PostScRxipt – PrimaRxy Care

JULY 2007

AUDIT OF ANGIOTENSIN II RECEPTOR ANTAGONISTS (AIIRAs) IN NHSGGC: The volume of AIIRA prescribing has increased by 29% in the last three years with a 27% increase in costs. ACEI prescribing has grown by 15% but there has been a 12% reduction in costs mainly due to patent expiry, eg ramipril.

AIIRAs should only be prescribed in patients with hypertension, heart failure or diabetic nephropathy who cannot tolerate an ACEI Prescribing a combination of AIIRA and ACEI should be reserved for patients with heart failure and the *NHSGGC Formulary* recommends it is restricted to initiation by a specialist only.

GP prescribing data shows significant variation in the prescribing of AIIRAs across practices. A prescribing indicator to encourage more appropriate use of AIIRAs in primary care was established in 2006/07 and is being repeated in 2007/08. Practices are encouraged to keep the proportion of AIIRA prescribing below 25% of combined AIIRA and ACEI prescribing.

To assist practices identify inappropriate prescribing of AIIRAs and inform their education and support needs an audit of AIIRA prescribing was carried out in selected practices across NHSGGC. The practices selected were above average users of AIIRAs. At least one GP practice from each CHP was included in the audit.

Data was collected for 1,811 patients in 31 GP practices across all 11 CHPs. Patients ranged in age from 23-95 years with an average age of 65 years and 47% of patients were male.

RESULTS:

- 82% of AIIRAs were initiated by GPs, 12% were initiated in hospital out-patients.
- 65% of patients received losartan or candesartan (NHSGGC preferred choices)
- The most common indications were hypertension (89%), diabetic nephropathy (9%) and LVSD (8%).
- 78% of patients had a blood pressure reading recorded within the last 12 months,
  - 74% of patients met GMS target (BP < 150/90mmHg)
  - 49% met BHS target (BP < 140/85mmHg).
- 8% of patients taking an AIIRA were also taking an ACEI,
  - this combination was initiated by a GP in 58% of patients.
  - 84% of patients were taking the combination for hypertension only (unlicensed).
- 53% of patients (56% started by GPs, 29% started by hospital) had no previous trial of ACEI.
- The most common reasons for stopping ACEI therapy where it had been tried previously were cough (58%), lack of efficacy (3%), angioedema (1%).
- Only 56% of patients on AIIRAs had had their U&Es checked in the previous 12 months.
- 88% of patients on ACEI and AIIRAs had their U&Es checked in the previous 12 months.

RECOMMENDATIONS:

- Prescribing of AIIRAs should be restricted to patients who have failed to tolerate an ACEI.
- The *Preferred List Formulary* options are ramipril (first choice), lisinopril, losartan and candesartan.
- Blood pressure should be monitored until at target and then at least annually.
- AIIRAs and ACEIs should be monitored in exactly the same way: U&Es at baseline, after initiation, after each dose increase and annually thereafter.
- Combination of ACEI plus AIIRA should be restricted for specialist initiation in patients with heart failure.

REVIEW OF NHS PRESCRIPTION CHARGES AND EXEMPTION ARRANGEMENTS IN SCOTLAND – RESPONSE TO CONSULTATION

A public consultation took place early in 2006 to seek views on the review of prescription charges. The Scottish Executive supported prescription charges as they:

- place value on the medicines patients require,
- reduce level of less urgent demands on GPs' time,
- provide revenue for the NHS.

The following views were collected:

Exemption on Medical Grounds: Similar proportions of respondents were for and against basing exemption on medical grounds alone. Reasons against this were that it would be fairer to base exemption on ability to pay and that defining a list of conditions to be exempted would be highly contentious. Most were in favour of reviewing the current list of conditions with the suggestion that all terminally ill or with life-long conditions should be exempt from charges. There was a divided response on giving exemption to drugs for the treatment of the condition in question rather than all prescriptions; however it was recognized that this may be difficult to define. There was an overwhelming opposition to basing exemption on a list of drugs as this would be difficult to maintain.

Affordability: Suggested changes to the pre-payment certificate (PPC) system included allowing payment in instalments, restructuring the minimum payment period, publicising it more and reducing the cost. A similar proportion of respondents were for and against a reduced flat fee for all. It would provide revenue to NHS and some exempt patients can afford to pay something towards prescriptions. The main argument against was that patients who require many prescriptions could incur a large cost.

A narrow majority were in favour of a monetary cap over time. This could benefit those on regular medication not benefiting from a PPC, but this could be difficult to implement and administer.

There was agreement that a concessionary rate triggered by the costs incurred over a period of time should not be adopted. It would benefit patients who need several medications but may still be unaffordable to some.

Exemptions for students and trainees: Most were in favour of extending the full-time student exemption to cover all students in tertiary education. Roughly equal proportions were for and against having concessionary charge arrangements for full-time students or trainees above set age thresholds.

Any change in the arrangements for prescription charges by the Scottish Executive in light of this review will be communicated in future editions of PSPC.

PRESCRIBING ISSUES: We have been asked to flag up some administrative prescribing issues for **all prescribers** including GPs, nurses and pharmacists.

SPECIFY QUANTITY: All prescribers are discouraged from using the ambiguous term "original pack" or "op". Using "op" often leads to incorrect payment as the pricing system defaults to the most cost-effective pack. 1 OP Simple Linctus will be priced as two litres. This has been a common issue with pharmacist prescribers since the introduction of the minor ailments scheme (MAS).

PRESCRIBE GENERICALLY: All prescribers should prescribe generically where possible. For GP prescribing, the average generic rate for NHSGGC is around 80%. Pharmacy contractors will shortly be receiving a MAS prescribing report with details of *Formulary* compliance and generic prescribing.

SIGN PRESCRIPTION FORMS: Work is ongoing to reduce the number of unsigned prescription forms issued which are technically illegal. With due consideration for patient care, pharmacists must endeavour to have the form signed before submission to PSD. Pharmacists should sign each registration and prescription form for MAS.

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