PATIENT GROUP DIRECTIONS IMPROVE PATIENT CARE

Anticoagulant therapy cover for patients undergoing colonoscopy procedure
Bowel cancer is the third most common cancer in Scotland after lung and breast cancer. Every year in Scotland over 3,000 people are diagnosed with the disease. Screening can reduce deaths from bowel cancer by 16%. All people in Scotland between the ages of 50 and 74 are invited to take part in the Scottish Bowel Screening Programme and will be sent a faecal occult blood (FOB) test kit to complete at home.

The first part of the screening process is the analysis of a three stool FOB sample. Patients with positive screening results are then invited to contact NHS Greater Glasgow & Clyde to undergo a pre-assessment of their fitness to proceed to colonoscopy.

Some patients who are taking warfarin, for example those with artificial heart valves, and who require colonoscopy, have a higher risk of bleeding complications and thrombotic events. To minimise the risks, patients are asked to stop their warfarin five days before undergoing their colonoscopy procedure. Enoxaparin is used as bridging therapy to reduce the risk of thromboembolism.

A Patient Group Direction (PGD) has been developed and implemented that allows pre-assessment nurses to do this. The PGD has been operating across the NHSGGC Endoscopy Service since May 2009 enabling the nurse endoscopists to supply enoxaparin for patients on warfarin with a high thrombotic risk for five days around the procedure. This removes the need for the anticoagulant service or general practitioner to prescribe the drug and reduces the waiting time for a colonoscopy appointment.

During the pre-assessment, the patient is given a prescription and instruction on how to administer enoxaparin. The nurses also link with the anticoagulant service to ensure appropriate follow-up and monitoring of the patient. The nurse endoscopists follow the NHSGGC clinical policy guidelines for the management of patients on anticoagulants undergoing colonoscopy procedure which can be found on Staffnet **www.staffnet.ggc.scot.nhs.uk/Corporate%20Services/Public%20Health/Public%20Health%20Screening/Pages/BowelScreeningClinicalPolicies.aspx**

Services like this within modern healthcare have evolved to make best use of the skills of different professionals and to ensure appropriately skilled staff perform specific duties. This is a good example of a service where medicines use follows a predictable pattern and there is less need for care to be individualised.

PGDs are generally most appropriate to manage a specific treatment episode (or episodes) and are less suited to provision of medicines on an ongoing basis. Another example of a successful PGD lies in the emergency supply of repeat medicines by community pharmacists.

PostScRipt
from the
NHSGGC Area Drug & Therapeutics Committee
Issue 58 July 2010

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Website
http://www.ggcformulary.scot.nhs.uk

The PGD:
- **improves access to treatment.**
- **reduces patient waiting times by removing the need to refer to a prescriber.**
- **offers an advantage to patient care without compromising patient safety.**
- **ensures the appropriate use and extension of the skills used by the various healthcare professionals detailed in the legislation.**

Continuity of supply of long term treatments
A patient who runs out of their prescribed medicine and cannot obtain a prescription for further supplies within a reasonable period can obtain an emergency supply from a pharmacist. Pharmacists can issue an emergency supply of up to five days’ worth provided they can satisfy the conditions in the Medicines Act. As this is not an NHS service, there will be a charge. Many drugs are very expensive and so this presented a significant barrier to a high proportion of patients.

A National PGD for the Urgent Supply of Repeat Medicines and Appliances has been developed by NHS 24 on behalf of NHS Scotland, and implemented by NHS Boards. The PGD enables community pharmacists to provide patients with up to one prescribing cycle of their repeat medicines and appliances when the patient’s prescriber is unavailable, eg the surgery is closed or an out-of-hours system is in operation.

There are strict criteria to ensure the patient is eligible for supplies to be made, that the medications requested are appropriate and that the patient is not receiving a second successive supply under the scheme. Should the pharmacist decide that it is not appropriate to supply the requested medicines and/or appliances under this scheme it is the pharmacists’ responsibility to:

contd on page 4

Latest ADTC decisions

For full details of all ADTC decisions and links to SMC recommendations go to:
www.ggcformulary.scot.nhs.uk/Latest%20news/formulary%20update%20bulletin.pdf

Major changes to the *Formulary*

• No major changes were made.

Minor changes to the *Formulary*

• **Sitagliptin/metformin** (Janumet®) has been added to the Total *Formulary* restricted to use in patients for whom a combination of sitagliptin and metformin is an appropriate choice of therapy and only when the addition of sulphonylureas to metformin monotherapy is not appropriate.
• A new indication for **raltegravir** (Isentress®) in the treatment of HIV has been approved. It is restricted to use by HIV specialists for patients intolerant of, or resistant to, non-nucleoside reverse transcriptase inhibitors or protease inhibitors or when these options are compromised due to drug interactions.

Non-*Formulary* - not recommended by SMC

• **Abatacept**
• **Certolizumab**
• **Gefitinib**
• **Telmisartan** for use in cardiovascular prevention (to reduce cardiovascular morbidity in patients with manifest atherothrombotic cardiovascular disease, history of coronary heart disease, stroke or peripheral arterial disease) or type 2 diabetes mellitus with documented target organ damage.

Dalteparin: a single low molecular weight heparin for treatment of VTE in NHSGCC

Low molecular weight heparins (LMWHs) are currently the primary therapeutic class of medicines used to prevent and treat venous thromboembolism (VTE) in NHS Greater Glasgow & Clyde. All acute sites use a single LMWH agent for thromboprophylaxis, but the agent used for treatment differs from site to site. As many medical staff move from site to site as part of their career development path, the use of three agents for the treatment of VTE introduces potential clinical risk.

Current LMWH agents used to treat VTE in non-pregnant adults
• Dalteparin is used for the treatment of VTE by hospitals in the north and west of Glasgow.
• Tinzaparin is used for the treatment of VTE by hospitals in the south of Glasgow.
• Enoxaparin is used for all indications by hospitals in Clyde.

Why change?
Junior medical staff rotate between sites where different agents are used for different indications and this leads to the potential for prescribing error. If all sites use the same agent for the same indication, the risk is reduced. If a single agent is used for the treatment of VTE across all sites, only one set of dosing instructions needs to be remembered and the guidance in *Therapeutics: A Handbook for Prescribers* can be simplified.

Of course, there is a short-term risk associated with changing practice in those sites affected and a requirement for training to be developed and delivered.

Which product?
The *Formulary* team compared the licensed indications for enoxaparin, dalteparin and tinzaparin and the costs of each product. A wide consultation exercise was undertaken involving the NHSGGC Thrombosis Group, Prescribing Management Group and the Area Drug & Therapeutics Committee.

It has been agreed that dalteparin will be used in all acute sites for VTE treatment in non-pregnant adults. This switch will not affect medical and surgical thromboprophylaxis (which will remain as enoxaparin) or the choice of agent for cardiology indications.

The change will be happening in August to coincide with the new rotation of medical staff plus the new edition of *Therapeutics: A Handbook for Prescribers*. Look out for more details and educational packages coming your way before the switch takes place.

Reducing waste medicines

In *PostScript* 48 we highlighted plans for a campaign to attempt to reduce waste medicines. Estimates suggest that in NHSGGC £24 million is wasted every year: this could instead be used for one of the following:
• 4,000 hip or knee replacements,
• 3,000 heart by-pass operations,
• 620 physiotherapists or community nurses.

Trying to cut down on waste isn't just about cost. It is also desirable to avoid the storage of unnecessary medications in patients' homes to reduce the risk of unintentional overdose, improve safety, including safe storage away from children, and to ensure medicines are used in correct date order.

The Inverclyde CHP prescribing team offered medication review to patients in the reception areas of the Greenock and Port Glasgow Health Centres in January, using displays to highlight costs and waste. Almost £1,400 worth of waste medicines was returned to one local community pharmacy in one week.

New lipid guidelines and removal of ezetimibe from the *Formulary*

Ezetimibe has been removed from the *Formulary* following a review of the NHSGGC *Guidelines for the Use of Cholesterol Lowering Medication*. Ezetimibe is known to reduce cholesterol concentrations effectively but, unlike statins, it lacks end-point evidence. It has not shown any evidence of reducing morbidity or mortality and is not licensed for primary or secondary prevention of cardiovascular disease.

Approximately 6,000 people are prescribed ezetimibe in NHSGGC. Given the lack of evidence of impact on clinical outcomes and ezetimibe's removal from the *Formulary*, it would be appropriate to review its continued appropriateness for these patients. A prescribing indicator has been set in primary care. The target is aimed at the average cost of prescribing in NHSGGC and therefore the measure should encourage higher than average prescribers to undertake a review. For the purposes of the Quality Outcomes Framework of the General Medical Services contract, patients can be "exception reported" if they are intolerant of, or do not respond to, cholesterol lowering treatments within NHSGGC guidelines.

A few other changes have been made to the lipid lowering guideline during this most recent review and a brief summary is below.

For primary prevention

- Treatment should only be considered for patients with risk of cardiovascular events above 30% over 10 years. Joint British Societies risk tables should continue to be used to calculate risk until the results of validation exercises looking at the ASSIGN model are available.
- Simvastatin 40mg is the treatment of choice.
- There is no evidence to support up-titration from simvastatin 40mg or the use of additional drugs.
- There is no target for cholesterol in primary prevention.

For secondary prevention

- Start with simvastatin 40mg and titrate as required to atorvastatin 40mg then 80mg to achieve cholesterol <5mmol/l with at least 1mmol/l reduction.
- Atorvastatin 80mg is no longer recommended as first line treatment for patients with new onset acute coronary syndrome. The main trial of this intervention compared atorvastatin 80mg with pravastatin 40mg. The Prescribing Management Group concluded that the relatively small health gain in relation to the overall expenditure did not support its continued use in this clinical scenario.

More details on implementation of these changes will follow. The guideline will be available on our website or under Clinical Info on Staffnet.

Pharmacist-led COPD clinics in primary care

Following support from NHSGGC Long Term Conditions Steering and Prescribing Management Groups in 2009, Prescribing Support Pharmacists (PSPs) have focused on delivering medication reviews for people with COPD in 53 GP practices across NHSGGC. The service has shown a reduction in prescribing costs through waste reduction, patient education and optimisation of treatment in line with local and national guidelines for all COPD patients.

COPD clinics complement and enhance services already offered to COPD patients in their GP practice. Patients are seen in the surgery or in their home for a full medication review with particular emphasis on their respiratory condition and medicines. The clinics look at:

- optimising inhaled therapy,
- identifying ordering and concordance issues,
- assessing breathlessness and exacerbation history,
- smoking status,
- immunisation status,
- education, discussion and advice on self-management.

There are opportunities for referral to a wide range of other services such as smoking cessation, pulmonary rehabilitation, outreach spirometry, Live Active.

Feedback from patients has highlighted that one of the key strengths of the clinics is patient education, for example:

- encouraging the patient to use their salbutamol, rather than their salmeterol, inhaler when they become breathless,
- confirming that the patient is receiving the full dose of medication from their new Spiriva Handihaler® despite not feeling the sweet lactose powder that they taste when they inhale from their Seretide Accuhaler®,
- reassuring patients who cannot feel any obvious difference in their breathing that treatment aims to reduce exacerbations and hospital admissions.

Some patients who noticed big improvements in their ability to carry out daily activities after they started tiotropium increased their dose to twice daily "because it worked so well". Education about tiotropium and why it is necessary only once a day seems simple enough but can leave the patients feeling empowered, knowing that they have a clear understanding of the role of their medications.

Home visits allow a unique opportunity to see patients storing their medications above their cooker or in an open box where their grandchildren play. They also identify stockpiling of medicines such as a gentleman who had 9 Seretide® 500 Accuhalers sitting on his dining table. While he knew that he was to use the inhaler regularly, no-one had ever shown him how to use the 'strange looking' device.

Many COPD patients would benefit from regular follow-up and support with their inhaled therapy. While patients are often followed up by the PSPs, community pharmacy may have a role in monitoring and encouraging correct inhaler technique and knowledge as well as addressing over- and under-ordering issues which can lead to poor compliance (and onward to poor disease management) and/or stockpiling of these expensive medicines.

For further information contact your local CH(C)P Prescribing Team or the Central COPD team, Joanna Johnson and Allen O'Neill on 0141 201 5333.

Patient group directions *contd from page 1*

• make a supply under the existing emergency supply regulations.
• sell an appropriate over-the-counter preparation or give advice.
• arrange to have the patient seen at the local out-of-hours service.

The PGD has been operating across Scotland since December 2005 and pharmacies in NHSGGC are now dispensing more than 2,000 supplies each month. This figure peaks over the Easter and Festive periods with more than 3,000 supplies being made. This service enables patients who cannot access their prescription from the GP to obtain their medication during the out-of-hours period. By doing so, this helps to reduce the burden on NHS 24 and the out-of-hours service for unscheduled care. Work continues within the Board with the pharmacies, NHS 24 and out-of-hours to promote the service and ensure appropriate patient pathways and improve patient care.

For a full description of the introduction, development and use of PGDs, please see our website for a more detailed article.

Extra help in smoking cessation:

Dual nicotine replacement therapy (NRT)

The Scottish Government has set NHS Boards a target through the HEAT (Health Efficiency Access and Treatment) scheme to support 8% of their smoking population in successfully quitting (at one month post quit) over the period 2008/09 - 2010/11. This is a significant challenge as NHSGGC has a relatively high proportion of smokers. To try and achieve this target, an addition to the Smokefree Services (Pharmacy, Community & Acute) is being introduced.

From June 2010 (initially for three months), a second NRT product can be supplied to clients during weeks 1-4 if the client is still smoking. Support for this has been granted by the ADTC and the Tobacco Planning and Implementation Group. NHSGGC, like all Health Boards, is under considerable financial pressure and is therefore unable to support the prescribing of a second NRT product after week 4. The client can, of course, buy additional NRT after that time period.

Prescribing of NRT

Nicorette® patches are the product of choice. The Invisipatch® should only be prescribed when the 25mg strength is required as this is not available in the regular Nicorette range. The Invisipatches are around 10% more expensive than the standard patches and the SPC indicates that there is no difference in efficacy.

The following protocol applies to all service providers:

	≥10 cigarettes/day	<10 cigarettes/day
Weeks 1-8	Nicorette Invisipatch 25mg	Nicorette 15mg Patch
Weeks 9 &10	Nicorette 15mg Patch	Nicorette 10mg Patch
Weeks 11 & 12	Nicorette 10mg Patch	Nicorette 5mg Patch

Person still smoking during weeks 1-4 of programme:
• Nicorette gum or microtabs can be given in addition to the patches
• If these are unsuitable, Nicorette inhalator or nasal spray can be used second line.
• No products outwith the Nicorette range can be supplied.

Please remember that GPs should not routinely be prescribing NRT but suggesting that the patient either goes directly to any community pharmacy or seeks advice from the local smoking cessation adviser (0800 84 84 84).

"If I could change one thing . . ."

As the summer holidays approach, spare a thought for the impact that travel to exotic destinations has on already busy general practice staff. A Glasgow practice nurse suggests the following:

I would like to suggest that travel vaccines should not be available on the NHS. More and more patients are travelling further afield and travel vaccine appointments are becoming very complex. Patients frequently come to see me at very short notice and expect their vaccines to be given immediately. Many patients are not happy that they can't get antimalarials on prescription and are further outraged that they have to pay for a script for those vaccines which should not be supplied on the NHS. (See *PostScript Primary Care* July 2009 for travel prescribing information.)

Times are hard - so we keep being told - so why should travellers be allowed to have any of their travel vaccines paid for by the NHS? Shouldn't all travellers be made to attend a private travel clinic and pay for all their vaccines?

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Ezetimibe

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