NHS
Buckinghamshire and Oxfordshire Cluster

Quick Prescribing Points for G.P. Locums

NB all hyperlinks from this document are only available via N3 connection(in practices) and are from the PCT intranet nww.oxfordshirepct.nhs.uk

Oxfordshire Traffic Light Classification for Prescribing

Across Oxfordshire we use traffic lights to classify prescribing.

- Red List – Specialist Prescribing Only
- Yellow (Near Patient Testing LES) – Transfer of prescribing to primary care in line with Shared Care Protocol. Monitoring in Primary Care
- Yellow - Transfer of prescribing to primary care. Monitoring in Secondary Care
- Yellow Continuation List– Appropriate for Continuation in Primary Care following specialist recommendation
- Brown – Prescribe only in restricted circumstances
- Black – Not recommended for use

These decisions are made by the Area Prescribing Committee Oxfordshire (APCO). Any requests for black or red listed drugs should be referred back to the requestor. The current traffic lights (updated every two months) Current Oxfordshire Traffic Light List

Useful information available on the Intranet:

- Clinical Guidelines
- Shared Care Guidelines
- Lavender statements (priority setting)
- Prescribing Points (medicines management newsletter)

For further medicines management advice /guidance for Oxfordshire please contact Sara Wilds (Primary Care Prescribing Lead Oxfordshire PCT) sara.wilds@oxfordshirepct.nhs.uk

Local Priorities

Review of Blood Glucose Testing prescribing & GlucoRx NEXUS Blood Glucose Meter

- This initiative has strong support of Oxfordshire Clinical Commissioning Group, Locality Leads and the LMC and has potential to save around £500k across Oxfordshire.
- Initiative to review prescribing of blood glucose monitoring prescribing to ensure that patients test appropriately, in line with NICE and Oxfordshire guidelines & Patient Information Leaflet. Ensure that test strips are only prescribed when testing is appropriate
- Oxfordshire agreed first line blood glucose meter (for appropriate patients) is GlucoRx NEXUS

Sara Wilds & Louisa Griffiths, Oxfordshire Medicines Management Team
Based on original document produced by Buckinghamshire Medicines Management Team
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Sip Feeds
If nutritional supplements are indicated (see guidelines for management of under nutrition in primary care) then the supplement of choice in Oxfordshire is Complan Shake. Initial prescriptions should be limited to a one week supply and subsequent prescriptions should be for a maximum of four weeks. Ensure regular review.

Wound care
The majority of the dressings that are used by a practice are first line formulary choices and should be ordered via ONPOS (Online Non Prescription Ordering System which all practices have access to - usually via Practice or District Nurses) and therefore should not need to be prescribed on FP10. A formulary summary is available here: Oxfordshire Wound Management Guidance

Oxfordshire Prescribing Incentive Scheme 2011/12

Indicator	Target	Rationale
Percentage of lipid lowering prescription items for rosuvastatin & ezetimibe	*4.6%, or less, of lipid lowering prescribing to be for either ezetimibe or rosuvastatin*	*Rationale:* Rosuvastatin should be reserved for 3rd line secondary prevention (high CV risk patients) and should only be used after simvastatin and atorvastatin have been tried. Ezetimibe should only be used 4th or 5th line after all statins have been tried. *A beneficial effect on cardiovascular morbidity and mortality in patients with cardiovascular disease has not yet been demonstrated by rosuvastatin or ezetimibe 4.6% is the current Oxfordshire average for rosuvastatin & ezetimibe prescribing.*
Percentage of Seretide prescription items for Seretide 250 Evohaler	*25%, or less, of all Seretide prescribing to be for Seretide 250 Evohaler*	*Rationale: BTS Guidelines for chronic asthma state that the dose of inhaled steroids should be titrated to the lowest dose at which effective control of asthma is maintained. Step-down of Seretide should not normally be done by varying the number of puffs since this may affect efficacy of salmeterol. It is usually more appropriate to prescribe a different strength inhaler. There should be very few asthma patients therefore requiring the extremely high dose delivered by Seretide Evohaler 250 (equivalent to Clenil 200 5 puffs bd). NICE Guidelines advocate inhaled steroids as an option in moderate to severe COPD (FEV1 <50%). Seretide Accuhaler 500 is the only Seretide preparation licensed for COPD and is more cost effective than Seretide Evohaler 250 at equivalent doses.*
Cost of Blood glucose testing reagents per patient on the diabetes register.	Cost of Blood glucose testing reagents to be £16, or less, per patient on the diabetes register.	*Rationale: NICE guidance on the place of SMBG in type 2 diabetes*

Note: Prescribing indicators will be monitored and reported quarterly to practices by the Medicines Management Team using NHS BSA Epact data

- Achievement will be measured based on Q4 January to March 2012 data.

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National Priorities

- **PPI's**

Patients prescribed a PPI long term for dyspepsia should be reviewed if they have not already had a review in the last year to see if their treatment can be stepped down or stopped.
Esomeprazole 20mg is black on the traffic lights, patients prescribed esomeprazole 20mg should be switched to lansoprazole or omeprazole. The use of esomeprazole 40mg in Oxfordshire is restricted for patients with significant symptoms requiring very high dose PPI treatment.

- **Statins**

Primary prevention: there is no target level for total LDL cholesterol for primary prevention of CVD. First choice is simvastatin 40mg. If simvastatin 10mg or 20mg are inappropriate due to intolerance or drug interactions use pravastatin 40mg
Secondary prevention & diabetes: Simvastatin 40mg is also first line for secondary prevention. Only consider titrating the dose of simvastatin upwards or using atorvastatin if the total cholesterol does not fall below 4 mmol/litre OR the LDL cholesterol does not fall below 2 mmol/litre.
Rosuvastatin should be reserved for 4th or 5th line use only if simvastatin, pravastatin and atorvastatin have been tried.
Ezetimibe: Evidence for efficacy of ezetimibe is based largely on surrogate outcomes (i.e. cholesterol lowering), not whether it reduces cardiovascular mortality or morbidity. Only consider ezetimibe in hypercholesteraemia where target is not reached with a recommended statin, or if all statins are contra-indicated.

- **ACEI/ ARBs**

For new patients, prescribe an ACEI first line. If the patient develops a cough, do not switch immediately, it may resolve, advise patient of this. The cough usually resolves within 1-4 weeks but may persist for up to 3 months. If it does not resolve and is due to the ACEI, try a second ACEI. If the patient is changed to an ARB and the cough still does not resolve, change back to an ACEI. Where an ARB is indicated, generic losartan is the most cost effective and should be the 1st choice when starting ARB therapy for hypertension.
The patient decision aid available on the NPCi website may be helpful in this National Support Materials Renin-Angiotensin System Drugs Patient Decision Aid

- **High risk antibiotics for C Diff**

Reduce the number of prescriptions for 'high-risk' antibiotics for C. Diff. This includes: co-amoxiclav, cephlosporins and quinolones. Refer to the Oxfordshire Prescribing Guidelines for the Use of Antimicrobial Agents in Primary Care

- **NSAIDs**

Follow recommendations outlined in table below
Consider gastroprotection in those at high risk – over 65 years, long-term or extended oral NSAID use, concomitant drugs increasing risk of GP bleed e.g. SSRIs, anti-platelets, warfarin, steroids & other immune-suppressants.

NSAID	GI Risk*	CV Risk*	Comments /Summary
Ibuprofen ≤ 1200mg /day	lowest	low	1st line oral NSAID of choice
Ibuprofen > 1200mg/day	Med high	Med high	Avoid in high CV risk pts
Naproxen 1000mg/day	high	low	2nd line oral NSAID.
Diclofenac 150mg/day	high	high	Avoid in CVD & high CV risk pts
Meloxicam 15mg/day	Med high	Med high	Avoid in CVD
Piroxicam all doses	Very high	Med high	Restricted use. To be initiated by specialists only
Etoricoxib/Celecoxib	low	high	CI in CVD & should be avoided in high CV risk pts
Coxibs + antiplatelets	high	high	Avoid combination
Naproxen + PPI	low	low	2nd line oral NSAID of choice

* *Evidence base for relative GI & CV safety relates largely to the COXIBs.*

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- **Venlafaxine**

Prescribe generically as venlafaxine MR tablets NOT venlafaxine MR capsules or Efexor XL capsules

- **Prednisolone 5mg**

Prescribe uncoated (plain) prednisolone NOT prednisolone enteric coated (EC) tablets. Prednisolone EC 5mg tablets are traffic lighted as black – no prescribing.

- **Tamsulosin**

Prescribe as tamsulosin MR capsules and NOT MR tablets

- **Dutasteride**

Not to be initiated in new patients – use finasteride & consider switches

- **Yasmin**

Recent evidence of increased risk of VTE by two to threefold and considerably more expensive than other COCs available with no evidence of any additional benefit.

Prescribing Specials – five guiding principles for prescribers ***National Prescribing Centre July 2011***

Five guiding principles for prescribers

1. **Establish clinical need –** only prescribe when the patient has an individual clinical need that cannot be met by a licensed medicine of establishes efficacy, quality and safety**.**
2. **Identify medicines and preparations –** take into account safety, effectiveness, quality and cost of all options
3. **Make a shared decision with the patient/carer**
4. **Ensure effective prescribing governance –** when taking over from secondary care ensure aware of the clinical need & implications. Consistency of formulation is important, ensure the details are communicated to ensure consistent supply. Record the Special prescribed & reason in patients notes.
5. **Monitor and review on an ongoing basis**

Tips to help prescribers identify Specials

Specials can be difficult to identify at the point of prescribing.

If in doubt clinicians should discuss with pharmacist colleagues before prescribing:

• If a medicine is not in the British National Formulary (BNF) it could be a Special.*

• Dermatology products, eye drops and liquid preparations are more commonly formulated as Specials.

• Electronic prescribing systems may not identify Specials. Some systems may use the letter 'U' to indicate an unlicensed medicine, or misleadingly highlight the cost of Specials as 'zero'.

• Clinical systems can be used to highlight that a Special is being selected and potentially suggest alternatives.

• Community pharmacists may wish to check with prescribers if they think a prescriber is unaware they are prescribing a Special. Pharmacists have a responsibility to help ensure that prescribers are aware they are prescribing an unlicensed medicine. (*GPC Standards of Conduct, ethics and performance Sept 2010*)

• In hospitals, clinical pharmacists may highlight to prescribers they are prescribing a Special.

** 'For some preparations the BNF and BNF for Children indicate whether the preparation needs to be obtained through a 'special-order' manufacturer, or a specialist importing company. Where an unlicensed drug is included in the BNF, this is indicated in square brackets after the entry. When the BNF suggests a use (or route) that is outside the licensed indication of a product ('off-label' use), this too is indicated. In the BNF for Children individual drug entries give an indication of the licensed status of the drug.'*

Sources of more information?

A summary of resources and links to them can be found by clicking here.

Community pharmacists, medicines management teams (contact sara.wilds@oxfordshirepct.nhs.uk for local advice) or medicines information colleagues will be able to advise about local guidance or specific medicines.

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