FOCUS ON PRESCRIBING INDICATORS

PostScRxipt
from the
NHSGGC Area Drug & Therapeutics Committee
Issue 63 May 2011

With the start of the new financial year comes the latest round of prescribing indicators for GP practices. Achievement of change in areas of prescribing has been part of the 'Quality and Outcomes Framework' of the new GP contract since its introduction in 2004. This year sees a significant change with a new set of 'Quality and Productivity' indicators. These aim to secure more effective use of NHS resources through improvements in the quality of primary care by rewarding more clinically appropriate and cost-efficient prescribing. It is important that colleagues in acute care are aware of the changes as prescribing by GPs is often influenced by specialist recommendations.

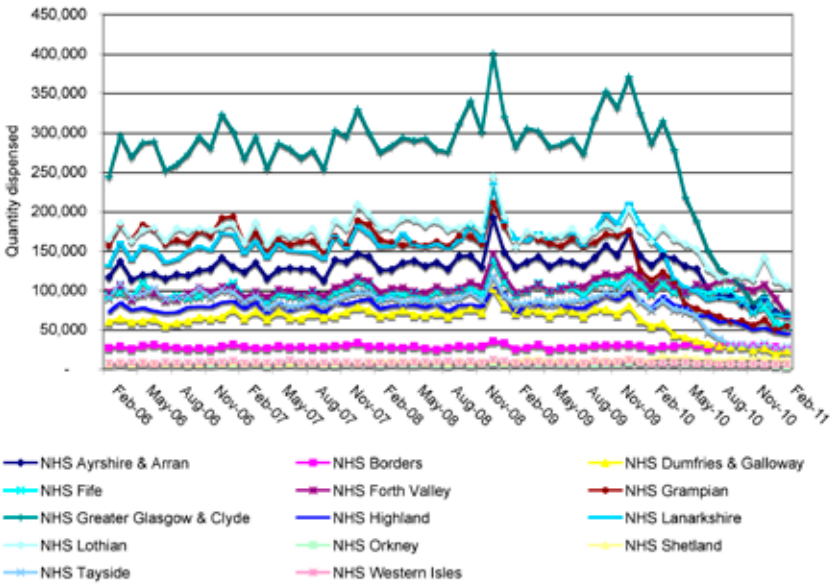
The existing requirements relating to meeting with a prescribing adviser at least annually, agreeing actions related to prescribing and subsequently providing evidence of change continue. The new indicators ask the practice to:

• conduct an internal review of their prescribing to assess whether it is clinically appropriate and cost effective, agree with NHSGGC three areas for improvement and produce a draft plan by the end of June;

• participate in an external peer review of prescribing with a group of practices and agree plans for three prescribing areas for improvement firstly with the group and then with NHSGGC by the end of September 2011.

Success is measured by the percentage of prescriptions complying with the agreed plan for the three improvement areas as a percentage of all prescriptions in that improvement area during the period 1 January to 31 March 2012. As this is a significant change to the contract, many of the details of how this will work are still being ironed out.

Figure 1 Primary care prescribing of prednisolone 5mg EC



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Website
http://www.ggcformulary.scot.nhs.uk

Work is ongoing through the Prescribing Management Groups to try to ensure that everyone within NHSGGC prescribes in a clinical and cost-effective manner. More of the indictors now focus on issues such as overall frequency of use rather than only on choice of drug.

Efficiency with medicines management is not confined to primary care. Within acute services, several directorates have established multi-disciplinary cost-containment groups. These groups will develop action plans to implement the clinically safe, cost effective and consistent use of medicines, reviewing both cost pressures and opportunities for cost efficiencies to contribute to the overall management of the Directorate budget.

There is an awareness of the impact of prescribing decisions across the primary-secondary interface and recent examples of consultation on such issues have been with the Chronic Pain MCN (fentanyl patches, MR analgesia) and urology/ oncology (LHRH analogues). Acute services also mirror primary care prescribing initiatives and in 2010/11 the reduction in vitamin B compound strong and prednisolone EC was apparent across both sectors. This illustrates the benefits of single system prescribing policies.

The monthly spend in primary care on prednisolone 5mg EC tablets reduced from £75,000 in April 2010 to £25,000 in February 2011 (see Figure 1).

The drop in vitamin B compound strong spend is even greater; from a peak of almost £100,000 a month in 2007 to £2,000 in February 2011 (see Figures 2 and 3).

Prescribers across all sectors are asked to take cognisance of the prescribing indicators to ensure that their actions complement this strategy and, where deviation is clinically indicated, the rationale should be clearly stated within any correspondence.

Some of the issues that may be particularly influenced by secondary care are:

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Focus on prescribing indicators *contd from page 1*

• Ulcer healing drugs
- Generic lansoprazole and omeprazole capsules as a % of all single agent oral proton pump inhibitors. Esomeprazole is the most frequently notified non-*Formulary* request from acute care.

• Anti-depressants
- Review of anti-depressants prescribed on repeat.
- Reduction in escitalopram and reboxetine as a % of all SSRIs. These products are often requested by specialist services.

• Pain
- Increase in Matrifen® patches as a % of all fentanyl patches. PDC now stocks this as the preferred brand.
- Morphine should account for at least 70% of all morphine and oxycodone.
- Reduction in cost/weighted patient for buprenorphine patch. Not recommended by SMC or the NHSGGC pain guidelines.
- Reduction in cost/weighted patient for lidocaine patches.

• Antibiotics
- Review of frequency of prescribing of antibiotics (BNF section 5.1) DDDs/patient.
- Review of prescribing of quinolones: defined daily doses/patient during winter (Oct-Mar) no higher than summer (Apr-Sep).
- Review of prescribing of 4C antibiotics: reduce as a % of all antibiotics (BNF section 5.1).

• Diabetes
- Review of oral hypoglycaemics in patients with Type 2 diabetes prescribed metformin.
- Review of insulins in patients with Type 2 diabetes prescribed human insulin.

• NSAIDs
- Generic Preferred List recommended oral NSAIDS as a % of all oral NSAIDS including COX-2s.

Figure 2 Primary care prescribing of vitamin B compound strong tablets

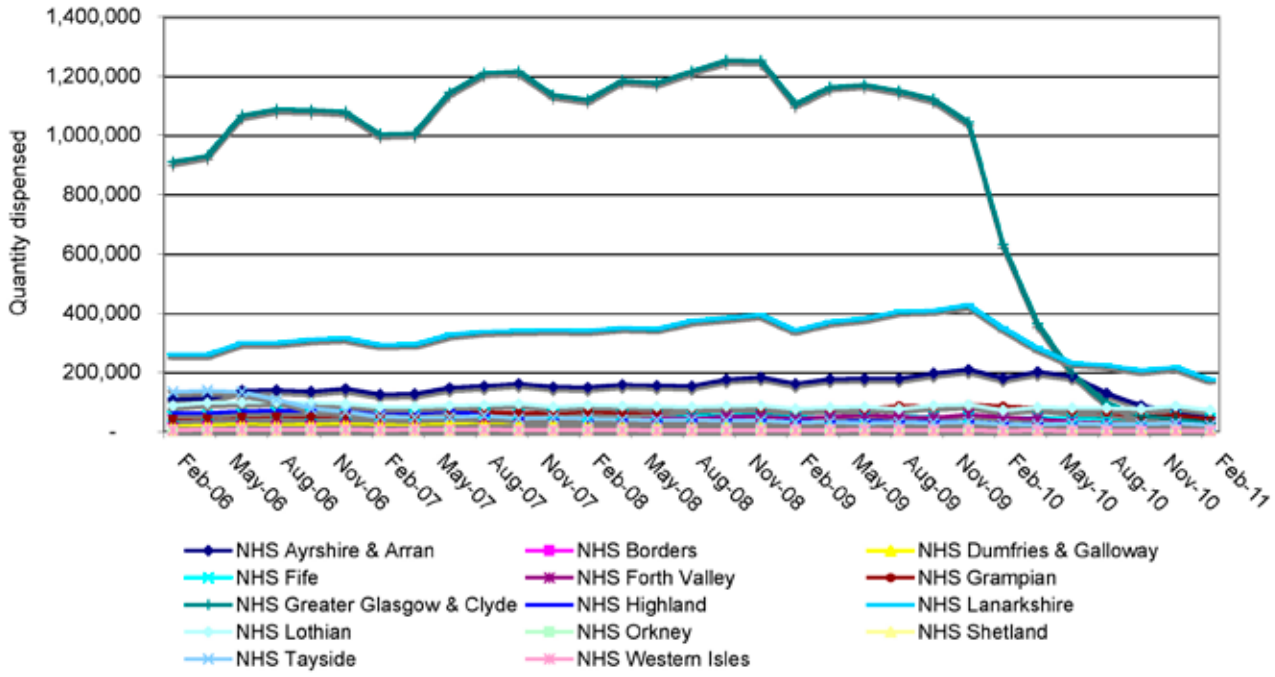
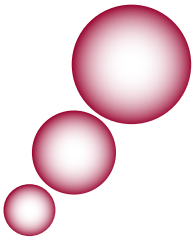


Figure 3 Acute care usage of vitamin B compound strong tablets

- Review of frequency of prescribing of NSAIDs (all oral and injectable NSAIDs including COX-2 selective inhibitors) measured as defined daily doses per patient.

The BMA has produced guidance on the contract for the coming year at **www.bma.org.uk/employmentandcontracts/independent_contractors/quality_outcomes_framework/qofguidance2011.jsp** Some of the other indicators focus on reducing emergency admissions by providing care to patients through the use of alternative care pathways and reducing hospital outpatient referrals. A future article will explore how these aspects are being taken forward in NHSGGC.

"If I could change one thing . . ."



Prescribing support pharmacists often come across examples of significant over-ordering of repeat medications. One of them has an idea to reduce the waste from repeat medicines.

In December 2007, the Scottish Government announced plans to phase out prescription charges, which at that time stood at £6.85 per item. There has since been a gradual reduction in charges for prescriptions and pre-payment certificates with abolition of charges on 1 April 2011. Prescription charges in England increased to £7.40 per item on the same date.

If I could change one thing, I would charge everyone £1.00 per item for their prescriptions. That way people might value them more and only order what they actually need. I have concerns that abolishing the prescription charge will lead to a prescription explosion.

Another pharmacist sees things somewhat differently.

23 million prescriptions were dispensed in NHSGGC in 2010, of which only around 1 million (4.4%) were subject to a charge. Undoubtedly there were inequalities in the existing system, with patients who needed treatment with thyroxine receiving prescription exemption certificates covering all prescribed medicines while those with coronary heart disease or stroke, who may have required five or six medicines, had to pay. Abolition of charges removes one of the barriers which may have reduced compliance with prescribed medicines. In turn, better use of prescribed medicines may reduce incidence of events and shorten or avoid hospital stays; the savings from which would far outweigh any lost prescription revenue.

Are there any precedents we can learn from?

The minor ailments service from community pharmacies means that patients who previously were exempt from prescription charges can receive a variety of treatments without charge (this has not been extended to cover patients who previously paid for prescriptions). The service allows a pharmacist to supply over-the-counter items such as analgesics, antihistamines and preparations for mouth ulcers after assessing the patient. Concerns from some people about the likely level of demand for this free service have not materialised. Prescription charges were abolished

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Latest ADTC decisions

Added with MINOR changes to the *Formulary*

Ⓢ **Botulinum toxin type A (Botox®)** Focal spasticity, including the treatment of wrist and hand due to upper limb spasticity associated with stroke in adults. Total *Formulary*.

Ⓢ **Dalteparin (Fragmin®)** Extended treatment of symptomatic venous thromboembolism (VTE) and prevention of its recurrence in patients with solid tumours. Total *Formulary*. Restricted to initiation by healthcare professionals experienced in the treatment of VTE and used according to local protocol.

Ⓢ **Exenatide (Byetta®)** Type 2 diabetes mellitus in combination with thiazolidinediones with or without metformin. Total *Formulary*. Restricted to use in combination with metformin and a thiazolidinedione as a third-line pre-insulin treatment option.

Ⓢ **Fosaprepitant dimeglumine powder (IVEMEND®)** Prevention of acute and delayed nausea and vomiting associated with highly emetogenic cisplatin-based cancer chemotherapy in adults. Total *Formulary*. Restricted to use according to regional protocol for the prevention of acute and delayed nausea and vomiting associated with highly-emetogenic cisplatin-based chemotherapy in adults as a second-line option after failure of an appropriate first line antiemetic.

Ⓢ **Sevelamer carbonate (Renvela®)** Control of hyperphosphataemia in adult patients receiving haemodialysis or peritoneal dialysis. Total *Formulary*. Restricted to second line management of hyperphosphataemia in adult patients receiving haemodialysis.

Ⓢ **Sildenafil citrate infusion (Revatio®)** Treatment of patients with pulmonary arterial hypertension who are temporarily unable to take oral sildenafil. Total *Formulary*. Restricted to use on the advice of specialists in the Scottish Pulmonary Vascular Unit and from the Scottish Adult Congenital Cardiac Service.

NON-*Formulary*

- **Adapalene/benzoyl peroxide (Epiduo®)** Treatment of acne vulgaris when comedones, papules and pastules are present.
- **Bendamustine (Levact®)** Treatment of multiple myeloma in combination with prednisone.
- **Bendamustine (Levact®)** Monotherapy for Non-Hodgkin's lymphoma.
- **Botulinum toxin type A (Botox®)** Prophylaxis of headaches in adults with chronic migraine.
- **Botulinum toxin type A (Bocouture®)** For the temporary improvement in the appearance of moderate to severe glabellar (frown) lines.
- **Calcium acetate/magnesium carbonate (Osvaren®)** Hyperphosphataemia associated with chronic renal insufficiency in patients undergoing dialysis.
- **Cannabinoid (Sativex®)** Symptomatic relief of moderate to severe spasticity due to multiple sclerosis.
- **Drospirenone/Ethinylestradiol (Yasmin®)** Oral contraception.
- **Nicotinic acid/laropiprant (Tredaptive®)** Treatment of dyslipidaemia.
- **Paliperidone (Invega®)** Treatment of psychotic or manic symptoms of schizoaffective disorder.
- **Vinflunine ditartrate (Javlor®)** Metastatic transitional cell carcinoma of the urothelial tract (TCCU).

Ⓢ specialist use only Ⓢ specialist initiation only

"If I could change one thing . . ." *contd from page 3*

in Wales in 2007. Studies have shown that although the rates of dispensing have increased, the increase is not more than that in an area of England where charges remained.

With the introduction of the chronic medication service as part of the community pharmacy contract and the medicines management local enhanced service for GPs, there are roles for all healthcare professionals involved in repeat prescribing to ensure that ordering systems are used appropriately and efficiently. Reduction in the ordering of unnecessary prescription medication is everyone's responsibility and a target for 2011/12.

Revised unlicensed medicines policy

The unlicensed medicines (ULM) policy has been revised following user feedback and the alterations have been approved by the ADTC. Some details are provided of the main changes.

Revision of the risk matrix
There has been some feedback on the practical implementation of the risk assessment of off-label medicines. It has been highlighted that the use of some medicines fulfilling the criteria for high risk would be established practice and therefore there is limited benefit in completing an unlicensed request form on each occasion. As a result the following criteria, formerly designated high risk, will now fall into the medium risk category:

- High risk of life threatening or disabling side effects/toxicity
- Teratogenic
- Carcinogenic
- Medicines requiring ongoing monitoring
- Cytotoxics
- Biologic agents

For these medicines there is no requirement to complete a ULM request form on each occasion (see revised policy). However, prescribers are strongly encouraged to develop a protocol (or actively adopt one already available nationally) to describe their use. This is particularly important where the medicine will be continued in primary care.

Off-label medicines where the evidence base is small (eg evidence from phase 1 clinical trials or case reports) and medicines administered intrathecally or by the epidural route will continue to fall into the high risk category and a ULM request should be completed for all of these patients.

Patient information and informed consent
Following a review of this aspect of the policy, it is acknowledged that written informed consent is not a legal requirement and therefore the policy has been revised so that this is no longer essential for patients prescribed medicines off label, although the importance of providing appropriate information to the patient as per MHRA/GMC guidance remains (see ULM policy for details).

Minor changes have also been made to the policy's emphasis and wording. Full details can be found at **www.staffnet.ggc.scot.nhs.uk/Info%20Centre/GGC%20Formulary/Documents/9.1%20ULM%20Policy%20-%201101.pdf**

New licensed indication for dalteparin

There has been a protocol in place for some time in NHSGGC for the treatment and secondary prophylaxis of deep vein thrombosis (DVT) or pulmonary embolism (PE) in cancer patients. It can be found under haematology guidelines on the Clinical Info pages on Staffnet (**www.staffnet.ggc.scot.nhs.uk/Clinical Info/Clinical Guidelines/Clinical Guidelines By Clinical Topic/Documents/020_LMWH for VTE in Cancer v7 July2010.pdf**). Dalteparin is the only LMWH specifically licensed for this indication. SMC has accepted it and this licence extension is acknowledged on the NHSGGC *Formulary*.

The protocol is for use in those patients who have active cancer, eg recent diagnosis, undergoing chemotherapy, liver metastases and those in whom there are likely to be problems with maintaining a stable INR if warfarin is used. It is envisaged that the dalteparin will be administered by the patient or a carer.

One of the key challenges of implementing this protocol is communication. The treatment is initiated by the medical team diagnosing the DVT/PTE and it is responsible for the dose and initial monitoring, including platelet count checks for heparin induced thrombocytopenia (HIT) every two to three days until day 14 of treatment.

Subsequent responsibility for ongoing monitoring and completion of therapy (six months or longer if active cancer therapy continues) rests with the doctor managing the patient's cancer. That may be the oncologist, palliative care consultant or the patient's GP. This individual needs to be identified by the medical team and consulted prior to the patient's discharge from acute care. Responsibilities of ongoing care include a reduction in dose after one month, platelet checks (as per chemo) and awareness of the need for dose adjustments if there are significant changes in body weight or renal function.

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Published by the Communications Sub-group to reflect the views of the Area Drug & Therapeutics Committee but not necessarily those of NHS Greater Glasgow and Clyde.

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