EXTENSION OF NON-MEDICAL PRESCRIBING

PostScRxipt
from the
NHSGGC Area Drug & Therapeutics Committee
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Website
http://www.glasgowformulary.scot.nhs.uk

Recent legislation is likely to impact significantly on the roll-out of extended prescribing. The Medicines and Human Use (Prescribing) (Miscellaneous Amendments) Order of May 2006 means that non-medical prescribers can independently prescribe any drug for any condition, given they are trained appropriately and are competent to do so.

With the extension of non-medical prescribing, the government aims to:

- improve patient care without compromising safety
- make it easier for patients to get the medicines they need
- increase patient choice in accessing medicines
- make better use of the skills of health professionals
- contribute to the introduction of more flexible team working across the NHS.

Nurse prescribing is the most developed of all non-medical prescribing. Pharmacist prescribing has been established more recently, initially covering only supplementary prescribing with independent prescriber status having only been recently available. Some Allied Health Professionals, such as physiotherapists, radiographers and podiatrists, will soon join the ranks of prescribers as the courses are being extended to include these practitioners.

Prescribing by nurses makes up a small but growing proportion of overall activity. There were only six nurse prescribers in Scotland in 1996, now there are over 3,200; the number of prescriptions written each year has risen from less than 2,000 in 1997 to almost 500,000. Pharmacist prescribing was much lower with only around 10,000 prescriptions from supplementary prescribers. However, another 430,000 scripts were written by community pharmacists for prescribing under other schemes such as the Minor Ailments Scheme and Urgent Supply of Repeat Medicines.

Non-medical prescribing is best thought of as an enhancement to specific roles rather than a generic process. Just over half of all nurse prescribing is currently performed by district nurses. It is clearly useful for district nurses to be able to prescribe. They are experts in dressings and so are the most appropriate people to be prescribing them. The same is not necessarily true across all sectors. For some clinicians it has been impractical to prescribe as more experienced practitioners are readily available, or support structures are not in place. Unlike most GPs and primary care nurses, community pharmacists are not linked to specific medical practices and can have difficulty in accessing medical records.

See our website for personal accounts from nurses and pharmacists who have successfully implemented independent and supplementary prescribing within their specialist areas. They provide strong cases for the continuation of both models.

• Jane, a practice nurse, describes how independent prescribing has enhanced her role, especially in relation to chronic disease management and the diagnosis and treatment of minor ailments.
• Shona, a Parkinson's disease nurse specialist, describes how supplementary prescribing has allowed her to provide better care in relation to prescribing and alteration of apomorphine infusions for this group of patients with complex medical needs. It has also allowed her to enhance communication with primary care when patients are discharged.
• Peter, a clinical pharmacist working with neonates, tells how supplementary prescribing has helped him to care for this vulnerable group of patients and why supplementary prescribing will continue to be an important method of service delivery where large numbers of unlicensed medicines are used.
• Iain, a primary care pharmacist, talks of how supplementary prescribing has aided chronic disease management, but says it has limitations which make the introduction of independent prescribing by pharmacists a welcome development.

All practitioners note that prescribing has improved the efficiency of their work.

Conclusion

Non-medical prescribing has been included in Scottish Policy white papers, *Delivering for Health* and *Delivering Care Enabling Health*. These case studies demonstrate the benefits of non-medical prescribing, extending practitioner roles and supporting patients in the community, both aims of the NHS in Scotland. Nurses have been compared to doctors in community settings and have demonstrated their ability to care for patients effectively. There is less evidence for other non-medical prescribers as their roles are less well established, but that should follow in time. The future of non-medical prescribing is certain and now must be planned to ensure it is part of career progression and development for advanced practitioners.

For all article references, check our website
http://www.glasgowformulary.scot.nhs.uk

Alphabetical list of most recent ADTC decisions

For full details of SMC advice, visit **www.scottishmedicines.org** For NICE advice, visit **www.nice.org.uk** For previous ADTC decisions, visit **www.glasgowformulary.scot.nhs.uk**

Drug	Indication under consideration (There may be other licensed indications)	Glasgow decision	
Budesonide/formoterol turbohaler (Symbicort SMART®)	Regular treatment of asthma as maintenance preventative treatment and as needed in response to symptoms.	*Formulary*. Acknowledge new indication.	✓
Cinacalcet (Mimpara®)	Secondary hyperparathyroidism in end stage renal disease.	*Formulary*. Restricted to specialist use only in accordance with local protocol.	✓R
Darifenacin (Emselex®)	Symptomatic treatment of urge incontinence and/or increased urinary frequency and urgency as may occur in patients with overactive bladder syndrome.	*Formulary*. Restricted to second-line use in patients who fail to respond to, or are unable to tolerate, standard release oxybutynin.	✓R
Darunavir (Prezista®)	Treatment of HIV-1 infection in highly pre-treated adult patients who have failed on more than one regimen containing a protease inhibitor.	*Formulary*. Restricted to use by HIV specialists.	✓R
Dasatinib (Sprycel®)	Treatment of adults with Philadelphia chromosome positive acute lymphoblastic leukaemia with resistance or intolerance to prior therapy.	Non-*Formulary*.	x
Dasatinib (Sprycel®)	Treatment of adults with chronic myeloid leukaemia (CML) with resistance or intolerance to prior therapy including imatinib mesylate.	Interim non-*Formulary*. Deferred for consultation with the Regional Cancer Advisory Group.	?
Dibotermin alfa (recombinant human bone morphogenetic protein-2/absorbable collagen sponge; rhBMP-2/ACS) (InductOs®)	Treatment of acute tibia fractures in adults, as an adjunct to standard care using open fracture reduction and intramedullary nail fixation in patients in whom there is a substantial risk of non-union. Restricted to patients with un-reamed intramedullary nails.	Non-*Formulary*. This type of preparation is not included in the *Formulary*.	x
Docetaxel (Taxotere®)	Induction treatment of patients with unresectable locally advanced squamous cell carcinoma of the head and neck in combination with cisplatin and 5-fluorouracil.	Interim non-*Formulary*. Deferred for consultation with the Regional Cancer Advisory Group.	?
Esomeprazole (Nexium®)	Gastro-oesophageal reflux disease in patients from 12 years of age.	Non-*Formulary*.	x
Estradiol (Oestrogel®)	Symptoms associated with menopause.	*Formulary*. Restricted to patients who fail to tolerate oral or patch preparations.	✓R
Formoterol (Easyhaler®)	Treatment of asthma in patients treated with inhaled corticosteroids and who also require a long-acting beta2-agonist in accordance with current treatment guidelines; and for the relief of reversible airways obstruction in patients with chronic obstructive pulmonary disease requiring long-term bronchodilator therapy.	*Formulary*. Acknowledge new formulation.	✓
Infliximab (Remicade®)	Maintenance treatment of severe, active Crohn's disease, in patients who have not responded despite a full and adequate course of therapy with a corticosteroid and/or an immunosuppressant; or who are intolerant to, or have medical contraindications for, such therapies.	Non-*Formulary* for this indication.	x
Infliximab (Remicade®)	Maintenance treatment of fistulising, active Crohn's disease, in patients who have not responded despite a full and adequate course of therapy with conventional treatment (including antibiotics, drainage and immunosuppressive therapy).	Non-*Formulary* for this indication.	x
Moxifloxacin (Avelox®)	Community-acquired pneumonia.	*Formulary*. Restricted to second line use by hospital specialists for penicillin-allergic patients with community-acquired pneumonia or for cystic fibrosis patients intolerant of ciprofloxacin where a quinolone is required.	✓R
Oral Rehydration sachets (Rapolyte®)	Fluid and electrolyte loss in diarrhoea.	*Formulary*.	✓
Posaconazole (Noxafil®)	Prophylaxis of invasive fungal infections in immunocompromised patients.	*Formulary*. Acknowledge new indication. Restricted to patients in whom there is a specific risk of aspergillus infection or where fluconazole or itraconazole are not tolerated. To be used in accordance with local protocol.	✓R
Propiverine (Detrunorm XL®)	Urinary frequency, urgency and incontinence.	Non-*Formulary*.	x
Ranibizumab (Lucentis®)	Treatment of neovascular (wet) age-related macular degeneration.	*Formulary*. Restricted to specialist use in line with local protocol.	✓R
Standardised allergen extract of grass pollen from Timothy (Phleum pratense) (Grazax®)	Treatment of grass pollen induced rhinitis and conjunctivitis in adult patients with clinically relevant symptoms and diagnosed with a positive skin prick test and/or specific IgE test to grass pollen.	Non-*Formulary*.	x
Testosterone (Tostran®)	Replacement therapy for male hypogonadism when testosterone deficiency has been confirmed by clinical symptoms and laboratory analyses.	*Formulary*. Acknowledge new formulation. Restricted to use as an alternative to patches for patients requiring transdermal therapy.	✓R
Topotecan (Hycamtin®)	Treatment of patients with relapsed small cell lung cancer for whom re-treatment with the first-line regimen is not considered appropriate.	Non-*Formulary*.	x

✓= *Formulary* ✓R = *Formulary* (restricted) **x** = non-*Formulary* **?** = awaiting final decision

Behind the medical headlines (http://www.behindthemedicalheadlines.com/)

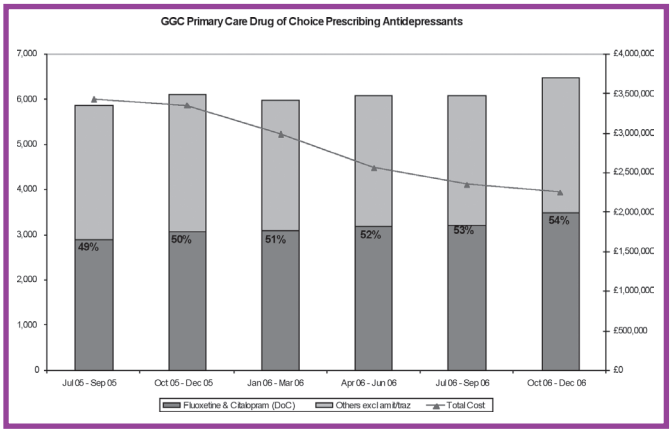
This website is produced by the Royal College of Physicians of Edinburgh, the Royal College of Surgeons of Edinburgh, and the Royal College of Physicians & Surgeons of Glasgow. It has been developed to provide authoritative and independent expert commentaries on topical medical matters reported in the international media.

It targets both the public and health professionals in an attempt to reduce the confusion which can often arise from conflicting, incomplete or misleading media reports of medical areas. The website makes use of the Colleges' collective world-wide membership of 30,000 consultant physicians and surgeons to commission articles from leading medical experts.

Media coverage of medical issues reported around the world is monitored daily with hyperlinks to a small selection included in the 'Breaking News' section. Where media reports are considered to be of major significance or appear on a recurring basis, articles are commissioned from recognised medical experts. In addition to commissioning articles, suggestions from users of the website for future articles are welcomed.

Antidepressant prescribing

Fluoxetine and citalopram are both NHSGGC Drugs of Choice (DoC) for antidepressant treatment. The treatment guideline states that patients who have previously responded to a particular antidepressant should be offered that drug for further depressive episodes. For new patients, or where a change of therapy is indicated, fluoxetine or citalopram should be used. Work across the area has slowly increased prescribing of these drugs as can been seen below.



Looking at antidepressant treatment in more detail shows:

- Community prescribing costs are around sixty times that of hospitals.
- GGC has the third highest use of fluoxetine and citalopram in Scotland at 54% of primary care antidepressant prescribing. The average is 51%.
- Frequency of prescribing of antidepressants varies by more than 50% across CHPs.
  - East Dunbartonshire has the lowest rate of prescribing but is one of three CHPs with the highest use of DoCs at 57%.
  - Inverclyde has the highest rate of prescribing, but the lowest use of DoCs at 48% of defined daily doses issued.
- Prescribing of DoCs has increased from 54% to 58% in secondary care from April 2006-December 2006
- In acute care, the Victoria Infirmary supplied 46% of defined daily doses of antidepressants as DoCs while the Western Infirmary, which issued a significantly smaller number overall, prescribed 72% of defined daily doses as DoCs. Work is ongoing to identify prescribing patterns at directorate level.

A more detailed report can be found on our website.

Ivabradine (Procoralan®)

The ADTC has not added ivabradine to the *Formulary*. The SMC accepted it for the symptomatic treatment of chronic stable angina pectoris in patients with normal sinus rhythm for whom heart rate control is desirable and who have a contra-indication or intolerance to beta-blockers and rate-limiting calcium-channel blockers. The ADTC decision was based on the conclusion that, with these restrictions, only a very small cohort of patients would be suitable. It also noted that the evidence is limited and there are other treatment options.

Ivabradine is a novel selective sinus node I_f inhibitor which slows the diastolic depolarisation slope of the SA-node resulting in a reduction in heart rate. Clinical trials have demonstrated non-inferiority to atenolol and amlodipine in patients with positive exercise tolerance test and at least a three-month history of chronic effort angina. Ivabradine has been shown to reduce the number of angina attacks and consumption of short acting nitrates in trials up to one year in duration. It is difficult to ascertain the place in therapy, as the trial populations may not be representative. Treatment was not limited to patients unable to use beta-blockers (any contraindication to atenolol was a specific exclusion criterion in the study using atenolol). For full details, see the Detailed Advice Document on the SMC website.

The effect of ivabradine on morbidity and mortality in cardiovascular disease has not been determined. SIGN guideline 96, *Management of Stable Angina* (February 2007) recommends beta-blockers as first-line therapy and adds that rate-limiting calcium-channel blockers, long-acting nitrates or nicorandil are options for patients intolerant to beta-blockers. Ivabradine is not included in any recommendation.

Adverse effects include phosphene-like events (transient enhanced brightness in a limited area of the visual field) which appear to be dose related and were mainly mild-to-moderate, resolved during treatment with low impact on patients' daily life.

Summary

• Ivabradine has not been added to the *Formulary*.
• *Formulary* treatment options for angina include beta-blockers, calcium-channel blockers, nitrates and nicorandil.
• The SIGN guidelines do not make any recommendation for ivabradine use.

NHSGGC *Formulary*: first edition

Look out for the first edition of the new *NHS Greater Glasgow and Clyde Formulary* which will be circulated at the beginning of August. Details on the structure and development process were given in the last edition of *PostScript*. Both the current *Formulary* and all editions of *PostScript* are available on our website.

NHS Greater Glasgow and Clyde

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