LOTHIAN PRESCRIBING BULLETIN

Supporting prescribing excellence - informing colleagues in primary and secondary care

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NHS Lothian

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Changes in the management of Controlled Drugs

Following recent Scottish Executive advice, new arrangements for prescribing and dispensing controlled drugs will start on 5 June 2006 (NHS HDL(2006)27)[1]. These changes will become mandatory when amendments to the Misuse of Drug Regulations 2001 come into force. The changes are in response to the recommendations of the Shipman Inquiry and cover both NHS and private prescriptions.

Private and NHS prescriptions for Schedule 2, 3 and 4 Controlled Drugs will only be valid for 28 days from the date the prescription is signed or from a start date specified by the prescriber.

- For instalment prescriptions, the first instalment must be dispensed within the 28-day limit, with the remainder instalments dispensed in accordance with the instructions.

It is strongly advised that prescriptions for Schedule 2, 3 and 4 Controlled Drugs should be limited to a 30-day supply.

- Where a prescriber, in exceptional circumstances, considers it clinically appropriate to supply more than a 30-day quantity and this does not pose an unacceptable risk to patient safety, the patient's notes should be annotated to that effect.
- For instalment prescriptions, local approval has been agreed in Lothian for the current practice of issuing prescriptions for supplies greater than 30 days to continue.

Prescription forms (private and NHS) will be amended so that there is space on the back of the form for persons collecting Schedule 2 and 3 Controlled Drugs to sign.

- Stocks of amended NHS prescriptions will be distributed by August/September 2006.
- Patients will not be required to sign for each instalment dispensing.
- People collecting Schedule 2 Controlled Drugs should also be asked to provide evidence of identity. If evidence is not provided this should be recorded in the CD register.
- Pharmacists will be expected to use their professional discretion regarding supply, if the person collecting does not wish to sign the back of the prescriptions and/or does not provide evidence of identity.

Introduction of a standardised private prescription form PPCD(1) for Schedule 2 and 3 Controlled Drugs.

- For details on how to register as a private prescriber and how to obtain supplies of PPCD(1) forms, refer to NHS HDL(2006)27.
- Pharmacists should submit these forms monthly to NHS National Services Scotland in order that the same monitoring requirements as NHS prescriptions apply.

Guide to Controlled Drugs

Schedule 2 - morphine, methadone and methylyphenidate

Schedule 3 - barbiturates, temazepam and buprenorphine

Schedule 4 - benzodiazepines (except temazepam) and zolpidem

Reference

1. Safer Management of Controlled Drugs (CDs): Private CD Prescriptions and Changes to NHS Prescriptions. Scottish Executive Health Department Letter. NHS HDL(2006)27, 10 May 2006. http://www.show.scot.nhs.uk/sehd/mels/HDL2006 27.pdf

Thanks to Elaine Rankine, Specialist Pharmacist in Substance Misuse, NHS Lothian for contributing to this article.

Prescribing Indicators for Primary Care 2006/07

Lothian Prescribing Indicators (PIs) are designed to encourage cost effective and quality prescribing, and compliance with the Lothian Joint Formulary (LJF). For 2006/07, the generic prescribing PI will remain a 'gateway' to the PI section of the incentive scheme.

A further 13 PIs have been set, with targets for 3 PIs having been refined and 2 new PIs introduced. The target for the ulcer healing drugs PI has still to be confirmed.

PI	Target	
GENERIC PRESCRIBING	Generic rate ≥ 70% per quarter	GATEWAY TO PI SECTION OF INCENTIVE SCHEME
NON-STEROIDAL ANTI-INFLAMMATORY DRUGS (NSAIDs)	Cost per patient for all oral and injectable NSAIDs including COX-2 inhibitors ≤ £0.85 per quarter	NO CHANGE
TOPICAL NSAIDs	Cost per patient ≤ £0.10 per quarter	NO CHANGE
TOTAL ANTIBIOTICS	Items per 100 patients ≤ 70 per annum	NO CHANGE
CO-AMOXICLAV	Items per 100 patients ≤ 6 per annum	NO CHANGE
QUINOLONES	Items per 100 patients ≤ 3 per annum	REVISED TARGET
BECLOMETASONE	Total number of items ≥ 45% of all nasal steroids per annum	REVISED TIME PERIOD
HYPNOTICS INCLUDING TEMAZEPAM	Cost per patient ≤ £0.15 per quarter	NO CHANGE
MODIFIED RELEASE ISOSORBIDE MONONITRATE (ISMN)	Total number of plain ISMN scripts ≥ 25% of all ISMN scripts per quarter	REVISED TARGET
ANGIOTENSIN-II RECEPTOR ANTAGONISTS (ARAs)	Total number of ARA scripts ≤ 25% of all scripts for renin system antihypertensives (ARAs + ACEIs) per quarter	NO CHANGE
SIMVASTATIN	Total number of simvastatin items ≥ 50% of all statins per quarter	NO CHANGE
ORAL ANALGESICS	Total number of plain formulations of oral analgesics ≥70% of oral analgesics (excluding liquids) per quarter	NEW PI
WOUND DRESSINGS	Cost per patient ≤ £3.00 per annum	NEW PI
ULCER HEALING DRUGS	Target to be confirmed	RECLASSIFICATION

Wound dressings PI

The 2006/07 PIs include a new measure of wound dressing costs per patient per annum. This PI has been designed to encourage formulary compliance in both primary and secondary care.

It is likely that in future years the Prescribing Budget Setting Group will introduce more indicators to encourage cost effective and quality nurse prescribing.

Practice teams may need to spend some time preparing for changes in prescribing to reflect the recommendations in the forthcoming Wound Management section of the LJF.

Further information

- Prescribing Budget Setting Group. Prescribing Budget Setting Group Report 2006 - 2007. February 2006.

Using eGFR - is the information filtering through?

In line with the National Service Framework of renal services, the clinical biochemistry laboratories are now reporting estimated glomerular filtration rate (eGFR) for all adult samples in Lothian.

GFR is an important test of kidney function and knowledge of GFR is essential for the diagnosis and management of chronic kidney disease. Serum creatinine measurement is insufficiently sensitive to detect moderate kidney disease and is affected by a number of non-renal factors. An alternative is to measure serum creatinine and estimate GFR using an equation that corrects for some of the more significant non-renal factors.

The equation being used, calculates eGFR using a Modification of Diet in Renal Disease (MDRD) equation. The MDRD has not been validated for use in acute renal failure, pregnancy, oedematous states, muscle wasting disorders, amputees and malnourished people. The equation was designed to identify people at the abnormal end of the spectrum and there can be variation at the normal/middle range.

Calculating eGFR is the key stage in diagnosis, staging and management of chronic kidney disease (CKD) but is only one aspect of clinical assessment. There are specific groups of patients that should be screened for CKD, i.e. people with diabetes, vascular disease, heart failure, hypertension, urinary tract obstruction, neurogenic bladder or surgical urinary diversion, people taking diuretics, angiotensin converting enzyme inhibitors or angiotensin-II receptor blockers and people with a family history or genetic risk of kidney disease.

CKD affects about 10% of the population and is often asymptomatic until renal function is severely reduced. Mild CKD is also important as it represents a significant risk factor for cardiovascular disease. Patients with progressive CKD can be treated to preserve remaining renal function and to manage potential complications such as cardiovascular disease. Management of cardiovascular risk factors should be undertaken for all patients with stage 3-5 renal disease (see table below).

The introduction of eGFR reporting will enable GPs to create a register of patients with CKD stages 3-5, in line with the new clinical indicator set in the nGMS contract. This will allow identification of those that require referral to renal services and management of those with stable CKD. Information on management and referral criteria is available on the websites listed at the end of this article.

There is a decline in eGFR as people age, which is predominantly related to disease. In CKD the eGFR falls at a predictable rate. Monitoring trends in eGFR, with identification of increased rates of decline, will provide an important indicator of need for intervention on CKD patients. In this initial implementation stage an abnormal eGFR should be compared with current and old creatinine levels to check for stability.

MDRD should be used with caution when calculating drug doses, as the vast majority of published dosing information is based on estimation of creatinine clearance using Cockcroft and Gault equation. The patient's clinical condition and any potential adverse effects of the medicine need to be taken into consideration when prescribing.

Relationship between eGFR and stages of renal disease

Stage	mL/min/1.73m^2	Frequency of testing
1 Normal GFR*	>90	Annually
2 Mild impairment*	60-89	Annually
3 Moderate impairment	30-59	6 monthly
4 Severe impairment	15-29	3 monthly
5 Established	<15	3 monthly

* the terms stage 1 and stage 2 CKD are only applied when there is a structural abnormality confirmed by renal ultrasound or a functional abnormality such as persistent proteinuria or microscopic haematuria. If no such abnormality, an eGFR of 60-89mL/min/1.73m^2 is not regarded as abnormal.

Key messages:

- **All adult biochemistry samples will now report eGFR values.**
- **eGFR can be used to monitor patients for chronic kidney disease and identify those at risk of cardiovascular disease.**
- **Chronic kidney disease is a risk factor for cardiovascular disease.**

Further information

- http://www.edren.org
- http://www.renal.org/CKDguide/ckd.html
- Chronic Kidney Disease in the New Quality and Outcomes Framework (nGMS contract) for 2006/07. NHS Circular: PCA(M)(2006)2

LJF for Adults - treatment of infections

This guidance is for general practice and hospitals. For treatment of severe infections, and specific treatments within specialised units, hospital doctors should refer to departmental antibiotic guidelines.

MRSA (methicillin resistant *Staphylococcus aureus*)

Key messages:

- Like other *Staph. aureus*, MRSA may be part of normal colonising flora. The criteria for treatment are the same as for any other pathogen - clinical evidence of infection.
- Eradication of carriage of MRSA is rarely indicated.

Guidance can be found on the LJF website for management of:

- MRSA soft tissue infections
- MRSA chest infections
- MRSA urinary tract infections

See www.ljf.scot.nhs.uk/exist/xmldb/db/ljf_v2/unified/unified5_g.xml

DIABETIC ULCERS

- Antibiotic treatment must be accompanied by attention to diabetic control, peripheral circulation, pressure-relief, suitable dressings and regular debridement by a podiatrist.
- Osteomyelitis should be suspected in ulcers persisting for longer than 8 weeks.

Guidance on antibiotic treatment is given at www.ljf.scot.nhs.uk/exist/xmldb/db/ljf_v2/unified/unified5_f.xml

DENTAL INFECTIONS

- This LJF (Adult) section has been expanded to cover acute and ulcerative gingivitis in addition to dental abscesses. Note that this is in addition to dental abscesses.
- See LJF website for both LJF (Adult) and Lothian Dental Formulary recommendations. www.ljf.scot.nhs.uk

Thanks to Dr Steven Haigh, Chair of the Infection Working Group for contributing to this article.

eLJF-GPASS v2006 upgrade

The latest version of eLJF-GPASS was recently circulated to all practices by email. Please note that all future upgrades of eLJF-GPASS will be distributed by email and CD-ROMs will no longer be sent out. Practices requiring additional laminate sheets of the Formulary Headings should contact the Medicines Management Team - email prescribing@lpct.scot.nhs.uk.

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