All Wales Medicines Strategy Group
Grŵp Strategaeth Meddyginiaethau Cymru Gyfan

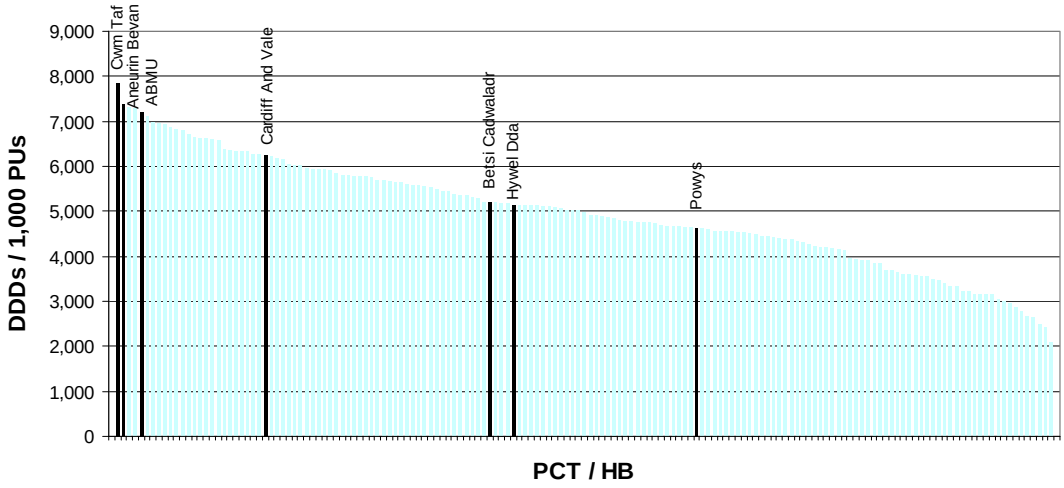
NATIONAL PRESCRIBING INDICATORS 2013–2014: SUPPORTING INFORMATION FOR PRESCRIBERS

The table below summarises the All Wales Medicines Strategy Group (AWMSG) National Prescribing Indicators for 2013–2014 and provides associated key messages and supporting materials. The complete National Prescribing Indicators document with supporting evidence is available on the AWMSG website.

Points for prescribers' consideration:

- Do you want to demonstrate quality improvement in therapeutics as part of revalidation (see General Medical Council requirements for revalidation)?
- In which forums can the following key messages be discussed with colleagues?
- Can a collaborative approach be achieved through locality networks/cluster groups?

LIPID-MODIFYING DRUGS	
Measure	Items of low acquisition cost (LAC) statins as a percentage of all statin, ezetimibe and simvastatin/ezetimibe combination prescribing
Key messages	**Points for prescribers' consideration** • There are still substantial savings to be made by some NHS organisations through the use of LAC statins. • Simvastatin, atorvastatin and pravastatin remain the agents of choice. • If one statin is not tolerated, a lower dose or an alternative LAC statin should be offered. • Primary prevention (without type 2 diabetes) – NICE CG67: Lipid Modification recommends first-line treatment simvastatin 40 mg. There is no target level for total or low-density lipoprotein cholesterol and routine repeat lipid profile is not necessary. Do not use higher intensity statins routinely. • There is an increased risk of myopathy associated with simvastatin 80 mg daily (Medicines and Healthcare Products Regulatory Agency [MHRA] Drug Safety Update).
Supporting materials	AWMSG Statin Template Guidance - Use of Statins in Primary and Secondary Prevention of Vascular Disease provides templates for the use of statins.
HYPNOTICS AND ANXIOLYTICS	
Measure	Average daily quantities (ADQs) per 1,000 specific therapeutic group age-sex related prescribing units (STAR-PUs)
Key messages	There is still large variation in prescribing rates of these drugs across health boards (HBs) and between GP practices. Wales prescribes 47% more hypnotic and anxiolytic items per 1,000 patients than a demographically similar primary care trust in England. **Points for prescribers' consideration** Have you accessed the AWMSG Hypnotics and Anxiolytics Educational Resource Pack? It contains material to aid appropriate prescribing of hypnotics and anxiolytics across Wales, including: • Materials to support the review and discontinuation of hypnotic and anxiolytic treatment, either via consultation or by letter. • Hypnotic audit – Have patients been appropriately counselled? Have they been assessed for suitability for withdrawal in the last 12 months? • Practice policy – Have clinicians agreed a consistent approach for the prescribing of hypnotics and anxiolytics? **Points for consideration in the hospital setting** • Do psychiatric/pain management teams provide clear guidance, including management plan and review, to GPs for patients initiated on these medications? • Do discharge summaries provide advice on review and discontinuation of these medications?
Supporting materials	The AWMSG Hypnotics and Anxiolytics Educational Resource Pack provides material to support appropriate prescribing of hypnotics and anxiolytics across Wales.

DOSULEPIN	
Measure	Defined daily doses (DDDs) per 1,000 prescribing units (PUs)
Key messages	The British National Formulary (BNF) lists dosulepin as "less suitable for prescribing". NICE CG90: Depression in Adults states, "*Do not switch to, or start, dosulepin because evidence supporting its tolerability relative to other antidepressants is outweighed by the increased cardiac risk and toxicity in overdose*". **Points for prescribers' consideration** • Have you reviewed patients taking dosulepin? • Has your practice run a report to identify how many patients are prescribed dosulepin? • Some patients may not be taking their dosulepin regularly – could it be removed from their repeat prescription? ***Examples of good practice*** • Whitchurch Hospital Cardiff routinely reviews and stops dosulepin when patients are admitted. • Cardiff and Vale and Cwm Taf HBs have developed audits to review dosulepin in GP practices. In Cardiff and Vale HB, of 1,215 patients prescribed dosulepin, 845 (69.5%) were reviewed. Of those, 30% stopped treatment with no alternative therapy prescribed and 49% were switched to an alternative therapy. **Points for consideration in the hospital setting** • Has hospital prescribing data been analysed to monitor extent of prescribing? • Are some directorates initiating dosulepin? Anecdotal evidence suggests that dosulepin is still being initiated by some chronic pain and mental health teams.
Supporting materials	The dosulepin audits developed by Cardiff and Vale HB and adapted by Cwm Taf HB are available from the respective Medicines Management teams.
ANTIDEPRESSANTS	
Measure	ADQs per 1,000 STAR-PUs
Key messages	The following graph provides an indication of the regional variation in use of antidepressants. Antidepressant usage in England and Wales – Quarter ending September 2012 *  ** Future graphs will be adjusted to ADQs per 1,000 STAR-PUs when the March 2013 data are available*. To assess whether use is in line with NICE guidance, consider undertaking the AWMSG National Audit. Practices need to identify mental health support services available to their patients.
Supporting materials	CEPP National Audit: Towards more Appropriate Management of Depression in a Primary Care Setting Wales Mental Health in Primary Care (WaMH in PC) aims to promote primary mental health care and improve mental health services across Wales. It has produced resources to help GPs and their teams understand how the recently launched Part 1 of the Mental Health Measure is going to change and improve mental health services across Wales.

OPIOIDS

Measure

Morphine as a percentage of strong opioid prescribing

Key messages

World Health Organisation Guidelines: If pain occurs, there should be prompt oral administration of drugs in the following order: non-opioids (aspirin and paracetamol); then, as necessary, mild opioids (codeine); then strong opioids such as morphine, until the patient is free of pain". Where possible, modified-release (MR) opioids administered at regular intervals should be used in the management of patients with persistent pain.

NICE CG140: Opioids in Palliative Care: When starting treatment with strong opioids, offer patients with advanced and progressive disease regular oral modified-release or oral immediate-release morphine (depending on patient preference), with rescue doses of oral immediate-release morphine for breakthrough pain.

- Do not routinely offer transdermal patch formulations as first-line maintenance treatment to patients in whom oral opioids are suitable.

British Pain Society: Clinical experience suggests that immediate-release preparations are more frequently associated with tolerance and problem drug use. The need for immediate-release opioids for persistent pain should prompt specialist review.

Points for prescribers' consideration

- Do you prescribe MR (branded) morphine first-line when initiating strong opioid therapy?
- Have you discussed first-line treatment with the local palliative care team?
- Do you know the relative strength of opioid therapies? The following extract is adapted from the BNF 64 January 2013 update on pain management with opioids: Approximate guide only (doses may not correspond with those given in clinical practice); patients should be carefully monitored after any change in medication, dose titration may be required.

Equivalent doses of oral opioids

Analgesic	Codeine	Dihydrocodeine	Morphine	Oxycodone	Tramadol
Dose	100 mg	100 mg	10 mg	6.6 mg	100 mg

Transdermal patches are approximately equivalent to the following 24-hour doses of oral morphine. (Note: Conversion ratios vary and these figures are a guide only.)

Oral morphine salt (mg/24 hrs)	12	24	30	48	60	84	120	126	168	180	240
Transdermal buprenorphine (mcg/hr)	5	10		20		35		52.5	70		
Transdermal fentanyl (mcg/hr)			12		25		50			75	100

When transdermal fentanyl is removed, a subcutaneous depot remains; significant levels of the drug persist in the blood for 24 hours or more after the patch has been removed. Prescribers should ensure that they are familiar with the correct use of transdermal preparations; inappropriate use has caused fatalities.

Points for consideration in the hospital setting

Have secondary care clinicians seen the prescribing data of their teams? (Clinicians have expressed interest in seeing this.)

Supporting materials

Consider using these resources for your continuing professional development:

The British Pain Society: Opioids for Persistent Pain: Good Practice – clear guidance for prescribers

The National Patient Safety Agency: Reducing Dosing Errors with Opioid Medicines

MHRA: Opioids Learning Module

MHRA Drug Safety Update: Fentanyl patches: serious and fatal overdose from dosing errors, accidental exposure, and inappropriate use.

ANTIBIOTICS

Measures

Antibacterial items per 1,000 STAR-PUs

Cephalosporins as a percentage of total antibacterial items

Quinolones as a percentage of total antibacterial items

Co-amoxiclav as a percentage of total antibacterial items

Key messages

Prescribing volume is increasing: The total number of antimicrobial prescription items dispensed in primary care across Wales over the last year has increased compared to 2008.

Resistance: The use of simple generic antibiotics and the avoidance of broad-spectrum antibiotics (e.g. co-amoxiclav, quinolones and cephalosporins) preserve these from resistance and reduce the risk of *C. difficile*, MRSA and resistant urinary tract infections.

C. difficile: There is an association between quinolone (-ofloxacins), cephalosporin and co-amoxiclav use and the incidence of *C. difficile* acute diarrhoea. Cephalosporins are not listed as first- or second-line treatments in the Health Protection Agency (HPA) report: Management of infection guidance for primary care.

	Points for prescribers' consideration • Have you recently compared your prescribing practice against guidance, e.g. HPA guidance, BNF or local guidance? Have you read the recent Welsh Medicines Resource Centre (WeMeReC) bulletin discussing antibiotics?
Supporting materials	WeMeReC produces case studies, peer responses and bulletins. Are you registered to receive this resource? WeMeReC bulletin November 2012: Appropriate Antibiotic Use – Whose Responsibility? RCGP TARGET Antibiotics Toolkit AWMSG National Audit: Focus on Antibiotic Prescribing
INSULIN	
Measure	Long-acting insulin analogues as a percentage of total long- and intermediate-acting insulin (excluding biphasics)
Key messages	**Points for prescribers' consideration** • This is a good collaborative indicator and would be suitable for discussion at network/cluster group meetings. NICE CG87: Type 2 Diabetes – Newer Agents recommends that when insulin therapy is necessary, human isophane (NPH) insulin is the preferred option. Long-acting insulin analogues (detemir and glargine) offer no significant advantage over NPH insulin and are much more expensive. Long-acting insulin analogues should only be considered for: • People that require assistance with injecting insulin. • People whose lifestyle is significantly restricted by recurrent symptomatic hypoglycaemia. • People that would otherwise need twice-daily basal insulin injections in combination with oral antidiabetic drugs. • People that cannot use the device needed to inject isophane.
Supporting materials	More information on the use of long-acting insulin analogues in type 2 diabetes can be found in the March 2012 Medicines Resource Centre (MeReC) Bulletin. NPC e-learning materials: Diabetes Type 2
NON-STEROIDAL ANTI-INFLAMMATORY DRUGS (NSAIDS)	
Measures	ADQs per 1,000 STAR-PUs Ibuprofen and naproxen as a percentage of NSAID items
Key messages	NSAIDs are associated with increased risk of: • Serious gastro-intestinal toxicity, especially in patients over 75 years. • Renal failure in otherwise healthy patients (MHRA). • Heart failure: NSAID treatment is contraindicated in severe heart failure. • Thrombosis: Diclofenac 150 mg daily has a thrombotic risk profile similar to selective COX-2 inhibitors. **Points for prescribers' consideration** Do you: • Encourage acute rather than repeat prescriptions for NSAIDs? • Set computer default to small quantities (e.g. 1–2 weeks supply) per script? • Advise patients about the risks of NSAID therapy? • Provide the AWMSG Patient Information Leaflet: Medicines for Mild to Moderate Pain Relief? • Prescribe naproxen 250 mg rather than 500 mg to allow patients to make dose adjustments? • Report adverse events using the MHRA Yellow Card reporting system? **Points for consideration in the hospital setting** • Have surgical teams reviewed their choice of peri-operative analgesics? • Promote post-operative pain management reviews. • NSAIDs are not recommended following hip fracture (NICE CG124: Hip Fracture).
Supporting materials	CEPP National Audit: Towards Appropriate NSAID Prescribing AWMSG Patient Information Leaflet: Medicines for Mild to Moderate Pain Relief Back Book Wales: Link to order

Note: Implementation of the national indicators does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer.

The prescribing indicators highlighted constitute guidance only and neither this document in isolation, nor as part of a wider policy, comprise a financial incentive scheme to any medical practices and/or practitioners to prescribe a specific named medicine.

For a full explanation of the definitions included in this document please refer to the complete National Prescribing Indicators on the AWMSG website.