Meeting Date	**27 April 2021**	**Agenda Item**	**4.2**
Report Title	**Update on Performance against All Wales Medicines Strategy Group Prescribing Indicators to September 2020**		
Report Author	Rhian Newton, Pharmacy Lead for Primary Care		
Report Sponsor	Judith Vincent, Clinical Director for Pharmacy		
Presented by	Judith Vincent		
Freedom of Information	Open		
Purpose of the Report	To inform Q&S Committee of the Health Boards latest position in relation to the All Wales Medicines Strategy Group (AWMSG) National Prescribing Indicators (September 2020), comparing performance against a national level and outlining supportive local measures in place.		
Key Issues	Swansea Bay University Health Board (SBU HB) continues to improve in many areas of prescribing. However some areas have seen increased growth such as gabapentinoids, hypnotics & anxiolytics and insulin analogues. Although Primary Care prescribing is supported in a number of ways it is important to note that overall prescribing is not exclusively due to GPs but is influenced to a certain extent by acute care clinicians and therefore raising awareness across sectors is vital for engagement.		

Specific Action Required ***(please choose one only)***	**Information**	**Discussion**	**Assurance**	**Approval**
	☐	☐	☒	☐

Recommendations	Members are asked to: • **Note** the contents of the report • **Note** the measures in place to support improvement in performance

Update on Performance against AWMSG Prescribing Indicators to September 2020

INTRODUCTION

This report provides and update on the Health Boards performance against the AWMSG Prescribing Indicators to September 2020, in addition to outlining local measures in place to encourage and support improvements within prescribing practice. The complete report can be found in appendix 1.

BACKGROUND

Since 2003 the All Wales Medicines Strategy Group (AWMSG) has endorsed a set of National Prescribing Indicators (NPIs) as a means of promoting safe and cost effective prescribing within NHS Wales. Each year the NPIs are refreshed in line with current prescribing practice to ensure they are meaningful and retain their relevance.

For 2020/2021 the focus is on three priority areas in addition to safety and efficiency domains:

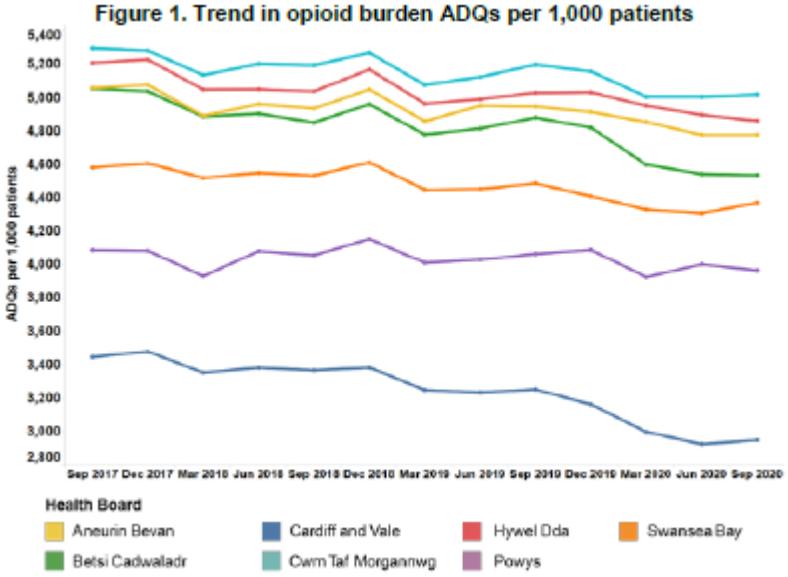
Priority Areas:

1. **Analgesics in Primary Care**

1.1 Opioid burden

The aim of this indicator is to reduce prescribing as there is a lack of consistent good quality evidence to support long term use in chronic non-cancer pain with side effects, tolerance and dependence well established. It includes a range of opioids such as morphine, fentanyl, codeine, co-codamol, co-dydramol etc. Figure 1 shows that SB has reduced prescribed comparing Sept 2020 to Sept 2019.

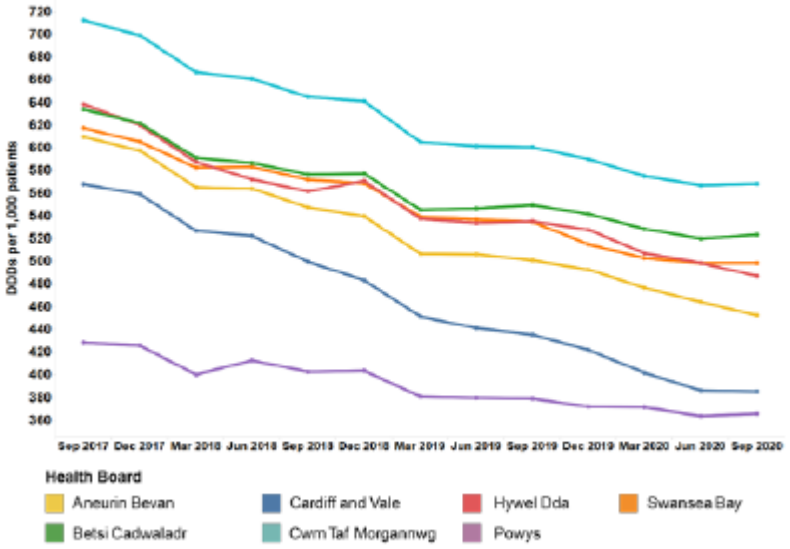
Figure 1. Trend in opioid burden ADQs per 1,000 patients



1.2 Tramadol

While there is a recognised place in pain management there are risks associated with dependence, diversion, misuse and adverse drug reactions. The aim is to take a prudent view and review patients in a timely manner taking into account risks and benefits. Figure 2 shows that SB has reduced prescribing from Sept 2019.

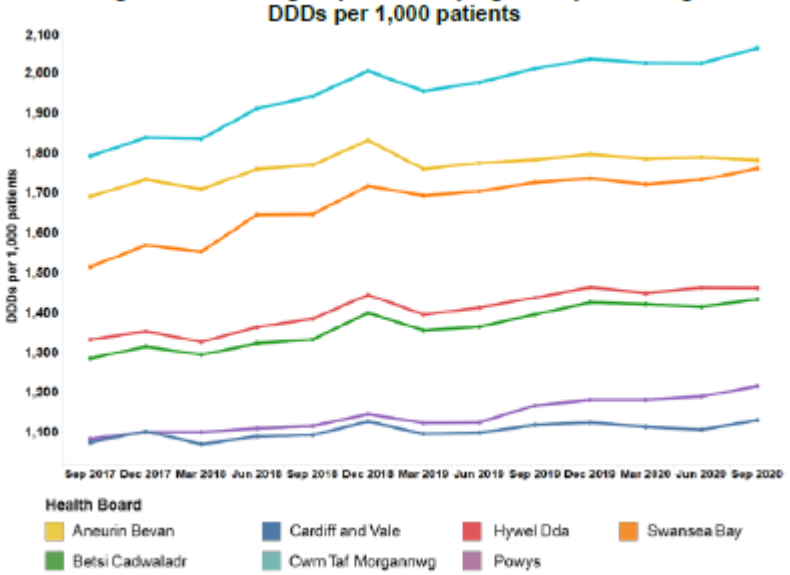
Figure 2. Trend in tramadol prescribing
DDDs per 1,000 patients



1.3 Gabapentin and pregabalin

Both drugs have evidence to support prescribing in epilepsy and neuropathic pain with pregabalin also used to treat generalised anxiety disorder. However there are also risks associated with dependence, misuse, diversion and adverse drug reactions. Figure 3 shows that prescribing in SB continues to increase as seen in other HBs.

Figure 3. Trend in gabapentin and pregabalin prescribing
DDDs per 1,000 patients

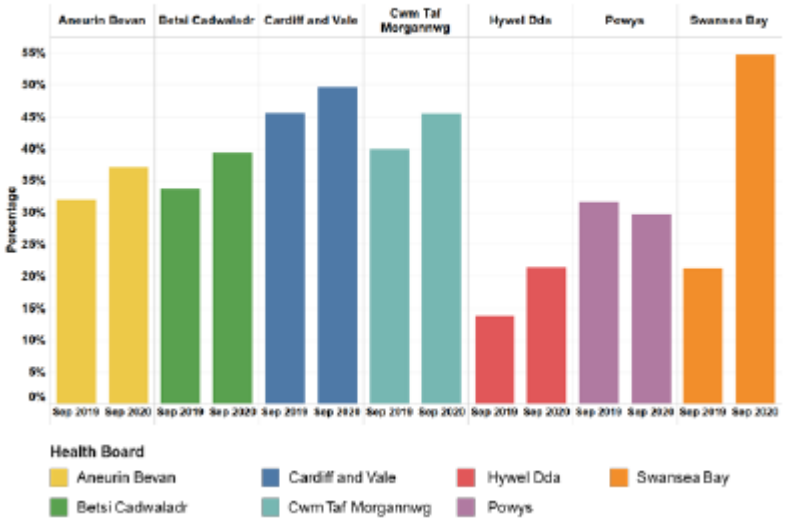


2. Anticoagulants in atrial fibrillation

2.1 The number of patients with atrial fibrillation (AF) and a CHA2DS2-VASc score of 2 or more who are currently prescribed an anticoagulant: data for this indicator are currently unavailable.

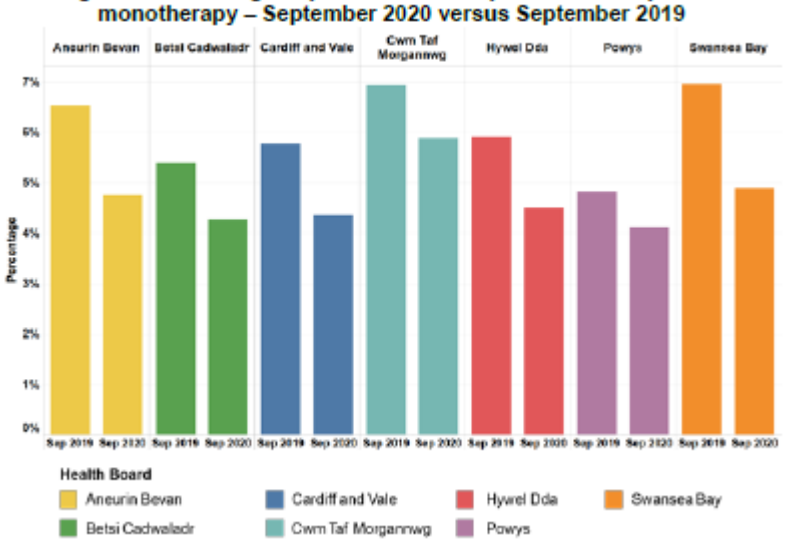
2.2 The number of patients diagnosed with AF who are prescribed an anticoagulant and have received an anticoagulant review within the last 12 months. Patients prescribed these drugs are at risk if serious side effects such as increased bleeding or decreased stroke prevention if inadequately monitored. Figure 4 shows that SB has significantly increased the percentage of patients who have been reviewed over the past year.

Figure 4. Percentage of patients who are currently prescribed an anticoagulant and have received an anticoagulant review within the last 12 months – September 2020 versus September 2019



2.3 The number of patients diagnosed with AF who are prescribed antiplatelet monotherapy. Aspirin monotherapy is no longer recommended by NICE as the risks outweigh the benefits (AF patients may still require aspirin for other indications). Figure 5 shows that SB has significantly reduced the percentage of patients prescribed monotherapy.

Figure 5. Percentage of patients who are prescribed antiplatelet monotherapy – September 2020 versus September 2019

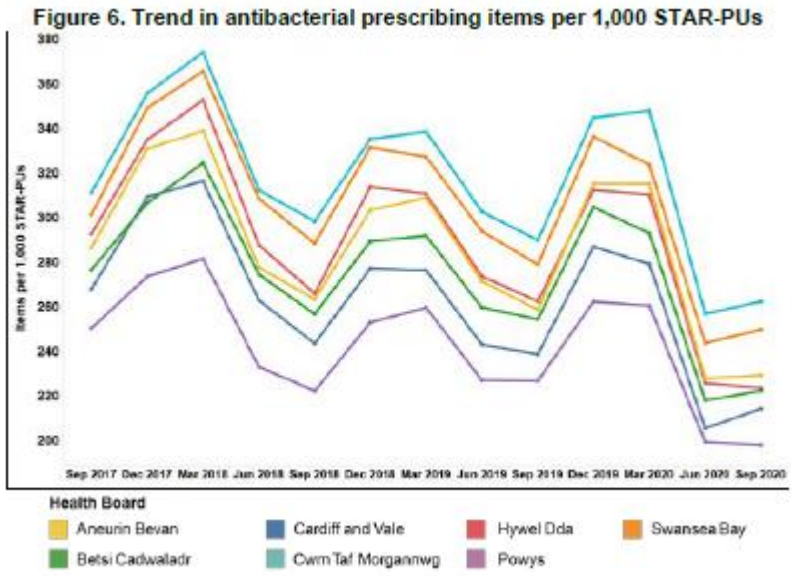


3. Antimicrobial stewardship

3.1 Total Antibacterial Items

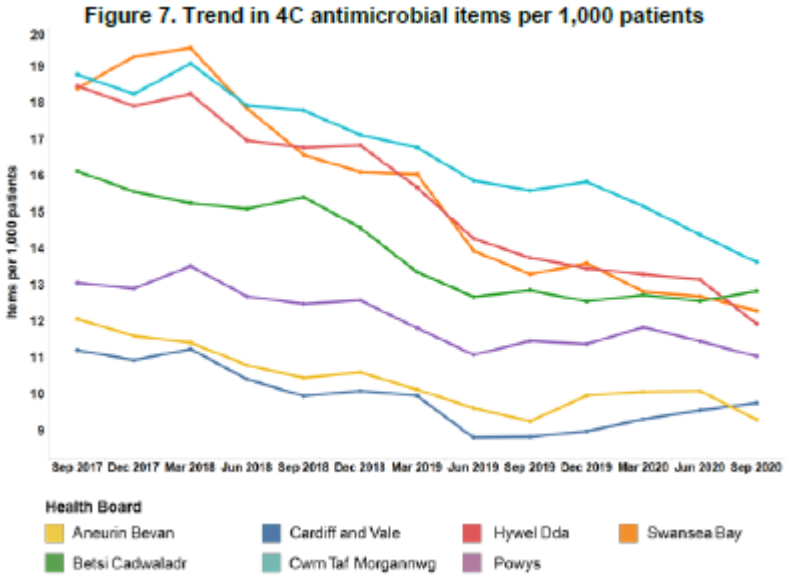
The purpose is to encourage appropriate antibacterial prescribing within primary care and not to stop prescribing where it is clinically indicated. Figure 6 shows that SB has made improvements in line with other HB.

Figure 6. Trend in antibacterial prescribing items per 1,000 STAR-PUs



3.2 4C (co-amoxiclav, cephalosporins, fluoroquinolones and clindamycin) items

The aim of this indicator is to reduce overall prescribing of these broad spectrum antibiotics, reducing the risk of resistance, *C. difficile* infection, MRSA and resistant urinary tract infections. Figure 7 shows that SB has significantly reduced prescribing.



Safety Domain:

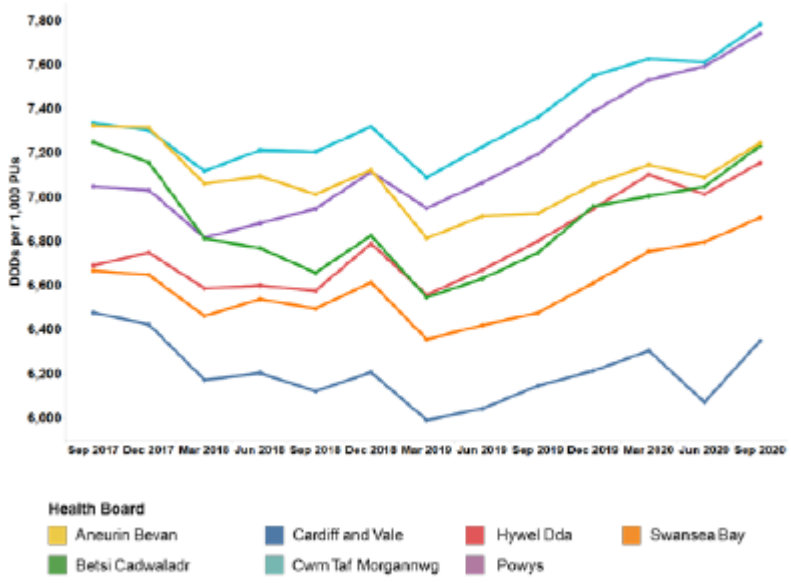
Prescribing Safety Indicators

The aim of these indicators is to identify patients at high risk of adverse drug reactions and medicines related harm in primary care. There are 18 measures and detailed information can be found within the report in appendix 1.

Proton pump inhibitors

Proton pump inhibitors include drugs such as omeprazole and lansoprazole. Although generally well tolerated, long term use may be linked with serious side effects such as hip, wrist and spine fractures, *C. difficile* and low magnesium levels. The aim is to encourage review of patient's prescribed long term to check for appropriateness and aim to stop where not clinically indicated. Figure 9 shows that prescribing in SB has increased in line with other HBs. This increase has been attributed to a national shortage of ranitidine, due to safety concerns and the subsequent use of proton pump inhibitors as an alternative.

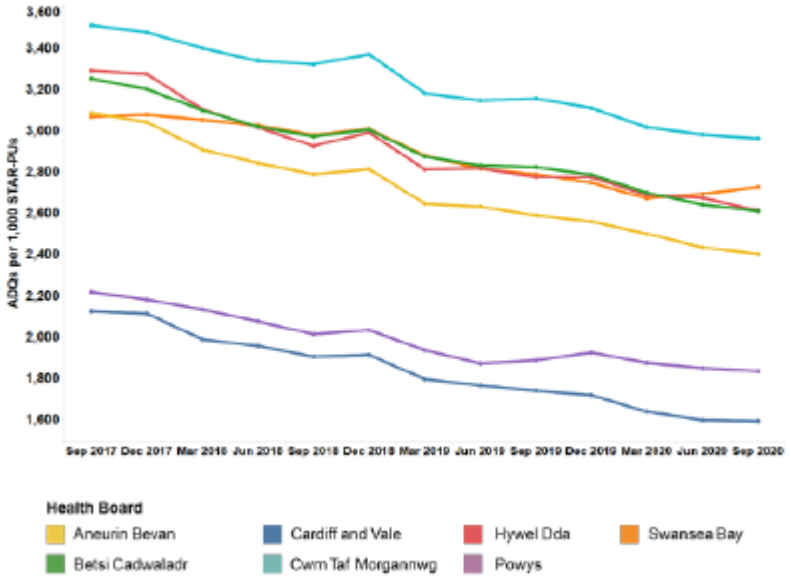
Figure 9. Trend in PPI prescribing DDDs per 1,000 PUs



Hypnotics and anxiolytics

Prescribing of hypnotics and anxiolytics is of a concern nationally as some of this prescribing could be inappropriate and linked to physical and psychological dependence and could potentially mask underlying depression. Figure 10 shows that SB has seen an increase in prescribing since March 2020. This increase has been explored with GPs at Cluster Prescribing Leads meetings to identify potential reasons and for them to raise awareness within practice teams to minimise new prescribing decrease existing prescribing.

Figure 10. Trend in hypnotic and anxiolytic prescribing ADQs per 1,000 STAR-PUs



Yellow Cards

Annual targets have been set for these indicators, with the aim of increasing the number of Yellow Card reports submitted by:

- GP practices
- Secondary care
- Members of the public
- Community Pharmacy

Information and graphs relating to this indicator can be found in appendix 1.

Efficiency Domain:

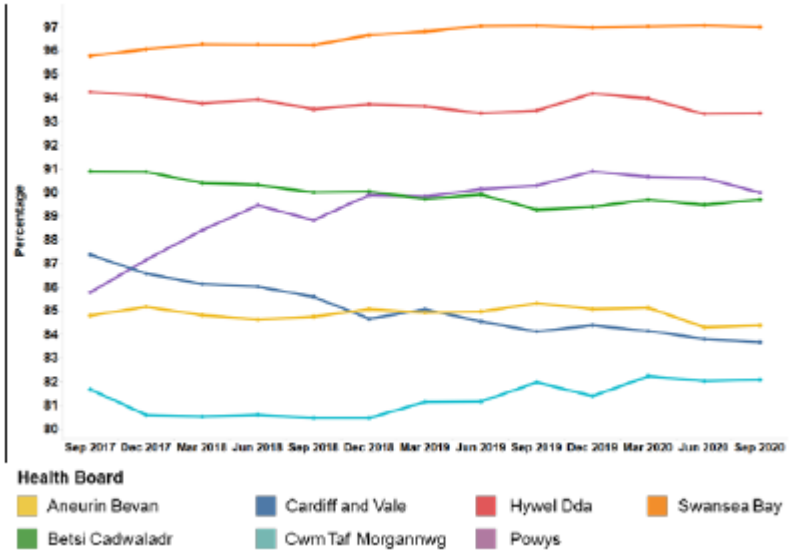
Biological Medicines

The aim of this indicator is to increase use in 6 specific drugs (adalimumab, infliximab, rituximab, teriparatide and trastuzumab etanercept), switching the original to a biosimilar rather than the original biological medicine and therefore supporting cost efficiencies. Prescribing rates of these drugs can be found in the AWMSG report (appendix 1)

Insulin

The aim of this indicator is to decrease prescribing of long-acting insulin analogues in primary care and secondary care. NICE recommends that human isophane insulin should be the first choice when prescribing in Type 2 diabetes, as they offer no significant benefit and are more expensive. Figure 25 shows that SB are very high prescribers. Currently within SB all initiation of insulin is undertaken by acute care diabetes teams; therefore clinical engagement is required if improvements are to be made in this area.

Figure 25. Trend in long-acting analogue prescribing as a percentage of total long- and intermediate-acting insulin prescribed in primary care



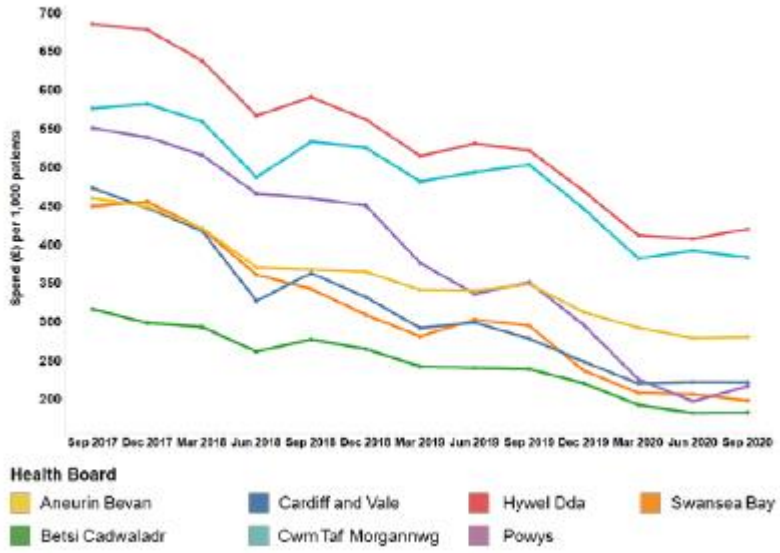
Low value for prescribing

The aim of this indicator is to reduce prescribing of a range of drugs which offer limited clinical benefit to patients and where more cost effective treatments are available:

- Co-proxamol
- lidocaine plasters
- tadalafil once-daily preparations
- liothyronine
- doxazosin modified release tablets
- omega-3 fatty acid compounds
- oxycodone and naloxone combination product
- paracetamol and tramadol combination product
- perindopril arginine

Figure 26 shows that prescribing of these drugs in SB is very low and improvements continue to be made.

Figure 26. Trend in low value for prescribing UDG spend per 1,000 patients



GOVERNANCE AND RISK ISSUES

The Health Board are monitored at a National level against performance within the NPIs. Frequent presentations are also made to the Medicines Management Strategy Board (MMSB), to engage the wider HB and Delivery Groups in discussions with the aim of raising awareness and hence improvement. Although many of the indicators have a primary care prescribing focus it needs to be remembered that acute care prescribing is a key influencer of primary care prescribing both indirectly and directly. The Medicines Management Team (MMT) based in Primary Care encourage and support GP practices to review prescribing and employ a number of mechanisms:

- Provision of a Prescribing Management Scheme which incorporates key indicators and will reward practices for improvements in prescribing. Details of the scheme can be found in Appendix 2, and the key focus is on improving prescribing within the NPIs. This is a mechanism that has been used for over

15 years and gives demonstrable improvements in prescribing, from both a quality, safety and cost perspective.

- A Primary Care Prescribing Advisory Group, a subgroup of the Medicines Management Operational Board (MMOB), which aims to promote and facilitate high quality and cost effective prescribing. This has GP representation from each of the 8 clusters, in addition to a LMC representative and pharmacists.
- Prior to Covid, the MMT provided quarterly Prescribing Leads Sessions to update on prescribing issues and provide relevant education. These were attended by a GP from each of the 49 practices. During Covid the opportunity was afforded to change these sessions into 'Cluster Prescribing Leads' meetings run via Teams. These have allowed for in-depth discussions with practices in relation to the NPIs and sharing of best practise amongst peers. Review and analysis of prescribing data over the coming months will be required to determine what effect this approach has made.
- The provision of 'Script Switch' within each GP practice; a software program deployed to all GPs which alerts them to the appropriateness of their 'prescribing' at the point of prescribing. The contents of this program are managed and updated by the MMT covering safety, quality and cost effectives aspects of prescribing in addition to elements of the NPIs.
- Going forward better awareness of indicators within the acute sector is required to support changes or improvements.

FINANCIAL IMPLICATIONS

The NPIs have a cost effective element attached to them but the main aim is to ensure safe prescribing. Any improvements seen in prescribing also has the potential to avoid costs. Some of the areas involved are low cost and high volume and dependent upon national pricing structures so that small reductions in prescribing won't release large spend. Whereas some areas such as low value drugs and biosimilars will result in cost savings for relatively small decreases in prescribing.

RECOMMENDATION

Members are asked to:

- **Note** the HBs position against the NPIs
- **Note** the mechanisms and support put in place by MMT for the NPIs
- **Note** that greater awareness of the NPIs is required across the whole HB

Governance and Assurance		
Link to Enabling Objectives ***(please choose)***	**Supporting better health and wellbeing by actively promoting and empowering people to live well in resilient communities**	
	Partnerships for Improving Health and Wellbeing	☒
	Co-Production and Health Literacy	☒
	Digitally Enabled Health and Wellbeing	☐
	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	
	Best Value Outcomes and High Quality Care	☒
	Partnerships for Care	☒
	Excellent Staff	☒
	Digitally Enabled Care	☐
	Outstanding Research, Innovation, Education and Learning	☒
Health and Care Standards		
(please choose)	Staying Healthy	☒
	Safe Care	☒
	Effective Care	☒
	Dignified Care	☒
	Timely Care	☒
	Individual Care	☒
	Staff and Resources	☒
Quality, Safety and Patient Experience		
During Covid learning and support for improvement in these quality and safety indicators has switched to virtual meetings.		
Financial Implications		
Improvements in some areas of prescribing will realise cost savings however this often requires a whole system approach.		
Legal Implications (including equality and diversity assessment)		
The HB has a duty to review and improve performance against the NPIs as these are set by the AWMSG		
Staffing Implications		
The MMT actively support delivery against these indicators as a key part of their role in primary care.		
Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)		
NPIs have existed for nearly 20 years and are likely to continue in the longer term and therefore will need ongoing HB engagement.		
Report History	First report on NPIs	
Appendices	Appendix 1 and Appendix 2	