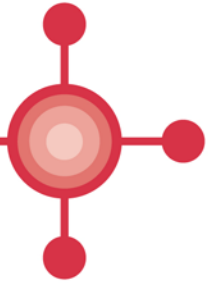


All Wales Medicines Strategy Group

Grŵp Strategaeth Meddyginiaethau Cymru Gyfan



# National Prescribing Indicators 2014–2015

## Supporting Information for Prescribers

April 2014

This report has been prepared by a multiprofessional collaborative group, with support from the All Wales Prescribing Advisory Group (AWPAG) and the All Wales Therapeutics and Toxicology Centre (AWTTC), and has subsequently been endorsed by the All Wales Medicines Strategy Group (AWMSG).

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For a full explanation of the evidence supporting the National Prescribing Indicators (NPIs), prescribing data and the terms used in this document, please refer to the [National Prescribing Indicators 2014–2015](#) document on the All Wales Medicines Strategy Group (AWMSG) website.

This document summarises the AWMSG NPIs for 2014–2015 and provides points for consideration and links to supporting materials. The NPIs and supporting resources can be used to:

- Demonstrate quality improvement in therapeutics as part of revalidation (see [General Medical Council requirements for revalidation](#));
- Encourage discussion and collaborative working through locality networks and cluster groups.

## LIPID-MODIFYING DRUGS

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**Measure:** Low acquisition cost (LAC) statins as a percentage of all statin, ezetimibe and simvastatin/ezetimibe combination prescribing.

### Points for consideration

- Simvastatin, atorvastatin and pravastatin are LAC statins and remain the lipid-modifying drugs of choice.
- If one statin is not tolerated, a lower dose or an alternative LAC statin should be offered.
- Simvastatin 40 mg is recommended as first-line treatment for primary prevention (without type 2 diabetes) ([National Institute for Health and Care Excellence \[NICE\] Clinical Guideline \[CG\] 67](#))\*. There is no target level for total or low-density lipoprotein cholesterol, and routine repeat lipid profile is not necessary. Higher intensity statins should not be used routinely.
- The maximum daily dose of simvastatin in conjunction with amiodarone, verapamil, diltiazem, amlodipine and ranolazine is 20 mg.
- [AWMSG: Statin Template Guidance – Use of Statins in Primary and Secondary Prevention of Vascular Disease](#) is an aid to the implementation of NICE CG67.

\*NICE CG67 is currently being updated: anticipated publication date July 2014.

## HYPNOTICS AND ANXIOLYTICS

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**Measure:** Average daily quantities (ADQs) per 1,000 specific therapeutic group age–sex related prescribing units (STAR-PU) of hypnotics and anxiolytics.

### Points for consideration

- For the year April 2012–March 2013, Wales prescribed 50% more hypnotic and anxiolytic items per 1,000 patients than North East England (the area of England most similar to Wales demographically). There is still large variation in prescribing rates of these drugs across health boards in Wales (range 1,423–2,578 ADQs per 1,000 STAR-PU for quarter ending September 2013).
- Practice policy – Appendices 11 and 12 of the [AWMSG Hypnotics and Anxiolytics Educational Pack](#) provide examples of practice protocols to allow clinicians to agree a consistent approach for the prescribing and review of hypnotics and anxiolytics.
- The [AWMSG Hypnotics and Anxiolytics Educational Pack](#) also provides materials to support the review and discontinuation of hypnotic and anxiolytic treatment. This may be via consultation or by letter; both have been used successfully in practices within Wales.
- Discharge summaries, and psychiatric and pain management plans should provide clear guidance on review or discontinuation of these medicines.

## ANTIDEPRESSANTS

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**Measure:** ADQs per 1,000 STAR-PUUs for a selected group of antidepressants.

### Points for consideration

- Data indicate that antidepressant prescribing is increasing, and there is a 40% difference in use between the highest and the lowest prescribing health boards in Wales (range 1,544–2,601 ADQs per 1,000 STAR-PUUs for quarter ending September 2013).
- It is unclear what level of antidepressant prescribing is considered appropriate; observed variations may be associated with deprivation rates and availability of non-pharmacological services. The [AWMSG CEPP National Audit: Towards More Appropriate Management of Depression in a Primary Care Setting](#) is a resource to review prescribing within a practice.

## OPIOID ANALGESICS

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**Measures:** 1) Total opioid analgesics per 1,000 prescribing units (PUs) for all opioid analgesics (including combination products containing codeine and dihydrocodeine 30 mg); 2) Morphine as a percentage of strong opioids; 3) Defined daily doses (DDDs) of tramadol per 1,000 patients.

### Points for consideration

- Do not routinely offer transdermal patch formulations as first-line maintenance treatment to palliative care patients in whom oral opioids are suitable ([NICE CG140](#)). 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.
- 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 ([British Pain Society: Opioids for Persistent Pain: Good Practice](#)).
- 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. Inappropriate use of transdermal preparations has caused fatalities ([Medicines and Healthcare Products Regulatory Agency \[MHRA\] Drug Safety Update on fentanyl patches](#)).
- To support these and other key messages, the MHRA has developed an [Opioids Learning Module](#).
- Tramadol is subject to abuse and dependence. Deaths related to the misuse of tramadol in England and Wales increased from 83 in 2008 to 175 in 2012.
- AWMSG [Tramadol Educational Resource Materials](#) have been developed to support the review of tramadol.
- Avoid abrupt withdrawal after long-term tramadol treatment. Where physical dependence to tramadol develops, the withdrawal syndrome can be severe, with symptoms typical of opiate withdrawal sometimes accompanied by seizures, hallucinations and anxiety.
- Tramadol reduces the seizure threshold. Patients with a history of epilepsy should be prescribed tramadol only if there are compelling reasons to do so. Tramadol should be used with caution in patients taking concomitant drugs that can lower the seizure threshold (tricyclic antidepressants, selective serotonin reuptake inhibitors) ([MHRA Current Problems in Pharmacovigilance](#)).
- Tramadol enhances the anticoagulant effect of warfarin, increasing the risk of bleeding.

## ANTIBIOTICS

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**Measures:** 1) Total antibacterials per 1,000 STAR-PU; 2) Quinolones as a percentage of total antibacterials; 3) Cephalosporins as a percentage of total antibacterials; 4) Co-amoxiclav as a percentage of total antibacterials.

### Points for consideration

- ‘Start smart – then focus’ ([Public Health Wales: Antimicrobial Stewardship](#)):
  - Do not start antibiotics in the absence of clinical evidence of bacterial infection.
  - If there is evidence of bacterial infection, prescribe according to national or local guidelines.
  - Document in medical notes and on drug chart: clinical indication, duration or review date, route and dose.
  - For surgical prophylaxis, prescribe single dose where antibiotics have been shown to be effective.
  - In the hospital setting, review the clinical diagnosis and the continuing need for antibiotics by 48 hours and make a clear plan of action.
- Resistance and *Clostridium difficile*: 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*, methicillin-resistant *Staphylococcus aureus* and resistant urinary tract infections.
- Resources are available to support appropriate antibiotic prescribing:
  - Welsh Medicines Resource Centre (WeMeReC) bulletin: [Appropriate Antibiotic Use – Whose Responsibility?](#)
  - Royal College of General Practitioners: [TARGET Antibiotics Toolkit](#);
  - [AWMSG CEPP National Audit: Focus on Antibiotic Prescribing](#) – this audit consists of stand-alone bite-size components (e.g. sore throat, acute rhinosinusitis, UTI in females, acute cough or bronchitis, quinolone prescribing, co-amoxiclav prescribing, hospital prescribing of antibiotics, delayed prescriptions, read coding to identify HCAI).

## INSULIN

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**Measure:** Long-acting insulin analogues as a percentage of total long- and intermediate-acting insulin (excluding biphasics).

### Points for consideration

- [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 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.

## NON-STEROIDAL ANTI-INFLAMMATORY DRUGS

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**Measures:** 1) Non-steroidal anti-inflammatory drug (NSAID) ADQs per 1,000 STAR-PU; 2) Ibuprofen and naproxen as a percentage of total NSAIDs.

### Points for consideration

- NSAIDs are associated with increased risk of:
  - Serious gastro-intestinal toxicity, especially in patients over 75 years;
  - Renal failure in otherwise healthy patients ([MHRA Drug Safety Update on NSAIDs](#));
  - 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.
- NSAIDs are not recommended following hip fracture ([NICE CG124: Hip Fracture](#)).
- NSAIDs should be used with caution in uncontrolled hypertension, heart failure, ischaemic heart disease, peripheral artery disease, cerebrovascular disease, and when used long term for people with risk factors for cardiovascular disease.
- It is recommended that prescribers should:
  - Review their NSAID prescribing using the [AWMSG CEPP National Audit: Towards Appropriate NSAID Prescribing](#);
  - Use acute rather than repeat prescriptions for NSAIDs;
  - Set the 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;
  - Promote post-operative pain management reviews;
  - Consider using Back Book Wales: [Link to order](#).

## YELLOW CARDS

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**Measure:** Number of yellow cards submitted per practice and per health board.

### Points for consideration

- Yellow card reporting supports the identification and collation of adverse drug reactions (ADRs), which might not have been known about before. Data obtained from [Yellow Card Centre \(YCC\) Wales](#) show that the number of ADRs reported to the MHRA from Wales fell by 9% in 2012–2013. The total annual number of reports is the lowest for the past ten years.
- Yellow card champions are available in each health board to provide local GP training.
- [Yellow card reports can be completed on-line](#).

## NOTES

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Implementation of the NPIs 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 NPIs 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.