LOTHIAN PRESCRIBING BULLETIN

Supporting prescribing excellence - informing colleagues in primary and secondary care

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NHS Lothian

In this issue ...

Continuing to promote quality and cost effective prescribing

General practice prescribing budgets 2007/08

The Prescribing Budget Setting Group (PBSG) has been tasked over the past few years with developing a budget setting formula for general practice prescribing budgets. The group has representatives from Community Health Partnerships (CHPs), Finance, Public Health, GPs, Primary Care Pharmacists, Medicines Management Team and NHS Scotland Information Services. The PBSG recommends how to cut up the budgetary cake but not on how big it is. The budget formula has been developed to incorporate census illness data and disease prevalence data from practices. For 2007/08 the model used has been re-evaluated. The analysis found the model to have remained consistent. As a result the PBSG budgetary model recommended for 2007/08 now accounts for 80% of the variations in primary care prescribing costs. This is a better predictor of Lothian prescribing than the formula (a development of the Arbuthnott formula) used by the new National Resource Allocation Committee. Further details are set out in the PBSG Report 2007/08[1], which can be requested from prescribing@lpct.scot.nhs.uk.

The PBSG Report 2007/08 was approved by the General Practice Prescribing Committee and forwarded to the Director of Finance, LPCO, for discussion with, and approval by, the Lothian CHPs.

Prescribing Indicators from the PBSG Report 2007/08

The PBSG recommends Prescribing Indicators (PIs) to promote quality and cost effective prescribing in primary care.

Several changes to PI target levels are proposed. Three new PIs addressing the prescribing of 'me-too' drugs have been introduced and 6 existing PIs have been modified. Two PIs have been dropped this year. The net result is 14 PIs plus the 'gateway' generic PI.

The key recommendations of the PBSG Report 2007/08 are:

- Practice budgets should be set using 60% weighted capitation element (PBSG budgetary model) and 40% historic spend.
- There should be risk sharing of CHP prescribing costs across Lothian.
- The funding for shared care protocol (SCP) drugs (approximately £8.4 million in 2006/07) should continue in its present format.
- The contingency fund for costly non-SCP medicines should remain at the current level of £600,000.
- Incentive payments for PI achievement should continue to be funded Lothian-wide by topslicing the Lothian primary care prescribing budget.
- Incentive payments should be solely for PI achievement and not for meeting budget targets.
- If CHPs set their own fiscal incentives, these should be clearly identified and differentiated from those of the PBSG.

The CHPs have agreed to the recommendations although the funding of PI incentives is yet to be agreed.

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Continued from previous page

Prescribing Indicator (PI)	Commentary[1]
Generic prescribing Generic rate ≥ 75% per quarter *(revised target)*	Practices must attain this PI to be eligible for incentive payments for the other PIs.
Non-steroidal anti-inflammatory drugs (NSAIDs) Cost per patient ≤ £0.85 per quarter for all oral and injectable NSAIDs including COX-2 selective inhibitors	NSAIDs which balance efficacy and adverse effects are preferred. The LJF recommended NSAIDs have a low incidence of side effects combined with good efficacy. About 60% of patients will respond to any NSAID; of the others, those who do not respond to one may well respond to another.
Total antibiotics Items per 100 patients ≤ 70 per annum for all antibiotics	This indicator takes into account the Standing Medical Advisory Committee, Sub-Group on Antimicrobial Resistance report 'The Path of Least Resistance'[2]. Reinforces further guidance on reducing antibiotic prescribing from the Scottish Executive.
Co-amoxiclav Items per 100 patients ≤ 6 per annum for co-amoxiclav	Co-amoxiclav is best reserved for bacterial infections likely or known to be caused by amoxicillin resistant β-lactamase producing strains. Routine use should be discouraged to avoid the development of microbial resistance.
Quinolones Items per 100 patients ≤ 3 per annum for quinolones	These drugs are normally regarded as second line agents and routine use should be discouraged to avoid the development of microbial resistance.
Hypnotics including temazepam Defined Daily Doses (DDDs) per patient ≤ 1.5 per quarter *(revised measure)*	In general all hypnotics should be reserved for prescribing in short courses when insomnia is severe, disabling or subjecting the individual to extreme distress.
Modified release (MR) isosorbide mononitrate (ISMN) Plain ISMN prescriptions ≥ 33% of all ISMN prescriptions per quarter *(revised target)*	ISMN is a clinically effective treatment for the management of the symptoms of angina. The benefits of increased patient convenience with once daily MR ISMN should be compared against the increased cost in the individual patient and may be justified in some patients where compliance is an issue.
Angiotensin-II receptor antagonists (ARAs) ARA prescriptions ≤ 25% of all prescriptions for renin-angiotensin system antihypertensives (ARAs + ACEIs) per quarter	The LJF reserves ARAs as an alternative for patients who require angiotensin-converting enzyme (ACE) inhibition but cannot tolerate an ACE inhibitor.
Simvastatin Total number of items of simvastatin ≥ 60% of all statins per quarter *(revised target)*	Simvastatin is cost effective compared to other statins. From dosing studies, simvastatin 40mg lowers LDL by 3% more than atorvastatin 10mg and 4% less than atorvastatin 20mg but it has a larger HDL raising effect than atorvastatin 10-80mg.
Oral analgesics Plain formulations of oral analgesics ≥ 87.5% of oral analgesics (excluding liquids) per quarter *(revised target)*	Effervescent or MR formulations of analgesics are no more effective than the plain versions. There are also concerns that effervescent tablets contain high amounts of sodium.
Wound dressings Wound management products cost per weighted patient ≤ £3.00 per annum *(revised measure)*	LJF recommended dressings are cost effective options for the various classes of dressing, prescribing of LJF recommended wound management products will result in cost efficiencies.
Ulcer healing drugs (UHDs) DDDs per weighted population ≤ 7 per quarter *(revised target)*	NICE guidelines[3] state that the lowest possible dose of proton pump inhibitor (PPI) should be used, therefore, the prescribing is to be measured by DDDs with a weighted population to allow for consideration to be given to age, deprivation and mortality ratio.
Esomeprazole Total number of items of esomeprazole ≤ 5% of esomeprazole and LJF recommended PPIs per quarter *(new PI)*	Oral esomeprazole is not recommended for use in NHS Scotland following assessment by the Scottish Medicines Consortium. No trials have demonstrated a therapeutic advantage of esomeprazole over the other PPIs when the treatments are given at equivalent doses. Non-LJF drug.
Antihistamines Total number of items of desloratadine and levocetirizine ≤ 10% of desloratadine, levocetirizine and LJF recommended antihistamines per annum *(new PI)*	There is currently little evidence that third generation antihistamines (desloratadine or levocetirizine) provide any clinical benefit over second generation antihistamines (loratadine or cetirizine). Non-LJF drugs.
Escitalopram Total number of items of escitalopram ≤ 10% of all selective serotonin re-uptake inhibitors per annum *(new PI)*	There is currently little evidence that escitalopram, the *S*-enantiomer of the antidepressant citalopram, is any more effective or has a faster onset of action than citalopram. Escitalopram was launched before the patent for citalopram expired. Non-LJF drug.

References

1. Prescribing Budget Setting Group. Prescribing Budget Setting Group Report 2007 - 2008. February 2007.
2. Department of Health. Standing Medical Advisory Committee, Sub-Group on Antimicrobial Resistance. The Path of Least Resistance. September 1998.
3. NICE. Dyspepsia - proton pump inhibitors. Technology Appraisal Guidance No. 7, July 2000.

CFC-free beclometasone dipropionate pMDIs

A recent letter from the MHRA[1] highlighted that the two CFC-free beclometasone dipropionate pressurised metered dose inhalers (pMDIs) now on the UK market, Clenil Modulite® and QVAR®, are not equipotent (see BNF for full dosing information).

When a prescriber wishes a patient to have a CFC-free formulation of beclometasone dipropionate, it should be made clear by prescribing the product by brand name. **Please note, however, there is no current requirement for prescribers to switch patients to CFC-free inhalers.**

Key messages:

- **No urgency to transfer patients to CFC-free beclometasone dipropionate pMDIs.**
- **Clenil Modulite® and QVAR® are not equipotent; if prescribing these products, prescribe by brand name.**

Reference

1. Beclometasone dipropionate pressurised metered dose inhaler. Urgent Message. Scottish Executive. 8 August 2006. www.mhra.gov.uk

Guidance on oral magnesium supplementation

Guidance for GPs and community pharmacists on the treatment of hypomagnesaemia has been produced by oncology services at the Western General Hospital. This guidance will be provided, along with an accompanying letter, when patients are discharged from hospital.

The recommended preparation is **Magnaspartate®** (magnesium-L-aspartate).

Magnaspartate® is licensed as a 'food for special medical purposes', and community pharmacists should note that it is regarded as a 'specials' order. It is indicated for the dietary management of magnesium deficiency, which may occur due to intestinal failure, malabsorption disorders and post chemotherapy induced magnesium loss. Prescribers can refer to this guidance for information on dosing and monitoring.

… LJF updates … LJF updates … LJF updates … LJF updates …

There have been significant changes to some sections of the LJF over recent months; these include osteoporosis, genito-urinary medicine, obesity, oral nutritional supplements, antidepressants and contraception.

Section 4.3 - Newly diagnosed depression

First choice:	fluoxetine
Second choice:	citalopram

Section 6.6 - Drugs affecting bone metabolism

- Calcium and vitamin D preparation of choice changed to Calcichew-D_3® Forte. Patients established on Adcal-D_3® do not need to be switched.

Section 7.3 - Contraceptives

- Extensive changes and rewording of prescribing notes throughout the section.
- New sub-section in 7.3.1 for transdermal preparations (Evra®), for use in women who are unlikely to comply with oral preparations.
- In section 7.3.3 the choice of spermicidal agent has changed to Ortho-Creme® or Orthoforms®. Patient preference determines whether a cream or pessary is prescribed.
- In section 7.3.4 the choice of intra-uterine device has changed to TT 380 Slimline® or Nova-T® 380.

eLJF-GPASS v2007 upgrade

The latest version of eLJF-GPASS was recently circulated to all practices by email and will shortly be available on the LJF website - www.ljf.scot.nhs.uk. This includes all the latest changes to the LJF.

Please ensure that you upgrade your GPass system with this new version. EPASS accredited CPD packs for new users of eLJF-GPASS are available free of charge from the Medicines Management Team.

Drugs Not Recommended by the Scottish Medicines Consortium

A list of all drugs not recommended by the Scottish Medicines Consortium is now available at http://www.ljf.scot.nhs.uk/smc_lists/smc_not_recommended_drugs.pdf.

Nurse prescribing in Lothian

Patricia McIntosh, Clinical Nurse Manager, and Jane Findlay, Nurse Practitioner, Gracemount Medical Practice, write:

District nurses and health visitors have been prescribing from a limited formulary in Scotland since 1996. From 2006 these nurse prescribers, now referred to as community nurse prescribers, can still only prescribe from the limited formulary in the BNF, and only within their competence. They are annotated on the Nursing and Midwifery Council (NMC www.nmc-uk.org) register as V100 community nurse prescribers.

In 2001 prescribing was extended to allow all first level registered nurses working with minor ailments, minor injuries, health promotion and palliative care to undertake an accredited nationally set course which, on successful completion, enabled registration as extended nurse prescribers, annotated on the NMC register as V200 extended independent nurse prescribers. In 2002 supplementary prescribing was introduced with the use of clinical management plans, and agreement between doctor, nurse and patient. These nurses were extended supplementary prescribers, annotated on the NMC register as V300. New legislation in 2006 enabled nurses who had undertaken extended/supplementary educational programmes to become independent prescribers. Supplementary prescribing still remains for those practitioners who wish to use it. The Scottish Executive issued guidance on nurse independent prescribing in September 2006[1].

Prescription pads

Nurse prescription pads were not recalled with the change in legislation from extended/supplementary to independent/supplementary nurse prescribing, and the DN/HV prescriber to community nurse prescriber, and this presents a challenge for community pharmacists at the point of dispensing. Prescribing software systems do not yet have the facility to alter the titles of the nurse prescriber but this is expected soon. In the meantime, the following nurse prescriber categories remain: DN/HV, community nurse, extended/supplementary, and independent/supplementary.

Maintaining competency and ensuring safe practice

Nurses have a professional responsibility to keep abreast of clinical and professional developments, and this includes prescribing. Employers must ensure access to relevant education and training, and that prescribing is a part of personal development plans. All nurses must prescribe within their competency, and NHS Lothian recommends that independent nurse prescribers create a personal core formulary, based on the Lothian Joint Formulary (LJF www.ljf.scot.nhs.uk), in agreement with a GP or Clinical Director. A Lothian framework for non-medical prescribing has been approved by Lothian NHS Board to support safe and effective prescribing. A steering group has been established to assess risk and put into place a strategy to ensure that controlled drug prescribing by nurses is safe and manageable. The NMC have published standards of proficiency for nurse prescribing[2], and this document is recommended for all personnel involved with nurse prescribing. The Royal College of Nursing (RCN www.rcn.org.uk) provides guidance on indemnity insurance by nurse prescribers.

Education and Training

All registered nurses undertaking independent/supplementary prescribing courses must be able to study at degree level. Courses teach the principles of prescribing over 26 taught days, and 12 supervised practice days where the nurse works with a medical practitioner. A range of competencies must be met and a written exam completed. In Lothian both Queen Margaret and Napier Universities offer courses. Some educational establishments are to offer prescribing at MSc level.

Contact

All administration for primary care nurse prescribing in Lothian is done through a single office based at Leith Community Treatment Centre, Junction Place, Edinburgh EH6 5JQ, tel. 0131 536 6396. Contact:

- Patricia McIntosh, Clinical Nurse Manager Patricia.McIntosh@lpct.scot.nhs.uk
- Jennifer Houliston, Administrative Assistant Jennifer.Houliston@lpct.scot.nhs.uk

References

1. Non Medical Prescribing in Scotland: Guidance for Nurse Independent Prescribers and for Community Practitioner Nurse Prescribers in Scotland: A Guide for Implementation. Scottish Executive. 13 September 2006. www.scotland.gov.uk/Resource/Doc/145797/0038160.pdf
2. Standards of proficiency for nurse and midwife prescribers. Nursing & Midwifery Council. April 2006. www.nmc-uk.org/aFrameDisplay.aspx?DocumentID=1645

Correspondence address:
Medicines Management Team
Stevenson House
555 Gorgie Road
Edinburgh
EH11 3LG Tel: 0131-537-8573