PCT Prescribing Report Jul - Sep 2006
Lipid-regulating drugs - Prescribing Guidance and Discussion Points

Discussion Points

1. Does your PCT have a policy for prescribing of statins which is consistent with the NICE Technology Appraisal? Has this policy been developed with input from providers in both primary and secondary care?

2. Has your PCT reviewed its performance against the NHS Institute Productivity Metric for statins prescribing? What actions have been identified to increase low cost statin prescribing to reach the level of prescribing achieved by the top quartile of PCTs?

One in three deaths in the UK is caused by cardiovascular disease (CVD) (216,000 deaths in 2004). Half of these CVD deaths are due to coronary heart disease (CHD) and a quarter due to stroke. One of the most important markers of progress for the National Service Framework (NSF) for CHD is the increase in provision of statins to patients. It is estimated that statin therapy is saving up to 9,000 lives per year as well as reducing the number of heart attacks. Prescription items for statins have trebled in the last 5 years to 9.7 million per quarter (Figure 1). Spending on these drugs has increased by 41% to £141 million per quarter (Figure 2).

The aim for primary prevention of CHD in the NSF is to target people for lipid lowering where they have a 30% or greater 10-year risk of developing CHD. For secondary prevention the NSF recommends that all people with CHD or other occlusive arterial disease receive statins. The NICE guidance on statins for the prevention of cardiovascular events (published in January 2006) recommends statins for adults with clinical evidence of CVD and for primary prevention of CVD in adults who have a 20% or greater 10-year risk of developing CVD. A 20% or greater 10-year risk of developing CVD is equivalent to a 15% or greater 10-year risk of developing CHD. Adoption of the NICE guidance therefore means that more people will be eligible to receive statins than using the NSF recommendation. NICE estimates that 5.2 million people in England will meet the criteria for receiving statins.

There is plenty of high quality evidence to support the effectiveness of statins in preventing cardiovascular events in people who already have CVD and in people who are at high risk of developing CVD. Good clinical outcome data are available to support the use of simvastatin, pravastatin and atorvastatin in reducing vascular events. NICE recommends that statin therapy is usually initiated using a drug with a low acquisition cost. The prices of the two statins (simvastatin and pravastatin) included in Category M of the Drug Tariff have fallen considerably, with further price reductions in October 2006. One of the new NHS Institute Productivity Metrics measures the percentage of items for simvastatin and pravastatin as a percentage of all statin prescribing. There is wide variation in this measure across PCTs (range 19% to 84%).

Figure 1: Trends in Prescribing of Statins in General Practice in England

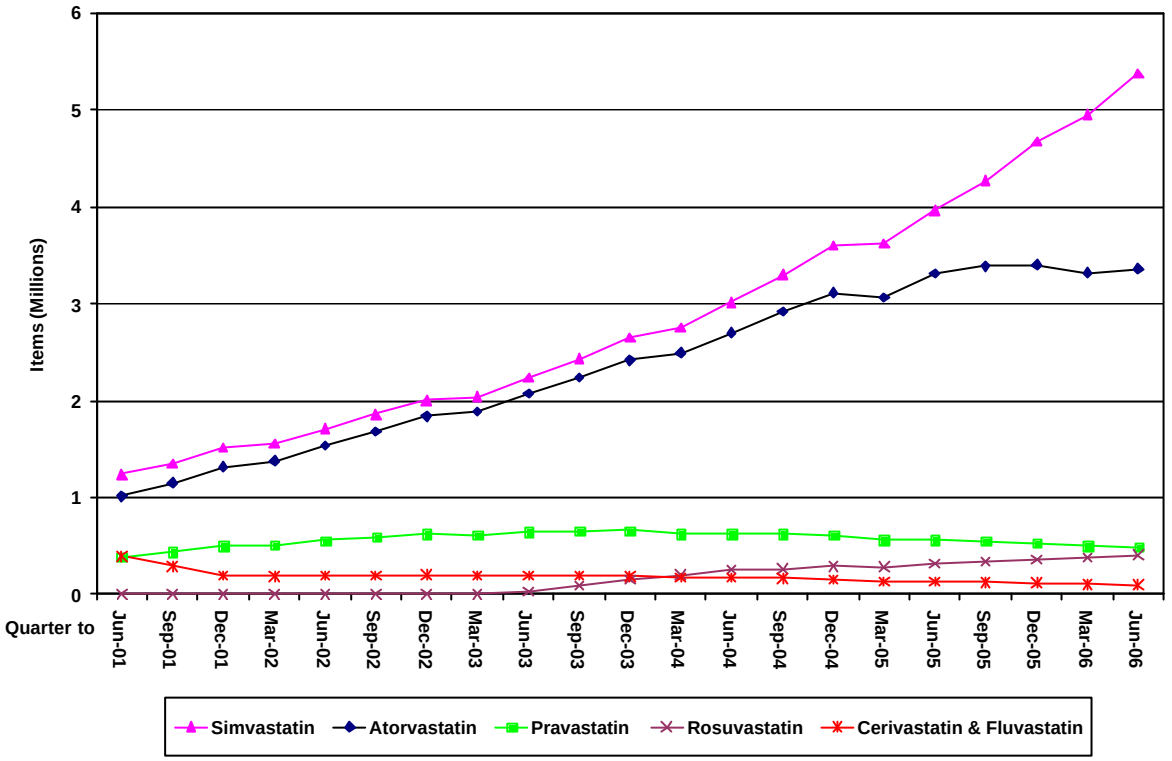
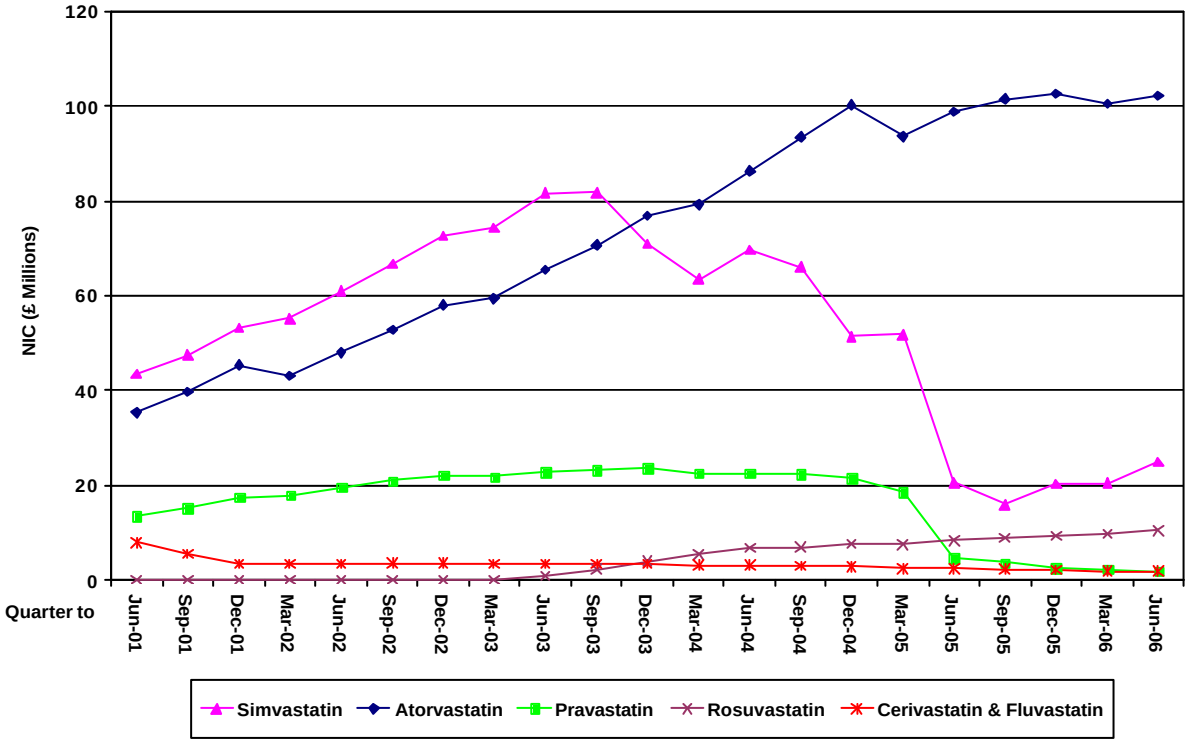


Figure 2: Trends in Spending on Statins in General Practice in England



PCT distribution of prescription items for simvastatin and pravastatin as a % of all statins items (Quarter to June 2006)

	Number of PCTs
1 to 20 %	1
21 to 30 %	3
31 to 40 %	13
41 to 50 %	27
51 to 60 %	95
61 to 70 %	97
71 to 80 %	59
>80 %	8

In the quarter to June 2006 the most commonly prescribed strength of atorvastatin was 10mg (44% of items) whereas the most common strength of simvastatin was 40mg (44%). There is no evidence that 10mg atorvastatin is more effective than 40mg simvastatin and it costs more than five times as much. The NHS Institute Productivity Metric for statin prescribing shows how the NHS could release £80 million a year by adopting the kind of prescribing practice that is already happening in many PCTs.

There is ongoing debate about how far to lower blood lipids. The NSF for CHD target is to reduce total cholesterol to < 5mmol/l or by 20 to 25%. The Quality and Outcomes Framework of the GMS contract contains targets to achieve total cholesterol = 5mmol/l in three domains: secondary prevention of CHD, stroke or transient ischaemic attack and diabetes. Maximum quality points are awarded if 60% of patients reach the target in each domain. The Joint British Societies' guidelines (JBS 2) on prevention of CVD in clinical practice recommend optimal targets for lowering total cholesterol of < 4mmol/l (LDL cholesterol to < 2mmol/l) or a 25% reduction of total cholesterol (30% reduction in LDL cholesterol) whichever gets the person to the lowest absolute value. However the evidence to support intensive lipid lowering (e.g. LDL cholesterol < 3.36 mmol/l) is not robust. Achieving the lower targets for blood cholesterol will involve frequent use of multidrug therapy and greater costs to the patient and NHS. The routine use of statins at very high dose is not recommended by NICE. The NICE clinical guideline on lipid modification for the primary and secondary prevention of cardiovascular disease (due in December 2007) should clarify the targets for cholesterol lowering.

Sources of further information

1. Information on prescribing for the PCT is available using ePACT.net and the Prescribing Toolkit. The NHS Institute Productivity Metric for statins prescribing is now available within the Prescribing Toolkit.

2. Department of Health. Coronary Heart Disease National Service Framework. Leading the way - Progress report. March 2005. www.dh.gov.uk/assetRoot/04/10/52/82/04105282.pdf

3. NICE clinical guidelines and appraisals can be found on their website at www.nice.org.uk

- Statins for the prevention of cardiovascular events. Technology Appraisal 94. January 2006 www.nice.org.uk/page.aspx?o=TA094guidance
- Cardiovascular risk assessment: the modification of blood lipids for the primary and secondary prevention of cardiovascular disease. Final scope. August 2005 www.nice.org.uk/page.aspx?o=269597
- Management of Type 2 diabetes – management of blood pressure and blood lipids www.nice.org.uk/pdf/NICE_INHERITEd_Hv8.pdf
- Post Myocardial Infarction: Secondary prevention in primary and secondary care for patients following a myocardial infarction. Full Guideline. First Draft. August 2006. www.nice.org.uk/page.aspx?o=352622

4. Information for prescribing leads and prescribing advisers that could stimulate debate on the content and development of prescribing policies includes:

    - National Prescribing Centre. Update on Statins. MeReC Briefing 2005; 28: 1 - 8 www.npc.co.uk/MeReC_Briefings/2004/briefing_no_28.pdf
    - Moon J. Switching Statins. BMJ 2006; 332:1344-1345
    - JBS 2: Joint British Societies'guidelines on prevention of cardiovascular disease in clinical practice. Heart 2005; 91 : 1-52
    - Hayward RA, Hofer TP, Vijan S. Narrative review: lack of evidence for recommended low-density lipoprotein treatment targets: a solvable problem. Annals of Internal Medicine 2006; 145: 520-530
    - National Prescribing Centre. Intensive lipid lowering with atorvastatin: the TNT study. MeReC Extra 2005; issue 17 www.npc.ppa.nhs.uk/MeReC_Extra/2005/no17_2005.pdf
    - National Prescribing Centre. Statins for secondary prevention: what is ideal? MeReC Extra 2005; issue 21 www.npc.ppa.nhs.uk/MeReC_Extra/2006/no21_2006.pdf
    - LaRosa J, Grundy S, Waters D, Shear C et al. Intensive Lipid Lowering with Atorvastatin in Patients with Stable Coronary Disease. New Eng J Med 2005; 352: 1425-1436

5. The NHS Productivity Metrics can be found at www.productivity.nhs.uk/index.asp