RESISTANT CAPSULE]	£7,577
5	XALATAN 2.5ML [EYE DROP]	388	6,677	LATANOPROST 50MICROGRAMS/ML [EYE DROP]	£5,612
6	ARIMIDEX 1MG [TABLET]	47	4,456	ANASTROZOLE 1MG [TABLET]	£4,331
7	PLAVIX 75MG [TABLET]	86	4,037	CLOPIDOGREL 75MG [TABLET]	£3,826
8	ARICEPT 10MG [TABLET]	36	3,439	DONEPEZIL 10MG [TABLET]	£3,369
9	SINGULAIR PAEDIATRIC CHEWABLE 5MG [TABLET]	128	3,693	MONTELUKAST SF 5MG [CHEWABLE TABLET]	£3,352
10	BONVIVA F/C 150MG [TABLET]	105	3,496	IBANDRONIC ACID 150MG [TABLET]	£2,922
11	LIPITOR 20MG [TABLET]	70	2,661	ATORVASTATIN 20MG [TABLET]	£2,509
12	SINGULAIR PAEDIATRIC CHEWABLE 4MG [TABLET]	99	2,691	MONTELUKAST SF 4MG [CHEWABLE TABLET]	£2,460
13	ACTONEL ONCE A WEEK 35MG [TABLET]	102	2,581	RISEDRONATE 35MG [TABLET]	£2,425
14	APROVEL 150MG [TABLET]	162	2,796	IRBESARTAN 150MG [TABLET]	£2,402
15	LIPITOR 10MG [TABLET]	120	2,483	ATROVASTATIN 10MG [TABLET]	£2,267
16	SINGULAIR PAEDIATRIC GRANULES 4MG [SACHET]	104	2,608	MONTELUKAST SF 4MG [GRANULE]	£2,200
17	EBIXA 20MG [TABLET]	76	5,664	MEMANTINE 20MG [TABLET]	£2,195
18	LIPITOR 40MG [TABLET]	53	2,341	ATORVASTATIN 40MG [TABLET]	£2,186
19	XALACOM 2.5ML [EYE DROP]	169	3,289	LATANOPROST/TIMOLOL 50MICROGRAMS/ML / 5MG/M	£2,113
20	OPTICROM ALLERGY 2% [EYE DROP]	785	2,754	SODIUM CROMOGLICATE 2% [EYE DROP]	£2,076
	Total	**3,806**	**96,441**		**£80,041**

Potential savings per annum = £320,164

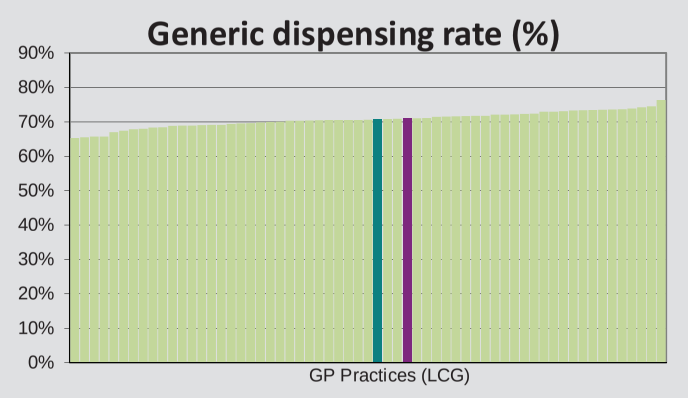
Top cost effective switches

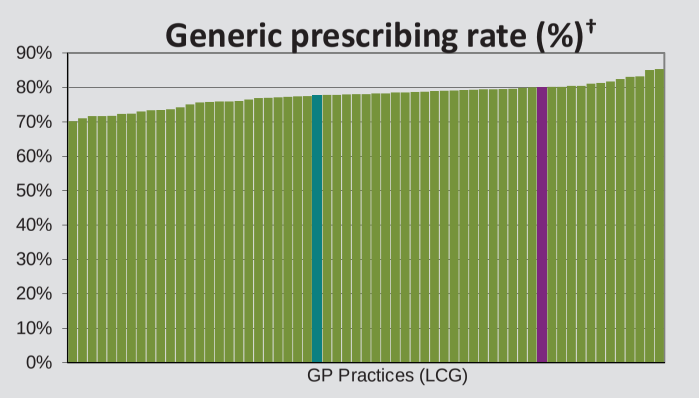
Western LCG

	Drug name	Number of Items	Spend	Cost effective choice	Potential Savings for the quarter
1	SOLIFENACIN (DT) 5MG [TABLET]	1,710	£52,879	TOLTERODINE (DT) 2MG [TABLET]	£47,381
2	SOLIFENACIN (DT) 10MG [TABLET]	951	£37,617	TOLTERODINE (DT) 2MG [TABLET]	£34,609
3	FESOTERODINE (DT) 4MG [MODIFIED-RELEASE TABLET]	976	£29,086	TOLTERODINE (DT) 2MG [TABLET]	£26,062
4	DOXAZOSIN (DT) 8MG [MODIFIED-RELEASE TABLET]	1,530	£22,992	DOXAZOSIN (DT) 4MG [TABLET]	£20,619
5	FESOTERODINE (DT) 8MG [MODIFIED-RELEASE TABLET]	594	£17,846	TOLTERODINE (DT) 2MG [TABLET]	£15,991
6	VESICARE FILM COATED 5MG [TABLET]	532	£17,802	TOLTERODINE (DT) 2MG [TABLET]	£15,951
7	MOMETASONE NASAL (DT) 50MICROGRAMS/DOSE [SPRAY]	2,817	£22,114	BECLOMETASONE NASAL (DT) 50MCG [SPRAY]	£13,495
8	AZITHROMYCIN (DT) 250MG [CAPSULE]	454	£15,406	AZITHROMYCIN (DT) 250MG [TABLET]	£12,028
9	TOVIAZ 4MG [TABLET]	401	£12,036	TOLTERODINE (DT) 2MG [TABLET]	£10,784
10	VESICARE FILM COATED 10MG [TABLET]	254	£11,445	TOLTERODINE (DT) 2MG [TABLET]	£10,530
11	DOXAZOSIN (DT) 4MG [MODIFIED-RELEASE TABLET]	1,554	£11,988	DOXAZOSIN (DT) 2MG [TABLET]	£9,926
12	SALINE STERI-NEB [AMPOULE]	418	£24,267	STERIPOULES SODIUM CHLORIDE 2.5ML [AMPOULE]	£9,170
13	TOVIAZ 8MG [TABLET]	341	£10,002	TOLTERODINE (DT) 2MG [TABLET]	£8,962
14	NASONEX AQUEOUS 140 DOSE 50 MCG/DOSE [NASAL SPRAY]	1,330	£10,844	BECLOMETASONE NASAL (DT) 50MCG [SPRAY]	£6,653
15	REGURIN XL 60MG [CAPSULE]	284	£7,392	TOLTERODINE (DT) 2MG [TABLET]	£6,533
16	NYSTATIN (DT) 100,000UNITS/ML [ORAL SUSPENSION]	526	£11,979	MICONAZOLE SUGAR FREE (DT) 20MG/G [OROMUCOSAL GEL]	£6,059
17	CARDURA XL 8MG [TABLET]	388	£6,185	DOXAZOSIN (DT) 4MG [TABLET]	£5,547
18	AVAMYS NASAL 120 DOSE [SPRAY]	1,313	£8,803	BECLOMETASONE NASAL (DT) 50MCG [SPRAY]	£5,326
19	MOVICOL POWDER [SACHET]	2,428	£23,170	LAXIDO ORANGE SUGAR FREE [ORAL POWDER SACHET]	£4,659
20	PARACETAMOL 500MG SOLUBLE TABLETS (DT) 500MG [EFFERVESCENT TABLET]	1,086	£6,643	PARACETAMOL (DT) 500MG [TABLET]	£4,547
21	FLUTICASONE PROPIONATE (DT) 50MICROGRAMS/DOSE [NASAL SPRAY]	546	£6,375	BECLOMETASONE NASAL (DT) 50MCG [SPRAY]	£4,534
	Total	**20,433**	**£366,871**		**£279,367**

Overall Generic Dispensing

Western LCG





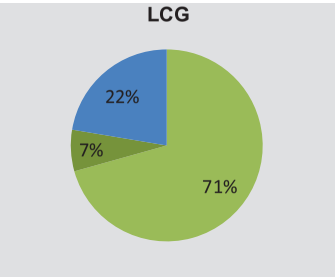
The range of generic drugs listed within Part I of the NI drug tariff increased in April 2011. This change may have increased the generic dispensing rate.

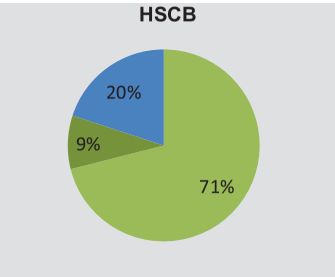
LCG Average | HSCB Average

Prescribed and dispensed generically
Prescribed generically and dispensed by brand as no generic is currently available
Presribed and dispensed by brand

†The generic **prescribing** rates chart is new. This chart reports GP prescribing of generics. This will include drugs that, although prescribed generically, will have been dispensed by brand as no generic is currently available.

NB 100% generic prescribing rate is not achievable or desired as there are a number of items unsuitable for generic prescribing. See link below:
http://www.hscboard.hscni.net/medicinesmanagement/Prescribing%20Guidance/index.html

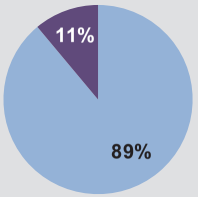




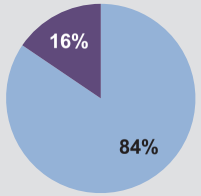
Proton Pump Inhibitors (PPIs)

Western LCG

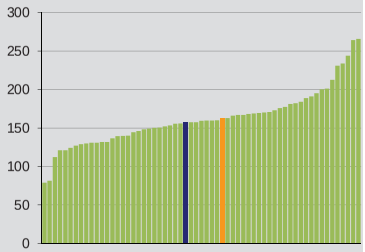
LCG



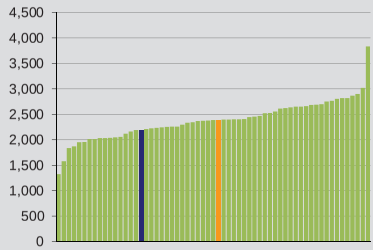
HSCB



PPIs - Cost /1000 NPUs



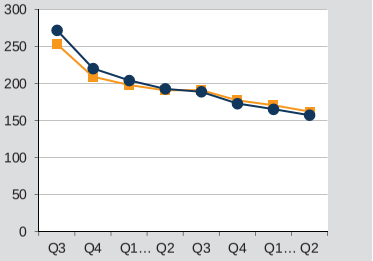
PPIs - DDDs /1000 NIPUs



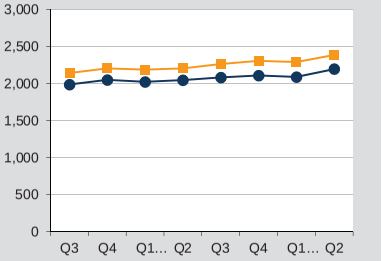
Drug name	Items	%
Lansoprazole	20504	21.11%
Omeprazole	65883	67.82%
Pantoprazole	3082	3.17%
Losec	384	0.40%
Protium	0	0.00%
Esomeprazole (tablets)	5496	5.66%
Lansoprazole orodispersible†	0	0.00%
Omeprazole dispersible†	0	0.00%
Rabeprazole	241	0.25%
Emozul (capsules)	18	0.02%
Nexium (tablets)	660	0.68%
Pariet	58	0.06%
Losec MUPS†	519	0.53%
Zoton FasTab†	305	0.31%

Drug name	Items	%
Lansoprazole	158553	31.26%
Omeprazole	269884	53.21%
Pantoprazole	30291	5.97%
Losec	1611	0.32%
Protium	0	0.00%
Esomeprazole (tablets)	37843	7.46%
Lansoprazole orodispersible†	0	0.00%
Omeprazole dispersible†	0	0.00%
Rabeprazole	2414	0.48%
Emozul (capsules)	95	0.02%
Nexium (tablets)	2883	0.57%
Pariet	281	0.06%
Losec MUPS†	1884	0.37%
Zoton FasTab†	1459	0.29%

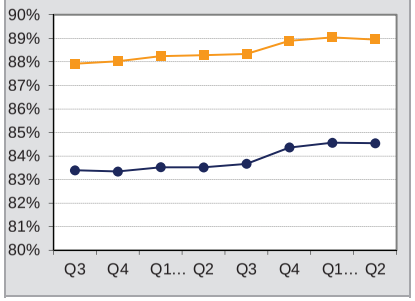
PPIs - Cost /1000 NIPUs



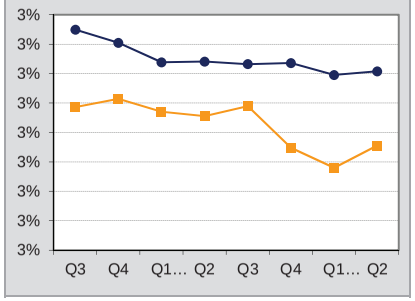
PPIs - DDDs /1000 NIPUs



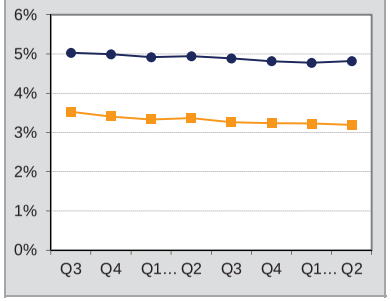
% generic omeprazole and lansoprazole of all PPI items (↑)



% esomeprazole 20mg of all PPI items (↓)



% esomeprazole 40mg of all PPI items (↓)



Key

Pie charts

Preferred choices

Other items

† If patients do not have swallowing difficulties, they could be switched to omeprazole or lansoprazole capsules.

Line charts

Q1 = Jan/Mar

LCG

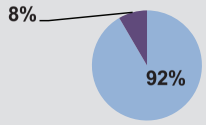
HSCB

Upward trend preferable ↑

Downward trend preferable ↓

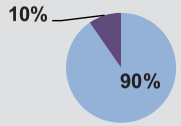
Lipid lowering drugs

LCG



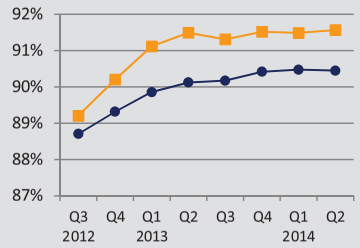
Drug name	Items	%
Simvastatin 10mg	1344	1.48%
Simvastatin 20mg	10462	11.51%
Simvastatin 40mg	30818	33.89%
Simvastatin 80mg	62	0.07%
Simvastatin 20mg/5ml	42	0.05%
Simvastatin 40mg/5ml	39	0.04%
Atorvastatin 10mg	6951	7.64%
Atorvastatin 20mg	11232	12.35%
Atorvastatin 40mg	16903	18.59%
Atorvastatin 80mg	2053	2.26%
Pravastatin	3380	3.72%
Fluvastatin	143	0.16%
Rosuvastatin	6015	6.62%
Simvastatin + Ezetimibe	58	0.06%
Lescol /other brands	12	0.01%
Lipostat	27	0.03%
Zocor	16	0.02%
Crestor	1085	1.19%
Inegy	29	0.03%
Lipitor 10mg	121	0.13%
Lipitor 20mg	71	0.08%
Lipitor 40mg	53	0.06%
Lipitor 80mg	7	0.01%

HSCB

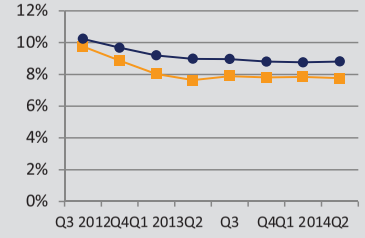


Drug name	Items	%
Simvastatin 10mg	9184	2.00%
Simvastatin 20mg	48808	10.62%
Simvastatin 40mg	153242	33.35%
Simvastatin 80mg	415	0.09%
Simvastatin 20mg/5ml	141	0.03%
Simvastatin 40mg/5ml	269	0.06%
Atorvastatin 10mg	37453	8.15%
Atorvastatin 20mg	53985	11.75%
Atorvastatin 40mg	80607	17.54%
Atorvastatin 80mg	6831	1.49%
Pravastatin	24277	5.28%
Fluvastatin	1101	0.24%
Rosuvastatin	37184	8.09%
Simvastatin + Ezetimibe	427	0.09%
Lescol /other brands	73	0.02%
Lipostat	114	0.02%
Zocor	102	0.02%
Crestor	3913	0.85%
Inegy	216	0.05%
Lipitor 10mg	418	0.09%
Lipitor 20mg	364	0.08%
Lipitor 40mg	291	0.06%
Lipitor 80mg	30	0.01%

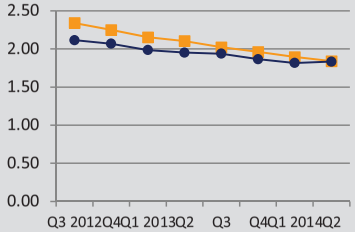
% simvastatin, atorvastatin and pravastatin of all statin items (↑)



% rosuvastatin of all statin items (↓)



Ezetimibe, Items /1000 NIPUs (↓)
(includes Ezetrol and Inegy)



Key

Pie charts

Preferred choices

Other items

Line charts

Q1 = Jan/Mar

LCG

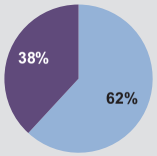
HSCB

Upward trend preferable ↑

SSRIs and related antidepressant drugs

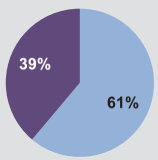
Western LCG

LCG



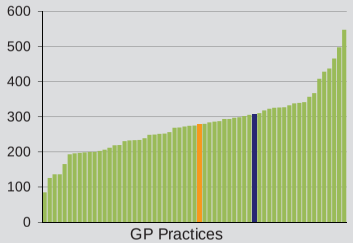
Drug name	Items	%
Citalopram	22006	23.17%
Fluoxetine	17671	18.60%
Sertraline	19086	20.09%
Duloxetine	2906	3.06%
Escitalopram	3512	3.70%
Flupentixol	44	0.05%
Fluvoxamine	32	0.03%
Mirtazapine	10722	11.29%
Paroxetine	3088	3.25%
Reboxetine	43	0.05%
Venlafaxine (incl. XL)	1236	1.30%
Cipramil	68	0.07%
Efexor /XL /other brands	12587	13.25%
Faverin	5	0.01%
Lustral	86	0.09%
Prozac	83	0.09%
Seroxat	60	0.06%
Cipralex	672	0.71%
Cymbalta	866	0.91%
Edronax	19	0.02%
Fluanxol	116	0.12%
Optimax	2	0.00%
Zispin SolTab	86	0.09%

HSCB

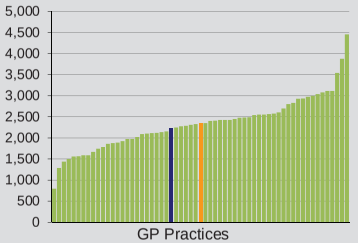


Drug name	Items	%
Citalopram	129369	25.02%
Fluoxetine	94531	18.28%
Sertraline	92071	17.81%
Duloxetine	21892	4.23%
Escitalopram	23441	4.53%
Flupentixol	389	0.08%
Fluvoxamine	210	0.04%
Mirtazapine	64596	12.49%
Paroxetine	11764	2.28%
Reboxetine	430	0.08%
Venlafaxine (incl. XL)	10841	2.10%
Cipramil	282	0.05%
Efexor /XL /other brands	58338	11.28%
Faverin	30	0.01%
Lustral	436	0.08%
Prozac	325	0.06%
Seroxat	388	0.08%
Cipralex	2331	0.45%
Cymbalta	4592	0.89%
Edronax	137	0.03%
Fluanxol	371	0.07%
Optimax	12	0.00%
Zispin SolTab	258	0.05%

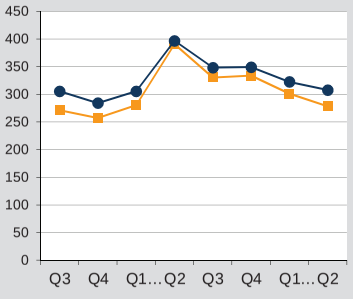
SSRIs and related antidepressants Cost /1000 NIPUs



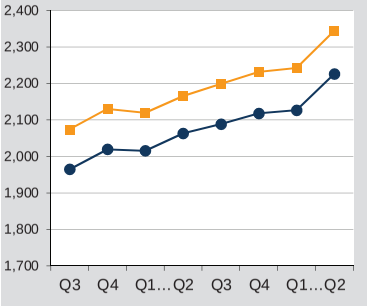
SSRIs and related antidepressants DDDs /1000 NIPUs



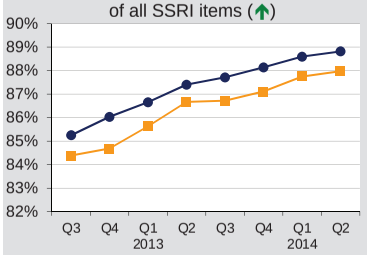
SSRIs and related antidepressants Cost /1000 NIPUs



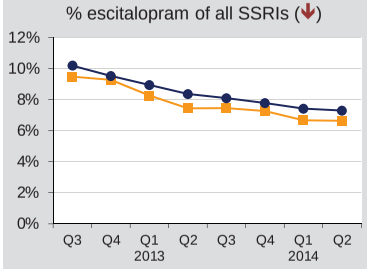
SSRIs and related antidepressants DDDs /1000 NIPUs

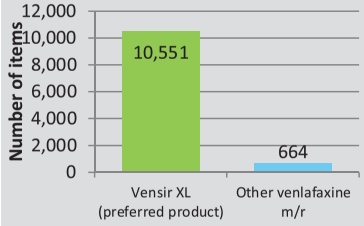


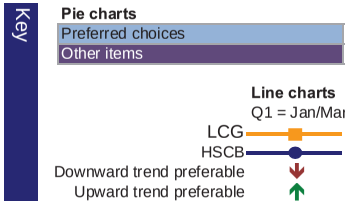
% generic citalopram, fluoxetine and sertraline of all SSRI items (↑)

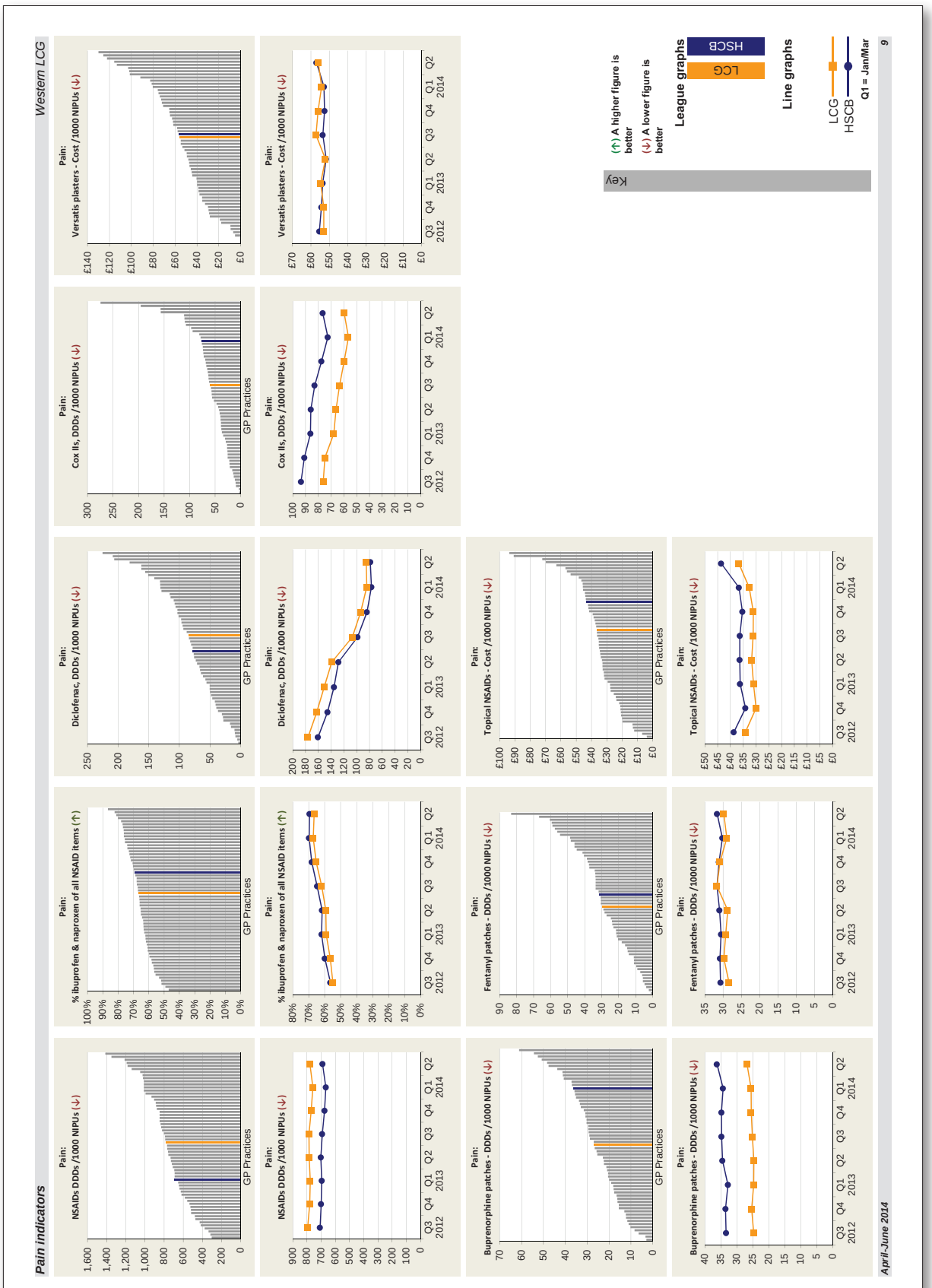


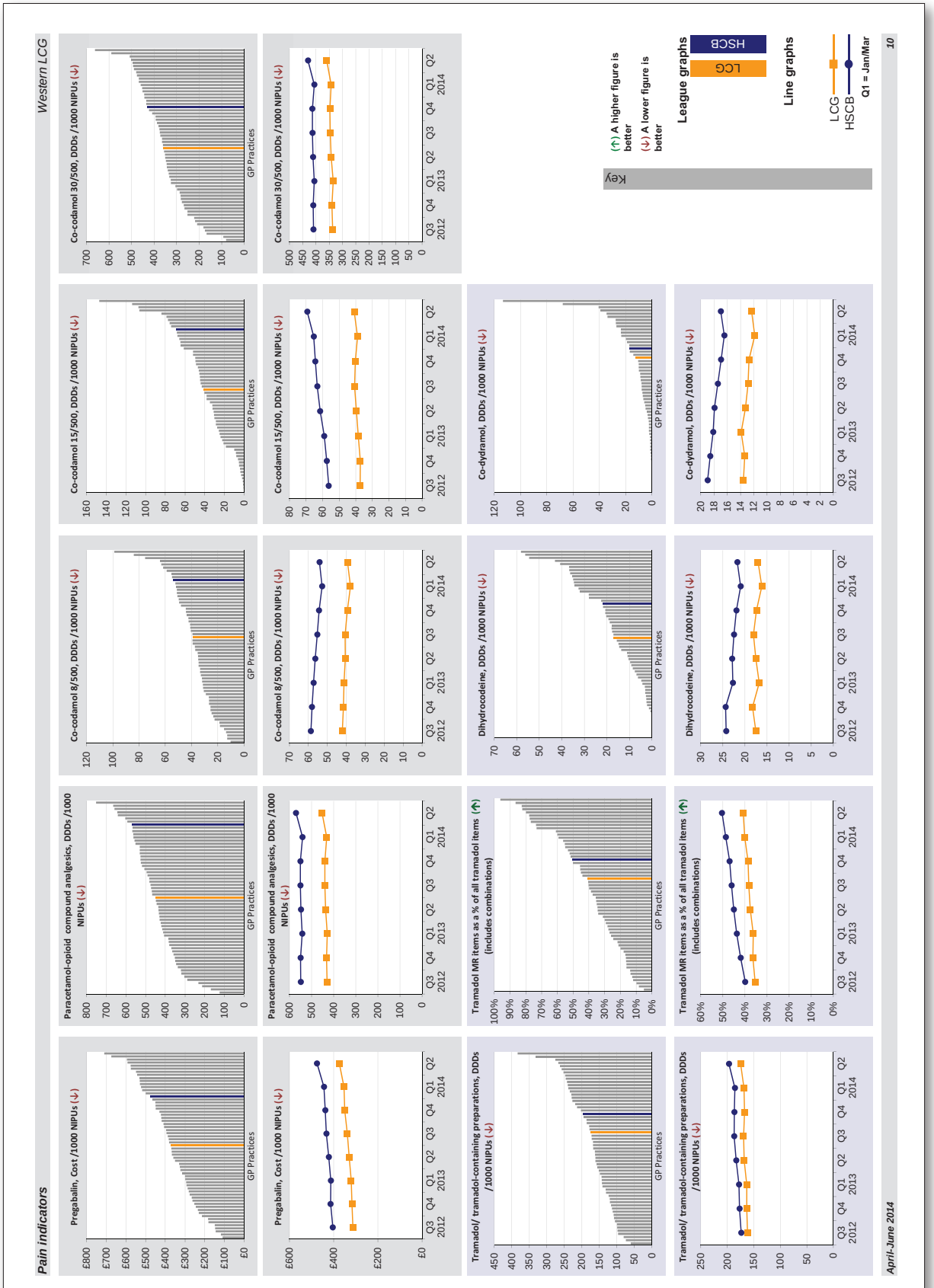
% escitalopram of all SSRIs (↓)








Pain indicators
Western LCG
Pain:
NSAIDs DDDs /1000 NIPUs (↓)
Pain:
% ibuprofen & naproxen of all NSAID items (↑)
Pain:
Diclofenac, DDDs /1000 NIPUs (↓)
Pain:
Cox IIs, DDDs /1000 NIPUs (↓)
Pain:
Versatis plasters - Cost /1000 NIPUs (↓)
Pain:
Buprenorphine patches - DDDs /1000 NIPUs (↓)
Pain:
Fentanyl patches - DDDs /1000 NIPUs (↓)
Pain:
Topical NSAIDs - Cost /1000 NIPUs (↓)
GP Practices
Q3 2012
Q4
Q1 2013
Q2
Q3
Q4
Q1 2014
Q2
Key
(↑) A higher figure is better
(↓) A lower figure is better
League graphs
LCG
HSCB
Line graphs
LCG
HSCB
Q1 = Jan/Mar
April-June 2014
9


Western LCG
Pain indicators
Co-codamol 30/500, DDDs /1000 NIPUs (↓)
Co-codamol 15/500, DDDs /1000 NIPUs (↓)
Co-dydramol, DDDs /1000 NIPUs (↓)
Co-codamol 8/500, DDDs /1000 NIPUs (↓)
Dihydrocodeine, DDDs /1000 NIPUs (↓)
Paracetamol-opioid compound analgesics, DDDs /1000 NIPUs (↓)
Tramadol MR items as a % of all tramadol items (↑) (includes combinations)
Pregabalin, Cost /1000 NIPUs (↓)
Tramadol/ tramadol-containing preparations, DDDs /1000 NIPUs (↓)
GP Practices
Q3 2012
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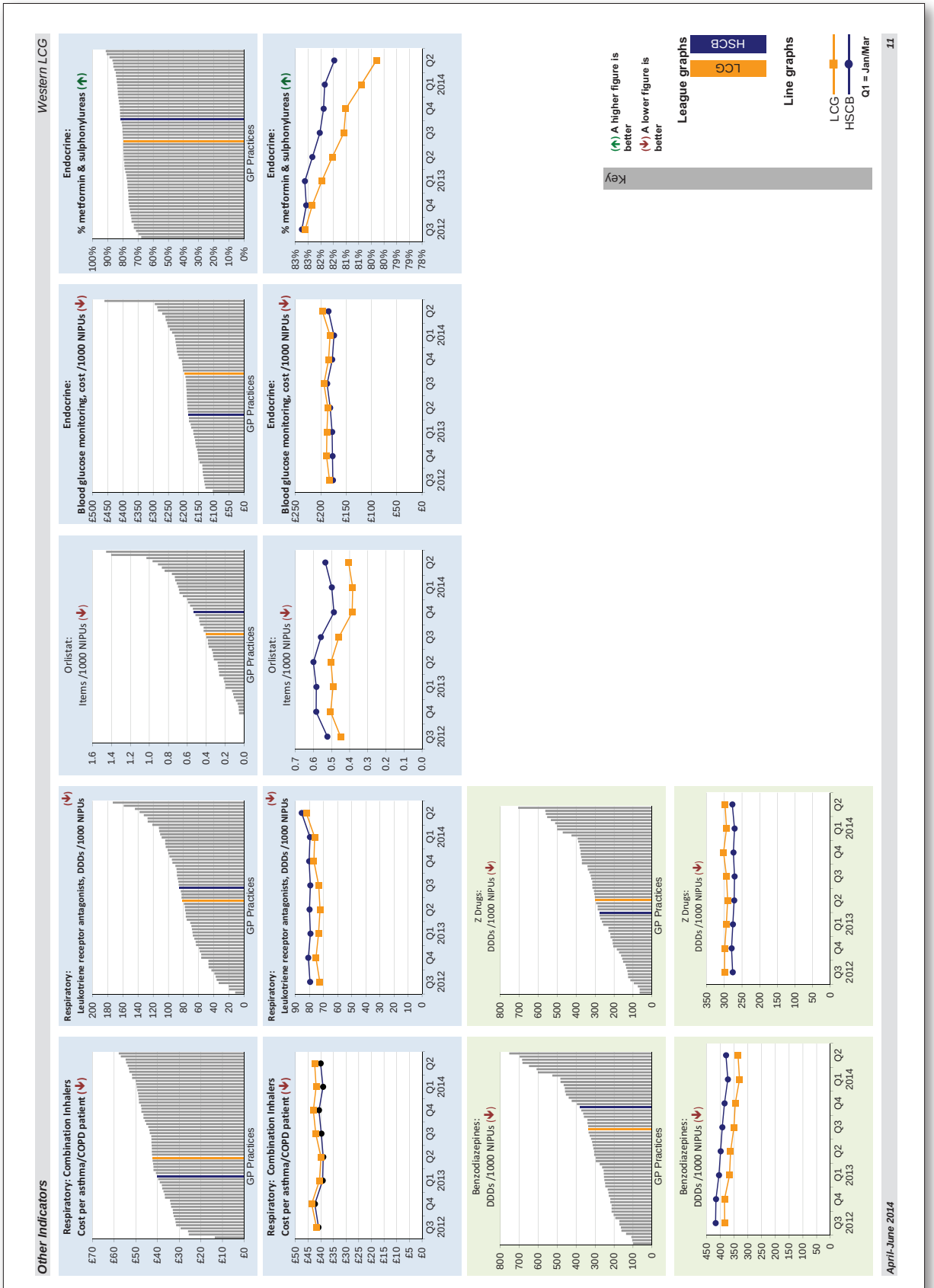
Western LCG
Other Indicators
Endocrine: % metformin & sulphonylureas (↑)
Endocrine: Blood glucose monitoring, cost /1000 NIPUs (↓)
Orlistat: Items /1000 NIPUs (↓)
Respiratory: Leukotriene receptor antagonists, DDDs /1000 NIPUs (↓)
Z Drugs: DDDs /1000 NIPUs (↓)
Respiratory: Combination Inhalers Cost per asthma/COPD patient (↓)
Benzodiazepines: DDDs /1000 NIPUs (↓)
GP Practices
Q3 2012
Q4
Q1 2013
Q2
Q3
Q4
Q1 2014
Q2
Key
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League graphs
LCG
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Q1 = Jan/Mar
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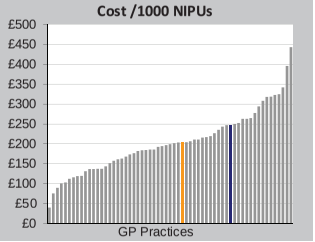
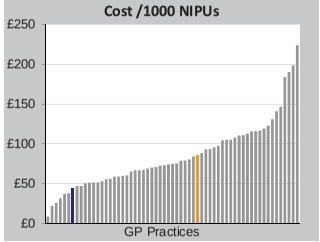
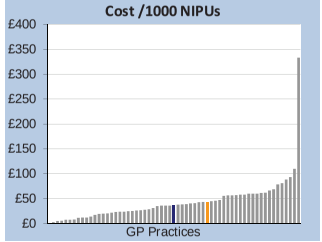
Nutrition: Oral nutritional supplements
Cost /1000 NIPUs



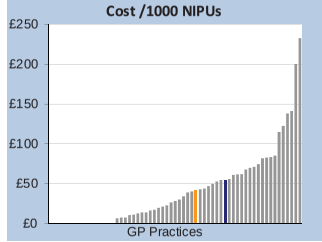
Nutrition: Gluten free products
Cost /1000 NIPUs



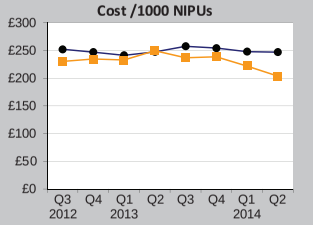
Infant feeding, Extensively hydrolysed
Cost /1000 NIPUs



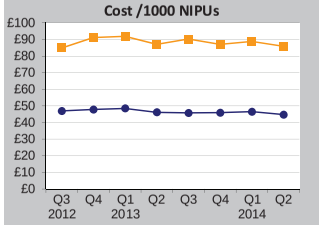
Infant feeding, Amino acid milks
Cost /1000 NIPUs



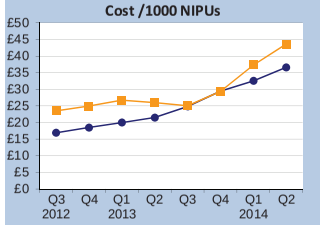
Nutrition: Oral nutritional supplements
Cost /1000 NIPUs



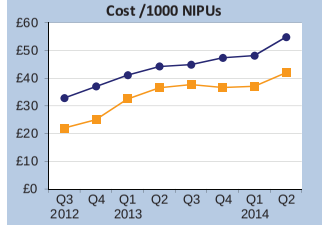
Nutrition: Gluten free products
Cost /1000 NIPUs



Infant feeding, Extensively hydrolysed
Cost /1000 NIPUs



Infant feeding, Amino acid milks
Cost /1000 NIPUs



Key

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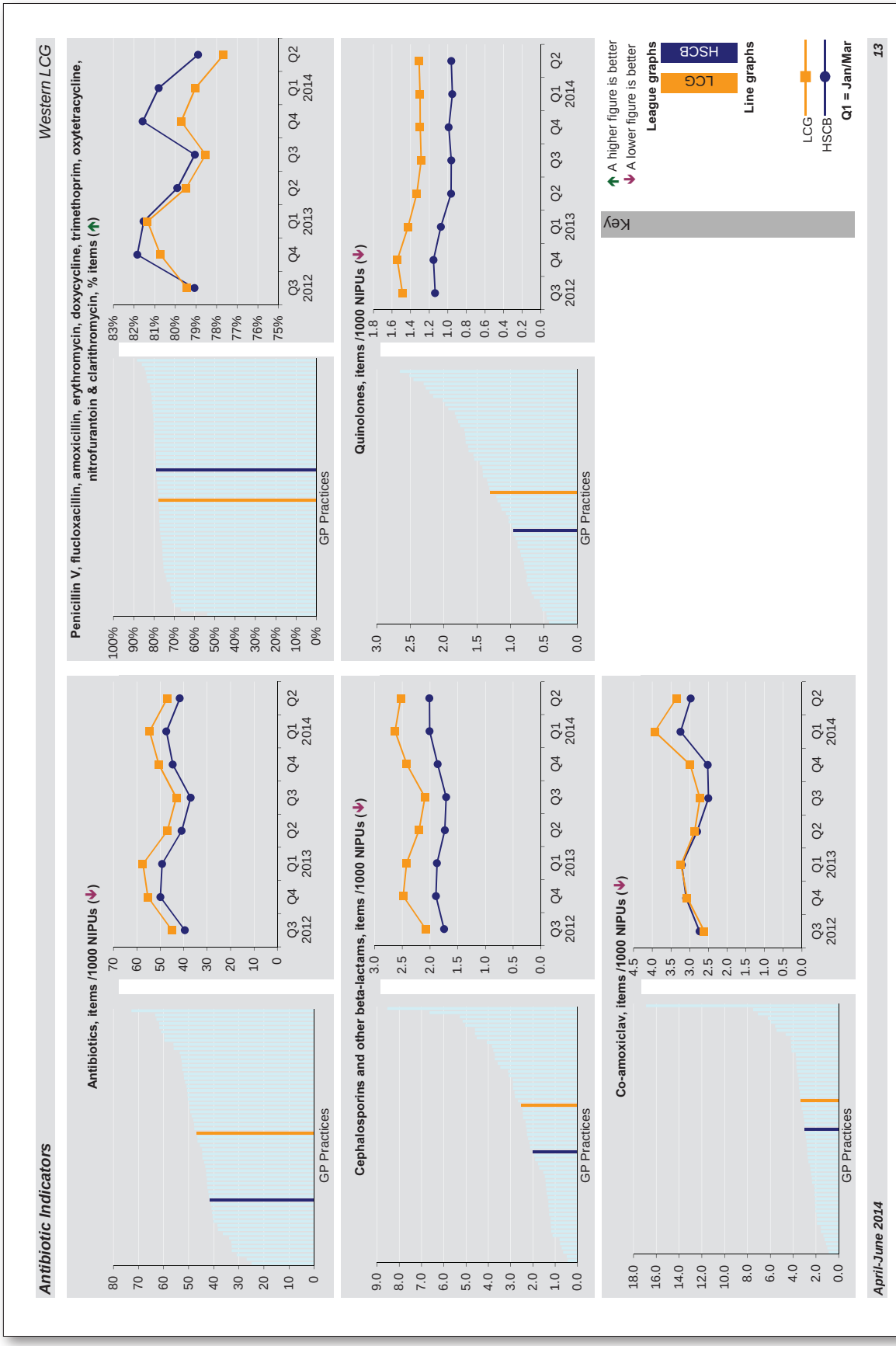
League graphs

LCG HSCB

Line graphs

LCG
HSCB

Q1 = Jan/Mar


Antibiotic Indicators
Western LCG
Penicillin V, flucloxacillin, amoxicillin, erythromycin, doxycycline, trimethoprim, oxytetracycline, nitrofurantoin & clarithromycin, % items (↑)
Quinolones, items /1000 NIPUs (↓)
Antibiotics, items /1000 NIPUs (↓)
Cephalosporins and other beta-lactams, items /1000 NIPUs (↓)
Co-amoxiclav, items /1000 NIPUs (↓)
GP Practices
Q3 2012
Q4
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HSCB
LCG
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Stock Prescribing

High Risk Drugs

Drug name/group	Items	Quantity
Warfarin 0.5mg	6	197
Warfarin 5mg	4	298
Methotrexate 10mg	7	236
Red List drugs	11	N/A

IV antibiotics: patient prescribing

Drug name	Items	Quantity
Augmentin Intravenous 1.2g powder for solution for injection vials	5	75
Augmentin Intravenous 600mg powder for solution for injection vials	1	15
Ceftriaxone 1g powder for solution for injection vials	15	81
Ceftriaxone 2g powder for solution for injection vials	11	64
Cidomycin Adult Injectable 80mg/2ml solution for injection ampoules	1	25
Cidomycin Adult Injectable 80mg/2ml solution for injection vials	2	15
Clarithromycin 500mg powder for solution for infusion vials	1	14
Crystapen 1.2g powder for solution for injection vials	1	28
Crystapen 600mg powder for solution for injection vials	1	1
Fortum 1g powder for solution for injection vials	2	14
Fortum 2g powder for solution for injection vials	1	42
Genticin Injectable 80mg/2ml solution for injection ampoules	2	40
Meronem 1g powder for solution for injection vials	3	53
Meronem 500mg powder for solution for injection vials	1	14
Rocephin 1g powder for solution for injection vials	3	17
Rocephin 2g powder for solution for injection vials	1	5
Targocid 200mg powder and solvent for solution for injection vials	1	12
Targocid 400mg powder and solvent for solution for injection vials	1	12
Tazocin 4.5g powder for solution for injection vials	2	63
Zinacef 750mg powder for injection vials	3	86
Totals	**58**	

Top 15 Stock Items by Cost (excluding dressings & appliances)

	Drug name	Cost (£)	Items	Quantity
1	Nexplanon 68mg implant	£12,793	16	161
2	Mirena 20micrograms/24hours intrauterine device	£4,752	9	54
3	EpiPen Jr. 150micrograms/0.3ml (1 in 2,000) solution for injection auto-injectors	£1,164	27	44
4	Depo-Medrone with Lidocaine suspension for injection 1ml vials	£1,098	16	282
5	Sodium chloride 0.9% irrigation solution 20ml Steripod unit dose	£994	27	3171
6	Depo-Medrone with Lidocaine suspension for injection 2ml vials	£985	11	140
7	Chlorphenamine 10mg/1ml solution for injection ampoules	£955	52	318
8	EpiPen 300micrograms/0.3ml (1 in 1,000) solution for injection auto-injectors	£952	23	36
9	Revaxis vaccine suspension for injection 0.5ml pre-filled syringes	£871	13	134
10	Depo-Medrone 80mg/2ml suspension for injection vials	£843	13	137
11	Pneumovax II vaccine solution for injection 0.5ml vials	£757	8	91
12	Depo-Medrone 40mg/1ml suspension for injection vials	£642	16	188
13	Zipzoc stockings	£619	18	198
14	Pulmicort 1mg Respules	£520	11	260
15	Flamazine 1% cream	£481	36	7108
	Total	**£28,425**	**296**	
	Total of all Stock (including dressings and appliances)	**£163,374**	**4,423**	

Top 15 CDs (schedules 2, 3, 4 and 5)

	Drug name	Cost (£)	Items	Quantity
1	Diamorphine 5mg powder for solution for injection ampoules	£157	11	69
2	Midazolam 10mg/2ml oromucosal solution pre-filled oral syringes	£137	3	6
3	Buccolam 10mg/2ml oromucosal solution pre-filled oral syringes	£92	1	4
4	Cyclimorph 10 solution for injection 1ml ampoules	£88	8	50
5	Buccolam 5mg/1ml oromucosal solution pre-filled oral syringes	£86	1	4
6	Diamorphine 10mg powder for solution for injection ampoules	£69	5	27
7	Diazepam 5mg/2.5ml rectal solution tube	£50	9	46
8	Co-codamol 8mg/500mg effervescent tablets	£35	5	500
9	Diazepam 10mg/2ml solution for injection ampoules	£34	8	75
10		£21	2	15
11	Stesolid 5mg rectal tube	£21	3	15
12	Diazemuls 10mg/2ml emulsion for injection ampoules	£18	2	20
13	Diazepam 10mg/2.5ml rectal solution tube	£14	2	10
14	Diazepam 5mg RecTubes	£13	1	10
15	Co-codamol 8mg/500mg tablets	£13	6	372
	Total	**£847**	**67**	

Appendix: COMPASS Explanatory Notes

Glossary			
ICPs	Integrated Care Partnerships	NIPUs	Northern Ireland Prescribing Units
LCG	Local Commissioning Group		
HSCB	Health and Social Care Board		

Quarter: Information in the COMPASS report is based on three months of prescribing data, i.e. one quarter.

ICP average: Figures refer to the average of all practices within the respective ICP.

LCG average: Figures refer to the average of all practices within the respective LCG.

HSCB average: Figures refer to the average of all practices within the HSCB, i.e. all practices in NI.

Cost (£): Net ingredient cost, equivalent to England's Net Ingredient Cost (NIC). Cost is useful in terms of monitoring the overall drugs bill, checking spend within prescribing budgets and calculating savings made or potential savings. Cost is less useful as a measure of drug consumption because of the differences in cost of alternative preparations and changes in prices.

Items: Number of prescription items. Count of items is a reasonable measure of the number of courses of treatments for vaccinations and acute treatments such as short courses of antibiotics. For other treatments it is less useful because of the wide variation in duration of supply per item.

NIPUs: In measuring prescribing, differences between practices need to be taken account of in order to make valid comparisons with local and national averages. NIPUs standardise for differences between practices in terms of patient list size, age/sex structure and additional needs.

Quantity: Number of physical units, i.e. tablets, capsules, patches, mLs, inhalers, vials etc. Quantity is a useful measure of prescribing when looking at individual preparations, e.g. methotrexate 10mg or warfarin 0.5mg and 5mg.

Change from Last Year: The actual change from the same quarter in the previous year.

Defined Daily Dose (DDD): The DDD is a unit of measurement based on the assumed average maintenance dose per day used for its main indication in adults. The World Health Organisation (WHO) developed the DDD as a method to compare drugs of different chemical structures and potencies. The DDD methodology standardises quantities prescribed into number of daily doses. See worked example below. The number of DDDs is calculated as follows:

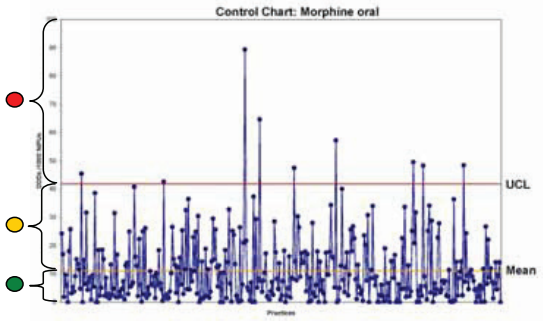
$$\text{Number of DDDs} = \frac{\text{Strength (mg) x quantity}}{\text{DDD (mg)}}$$

Worked example	Quantity (no. of tabs /caps)	DDD (mg)	No. of DDDs
Ibuprofen 200mg 2 caps 3 times a day	168	1200	$\frac{200 \times 168}{1200} = 28$
Ranitidine 150mg 1 tablet twice a day	56	300	$\frac{150 \times 56}{300} = 28$
Lansoprazole 30mg 1 capsule once a day	28	30	$\frac{30 \times 28}{30} = 28$

Prescribing Indicators listed throughout the report give some indication of prescribing quality but are not quantitative measures of good prescribing. Arrows indicate whether a larger figure or a smaller figure suggests 'better' prescribing. Values are given for the practice, locality average, LCG average and HSCB average. They are, therefore, useful in identifying outliers i.e. practice's whose prescribing differs substantially from other practices and to highlight areas for further analysis.

Red List Drugs: The Red list is an advisory list where it is considered by the Regional Group on Specialist Medicines, that responsibility for prescribing should remain with the consultant or specialist clinician. It is recommended that the supply of these specialist medicines should be organised via the hospital pharmacy.

Controlled Drugs (CDs): On the patient and stock prescribing pages there are red, orange and green dots. Each dot represents where a practice is on a control chart in relation to the Upper Control Limit (UCL) and the mean for all practices in NI (see chart below). The UCL is the mean + 3 standard deviations. A green dot represents a practice at the mean or below. An orange dot represents a practice above the mean but below the UCL. A red dot represents a practice above the UCL.




COMPASS Report
April-June 2014
BLCG Practice Report
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Quarter this year
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Practice
ICP
LCG
HSCB
Cost (£) /1000 NIPUs†
% change from last year
Items /1000 NIPUs†
Cost (£) /Item
Generic dispensing rate (%)
†See explanatory notes at end of report for more information.
Web site: http://www.hscbusiness.hscni.net/services.htm
Tel: 028 9053 5661

Top 20 : Twenty most costly drugs in your practice

	Drug Name	Drug's position in HSCB's most costly drugs*	Cost (£)	No of Items	Quantity	Cost (£) /Item	% of Practice Total Cost	Change from last year
1	Temazepam 10mg tablets 10MG [TABLET]	5	2,281	158	3,107	14.43	2.64	-0.83
2	Symbicort 200/6 Turbohaler 200/6 [TURBOHALER]	6	1,938	33	51	58.73	2.24	-0.53
3	Pregabalin 150mg capsules 150MG [CAPSULE]	4	1,573	19	1,368	82.80	1.82	0.53
4	Seretide 250 Evohaler 250MCG/25 [EVOHALER]	2	1,428	16	24	89.22	1.65	0.04
5	Fortisip Bottle assorted 200ML [BOTTLE]	42	1,341	23	651	58.31	1.55	0.28
6	PaediaSure fibre liquid banana 200ML [BOTTLE]	1912	1,243	3	478	414.27	1.44	1.44
7	NovoMix 30 FlexPen 100units/ml suspension for injection 3ml pre-filled pen 3ML [INJ	20	1,225	15	205	81.70	1.42	0.15
8	Pro-Cal shot gluten free neutral 250ML [LIQUID]	72	1,223	13	250	94.04	1.41	0.52
9	Aviva testing strips [REAGENT]	12	1,200	26	3,850	46.17	1.39	-0.81
10	Tiotropium bromide 18microgram inhalation powder capsules 18MICROGRAM [INHA	1	1,139	30	1,020	37.97	1.32	0.10
11	Risperdal Consta 50mg powder and solvent for suspension for injection vials 50MG [I	95	857	1	6	856.56	0.99	-0.02
12	Symbicort 400/12 Turbohaler 400/12 [TURBOHALER]	30	836	10	22	83.60	0.97	-0.11
13	Hydrocortisone 10mg tablets 10MG [TABLET]	28	759	2	372	379.55	0.88	0.22
14	Cialis 10mg tablets 10MG [TABLET]	695	756	4	112	188.93	0.87	0.14
15	Lantus 100units/ml solution for injection 3ml pre-filled SoloStar pen 3ML [PRE-FILLE	8	747	11	90	67.91	0.86	0.03
16	Pregabalin 75mg capsules 75MG [CAPSULE]	3	731	10	636	73.14	0.85	0.71
17	Victoza 6mg/ml solution for injection 3ml pre-filled pen 3ML [PRE-FILLED INJECTIO	13	706	7	18	100.90	0.82	0.31
18	Simvastatin 40mg/5ml oral suspension sugar free 40MG/5ML [ORAL SUSPENSION]	419	681	4	600	170.24	0.79	0.04
19	Pregabalin 50mg capsules 50MG [CAPSULE]	14	676	7	588	96.60	0.78	0.44
20	Spiriva 18microgram inhalation powder capsules 18MCG [CAPSULE]	34	670	19	600	35.26	0.78	-0.29
	TOTAL		**22,010**	**411**			**25.46**	

▼ Black Triangle Drug

The range of generic drugs listed in Part I of the NI drug tariff increased in April 2011. This change means the list above may include generic drugs that, although prescribed generically, will have been dispensed by brand as no generics are currently available. If you have any queries regarding this please contact your Medicines Management Adviser (MMA).

*This is the drug's position in the HSCB's most costly drugs. For example, your practice's 20th most costly drug is Spiriva 18microgram inhalation powder capsules 18MCG [CAPSULE]. This drug is number 34 in the HSCB's most costly drugs.

Priority generic switches

During this quarter if there were problems with the supply of high volume generics then shortages will have occurred and this may affect prescribing data presented in this page.

	Proprietary Drug	*Number of Items*	*Cost (£)*	*Generic equivalent*	*Potential Savings for the quarter (£)*
1	SINGULAIR 10MG [TABLET]	9	217	MONTELUKAST 10MG [TABLET]	£196
2	ZOMIG 2.5MG [TABLET]	3	144	ZOLMITRIPTAN 2.5MG [TABLET]	£135
3	NEXIUM 20MG [TABLET]	1	111	ESOMEPRAZOLE 20MG [GASTRO-RESISTANT TABLET]	£82
4	LOSEC 20MG [CAPSULE]	6	84	OMEPRAZOLE 20MG [GASTRO-RESISTANT CAPSULE]	£76
5	ACTONEL ONCE A WEEK 35MG [TABLET]	4	76	RISEDRONATE 35MG [TABLET]	£72
6	ZISPIN SOLTAB 30MG [TABLET]	5	70	MIRTAZAPINE ORO-DISP 30MG [ORODISPERSIBLE TABLET]	£63
7	NEOCLARITYN 5MG [TABLET]	9	73	DESLORATADINE 5MG [TABLET]	£54
8	APROVEL 150MG [TABLET]	5	59	IRBESARTAN 150MG [TABLET]	£51
	Total	**42**	**834**		**£729**

NB Only individual switches that have the potential to release efficiencies ≥ £200 per annum are now included above.
If you would like data below this threshold please contact your Medicines Management Adviser (MMA).

Potential savings per annum **£2,917**

Top Cost Effective Choices

These should be considered for all new starts and at review in line with relevant guidance and SPC

		Drug name	Number of Items	Spend	Cost effective choice	Potential Savings for the quarter
1	††	SOLIFENACIN (DT) 10MG [TABLET]	4	£211	TOLTERODINE (DT) 2MG [TABLET]	£194
2	††	VESICARE FILM COATED 10MG [TABLET]	2	£144	TOLTERODINE (DT) 2MG [TABLET]	£132
3		OMEPRAZOLE (DT) 40MG [GASTRO-RESISTANT CAPSULE]	36	£250	OMEPRAZOLE (DT) 20MG [GASTRO-RESISTANT CAPSULE]	£122
4	††	SOLIFENACIN (DT) 5MG [TABLET]	3	£131	TOLTERODINE (DT) 2MG [TABLET]	£117
5		CO-CODAMOL (DT) 8MG/500MG [EFFERVESCENT TABLET]	35	£196	CO-CODAMOL (DT) 8MG/500MG [TABLET]	£102
6	§	DOXAZOSIN (DT) 8MG [MODIFIED-RELEASE TABLET]	7	£112	DOXAZOSIN (DT) 4MG [TABLET]	£100
7	††	REGURIN XL 60MG [CAPSULE]	2	£92	TOLTERODINE (DT) 2MG [TABLET]	£81
8	*	OMEPRAZOLE DISPERSIBLE (DT) 20MG [GASTRO-RESISTANT TABLET]	4	£93	LANSOPRAZOLE (DT) 15MG [ORODISPERSIBLE TABLET]	£68
9		CO-CODAMOL (DT) 30MG/500MG [EFFERVESCENT TABLET]	14	£142	CO-CODAMOL (DT) 30MG/500MG [TABLET]	£66
10		NEOCLARITYN 5MG [TABLET]	9	£73	LORATADINE (DT) 10MG [TABLET]	£62
11	§	DOXAZOSIN (DT) 4MG [MODIFIED-RELEASE TABLET]	7	£65	DOXAZOSIN (DT) 2MG [TABLET]	£54
		Total	**123**	**£1,509**		**£1,099**

NB Only individual switches that have the potential to release efficiencies ≥ £200 per annum are included above, up to a maximum of 20 switches.

Potential savings per annum **£4,395**

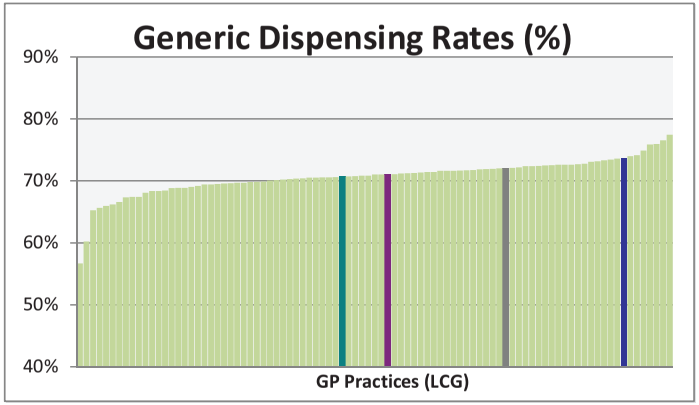
Prior to initiating/switching to the cost-effective choice please refer to the additional information provided on the HSCB website:

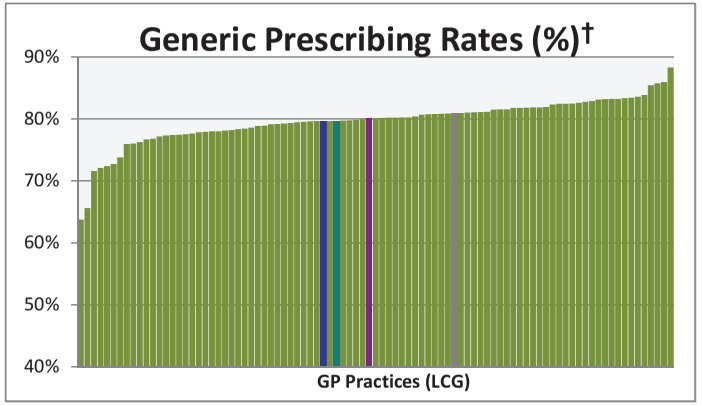
* Lansoprazole orodispersible tablets should be considered for all appropriate patients who require a dispersible PPI. For guidance on the treatment of children please refer to the BNF for Children.

§ http://primarycare.hscni.net/pdf/Doxazosin_Switch_Guidance_April_2012.pdf

†† These should only be initiated after a trial of oral oxybutynin or tolterodine has been ineffective

Overall Generic Rates





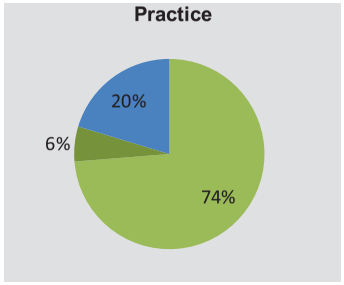
The range of generic drugs listed within Part I of the NI drug tariff increased in April 2011. This change may have increased your generic dispensing rate.

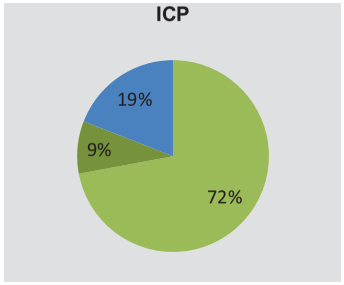
Your Practice | ICP Average | LCG Average | HSCB Average

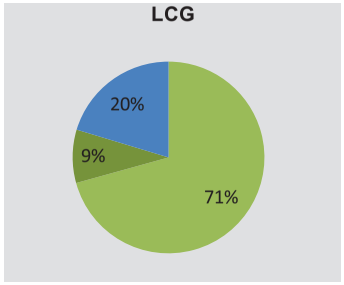
Prescribed and dispensed generically
Prescribed generically and dispensed by brand as no generic is currently available
Presribed and dispensed by brand

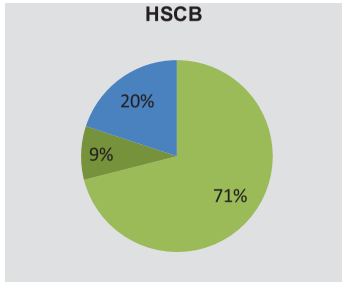
†The generic **prescribing** rates chart is new. This chart reports GP prescribing of generics. This will include drugs that, although prescribed generically, will have been dispensed by brand as no generic is currently available.

NB 100% generic prescribing rate is not achievable or desired as there are a number of items unsuitable for generic prescribing. See link below:
http://www.hscboard.hscni.net/medicinesmanagement/Prescribing%20Guidance/index.html







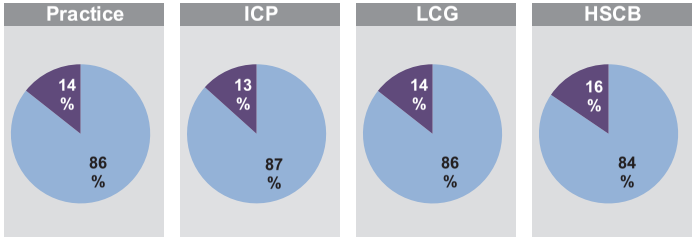


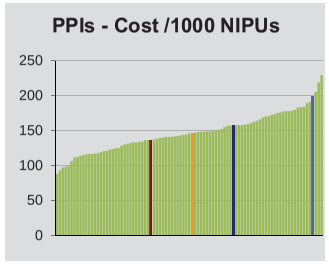
Proton Pump Inhibitors (PPIs)

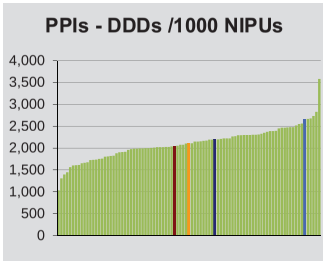
Preferred choices

Other items

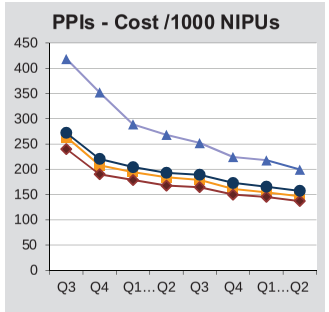
† If patients do not have swallowing difficulties, they could be switched to omeprazole or lansoprazole capsules.

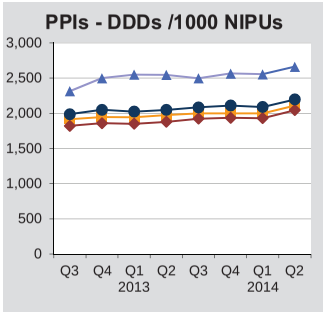


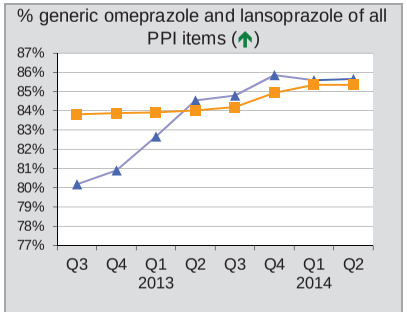


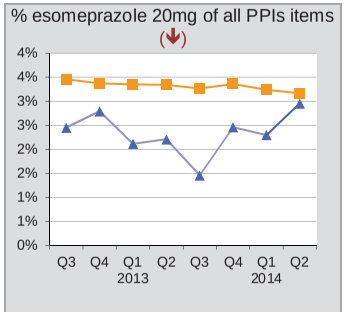


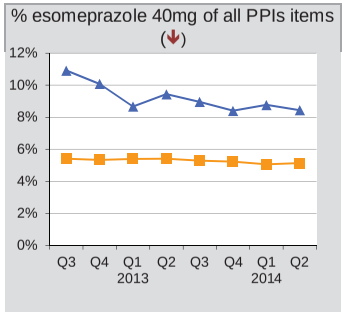
Drug name	Items	%	Items	%	Items	%	Items	%
Lansoprazole	91	19.20%	10813	30.41%	36084	31.14%	158553	31.26%
Omeprazole	315	66.46%	20006	56.26%	63116	54.47%	269884	53.21%
Pantoprazole	3	0.63%	1828	5.14%	5641	4.87%	30291	5.97%
Losec	6	1.27%	87	0.24%	264	0.23%	1611	0.32%
Protium	0	0.00%	0	0.00%	0	0.00%	0	0.00%
Esomeprazole (tablets)	53	11.18%	2419	6.80%	8931	7.71%	37843	7.46%
Lansoprazole orodispersible†	0	0.00%	0	0.00%	0	0.00%	0	0.00%
Omeprazole dispersible†	0	0.00%	0	0.00%	0	0.00%	0	0.00%
Rabeprazole	0	0.00%	129	0.36%	488	0.42%	2414	0.48%
Emozul (capsules)	0	0.00%	0	0.00%	29	0.03%	95	0.02%
Nexium (tablets)	1	0.21%	116	0.33%	523	0.45%	2883	0.57%
Pariet	0	0.00%	15	0.04%	43	0.04%	281	0.06%
Losec MUPS†	0	0.00%	86	0.24%	428	0.37%	1884	0.37%
Zoton FasTab†	5	1.05%	60	0.17%	330	0.28%	1459	0.29%











Key

Line charts

Q1 = Jan/Mar

Practice

ICP

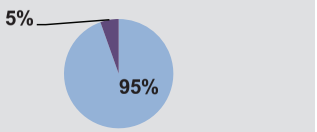
LCG

HSCB

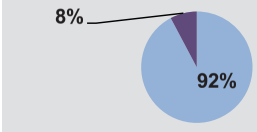
Upward trend preferable ↑

Downward trend preferable ↓

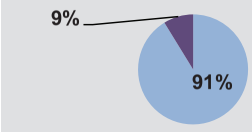
Lipid lowering drugs



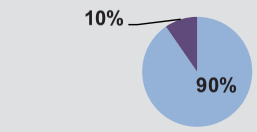
Drug name	Items	%
Simvastatin 10mg	8	1.69%
Simvastatin 20mg	47	9.92%
Simvastatin 40mg	203	42.83%
Simvastatin 80mg	0	0.00%
Simvastatin 20mg/5ml	0	0.00%
Simvastatin 40mg/5ml	4	0.84%
Atorvastatin 10mg	42	8.86%
Atorvastatin 20mg	80	16.88%
Atorvastatin 40mg	41	8.65%
Atorvastatin 80mg	2	0.42%
Pravastatin	21	4.43%
Fluvastatin	0	0.00%
Rosuvastatin	26	5.49%
Simvastatin + Ezetimibe	0	0.00%
Lescol /other brands	0	0.00%
Lipostat	0	0.00%
Zocor	0	0.00%
Crestor	0	0.00%
Inegy	0	0.00%
Lipitor 10mg	0	0.00%
Lipitor 20mg	0	0.00%
Lipitor 40mg	0	0.00%
Lipitor 80mg	0	0.00%



Drug name	Items	%
Simvastatin 10mg	654	2.05%
Simvastatin 20mg	4173	13.11%
Simvastatin 40mg	10655	33.47%
Simvastatin 80mg	18	0.06%
Simvastatin 20mg/5ml	17	0.05%
Simvastatin 40mg/5ml	21	0.07%
Atorvastatin 10mg	2728	8.57%
Atorvastatin 20mg	3795	11.92%
Atorvastatin 40mg	5479	17.21%
Atorvastatin 80mg	578	1.82%
Pravastatin	1235	3.88%
Fluvastatin	60	0.19%
Rosuvastatin	2208	6.94%
Simvastatin + Ezetimibe	21	0.07%
Lescol /other brands	11	0.03%
Lipostat	6	0.02%
Zocor	7	0.02%
Crestor	101	0.32%
Inegy	18	0.06%
Lipitor 10mg	19	0.06%
Lipitor 20mg	11	0.03%
Lipitor 40mg	13	0.04%
Lipitor 80mg	5	0.02%

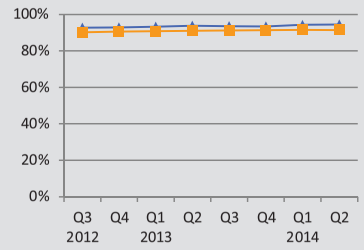


Drug name	Items	%
Simvastatin 10mg	2144	2.11%
Simvastatin 20mg	12503	12.30%
Simvastatin 40mg	33785	33.23%
Simvastatin 80mg	50	0.05%
Simvastatin 20mg/5ml	28	0.03%
Simvastatin 40mg/5ml	53	0.05%
Atorvastatin 10mg	8943	8.80%
Atorvastatin 20mg	12793	12.58%
Atorvastatin 40mg	16661	16.39%
Atorvastatin 80mg	1388	1.37%
Pravastatin	4442	4.37%
Fluvastatin	277	0.27%
Rosuvastatin	7587	7.46%
Simvastatin + Ezetimibe	95	0.09%
Lescol /other brands	16	0.02%
Lipostat	15	0.01%
Zocor	29	0.03%
Crestor	648	0.64%
Inegy	52	0.05%
Lipitor 10mg	52	0.05%
Lipitor 20mg	66	0.06%
Lipitor 40mg	44	0.04%
Lipitor 80mg	5	0.00%

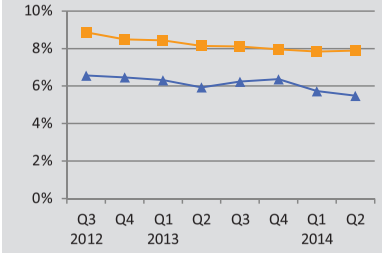


Drug name	Items	%
Simvastatin 10mg	9184	2.00%
Simvastatin 20mg	48808	10.62%
Simvastatin 40mg	153242	33.35%
Simvastatin 80mg	415	0.09%
Simvastatin 20mg/5ml	141	0.03%
Simvastatin 40mg/5ml	269	0.06%
Atorvastatin 10mg	37453	8.15%
Atorvastatin 20mg	53985	11.75%
Atorvastatin 40mg	80607	17.54%
Atorvastatin 80mg	6831	1.49%
Pravastatin	24277	5.28%
Fluvastatin	1101	0.24%
Rosuvastatin	37184	8.09%
Simvastatin + Ezetimibe	427	0.09%
Lescol /other brands	73	0.02%
Lipostat	114	0.02%
Zocor	102	0.02%
Crestor	3913	0.85%
Inegy	216	0.05%
Lipitor 10mg	418	0.09%
Lipitor 20mg	364	0.08%
Lipitor 40mg	291	0.06%
Lipitor 80mg	30	0.01%

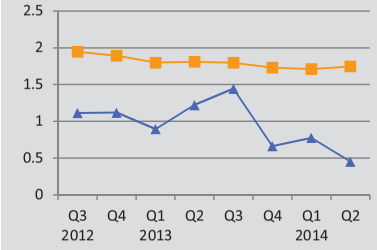
% simvastatin, atorvastatin and pravastatin of all statin items (↑)



% rosuvastatin of all statin items (↓)



Ezetimibe, Items /1000 NIPUs (↓)
(includes Ezetrol and Inegy)



Key

Pie charts

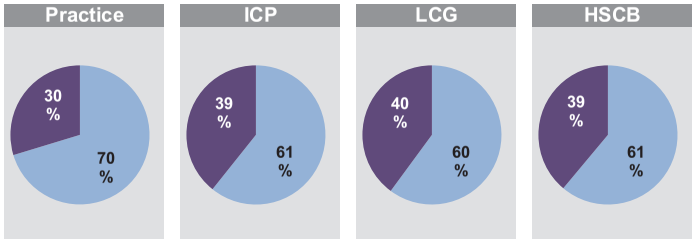
- Preferred choices
- Other items

Line charts

Q1 = Jan/Mar

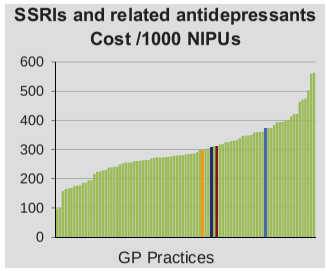
- Practice
- LCG
- Upward trend preferable ↑
- Downward trend preferable ↓

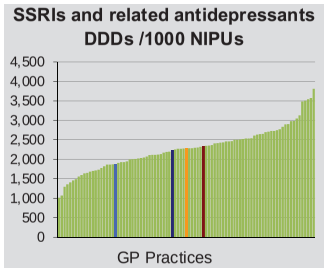
SSRIs and related antidepressant drugs

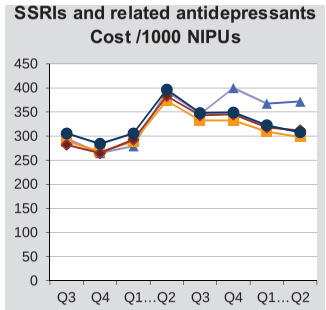


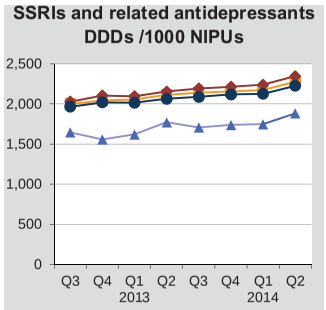
Preferred choices
Other items

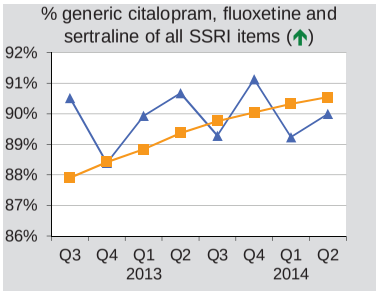
Drug name	Practice Items	Practice %	ICP Items	ICP %	LCG Items	LCG %	HSCB Items	HSCB %
Citalopram	197	43.97%	9563	23.99%	32292	25.18%	129369	25.02%
Fluoxetine	40	8.93%	7548	18.93%	23958	18.68%	94531	18.28%
Sertraline	78	17.41%	7099	17.81%	20807	16.23%	92071	17.81%
Duloxetine	17	3.79%	1394	3.50%	5098	3.98%	21892	4.23%
Escitalopram	10	2.23%	1307	3.28%	4717	3.68%	23441	4.53%
Flupentixol	0	0.00%	18	0.05%	22	0.02%	389	0.08%
Fluvoxamine	0	0.00%	21	0.05%	51	0.04%	210	0.04%
Mirtazapine	27	6.03%	5653	14.18%	18805	14.67%	64596	12.49%
Paroxetine	18	4.02%	996	2.50%	2596	2.02%	11764	2.28%
Reboxetine	3	0.67%	27	0.07%	79	0.06%	430	0.08%
Venlafaxine (incl. XL)	26	5.80%	1157	2.90%	2956	2.31%	10841	2.10%
Cipramil	7	1.56%	19	0.05%	80	0.06%	282	0.05%
Efexor /XL /other brands	6	1.34%	4145	10.40%	14500	11.31%	58338	11.28%
Faverin	0	0.00%	0	0.00%	3	0.00%	30	0.01%
Lustral	0	0.00%	25	0.06%	78	0.06%	436	0.08%
Prozac	0	0.00%	13	0.03%	79	0.06%	325	0.06%
Seroxat	0	0.00%	27	0.07%	118	0.09%	388	0.08%
Cipralex	0	0.00%	64	0.16%	396	0.31%	2331	0.45%
Cymbalta	11	2.46%	746	1.87%	1417	1.11%	4592	0.89%
Edronax	0	0.00%	5	0.01%	35	0.03%	137	0.03%
Fluanxol	0	0.00%	15	0.04%	62	0.05%	371	0.07%
Optimax	0	0.00%	0	0.00%	0	0.00%	12	0.00%
Zispin SolTab	8	1.79%	27	0.07%	76	0.06%	258	0.05%

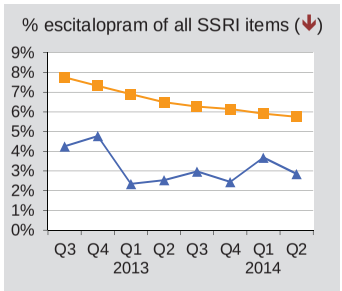


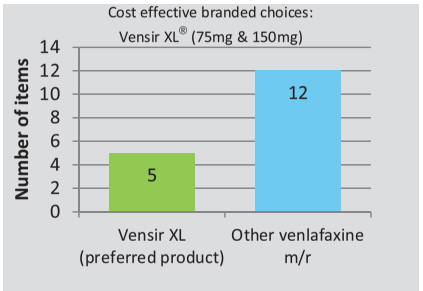






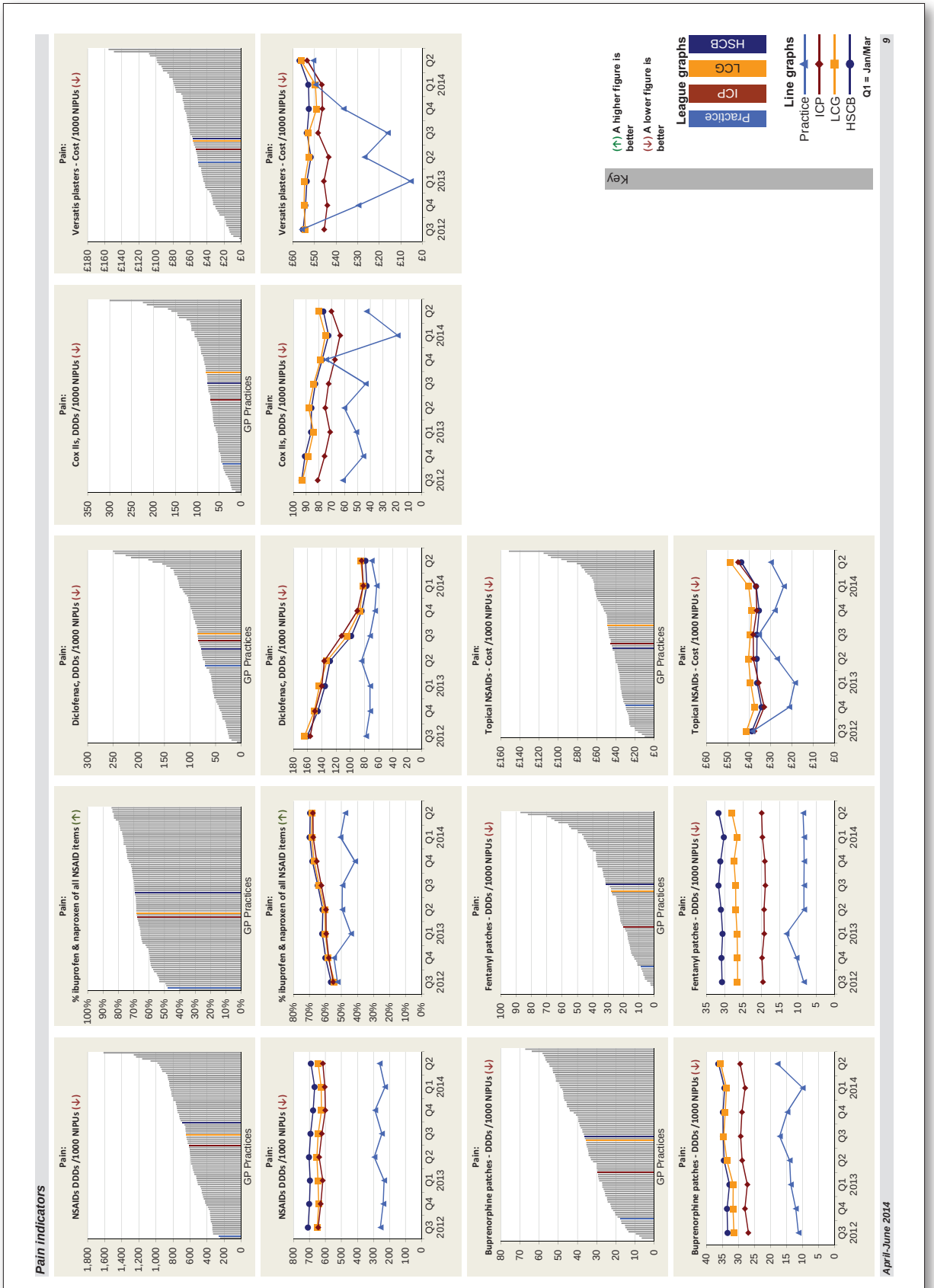


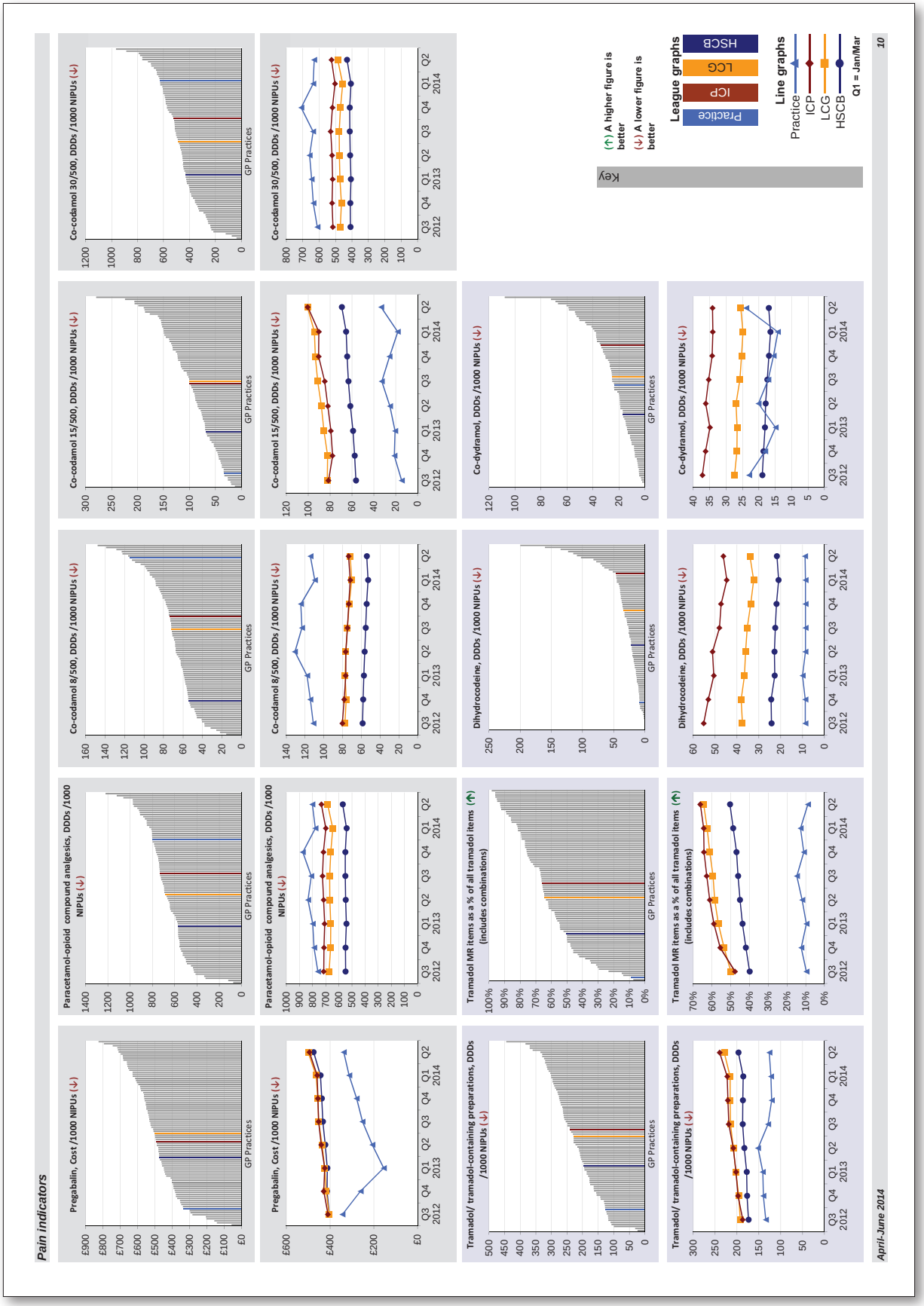


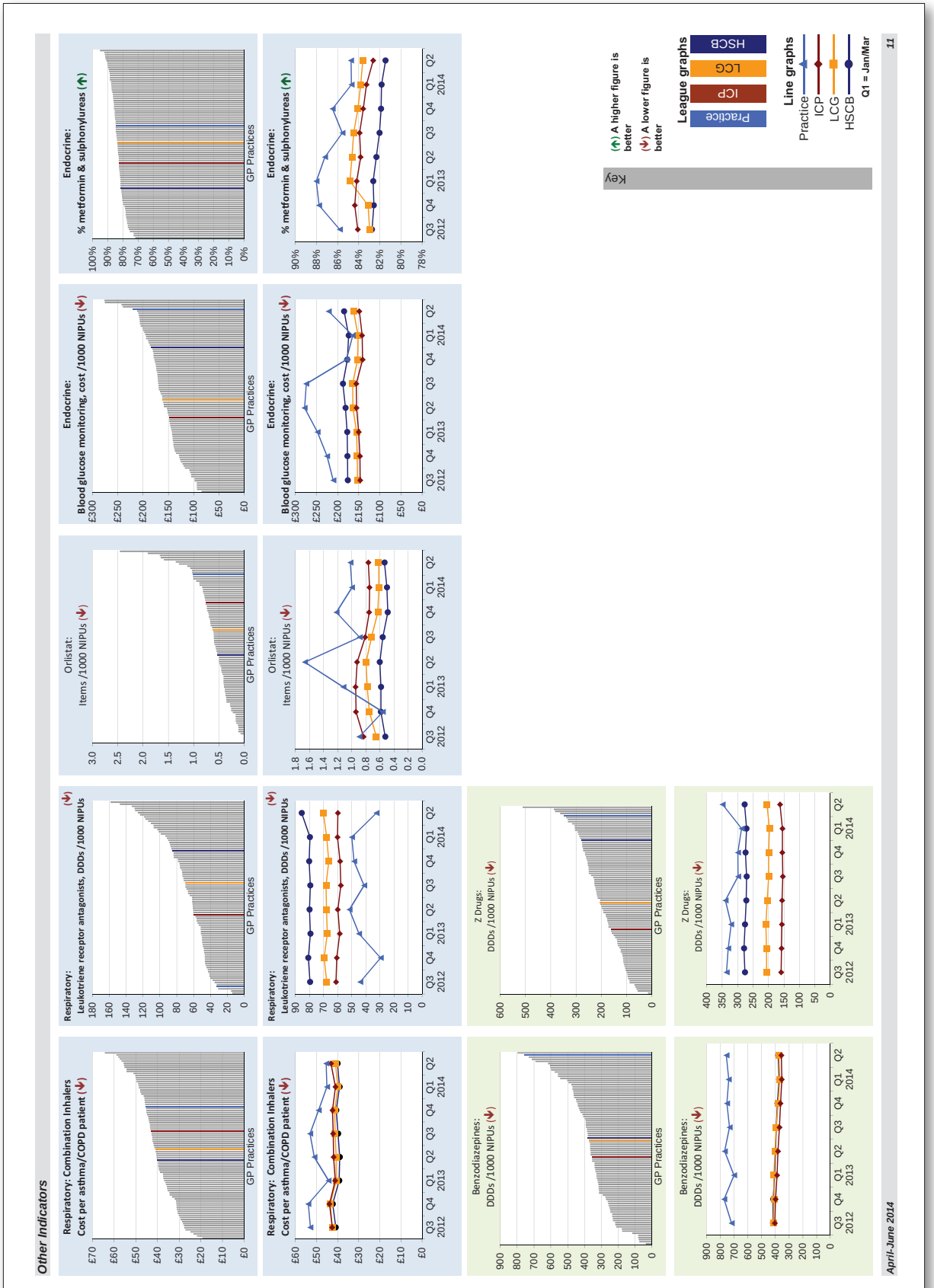


Key

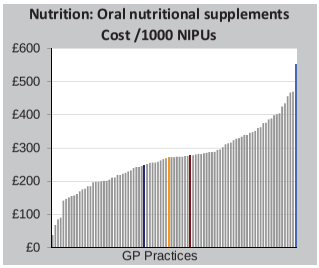
Line charts
Q1 = Jan/Mar
Practice
ICP
LCG
HSCB
Upward trend preferable ↑
Downward trend preferable ↓

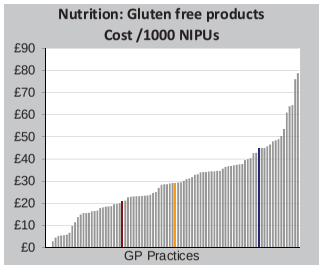

Pain indicators
Pain: NSAIDs DDDs /1000 NIPUs (↓)
Pain: % ibuprofen & naproxen of all NSAID items (↑)
Pain: Diclofenac, DDDs /1000 NIPUs (↓)
Pain: Cox IIs, DDDs /1000 NIPUs (↓)
Pain: Versatis plasters - Cost /1000 NIPUs (↓)
Pain: Buprenorphine patches - DDDs /1000 NIPUs (↓)
Pain: Fentanyl patches - DDDs /1000 NIPUs (↓)
Pain: Topical NSAIDs - Cost /1000 NIPUs (↓)
GP Practices
Key
(↑) A higher figure is better
(↓) A lower figure is better
League graphs
Practice
ICP
LCG
HSCB
Line graphs
Practice
ICP
LCG
HSCB
Q1 = Jan/Mar
April-June 2014
9

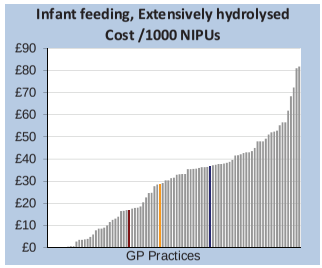

Pain indicators
Pregabalin, Cost /1000 NIPUs (↓)
Co-codamol 30/500, DDDs /1000 NIPUs (↓)
Co-codamol 15/500, DDDs /1000 NIPUs (↓)
Co-codamol 8/500, DDDs /1000 NIPUs (↓)
Co-dydramol, DDDs /1000 NIPUs (↓)
Dihydrocodeine, DDDs /1000 NIPUs (↓)
Paracetamol-opioid compound analgesics, DDDs /1000 NIPUs (↓)
Tramadol MR items as a % of all tramadol items (↑) (includes combinations)
Tramadol/ tramadol-containing preparations, DDDs /1000 NIPUs (↓)
GP Practices
Q3 2012
Q4
Q1 2013
Q2
Q3
Q4
Q1 2014
Q2
Key
(↑) A higher figure is better
(↓) A lower figure is better
League graphs
Practice
ICP
LCG
HSCB
Line graphs
Practice
ICP
LCG
HSCB
Q1 = Jan/Mar
April-June 2014
10

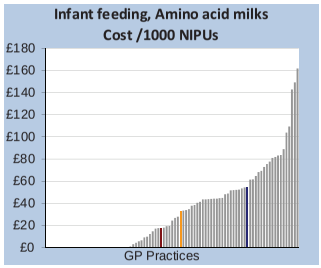

Other Indicators
Respiratory: Combination Inhalers
Cost per asthma/COPD patient (↓)
Respiratory:
Leukotriene receptor antagonists, DDDs /1000 NIPUs (↓)
Orlistat:
Items /1000 NIPUs (↓)
Endocrine:
Blood glucose monitoring, cost /1000 NIPUs (↓)
Endocrine:
% metformin & sulphonylureas (↑)
Benzodiazepines:
DDDs /1000 NIPUs (↓)
Z Drugs:
DDDs /1000 NIPUs (↓)
GP Practices
Key
(↑) A higher figure is better
(↓) A lower figure is better
League graphs
Practice
ICP
LCG
HSCB
Line graphs
Practice
ICP
LCG
HSCB
Q1 = Jan/Mar
April-June 2014
11

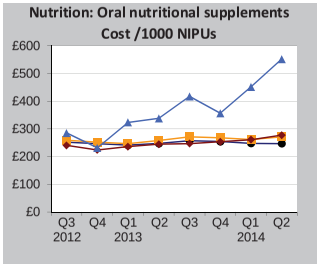
Other indicators cont'd

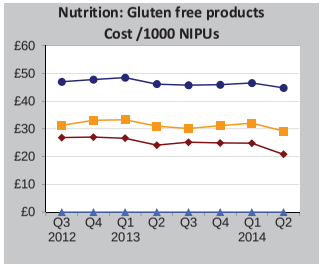


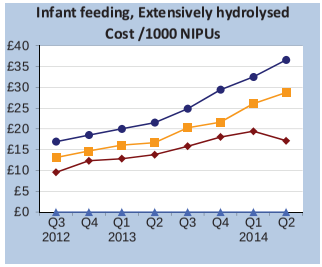


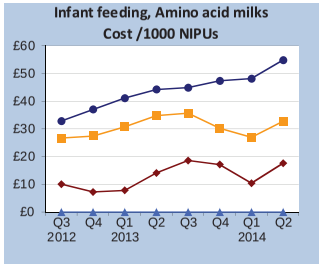












Key

(↑) A higher figure is better

(↓) A lower figure is better

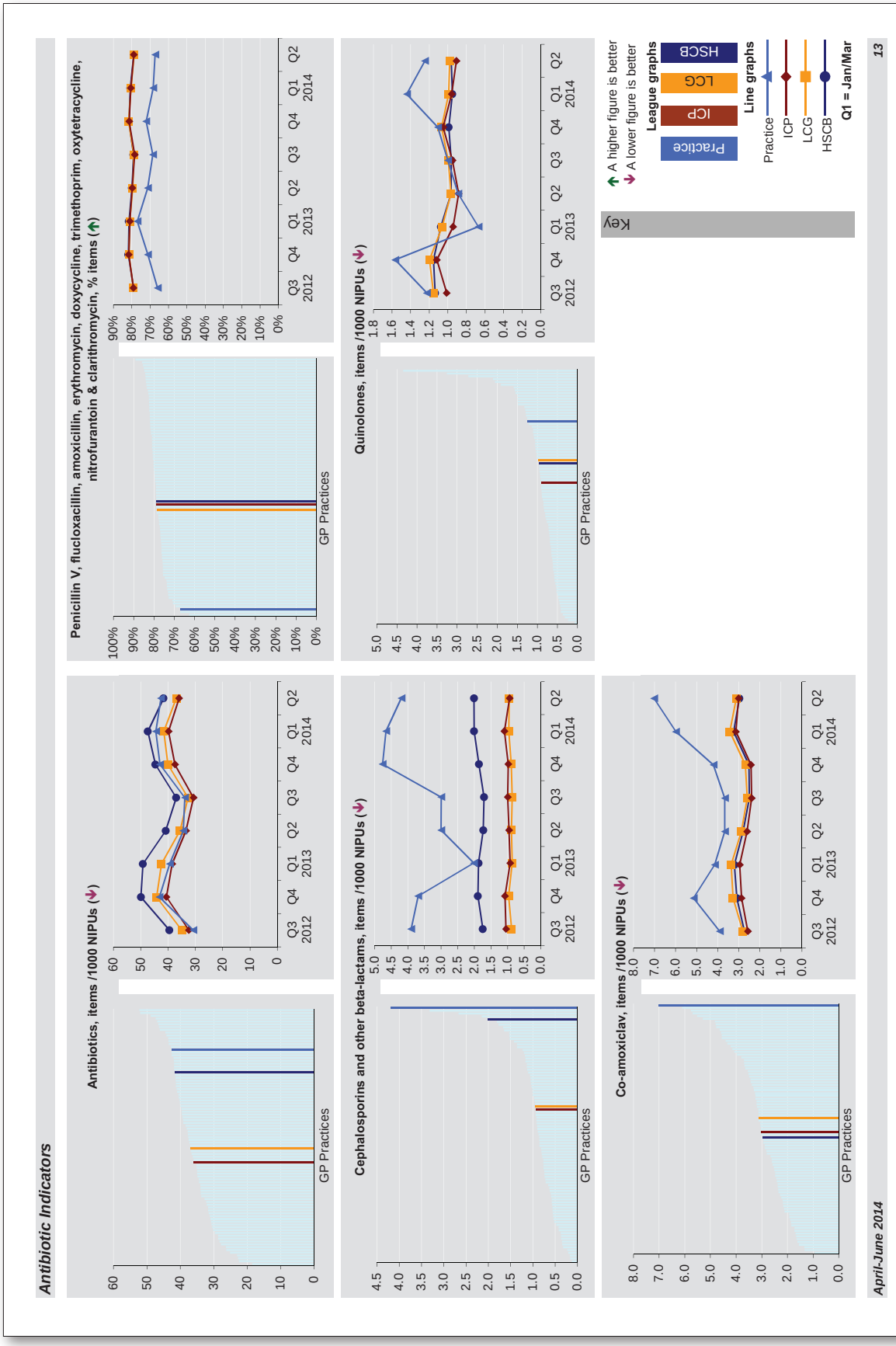
League graphs

Practice ICP LCG HSCB

Line graphs

Practice
ICP
LCG
HSCB

Q1 = Jan/Mar


Antibiotic Indicators
Penicillin V, flucloxacillin, amoxicillin, erythromycin, doxycycline, trimethoprim, oxytetracycline, nitrofurantoin & clarithromycin, % items (↑)
Quinolones, items /1000 NIPUs (↓)
Antibiotics, items /1000 NIPUs (↓)
Cephalosporins and other beta-lactams, items /1000 NIPUs (↓)
Co-amoxiclav, items /1000 NIPUs (↓)
GP Practices
Q3 2012
Q4
Q1 2013
Q2
Q3
Q4
Q1 2014
Q2
Key
A higher figure is better
A lower figure is better
League graphs
Practice
ICP
LCG
HSCB
Line graphs
Practice
ICP
LCG
HSCB
Q1 = Jan/Mar
April-June 2014
13

High Risk Drugs

High Risk Drugs

Drug name/group	Items	Quantity
Warfarin 0.5mg	-	-
Warfarin 5mg	-	-
Methotrexate 10mg	-	-
Red List drugs	-	N/A

IV antibiotics: patient prescribing

Drug name	Items	Quantity
Totals	**0**	

Stock Prescribing

Top 15 Stock Items by Cost (excludes dressings & appliances)

	Drug name	Cost (£)	Items	Quantity
1	Chlorphenamine 10mg/1ml solution for injection ampoules	£16.06	1	5
2	Sodium chloride 0.9% irrigation solution 20ml Steripod unit dose	£15.68	2	50
3	Emla 5% cream	£11.25	2	25
4	Doublebase gel	£5.83	1	500
5	Flamazine 1% cream	£2.91	1	20
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
	Total	**£52**	**7**	
	Total of all Stock (includes dressings and appliances)	**£525**	**40**	

Stock CDs (schedules 2, 3, 4 and 5)

	Drug name	Cost (£)	Items	Quantity
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
	Total	**£0**	**0**	

Stock forms (definition):
Forms used for ordering stocks of drugs and appliances which are needed by GPs for the immediate treatment of patients; for use before a patient's needs can be met by giving a prescription in the ordinary way; and for administration by the doctor in person or a person acting under his direction.

Controlled Drug Prescribing - Patient Prescribing

DDDs /1000 NIPUs

	Jul/Sep 12	Oct/Dec	Jan/Mar 13	Apr/Jun	Jul/Sep	Oct/Dec	Jan/Mar 14	Apr/Jun	Trend
Total volume of CD prescribing	●	●	●	●	●	●	●	●	
Total volume of CD prescribing minus methadone liquid and buprenorphine tabs	●	●	●	●	●	●	●	●	
Alfentanil inj	○	○	○	○	○	○	○	○	
Buprenorphine inj	○	○	○	○	○	○	○	○	
Buprenorphine patches	●	●	●	●	●	●	●	●	
Buprenorphine tabs	○	○	○	○	○	○	○	○	
Cocaine eye drops	○	○	○	○	○	○	○	○	
Cyclimorph inj	○	○	○	○	○	○	○	○	
Dexamfetamine	○	○	○	○	○	○	○	○	
Diamorphine inj	○	○	○	○	○	○	○	○	
Diamorphine tabs	○	○	○	○	○	○	○	○	
Dihydrocodeine inj	○	○	○	○	○	○	○	○	
Dipipanone tabs	○	○	○	○	○	○	○	○	
Fentanyl intranasal	○	○	○	○	○	○	○	○	
Fentanyl oral	○	○	○	○	○	○	○	○	
Fentanyl patches	●	●	●	●	●	●	●	●	
Hydromorphone caps	○	○	○	○	○	○	○	○	
Lisdexamfetamine	○	○	○	○	○	○	○	○	
Methadone inj	○	○	○	○	○	○	○	○	
Methadone liquid	○	○	○	○	○	○	○	○	
Methadone tabs	○	○	○	○	○	○	○	○	
Methylphenidate	●	●	●	●	●	●	●	●	
Morphine inj (excl. Cyclimorph®)	○	○	○	○	○	○	○	○	
Morphine oral	○	○	●	●	○	●	●	○	
Morphine oral solutions	○	○	○	○	○	○	○	○	
Morphine suppositories	○	○	○	○	○	○	○	○	
Nabilone caps (Red List Drug)	○	○	○	○	○	○	○	○	
Oxycodone caps and tabs	○	○	○	●	●	●	●	●	
Oxycodone inj	○	○	○	○	○	○	○	○	
Oxycodone liquid	○	○	○	○	○	○	○	○	
Pentazocine caps, tabs, suppos	○	○	○	○	○	○	○	○	
Pentazocine inj	○	○	○	○	○	○	○	○	
Pethidine inj	○	○	○	○	○	○	○	○	
Pethidine tabs	○	○	○	○	○	○	○	○	
Tapentadol tabs	●	●	●	●	●	●	●	●	

Controlled Drug prescribing indicators

The controlled drugs monitoring indicators are based on the mean of the prescribing of all practices in the HSCB.

● The red indicator represents prescribing that falls above the upper control limit (UCL). This represents the top 1% of prescribing. The UCL is based on three standard deviations from the mean for each drug.

● The orange indicator represents prescribing that falls between the mean prescribing and the UCL.

● The green indicator represents prescribing that falls between the mean prescribing and no prescribing.

○ The white indicator represents no prescribing.

← Methylphenidate includes all strengths and formulations, including m/r

Appendix: COMPASS Explanatory Notes

Glossary			
ICPs	Integrated Care Partnerships	NIPUs	Northern Ireland Prescribing Units
LCG	Local Commissioning Group		
HSCB	Health and Social Care Board		

Quarter: Information in the COMPASS report is based on three months of prescribing data, i.e. one quarter.

ICP average: Figures refer to the average of all practices within the respective ICP.

LCG average: Figures refer to the average of all practices within the respective LCG.

HSCB average: Figures refer to the average of all practices within the HSCB, i.e. all practices in NI.

Cost (£): Net ingredient cost, equivalent to England's Net Ingredient Cost (NIC). Cost is useful in terms of monitoring the overall drugs bill, checking spend within prescribing budgets and calculating savings made or potential savings. Cost is less useful as a measure of drug consumption because of the differences in cost of alternative preparations and changes in prices.

Items: Number of prescription items. Count of items is a reasonable measure of the number of courses of treatments for vaccinations and acute treatments such as short courses of antibiotics. For other treatments it is less useful because of the wide variation in duration of supply per item.

NIPUs: In measuring prescribing, differences between practices need to be taken account of in order to make valid comparisons with local and national averages. NIPUs standardise for differences between practices in terms of patient list size, age/sex structure and additional needs.

Quantity: Number of physical units, i.e. tablets, capsules, patches, mLs, inhalers, vials etc. Quantity is a useful measure of prescribing when looking at individual preparations, e.g. methotrexate 10mg or warfarin 0.5mg and 5mg.

Change from Last Year: The actual change from the same quarter in the previous year.

Defined Daily Dose (DDD): The DDD is a unit of measurement based on the assumed average maintenance dose per day used for its main indication in adults. The World Health Organisation (WHO) developed the DDD as a method to compare drugs of different chemical structures and potencies. The DDD methodology standardises quantities prescribed into number of daily doses. See worked example below. The number of DDDs is calculated as follows:

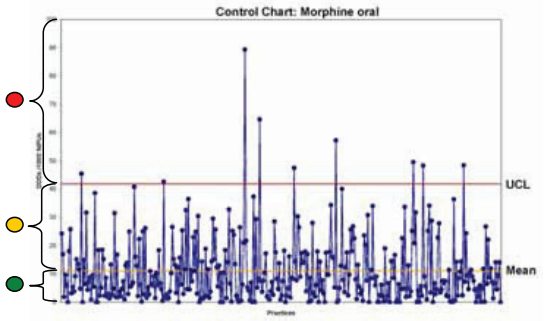
$$\text{Number of DDDs} = \frac{\text{Strength (mg) x quantity}}{\text{DDD (mg)}}$$

Worked example	Quantity (no. of tabs /caps)	DDD (mg)	No. of DDDs
Ibuprofen 200mg 2 caps 3 times a day	168	1200	$\frac{200 \times 168}{1200} = 28$
Ranitidine 150mg 1 tablet twice a day	56	300	$\frac{150 \times 56}{300} = 28$
Lansoprazole 30mg 1 capsule once a day	28	30	$\frac{30 \times 28}{30} = 28$

Prescribing Indicators listed throughout the report give some indication of prescribing quality but are not quantitative measures of good prescribing. Arrows indicate whether a larger figure or a smaller figure suggests 'better' prescribing. Values are given for the practice, locality average, LCG average and HSCB average. They are, therefore, useful in identifying outliers i.e. practice's whose prescribing differs substantially from other practices and to highlight areas for further analysis.

Red List Drugs: The Red list is an advisory list where it is considered by the Regional Group on Specialist Medicines, that responsibility for prescribing should remain with the consultant or specialist clinician. It is recommended that the supply of these specialist medicines should be organised via the hospital pharmacy.

Controlled Drugs (CDs): On the patient and stock prescribing pages there are red, orange and green dots. Each dot represents where a practice is on a control chart in relation to the Upper Control Limit (UCL) and the mean for all practices in NI (see chart below). The UCL is the mean + 3 standard deviations. A green dot represents a practice at the mean or below. An orange dot represents a practice above the mean but below the UCL. A red dot represents a practice above the UCL.



COMPASS Report

Contents

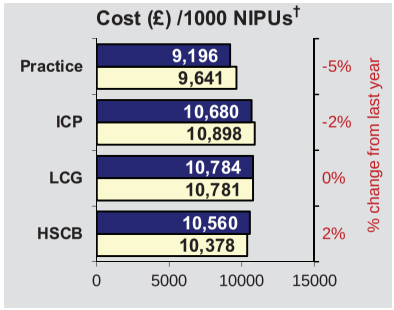
Contents cont'd

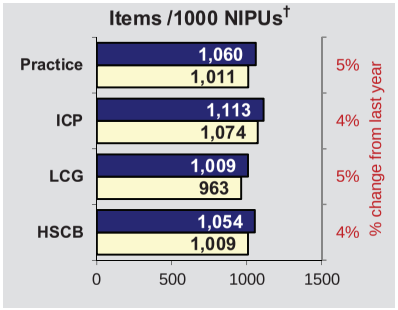
SELCG Practice Report

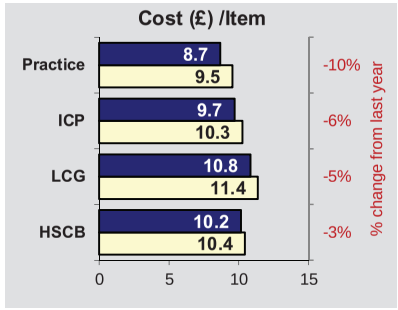
Key

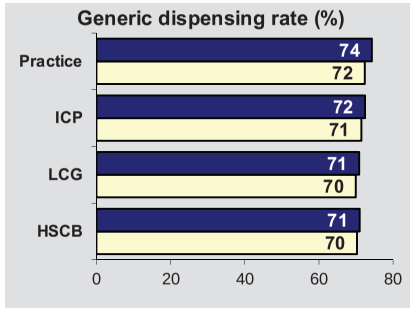
Quarter this year: Apr-Jun 14
Quarter last year: Apr-Jun 13
Practice
ICP
LCG
HSCB

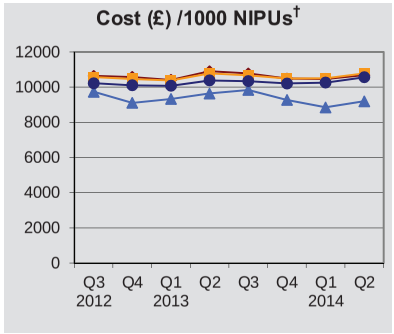
April-June 2014

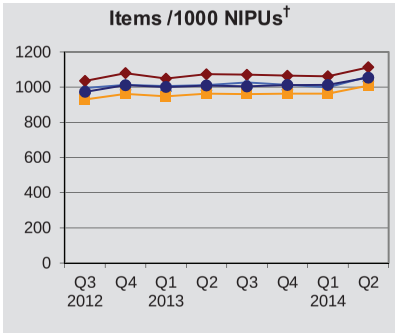


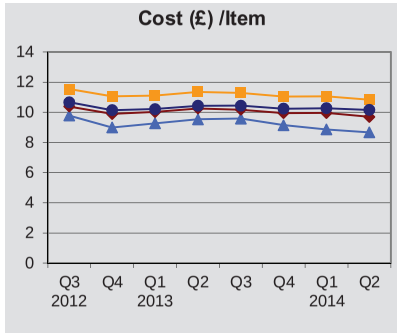


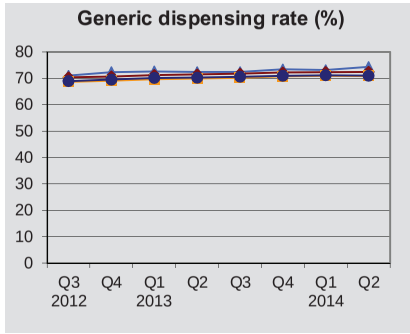












†See explanatory notes at end of report for more information.

Web site: http://www.hscbusiness.hscni.net/services.htm Tel: 028 9053 5661

Top 20 : Twenty most costly drugs in your practice

	Drug Name	Drug's position in HSCB's most costly drugs*	Cost (£)	No of Items	Quantity	Cost (£) /Item	% of Practice Total Cost	Change from last year
1	Budesonide 200micrograms/dose / Formoterol 6micrograms/dose dry powder inhaler	10	1,634	35	43	46.69	1.74	0.18
2	Goserelin 10.8mg implant pre-filled syringes 10.8MG [IMPLANT]	78	1,175	5	5	235.00	1.25	0.54
3	Rosuvastatin 10mg tablets 10MG [TABLET]	17	1,154	39	1,792	29.59	1.23	-0.49
4	Eplerenone 25mg tablets 25MG [TABLET]	79	1,111	25	728	44.43	1.18	0.28
5	Pregabalin 300mg capsules 300MG [CAPSULE]	9	1,101	18	957	61.14	1.17	0.14
6	Fluticasone 250micrograms/dose / Salmeterol 25micrograms/dose inhaler CFC free	7	1,071	17	18	62.98	1.14	0.01
7	Genotropin 12mg powder and solvent for solution for injection cartridges 12MG [REFI	306	1,043	5	5	208.65	1.11	0.06
8	Dutasteride 500microgram capsules 500MICROGRAM [CAPSULE]	41	937	26	944	36.03	1.00	-0.12
9	Liothyronine 20microgram tablets 20MICROGRAM [TABLET]	231	921	3	252	306.90	0.98	0.98
10	Ezetimibe 10mg tablets 10MG [TABLET]	11	895	19	952	47.08	0.95	0.05
11	OneTouch Ultra testing strips [REAGENT]	35	827	22	3,450	37.61	0.88	-0.04
12	Phenytoin sodium 100mg capsules 100MG [CAPSULE]	127	806	14	1,176	57.54	0.86	0.32
13	Temazepam 10mg tablets 10MG [TABLET]	5	763	47	1,039	16.23	0.81	0.03
14	Lantus 100units/ml solution for injection 3ml pre-filled SoloStar pen 3ML [PRE-FILLE	8	747	17	90	43.94	0.79	0.09
15	Co-codamol 30mg/500mg tablets 30MG/500MG [TABLET]	22	688	208	15,632	3.31	0.73	-0.05
16	Pregabalin 200mg capsules 200MG [CAPSULE]	39	644	10	560	64.40	0.69	0.56
17	Hydrocortisone 10mg tablets 10MG [TABLET]	28	638	6	300	106.25	0.68	0.38
18	Salbutamol 4mg tablets 4MG [TABLET]	843	635	4	224	158.68	0.68	0.32
19	Memantine 20mg tablets 20MG [TABLET]	54	635	22	616	28.85	0.68	0.05
20	BuTrans 20micrograms/hour transdermal patches 20MCG/HR [TRANSDERMAL PAT	31	632	7	44	90.29	0.67	0.15
	TOTAL		**18,053**	**549**			**19.21**	

▼ Black Triangle Drug

The range of generic drugs listed in Part I of the NI drug tariff increased in April 2011. This change means the list above may include generic drugs that, although prescribed generically, will have been dispensed by brand as no generics are currently available. If you have any queries regarding this please contact your Medicines Management Adviser (MMA).

*This is the drug's position in the HSCB's most costly drugs. For example, your practice's 20th most costly drug is BuTrans 20micrograms/hour transdermal patches 20MCG/HR [TRANSDERMAL PATCH]. This drug is number 31 in the HSCB's most costly drugs.

Priority generic switches

During this quarter if there were problems with the supply of high volume generics then shortages will have occurred and this may affect prescribing data presented in this page.

	Proprietary Drug	Number of Items	Cost (£)	Generic equivalent	Potential Savings for the quarter (£)
1	ACTOS 30MG [TABLET]	2	144	PIOGLITAZONE 30MG [TABLET]	£136
2	PLAVIX 75MG [TABLET]	2	133	CLOPIDOGREL 75MG [TABLET]	£126
3	XALATAN 2.5ML [EYE DROP]	12	150	LATANOPROST 50MICROGRAMS/ML [EYE DROP]	£126
4	IMIGRAN 50 50MG [TABLET]	3	85	SUMATRIPTAN 50MG [TABLET]	£80
5	NEXIUM 40MG [TABLET]	2	101	ESOMEPRAZOLE 40MG [GASTRO-RESISTANT TABLET]	£79
6	PROSCAR 5MG [TABLET]	3	84	FINASTERIDE 5MG [TABLET]	£74
7	ZOMIG 2.5MG [TABLET]	3	72	ZOLMITRIPTAN 2.5MG [TABLET]	£68
8	LOSEC 20MG [CAPSULE]	4	70	OMEPRAZOLE 20MG [GASTRO-RESISTANT CAPSULE]	£63
9	ACTONEL ONCE A WEEK 35MG [TABLET]	3	57	RISEDRONATE 35MG [TABLET]	£54
	Total	**34**	**894**		**£806**

NB Only individual switches that have the potential to release efficiencies ≥ £200 per annum are now included above.
If you would like data below this threshold please contact your Medicines Management Adviser (MMA).

Potential savings per annum £3,225

Top Cost Effective Choices

These should be considered for all new starts and at review in line with relevant guidance and SPC

		Drug name	*Number of Items*	*Spend*	*Cost effective choice*	*Potential Savings for the quarter*
1	††	SOLIFENACIN (DT) 5MG [TABLET]	13	£455	TOLTERODINE (DT) 2MG [TABLET]	£408
2	††	SOLIFENACIN (DT) 10MG [TABLET]	8	£287	TOLTERODINE (DT) 2MG [TABLET]	£264
3	§	DOXAZOSIN (DT) 8MG [MODIFIED-RELEASE TABLET]	11	£200	DOXAZOSIN (DT) 4MG [TABLET]	£179
4	§	DOXAZOSIN (DT) 4MG [MODIFIED-RELEASE TABLET]	13	£155	DOXAZOSIN (DT) 2MG [TABLET]	£128
5	**	MOMETASONE NASAL (DT) 50MICROGRAMS/DOSE [SPRAY]	24	£206	BECLOMETASONE NASAL (DT) 50MCG [SPRAY]	£125
6		AZITHROMYCIN (DT) 250MG [CAPSULE]	3	£89	AZITHROMYCIN (DT) 250MG [TABLET]	£69
7	††	FESOTERODINE (DT) 4MG [MODIFIED-RELEASE TABLET]	3	£77	TOLTERODINE (DT) 2MG [TABLET]	£69
8	**	FLUTICASONE PROPIONATE (DT) 50MICROGRAMS/DOSE [NASAL SPRAY]	7	£88	BECLOMETASONE NASAL (DT) 50MCG [SPRAY]	£63
9		PARACETAMOL 500MG SOLUBLE TABLETS (DT) 500MG [EFFERVESCENT	15	£83	PARACETAMOL (DT) 500MG [TABLET]	£57
		Total	**97**	**£1,639**		**£1,363**

NB Only individual switches that have the potential to release efficiencies ≥ £200 per annum are included above, up to a maximum of 20 switches.

Potential savings per annum **£5,450**

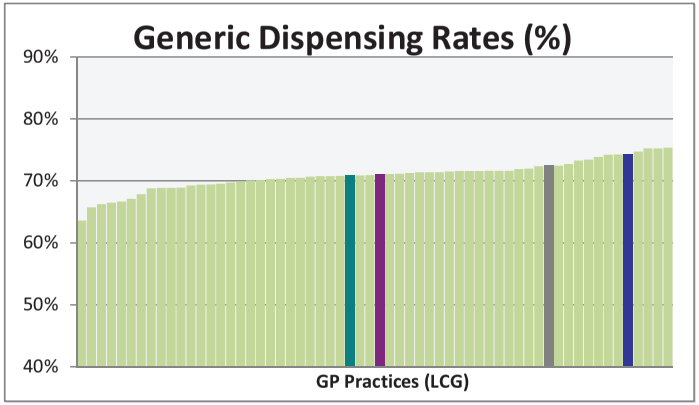
Prior to initiating/switching to the cost-effective choice please refer to the additional information provided on the HSCB website:

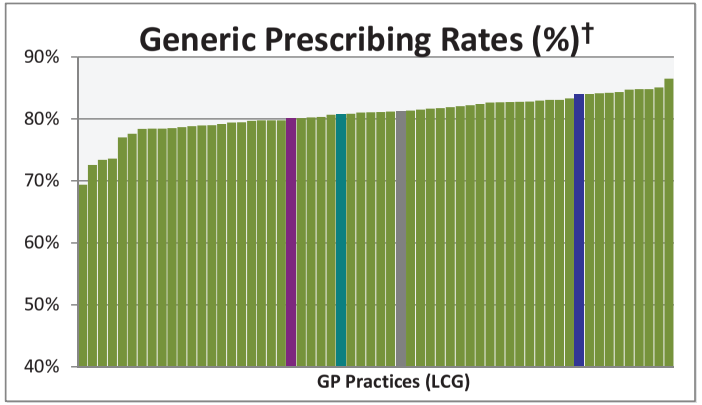
§ http://primarycare.hscni.net/pdf/Doxazosin_Switch_Guidance_April_2012.pdf

†† These should only be initiated after a trial of oral oxybutynin or tolterodine has been ineffective

** Beclometasone in hayfever

Overall Generic Rates





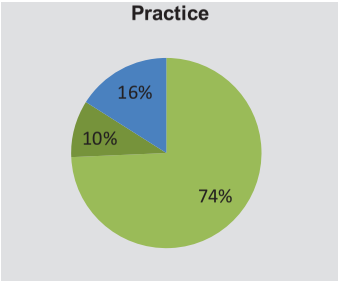
The range of generic drugs listed within Part I of the NI drug tariff increased in April 2011. This change may have increased your generic dispensing rate.

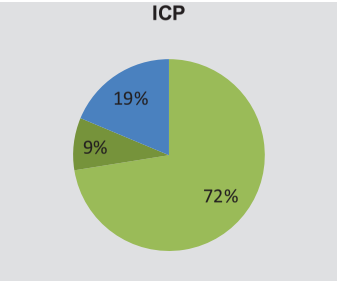
†The generic **prescribing** rates chart is new. This chart reports GP prescribing of generics. This will include drugs that, although prescribed generically, will have been dispensed by brand as no generic is currently available.

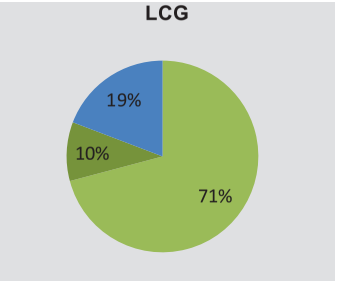
NB 100% generic prescribing rate is not achievable or desired as there are a number of items unsuitable for generic prescribing. See link below:
http://www.hscboard.hscni.net/medicinesmanagement/Prescribing%20Guidance/index.html

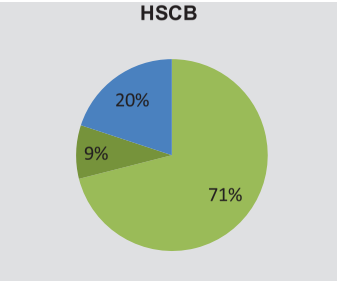
Your Practice | ICP Average | LCG Average | HSCB Average

Prescribed and dispensed generically
Prescribed generically and dispensed by brand as no generic is currently available
Presribed and dispensed by brand







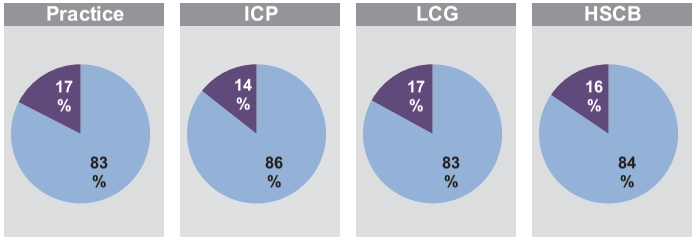


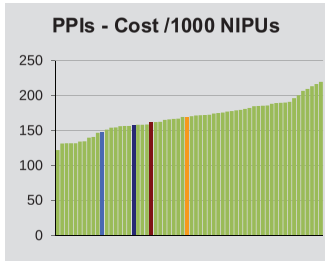
Proton Pump Inhibitors (PPIs)

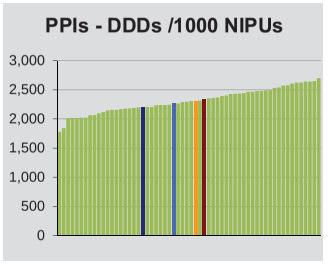
Preferred choices

Other items

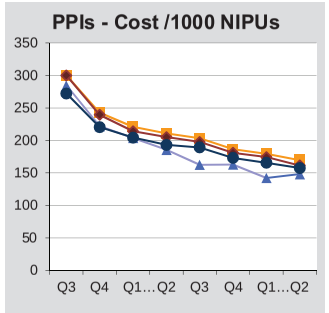
† If patients do not have swallowing difficulties, they could be switched to omeprazole or lansoprazole capsules.

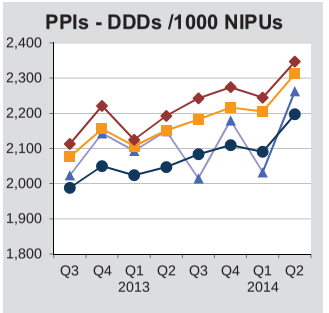


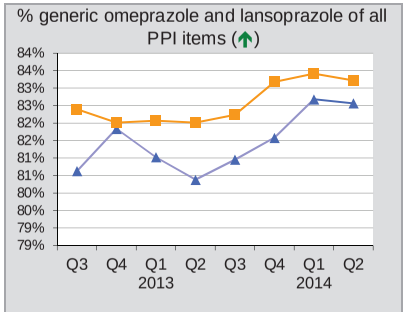


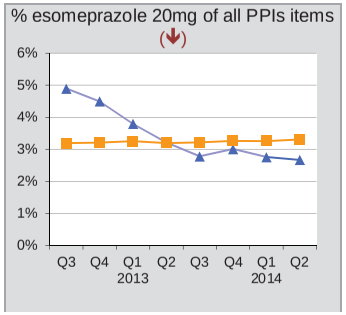


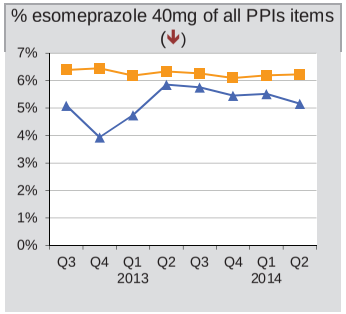
Drug name	Items	%	Items	%	Items	%	Items	%
Lansoprazole	140	24.91%	5929	27.86%	26308	31.22%	158553	31.26%
Omeprazole	324	57.65%	12286	57.74%	43643	51.78%	269884	53.21%
Pantoprazole	46	8.19%	912	4.29%	4927	5.85%	30291	5.97%
Losec	4	0.71%	39	0.18%	210	0.25%	1611	0.32%
Protium	0	0.00%	0	0.00%	0	0.00%	0	0.00%
Esomeprazole (tablets)	42	7.47%	1830	8.60%	7688	9.12%	37843	7.46%
Lansoprazole orodispersible†	0	0.00%	0	0.00%	0	0.00%	0	0.00%
Omeprazole dispersible†	0	0.00%	0	0.00%	0	0.00%	0	0.00%
Rabeprazole	4	0.71%	75	0.35%	406	0.48%	2414	0.48%
Emozul (capsules)	0	0.00%	0	0.00%	30	0.04%	95	0.02%
Nexium (tablets)	2	0.36%	92	0.43%	512	0.61%	2883	0.57%
Pariet	0	0.00%	2	0.01%	43	0.05%	281	0.06%
Losec MUPS†	0	0.00%	72	0.34%	295	0.35%	1884	0.37%
Zoton FasTab†	0	0.00%	42	0.20%	217	0.26%	1459	0.29%

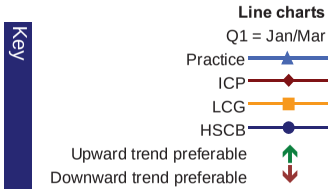






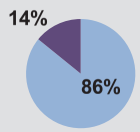






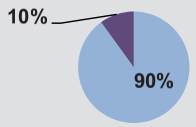
Lipid lowering drugs

Practice



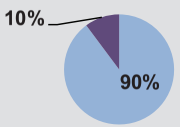
Drug name	Items	%
Simvastatin 10mg	5	0.87%
Simvastatin 20mg	74	12.80%
Simvastatin 40mg	195	33.74%
Simvastatin 80mg	3	0.52%
Simvastatin 20mg/5ml	0	0.00%
Simvastatin 40mg/5ml	0	0.00%
Atorvastatin 10mg	56	9.69%
Atorvastatin 20mg	60	10.38%
Atorvastatin 40mg	91	15.74%
Atorvastatin 80mg	7	1.21%
Pravastatin	5	0.87%
Fluvastatin	0	0.00%
Rosuvastatin	75	12.98%
Simvastatin + Ezetimibe	1	0.17%
Lescol /other brands	0	0.00%
Lipostat	0	0.00%
Zocor	0	0.00%
Crestor	6	1.04%
Inegy	0	0.00%
Lipitor 10mg	0	0.00%
Lipitor 20mg	0	0.00%
Lipitor 40mg	0	0.00%
Lipitor 80mg	0	0.00%

ICP



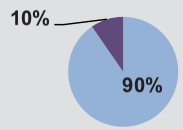
Drug name	Items	%
Simvastatin 10mg	255	1.27%
Simvastatin 20mg	1859	9.25%
Simvastatin 40mg	7060	35.11%
Simvastatin 80mg	55	0.27%
Simvastatin 20mg/5ml	0	0.00%
Simvastatin 40mg/5ml	3	0.01%
Atorvastatin 10mg	1669	8.30%
Atorvastatin 20mg	2193	10.91%
Atorvastatin 40mg	3521	17.51%
Atorvastatin 80mg	528	2.63%
Pravastatin	960	4.77%
Fluvastatin	44	0.22%
Rosuvastatin	1766	8.78%
Simvastatin + Ezetimibe	24	0.12%
Lescol /other brands	1	0.00%
Lipostat	1	0.00%
Zocor	2	0.01%
Crestor	136	0.68%
Inegy	0	0.00%
Lipitor 10mg	6	0.03%
Lipitor 20mg	7	0.03%
Lipitor 40mg	13	0.06%
Lipitor 80mg	5	0.02%

LCG



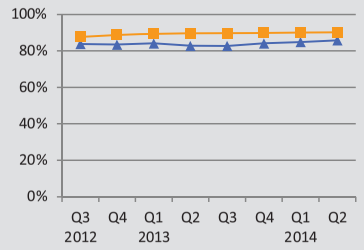
Drug name	Items	%
Simvastatin 10mg	2192	2.84%
Simvastatin 20mg	7893	10.24%
Simvastatin 40mg	26269	34.09%
Simvastatin 80mg	146	0.19%
Simvastatin 20mg/5ml	23	0.03%
Simvastatin 40mg/5ml	77	0.10%
Atorvastatin 10mg	7316	9.49%
Atorvastatin 20mg	8142	10.56%
Atorvastatin 40mg	11845	15.37%
Atorvastatin 80mg	1238	1.61%
Pravastatin	4048	5.25%
Fluvastatin	218	0.28%
Rosuvastatin	6918	8.98%
Simvastatin + Ezetimibe	82	0.11%
Lescol /other brands	6	0.01%
Lipostat	27	0.04%
Zocor	13	0.02%
Crestor	413	0.54%
Inegy	23	0.03%
Lipitor 10mg	71	0.09%
Lipitor 20mg	45	0.06%
Lipitor 40mg	53	0.07%
Lipitor 80mg	8	0.01%

HSCB

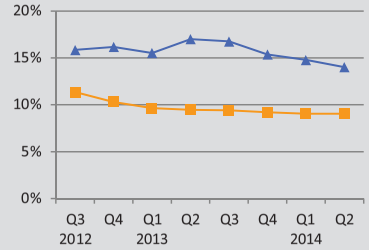


Drug name	Items	%
Simvastatin 10mg	9184	2.00%
Simvastatin 20mg	48808	10.62%
Simvastatin 40mg	153242	33.35%
Simvastatin 80mg	415	0.09%
Simvastatin 20mg/5ml	141	0.03%
Simvastatin 40mg/5ml	269	0.06%
Atorvastatin 10mg	37453	8.15%
Atorvastatin 20mg	53985	11.75%
Atorvastatin 40mg	80607	17.54%
Atorvastatin 80mg	6831	1.49%
Pravastatin	24277	5.28%
Fluvastatin	1101	0.24%
Rosuvastatin	37184	8.09%
Simvastatin + Ezetimibe	427	0.09%
Lescol /other brands	73	0.02%
Lipostat	114	0.02%
Zocor	102	0.02%
Crestor	3913	0.85%
Inegy	216	0.05%
Lipitor 10mg	418	0.09%
Lipitor 20mg	364	0.08%
Lipitor 40mg	291	0.06%
Lipitor 80mg	30	0.01%

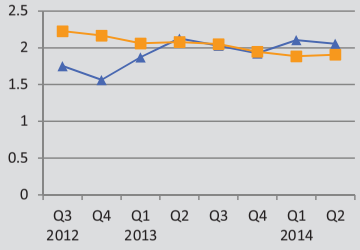
% simvastatin, atorvastatin and pravastatin of all statin items (↑)



% rosuvastatin of all statin items (↓)



Ezetimibe, Items /1000 NIPUs (↓)
(includes Ezetrol and Inegy)



Key

Pie charts

Preferred choices

Other items

Line charts

Q1 = Jan/Mar

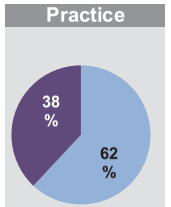
Practice

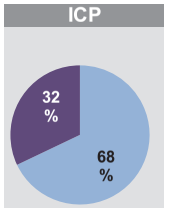
LCG

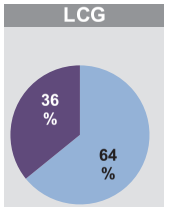
Upward trend preferable ↑

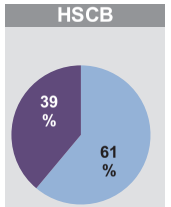
Downward trend preferable ↓

SSRIs and related antidepressant drugs



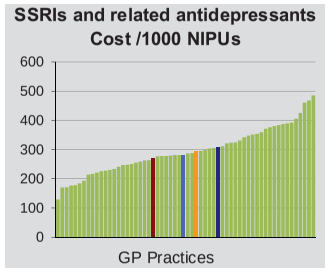


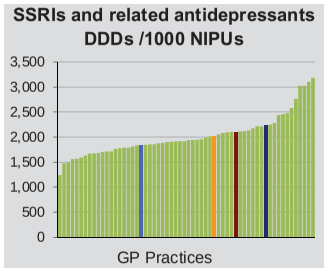


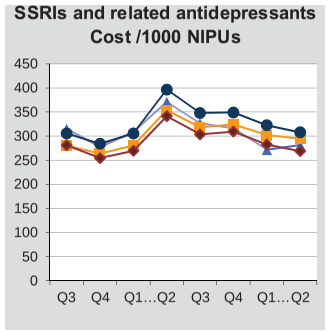


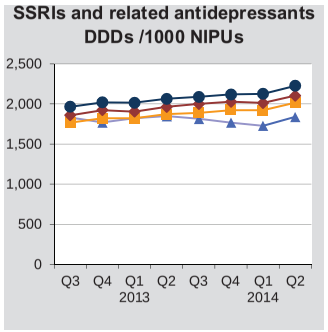
Preferred choices
Other items

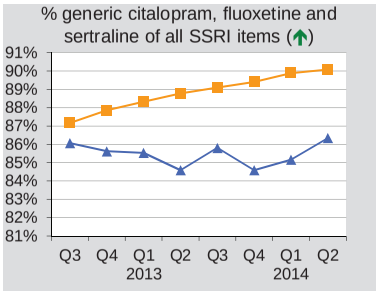
Drug name	Practice Items	Practice %	ICP Items	ICP %	LCG Items	LCG %	HSCB Items	HSCB %
Citalopram	104	23.69%	6088	31.87%	23424	30.11%	129369	25.02%
Fluoxetine	108	24.60%	3989	20.88%	14973	19.25%	94531	18.28%
Sertraline	60	13.67%	2902	15.19%	11505	14.79%	92071	17.81%
Duloxetine	22	5.01%	776	4.06%	4425	5.69%	21892	4.23%
Escitalopram	23	5.24%	761	3.98%	3675	4.72%	23441	4.53%
Flupentixol	0	0.00%	75	0.39%	117	0.15%	389	0.08%
Fluvoxamine	0	0.00%	5	0.03%	30	0.04%	210	0.04%
Mirtazapine	64	14.58%	1650	8.64%	7994	10.28%	64596	12.49%
Paroxetine	18	4.10%	361	1.89%	1442	1.85%	11764	2.28%
Reboxetine	0	0.00%	24	0.13%	102	0.13%	430	0.08%
Venlafaxine (incl. XL)	3	0.68%	269	1.41%	1366	1.76%	10841	2.10%
Cipramil	0	0.00%	6	0.03%	45	0.06%	282	0.05%
Efexor /XL /other brands	31	7.06%	1992	10.43%	7473	9.61%	58338	11.28%
Faverin	0	0.00%	0	0.00%	8	0.01%	30	0.01%
Lustral	0	0.00%	7	0.04%	47	0.06%	436	0.08%
Prozac	0	0.00%	8	0.04%	46	0.06%	325	0.06%
Seroxat	0	0.00%	10	0.05%	35	0.04%	388	0.08%
Cipralex	2	0.46%	51	0.27%	189	0.24%	2331	0.45%
Cymbalta	4	0.91%	115	0.60%	809	1.04%	4592	0.89%
Edronax	0	0.00%	9	0.05%	20	0.03%	137	0.03%
Fluanxol	0	0.00%	4	0.02%	27	0.03%	371	0.07%
Optimax	0	0.00%	0	0.00%	1	0.00%	12	0.00%
Zispin SolTab	0	0.00%	1	0.01%	29	0.04%	258	0.05%

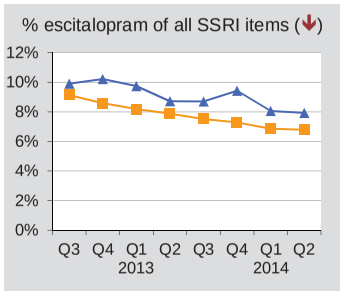


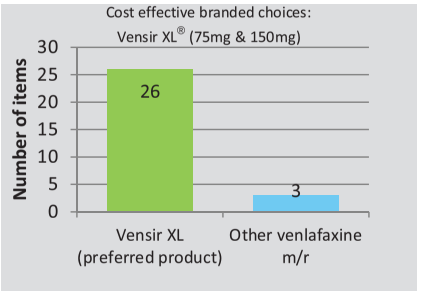






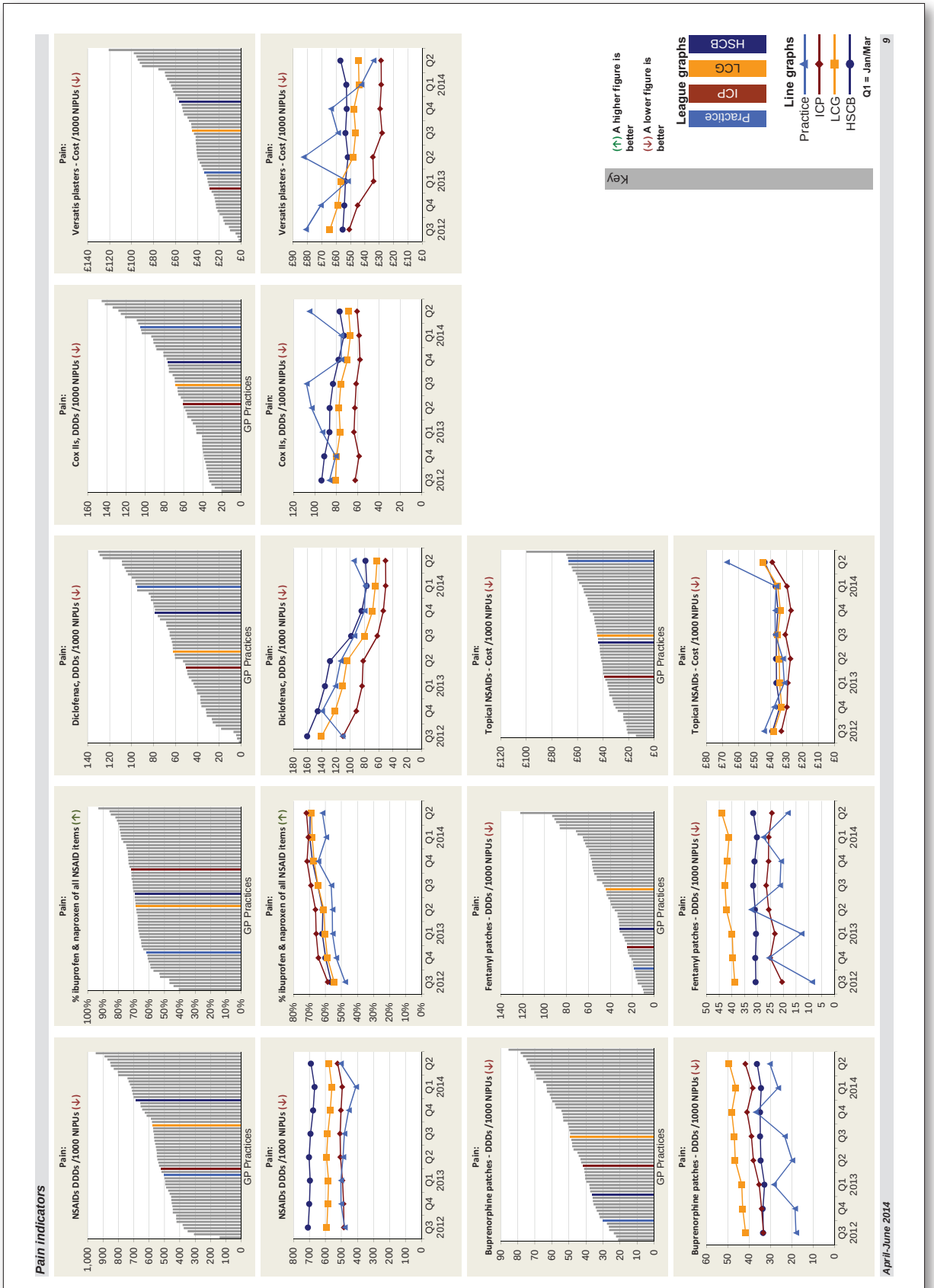


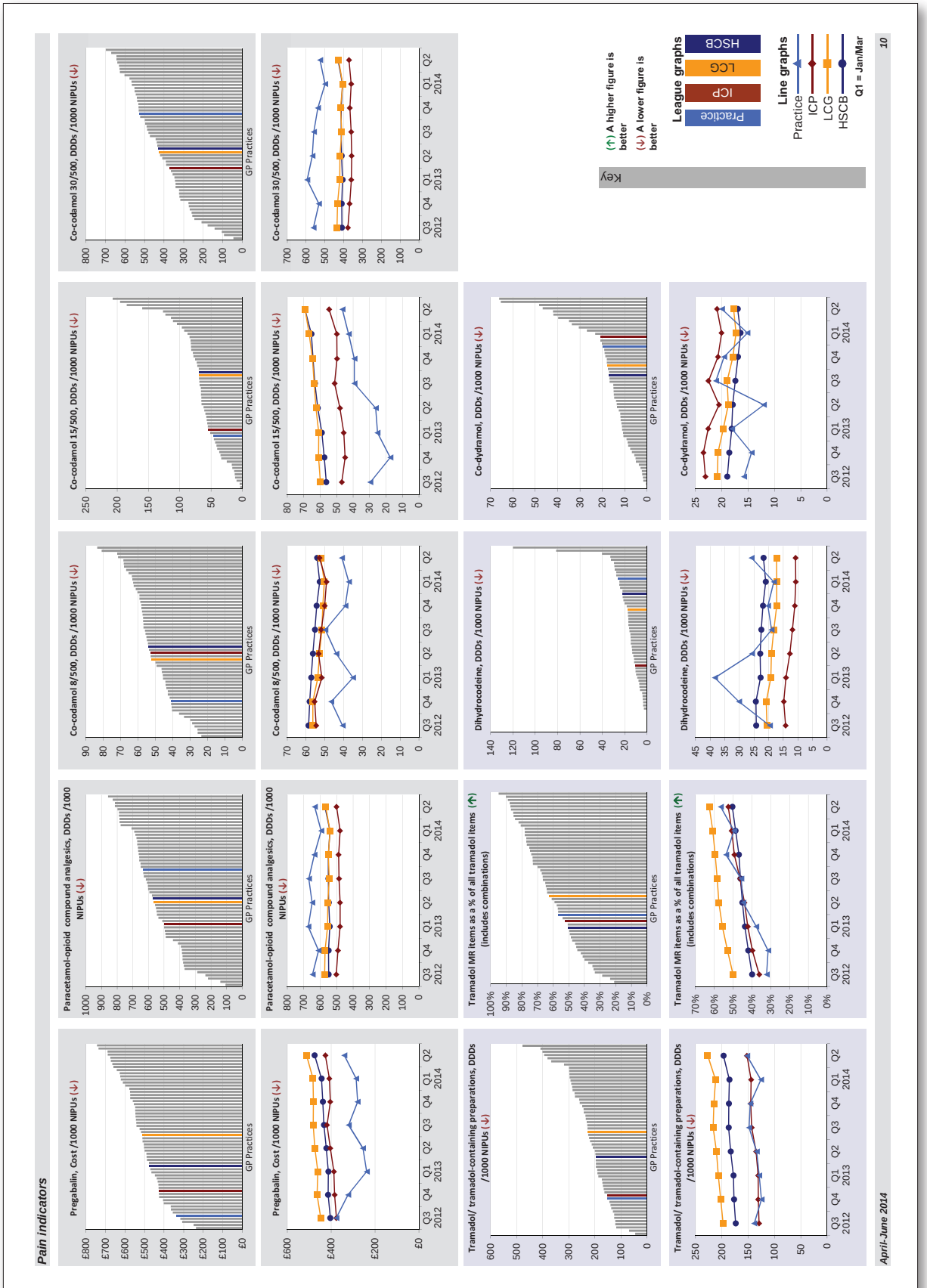




Key

Line charts
Q1 = Jan/Mar
Practice
ICP
LCG
HSCB
Upward trend preferable
Downward trend preferable


Pain indicators
Pain: NSAIDs DDDs /1000 NIPUs (↓)
Pain: % ibuprofen & naproxen of all NSAID items (↑)
Pain: Diclofenac, DDDs /1000 NIPUs (↓)
Pain: Cox IIs, DDDs /1000 NIPUs (↓)
Pain: Versatis plasters - Cost /1000 NIPUs (↓)
Pain: Buprenorphine patches - DDDs /1000 NIPUs (↓)
Pain: Fentanyl patches - DDDs /1000 NIPUs (↓)
Pain: Topical NSAIDs - Cost /1000 NIPUs (↓)
GP Practices
Key
(↑) A higher figure is better
(↓) A lower figure is better
League graphs
Practice
ICP
LCG
HSCB
Line graphs
Practice
ICP
LCG
HSCB
Q1 = Jan/Mar
April-June 2014
9


Pain indicators
Pregabalin, Cost /1000 NIPUs (↓)
£800
£700
£600
£500
£400
£300
£200
£100
£0
GP Practices
Q3 2012
Q4
Q1 2013
Q2
Q3
Q4
Q1 2014
Q2
Pregabalin, Cost /1000 NIPUs (↓)
£600
£400
£200
£0
Tramadol/ tramadol-containing preparations, DDDs /1000 NIPUs (↓)
600
500
400
300
200
100
0
GP Practices
Tramadol/ tramadol-containing preparations, DDDs /1000 NIPUs (↓)
250
200
150
100
50
0
Paracetamol-opioid compound analgesics, DDDs /1000 NIPUs (↓)
1000
900
800
700
600
500
400
300
200
100
0
GP Practices
Paracetamol-opioid compound analgesics, DDDs /1000 NIPUs (↓)
800
700
600
500
400
300
200
100
0
Tramadol MR items as a % of all tramadol items (↑) (includes combinations)
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
GP Practices
Tramadol MR items as a % of all tramadol items (↑) (includes combinations)
70%
60%
50%
40%
30%
20%
10%
0%
Co-codamol 8/500, DDDs /1000 NIPUs (↓)
90
80
70
60
50
40
30
20
10
0
GP Practices
Co-codamol 8/500, DDDs /1000 NIPUs (↓)
70
60
50
40
30
20
10
0
Dihydrocodeine, DDDs /1000 NIPUs (↓)
140
120
100
80
60
40
20
0
GP Practices
Dihydrocodeine, DDDs /1000 NIPUs (↓)
45
40
35
30
25
20
15
10
5
0
Co-codamol 15/500, DDDs /1000 NIPUs (↓)
250
200
150
100
50
0
GP Practices
Co-codamol 15/500, DDDs /1000 NIPUs (↓)
80
70
60
50
40
30
20
10
0
Co-dydramol, DDDs /1000 NIPUs (↓)
70
60
50
40
30
20
10
0
GP Practices
Co-dydramol, DDDs /1000 NIPUs (↓)
25
20
15
10
5
0
Co-codamol 30/500, DDDs /1000 NIPUs (↓)
800
700
600
500
400
300
200
100
0
GP Practices
Co-codamol 30/500, DDDs /1000 NIPUs (↓)
700
600
500
400
300
200
100
0
Key
(↑) A higher figure is better
(↓) A lower figure is better
League graphs
Practice
ICP
LCG
HSCB
Line graphs
Practice
ICP
LCG
HSCB
Q1 = Jan/Mar
April-June 2014
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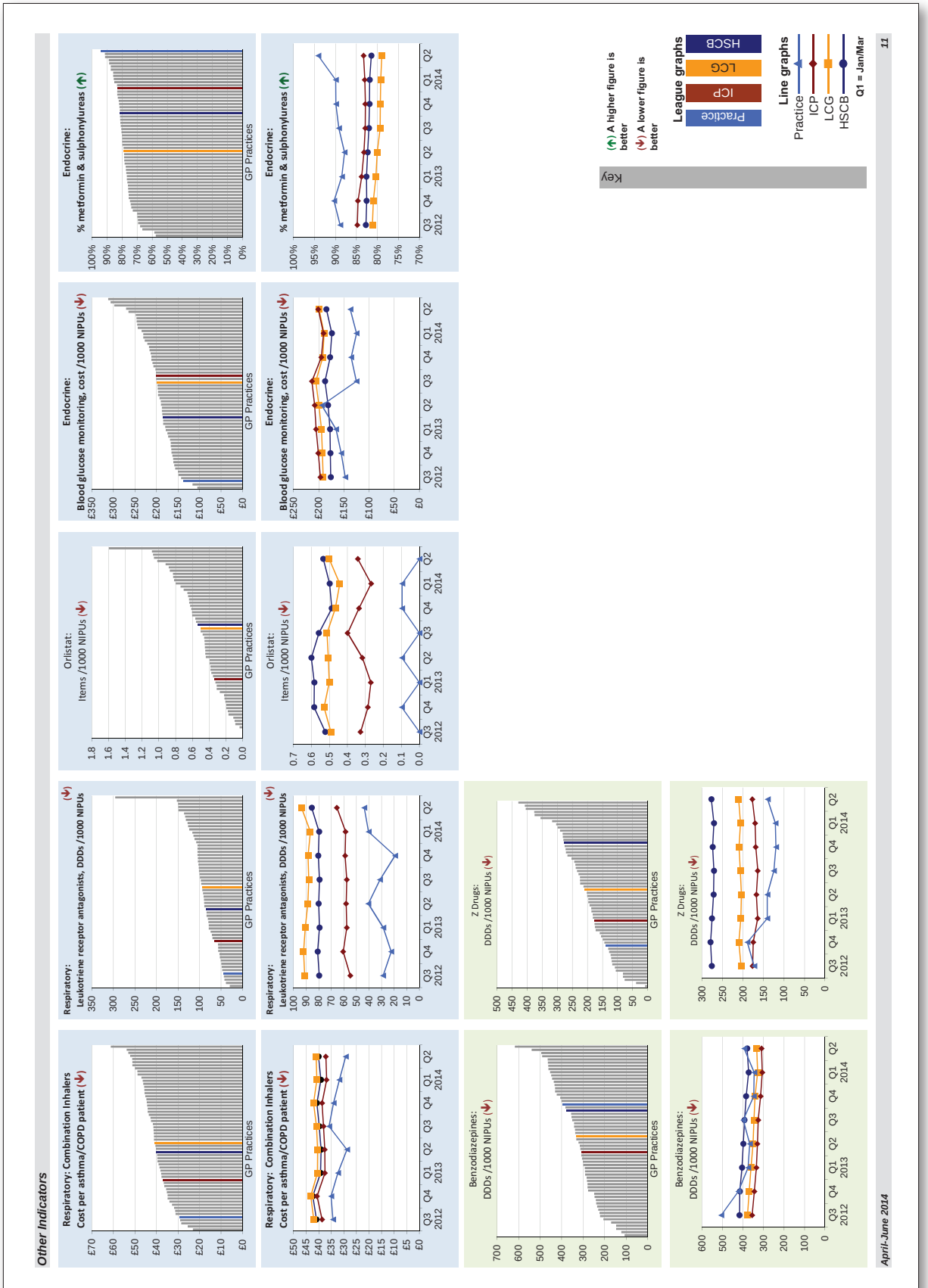
Other Indicators
Respiratory: Combination Inhalers
Cost per asthma/COPD patient (↓)
Respiratory: Leukotriene receptor antagonists, DDDs /1000 NIPUs (↓)
Orlistat: Items /1000 NIPUs (↓)
Endocrine: Blood glucose monitoring, cost /1000 NIPUs (↓)
Endocrine: % metformin & sulphonylureas (↑)
Benzodiazepines: DDDs /1000 NIPUs (↓)
Z Drugs: DDDs /1000 NIPUs (↓)
GP Practices
Q3 2012
Q4
Q1 2013
Q2
Q3
Q4
Q1 2014
Q2
Key
(↑) A higher figure is better
(↓) A lower figure is better
League graphs
Practice
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Q1 = Jan/Mar
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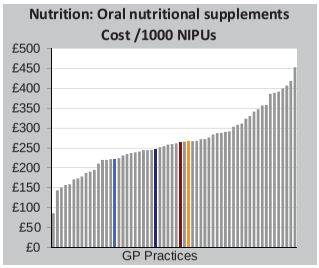
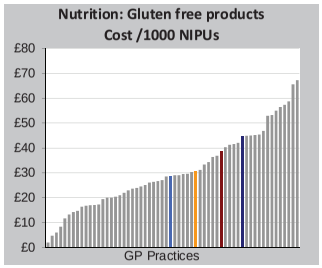
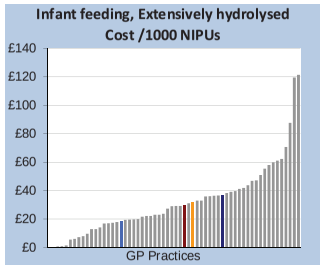
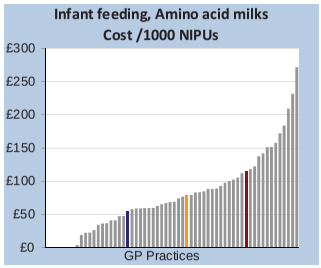
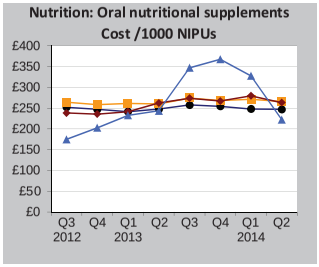
Other indicators cont'd

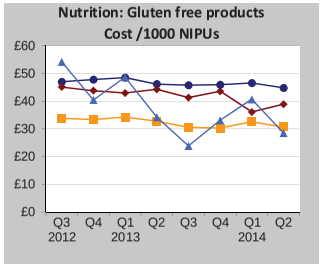


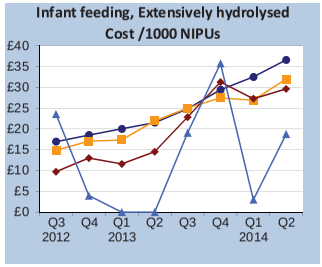


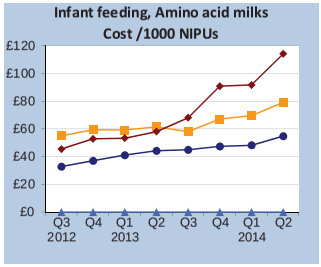












Key

(↑) A higher figure is better

(↓) A lower figure is better

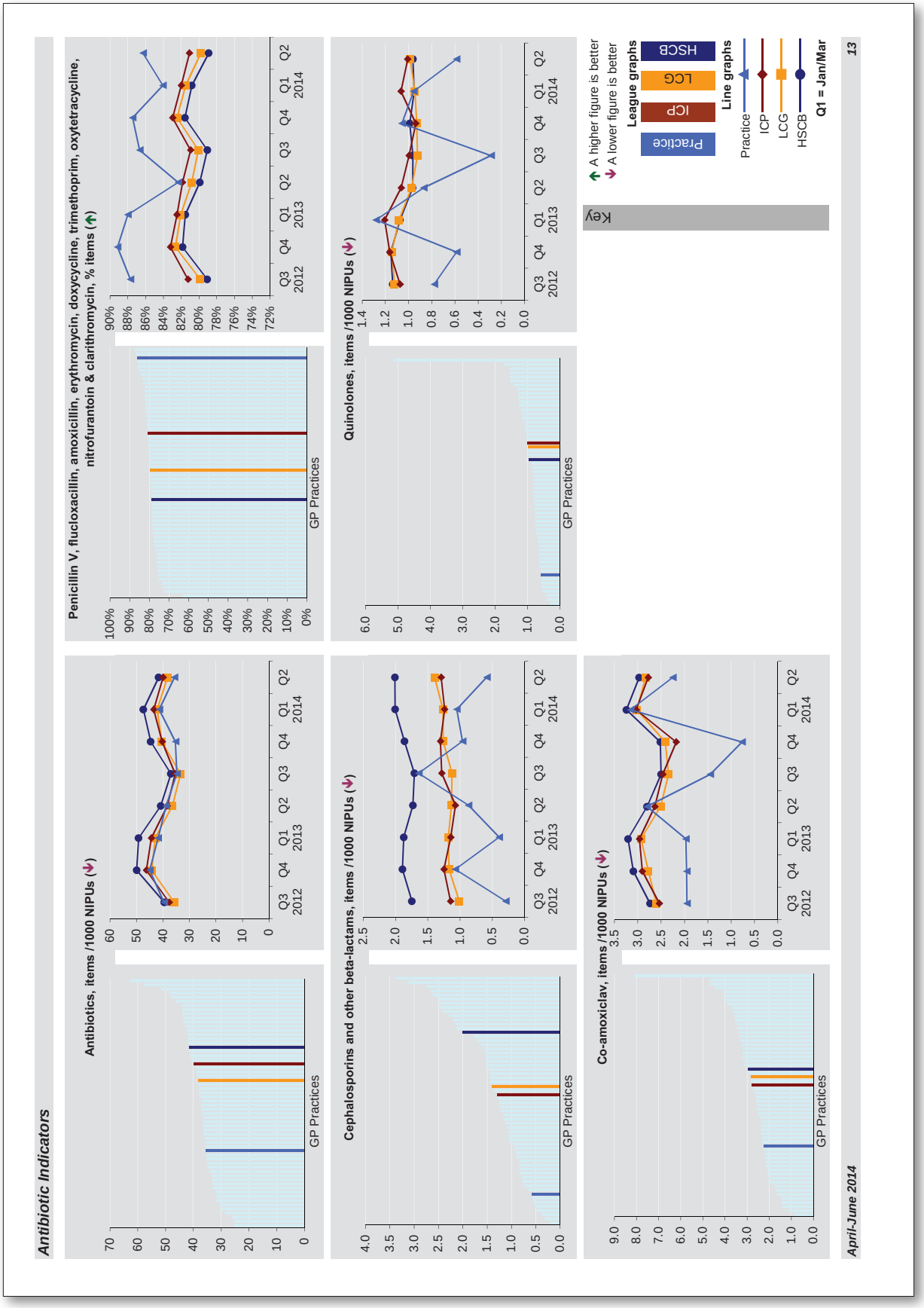
League graphs

Practice ICP LCG HSCB

Line graphs

Practice
ICP
LCG
HSCB

Q1 = Jan/Mar


Antibiotic Indicators
Penicillin V, flucloxacillin, amoxicillin, erythromycin, doxycycline, trimethoprim, oxytetracycline, nitrofurantoin & clarithromycin, % items (↑)
Quinolones, items /1000 NIPUs (↓)
Antibiotics, items /1000 NIPUs (↓)
Cephalosporins and other beta-lactams, items /1000 NIPUs (↓)
Co-amoxiclav, items /1000 NIPUs (↓)
GP Practices
Q3 2012
Q4
Q1 2013
Q2
Q3
Q4
Q1 2014
Q2
Key
A higher figure is better
A lower figure is better
League graphs
Practice
ICP
LCG
HSCB
Line graphs
Practice
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High Risk Drugs

High Risk Drugs

Drug name/group	Items	Quantity
Warfarin 0.5mg	-	-
Warfarin 5mg	-	-
Methotrexate 10mg	-	-
Red List drugs	-	N/A

IV antibiotics: patient prescribing

Drug name	Items	Quantity
Totals	**0**	

Stock Prescribing

Top 15 Stock Items by Cost (excludes dressings & appliances)

	Drug name	Cost (£)	Items	Quantity
1	Minims tropicamide 0.5% eye drops 0.5ml unit dose	£10.30	1	20
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
	Total	**£10**	**1**	
	Total of all Stock (includes dressings and appliances)	**£306**	**21**	

Stock CDs (schedules 2, 3, 4 and 5)

	Drug name	Cost (£)	Items	Quantity
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
	Total	**£0**	**0**	

Stock forms (definition):
Forms used for ordering stocks of drugs and appliances which are needed by GPs for the immediate treatment of patients; for use before a patient's needs can be met by giving a prescription in the ordinary way; and for administration by the doctor in person or a person acting under his direction.

Controlled Drug Prescribing - Patient Prescribing

DDDs /1000 NIPUs

	Jul/Sep 12	Oct/Dec	Jan/Mar 13	Apr/Jun	Jul/Sep	Oct/Dec	Jan/Mar 14	Apr/Jun	Trend
Total volume of CD prescribing	●	●	●	●	●	●	●	●	
Total volume of CD prescribing minus methadone liquid and buprenorphine tabs	●	●	●	●	●	●	●	●	
Alfentanil inj	○	○	○	○	○	●	○	○	
Buprenorphine inj	○	○	○	○	○	○	○	○	
Buprenorphine patches	●	●	●	●	●	●	●	●	
Buprenorphine tabs	○	○	○	○	○	○	○	○	
Cocaine eye drops	○	○	○	○	○	○	○	○	
Cyclimorph inj	○	○	○	○	○	○	○	○	
Dexamfetamine	○	○	○	○	○	○	○	○	
Diamorphine inj	●	●	●	○	○	○	●	●	
Diamorphine tabs	○	○	○	○	○	○	○	○	
Dihydrocodeine inj	○	○	○	○	○	○	○	○	
Dipipanone tabs	○	○	○	○	○	○	○	○	
Fentanyl intranasal	○	○	○	○	○	○	○	○	
Fentanyl oral	○	○	○	○	○	○	○	○	
Fentanyl patches	●	●	●	●	●	●	●	●	
Hydromorphone caps	○	○	○	○	○	○	○	○	
Lisdexamfetamine	○	○	○	○	○	○	○	○	
Methadone inj	○	○	○	○	○	○	○	○	
Methadone liquid	○	○	○	○	○	○	○	○	
Methadone tabs	○	○	○	○	○	○	○	○	
Methylphenidate	●	●	●	●	●	●	●	●	
Morphine inj (excl. Cyclimorph®)	○	○	○	○	○	○	○	●	
Morphine oral	●	●	●	●	●	●	●	●	
Morphine oral solutions	○	○	○	○	○	○	○	○	
Morphine suppositories	○	○	○	○	○	○	○	○	
Nabilone caps (Red List Drug)	○	○	○	○	○	○	○	○	
Oxycodone caps and tabs	●	●	●	●	●	●	●	●	
Oxycodone inj	●	●	●	●	●	○	●	○	
Oxycodone liquid	●	○	●	●	●	●	●	○	
Pentazocine caps, tabs, suppos	○	○	○	○	○	○	○	○	
Pentazocine inj	○	○	○	○	○	○	○	○	
Pethidine inj	○	○	○	○	○	○	○	○	
Pethidine tabs	○	○	○	○	○	○	○	○	
Tapentadol tabs	○	○	○	●	●	●	●	●	

Controlled Drug prescribing indicators

The controlled drugs monitoring indicators are based on the mean of the prescribing of all practices in the HSCB.

● The red indicator represents prescribing that falls above the upper control limit (UCL). This represents the top 1% of prescribing. The UCL is based on three standard deviations from the mean for each drug.

● The orange indicator represents prescribing that falls between the mean prescribing and the UCL.

● The green indicator represents prescribing that falls between the mean prescribing and no prescribing.

○ The white indicator represents no prescribing.

← Methylphenidate includes all strengths and formulations, including m/r

Appendix: COMPASS Explanatory Notes

Glossary			
ICPs	Integrated Care Partnerships	NIPUs	Northern Ireland Prescribing Units
LCG	Local Commissioning Group		
HSCB	Health and Social Care Board		

Quarter: Information in the COMPASS report is based on three months of prescribing data, i.e. one quarter.

ICP average: Figures refer to the average of all practices within the respective ICP.

LCG average: Figures refer to the average of all practices within the respective LCG.

HSCB average: Figures refer to the average of all practices within the HSCB, i.e. all practices in NI.

Cost (£): Net ingredient cost, equivalent to England's Net Ingredient Cost (NIC). Cost is useful in terms of monitoring the overall drugs bill, checking spend within prescribing budgets and calculating savings made or potential savings. Cost is less useful as a measure of drug consumption because of the differences in cost of alternative preparations and changes in prices.

Items: Number of prescription items. Count of items is a reasonable measure of the number of courses of treatments for vaccinations and acute treatments such as short courses of antibiotics. For other treatments it is less useful because of the wide variation in duration of supply per item.

NIPUs: In measuring prescribing, differences between practices need to be taken account of in order to make valid comparisons with local and national averages. NIPUs standardise for differences between practices in terms of patient list size, age/sex structure and additional needs.

Quantity: Number of physical units, i.e. tablets, capsules, patches, mLs, inhalers, vials etc. Quantity is a useful measure of prescribing when looking at individual preparations, e.g. methotrexate 10mg or warfarin 0.5mg and 5mg.

Change from Last Year: The actual change from the same quarter in the previous year.

Defined Daily Dose (DDD): The DDD is a unit of measurement based on the assumed average maintenance dose per day used for its main indication in adults. The World Health Organisation (WHO) developed the DDD as a method to compare drugs of different chemical structures and potencies. The DDD methodology standardises quantities prescribed into number of daily doses. See worked example below. The number of DDDs is calculated as follows:

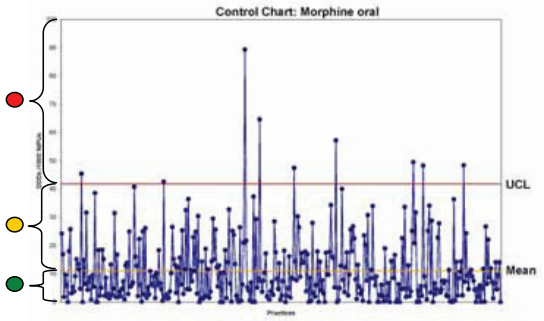
$$\text{Number of DDDs} = \frac{\text{Strength (mg) x quantity}}{\text{DDD (mg)}}$$

Worked example	Quantity (no. of tabs /caps)	DDD (mg)	No. of DDDs
Ibuprofen 200mg 2 caps 3 times a day	168	1200	$\frac{200 \times 168}{1200} = 28$
Ranitidine 150mg 1 tablet twice a day	56	300	$\frac{150 \times 56}{300} = 28$
Lansoprazole 30mg 1 capsule once a day	28	30	$\frac{30 \times 28}{30} = 28$

Prescribing Indicators listed throughout the report give some indication of prescribing quality but are not quantitative measures of good prescribing. Arrows indicate whether a larger figure or a smaller figure suggests 'better' prescribing. Values are given for the practice, locality average, LCG average and HSCB average. They are, therefore, useful in identifying outliers i.e. practice's whose prescribing differs substantially from other practices and to highlight areas for further analysis.

Red List Drugs: The Red list is an advisory list where it is considered by the Regional Group on Specialist Medicines, that responsibility for prescribing should remain with the consultant or specialist clinician. It is recommended that the supply of these specialist medicines should be organised via the hospital pharmacy.

Controlled Drugs (CDs): On the patient and stock prescribing pages there are red, orange and green dots. Each dot represents where a practice is on a control chart in relation to the Upper Control Limit (UCL) and the mean for all practices in NI (see chart below). The UCL is the mean + 3 standard deviations. A green dot represents a practice at the mean or below. An orange dot represents a practice above the mean but below the UCL. A red dot represents a practice above the UCL.



COMPASS Report

NLCG Practice Report

April-June 2014

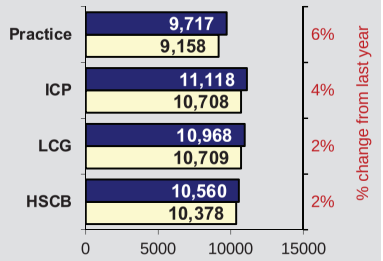
Contents

Contents cont'd

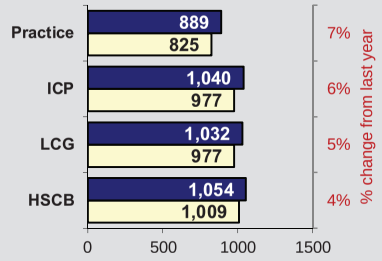
Key

Quarter this year: Apr-Jun 14
Quarter last year: Apr-Jun 13
Practice
ICP
LCG
HSCB

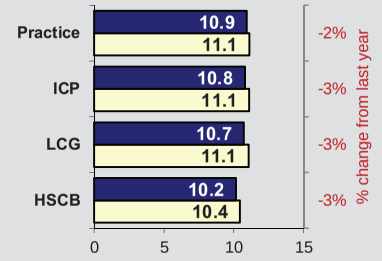
Cost (£) /1000 NIPUs†



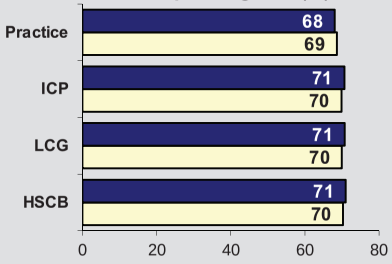
Items /1000 NIPUs†



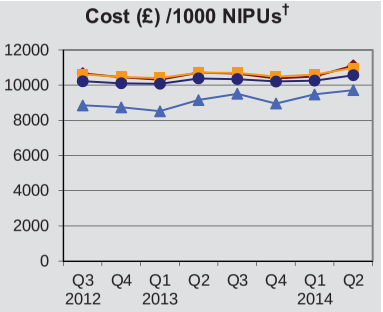
Cost (£) /Item



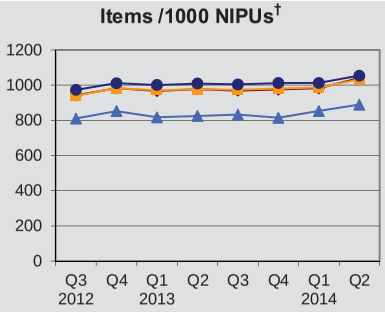
Generic dispensing rate (%)



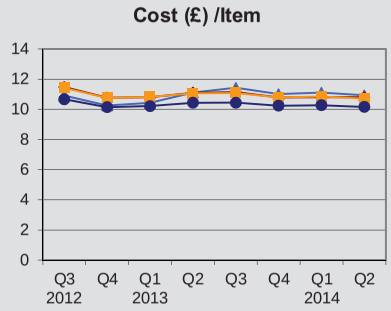
Cost (£) /1000 NIPUs†



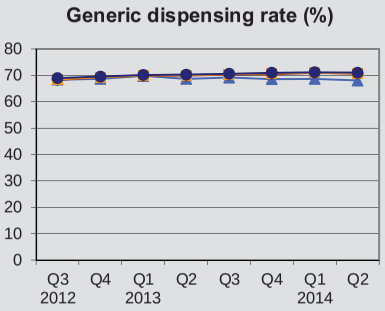
Items /1000 NIPUs†



Cost (£) /Item



Generic dispensing rate (%)



†See explanatory notes at end of report for more information.

Web site: http://www.hscbusiness.hscni.net/services.htm Tel: 028 9053 5661

Top 20 : Twenty most costly drugs in your practice

	Drug Name	Drug's position in HSCB's most costly drugs*	Cost (£)	No of Items	Quantity	Cost (£) /Item	% of Practice Total Cost	Change from last year
1	Tiotropium bromide 18microgram inhalation powder capsules 18MICROGRAM [INHA	1	3,819	71	3,420	53.79	1.85	-0.06
2	Budesonide 200micrograms/dose / Formoterol 6micrograms/dose dry powder inhaler	10	3,724	80	98	46.55	1.80	0.05
3	Fluticasone 250micrograms/dose / Salmeterol 25micrograms/dose inhaler CFC free	7	3,688	53	62	69.58	1.78	-0.12
4	Rosuvastatin 10mg tablets 10MG [TABLET]	17	3,426	99	5,320	34.60	1.66	0.01
5	Irbesartan 300mg / Hydrochlorothiazide 12.5mg tablets 300MG / 12.5MG [TABLET]	185	2,979	94	5,796	31.69	1.44	0.10
6	Rosuvastatin 20mg tablets 20MG [TABLET]	24	2,680	57	2,884	47.02	1.30	-0.12
7	Pregabalin 75mg capsules 75MG [CAPSULE]	3	2,576	41	2,240	62.83	1.24	0.26
8	Fortisip Compact liquid apricot 125ML [BOTTLE]	26	2,287	16	1,132	142.92	1.11	0.19
9	Fortisip Compact Fibre liquid vanilla 4X125ML [FOOD]	300	1,873	10	224	187.26	0.91	0.85
10	Risperdal Consta 50mg powder and solvent for suspension for injection vials 50MG [I	95	1,428	5	10	285.52	0.69	0.26
11	Temazepam 10mg tablets 10MG [TABLET]	5	1,333	83	1,816	16.06	0.64	-0.28
12	Pregabalin 100mg capsules 100MG [CAPSULE]	21	1,288	16	1,120	80.50	0.62	0.30
13	Oxygen cylinders size DD with integral headset 2 and 4litres/minute flow rate 460L [C	125	1,287	1	56	1286.88	0.62	0.18
14	OxyNorm 50mg/1ml solution for injection ampoules 50MG/ML [AMPOULE]	1204	1,262	6	90	210.30	0.61	0.61
15	BuTrans 20micrograms/hour transdermal patches 20MCG/HR [TRANSDERMAL PAT	31	1,221	21	85	58.14	0.59	0.01
16	BuTrans 10micrograms/hour transdermal patches 10MCG/HR [TRANSDERMAL PAT	45	1,167	29	148	40.25	0.56	0.07
17	Budesonide 400micrograms/dose / Formoterol 12micrograms/dose dry powder inhale	55	1,064	17	28	62.59	0.51	-0.26
18	Lantus 100units/ml solution for injection 3ml pre-filled SoloStar pen 3ML [PRE-FILLE	8	1,038	22	125	47.16	0.50	0.04
19	Solifenacin 5mg tablets 5MG [TABLET]	23	1,016	26	1,104	39.09	0.49	0.18
20	Asacol 400mg MR gastro-resistant tablets 400MG [MODIFIED-RELEASE TABLET]	96	1,002	11	3,068	91.13	0.48	0.31
	TOTAL		**40,157**	**758**			**19.41**	

▼ Black Triangle Drug

The range of generic drugs listed in Part I of the NI drug tariff increased in April 2011. This change means the list above may include generic drugs that, although prescribed generically, will have been dispensed by brand as no generics are currently available. If you have any queries regarding this please contact your Medicines Management Adviser (MMA).

*This is the drug's position in the HSCB's most costly drugs. For example, your practice's 20th most costly drug is Asacol 400mg MR gastro-resistant tablets 400MG [MODIFIED-RELEASE TABLET]. This drug is number 96 in the HSCB's most costly drugs.

Priority generic switches

During this quarter if there were problems with the supply of high volume generics then shortages will have occurred and this may affect prescribing data presented in this page.

	Proprietary Drug	Number of Items	Cost (£)	Generic equivalent	Potential Savings for the quarter (£)
1	LOSEC 20MG [CAPSULE]	12	348	OMEPRAZOLE 20MG [GASTRO-RESISTANT CAPSULE]	£317
2	NEXIUM 20MG [TABLET]	9	352	ESOMEPRAZOLE 20MG [GASTRO-RESISTANT TABLET]	£260
3	APROVEL 300MG [TABLET]	4	127	IRBESARTAN 300MG [TABLET]	£109
4	SEROQUEL 100MG [TABLET]	1	106	QUETIAPINE 100MG [TABLET]	£103
5	BONVIVA F/C 150MG [TABLET]	2	110	IBANDRONIC ACID 150MG [TABLET]	£92
6	IMIGRAN 100MG [TABLET]	1	86	SUMATRIPTAN 100MG [TABLET]	£82
7	DESMOTABS 200MCG [TABLET]	2	118	DESMOPRESSIN 200MICROGRAM [TABLET]	£78
8	PLAVIX 75MG [TABLET]	1	71	CLOPIDOGREL 75MG [TABLET]	£68
	Total	32	1,318		£1,109

NB Only individual switches that have the potential to release efficiencies ≥ £200 per annum are now included above.
If you would like data below this threshold please contact your Medicines Management Adviser (MMA).

Potential savings per annum £4,435

Top Cost Effective Choices

These should be considered for all new starts and at review in line with relevant guidance and SPC

		Drug name	Number of Items	Spend	Cost effective choice	Potential Savings for the quarter
1	††	SOLIFENACIN (DT) 5MG [TABLET]	26	£1,016	TOLTERODINE (DT) 2MG [TABLET]	£911
2		SALINE STERI-NEB [AMPOULE]	7	£564	STERIPOULES SODIUM CHLORIDE 2.5ML [AMPOULE]	£213
3	††	FESOTERODINE (DT) 4MG [MODIFIED-RELEASE TABLET]	7	£232	TOLTERODINE (DT) 2MG [TABLET]	£208
4	**	FLUTICASONE PROPIONATE (DT) 50MICROGRAMS/DOSE [NASAL SPRAY]	21	£242	BECLOMETASONE NASAL (DT) 50MCG [SPRAY]	£172
5	††	TOVIAZ 4MG [TABLET]	4	£180	TOLTERODINE (DT) 2MG [TABLET]	£162
6	††	SOLIFENACIN (DT) 10MG [TABLET]	2	£144	TOLTERODINE (DT) 2MG [TABLET]	£132
7	*	OMEPRAZOLE DISPERSIBLE (DT) 20MG [GASTRO-RESISTANT TABLET]	8	£151	LANSOPRAZOLE (DT) 15MG [ORODISPERSIBLE TABLET]	£111
8	†	NYSTATIN (DT) 100,000UNITS/ML [ORAL SUSPENSION]	9	£205	MICONAZOLE SUGAR FREE (DT) 20MG/G [OROMUCOSAL GEL]	£103
9	**	MOMETASONE NASAL (DT) 50MICROGRAMS/DOSE [SPRAY]	17	£153	BECLOMETASONE NASAL (DT) 50MCG [SPRAY]	£93
10	††	VESICARE FILM COATED 5MG [TABLET]	2	£81	TOLTERODINE (DT) 2MG [TABLET]	£73
11		CO-CODAMOL (DT) 8MG/500MG [EFFERVESCENT TABLET]	20	£140	CO-CODAMOL (DT) 8MG/500MG [TABLET]	£72
12	‡	PREDNISOLONE (DT) 5MG [GASTRO-RESISTANT TABLET]	42	£209	PREDNISOLONE (DT) 5MG [TABLET]	£64
13	§	DOXAZOSIN (DT) 8MG [MODIFIED-RELEASE TABLET]	5	£70	DOXAZOSIN (DT) 4MG [TABLET]	£63
14		OMEPRAZOLE (DT) 40MG [GASTRO-RESISTANT CAPSULE]	13	£108	OMEPRAZOLE (DT) 20MG [GASTRO-RESISTANT CAPSULE]	£52
		Total	**183**	**£3,494**		**£2,429**

NB Only individual switches that have the potential to release efficiencies ≥ £200 per annum are included above, up to a maximum of 20 switches. **Potential savings per annum** **£9,718**

Prior to initiating/switching to the cost-effective choice please refer to the additional information provided on the HSCB website:

† http://primarycare.hscni.net/pdf/guideline_for_the_treatment_of_oral_thrush_in_babies.pdf

‡ http://primarycare.hscni.net/pdf/PrednisoloneEC_SwitchSOP_Nov2011.pdf

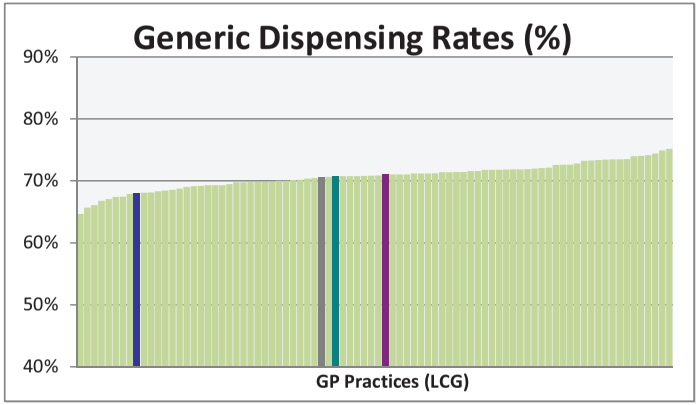
* Lansoprazole orodispersible tablets should be considered for all appropriate patients who require a dispersible PPI. For guidance on the treatment of children please refer to the BNF for Children.

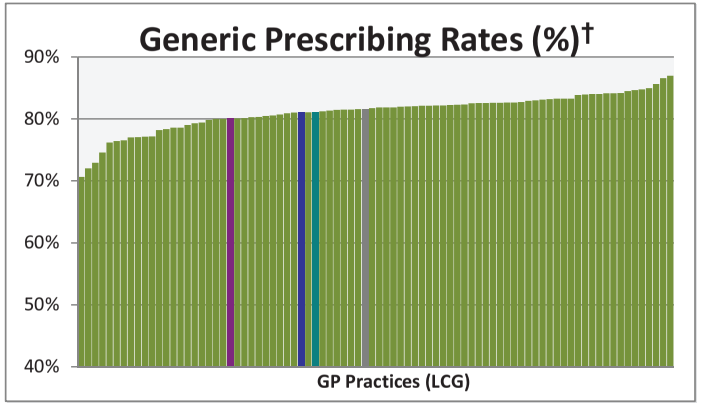
§ http://primarycare.hscni.net/pdf/Doxazosin_Switch_Guidance_April_2012.pdf

†† These should only be initiated after a trial of oral oxybutynin or tolterodine has been ineffective

** Beclometasone in hayfever

Overall Generic Rates





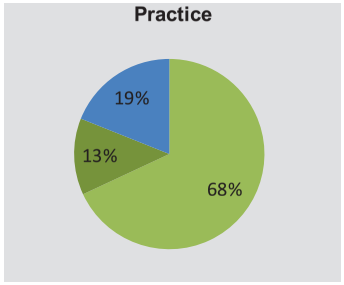
The range of generic drugs listed within Part I of the NI drug tariff increased in April 2011. This change may have increased your generic dispensing rate.

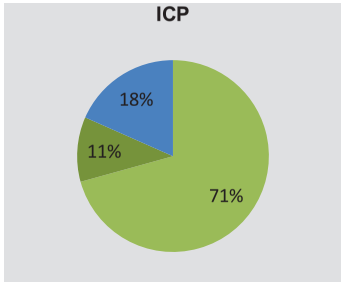
Your Practice | ICP Average | LCG Average | HSCB Average

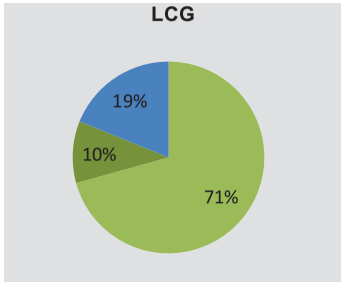
†The generic **prescribing** rates chart is new. This chart reports GP prescribing of generics. This will include drugs that, although prescribed generically, will have been dispensed by brand as no generic is currently available.

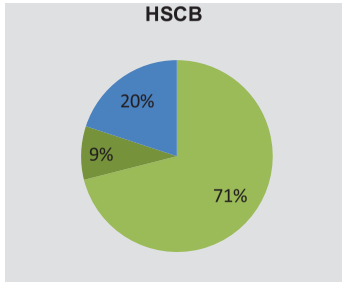
NB 100% generic prescribing rate is not achievable or desired as there are a number of items unsuitable for generic prescribing. See link below:
http://www.hscboard.hscni.net/medicinesmanagement/Prescribing%20Guidance/index.html

Prescribed and dispensed generically
Prescribed generically and dispensed by brand as no generic is currently available
Presribed and dispensed by brand







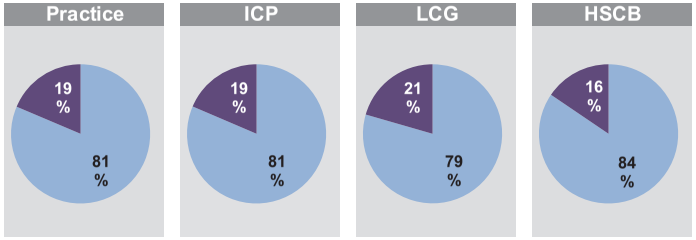


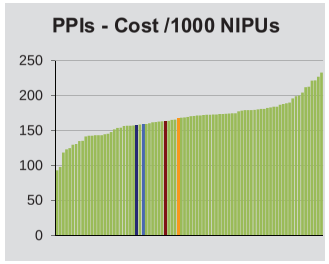
Proton Pump Inhibitors (PPIs)

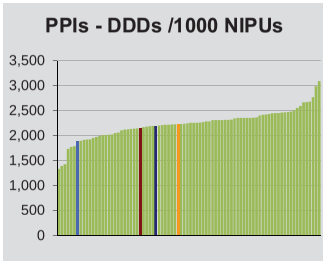
Preferred choices

Other items

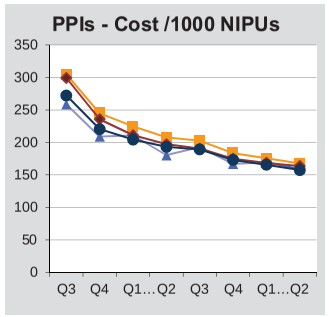
† If patients do not have swallowing difficulties, they could be switched to omeprazole or lansoprazole capsules.

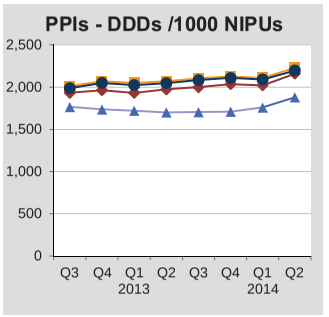


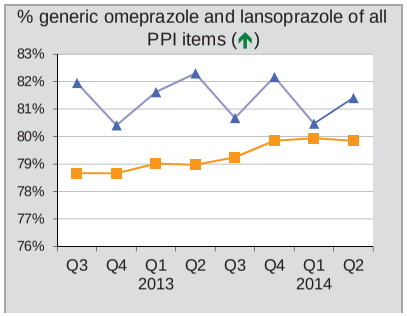


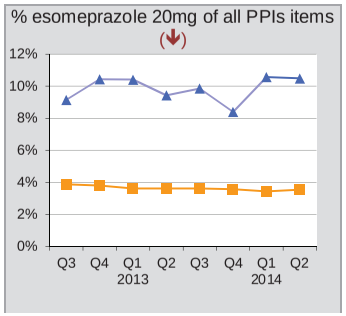


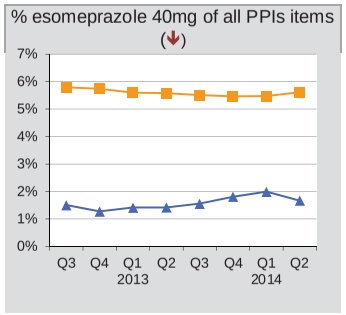
Drug name		Items	%	Items	%	Items	%	Items	%
Lansoprazole		201	23.96%	9921	34.98%	34755	30.85%	158553	31.26%
Omeprazole		482	57.45%	13170	46.44%	54781	48.63%	269884	53.21%
Pantoprazole		34	4.05%	1886	6.65%	10431	9.26%	30291	5.97%
Losec		13	1.55%	105	0.37%	356	0.32%	1611	0.32%
Protium		0	0.00%	0	0.00%	0	0.00%	0	0.00%
Esomeprazole (tablets)		92	10.97%	2641	9.31%	9890	8.78%	37843	7.46%
Lansoprazole orodispersible†		0	0.00%	0	0.00%	0	0.00%	0	0.00%
Omeprazole dispersible†		0	0.00%	0	0.00%	0	0.00%	0	0.00%
Rabeprazole		2	0.24%	218	0.77%	926	0.82%	2414	0.48%
Emozul (capsules)		0	0.00%	2	0.01%	2	0.00%	95	0.02%
Nexium (tablets)		10	1.19%	206	0.73%	775	0.69%	2883	0.57%
Pariet		0	0.00%	16	0.06%	76	0.07%	281	0.06%
Losec MUPS†		4	0.48%	103	0.36%	318	0.28%	1884	0.37%
Zoton FasTab†		1	0.12%	92	0.32%	341	0.30%	1459	0.29%











Key

Line charts

Q1 = Jan/Mar

Practice

ICP

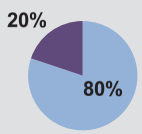
LCG

HSCB

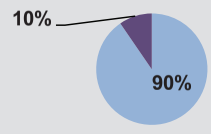
Upward trend preferable

Downward trend preferable

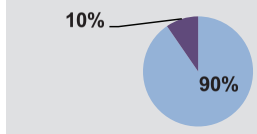
Lipid lowering drugs



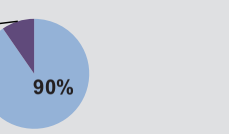
Drug name	Items	%
Simvastatin 10mg	3	0.34%
Simvastatin 20mg	75	8.51%
Simvastatin 40mg	367	41.66%
Simvastatin 80mg	1	0.11%
Simvastatin 20mg/5ml	0	0.00%
Simvastatin 40mg/5ml	0	0.00%
Atorvastatin 10mg	20	2.27%
Atorvastatin 20mg	49	5.56%
Atorvastatin 40mg	60	6.81%
Atorvastatin 80mg	12	1.36%
Pravastatin	119	13.51%
Fluvastatin	0	0.00%
Rosuvastatin	169	19.18%
Simvastatin + Ezetimibe	0	0.00%
Lescol /other brands	0	0.00%
Lipostat	0	0.00%
Zocor	0	0.00%
Crestor	6	0.68%
Inegy	0	0.00%
Lipitor 10mg	0	0.00%
Lipitor 20mg	0	0.00%
Lipitor 40mg	0	0.00%
Lipitor 80mg	0	0.00%



Drug name	Items	%
Simvastatin 10mg	428	1.80%
Simvastatin 20mg	2162	9.08%
Simvastatin 40mg	7408	31.12%
Simvastatin 80mg	14	0.06%
Simvastatin 20mg/5ml	4	0.02%
Simvastatin 40mg/5ml	23	0.10%
Atorvastatin 10mg	1861	7.82%
Atorvastatin 20mg	3276	13.76%
Atorvastatin 40mg	3773	15.85%
Atorvastatin 80mg	221	0.93%
Pravastatin	2355	9.89%
Fluvastatin	43	0.18%
Rosuvastatin	1951	8.20%
Simvastatin + Ezetimibe	43	0.18%
Lescol /other brands	5	0.02%
Lipostat	11	0.05%
Zocor	1	0.00%
Crestor	154	0.65%
Inegy	8	0.03%
Lipitor 10mg	18	0.08%
Lipitor 20mg	32	0.13%
Lipitor 40mg	13	0.05%
Lipitor 80mg	3	0.01%

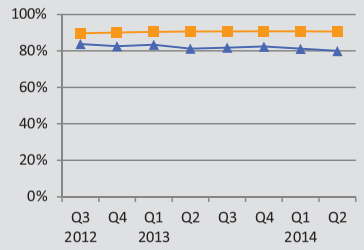


Drug name	Items	%
Simvastatin 10mg	2054	2.09%
Simvastatin 20mg	9574	9.76%
Simvastatin 40mg	28458	29.00%
Simvastatin 80mg	81	0.08%
Simvastatin 20mg/5ml	31	0.03%
Simvastatin 40mg/5ml	49	0.05%
Atorvastatin 10mg	8771	8.94%
Atorvastatin 20mg	13787	14.05%
Atorvastatin 40mg	16812	17.13%
Atorvastatin 80mg	1066	1.09%
Pravastatin	8088	8.24%
Fluvastatin	253	0.26%
Rosuvastatin	7943	8.09%
Simvastatin + Ezetimibe	117	0.12%
Lescol /other brands	20	0.02%
Lipostat	34	0.03%
Zocor	20	0.02%
Crestor	605	0.62%
Inegy	56	0.06%
Lipitor 10mg	113	0.12%
Lipitor 20mg	133	0.14%
Lipitor 40mg	70	0.07%
Lipitor 80mg	9	0.01%

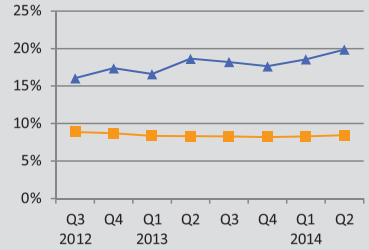


Drug name	Items	%
Simvastatin 10mg	9184	2.00%
Simvastatin 20mg	48808	10.62%
Simvastatin 40mg	153242	33.35%
Simvastatin 80mg	415	0.09%
Simvastatin 20mg/5ml	141	0.03%
Simvastatin 40mg/5ml	269	0.06%
Atorvastatin 10mg	37453	8.15%
Atorvastatin 20mg	53985	11.75%
Atorvastatin 40mg	80607	17.54%
Atorvastatin 80mg	6831	1.49%
Pravastatin	24277	5.28%
Fluvastatin	1101	0.24%
Rosuvastatin	37184	8.09%
Simvastatin + Ezetimibe	427	0.09%
Lescol /other brands	73	0.02%
Lipostat	114	0.02%
Zocor	102	0.02%
Crestor	3913	0.85%
Inegy	216	0.05%
Lipitor 10mg	418	0.09%
Lipitor 20mg	364	0.08%
Lipitor 40mg	291	0.06%
Lipitor 80mg	30	0.01%

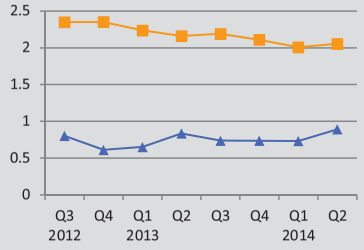
% simvastatin, atorvastatin and pravastatin of all statin items (↑)



% rosuvastatin of all statin items (↓)



Ezetimibe, Items /1000 NIPUs (↓)
(includes Ezetrol and Inegy)



Key

Pie charts

Preferred choices

Other items

Line charts

Q1 = Jan/Mar

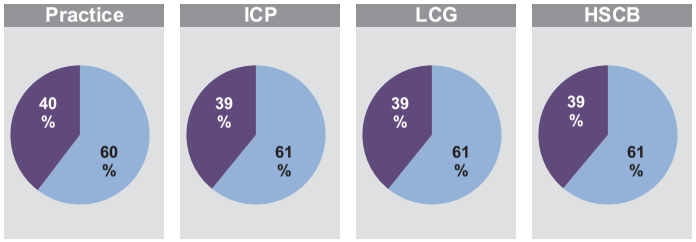
Practice

LCG

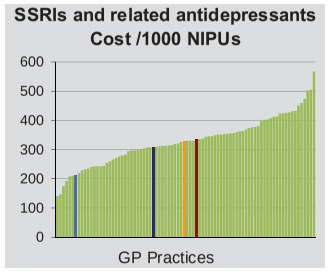
Upward trend preferable ↑

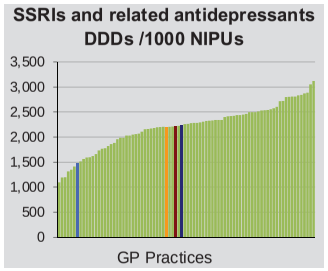
Downward trend preferable ↓

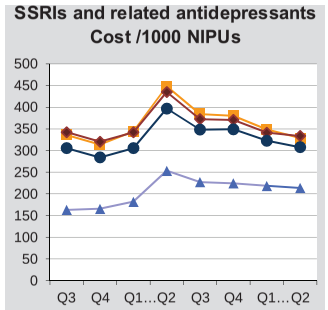
SSRIs and related antidepressant drugs

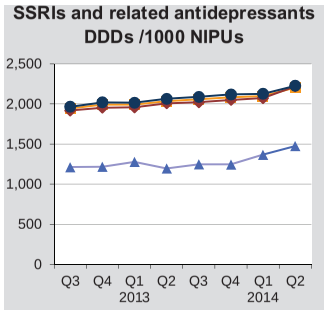


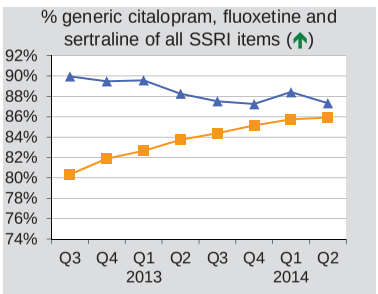
Drug name	Practice Items	Practice %	ICP Items	ICP %	LCG Items	LCG %	HSCB Items	HSCB %
Citalopram	150	22.26%	7633	25.21%	26867	23.31%	129369	25.02%
Fluoxetine	119	17.66%	5049	16.68%	18813	16.32%	94531	18.28%
Sertraline	138	20.47%	5757	19.01%	24395	21.17%	92071	17.81%
Duloxetine	17	2.52%	1361	4.50%	5448	4.73%	21892	4.23%
Escitalopram	48	7.12%	2250	7.43%	7648	6.64%	23441	4.53%
Flupentixol	0	0.00%	79	0.26%	101	0.09%	389	0.08%
Fluvoxamine	0	0.00%	4	0.01%	72	0.06%	210	0.04%
Mirtazapine	106	15.73%	3454	11.41%	13935	12.09%	64596	12.49%
Paroxetine	11	1.63%	682	2.25%	2329	2.02%	11764	2.28%
Reboxetine	0	0.00%	40	0.13%	136	0.12%	430	0.08%
Venlafaxine (incl. XL)	4	0.59%	671	2.22%	2323	2.02%	10841	2.10%
Cipramil	0	0.00%	12	0.04%	49	0.04%	282	0.05%
Efexor /XL /other brands	81	12.02%	2927	9.67%	11512	9.99%	58338	11.28%
Faverin	0	0.00%	0	0.00%	6	0.01%	30	0.01%
Lustral	0	0.00%	40	0.13%	120	0.10%	436	0.08%
Prozac	0	0.00%	14	0.05%	45	0.04%	325	0.06%
Seroxat	0	0.00%	21	0.07%	85	0.07%	388	0.08%
Cipralex	0	0.00%	106	0.35%	529	0.46%	2331	0.45%
Cymbalta	0	0.00%	141	0.47%	728	0.63%	4592	0.89%
Edronax	0	0.00%	4	0.01%	20	0.02%	137	0.03%
Fluanxol	0	0.00%	25	0.08%	51	0.04%	371	0.07%
Optimax	0	0.00%	0	0.00%	0	0.00%	12	0.00%
Zispin SolTab	0	0.00%	7	0.02%	36	0.03%	258	0.05%

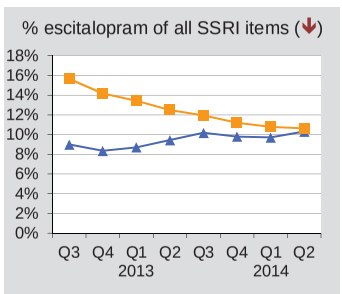


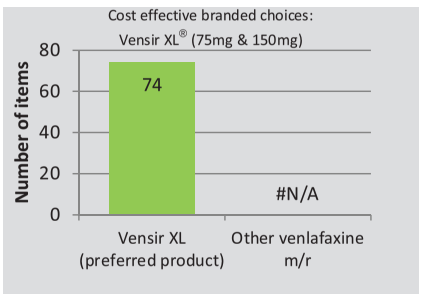


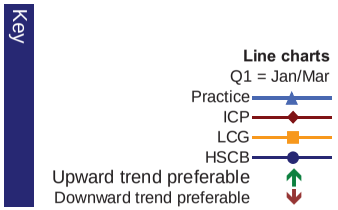


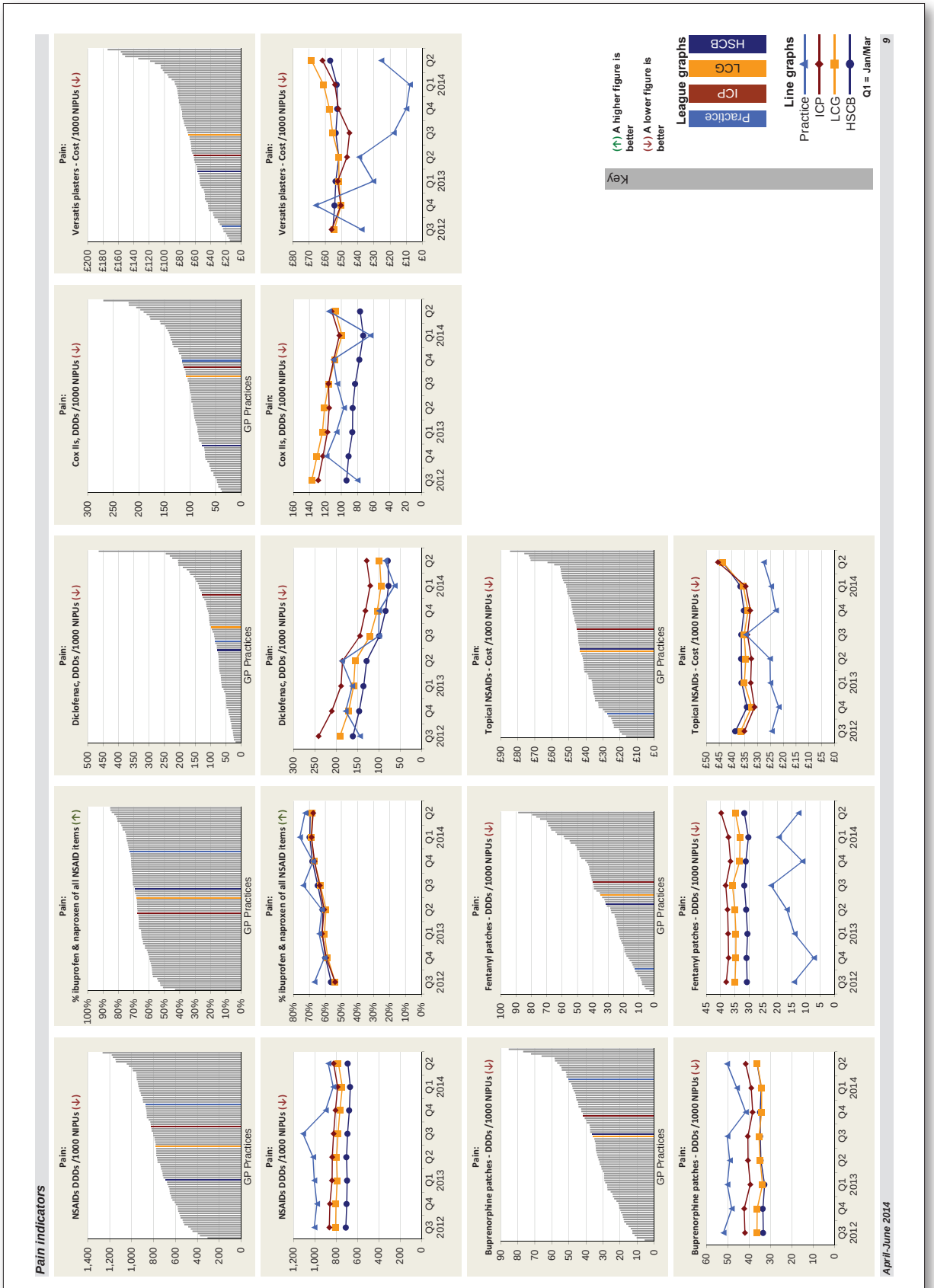











Pain indicators
Pain: NSAIDs DDDs /1000 NIPUs (↓)
Pain: % ibuprofen & naproxen of all NSAID items (↑)
Pain: Diclofenac, DDDs /1000 NIPUs (↓)
Pain: Cox IIs, DDDs /1000 NIPUs (↓)
Pain: Versatis plasters - Cost /1000 NIPUs (↓)
Pain: Buprenorphine patches - DDDs /1000 NIPUs (↓)
Pain: Fentanyl patches - DDDs /1000 NIPUs (↓)
Pain: Topical NSAIDs - Cost /1000 NIPUs (↓)
GP Practices
Q3 2012
Q4
Q1 2013
Q2
Q3
Q4
Q1 2014
Q2
Key
(↑) A higher figure is better
(↓) A lower figure is better
League graphs
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Line graphs
Practice
ICP
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HSCB
Q1 = Jan/Mar
April-June 2014
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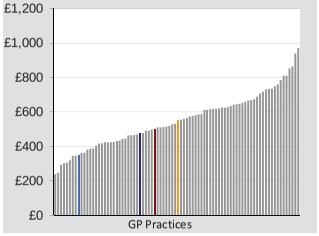
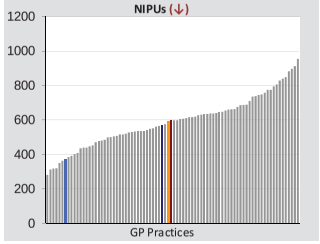
Pain indicators

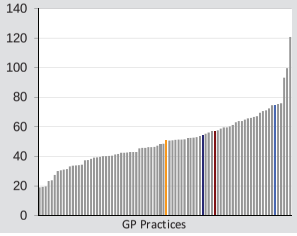
Pregabalin, Cost /1000 NIPUs (↓)



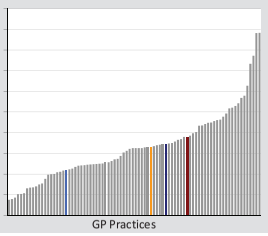
Paracetamol-opioid compound analgesics, DDDs /1000 NIPUs (↓)



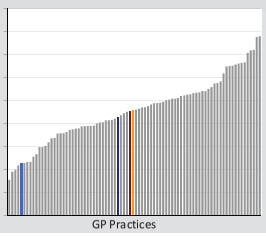
Co-codamol 8/500, DDDs /1000 NIPUs (↓)



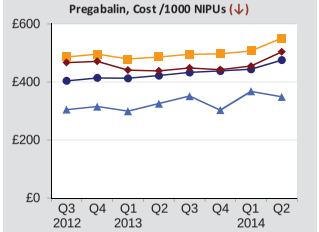
Co-codamol 15/500, DDDs /1000 NIPUs (↓)



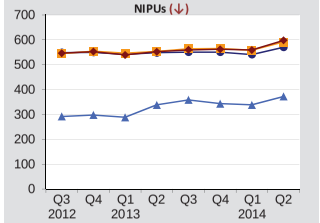
Co-codamol 30/500, DDDs /1000 NIPUs (↓)



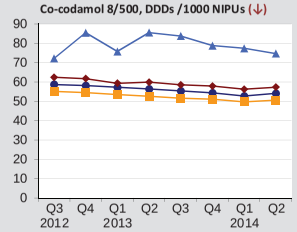
Pregabalin, Cost /1000 NIPUs (↓)



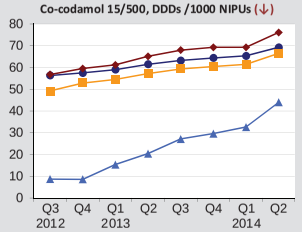
Paracetamol-opioid compound analgesics, DDDs /1000 NIPUs (↓)



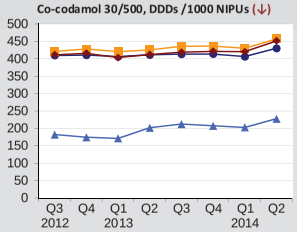
Co-codamol 8/500, DDDs /1000 NIPUs (↓)



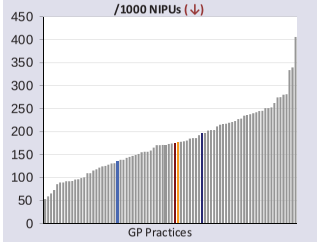
Co-codamol 15/500, DDDs /1000 NIPUs (↓)



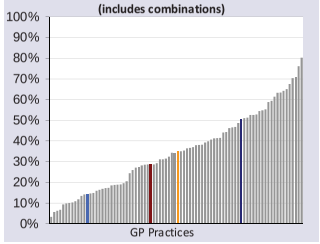
Co-codamol 30/500, DDDs /1000 NIPUs (↓)



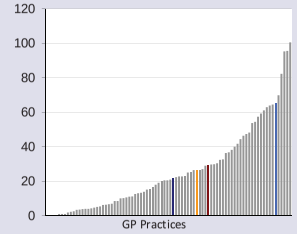
Tramadol/ tramadol-containing preparations, DDDs /1000 NIPUs (↓)



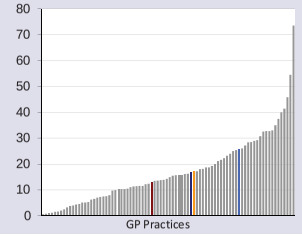
Tramadol MR items as a % of all tramadol items (↑) (includes combinations)



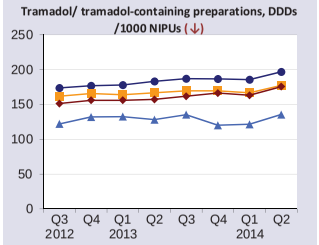
Dihydrocodeine, DDDs /1000 NIPUs (↓)



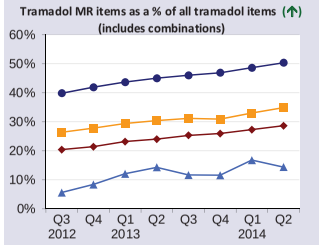
Co-dydramol, DDDs /1000 NIPUs (↓)



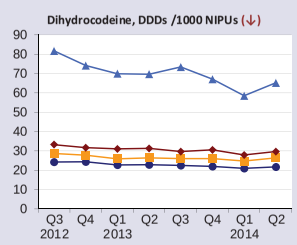
Tramadol/ tramadol-containing preparations, DDDs /1000 NIPUs (↓)



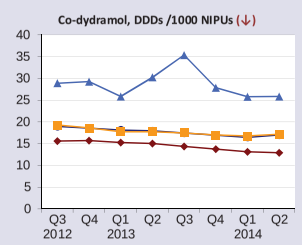
Tramadol MR items as a % of all tramadol items (↑) (includes combinations)



Dihydrocodeine, DDDs /1000 NIPUs (↓)



Co-dydramol, DDDs /1000 NIPUs (↓)



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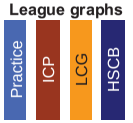
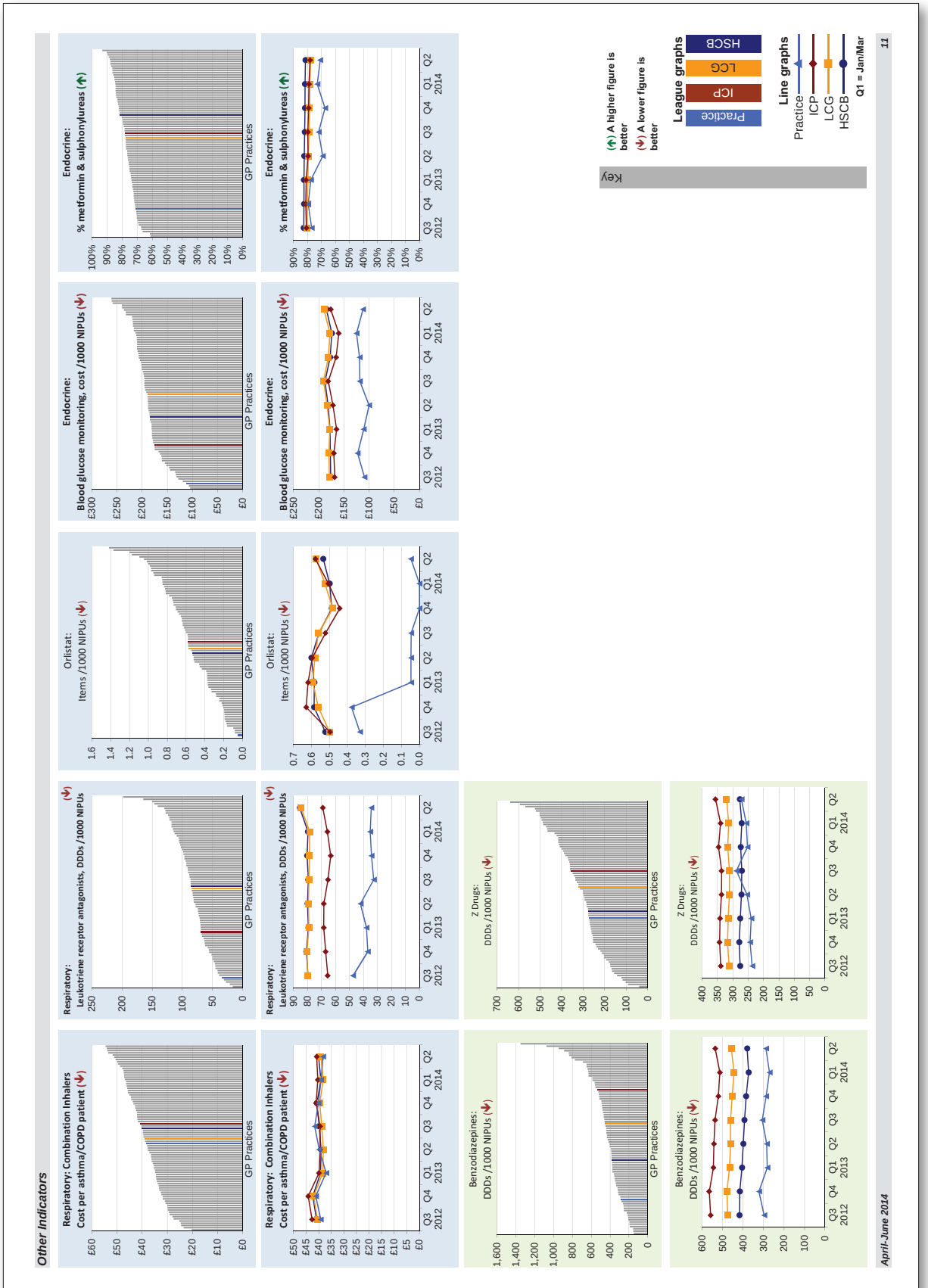
League graphs



Line graphs

Practice
ICP
LCG
HSCB

Q1 = Jan/Mar


Other Indicators
Respiratory: Combination Inhalers
Cost per asthma/COPD patient (↓)
Respiratory: Leukotriene receptor antagonists, DDDs /1000 NIPUs (↓)
Orlistat: Items /1000 NIPUs (↓)
Endocrine: Blood glucose monitoring, cost /1000 NIPUs (↓)
Endocrine: % metformin & sulphonylureas (↑)
Benzodiazepines: DDDs /1000 NIPUs (↓)
Z Drugs: DDDs /1000 NIPUs (↓)
GP Practices
Q3 2012
Q4 2012
Q1 2013
Q2 2013
Q3 2013
Q4 2013
Q1 2014
Q2 2014
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Line graphs
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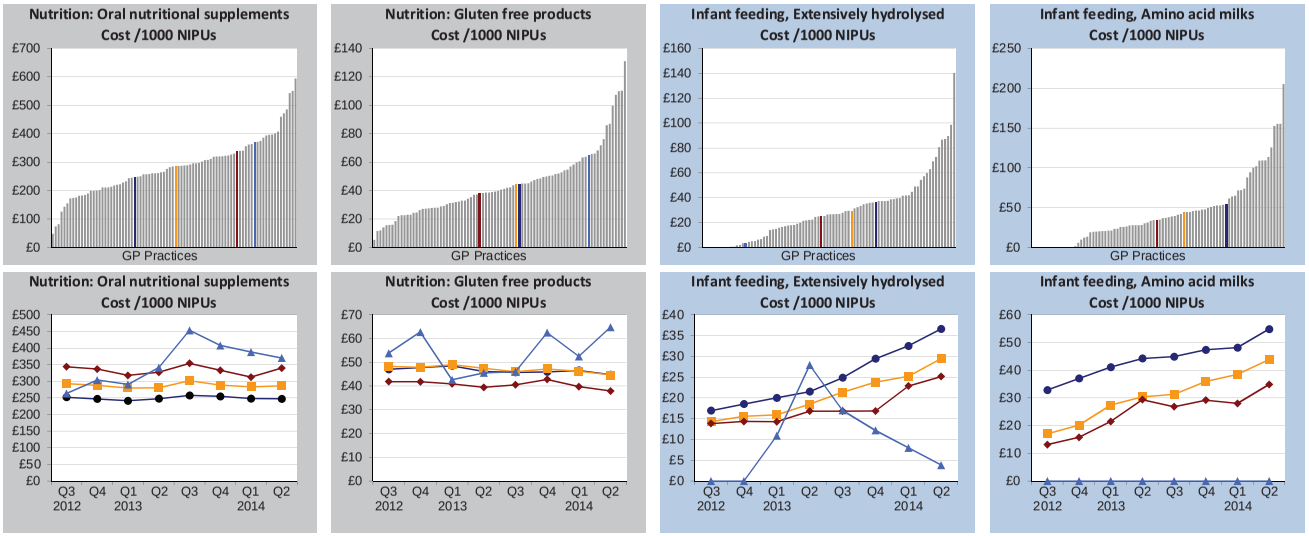
Other indicators cont'd



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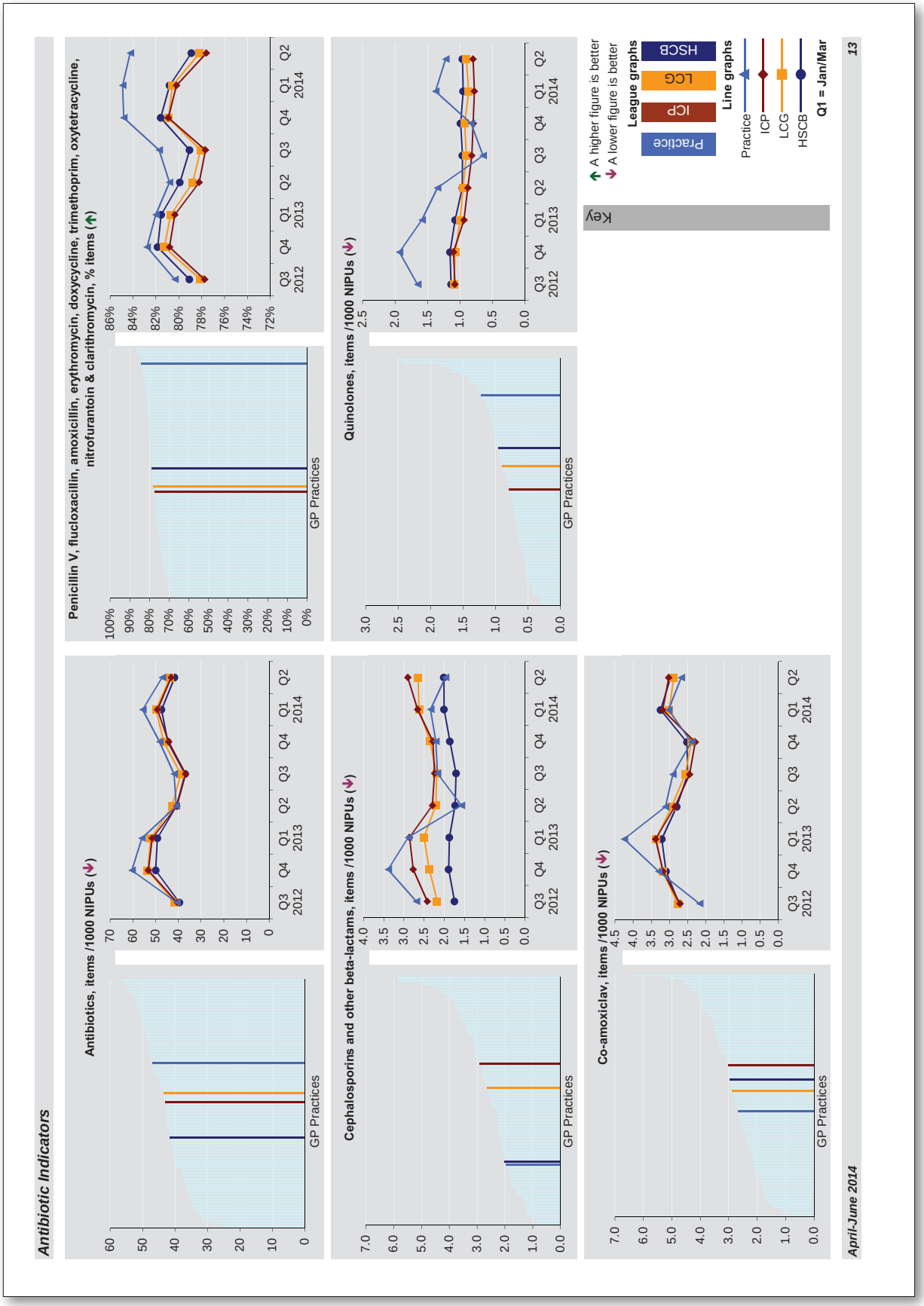
League graphs

Practice ICP LCG HSCB

Line graphs

Practice
ICP
LCG
HSCB

Q1 = Jan/Mar


Antibiotic Indicators
Penicillin V, flucloxacillin, amoxicillin, erythromycin, doxycycline, trimethoprim, oxytetracycline, nitrofurantoin & clarithromycin, % items (↑)
Quinolones, items /1000 NIPUs (↓)
Antibiotics, items /1000 NIPUs (↓)
Cephalosporins and other beta-lactams, items /1000 NIPUs (↓)
Co-amoxiclav, items /1000 NIPUs (↓)
GP Practices
Q3 2012
Q4
Q1 2013
Q2
Q3
Q4
Q1 2014
Q2
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High Risk Drugs

High Risk Drugs

Drug name/group	Items	Quantity
Warfarin 0.5mg	-	-
Warfarin 5mg	-	-
Methotrexate 10mg	-	-
Red List drugs	-	N/A

IV antibiotics: patient prescribing

Drug name	Items	Quantity
Totals	**0**	

Stock Prescribing

Top 15 Stock Items by Cost (excludes dressings & appliances)

	Drug name	Cost (£)	Items	Quantity
1	Dermol 500 lotion	£72.48	2	6000
2	Minims tropicamide 1% eye drops 0.5ml unit dose	£72.24	1	140
3	Depo-Medrone with Lidocaine suspension for injection 2ml vials	£70.13	1	10
4	Emla 5% cream	£45.00	1	100
5	Chlorphenamine 10mg/1ml solution for injection ampoules	£16.06	1	5
6	GlucoGel 40% gel original	£14.13	2	148
7	Diclofenac 75mg/3ml solution for injection ampoules	£8.26	1	10
8	Metoclopramide 10mg/2ml solution for injection ampoules	£3.00	1	10
9	Adrenaline (base) 1mg/1ml (1 in 1,000) solution for injection ampoules	£2.36	1	6
10	Sodium chloride 0.9% solution for injection 2ml ampoules	£2.07	1	10
11	Ventolin 100micrograms/dose Evohaler	£1.50	1	1
12				
13				
14				
15				
	Total	**£307**	**13**	
	Total of all Stock (includes dressings and appliances)	**£3,033**	**69**	

Stock CDs (schedules 2, 3, 4 and 5)

	Drug name	Cost (£)	Items	Quantity
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
	Total	**£0**	**0**	

Stock forms (definition):
Forms used for ordering stocks of drugs and appliances which are needed by GPs for the immediate treatment of patients; for use before a patient's needs can be met by giving a prescription in the ordinary way; and for administration by the doctor in person or a person acting under his direction.

Controlled Drug Prescribing - Patient Prescribing

DDDs /1000 NIPUs

	Jul/Sep 12	Oct/Dec	Jan/Mar 13	Apr/Jun	Jul/Sep	Oct/Dec	Jan/Mar 14	Apr/Jun	Trend
Total volume of CD prescribing	●	●	●	●	●	●	●	●	
Total volume of CD prescribing minus methadone liquid and buprenorphine tabs	●	●	●	●	●	●	●	●	
Alfentanil inj	○	○	○	○	○	○	○	○	
Buprenorphine inj	○	○	○	○	○	○	○	○	
Buprenorphine patches	●	●	●	●	●	●	●	●	
Buprenorphine tabs	●	●	●	●	●	●	●	●	
Cocaine eye drops	○	○	○	○	○	○	○	○	
Cyclimorph inj	○	○	○	○	○	○	○	○	
Dexamfetamine	○	○	○	○	○	○	○	○	
Diamorphine inj	●	○	○	○	●	●	○	○	
Diamorphine tabs	○	○	○	○	○	○	○	○	
Dihydrocodeine inj	○	○	○	○	○	○	○	○	
Dipipanone tabs	○	○	○	○	○	○	○	○	
Fentanyl intranasal	○	○	○	○	○	○	○	○	
Fentanyl oral	●	○	○	●	○	○	●	○	
Fentanyl patches	●	●	●	●	●	●	●	●	
Hydromorphone caps	○	○	○	○	○	○	○	○	
Lisdexamfetamine	○	○	○	○	○	○	○	○	
Methadone inj	○	○	○	○	○	○	○	○	
Methadone liquid	○	○	○	○	○	○	○	○	
Methadone tabs	○	○	○	○	○	○	○	○	
Methylphenidate	○	○	○	○	●	○	○	●	
Morphine inj (excl. Cyclimorph®)	○	○	○	○	○	○	○	○	
Morphine oral	○	○	○	○	●	●	○	●	
Morphine oral solutions	○	○	○	○	○	○	○	○	
Morphine suppositories	○	○	○	○	○	○	○	○	
Nabilone caps (Red List Drug)	○	○	○	○	○	○	○	○	
Oxycodone caps and tabs	●	●	●	●	●	●	●	●	
Oxycodone inj	○	○	○	○	○	○	○	●	
Oxycodone liquid	○	○	○	●	○	●	●	●	
Pentazocine caps, tabs, suppos	○	○	○	○	○	○	○	○	
Pentazocine inj	○	○	○	○	○	○	○	○	
Pethidine inj	○	○	○	○	○	○	○	○	
Pethidine tabs	●	●	●	●	●	●	●	●	
Tapentadol tabs	○	●	●	●	○	○	●	●	

Controlled Drug prescribing indicators

The controlled drugs monitoring indicators are based on the mean of the prescribing of all practices in the HSCB.

● The red indicator represents prescribing that falls above the upper control limit (UCL). This represents the top 1% of prescribing. The UCL is based on three standard deviations from the mean for each drug.

● The orange indicator represents prescribing that falls between the mean prescribing and the UCL.

● The green indicator represents prescribing that falls between the mean prescribing and no prescribing.

○ The white indicator represents no prescribing.

← Methylphenidate includes all strengths and formulations, including m/r

Appendix: COMPASS Explanatory Notes

Glossary			
ICPs	Integrated Care Partnerships	NIPUs	Northern Ireland Prescribing Units
LCG	Local Commissioning Group		
HSCB	Health and Social Care Board		

Quarter: Information in the COMPASS report is based on three months of prescribing data, i.e. one quarter.

ICP average: Figures refer to the average of all practices within the respective ICP.

LCG average: Figures refer to the average of all practices within the respective LCG.

HSCB average: Figures refer to the average of all practices within the HSCB, i.e. all practices in NI.

Cost (£): Net ingredient cost, equivalent to England's Net Ingredient Cost (NIC). Cost is useful in terms of monitoring the overall drugs bill, checking spend within prescribing budgets and calculating savings made or potential savings. Cost is less useful as a measure of drug consumption because of the differences in cost of alternative preparations and changes in prices.

Items: Number of prescription items. Count of items is a reasonable measure of the number of courses of treatments for vaccinations and acute treatments such as short courses of antibiotics. For other treatments it is less useful because of the wide variation in duration of supply per item.

NIPUs: In measuring prescribing, differences between practices need to be taken account of in order to make valid comparisons with local and national averages. NIPUs standardise for differences between practices in terms of patient list size, age/sex structure and additional needs.

Quantity: Number of physical units, i.e. tablets, capsules, patches, mLs, inhalers, vials etc. Quantity is a useful measure of prescribing when looking at individual preparations, e.g. methotrexate 10mg or warfarin 0.5mg and 5mg.

Change from Last Year: The actual change from the same quarter in the previous year.

Defined Daily Dose (DDD): The DDD is a unit of measurement based on the assumed average maintenance dose per day used for its main indication in adults. The World Health Organisation (WHO) developed the DDD as a method to compare drugs of different chemical structures and potencies. The DDD methodology standardises quantities prescribed into number of daily doses. See worked example below. The number of DDDs is calculated as follows:

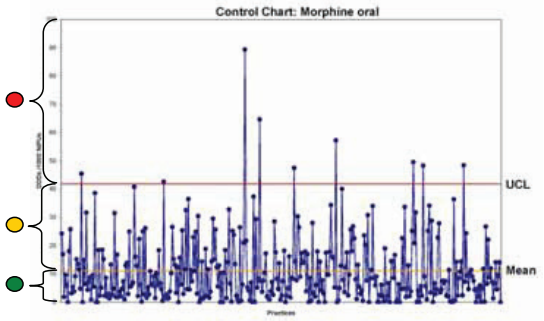
$$\text{Number of DDDs} = \frac{\text{Strength (mg) x quantity}}{\text{DDD (mg)}}$$

Worked example	Quantity (no. of tabs /caps)	DDD (mg)	No. of DDDs
Ibuprofen 200mg 2 caps 3 times a day	168	1200	$\frac{200 \times 168}{1200} = 28$
Ranitidine 150mg 1 tablet twice a day	56	300	$\frac{150 \times 56}{300} = 28$
Lansoprazole 30mg 1 capsule once a day	28	30	$\frac{30 \times 28}{30} = 28$

Prescribing Indicators listed throughout the report give some indication of prescribing quality but are not quantitative measures of good prescribing. Arrows indicate whether a larger figure or a smaller figure suggests 'better' prescribing. Values are given for the practice, locality average, LCG average and HSCB average. They are, therefore, useful in identifying outliers i.e. practice's whose prescribing differs substantially from other practices and to highlight areas for further analysis.

Red List Drugs: The Red list is an advisory list where it is considered by the Regional Group on Specialist Medicines, that responsibility for prescribing should remain with the consultant or specialist clinician. It is recommended that the supply of these specialist medicines should be organised via the hospital pharmacy.

Controlled Drugs (CDs): On the patient and stock prescribing pages there are red, orange and green dots. Each dot represents where a practice is on a control chart in relation to the Upper Control Limit (UCL) and the mean for all practices in NI (see chart below). The UCL is the mean + 3 standard deviations. A green dot represents a practice at the mean or below. An orange dot represents a practice above the mean but below the UCL. A red dot represents a practice above the UCL.



COMPASS Report

SLCG Practice Report

April-June 2014

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Quarter this year: Apr-Jun 14
Quarter last year: Apr-Jun 13
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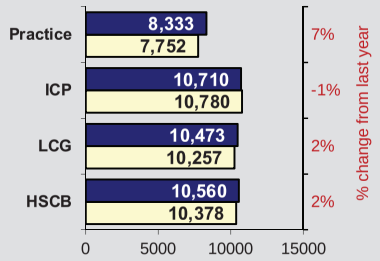
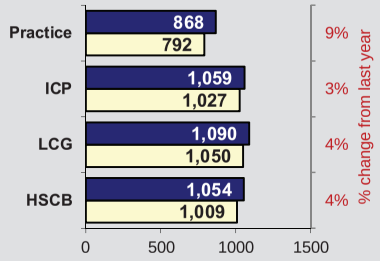
LCG
HSCB

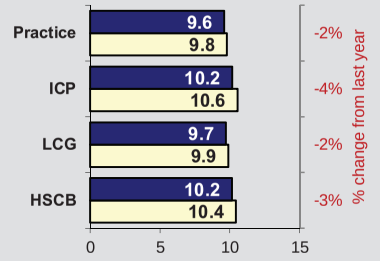
Cost (£) /1000 NIPUs†



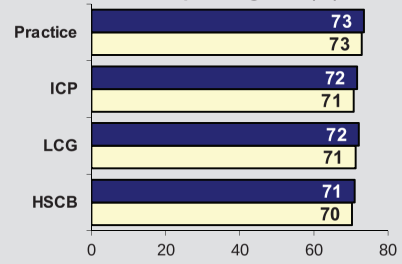
Items /1000 NIPUs†



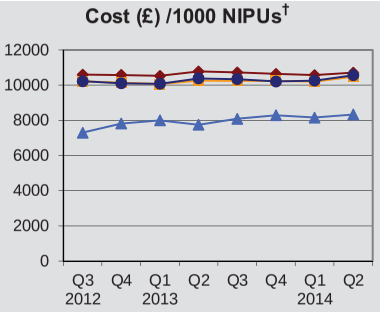
Cost (£) /Item



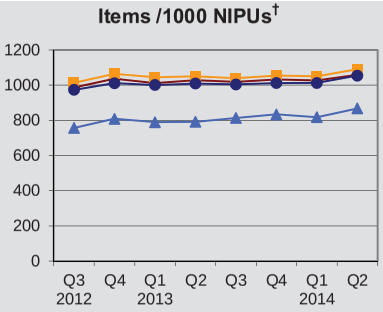
Generic dispensing rate (%)



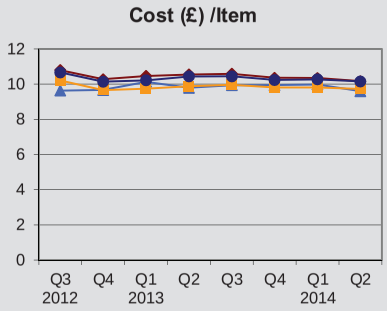
Cost (£) /1000 NIPUs†



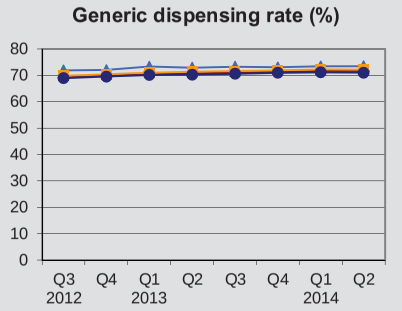
Items /1000 NIPUs†



Cost (£) /Item



Generic dispensing rate (%)



†See explanatory notes at end of report for more information.

Web site: http://www.hscbusiness.hscni.net/services.htm Tel: 028 9053 5661

Top 20 : Twenty most costly drugs in your practice

	Drug Name	Drug's position in HSCB's most costly drugs*	Cost (£)	No of Items	Quantity	Cost (£) /Item	% of Practice Total Cost	Change from last year
1	Symbicort 200/6 Turbohaler 200/6 [TURBOHALER]	6	2,888	62	76	46.58	1.50	-0.13
2	Seretide 250 Evohaler 250MCG/25 [EVOHALER]	2	2,379	30	40	79.31	1.23	0.12
3	Dutasteride 500microgram capsules 500MICROGRAM [CAPSULE]	41	2,332	56	2,350	41.64	1.21	-0.23
4	Rosuvastatin 20mg tablets 20MG [TABLET]	24	2,004	40	2,156	50.09	1.04	-0.02
5	Tiotropium bromide 18microgram inhalation powder capsules 18MICROGRAM [INHA	1	1,865	39	1,670	47.82	0.97	-0.14
6	Liothyronine 20microgram tablets 20MICROGRAM [TABLET]	231	1,841	7	504	263.06	0.96	0.96
7	Pregabalin 75mg capsules 75MG [CAPSULE]	3	1,739	27	1,512	64.40	0.90	-0.02
8	Lantus 100units/ml solution for injection 3ml pre-filled SoloStar pen 3ML [PRE-FILLE	8	1,735	27	209	64.25	0.90	-0.17
9	Nutrini Peptisorb liquid 500ML [LIQUID]	1086	1,710	3	168	570.08	0.89	0.89
10	Symbicort 400/12 Turbohaler 400/12 [TURBOHALER]	30	1,596	29	42	55.03	0.83	0.10
11	Xeplion 150mg/1.5ml suspension for injection pre-filled syringes 150MG [PRE-FILLE	181	1,570	4	4	392.59	0.81	0.17
12	NovoMix 30 FlexPen 100units/ml suspension for injection 3ml pre-filled pen 3ML [INJ	20	1,524	35	255	43.55	0.79	-0.10
13	Propranolol 10mg tablets 10MG [TABLET]	133	1,522	100	9,020	15.22	0.79	0.60
14	Fortisip Compact liquid apricot 125ML [BOTTLE]	26	1,487	22	736	67.58	0.77	0.30
15	Solifenacin 5mg tablets 5MG [TABLET]	23	1,458	44	1,584	33.14	0.76	0.08
16	NovoRapid FlexPen 100units/ml solution for injection 3ml pre-filled pen 3ML [PRE-FI	18	1,377	21	225	65.57	0.71	-0.60
17	Victoza 6mg/ml solution for injection 3ml pre-filled pen 3ML [PRE-FILLED INJECTIO	13	1,295	14	33	92.49	0.67	0.18
18	Nutramigen 2 LIPIL powder 400G [POWDER]	193	1,258	15	118	83.86	0.65	0.65
19	Ezetimibe 10mg tablets 10MG [TABLET]	11	1,237	31	1,316	39.89	0.64	0.08
20	Nutrison Energy liquid 1.5 LITRE [FOOD]	1745	1,200	3	78	400.14	0.62	0.62
	TOTAL		**34,018**	**609**			**17.64**	

▼ Black Triangle Drug

The range of generic drugs listed in Part I of the NI drug tariff increased in April 2011. This change means the list above may include generic drugs that, although prescribed generically, will have been dispensed by brand as no generics are currently available. If you have any queries regarding this please contact your Medicines Management Adviser (MMA).

*This is the drug's position in the HSCB's most costly drugs. For example, your practice's 20th most costly drug is Nutrison Energy liquid 1.5 LITRE [FOOD]. This drug is number 1745 in the HSCB's most costly drugs.

Priority generic switches

During this quarter if there were problems with the supply of high volume generics then shortages will have occurred and this may affect prescribing data presented in this page.

	Proprietary Drug	Number of Items	Cost (£)	Generic equivalent	Potential Savings for the quarter (£)
1	PLAVIX 75MG [TABLET]	2	133	CLOPIDOGREL 75MG [TABLET]	£126
2	SINGULAIR PAEDIATRIC CHEWABLE 5MG [TABLET]	5	128	MONTELUKAST SF 5MG [CHEWABLE TABLET]	£117
3	SINGULAIR PAEDIATRIC GRANULES 4MG [SACHET]	4	128	MONTELUKAST SF 4MG [GRANULE]	£108
4	NEXIUM 40MG [TABLET]	2	126	ESOMEPRAZOLE 40MG [GASTRO-RESISTANT TABLET]	£99
5	LIPOSTAT 20MG [TABLET]	2	104	PRAVASTATIN 20MG [TABLET]	£98
6	SINGULAIR 10MG [TABLET]	2	108	MONTELUKAST 10MG [TABLET]	£98
7	DETRUSITOL 1MG [TABLET]	3	87	TOLTERODINE 1MG [TABLET]	£78
	Total	**20**	**815**		**£724**

NB Only individual switches that have the potential to release efficiencies ≥ £200 per annum are now included above.
If you would like data below this threshold please contact your Medicines Management Adviser (MMA).

Potential savings per annum £2,897

Top Cost Effective Choices

These should be considered for all new starts and at review in line with relevant guidance and SPC

		Drug name	Number of Items	Spend	Cost effective choice	Potential Savings for the quarter
1	††	SOLIFENACIN (DT) 5MG [TABLET]	44	£1,458	TOLTERODINE (DT) 2MG [TABLET]	£1,307
2	††	SOLIFENACIN (DT) 10MG [TABLET]	26	£1,039	TOLTERODINE (DT) 2MG [TABLET]	£956
3	§	DOXAZOSIN (DT) 8MG [MODIFIED-RELEASE TABLET]	21	£399	DOXAZOSIN (DT) 4MG [TABLET]	£358
4	††	FESOTERODINE (DT) 4MG [MODIFIED-RELEASE TABLET]	12	£309	TOLTERODINE (DT) 2MG [TABLET]	£277
5		PARACETAMOL 500MG SOLUBLE TABLETS (DT) 500MG [EFFERVESCENT	51	£344	PARACETAMOL (DT) 500MG [TABLET]	£235
6		AZITHROMYCIN (DT) 250MG [CAPSULE]	9	£299	AZITHROMYCIN (DT) 250MG [TABLET]	£234
7	**	MOMETASONE NASAL (DT) 50MICROGRAMS/DOSE [SPRAY]	38	£312	BECLOMETASONE NASAL (DT) 50MCG [SPRAY]	£191
8	§	DOXAZOSIN (DT) 4MG [MODIFIED-RELEASE TABLET]	27	£230	DOXAZOSIN (DT) 2MG [TABLET]	£190
9		SALINE STERI-NEB [AMPOULE]	5	£434	STERIPOULES SODIUM CHLORIDE 2.5ML [AMPOULE]	£164
10	*	OMEPRAZOLE DISPERSIBLE (DT) 20MG [GASTRO-RESISTANT TABLET]	12	£220	LANSOPRAZOLE (DT) 15MG [ORODISPERSIBLE TABLET]	£162
11	**	FLUTICASONE PROPIONATE (DT) 50MICROGRAMS/DOSE [NASAL SPRAY]	14	£176	BECLOMETASONE NASAL (DT) 50MCG [SPRAY]	£125
12		OMEPRAZOLE (DT) 40MG [GASTRO-RESISTANT CAPSULE]	41	£251	OMEPRAZOLE (DT) 20MG [GASTRO-RESISTANT CAPSULE]	£122
13	*	OMEPRAZOLE DISPERSIBLE (DT) 40MG [GASTRO-RESISTANT TABLET]	3	£139	LANSOPRAZOLE (DT) 30MG [ORODISPERSIBLE TABLET]	£109
14	‡‡	IBUPROFEN (DT) 10% [GEL]	39	£237	KETOPROFEN (DT) 2.5% [GEL]	£103
15	†	NYSTATIN (DT) 100,000UNITS/ML [ORAL SUSPENSION]	9	£184	MICONAZOLE SUGAR FREE (DT) 20MG/G [OROMUCOSAL GEL]	£93
16		LEVOCETIRIZINE (DT) 5MG [TABLET]	16	£97	CETIRIZINE (DT) 10MG [TABLET]	£71
17	††	FESOTERODINE (DT) 8MG [MODIFIED-RELEASE TABLET]	1	£77	TOLTERODINE (DT) 2MG [TABLET]	£69
18		CO-CODAMOL (DT) 8MG/500MG [EFFERVESCENT TABLET]	19	£126	CO-CODAMOL (DT) 8MG/500MG [TABLET]	£66
19	§	CARDURA XL 4MG [TABLET]	6	£71	DOXAZOSIN (DT) 2MG [TABLET]	£59
20	#	PROCTOSEDYL [OINTMENT]	9	£93	UNIROID HC [OINTMENT]	£55
		Total	**402**	**£6,499**		**£4,945**

NB Only individual switches that have the potential to release efficiencies ≥ £200 per annum are included above, up to a maximum of 20 switches. **Potential savings per annum** **£19,782**

Prior to initiating/switching to the cost-effective choice please refer to the additional information provided on the HSCB website:

† http://primarycare.hscni.net/pdf/guideline_for_the_treatment_of_oral_thrush_in_babies.pdf

* Lansoprazole orodispersible tablets should be considered for all appropriate patients who require a dispersible PPI. For guidance on the treatment of children please refer to the BNF for Children.

§ http://primarycare.hscni.net/pdf/Doxazosin_Switch_Guidance_April_2012.pdf

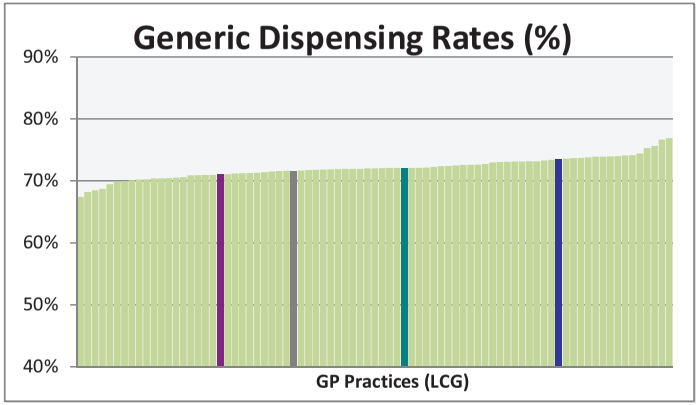
†† These should only be initiated after a trial of oral oxybutynin or tolterodine has been ineffective

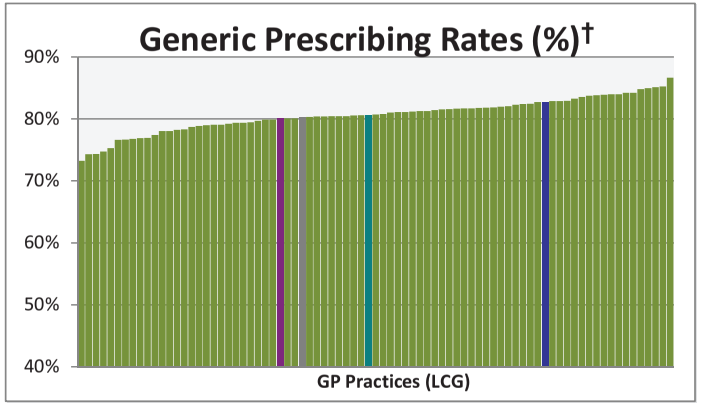
‡‡ If ketoprofen gel is unsuitable Ibuprofen gel should be considered

Uniroid HC ointment or Anusol HC ointment may be chosen

** Beclometasone in hayfever

Overall Generic Rates





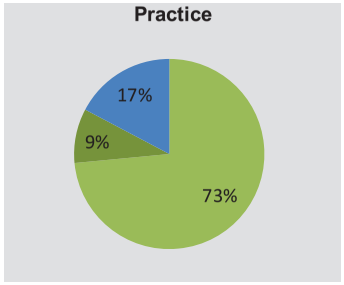
The range of generic drugs listed within Part I of the NI drug tariff increased in April 2011. This change may have increased your generic dispensing rate.

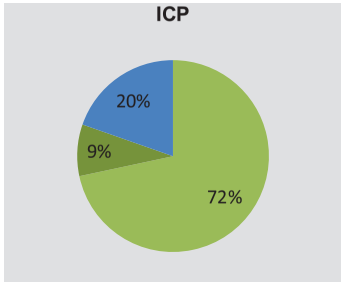
Your Practice | ICP Average | LCG Average | HSCB Average

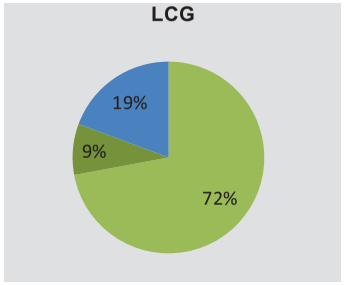
Prescribed and dispensed generically
Prescribed generically and dispensed by brand as no generic is currently available
Presribed and dispensed by brand

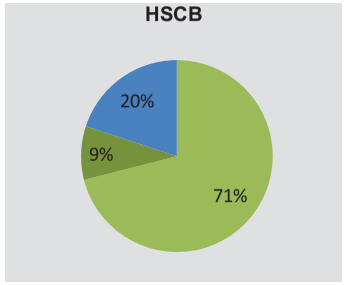
†The generic **prescribing** rates chart is new. This chart reports GP prescribing of generics. This will include drugs that, although prescribed generically, will have been dispensed by brand as no generic is currently available.

NB 100% generic prescribing rate is not achievable or desired as there are a number of items unsuitable for generic prescribing. See link below:
http://www.hscboard.hscni.net/medicinesmanagement/Prescribing%20Guidance/index.html







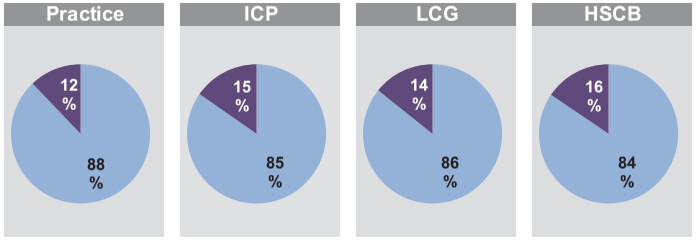


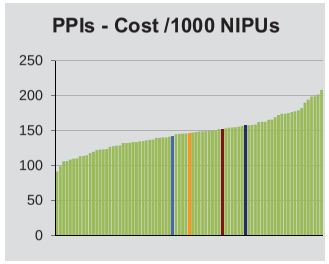
Proton Pump Inhibitors (PPIs)

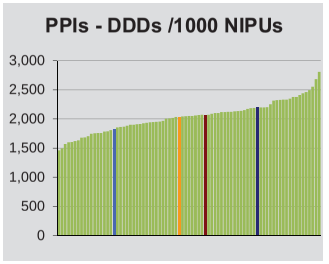
Preferred choices

Other items

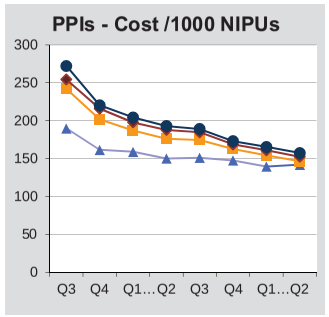
† If patients do not have swallowing difficulties, they could be switched to omeprazole or lansoprazole capsules.

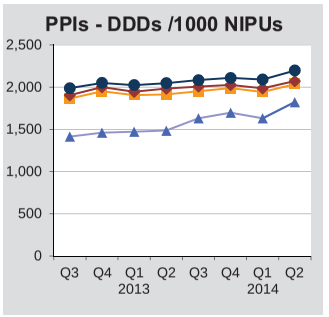


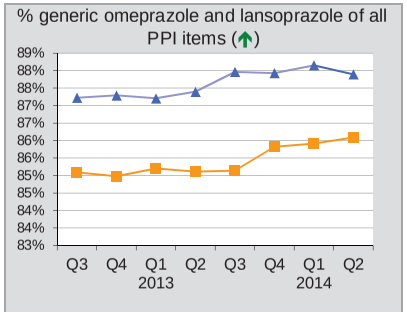


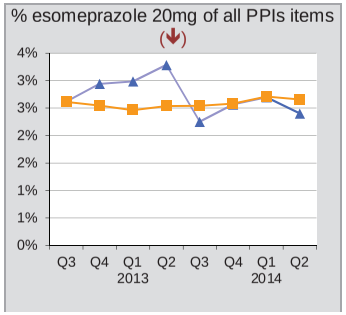


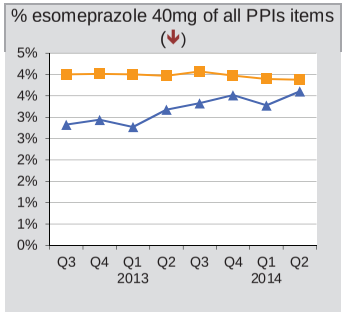
Drug name	Items	%	Items	%	Items	%	Items	%
Lansoprazole	331	30.59%	18376	45.98%	40902	42.06%	158553	31.26%
Omeprazole	620	57.30%	15467	38.70%	42461	43.67%	269884	53.21%
Pantoprazole	61	5.64%	2778	6.95%	6210	6.39%	30291	5.97%
Losec	5	0.46%	203	0.51%	397	0.41%	1611	0.32%
Protium	0	0.00%	0	0.00%	0	0.00%	0	0.00%
Esomeprazole (tablets)	62	5.73%	2466	6.17%	5838	6.00%	37843	7.46%
Lansoprazole orodispersible†	0	0.00%	0	0.00%	0	0.00%	0	0.00%
Omeprazole dispersible†	0	0.00%	0	0.00%	0	0.00%	0	0.00%
Rabeprazole	0	0.00%	174	0.44%	353	0.36%	2414	0.48%
Emozul (capsules)	0	0.00%	10	0.03%	16	0.02%	95	0.02%
Nexium (tablets)	3	0.28%	157	0.39%	413	0.42%	2883	0.57%
Pariet	0	0.00%	28	0.07%	61	0.06%	281	0.06%
Losec MUPS†	0	0.00%	159	0.40%	324	0.33%	1884	0.37%
Zoton FasTab†	0	0.00%	147	0.37%	266	0.27%	1459	0.29%

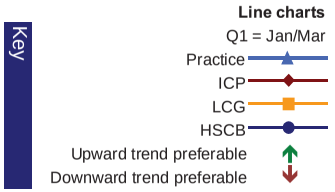




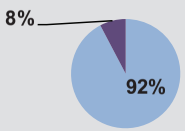




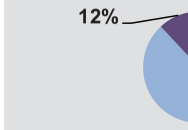




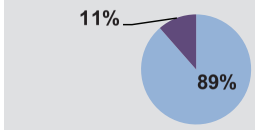
Lipid lowering drugs



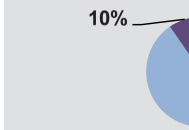
Drug name	Items	%
Simvastatin 10mg	32	3.13%
Simvastatin 20mg	162	15.85%
Simvastatin 40mg	288	28.18%
Simvastatin 80mg	0	0.00%
Simvastatin 20mg/5ml	0	0.00%
Simvastatin 40mg/5ml	0	0.00%
Atorvastatin 10mg	42	4.11%
Atorvastatin 20mg	108	10.57%
Atorvastatin 40mg	239	23.39%
Atorvastatin 80mg	9	0.88%
Pravastatin	63	6.16%
Fluvastatin	4	0.39%
Rosuvastatin	70	6.85%
Simvastatin + Ezetimibe	1	0.10%
Lescol /other brands	0	0.00%
Lipostat	2	0.20%
Zocor	0	0.00%
Crestor	0	0.00%
Inegy	2	0.20%
Lipitor 10mg	0	0.00%
Lipitor 20mg	0	0.00%
Lipitor 40mg	0	0.00%
Lipitor 80mg	0	0.00%



Drug name	Items	%
Simvastatin 10mg	479	1.34%
Simvastatin 20mg	3280	9.19%
Simvastatin 40mg	12209	34.19%
Simvastatin 80mg	29	0.08%
Simvastatin 20mg/5ml	13	0.04%
Simvastatin 40mg/5ml	18	0.05%
Atorvastatin 10mg	2127	5.96%
Atorvastatin 20mg	3467	9.71%
Atorvastatin 40mg	7847	21.98%
Atorvastatin 80mg	337	0.94%
Pravastatin	1629	4.56%
Fluvastatin	96	0.27%
Rosuvastatin	3544	9.93%
Simvastatin + Ezetimibe	31	0.09%
Lescol /other brands	7	0.02%
Lipostat	3	0.01%
Zocor	16	0.04%
Crestor	456	1.28%
Inegy	27	0.08%
Lipitor 10mg	29	0.08%
Lipitor 20mg	29	0.08%
Lipitor 40mg	33	0.09%
Lipitor 80mg	0	0.00%

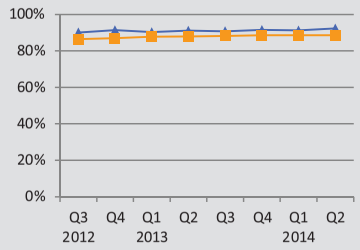


Drug name	Items	%
Simvastatin 10mg	1450	1.58%
Simvastatin 20mg	8376	9.14%
Simvastatin 40mg	33912	37.01%
Simvastatin 80mg	76	0.08%
Simvastatin 20mg/5ml	17	0.02%
Simvastatin 40mg/5ml	51	0.06%
Atorvastatin 10mg	5472	5.97%
Atorvastatin 20mg	8031	8.76%
Atorvastatin 40mg	18386	20.06%
Atorvastatin 80mg	1086	1.19%
Pravastatin	4319	4.71%
Fluvastatin	210	0.23%
Rosuvastatin	8721	9.52%
Simvastatin + Ezetimibe	75	0.08%
Lescol /other brands	19	0.02%
Lipostat	11	0.01%
Zocor	24	0.03%
Crestor	1162	1.27%
Inegy	56	0.06%
Lipitor 10mg	61	0.07%
Lipitor 20mg	49	0.05%
Lipitor 40mg	71	0.08%
Lipitor 80mg	1	0.00%

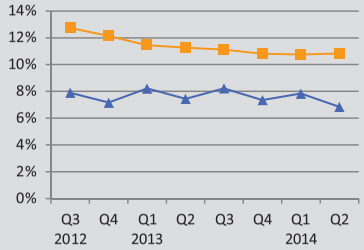


Drug name	Items	%
Simvastatin 10mg	9184	2.00%
Simvastatin 20mg	48808	10.62%
Simvastatin 40mg	153242	33.35%
Simvastatin 80mg	415	0.09%
Simvastatin 20mg/5ml	141	0.03%
Simvastatin 40mg/5ml	269	0.06%
Atorvastatin 10mg	37453	8.15%
Atorvastatin 20mg	53985	11.75%
Atorvastatin 40mg	80607	17.54%
Atorvastatin 80mg	6831	1.49%
Pravastatin	24277	5.28%
Fluvastatin	1101	0.24%
Rosuvastatin	37184	8.09%
Simvastatin + Ezetimibe	427	0.09%
Lescol /other brands	73	0.02%
Lipostat	114	0.02%
Zocor	102	0.02%
Crestor	3913	0.85%
Inegy	216	0.05%
Lipitor 10mg	418	0.09%
Lipitor 20mg	364	0.08%
Lipitor 40mg	291	0.06%
Lipitor 80mg	30	0.01%

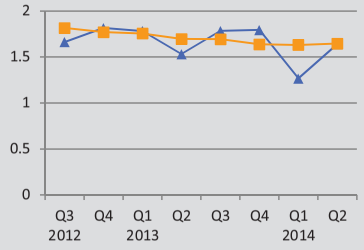
% simvastatin, atorvastatin and pravastatin of all statin items (↑)



% rosuvastatin of all statin items (↓)



Ezetimibe, Items /1000 NIPUs (↓)
(includes Ezetrol and Inegy)



Key

Pie charts

Preferred choices

Other items

Line charts

Q1 = Jan/Mar

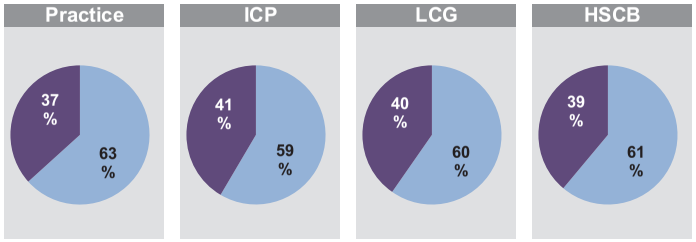
Practice

LCG

Upward trend preferable ↑

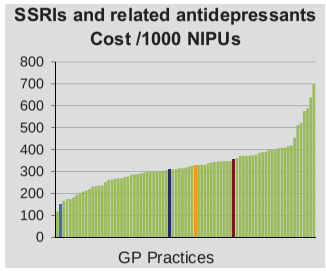
Downward trend preferable ↓

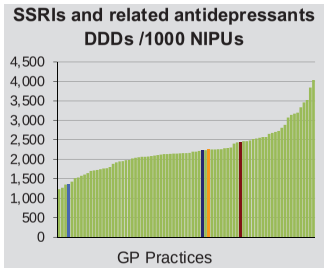
SSRIs and related antidepressant drugs

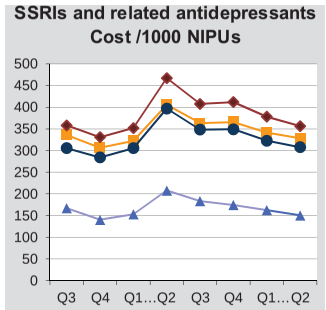


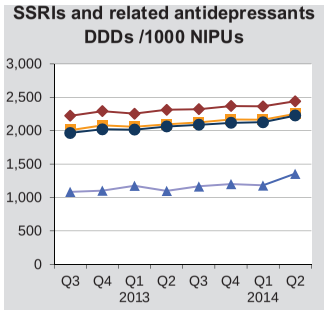
Preferred choices
Other items

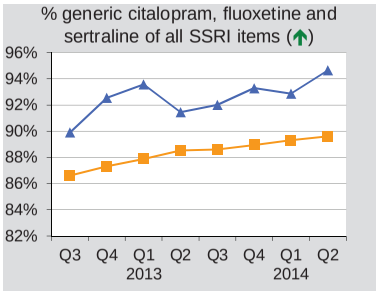
Drug name	Items	%	Items	%	Items	%	Items	%
Citalopram	304	38.73%	10699	24.51%	24780	24.59%	129369	25.02%
Fluoxetine	91	11.59%	7257	16.62%	19116	18.97%	94531	18.28%
Sertraline	102	12.99%	7586	17.38%	16278	16.15%	92071	17.81%
Duloxetine	15	1.91%	1717	3.93%	4015	3.98%	21892	4.23%
Escitalopram	6	0.76%	1926	4.41%	3889	3.86%	23441	4.53%
Flupentixol	0	0.00%	64	0.15%	105	0.10%	389	0.08%
Fluvoxamine	0	0.00%	8	0.02%	25	0.02%	210	0.04%
Mirtazapine	135	17.20%	6181	14.16%	13140	13.04%	64596	12.49%
Paroxetine	17	2.17%	896	2.05%	2309	2.29%	11764	2.28%
Reboxetine	3	0.38%	19	0.04%	70	0.07%	430	0.08%
Venlafaxine (incl. XL)	27	3.44%	1136	2.60%	2960	2.94%	10841	2.10%
Cipramil	1	0.13%	16	0.04%	40	0.04%	282	0.05%
Efexor /XL /other brands	72	9.17%	5472	12.53%	12266	12.17%	58338	11.28%
Faverin	0	0.00%	8	0.02%	8	0.01%	30	0.01%
Lustral	0	0.00%	39	0.09%	105	0.10%	436	0.08%
Prozac	0	0.00%	49	0.11%	72	0.07%	325	0.06%
Seroxat	2	0.25%	39	0.09%	90	0.09%	388	0.08%
Cipralex	2	0.25%	221	0.51%	545	0.54%	2331	0.45%
Cymbalta	0	0.00%	215	0.49%	772	0.77%	4592	0.89%
Edronax	0	0.00%	8	0.02%	43	0.04%	137	0.03%
Fluanxol	8	1.02%	90	0.21%	115	0.11%	371	0.07%
Optimax	0	0.00%	2	0.00%	9	0.01%	12	0.00%
Zispin SolTab	0	0.00%	8	0.02%	31	0.03%	258	0.05%

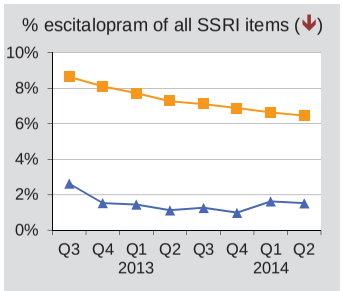


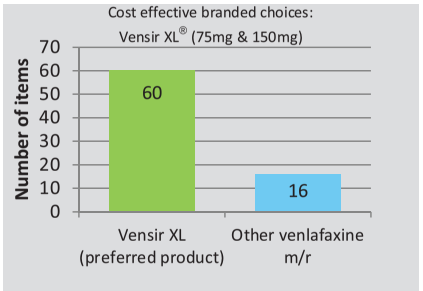






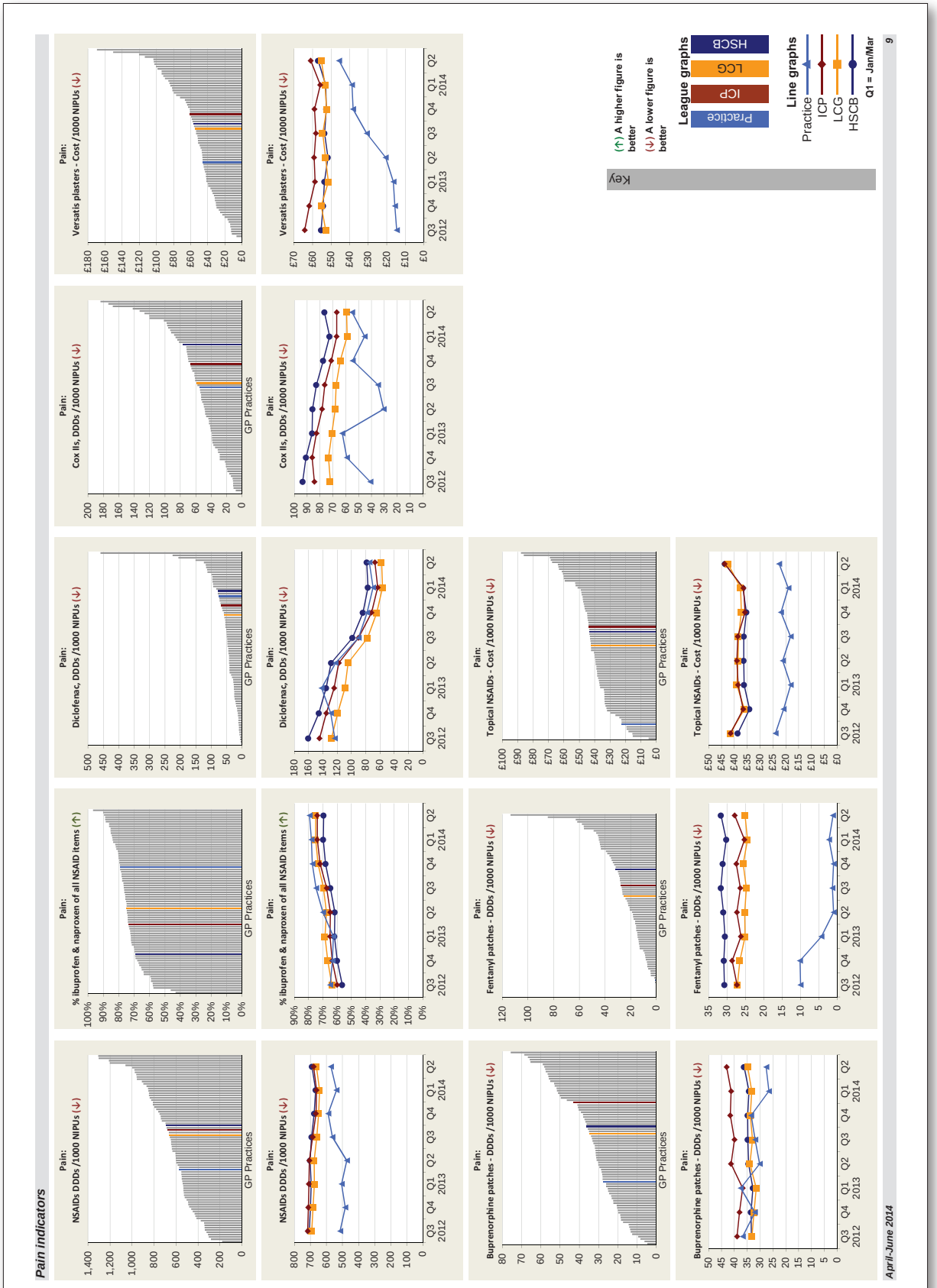






Key

Line charts
Q1 = Jan/Mar
Practice
ICP
LCG
HSCB
Upward trend preferable
Downward trend preferable


Pain indicators
Pain: NSAIDs DDDs /1000 NIPUs (↓)
Pain: % ibuprofen & naproxen of all NSAID items (↑)
Pain: Diclofenac, DDDs /1000 NIPUs (↓)
Pain: Cox IIs, DDDs /1000 NIPUs (↓)
Pain: Versatis plasters - Cost /1000 NIPUs (↓)
Pain: Buprenorphine patches - DDDs /1000 NIPUs (↓)
Pain: Fentanyl patches - DDDs /1000 NIPUs (↓)
Pain: Topical NSAIDs - Cost /1000 NIPUs (↓)
GP Practices
Key
(↑) A higher figure is better
(↓) A lower figure is better
League graphs
Practice
ICP
LCG
HSCB
Line graphs
Practice
ICP
LCG
HSCB
Q1 = Jan/Mar
April-June 2014
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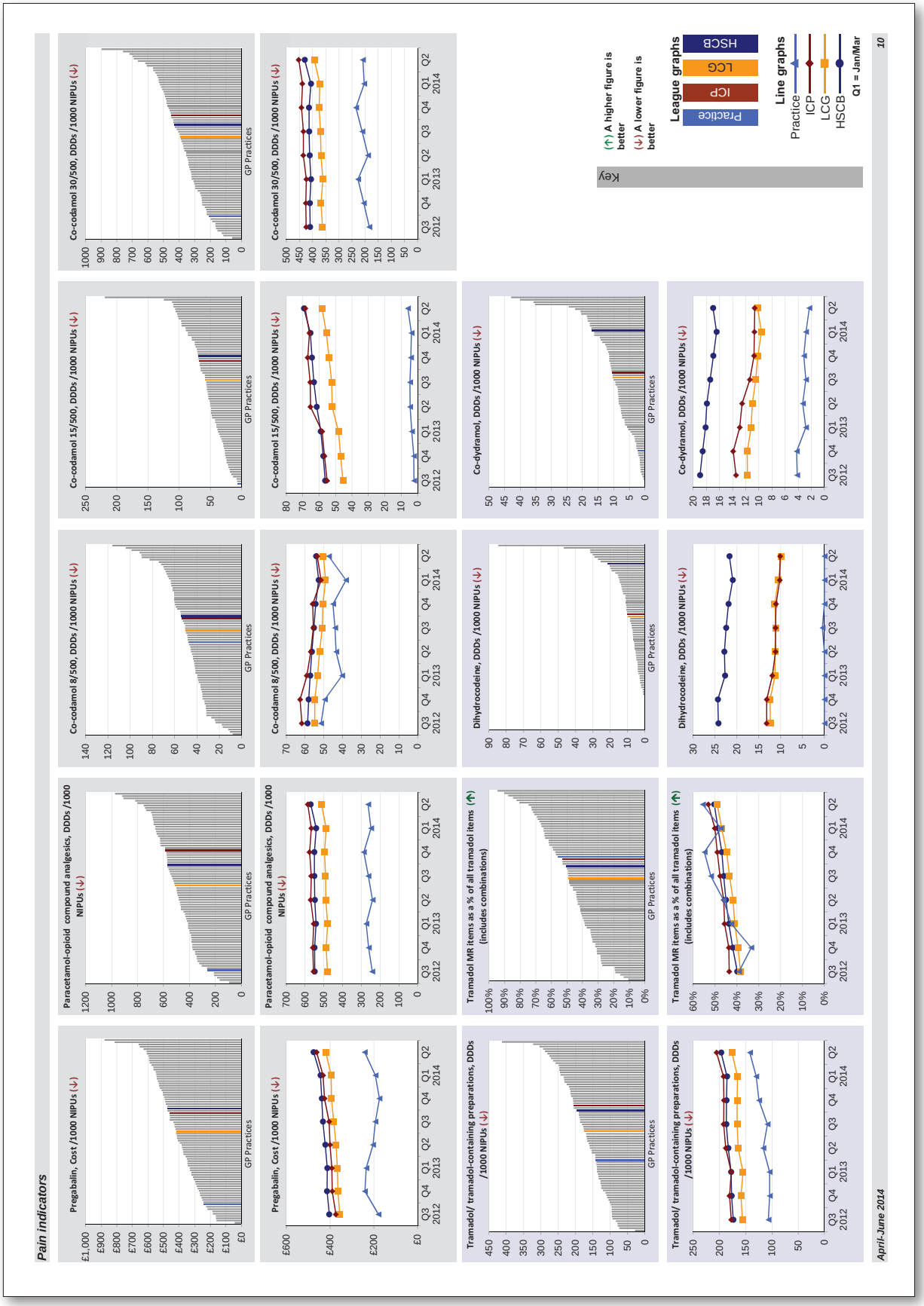
Pain indicators
Co-codamol 30/500, DDDs /1000 NIPUs (↓)
Co-codamol 15/500, DDDs /1000 NIPUs (↓)
Co-dydramol, DDDs /1000 NIPUs (↓)
Co-codamol 8/500, DDDs /1000 NIPUs (↓)
Dihydrocodeine, DDDs /1000 NIPUs (↓)
Paracetamol-opioid compound analgesics, DDDs /1000 NIPUs (↓)
Tramadol MR items as a % of all tramadol items (↑) (includes combinations)
Pregabalin, Cost /1000 NIPUs (↓)
Tramadol/ tramadol-containing preparations, DDDs /1000 NIPUs (↓)
GP Practices
Q3 2012
Q4
Q1 2013
Q2
Q3
Q4
Q1 2014
Q2
Key
(↑) A higher figure is better
(↓) A lower figure is better
League graphs
Practice
ICP
LCG
HSCB
Line graphs
Practice
ICP
LCG
HSCB
Q1 = Jan/Mar
April-June 2014
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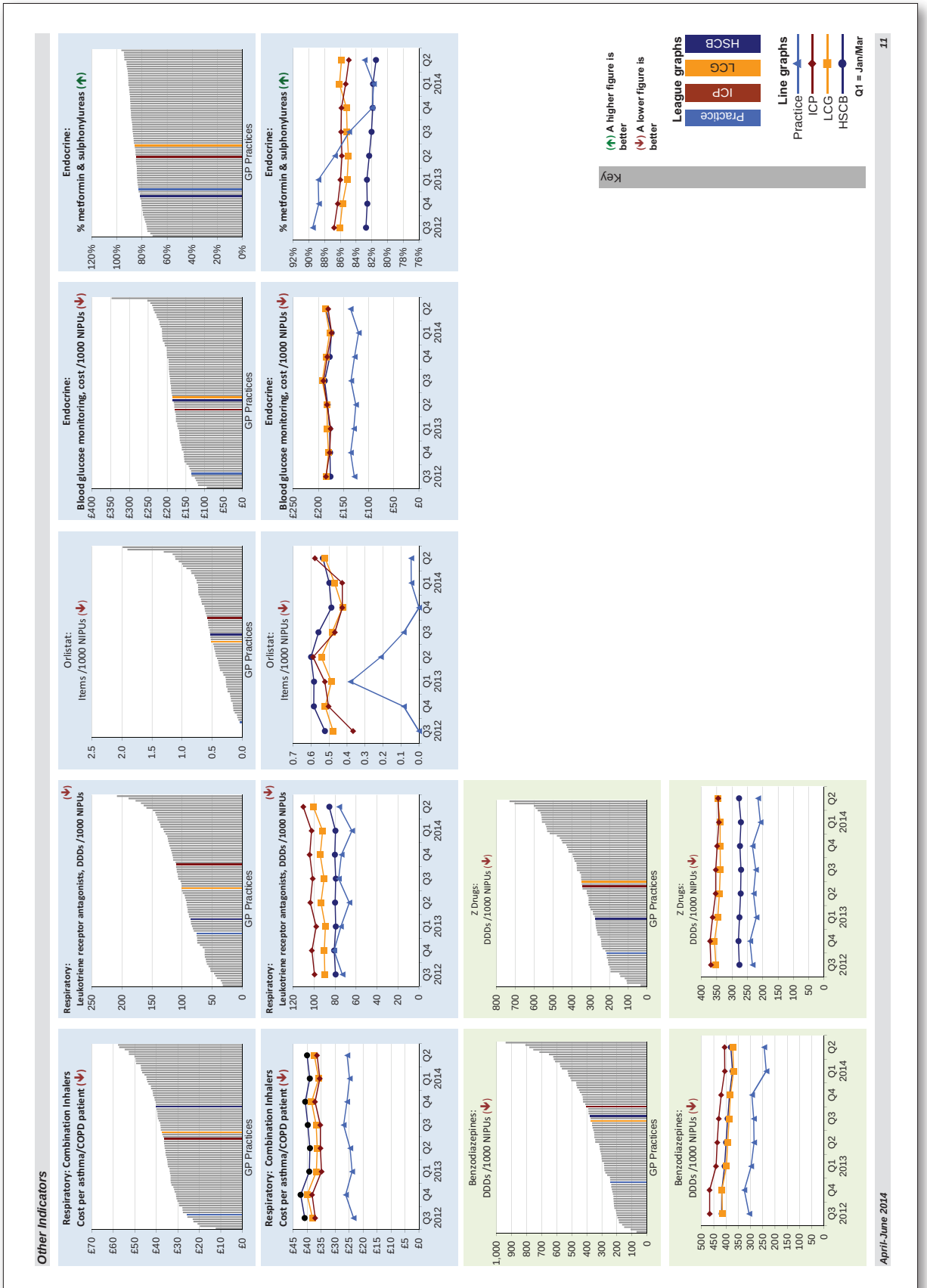
Other Indicators
Respiratory: Combination Inhalers
Cost per asthma/COPD patient (↓)
Respiratory:
Leukotriene receptor antagonists, DDDs /1000 NIPUs (↓)
Orlistat:
Items /1000 NIPUs (↓)
Endocrine:
Blood glucose monitoring, cost /1000 NIPUs (↓)
Endocrine:
% metformin & sulphonylureas (↑)
Benzodiazepines:
DDDs /1000 NIPUs (↓)
Z Drugs:
DDDs /1000 NIPUs (↓)
GP Practices
Q3 2012
Q4 2012
Q1 2013
Q2 2013
Q3 2013
Q4 2013
Q1 2014
Q2 2014
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League graphs
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Q1 = Jan/Mar
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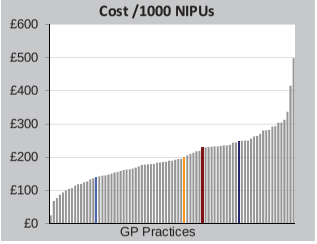
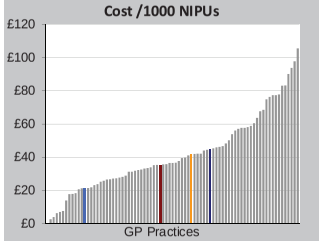
Other indicators cont'd

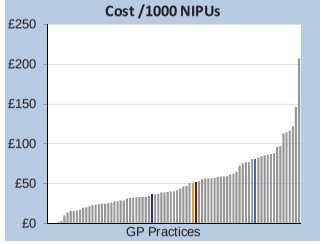
Nutrition: Oral nutritional supplements
Cost /1000 NIPUs



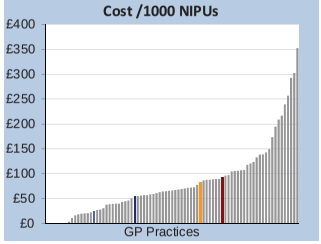
Nutrition: Gluten free products
Cost /1000 NIPUs



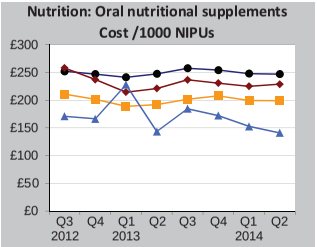
Infant feeding, Extensively hydrolysed
Cost /1000 NIPUs



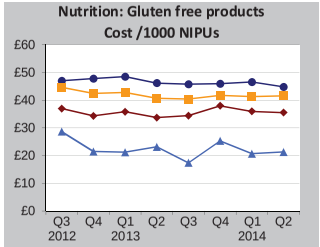
Infant feeding, Amino acid milks
Cost /1000 NIPUs



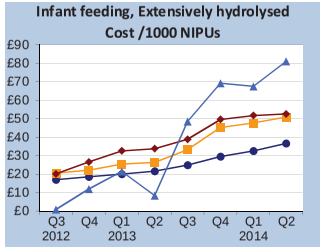
Nutrition: Oral nutritional supplements
Cost /1000 NIPUs



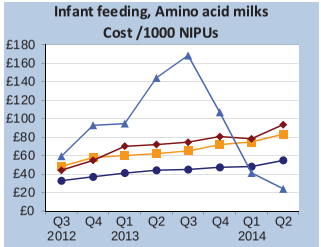
Nutrition: Gluten free products
Cost /1000 NIPUs



Infant feeding, Extensively hydrolysed
Cost /1000 NIPUs



Infant feeding, Amino acid milks
Cost /1000 NIPUs



Key

(↑) A higher figure is better

(↓) A lower figure is better

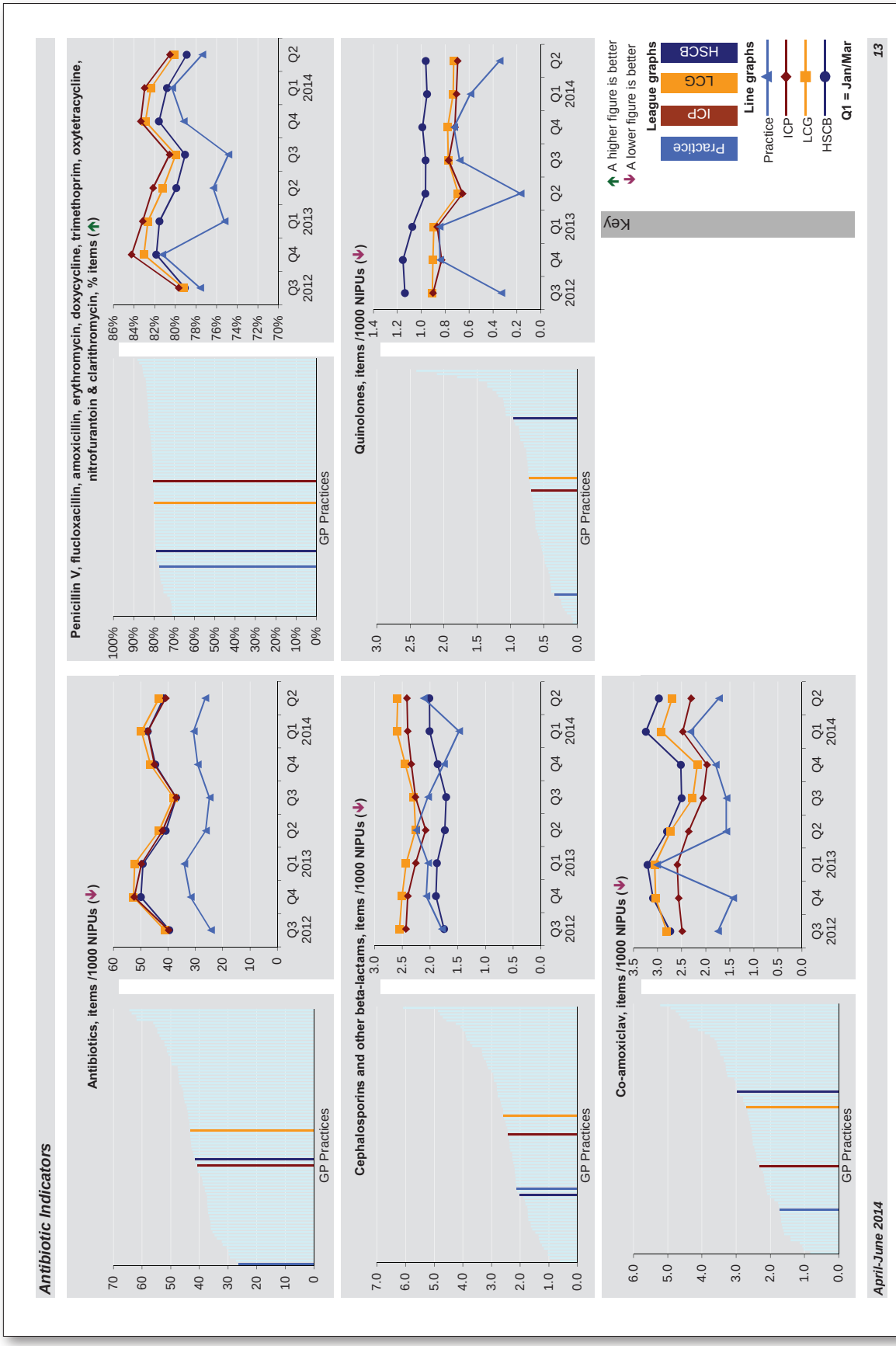
League graphs

Practice ICP LCG HSCB

Line graphs

Practice
ICP
LCG
HSCB

Q1 = Jan/Mar


Antibiotic Indicators
Penicillin V, flucloxacillin, amoxicillin, erythromycin, doxycycline, trimethoprim, oxytetracycline, nitrofurantoin & clarithromycin, % items (↑)
Quinolones, items /1000 NIPUs (↓)
Antibiotics, items /1000 NIPUs (↓)
Cephalosporins and other beta-lactams, items /1000 NIPUs (↓)
Co-amoxiclav, items /1000 NIPUs (↓)
GP Practices
Key
A higher figure is better
A lower figure is better
League graphs
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Line graphs
Practice
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High Risk Drugs

High Risk Drugs

Drug name/group	Items	Quantity
Warfarin 0.5mg	-	-
Warfarin 5mg	-	-
Methotrexate 10mg	-	-
Red List drugs	-	N/A

IV antibiotics: patient prescribing

Drug name	Items	Quantity
Totals	**0**	

Stock Prescribing

Top 15 Stock Items by Cost (excludes dressings & appliances)

	Drug name	Cost (£)	Items	Quantity
1	Helicobacter Test INFAI breath test kit	£192.00	1	10
2	Prednisolone 5mg soluble tablets	£85.56	1	60
3	Kenalog Intra-articular / Intramuscular 40mg/1ml suspension for injection vials	£59.60	1	40
4	Chlorphenamine 10mg/1ml solution for injection ampoules	£56.00	2	20
5	EpiPen 300micrograms/0.3ml (1 in 1,000) solution for injection auto-injectors	£52.90	1	2
6	Glucagon 1mg powder and solvent for solution for injection vials	£46.08	1	4
7	GlucoGel 40% gel original	£41.04	1	480
8	Hydrocortisone sodium succinate 100mg powder and solvent for solution for injection vials	£11.60	1	10
9	Minims fluorescein sodium 1% eye drops 0.5ml unit dose	£8.52	1	20
10	Voltarol 75mg/3ml solution for injection ampoules	£8.26	1	10
11	Cyclizine 50mg/1ml solution for injection ampoules	£6.50	1	10
12	Adrenaline (base) 1mg/1ml (1 in 1,000) solution for injection ampoules	£3.93	1	10
13	Salbutamol 5mg/2.5ml nebuliser liquid unit dose vials	£3.82	1	20
14	Voltarol 100mg suppositories	£3.03	1	10
15	Water for injections 10ml ampoules	£2.45	1	10
	Total	**£581**	**16**	
	Total of all Stock (includes dressings and appliances)	**£1,304**	**27**	

Stock CDs (schedules 2, 3, 4 and 5)

	Drug name	Cost (£)	Items	Quantity
1	Diamorphine 5mg powder for solution for injection ampoules	£11.36	1	5
2	Lorazepam 1mg tablets	£2.45	1	28
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
	Total	**£14**	**2**	

Stock forms (definition):
Forms used for ordering stocks of drugs and appliances which are needed by GPs for the immediate treatment of patients; for use before a patient's needs can be met by giving a prescription in the ordinary way; and for administration by the doctor in person or a person acting under his direction.

Controlled Drug Prescribing - Patient Prescribing

DDDs /1000 NIPUs

	Jul/Sep 12	Oct/Dec	Jan/Mar 13	Apr/Jun	Jul/Sep	Oct/Dec	Jan/Mar 14	Apr/Jun	Trend
Total volume of CD prescribing	●	●	●	●	●	●	●	●	
Total volume of CD prescribing minus methadone liquid and buprenorphine tabs	●	●	●	●	●	●	●	●	
Alfentanil inj	○	○	○	○	○	○	○	○	
Buprenorphine inj	○	○	○	○	○	○	○	○	
Buprenorphine patches	●	●	●	●	●	●	●	●	
Buprenorphine tabs	○	○	○	○	○	○	○	○	
Cocaine eye drops	○	○	○	○	○	○	○	○	
Cyclimorph inj	○	○	○	○	○	○	○	○	
Dexamfetamine	○	○	○	○	○	○	○	○	
Diamorphine inj	○	●	●	○	○	○	●	●	
Diamorphine tabs	○	○	○	○	○	○	○	○	
Dihydrocodeine inj	○	○	○	○	○	○	○	○	
Dipipanone tabs	○	○	○	○	○	○	○	○	
Fentanyl intranasal	○	○	○	○	○	○	○	○	
Fentanyl oral	○	○	○	○	○	●	○	○	
Fentanyl patches	●	●	●	●	●	●	●	●	
Hydromorphone caps	○	○	○	○	○	○	○	○	
Lisdexamfetamine	○	○	○	○	○	○	○	○	
Methadone inj	○	○	○	○	○	○	○	○	
Methadone liquid	○	○	○	○	○	○	○	○	
Methadone tabs	○	○	○	○	○	○	○	○	
Methylphenidate	●	●	●	●	●	●	●	●	
Morphine inj (excl. Cyclimorph®)	○	○	○	○	○	○	○	○	
Morphine oral	●	●	●	●	●	●	●	●	
Morphine oral solutions	○	○	●	○	○	○	○	○	
Morphine suppositories	○	○	○	○	○	○	○	○	
Nabilone caps (Red List Drug)	○	○	○	○	○	○	○	○	
Oxycodone caps and tabs	●	●	●	●	●	●	●	●	
Oxycodone inj	○	○	●	●	●	●	○	●	
Oxycodone liquid	●	●	●	○	○	●	○	○	
Pentazocine caps, tabs, suppos	○	○	○	○	○	○	○	○	
Pentazocine inj	○	○	○	○	○	○	○	○	
Pethidine inj	○	○	○	○	○	○	○	○	
Pethidine tabs	○	○	○	○	○	○	○	○	
Tapentadol tabs	○	○	○	○	●	●	●	●	

Controlled Drug prescribing indicators

The controlled drugs monitoring indicators are based on the mean of the prescribing of all practices in the HSCB.

● The red indicator represents prescribing that falls above the upper control limit (UCL). This represents the top 1% of prescribing. The UCL is based on three standard deviations from the mean for each drug.

● The orange indicator represents prescribing that falls between the mean prescribing and the UCL.

● The green indicator represents prescribing that falls between the mean prescribing and no prescribing.

○ The white indicator represents no prescribing.

← Methylphenidate includes all strengths and formulations, including m/r

Appendix: COMPASS Explanatory Notes

Glossary			
ICPs	Integrated Care Partnerships	NIPUs	Northern Ireland Prescribing Units
LCG	Local Commissioning Group		
HSCB	Health and Social Care Board		

Quarter: Information in the COMPASS report is based on three months of prescribing data, i.e. one quarter.

ICP average: Figures refer to the average of all practices within the respective ICP.

LCG average: Figures refer to the average of all practices within the respective LCG.

HSCB average: Figures refer to the average of all practices within the HSCB, i.e. all practices in NI.

Cost (£): Net ingredient cost, equivalent to England's Net Ingredient Cost (NIC). Cost is useful in terms of monitoring the overall drugs bill, checking spend within prescribing budgets and calculating savings made or potential savings. Cost is less useful as a measure of drug consumption because of the differences in cost of alternative preparations and changes in prices.

Items: Number of prescription items. Count of items is a reasonable measure of the number of courses of treatments for vaccinations and acute treatments such as short courses of antibiotics. For other treatments it is less useful because of the wide variation in duration of supply per item.

NIPUs: In measuring prescribing, differences between practices need to be taken account of in order to make valid comparisons with local and national averages. NIPUs standardise for differences between practices in terms of patient list size, age/sex structure and additional needs.

Quantity: Number of physical units, i.e. tablets, capsules, patches, mLs, inhalers, vials etc. Quantity is a useful measure of prescribing when looking at individual preparations, e.g. methotrexate 10mg or warfarin 0.5mg and 5mg.

Change from Last Year: The actual change from the same quarter in the previous year.

Defined Daily Dose (DDD): The DDD is a unit of measurement based on the assumed average maintenance dose per day used for its main indication in adults. The World Health Organisation (WHO) developed the DDD as a method to compare drugs of different chemical structures and potencies. The DDD methodology standardises quantities prescribed into number of daily doses. See worked example below. The number of DDDs is calculated as follows:

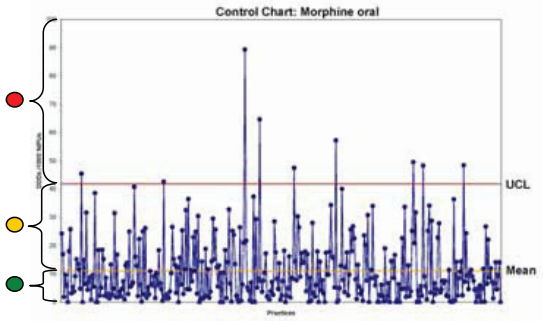
$$\text{Number of DDDs} = \frac{\text{Strength (mg) x quantity}}{\text{DDD (mg)}}$$

Worked example	Quantity (no. of tabs /caps)	DDD (mg)	No. of DDDs
Ibuprofen 200mg 2 caps 3 times a day	168	1200	$\frac{200 \times 168}{1200} = 28$
Ranitidine 150mg 1 tablet twice a day	56	300	$\frac{150 \times 56}{300} = 28$
Lansoprazole 30mg 1 capsule once a day	28	30	$\frac{30 \times 28}{30} = 28$

Prescribing Indicators listed throughout the report give some indication of prescribing quality but are not quantitative measures of good prescribing. Arrows indicate whether a larger figure or a smaller figure suggests 'better' prescribing. Values are given for the practice, locality average, LCG average and HSCB average. They are, therefore, useful in identifying outliers i.e. practice's whose prescribing differs substantially from other practices and to highlight areas for further analysis.

Red List Drugs: The Red list is an advisory list where it is considered by the Regional Group on Specialist Medicines, that responsibility for prescribing should remain with the consultant or specialist clinician. It is recommended that the supply of these specialist medicines should be organised via the hospital pharmacy.

Controlled Drugs (CDs): On the patient and stock prescribing pages there are red, orange and green dots. Each dot represents where a practice is on a control chart in relation to the Upper Control Limit (UCL) and the mean for all practices in NI (see chart below). The UCL is the mean + 3 standard deviations. A green dot represents a practice at the mean or below. An orange dot represents a practice above the mean but below the UCL. A red dot represents a practice above the UCL.



COMPASS Report

WLCG Practice Report

April-June 2014

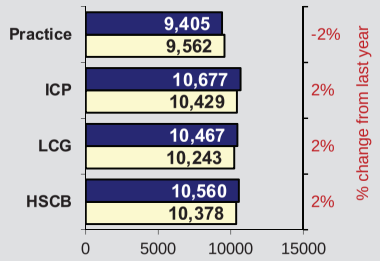
Contents

Contents cont'd

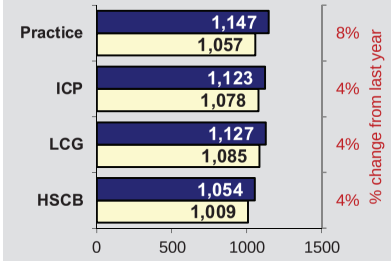
Key

Quarter this year: Apr-Jun 14
Quarter last year: Apr-Jun 13
Practice
ICP
LCG
HSCB

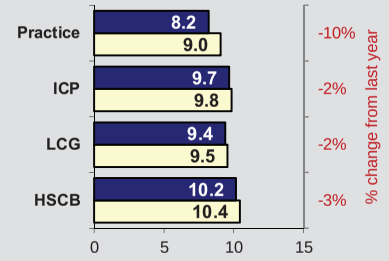
Cost (£) /1000 NIPUs†



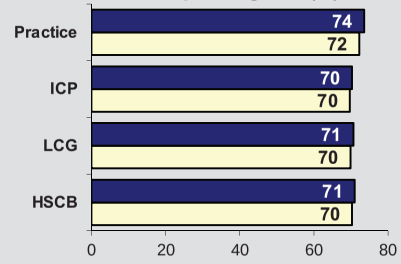
Items /1000 NIPUs†



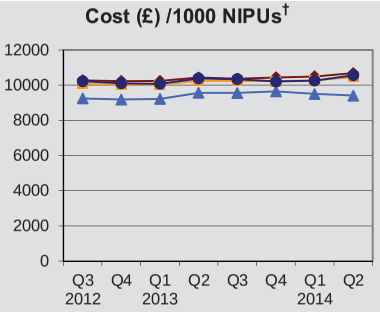
Cost (£) /Item



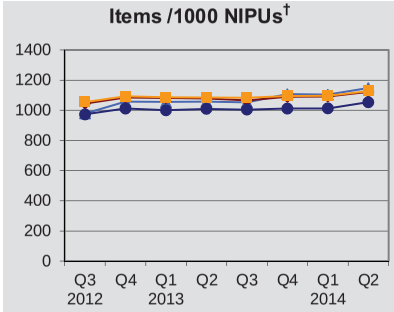
Generic dispensing rate (%)



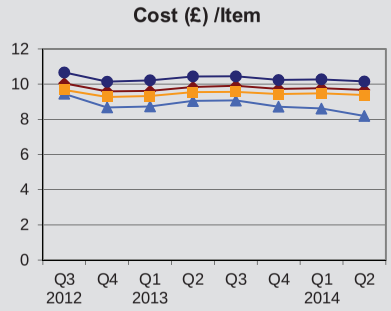
Cost (£) /1000 NIPUs†



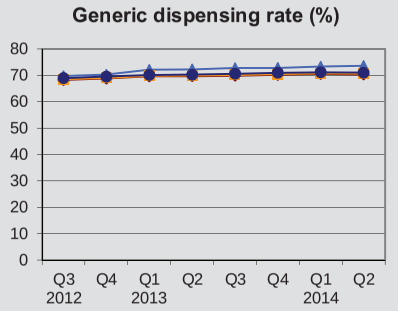
Items /1000 NIPUs†



Cost (£) /Item



Generic dispensing rate (%)



†See explanatory notes at end of report for more information.

Web site: http://www.hscbusiness.hscni.net/services.htm Tel: 028 9053 5661

Top 20 : Twenty most costly drugs in your practice

	Drug Name	Drug's position in HSCB's most costly drugs*	Cost (£)	No of Items	Quantity	Cost (£) /Item	% of Practice Total Cost	Change from last year
1	Symbicort 200/6 Turbohaler 200/6 [TURBOHALER]	6	3,192	65	84	49.11	2.33	-0.05
2	XLYS LOW TRY Maxamaid powder 500G [DIET SUPPLEMENT]	3116	2,246	2	24	1123.08	1.64	0.12
3	Symbicort 400/12 Turbohaler 400/12 [TURBOHALER]	30	2,090	32	55	65.31	1.52	-0.09
4	Hydrocortisone 10mg tablets 10MG [TABLET]	28	2,070	9	984	230.01	1.51	0.76
5	Pregabalin 150mg capsules 150MG [CAPSULE]	4	1,987	34	1,728	58.45	1.45	0.48
6	Aviva testing strips [REAGENT]	12	1,668	33	5,350	50.55	1.22	0.22
7	Lantus 100units/ml solution for injection 3ml pre-filled SoloStar pen 3ML [PRE-FILLE	8	1,544	36	186	42.88	1.13	-0.35
8	Versatis 5% medicated plasters [MEDICATED PLASTER]	15	1,337	17	554	78.65	0.97	0.45
9	Atomoxetine 10mg capsules 10MG [CAPSULE]	1133	1,312	12	588	109.31	0.96	0.39
10	Temazepam 10mg tablets 10MG [TABLET]	5	1,264	60	1,722	21.06	0.92	-0.87
11	Spiriva 18microgram inhalation powder capsules 18MCG [CAPSULE]	34	1,241	34	1,111	36.49	0.90	-0.34
12	Aripiprazole 10mg tablets 10MG [TABLET]	88	1,056	6	308	176.07	0.77	0.77
13	Neocate LCP powder 400G [FOOD]	82	1,019	8	36	127.35	0.74	0.74
14	Seretide 250 Evohaler 250MCG/25 [EVOHALER]	2	1,011	16	17	63.20	0.74	0.32
15	Demeclocycline 150mg capsules 150MG [CAPSULE]	420	978	4	336	244.47	0.71	0.52
16	Pregabalin 50mg capsules 50MG [CAPSULE]	14	966	12	840	80.50	0.70	0.52
17	Senna 7.5mg tablets 7.5MG [TABLET]	110	892	65	4,572	13.72	0.65	0.37
18	Risperdal Consta 50mg powder and solvent for suspension for injection vials 50MG [I	95	857	2	6	428.28	0.62	0.03
19	Omeprazole 20mg gastro-resistant capsules 20MG [GASTRO-RESISTANT CAPSUL	25	846	498	20,587	1.70	0.62	-0.03
20	Paracetamol 500mg tablets 500MG [TABLET]	49	783	368	29,790	2.13	0.57	0.07
	TOTAL		**28,358**	**1,313**			**20.67**	

▼ Black Triangle Drug

The range of generic drugs listed in Part I of the NI drug tariff increased in April 2011. This change means the list above may include generic drugs that, although prescribed generically, will have been dispensed by brand as no generics are currently available. If you have any queries regarding this please contact your Medicines Management Adviser (MMA).

*This is the drug's position in the HSCB's most costly drugs. For example, your practice's 20th most costly drug is Paracetamol 500mg tablets 500MG [TABLET]. This drug is number 49 in the HSCB's most costly drugs.

Priority generic switches

During this quarter if there were problems with the supply of high volume generics then shortages will have occurred and this may affect prescribing data presented in this page.

	Proprietary Drug	*Number of Items*	*Cost (£)*	*Generic equivalent*	*Potential Savings for the quarter (£)*
1	EBIXA 10MG [TABLET]	3	207	MEMANTINE 10MG [TABLET]	£132
2	XALATAN 2.5ML [EYE DROP]	5	116	LATANOPROST 50MICROGRAMS/ML [EYE DROP]	£98
3	ACTOS 30MG [TABLET]	1	72	PIOGLITAZONE 30MG [TABLET]	£68
	Total	**9**	**395**		**£298**

NB Only individual switches that have the potential to release efficiencies ≥ £200 per annum are now included above.
If you would like data below this threshold please contact your Medicines Management Adviser (MMA).

Potential savings per annum **£1,193**

Top Cost Effective Choices

These should be considered for all new starts and at review in line with relevant guidance and SPC

		Drug name	*Number of Items*	*Spend*	*Cost effective choice*	*Potential Savings for the quarter*
1	††	FESOTERODINE (DT) 4MG [MODIFIED-RELEASE TABLET]	17	£464	TOLTERODINE (DT) 2MG [TABLET]	£416
2	††	SOLIFENACIN (DT) 10MG [TABLET]	13	£400	TOLTERODINE (DT) 2MG [TABLET]	£368
3	††	TOVIAZ 4MG [TABLET]	8	£309	TOLTERODINE (DT) 2MG [TABLET]	£277
4	††	TOVIAZ 8MG [TABLET]	10	£271	TOLTERODINE (DT) 2MG [TABLET]	£243
5	††	FESOTERODINE (DT) 8MG [MODIFIED-RELEASE TABLET]	10	£245	TOLTERODINE (DT) 2MG [TABLET]	£219
6	††	SOLIFENACIN (DT) 5MG [TABLET]	7	£188	TOLTERODINE (DT) 2MG [TABLET]	£168
7	††	REGURIN XL 60MG [CAPSULE]	8	£184	TOLTERODINE (DT) 2MG [TABLET]	£163
8	§	DOXAZOSIN (DT) 8MG [MODIFIED-RELEASE TABLET]	8	£160	DOXAZOSIN (DT) 4MG [TABLET]	£143
9		NITROFURANTOIN (DT) 50MG [TABLET]	9	£191	NITROFURANTOIN (DT) 50MG [CAPSULE]	£89
10	**	MOMETASONE NASAL (DT) 50MICROGRAMS/DOSE [SPRAY]	12	£106	BECLOMETASONE NASAL (DT) 50MCG [SPRAY]	£65
11		MOVICOL POWDER [SACHET]	33	£320	LAXIDO ORANGE SUGAR FREE [ORAL POWDER SACHET]	£64
12	‡	PREDNISOLONE (DT) 5MG [GASTRO-RESISTANT TABLET]	70	£197	PREDNISOLONE (DT) 5MG [TABLET]	£60
13		CO-CODAMOL (DT) 8MG/500MG [CAPSULE]	57	£157	CO-CODAMOL (DT) 8MG/500MG [TABLET]	£60
14	*	OMEPRAZOLE DISPERSIBLE (DT) 20MG [GASTRO-RESISTANT TABLET]	7	£81	LANSOPRAZOLE (DT) 15MG [ORODISPERSIBLE TABLET]	£60
15	**	NASONEX AQUEOUS 140 DOSE 50 MCG/DOSE [NASAL SPRAY]	10	£84	BECLOMETASONE NASAL (DT) 50MCG [SPRAY]	£52
		Total	**279**	**£3,357**		**£2,447**

NB Only individual switches that have the potential to release efficiencies ≥ £200 per annum are included above, up to a maximum of 20 switches.

Potential savings per annum **£9,789**

Prior to initiating/switching to the cost-effective choice please refer to the additional information provided on the HSCB website:

‡ http://primarycare.hscni.net/pdf/PrednisoloneEC_SwitchSOP_Nov2011.pdf

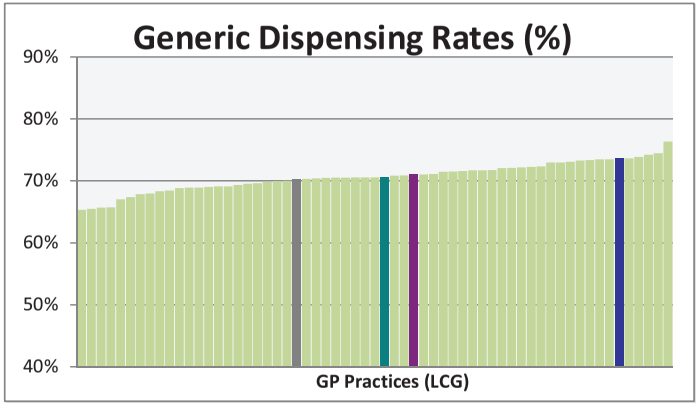
* Lansoprazole orodispersible tablets should be considered for all appropriate patients who require a dispersible PPI. For guidance on the treatment of children please refer to the BNF for Children.

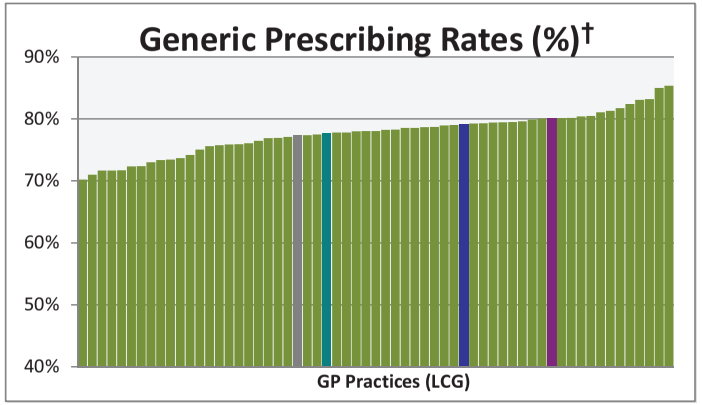
§ http://primarycare.hscni.net/pdf/Doxazosin_Switch_Guidance_April_2012.pdf

†† These should only be initiated after a trial of oral oxybutynin or tolterodine has been ineffective

** Beclometasone in hayfever

Overall Generic Rates





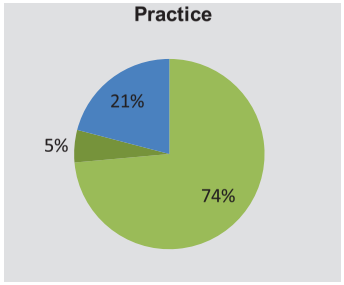
The range of generic drugs listed within Part I of the NI drug tariff increased in April 2011. This change may have increased your generic dispensing rate.

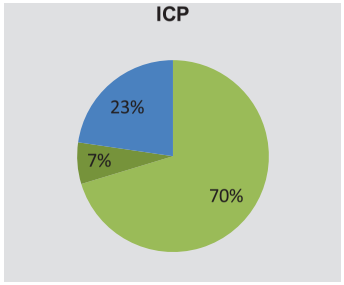
Your Practice | ICP Average | LCG Average | HSCB Average

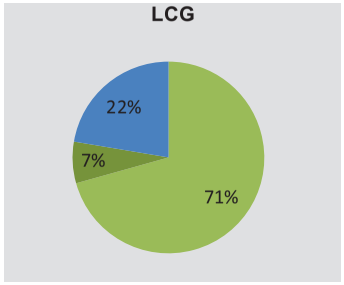
Prescribed and dispensed generically
Prescribed generically and dispensed by brand as no generic is currently available
Presribed and dispensed by brand

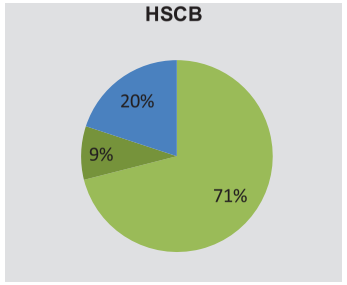
†The generic **prescribing** rates chart is new. This chart reports GP prescribing of generics. This will include drugs that, although prescribed generically, will have been dispensed by brand as no generic is currently available.

NB 100% generic prescribing rate is not achievable or desired as there are a number of items unsuitable for generic prescribing. See link below:
http://www.hscboard.hscni.net/medicinesmanagement/Prescribing%20Guidance/index.html







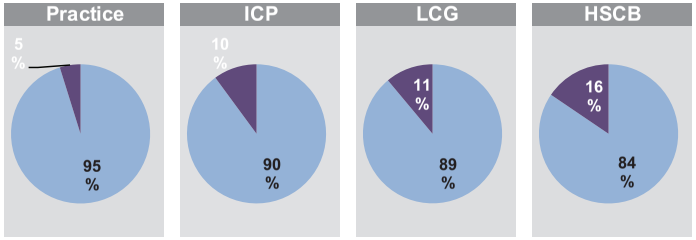


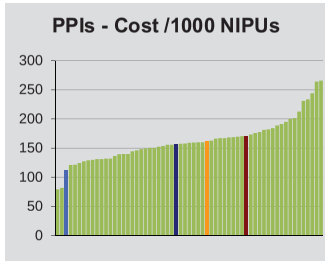
Proton Pump Inhibitors (PPIs)

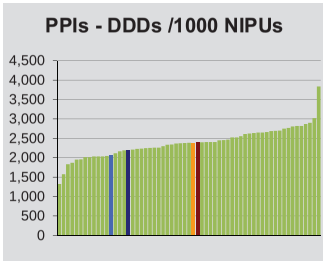
Preferred choices

Other items

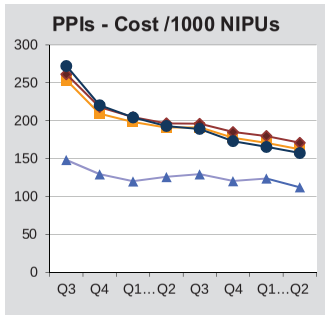
† If patients do not have swallowing difficulties, they could be switched to omeprazole or lansoprazole capsules.

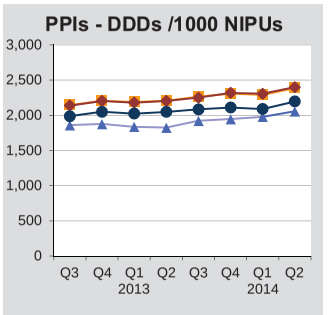


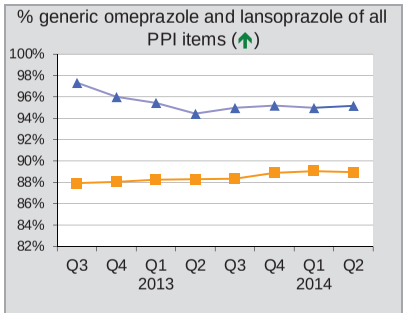


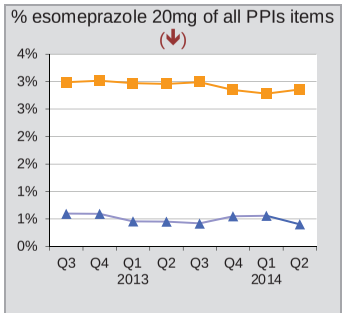


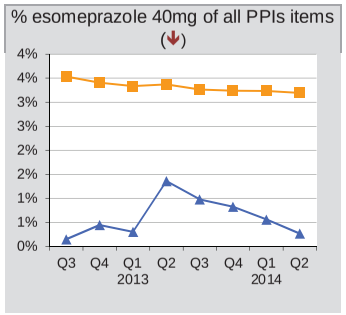
Drug name	Items	%	Items	%	Items	%	Items	%
Lansoprazole	171	22.95%	10641	28.89%	20504	21.11%	158553	31.26%
Omeprazole	538	72.21%	22481	61.03%	65883	67.82%	269884	53.21%
Pantoprazole	23	3.09%	801	2.17%	3082	3.17%	30291	5.97%
Losec	0	0.00%	235	0.64%	384	0.40%	1611	0.32%
Protium	0	0.00%	0	0.00%	0	0.00%	0	0.00%
Esomeprazole (tablets)	5	0.67%	1680	4.56%	5496	5.66%	37843	7.46%
Lansoprazole orodispersible†	0	0.00%	0	0.00%	0	0.00%	0	0.00%
Omeprazole dispersible†	0	0.00%	0	0.00%	0	0.00%	0	0.00%
Rabeprazole	2	0.27%	118	0.32%	241	0.25%	2414	0.48%
Emozul (capsules)	0	0.00%	16	0.04%	18	0.02%	95	0.02%
Nexium (tablets)	0	0.00%	279	0.76%	660	0.68%	2883	0.57%
Pariet	0	0.00%	29	0.08%	58	0.06%	281	0.06%
Losec MUPS†	4	0.54%	381	1.03%	519	0.53%	1884	0.37%
Zoton FasTab†	2	0.27%	173	0.47%	305	0.31%	1459	0.29%

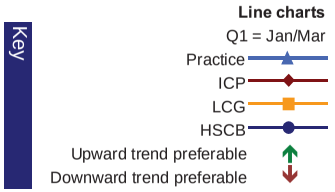




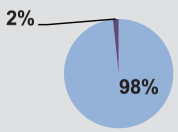




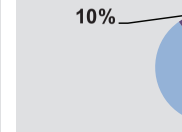




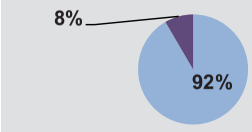
Lipid lowering drugs



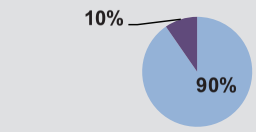
Drug name	Items	%
Simvastatin 10mg	0	0.00%
Simvastatin 20mg	79	11.25%
Simvastatin 40mg	270	38.46%
Simvastatin 80mg	1	0.14%
Simvastatin 20mg/5ml	0	0.00%
Simvastatin 40mg/5ml	0	0.00%
Atorvastatin 10mg	68	9.69%
Atorvastatin 20mg	62	8.83%
Atorvastatin 40mg	150	21.37%
Atorvastatin 80mg	16	2.28%
Pravastatin	44	6.27%
Fluvastatin	0	0.00%
Rosuvastatin	7	1.00%
Simvastatin + Ezetimibe	0	0.00%
Lescol /other brands	0	0.00%
Lipostat	0	0.00%
Zocor	0	0.00%
Crestor	5	0.71%
Inegy	0	0.00%
Lipitor 10mg	0	0.00%
Lipitor 20mg	0	0.00%
Lipitor 40mg	0	0.00%
Lipitor 80mg	0	0.00%



Drug name	Items	%
Simvastatin 10mg	705	1.97%
Simvastatin 20mg	3123	8.72%
Simvastatin 40mg	12827	35.82%
Simvastatin 80mg	32	0.09%
Simvastatin 20mg/5ml	18	0.05%
Simvastatin 40mg/5ml	31	0.09%
Atorvastatin 10mg	3660	10.22%
Atorvastatin 20mg	4116	11.49%
Atorvastatin 40mg	5857	16.35%
Atorvastatin 80mg	740	2.07%
Pravastatin	1225	3.42%
Fluvastatin	66	0.18%
Rosuvastatin	2611	7.29%
Simvastatin + Ezetimibe	22	0.06%
Lescol /other brands	0	0.00%
Lipostat	7	0.02%
Zocor	12	0.03%
Crestor	604	1.69%
Inegy	11	0.03%
Lipitor 10mg	75	0.21%
Lipitor 20mg	31	0.09%
Lipitor 40mg	33	0.09%
Lipitor 80mg	6	0.02%

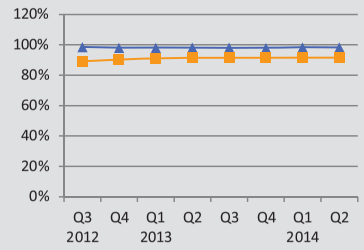


Drug name	Items	%
Simvastatin 10mg	1344	1.48%
Simvastatin 20mg	10462	11.51%
Simvastatin 40mg	30818	33.89%
Simvastatin 80mg	62	0.07%
Simvastatin 20mg/5ml	42	0.05%
Simvastatin 40mg/5ml	39	0.04%
Atorvastatin 10mg	6951	7.64%
Atorvastatin 20mg	11232	12.35%
Atorvastatin 40mg	16903	18.59%
Atorvastatin 80mg	2053	2.26%
Pravastatin	3380	3.72%
Fluvastatin	143	0.16%
Rosuvastatin	6015	6.62%
Simvastatin + Ezetimibe	58	0.06%
Lescol /other brands	12	0.01%
Lipostat	27	0.03%
Zocor	16	0.02%
Crestor	1085	1.19%
Inegy	29	0.03%
Lipitor 10mg	121	0.13%
Lipitor 20mg	71	0.08%
Lipitor 40mg	53	0.06%
Lipitor 80mg	7	0.01%

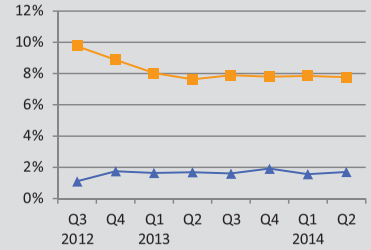


Drug name	Items	%
Simvastatin 10mg	9184	2.00%
Simvastatin 20mg	48808	10.62%
Simvastatin 40mg	153242	33.35%
Simvastatin 80mg	415	0.09%
Simvastatin 20mg/5ml	141	0.03%
Simvastatin 40mg/5ml	269	0.06%
Atorvastatin 10mg	37453	8.15%
Atorvastatin 20mg	53985	11.75%
Atorvastatin 40mg	80607	17.54%
Atorvastatin 80mg	6831	1.49%
Pravastatin	24277	5.28%
Fluvastatin	1101	0.24%
Rosuvastatin	37184	8.09%
Simvastatin + Ezetimibe	427	0.09%
Lescol /other brands	73	0.02%
Lipostat	114	0.02%
Zocor	102	0.02%
Crestor	3913	0.85%
Inegy	216	0.05%
Lipitor 10mg	418	0.09%
Lipitor 20mg	364	0.08%
Lipitor 40mg	291	0.06%
Lipitor 80mg	30	0.01%

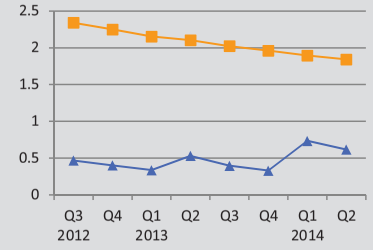
% simvastatin, atorvastatin and pravastatin of all statin items (↑)

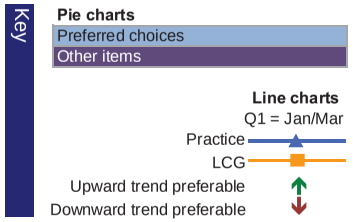


% rosuvastatin of all statin items (↓)

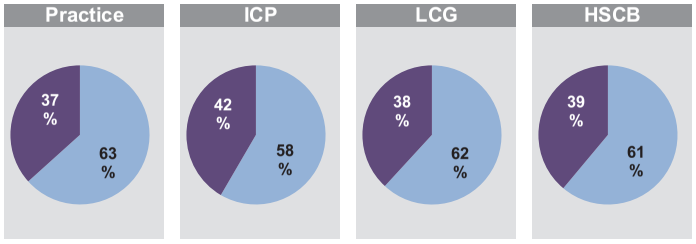


Ezetimibe, Items /1000 NIPUs (↓)
(includes Ezetrol and Inegy)



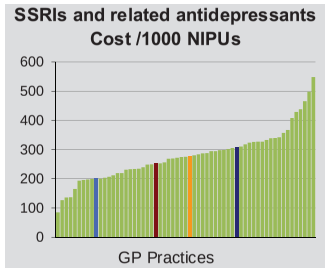


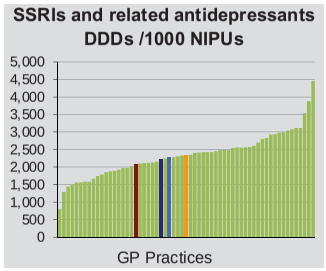
SSRIs and related antidepressant drugs

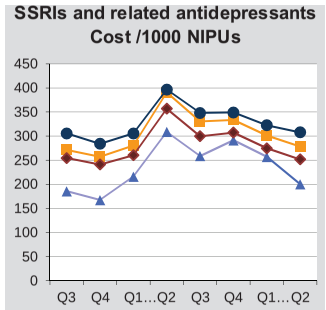


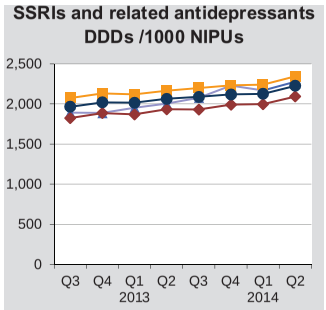
Preferred choices
Other items

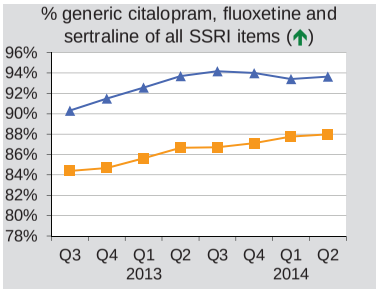
Drug name	Practice Items	Practice %	ICP Items	ICP %	LCG Items	LCG %	HSCB Items	HSCB %
Citalopram	181	21.55%	6898	20.23%	22006	23.17%	129369	25.02%
Fluoxetine	217	25.83%	6185	18.14%	17671	18.60%	94531	18.28%
Sertraline	134	15.95%	6830	20.03%	19086	20.09%	92071	17.81%
Duloxetine	8	0.95%	776	2.28%	2906	3.06%	21892	4.23%
Escitalopram	20	2.38%	1571	4.61%	3512	3.70%	23441	4.53%
Flupentixol	0	0.00%	0	0.00%	44	0.05%	389	0.08%
Fluvoxamine	0	0.00%	11	0.03%	32	0.03%	210	0.04%
Mirtazapine	180	21.43%	4683	13.73%	10722	11.29%	64596	12.49%
Paroxetine	9	1.07%	1044	3.06%	3088	3.25%	11764	2.28%
Reboxetine	0	0.00%	19	0.06%	43	0.05%	430	0.08%
Venlafaxine (incl. XL)	4	0.48%	427	1.25%	1236	1.30%	10841	2.10%
Cipramil	1	0.12%	40	0.12%	68	0.07%	282	0.05%
Efexor /XL /other brands	77	9.17%	4710	13.81%	12587	13.25%	58338	11.28%
Faverin	0	0.00%	1	0.00%	5	0.01%	30	0.01%
Lustral	0	0.00%	43	0.13%	86	0.09%	436	0.08%
Prozac	0	0.00%	53	0.16%	83	0.09%	325	0.06%
Seroxat	0	0.00%	29	0.09%	60	0.06%	388	0.08%
Cipralex	6	0.71%	432	1.27%	672	0.71%	2331	0.45%
Cymbalta	3	0.36%	303	0.89%	866	0.91%	4592	0.89%
Edronax	0	0.00%	5	0.01%	19	0.02%	137	0.03%
Fluanxol	0	0.00%	16	0.05%	116	0.12%	371	0.07%
Optimax	0	0.00%	1	0.00%	2	0.00%	12	0.00%
Zispin SolTab	0	0.00%	20	0.06%	86	0.09%	258	0.05%

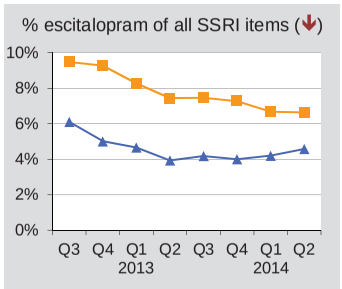


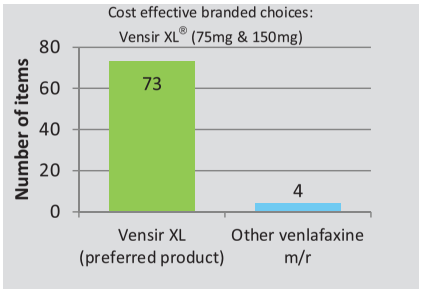






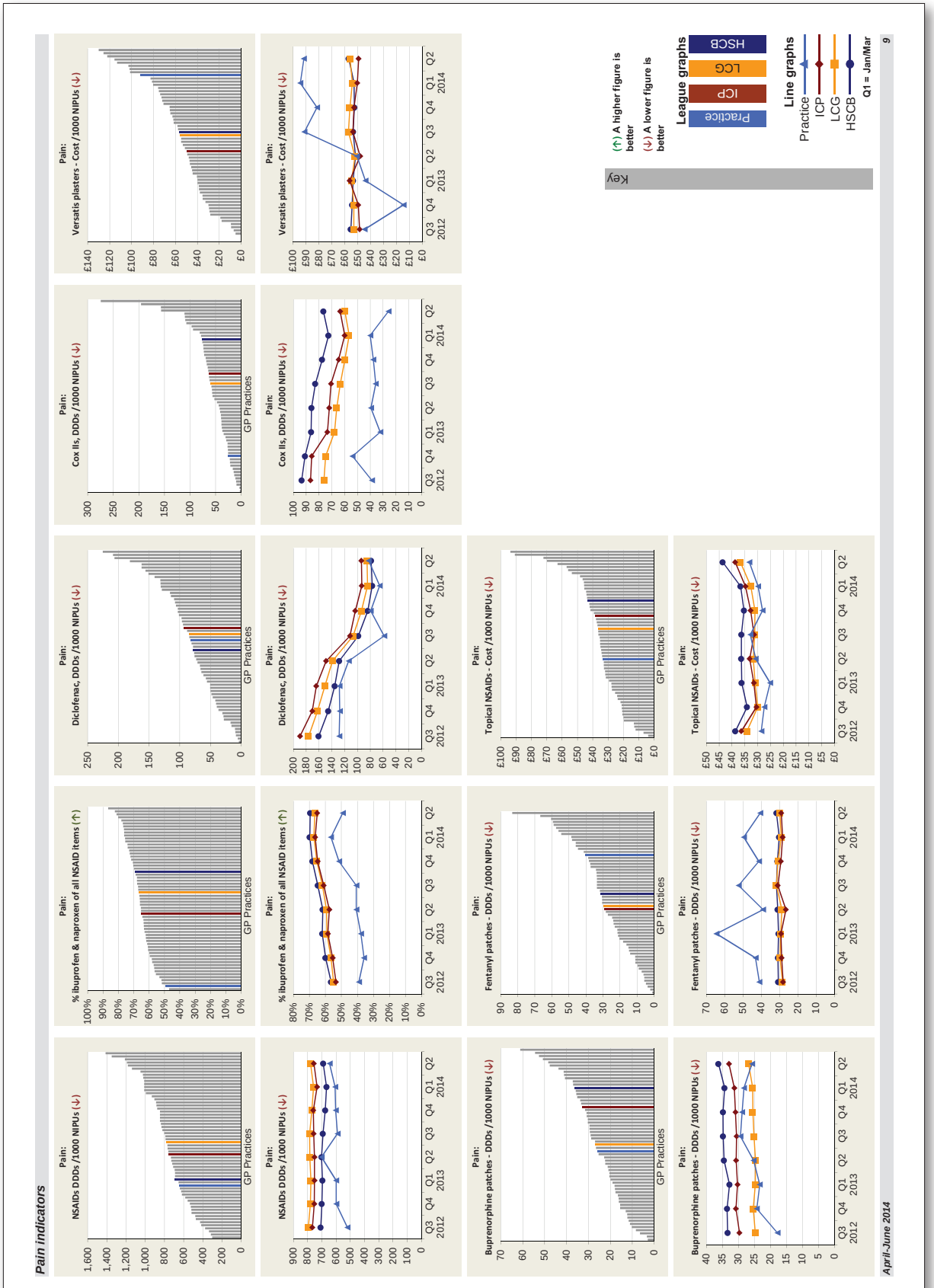


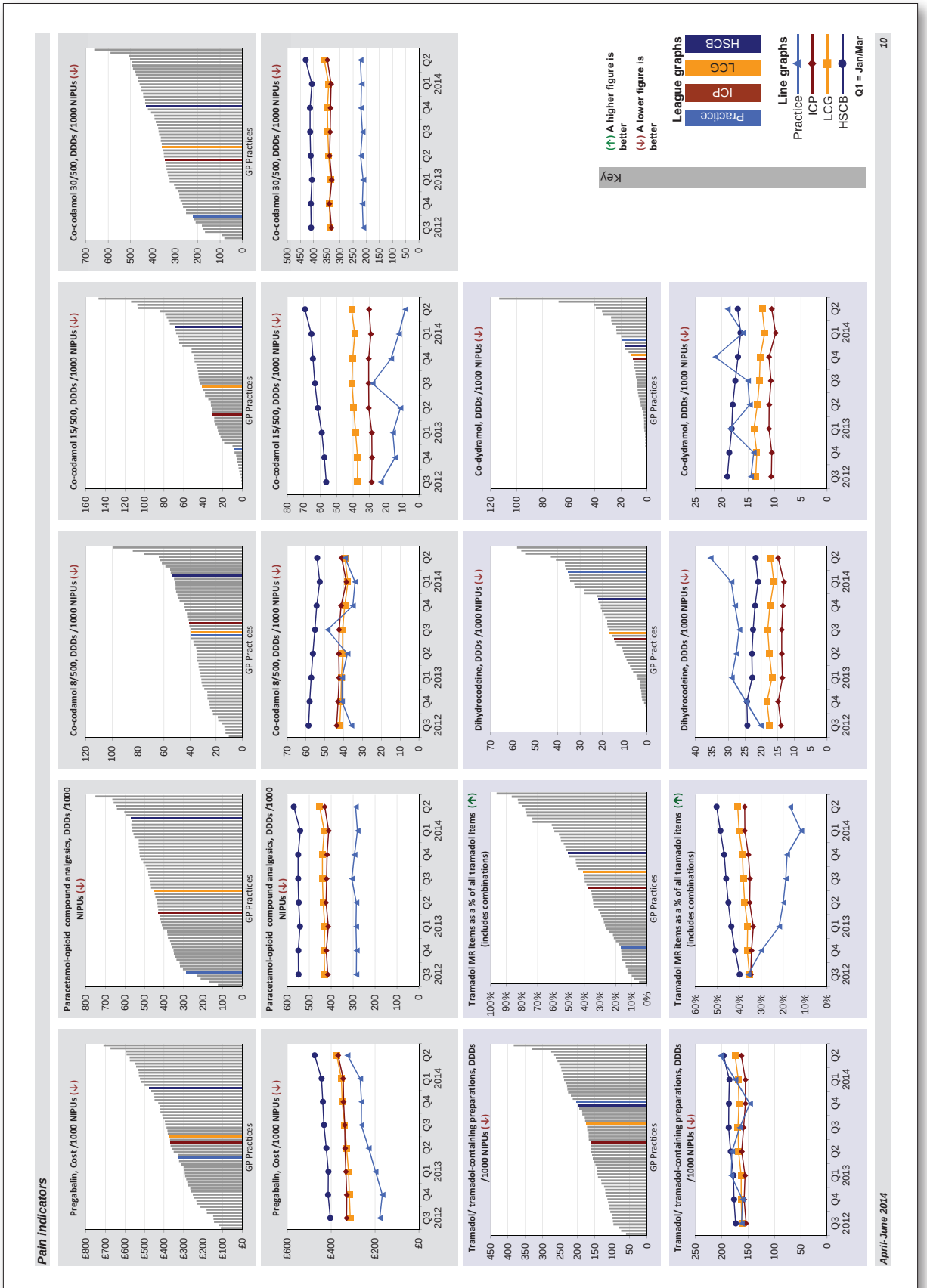


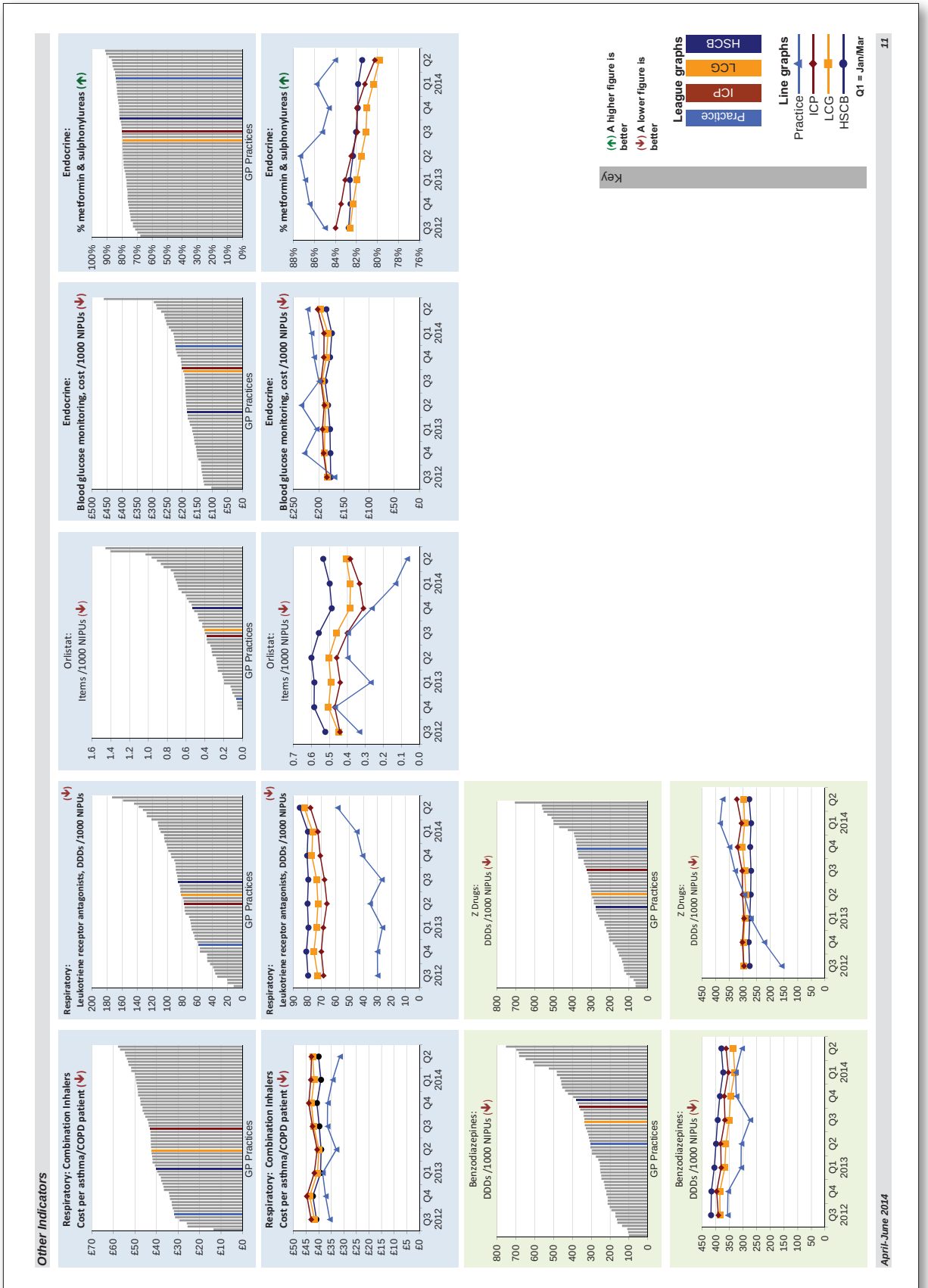


Key

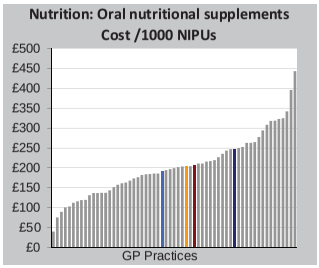
Line charts
Q1 = Jan/Mar
Practice
ICP
LCG
HSCB
Upward trend preferable
Downward trend preferable

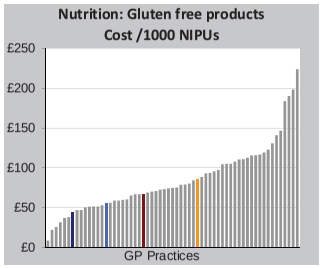

Pain indicators
Pain: NSAIDs DDDs /1000 NIPUs (↓)
Pain: % ibuprofen & naproxen of all NSAID items (↑)
Pain: Diclofenac, DDDs /1000 NIPUs (↓)
Pain: Cox IIs, DDDs /1000 NIPUs (↓)
Pain: Versatis plasters - Cost /1000 NIPUs (↓)
Pain: Buprenorphine patches - DDDs /1000 NIPUs (↓)
Pain: Fentanyl patches - DDDs /1000 NIPUs (↓)
Pain: Topical NSAIDs - Cost /1000 NIPUs (↓)
GP Practices
Key
(↑) A higher figure is better
(↓) A lower figure is better
League graphs
Practice
ICP
LCG
HSCB
Line graphs
Practice
ICP
LCG
HSCB
Q1 = Jan/Mar
April-June 2014
9

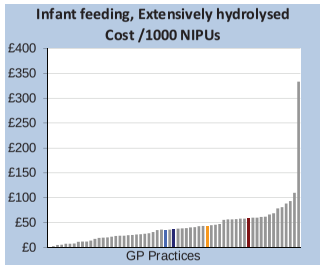

Pain indicators
Pregabalin, Cost /1000 NIPUs (↓)
Co-codamol 30/500, DDDs /1000 NIPUs (↓)
Co-codamol 15/500, DDDs /1000 NIPUs (↓)
Co-codamol 8/500, DDDs /1000 NIPUs (↓)
Co-dydramol, DDDs /1000 NIPUs (↓)
Dihydrocodeine, DDDs /1000 NIPUs (↓)
Paracetamol-opioid compound analgesics, DDDs /1000 NIPUs (↓)
Tramadol MR items as a % of all tramadol items (↑) (includes combinations)
Tramadol/ tramadol-containing preparations, DDDs /1000 NIPUs (↓)
GP Practices
Q3 2012
Q4
Q1 2013
Q2
Q3
Q4
Q1 2014
Q2
Key
(↑) A higher figure is better
(↓) A lower figure is better
League graphs
Practice
ICP
LCG
HSCB
Line graphs
Practice
ICP
LCG
HSCB
Q1 = Jan/Mar
April-June 2014
10

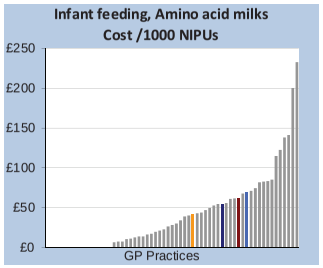

Other Indicators
Respiratory: Combination Inhalers
Cost per asthma/COPD patient (↓)
Respiratory: Leukotriene receptor antagonists, DDDs /1000 NIPUs (↓)
Orlistat: Items /1000 NIPUs (↓)
Endocrine: Blood glucose monitoring, cost /1000 NIPUs (↓)
Endocrine: % metformin & sulphonylureas (↑)
Benzodiazepines: DDDs /1000 NIPUs (↓)
Z Drugs: DDDs /1000 NIPUs (↓)
GP Practices
Q3 2012
Q4
Q1 2013
Q2
Q3
Q4
Q1 2014
Q2
Key
(↑) A higher figure is better
(↓) A lower figure is better
League graphs
Practice
ICP
LCG
HSCB
Line graphs
Practice
ICP
LCG
HSCB
Q1 = Jan/Mar
April-June 2014
11

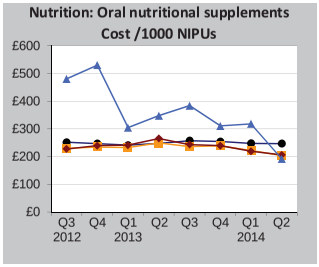
Other indicators cont'd

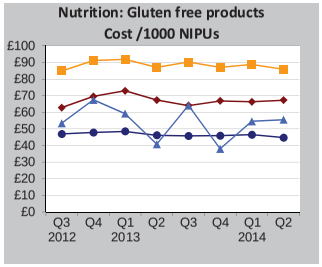


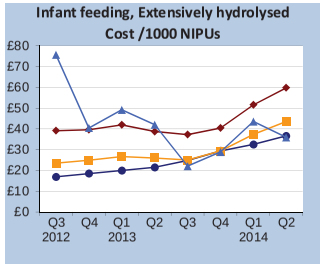


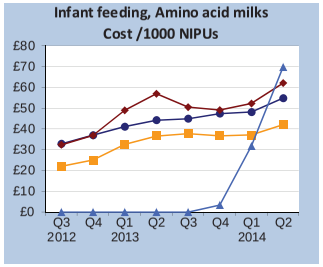












Key

(↑) A higher figure is better

(↓) A lower figure is better

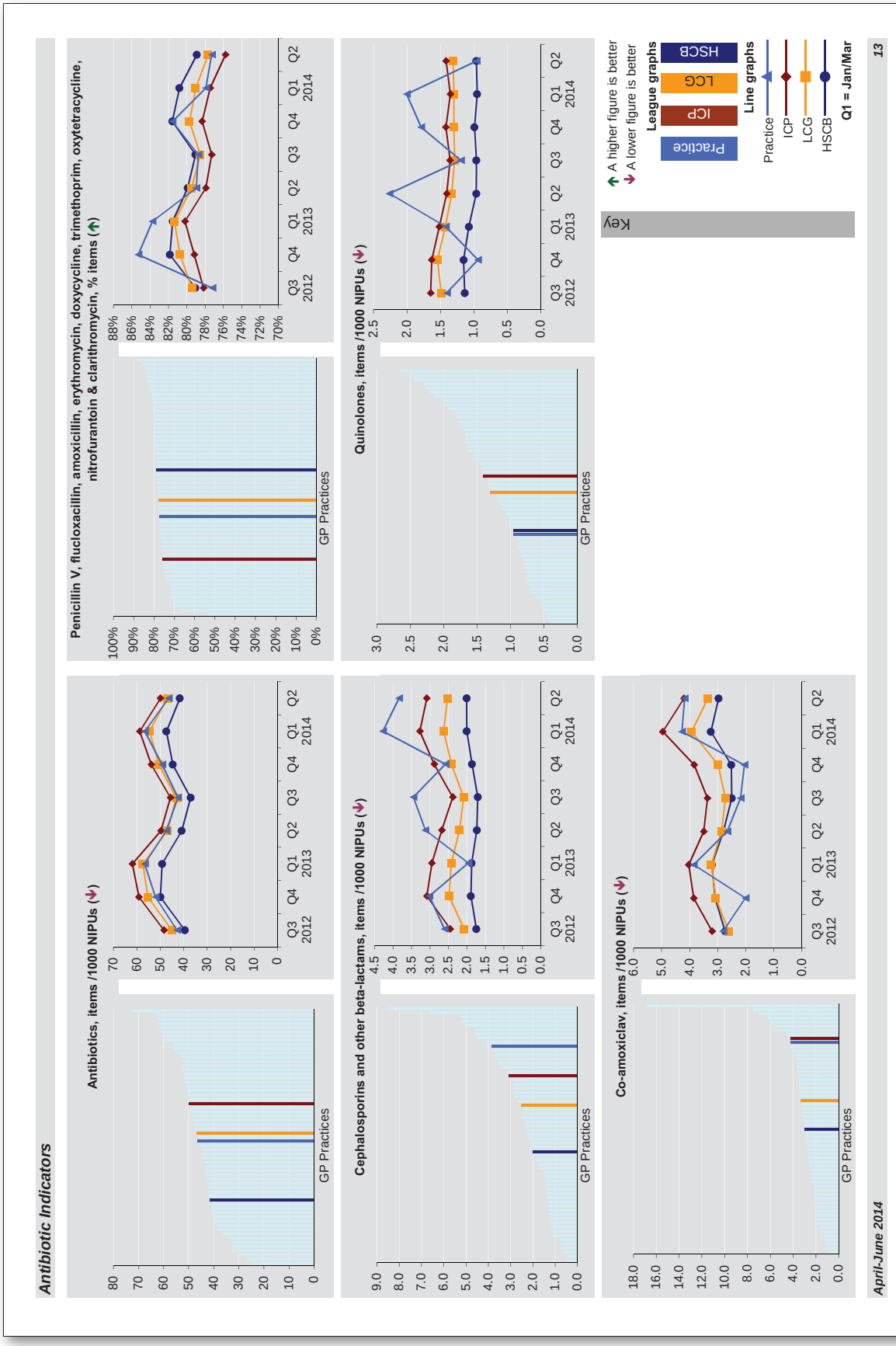
League graphs

Practice ICP LCG HSCB

Line graphs

Practice
ICP
LCG
HSCB

Q1 = Jan/Mar


Antibiotic Indicators
Penicillin V, flucloxacillin, amoxicillin, erythromycin, doxycycline, trimethoprim, oxytetracycline, nitrofurantoin & clarithromycin, % items (↑)
Quinolones, items /1000 NIPUs (↓)
Antibiotics, items /1000 NIPUs (↓)
Cephalosporins and other beta-lactams, items /1000 NIPUs (↓)
Co-amoxiclav, items /1000 NIPUs (↓)
GP Practices
Q3 2012
Q4
Q1 2013
Q2
Q3
Q4
Q1 2014
Q2
Key
A higher figure is better
A lower figure is better
League graphs
Practice
ICP
LCG
HSCB
Line graphs
Practice
ICP
LCG
HSCB
Q1 = Jan/Mar
April-June 2014
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High Risk Drugs

High Risk Drugs

Drug name/group	Items	Quantity
Warfarin 0.5mg	-	-
Warfarin 5mg	-	-
Methotrexate 10mg	-	-
Red List drugs	-	N/A

IV antibiotics: patient prescribing

Drug name	Items	Quantity
Totals	**0**	

Stock Prescribing

Top 15 Stock Items by Cost (excludes dressings & appliances)

	Drug name	Cost (£)	Items	Quantity
1	Iodoflex paste dressing	£100.50	1	25
2	Paracetamol 240mg suppositories	£22.01	1	10
3	Sterets Tisept solution 25ml sachets	£21.32	1	100
4	Trimovate cream	£9.87	1	90
5	Voltarol 75mg/3ml solution for injection ampoules	£8.26	1	10
6	Pure Health Liquid Paraffin/White Soft Paraffin	£2.21	1	500
7	Gynest 0.01% cream with applicator	£0.06	1	1
8				
9				
10				
11				
12				
13				
14				
15				
	Total	**£164**	**7**	
	Total of all Stock (includes dressings and appliances)	**£1,373**	**38**	

Stock CDs (schedules 2, 3, 4 and 5)

	Drug name	Cost (£)	Items	Quantity
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
	Total	**£0**	**0**	

Stock forms (definition):
Forms used for ordering stocks of drugs and appliances which are needed by GPs for the immediate treatment of patients; for use before a patient's needs can be met by giving a prescription in the ordinary way; and for administration by the doctor in person or a person acting under his direction.

Controlled Drug Prescribing - Patient Prescribing

DDDs /1000 NIPUs

	Jul/Sep 12	Oct/Dec	Jan/Mar 13	Apr/Jun	Jul/Sep	Oct/Dec	Jan/Mar 14	Apr/Jun	Trend
Total volume of CD prescribing	●	●	●	●	●	●	●	●	
Total volume of CD prescribing minus methadone liquid and buprenorphine tabs	●	●	●	●	●	●	●	●	
Alfentanil inj	●	○	○	○	○	○	○	○	
Buprenorphine inj	○	○	○	○	○	○	○	○	
Buprenorphine patches	●	●	●	●	●	●	●	●	
Buprenorphine tabs	○	○	○	○	○	○	○	○	
Cocaine eye drops	○	○	○	○	○	○	○	○	
Cyclimorph inj	○	○	○	○	○	○	○	○	
Dexamfetamine	○	○	○	○	○	○	○	○	
Diamorphine inj	○	●	●	○	●	●	●	●	
Diamorphine tabs	○	○	○	○	○	○	○	○	
Dihydrocodeine inj	○	○	○	○	○	○	○	○	
Dipipanone tabs	○	○	○	○	○	○	○	○	
Fentanyl intranasal	○	○	○	○	○	○	○	○	
Fentanyl oral	○	○	○	○	○	○	○	○	
Fentanyl patches	●	●	●	●	●	●	●	●	
Hydromorphone caps	○	○	○	○	○	○	○	○	
Lisdexamfetamine	○	○	○	○	○	○	○	○	
Methadone inj	○	○	○	○	○	○	○	○	
Methadone liquid	○	○	○	○	○	○	○	○	
Methadone tabs	○	○	○	○	○	○	○	○	
Methylphenidate	●	●	●	●	●	●	●	●	
Morphine inj (excl. Cyclimorph®)	○	○	○	○	○	○	○	○	
Morphine oral	●	●	●	●	●	●	●	●	
Morphine oral solutions	○	○	○	○	○	○	○	●	
Morphine suppositories	○	○	○	○	○	○	○	○	
Nabilone caps (Red List Drug)	○	○	○	○	○	○	○	○	
Oxycodone caps and tabs	●	●	●	●	●	●	●	●	
Oxycodone inj	●	●	○	○	●	○	○	○	
Oxycodone liquid	○	○	○	○	○	○	○	○	
Pentazocine caps, tabs, suppos	○	○	○	○	○	○	○	○	
Pentazocine inj	○	○	○	○	○	○	○	○	
Pethidine inj	○	○	○	○	○	○	○	○	
Pethidine tabs	○	○	○	○	○	○	○	○	
Tapentadol tabs	○	○	○	○	○	●	●	●	

Controlled Drug prescribing indicators

The controlled drugs monitoring indicators are based on the mean of the prescribing of all practices in the HSCB.

● The red indicator represents prescribing that falls above the upper control limit (UCL). This represents the top 1% of prescribing. The UCL is based on three standard deviations from the mean for each drug.

● The orange indicator represents prescribing that falls between the mean prescribing and the UCL.

● The green indicator represents prescribing that falls between the mean prescribing and no prescribing.

○ The white indicator represents no prescribing.

← Methylphenidate includes all strengths and formulations, including m/r

Appendix: COMPASS Explanatory Notes

Glossary			
ICPs	Integrated Care Partnerships	NIPUs	Northern Ireland Prescribing Units
LCG	Local Commissioning Group		
HSCB	Health and Social Care Board		

Quarter: Information in the COMPASS report is based on three months of prescribing data, i.e. one quarter.

ICP average: Figures refer to the average of all practices within the respective ICP.

LCG average: Figures refer to the average of all practices within the respective LCG.

HSCB average: Figures refer to the average of all practices within the HSCB, i.e. all practices in NI.

Cost (£): Net ingredient cost, equivalent to England's Net Ingredient Cost (NIC). Cost is useful in terms of monitoring the overall drugs bill, checking spend within prescribing budgets and calculating savings made or potential savings. Cost is less useful as a measure of drug consumption because of the differences in cost of alternative preparations and changes in prices.

Items: Number of prescription items. Count of items is a reasonable measure of the number of courses of treatments for vaccinations and acute treatments such as short courses of antibiotics. For other treatments it is less useful because of the wide variation in duration of supply per item.

NIPUs: In measuring prescribing, differences between practices need to be taken account of in order to make valid comparisons with local and national averages. NIPUs standardise for differences between practices in terms of patient list size, age/sex structure and additional needs.

Quantity: Number of physical units, i.e. tablets, capsules, patches, mLs, inhalers, vials etc. Quantity is a useful measure of prescribing when looking at individual preparations, e.g. methotrexate 10mg or warfarin 0.5mg and 5mg.

Change from Last Year: The actual change from the same quarter in the previous year.

Defined Daily Dose (DDD): The DDD is a unit of measurement based on the assumed average maintenance dose per day used for its main indication in adults. The World Health Organisation (WHO) developed the DDD as a method to compare drugs of different chemical structures and potencies. The DDD methodology standardises quantities prescribed into number of daily doses. See worked example below. The number of DDDs is calculated as follows:

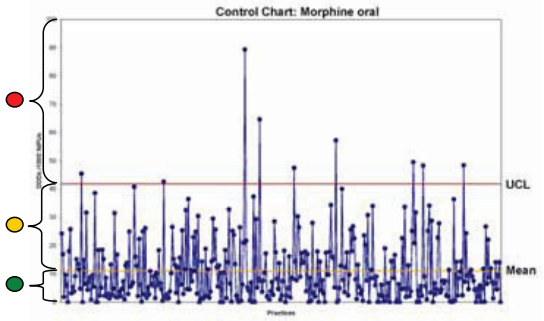
$$\text{Number of DDDs} = \frac{\text{Strength (mg) x quantity}}{\text{DDD (mg)}}$$

Worked example	Quantity (no. of tabs /caps)	DDD (mg)	No. of DDDs
Ibuprofen 200mg 2 caps 3 times a day	168	1200	$\frac{200 \times 168}{1200} = 28$
Ranitidine 150mg 1 tablet twice a day	56	300	$\frac{150 \times 56}{300} = 28$
Lansoprazole 30mg 1 capsule once a day	28	30	$\frac{30 \times 28}{30} = 28$

Prescribing Indicators listed throughout the report give some indication of prescribing quality but are not quantitative measures of good prescribing. Arrows indicate whether a larger figure or a smaller figure suggests 'better' prescribing. Values are given for the practice, locality average, LCG average and HSCB average. They are, therefore, useful in identifying outliers i.e. practice's whose prescribing differs substantially from other practices and to highlight areas for further analysis.

Red List Drugs: The Red list is an advisory list where it is considered by the Regional Group on Specialist Medicines, that responsibility for prescribing should remain with the consultant or specialist clinician. It is recommended that the supply of these specialist medicines should be organised via the hospital pharmacy.

Controlled Drugs (CDs): On the patient and stock prescribing pages there are red, orange and green dots. Each dot represents where a practice is on a control chart in relation to the Upper Control Limit (UCL) and the mean for all practices in NI (see chart below). The UCL is the mean + 3 standard deviations. A green dot represents a practice at the mean or below. An orange dot represents a practice above the mean but below the UCL. A red dot represents a practice above the UCL.



Rational Prescribing

1.1 Background

With the devolution of the medicines budget to the Health and Social Care Board, there is, more than ever, a greater focus on prescribing quality and efficiency.

The purpose of this paper is to consider the interplay of professional and contractual obligations and proposes a process to support rational prescribing.

By way of background, the contractual requirements are set out below:

1.2 Contractual

1.2.1 Excessive Prescribing

The Health and Personal Social Services (General Medical Services Contracts) Regulations (Northern Ireland) 2004 provides the legislative arrangements for the GMS contract and there are a number of pertinent elements with respect to prescribing.

The regulations have a specific reference to "excessive prescribing":

> ***Excessive prescribing***
> ***43.****—(1) The contractor shall not prescribe drugs, medicines or appliances whose cost or quantity, in relation to any patient, is, by reason of the character of the drug, medicine or appliance in question in excess of that which was reasonably necessary for the proper treatment of that patient.*
> *(2) In considering whether a contractor has breached his obligations under sub-paragraph (1), the Board shall seek the views of the Local Medical Committee (if any) for its area.*

This clause was further explained in guidance to 2006 GMS Contract revisions under Annex 8.

1.2.2 Other Relevant Clauses

Other relevant specific references in the contract include the following:

> ***Compliance with legislation and guidance***
> ***499.*** The Contractor shall comply with all relevant legislation and have regard to all relevant guidance issued by the Board or *the Department*.
> [77] This Part is required by *the Regulations* (see paragraph 117 of Schdule5).

> ***Clinical governance***

488. The Contractor shall have an effective *system of clinical governance*. The Contractor shall nominate a person who will have responsibility for ensuring the effective operation of the *system of clinical governance*. The person nominated shall be a person who performs or manages services under the Contract

1.2.3 Quality and Outcomes Framework

As part of the GMS contract, the Quality and Outcomes Framework has a specific section on medicines management. Particularly important are those actions the practice can take to optimise prescribing and these are carried out in line with indicators Medicines Management 6 and 10:

MED06	The practice meets the PCO prescribing adviser at least annually and agrees up to three actions related to prescribing	4
MED10	The practice meets the PCO prescribing adviser at least annually, has agreed up to three actions related to prescribing and subsequently provided evidence of change	4

2 Process for Supporting the Delivery of Rational Prescribing

There are a number of stages proposed as part of this process

2.1 Stage 1

The starting point is the GMS contract.

Each year, data from April to December is reviewed to inform a selection of common themes and targets for practices for the QOF Medicines Management visits in the first quarter. A range of items is prepared for Medicines Management Advisers (MMA) to apply to each of their respective practices. The purpose of the visit is to review prescribing performance and identify, prioritise and agree changes which could improve quality, safety and efficiency of prescribing.

At this stage all practices will be reviewed against a smaller set of quality prescribing parameters. These are set out in Appendix 1 and consist of indicators that are linked to NICE or other National guidance and/or policy.

It is proposed that following consideration by the Board/NIGPC group, the four LMCs will be consulted on this indicator set. Following consideration and adjustment if necessary, the indicator set will be shared with all practices prior to the start of the financial year.

A control chart for each indicator will be prepared which identifies those practices more than 2 standard deviations (54[*]) and 3 standard deviations (34[*]) from the mean (examples of control charts are given in appendix 2).

Two standard deviations is beyond expected norms requiring at least justification and possibly review and improvement. Three standard deviations is an unacceptable position requiring work to remedy the situation.

This indicator set will form a core part of discussions along with practice specific prescribing issues and general governance, quality, safety and efficiency issues.

The MMAs will seek a meeting with each GP practice in the first quarter of the year. It will be important that all principals (if possible) attend the meeting in order that full practice agreement to the actions is attained at the meeting. In previous years, there have been practices that have exhibited outlying prescribing activity. In some cases, when it came to the prescribing visit under QoF, there may have been insufficient attendance by all partners. For the 12/13 year and beyond, there needs to be sufficient attendance and input from all partners, particularly

[*] Number of practices assessed at two or three times the standard deviation from mean using Jan to March 2011 data

where there is outlying prescribing behaviour. Should the practice fail to facilitate such a meeting, the Board reserves the right not to award points for having met that adviser.

Issues will be raised to effect better prescribing and support offered to ensure that actions agreed are met within a reasonable time frame.

A report of the meeting and outcome will be prepared. The outcome will be one of two options:

1. Satisfactory

In the vast majority of visits, practices will want to meet and take forward the actions suggested by the MMA. Each action will have agreed milestones set at time periods during the year.

2. Unsatisfactory – recommend refer for further review

This could be because:

- Failure to meet with MMA within a reasonable time frame
- GP practice was not represented by GP(s) at meeting
- GP practice did not accept or failed to agree the governance, safety, quality issues raised

The sanction in this case will be that QOF MM points will not be awarded. There have been less than 5 cases of failure to meet to agree actions across all NI practices in recent years.

The agreements will be subject to review in year and consideration given to referring to Stage 2 should there be lack of progress and/or prescribing quality is deteriorating.

2.2 Stage 2

Should prescribing performance of a practice/practitioner raise concern, the issue will be considered further at the Board's local office by the Board's Integrated Care Local Management Team.

Consideration will be given to the following examples of possible excessive and/or inappropriate prescribing:

- Where this has been done for a significant proportion of patients and/or in a systematic manner and a reasonable explanation is not provided
- Under prescribing linked to possible poor clinical practice
- A greater purchase margin and costs the NHS more
- Varied according to the impact on practice income
- Excessive amounts of high-cost products*

- High quantities not consistent with other practitioners*

*where this has been subject to proper discussion and education

It is likely that should follow up visits be required, they will occur in Autumn. A decision will then be made around handling within a planned QOF follow-up visit; as a targeted QOF visit; or as a separate meeting.

Consideration will be given to inclusion of LCG support in challenging prescribing practice.

Throughout this process, the practice will be offered support to make changes including raising awareness of best practice and appropriate IT and practice management.

Where the practice can justify that prescribing shows clear evidence of clinical benefit to patients and takes account of available resources, national guidance and local policies, the practice will fall back into routine monitoring.

Where concerns exist that prescribing may be excessive and/or there may be professional concerns, the issue will move to the next stage. It is anticipated that this will be a rare occurrence but it is important that this process is outlined for such cases.

2.3 Stage 3

A report will be compiled consisting of:

- Practice and individual GP prescribing data to include cumulative and individual patient level information
- Description of process to engage practice and support change
- Any other related governance concern

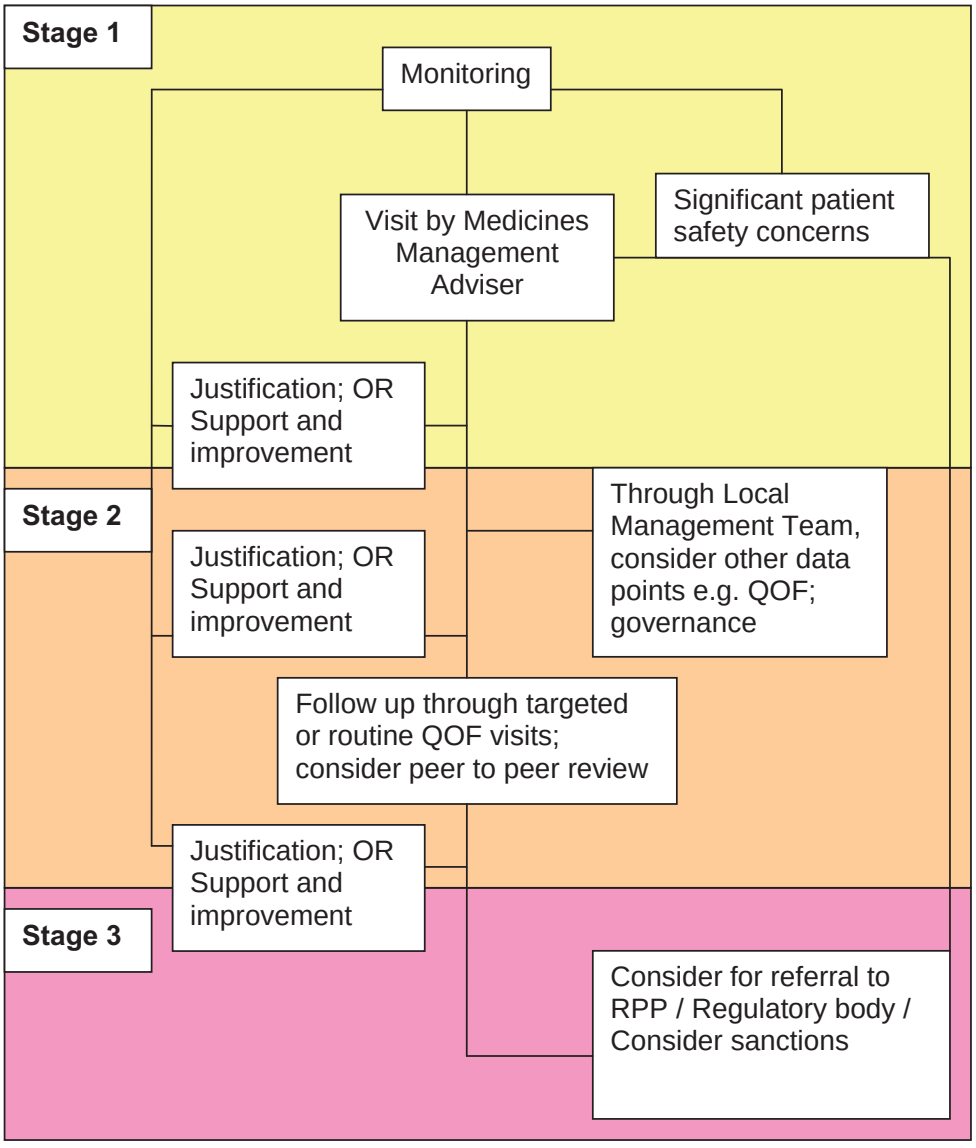
This will be presented to the Assistant Directors of Integrated Care (GMS and Pharmacy & Medicines Management) and set out recommendations to include:

- Referral to RPP
- Further support and ongoing review
- Contract remedial notice
- PMPL amendment to registration
- Referral to regulatory bodies

Sanctions to be considered may include those that affect financial remuneration.
.

The views of Local Medical Committee will also be sought.

This is summarised below:

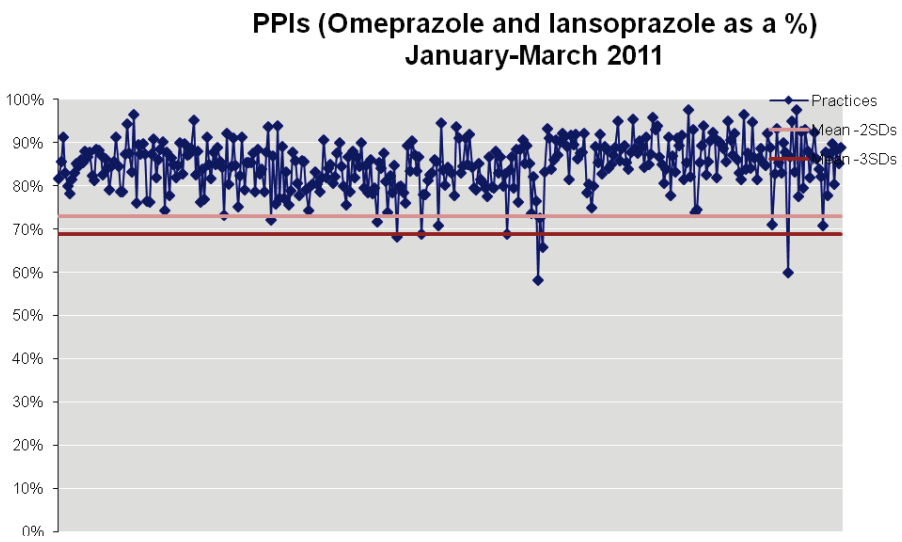


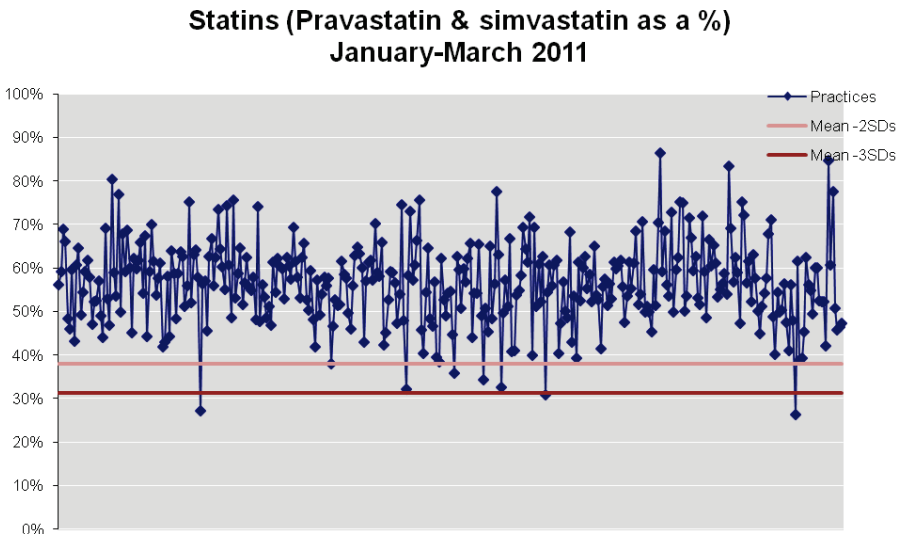
Appendix 1 – Quality Indicators

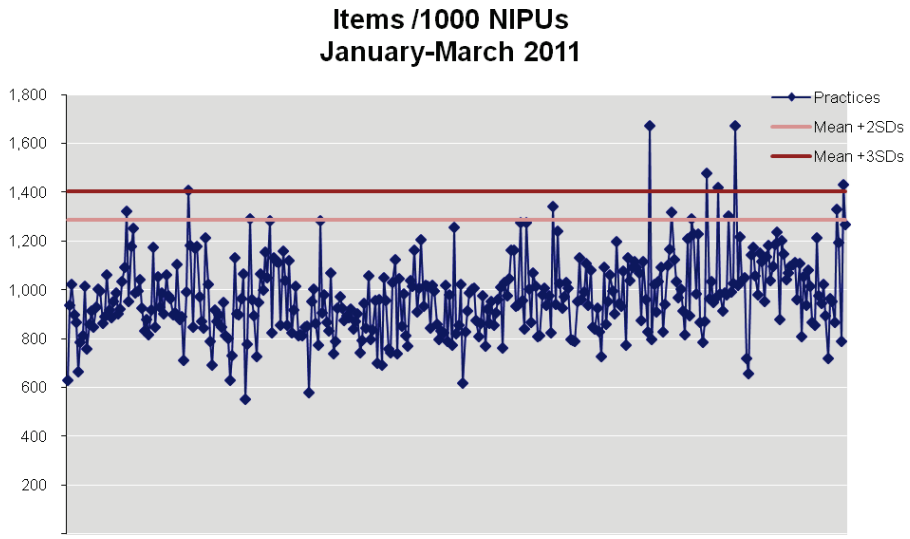
Basket of Indicators: Practice Level

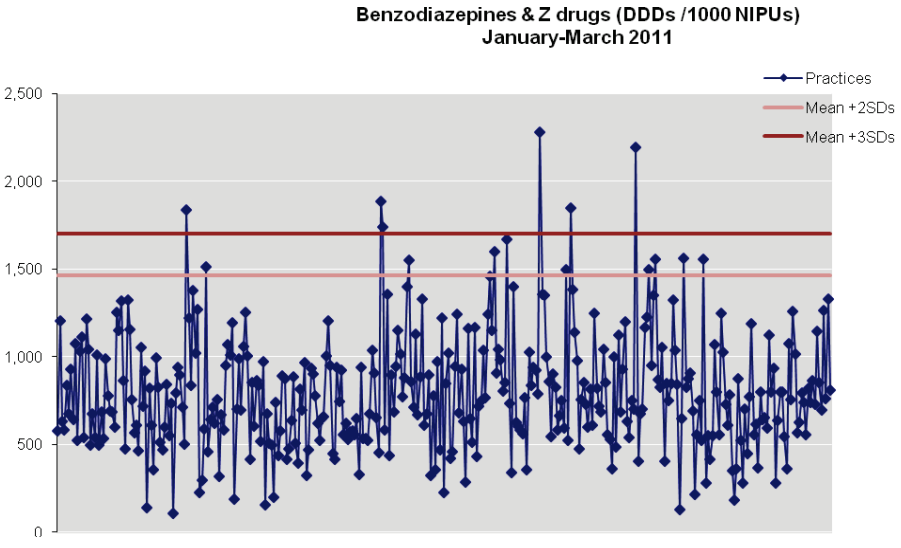
- Reduce items/1000 NIPUs whilst maintaining cost/item
- Increase proportion of PPIs prescribed as lansoprazole or omeprazole as % of all PPIs
- Increase proportion of simvastatin, pravastatin or atorvastatin as a % of all statins
- Reduce DDD/1000 NIPUs of benzodiazepines and Z drugs
- Increase proportion of citalopram, fluoxetine and sertraline items as a % of SSRIs
- Reduce DDD/1000 NIPUs of NSAIDs
- Reduce items /1000 NIPUs of antibiotics

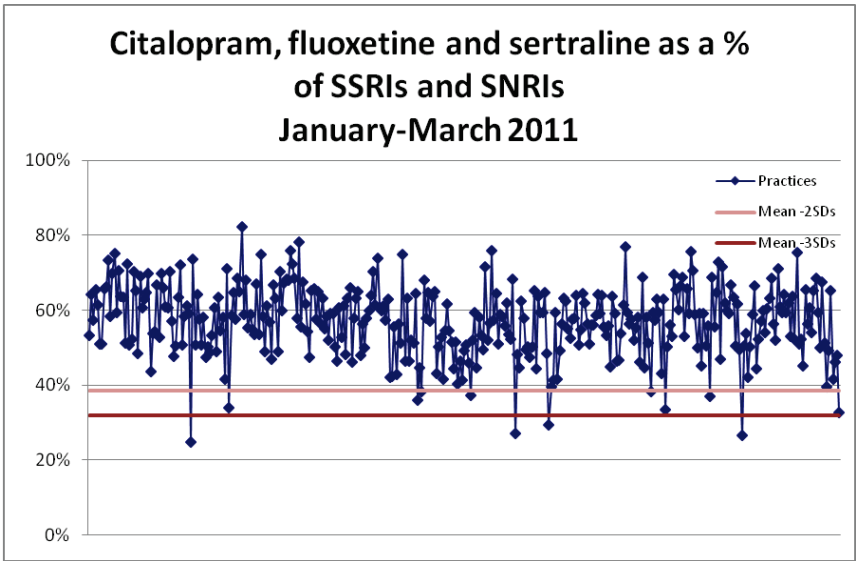
Appendix 2 Control Charts

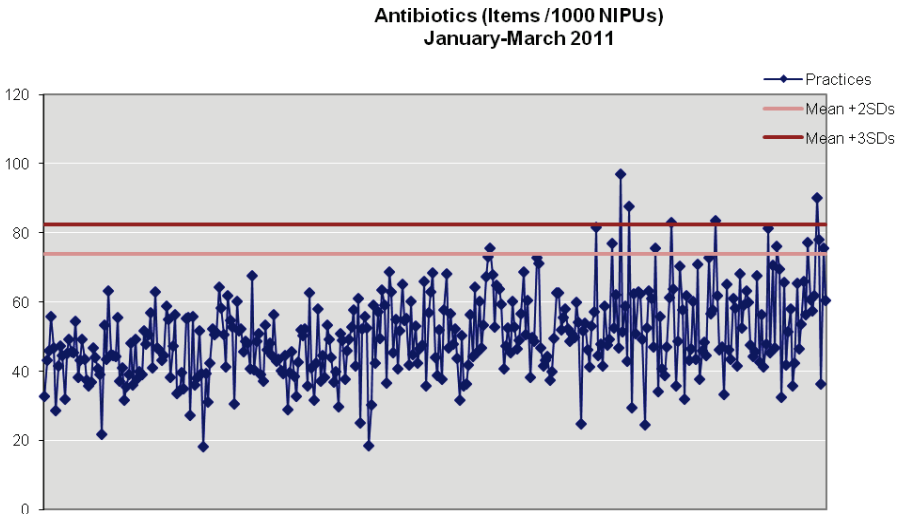


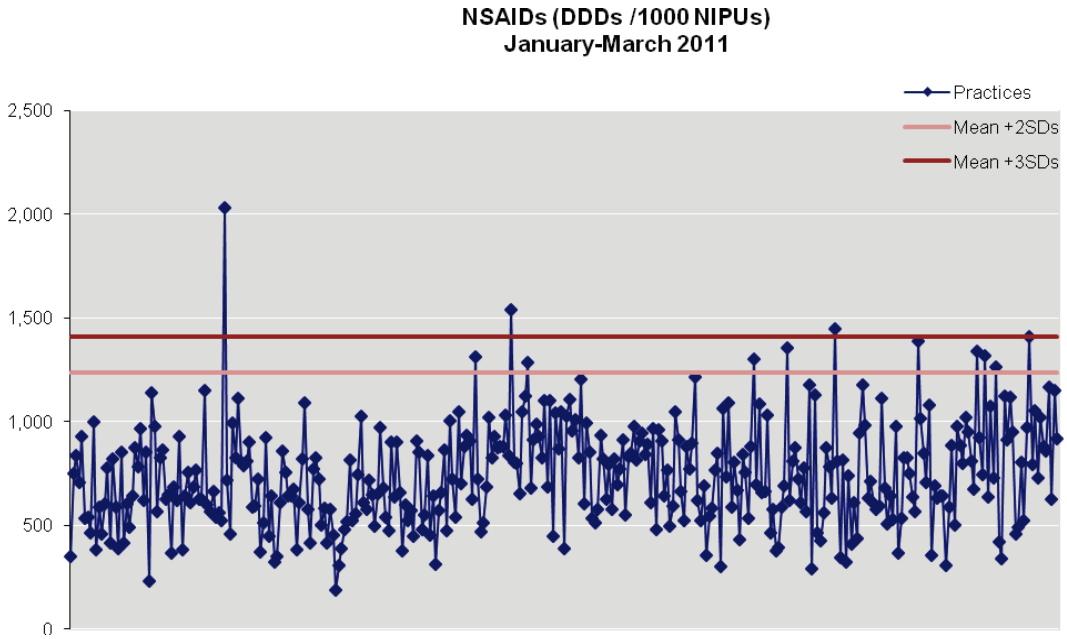


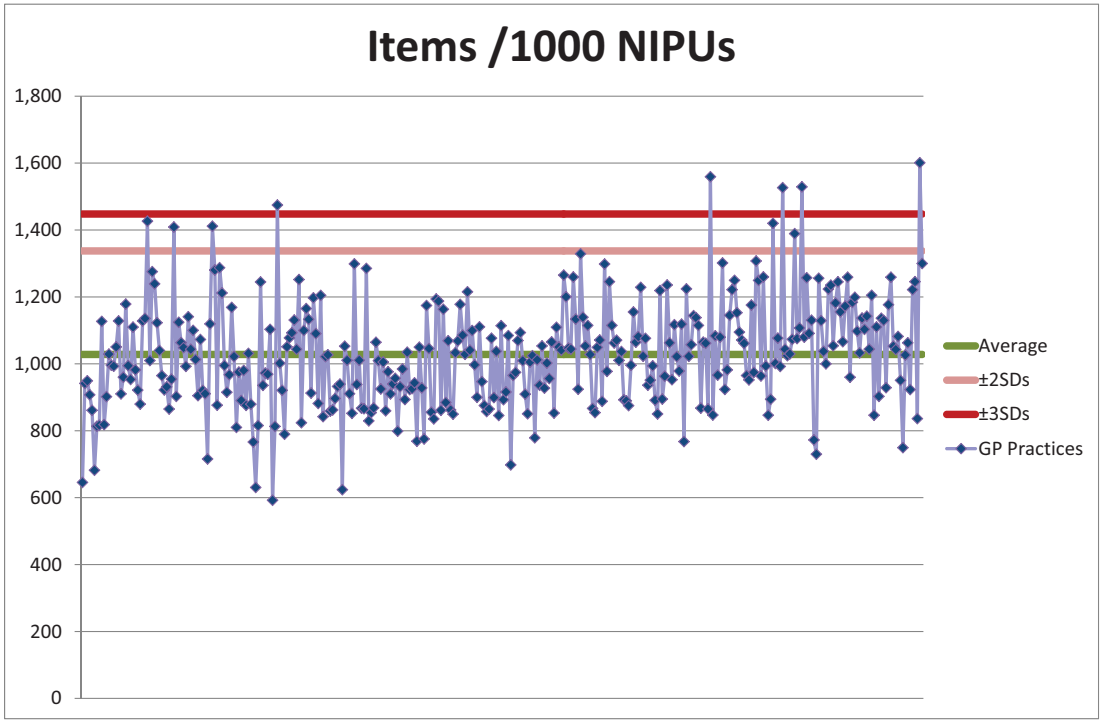

Items /1000 NIPUs
January-March 2011
1,800
1,600
1,400
1,200
1,000
800
600
400
200
Practices
Mean +2SDs
Mean +3SDs

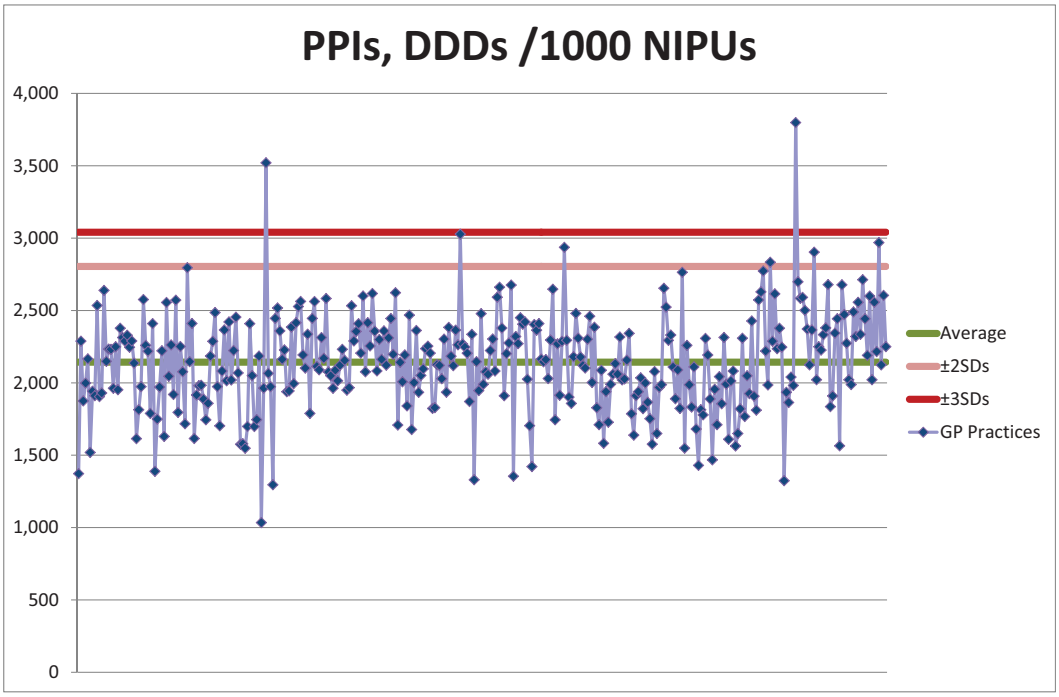

Benzodiazepines & Z drugs (DDDs /1000 NIPUs)
January-March 2011
2,500
2,000
1,500
1,000
500
0
Practices
Mean +2SDs
Mean +3SDs

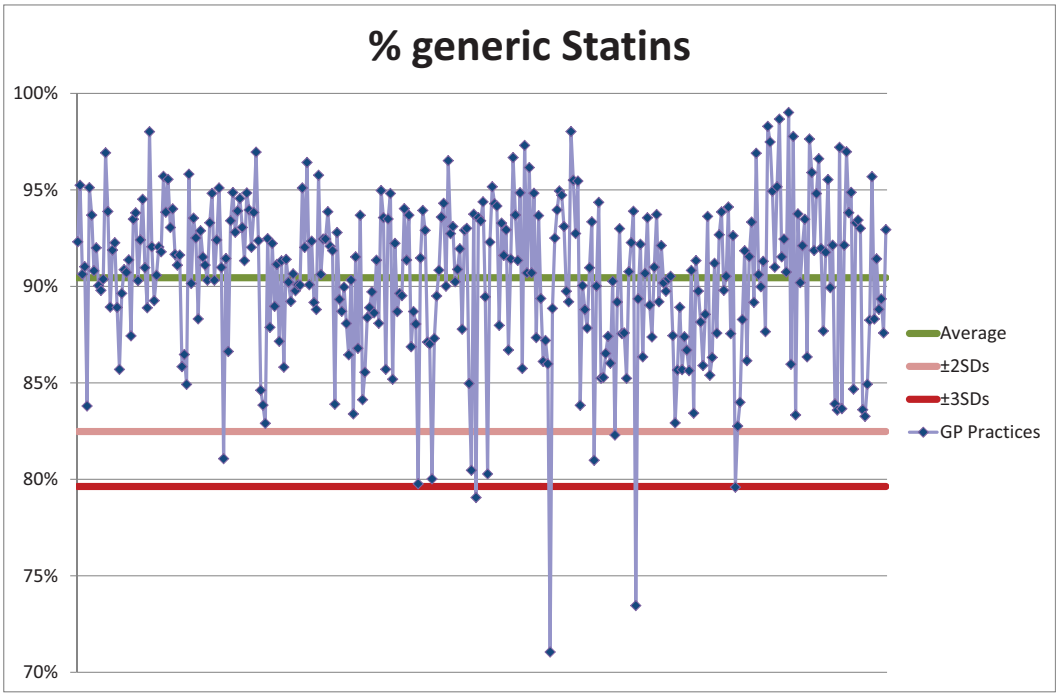

Citalopram, fluoxetine and sertraline as a %
of SSRIs and SNRIs
January-March 2011
100%
80%
60%
40%
20%
0%
Practices
Mean -2SDs
Mean -3SDs

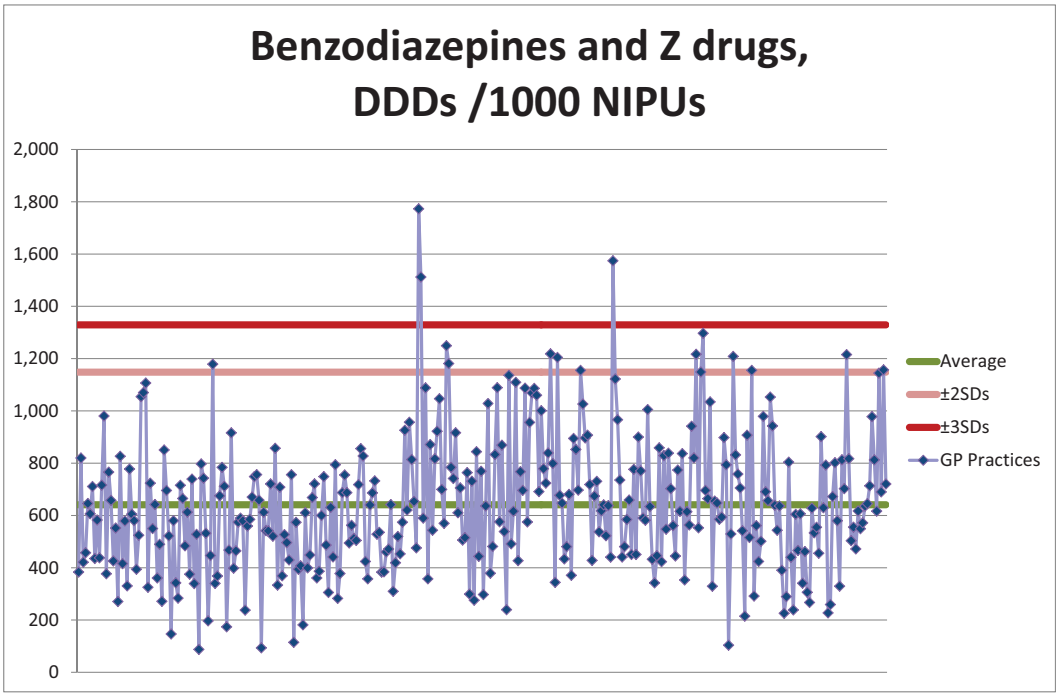

Antibiotics (Items /1000 NIPUs)
January-March 2011
120
100
80
60
40
20
0
Practices
Mean +2SDs
Mean +3SDs

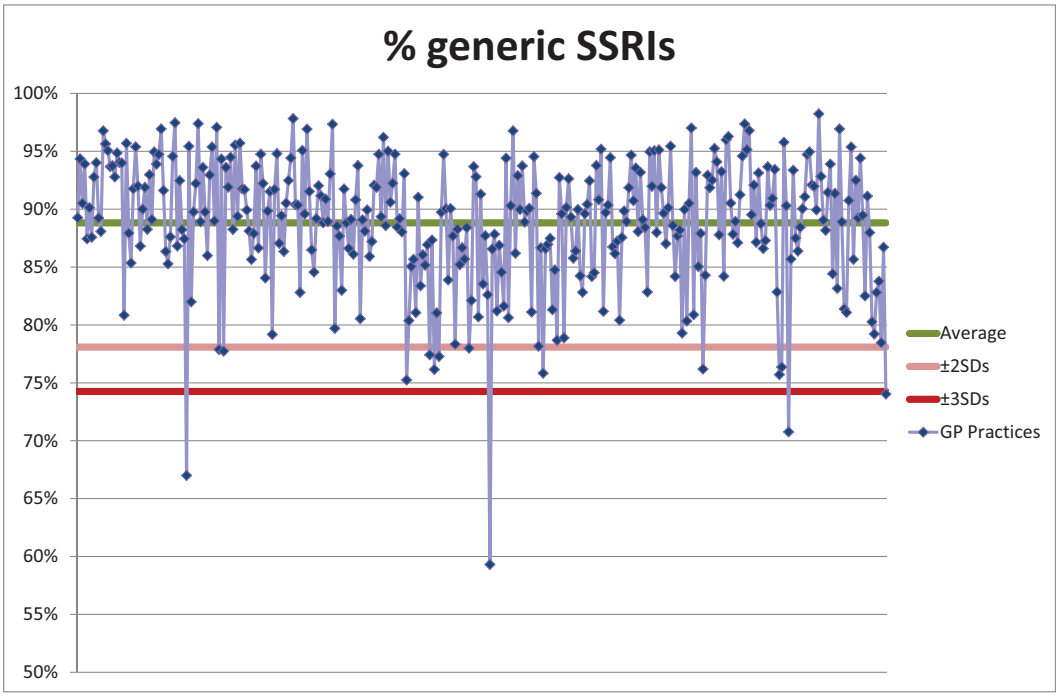

NSAIDs (DDDs /1000 NIPUs)
January-March 2011
Practices
Mean +2SDs
Mean +3SDs
2,500
2,000
1,500
1,000
500
0

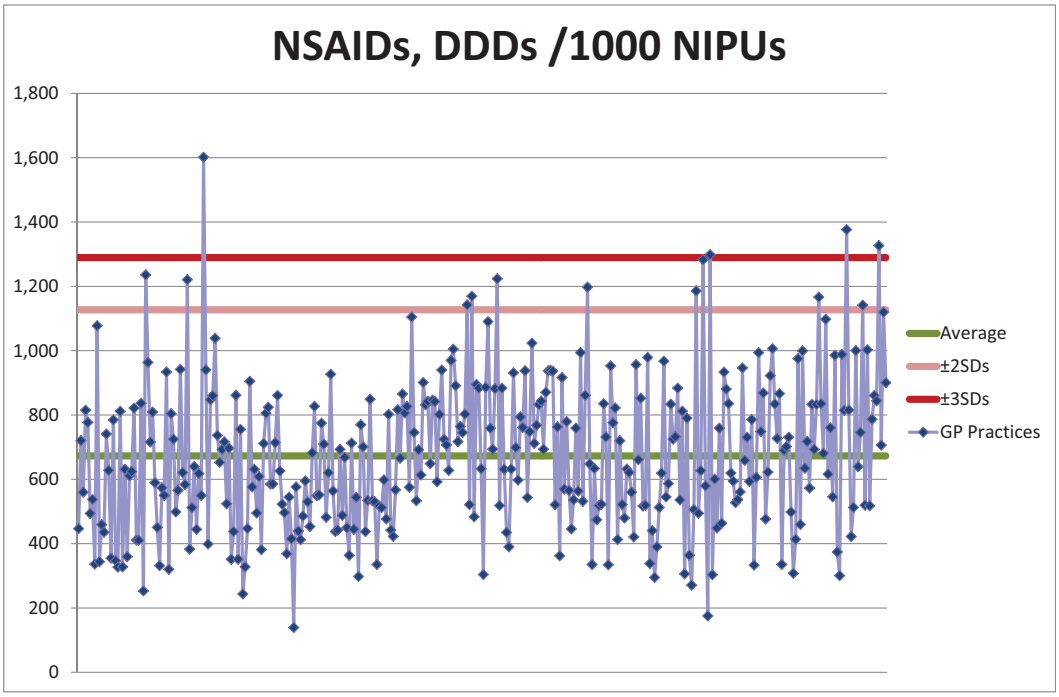

Items /1000 NIPUs
1,800
1,600
1,400
1,200
1,000
800
600
400
200
0
Average
±2SDs
±3SDs
GP Practices


PPIs, DDDs /1000 NIPUs
4,000
3,500
3,000
2,500
2,000
1,500
1,000
500
0
Average
±2SDs
±3SDs
GP Practices


% generic Statins
100%
95%
90%
85%
80%
75%
70%
Average
±2SDs
±3SDs
GP Practices


Benzodiazepines and Z drugs,
DDDs /1000 NIPUs
2,000
1,800
1,600
1,400
1,200
1,000
800
600
400
200
0
Average
±2SDs
±3SDs
GP Practices


% generic SSRIs
100%
95%
90%
85%
80%
75%
70%
65%
60%
55%
50%
Average
±2SDs
±3SDs
GP Practices


NSAIDs, DDDs /1000 NIPUs
1,800
1,600
1,400
1,200
1,000
800
600
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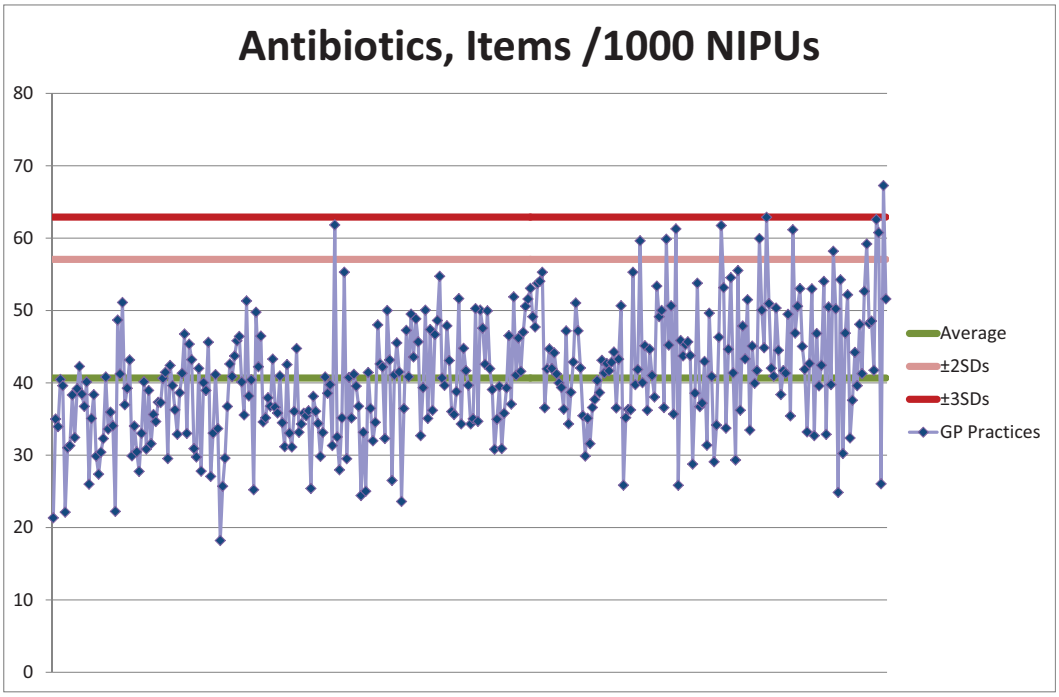
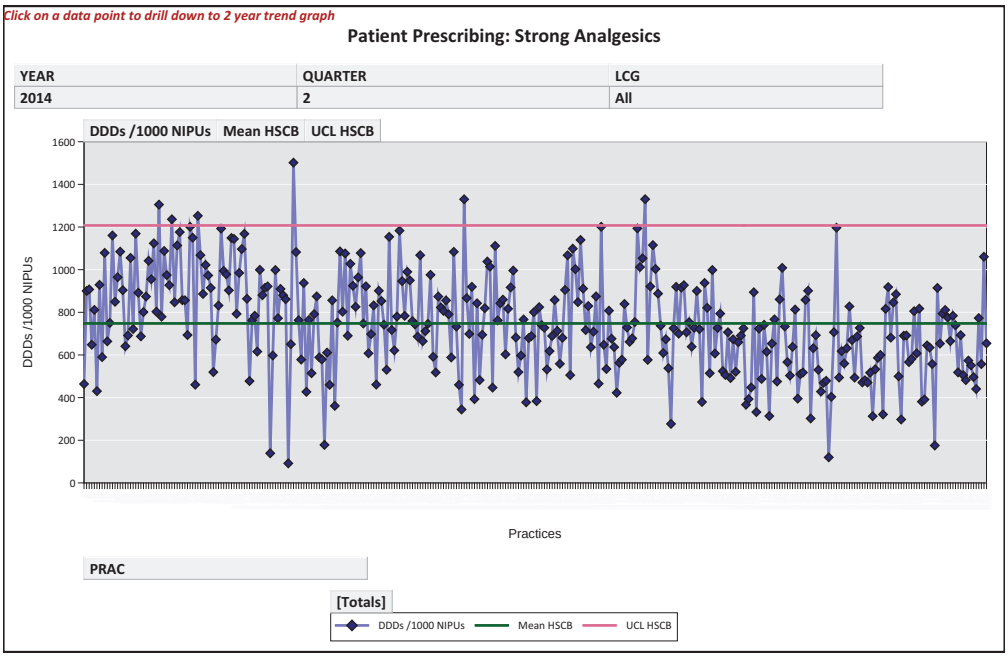
200
0
Average
±2SDs
±3SDs
GP Practices


Antibiotics, Items /1000 NIPUs
80
70
60
50
40
30
20
10
0
Average
±2SDs
±3SDs
GP Practices


Click on a data point to drill down to 2 year trend graph
Patient Prescribing: Strong Analgesics
YEAR
QUARTER
LCG
2014
2
All
DDDs /1000 NIPUs
Mean HSCB
UCL HSCB
1600
1400
1200
1000
800
600
400
200
0
DDDs /1000 NIPUs
Practices
PRAC
[Totals]
DDDs /1000 NIPUs
Mean HSCB
UCL HSCB

Northern Ireland Assembly

Appendix 4

List of Witnesses who Gave Oral Evidence to the Committee

List of Witnesses who Gave Oral Evidence to the Committee

- Mr Richard Pengelly, Accounting Officer, Department of Health, Social Services and Public Safety;
- Dr Mark Timoney, Chief Pharmaceutical Officer, Department of Health, Social Services and Public Safety;
- Mr Joe Brogan, Head of Pharmacy and Medicines Management, Health and Social Care Board;
- Mr Kieran Donnelly, Comptroller and Auditor General (C&AG); and
- Mr Jack Layberry, Treasury Officer of Accounts, Department of Finance and Personnel

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