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Integrated Care Board

WELCOME!
Non-Medical Prescribing Update for Barnsley
23 April 2025

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Introductions

Deborah Leese - Guest Speaker

Anna Young - South Yorkshire NMP/IP Development Lead

Emma Thompson – Nursing Director

Kel Tyers – Senior Pharmacist/ACP/NMP Development Lead

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Agenda

- Lunch
- Introductions – Kel Tyers
- South Yorkshire Hub Update – Emma Thompson and Anna Young
- Round table discussions – all
- Expanding Scope of Practice – Kel Tyers
- Tea Break
- Asthma clinical update – Deborah Leese

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Emma Thompson
Nursing Director

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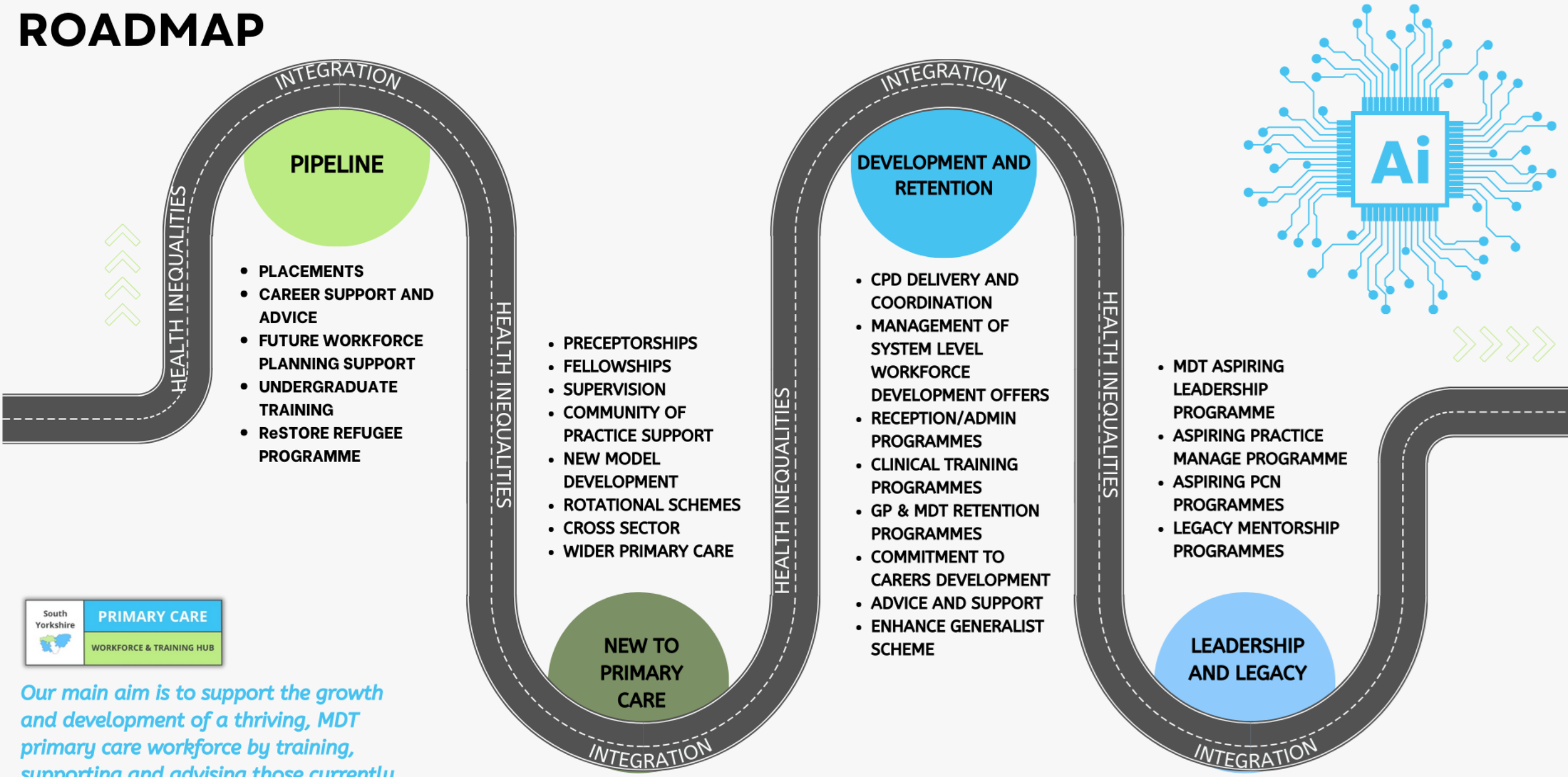
ROADMAP



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Our main aim is to support the growth and development of a thriving, MDT primary care workforce by training, supporting and advising those currently working, or hoping to work in primary care across South Yorkshire.

New to Practice Schemes for Nurses

VTS Preceptorship & Training 1 year Programme for new Practice Nurses (Autumn start)

NA Preceptorship & Training 1 year Programme for new Nursing Associates (Spring start – 8th May 2025)

HCA training sessions

Email: emma.thompson6@nhs.net

Nursing Times Workforce Summit & Awards Winner

2024 National Preceptorship for Nursing Quality Mark

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Could you host a student pharmacist on placement?

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The SY Primary Care Workforce & Training Hub in association with the University of Sheffield are looking for partner practices, Federations and PCNs who can host placements for student pharmacists from the new MPharm course.

University of Sheffield

A fantastic opportunity to:

- Support & shape the future pharmacy workforce
- Showcase primary care as a potential career path
- Receive a clinical tariff payment providing a small additional income stream

If your organisation can offer a supportive environment for a student to observe and learn then we'd love to hear from you!

To register your interest, please click on the QR code or to find out more email: pharmacy@sheffield.ac.uk

Help our primary care workforce to grow

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Fully funded CPD for nurses & AHPs:

including diplomas, face to face & virtual training days

- ✓ Anticoagulation training
- ✓ Asthma management (new guidelines)
- ✓ Dementia training
- ✓ Cervical Sample Taker Training
- ✓ Lifestyle Medicine
- ✓ Chronic disease training

See our website for more information

https://yhtraininghubs.co.uk/south-yorkshire/south-yorkshire-schemes/cpd-for-nurses-ahps/

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Thank you

Please get in touch for more information

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South Yorkshire Workforce and Training Hub

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Training Hubs

SharePoint Site

South Yorkshire

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Supporting and developing your prescribing practice

Anna Young (RGN, ANP, NMP development lead) & Kel Tyers (Pharmacist, ACP, NMP development lead SY)

Background

Improves patient care without compromising patient safety

Makes it easier for patients to get access to medicines needed

Increases patient choice in accessing medicines

Makes better use of our clinical skills.

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Hub Support

- Help organisations to understand their roles and responsibilities to NMP
- Provide a framework to support safe prescribing practice
- Education and Development of NMP practice
- Support applications for NMP

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Resources….

- SharePoint page: https://nhs.sharepoint.com/sites/msteams_85ed75/SitePages/Non-Medical-Prescribing-(NMP).aspx?CT=1673001680881&OR=OWA-NT&CID=94112470-06d2-3b81-6904-aee25ac289e2

- EOI for NMP: https://yhtraininghubs.co.uk/south-yorkshire/south-yorkshire-schemes/non-medical-prescribing/

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Thank you
Any Questions?

Round Table Discussions

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Round Table Discussions
Part 1

Expanding Scope of Practice

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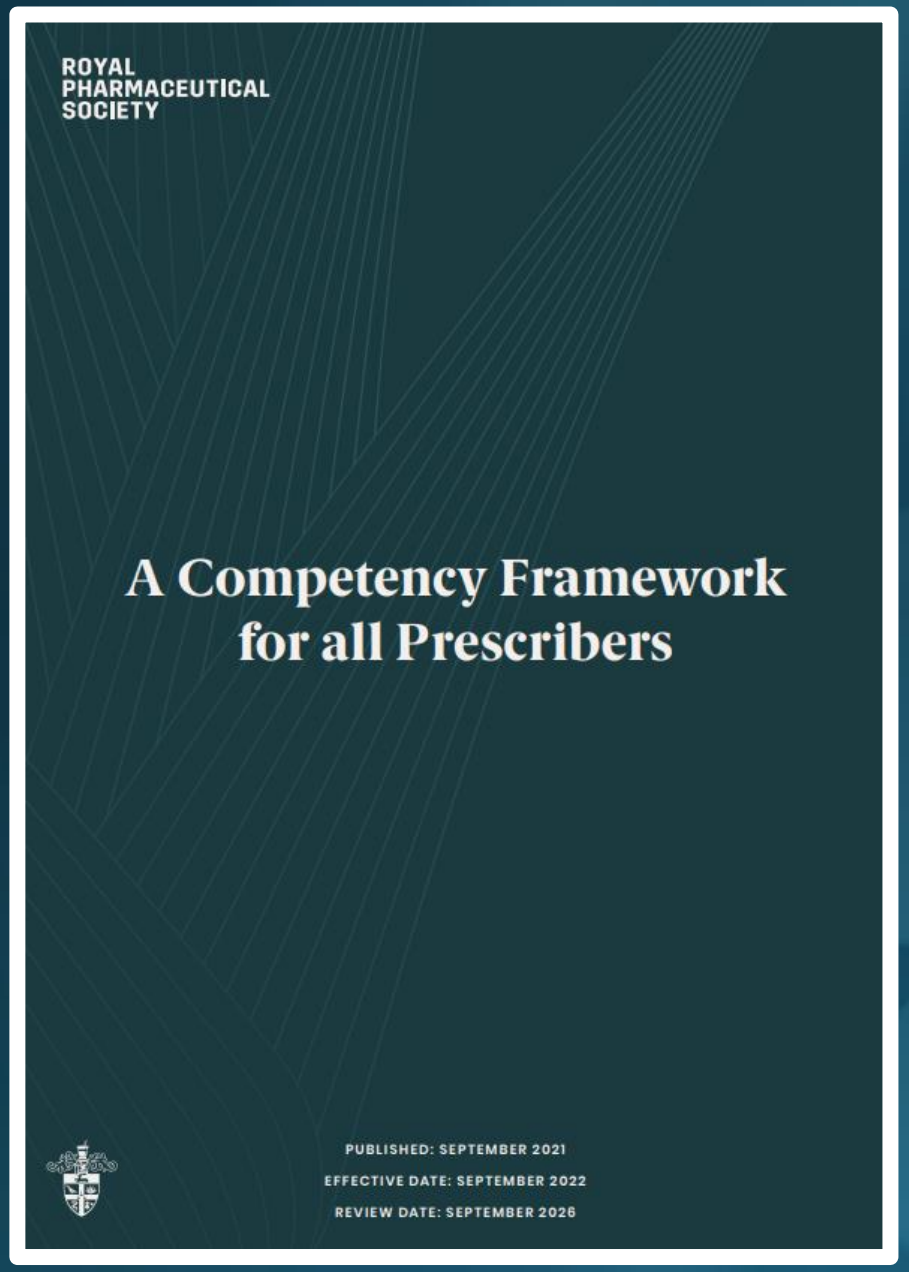
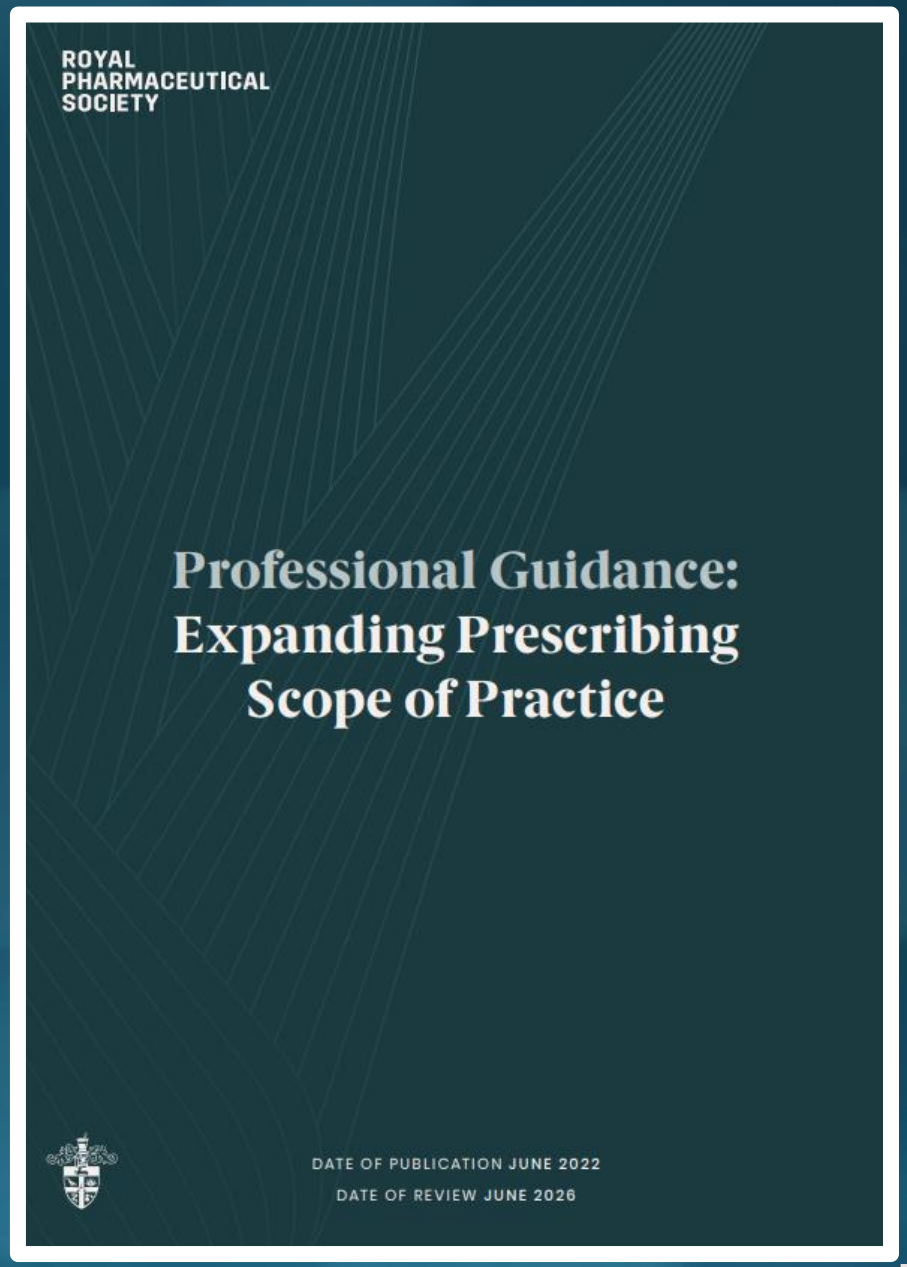
Guidance for Expanding Prescribing Scope of Practice

Kel Tyers
Reem El-Sharkawi





RPS English Competency Framework 3.pdf

RPS - Scope of Practice-English-220601.pdf

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EVENTS - PRESS PORTAL - Non Medical Prescribing 08.3.23

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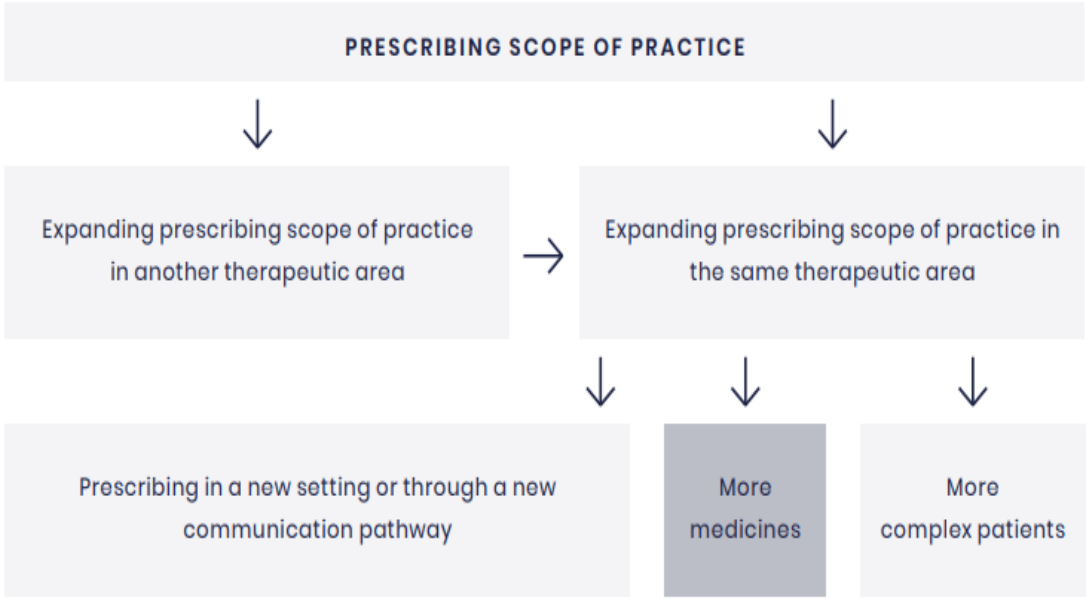
Timothy, Hospital Pharmacist

Timothy originally trained to prescribe warfarin to adult patients with atrial fibrillation. However, with management of patients with atrial fibrillation developing to include more anticoagulants, he wants to expand his prescribing scope of practice to include prescribing direct oral anticoagulants (DOACs) for adult patients.



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REFLECT

Timothy identified that many patients were being referred on for initiation of DOACs as an alternative treatment to warfarin. He identified that he would be in a good position to start or change treatment if appropriate.

His knowledge of atrial fibrillation was extensive, but he wanted to learn more about the management of atrial fibrillation in specific when DOACs can be used. He decided to focus his learning on the pharmacology aspect of these medicines.

PLAN

S – Timothy had good knowledge of atrial fibrillation. He wanted to focus his learning on the pharmacology aspect of DOACs learning more about the evidence-based treatment options available for clinical decision-making.

M – Timothy plans to carry out self-directed learning and also spend time shadowing cardiologist in atrial fibrillation clinic. He further plans to shadow another pharmacist who is already prescribing DOACs.

A – He feels it will be achievable as he understands anticoagulation in atrial fibrillation and he will focus more of his learning on the pharmacology aspect.

R – When Timothy discussed this with his colleague, consultant cardiologist, they felt he would be able to achieve it.

T – Due to his prior understanding and knowledge of atrial fibrillation, he was going to aim to start prescribing autonomously in 12 weeks after starting.

ACT

Timothy reflected on the guidelines for anticoagulation in atrial fibrillation, looking at NICE guidelines and also local formulary with regards to the DOACs available. Further NICE guidance was studied with regards to specific DOACs.

Timothy carried out an eLearning module on DOACs.

Timothy looked at various resources including the BNF, SPC (Rivaroxaban, Dabigatran, Apixaban and Edoxaban)

Shadowed consultant cardiologist during a 4 week period in clinics where patients would be initiated on DOACs. For a further 8 weeks, Timothy identified and initiated patients on DOAC treatment where necessary, under the supervision of the consultant cardiologist.

Timothy attended a conference where there were lectures on prescribing DOACs for patients with Atrial Fibrillation.

Timothy researched the literature and read multiple papers surrounding DOACs.

Timothy gave an education session on DOACs to his colleagues.

Timothy identified resources available to help patients in understanding their anticoagulation treatment (Rivaroxaban, Dabigatran, Apixaban and Edoxaban)

EVALUATE

Timothy discussed his expanded prescribing scope of practice with a cardiology consultant who specialised in anticoagulation. Both felt that all the initial competencies identified in competency framework had been met. Ongoing support was offered for Timothy. Timothy also plans to join a journal club.

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Round Table Discussions
Part 2

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Any Questions?

Refreshment Break

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Clinical Session - Asthma

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An Asthma Revolution

Deborah Leese

Senior Pharmacist Clinical Lead Respiratory (SYICB)

Co-Clinical Lead CYP Asthma (SYICB)

Boy, 10, died suddenly after 'feeling fine' as asthma attack deaths skyrocket by 25%

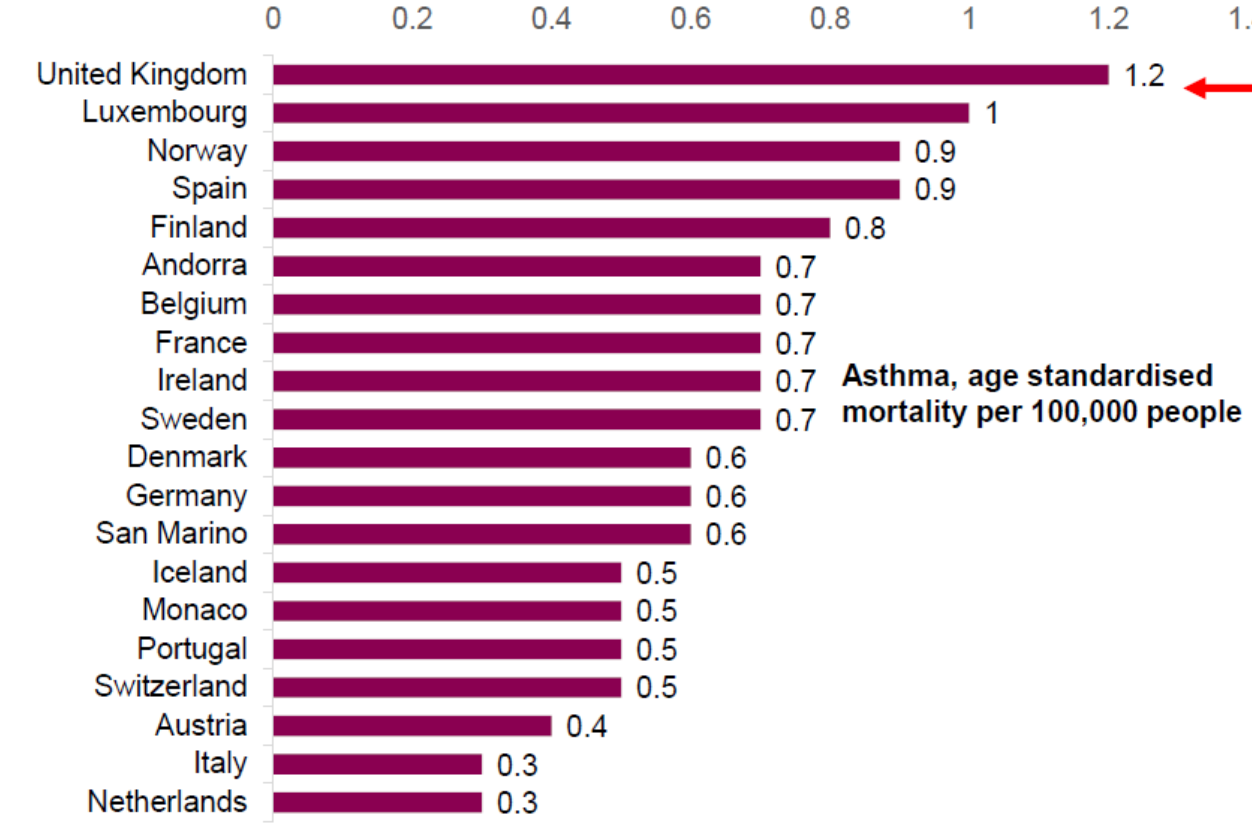
Asthma: Action needed on needless deaths, says charity

Charity warns asthma care at 'standstill' as grieving family calls for awareness

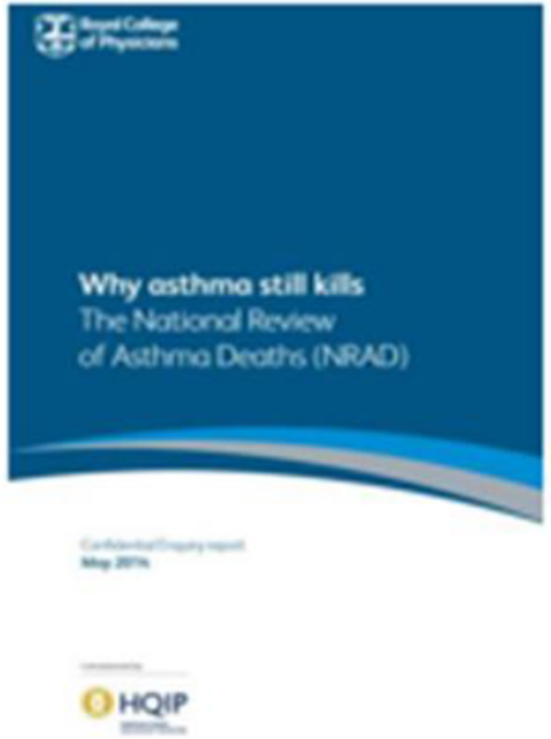
BBC NEWS

Mother makes asthma plea following daughter's sudden death

Age-standardised asthma mortality rate for the Western European Region in 2019[1*]



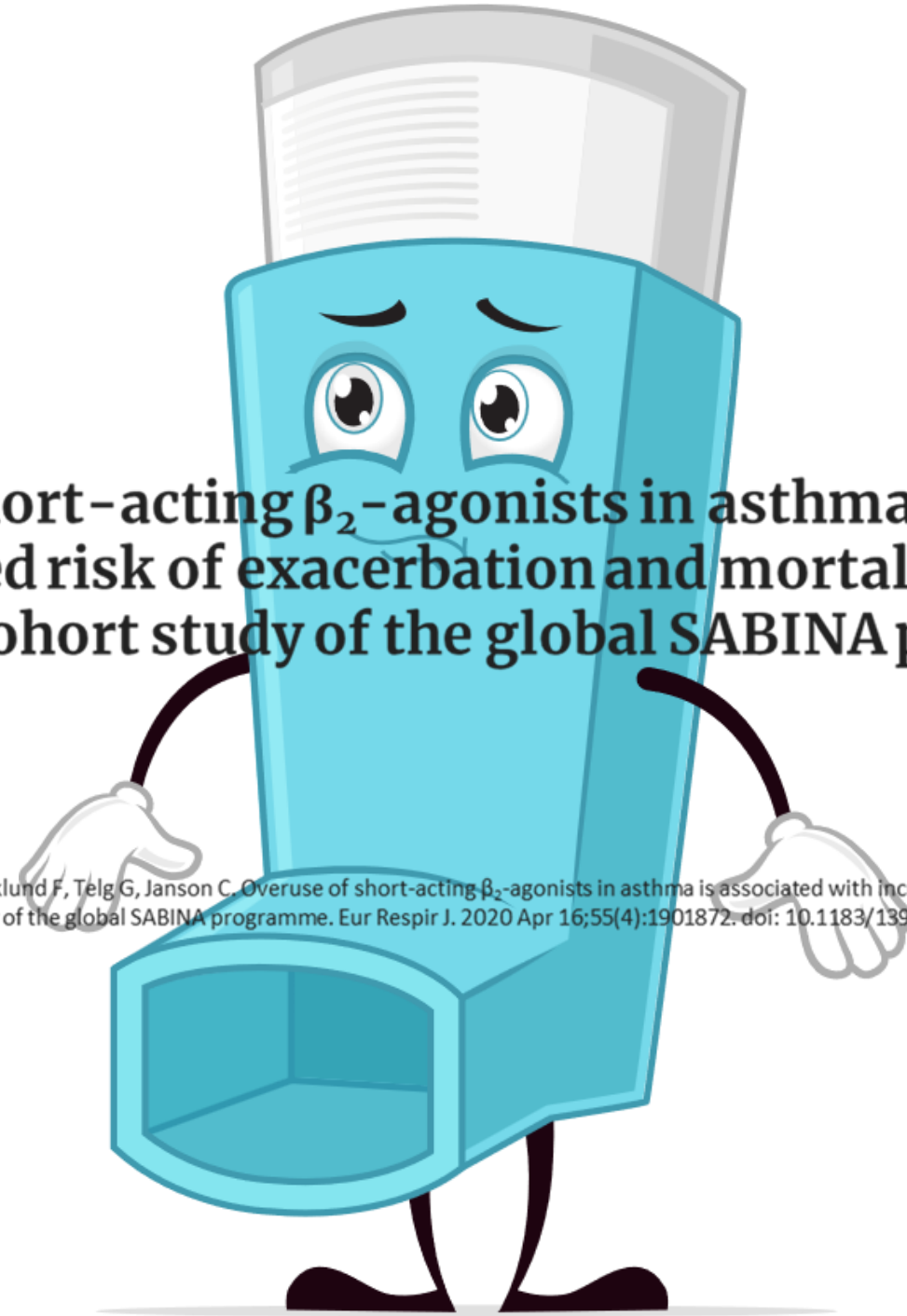
It is estimated that 2/3 of the UKs asthma deaths are preventable[2]



Adapted from: International Respiratory Coalition[1]

*The mortality rate shows the number of deaths per 100,000 people within the year. The rate is age standardised, which means it provides a weighted average that controls for differing age distributions between countries.1. International Respiratory Coalition. Asthma. Available from: https://international-respiratory-coalition.org/diseases/asthma/ (Accessed January 2024); 2. NRAD Royal College of Physicians (2014). Why asthma still kills. The National Review of Asthma Deaths (NRAD). Available at: https://www.rcplondon.ac.uk/projects/outputs/why-asthma-still-kills [Accessed January 2024].

Overuse of short-acting β_2-agonists in asthma is associated with increased risk of exacerbation and mortality: a nationwide cohort study of the global SABINA programme



Nwaru BI, Ekström M, Hasvold P, Wiklund F, Telg G, Janson C. Overuse of short-acting β_2-agonists in asthma is associated with increased risk of exacerbation and mortality: a nationwide cohort study of the global SABINA programme. Eur Respir J. 2020 Apr 16;55(4):1901872. doi: 10.1183/13993003.01872-2019. PMID: 31949111; PMCID: PMC7160635.

The coroner concluded that: ”William Gray died as a consequence of failures by healthcare professionals to recognise the severity and frequency of his asthma symptomatology and the consequential risk to his life that was obvious. William’s death was contributed to by neglect. William’s death was avoidable. There were multiple failures to escalate and treat William’s very poorly controlled asthma by healthcare professionals that would and should have saved William’s
life.”

Source

https://www.judiciary.uk/prevention-of-future-death-reports/william-gray-prevention-of-future-deaths-report/

What does good asthma control look like?

- No daytime symptoms
- No waking at night due to asthma
- No need for rescue medication
- No asthma attacks
- No limitation on activity inc exercise

The risks of ‘mild’ asthma

Patients with apparently mild asthma are still at risk of serious adverse events

30–37% of adults with acute asthma

16% of patients with near-fatal asthma

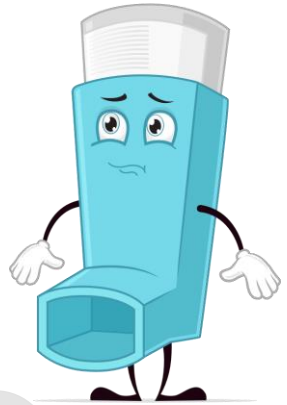
15–27% of adults dying of asthma

Had symptoms less than weekly in the previous 3 months (Dusser et al Allergy 2007)

Exacerbation triggers are unpredictable (viruses, pollens, pollution, poor adherence)

Even 4–5 lifetime OCS courses increase the risk of osteoporosis, diabetes, cataract *(Price et al, J Asthma Allerg 2018)*

Why shouldn’t we treat with SABA alone?



Inhaled SABA has been first-line treatment for asthma for 50 years

- Asthma was thought to be a disease of bronchoconstriction
- Role of SABA reinforced by rapid relief of symptoms and low cost

Regular use of SABA, even for 1–2 weeks, is associated with increased AHR, reduced bronchodilator effect, increased allergic response, increased eosinophils *(e.g. Hancox, 2000; Aldridge, 2000)*

- Can lead to a vicious cycle encouraging overuse
- Over-use of SABA associated with ↑ exacerbations and ↑ mortality *(e.g. Suissa 1994, Nwaru 2020)*

EDITORIAL
GINA 2019

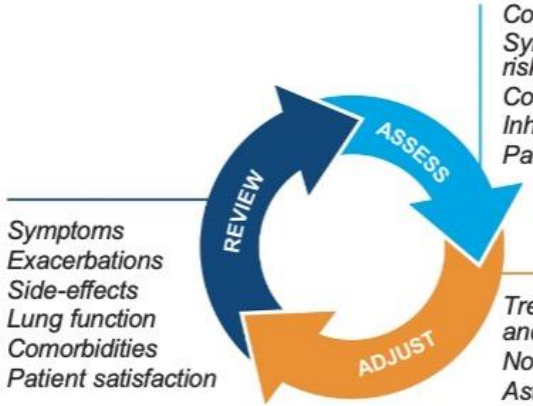
GINA 2019: a fundamental change in asthma management

Treatment of asthma with short-acting bronchodilators alone is no longer recommended for adults and adolescents

Helen K. Reddel[1], J. Mark FitzGerald[2], Eric D. Bateman[3], Leonard B. Bacharier[4], Allan Becker[5], Guy Brusselle[6], Roland Buhl[7], Alvaro A. Cruz[8], Louise Fleming[9], Hiromasa Inoue[10], Fanny Wai-san Ko[11], Jerry A. Krishnan[12], Mark L. Levy[13], Jiangtao Lin[14], Søren E. Pedersen[15], Aziz Sheikh[16], Arzu Yorgancioglu[17] and Louis-Philippe Boulet[18]

GINA 2024 – Adults & adolescents 12+ years

Personalized asthma management
Assess, Adjust, Review
for individual patient needs



Confirmation of diagnosis if necessary
Symptom control & modifiable risk factors (see Box 2-2)
Comorbidities
Inhaler technique & adherence
Patient preferences and goals

Symptoms
Exacerbations
Side-effects
Lung function
Comorbidities
Patient satisfaction

Treatment of modifiable risk factors and comorbidities
Non-pharmacological strategies
Asthma medications including ICS (as below)
Education & skills training

TRACK 1: PREFERRED CONTROLLER and RELIEVER
Using ICS-formoterol as the reliever* reduces the risk of exacerbations compared with using a SABA reliever, and is a simpler regimen

STEPS 1 – 2	STEP 3	STEP 4	STEP 5
As-needed-only low dose ICS-formoterol	Low dose maintenance ICS-formoterol	Medium dose maintenance ICS-formoterol	Add-on LAMA Refer for assessment of phenotype. Consider high dose maintenance ICS-formoterol, ± anti-IgE, anti-IL5/5R, anti-IL4Rα, anti-TSLP

RELIEVER: As-needed low-dose ICS-formoterol*

See GINA severe asthma guide

TRACK 2: Alternative **CONTROLLER and RELIEVER**
Before considering a regimen with SABA reliever, check if the patient is likely to adhere to daily controller treatment

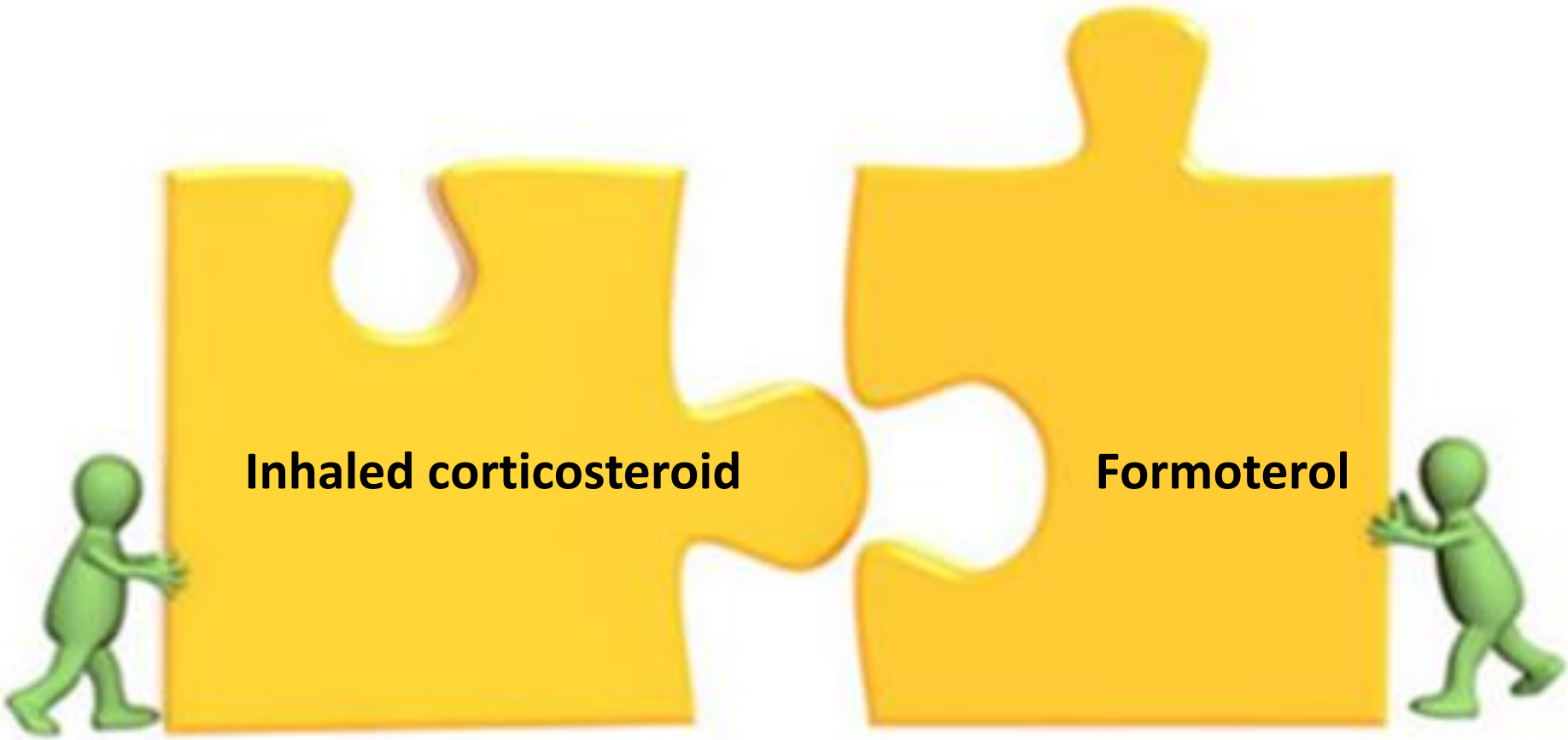
STEP 1	STEP 2	STEP 3	STEP 4	STEP 5
Take ICS whenever SABA taken*	Low dose maintenance ICS	Low dose maintenance ICS-LABA	Medium/high dose maintenance ICS-LABA	Add-on LAMA Refer for assessment of phenotype. Consider high dose maintenance ICS-LABA, ± anti-IgE, anti-IL5/5R, anti-IL4Rα, anti-TSLP

RELIEVER: As-needed ICS-SABA*, or as-needed SABA

Other controller options (limited indications, or less evidence for efficacy or safety – see text)

Low dose ICS whenever SABA taken, or daily LTRA†, or add HDM SLIT*	*Medium dose ICS, or add LTRA†, or add HDM SLIT*	*Add LAMA or add LTRA† or add HDM SLIT, or switch to high dose ICS-only*	*Add azithromycin (adults) or add LTRA†. As last resort consider adding low dose OCS but consider side-effects*

*Anti-inflammatory reliever; †advise about risk of neuropsychiatric adverse effects


Inhaled corticosteroid
Formoterol

ANTI-INFLAMMATORY RELIEVER THERAPY

A SINGLE INHALER FOR AS NEEDED USE IN ASTHMA

Benefits of As-needed low dose Budesonide-formoterol in mild asthma – what the data tells us…..

Compared with As-Needed SABA:

The risk of severe exacerbations was reduced by 60–64% (SYGMA 1, Novel START)

Compared with maintenance low dose ICS:

The risk of severe exacerbations was similar (SYGMA 1 & 2), or lower (Novel START, PRACTICAL)

Average ICS dose was ~50–100mcg budesonide/day

Benefits of Anti-inflammatory Reliever Therapy

Reduced exacerbations

Lower doses of ICS required for same level of control

One inhaler

- Simple
- One prescription charge
- Changing the inhaler not the behavior

Useful for patients with infrequent symptoms

Useful if compliance to regular daily dosing is a problem

Can be used from 12 years of age

MAINTAINANCE AND RELIEVER THERAPY (MART)

A SINGLE INHALER FOR DAILY TREATMENT AND ADDITIONAL AS NEEDED USE IN ASTHMA

Benefits of MART – what the data tells us…..

Beclometasone/formoterol MART significantly increased time to first severe exacerbation by 75 days vs Bec/For BD plus SABA as needed[1]

No. of days with mild asthma exacerbations lower[1]

Average daily dose = 2.8 puffs`

. Papi A, et al. Lancet Resp Med 2013;1:23-31

Benefits of MART

Reduced exacerbations

Reduced oral corticosteroid use

One inhaler

- Simple
- One prescription charge

Useful for patients having symptoms most days

Doesn't rely totally on patient being compliant to regular doses

Can be used from 12 years

- NB Beclometasone/ formoterol containing inhalers licensed 18+

Treatment Algorithm 1 – Flexible Regimen (for Adults and Children 12+)

GINA and locally preferred approach Step up if control not achieved → consider step down if appropriate ⇢

START HERE for mild asthma with infrequent symptoms

START HERE if symptoms most days or waking with asthma once a week

AS NEEDED ANTI-INFLAMMATORY (ICS/FORMOTEROL) RELIEVER*

Symbicort® 200/6 Turbohaler® 1 puff PRN (up to 8 puffs daily - rarely 12 puffs) age 12+

This step is intended for infrequent symptoms – regular use indicates step up is required

Patients using 4 or more puffs/day persistently require review – step up or add on treatment may be required

Seek urgent medical advice if you are unwell or needing 8 or more puffs a day

Low dose ICS/FORMOTEROL (MART)

Symbicort® 200/6 Turbohaler® 1 puff BD and PRN (up to 8 puffs daily - rarely 12 puffs) age 12+

Fobumix® Easyhaler 160/4.5 1 puff BD and PRN (up to 8 puffs daily - rarely 12 puffs) age 18+

Fostair® 100/6 NEXThaler or pMDI 1 puff BD and PRN (up to 8 puffs daily) age 18+

Seek medical advice if using additional rescue doses (above usual maintenance dose) persistently

Seek urgent medical advice if you are unwell or needing 8 or more puffs a day

Medium Dose ICS/FORMOTEROL (MART)

Symbicort® 200/6 Turbohaler® 2 puffs BD and PRN (up to 8 puffs daily - rarely 12 puffs) age 12+

Fobumix® Easyhaler 160/4.5 2 puffs BD and PRN (up to 8 puffs daily - rarely 12 puffs) age 18+

Fostair® 100/6 NEXThaler or pMDI 2 puffs BD and PRN (up to 8 puffs daily) age 18+

Seek medical advice if using additional rescue doses (above usual maintenance dose) persistently

Seek urgent medical advice if you are unwell or needing 8 or more puffs a day

High Dose ICS/LABA (Not MART) or add on

Consider trial of high dose ICS/LABA + SABA PRN (not MART regime)

Consider additional add on therapy if not previously tried

Refer for specialist care

High doses should only be used after referring the patient to secondary care

All patients on high dose ICS should receive a Steroid Emergency Card

SABA and Flexible Regimens

In some occasional instances, patients using flexible dosing regimes may have an in-date SABA pMDI (plus spacer) reserved for emergency use only, however for MOST patients flexible dosing regimens should be SABA free

For emergency treatment of acute asthma, a patient may take up to 6 puffs of ICS/formoterol at any one time (1-minute intervals) – if 6 puffs do not relieve symptoms seek urgent medical advice

Maintenance and Reliever Therapy (MART)

Stop SABA inhaler and remove from repeats

Important - See MART Regimes – further information

Seek medical advice if using additional rescue doses (above usual maintenance dose) persistently

Additional Information for Flexible Regimens

This flexible regimen is based on recommendations from 2023 GINA Report, Global Strategy for Asthma Management and Prevention

*Only Symbicort 200/6 Turbohaler has a licence to be used as a reliever alone without regular maintenance doses

The use of other ICS/formoterol inhalers as reliever alone (without maintenance ICS/formoterol too) is off-licence

Consider Montelukast#

Age 15+ 10mg OD

Age 12-14 chewable tab 5mg OD

Do not give montelukast 10mg tabs to children < 15 years of age

Consider patient factors: patient preference, compliance with inhaled ICS and oral therapy, prescription charges.

Review treatment at 4-8 weeks – stop if no response. Step up inhaled therapy if required

If response seen but control remains inadequate, continue montelukast and step-up inhaled therapy

Consider trials of add on therapy

Montelukast# – see above

LAMA for age 18+

If MART used - add Spiriva® Respimat®.

For high dose regimes add Spiriva® Respimat® or change to closed triple ICS/LABA/LAMA with asthma licence (Trimbow® pMDI/Enerzair®)+

If LAMA considered for age <18, please refer patient to SCH

+ Trelegy Ellipta does NOT have asthma licence #Caution Montelukast – Reminder of the risk of neuropsychiatric reactions

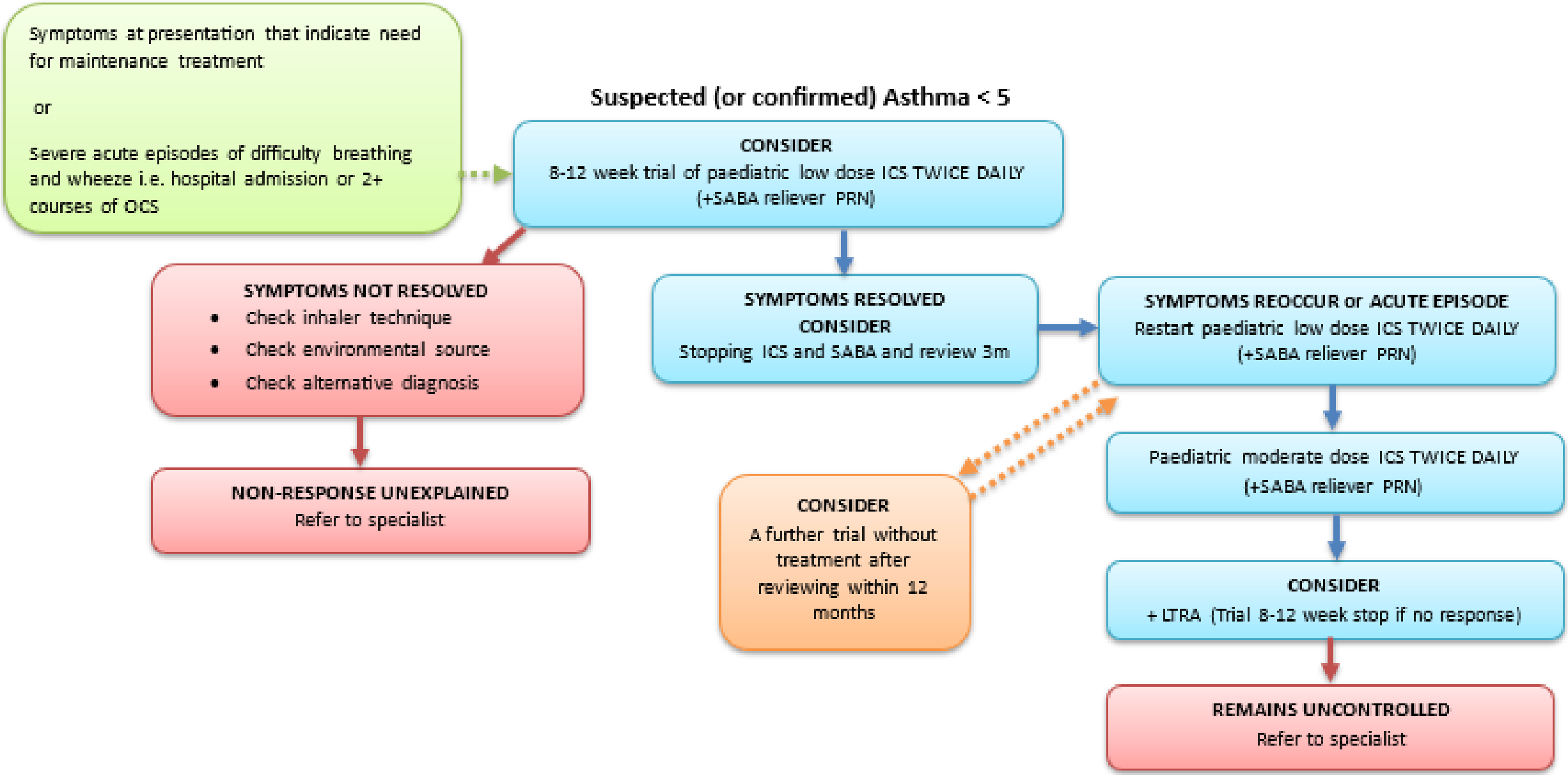

CHANGE

NICE National Institute for Health and Care Excellence

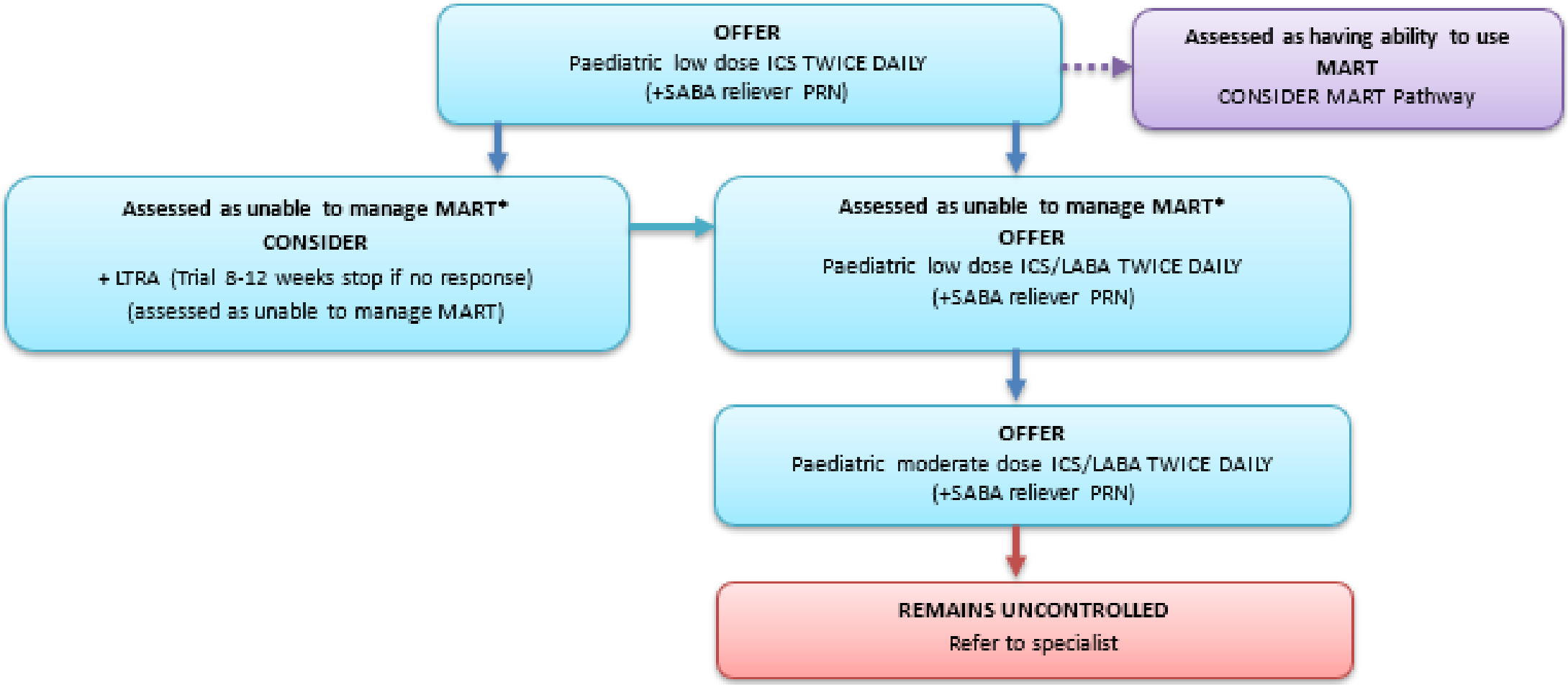
British Thoracic Society

Healthcare Improvement Scotland | SIGN

“Do not prescribe short-acting beta2 agonists to people of any age with asthma without a concomitant prescription of an ICS.” [BTS/NICE/SIGN 2024]

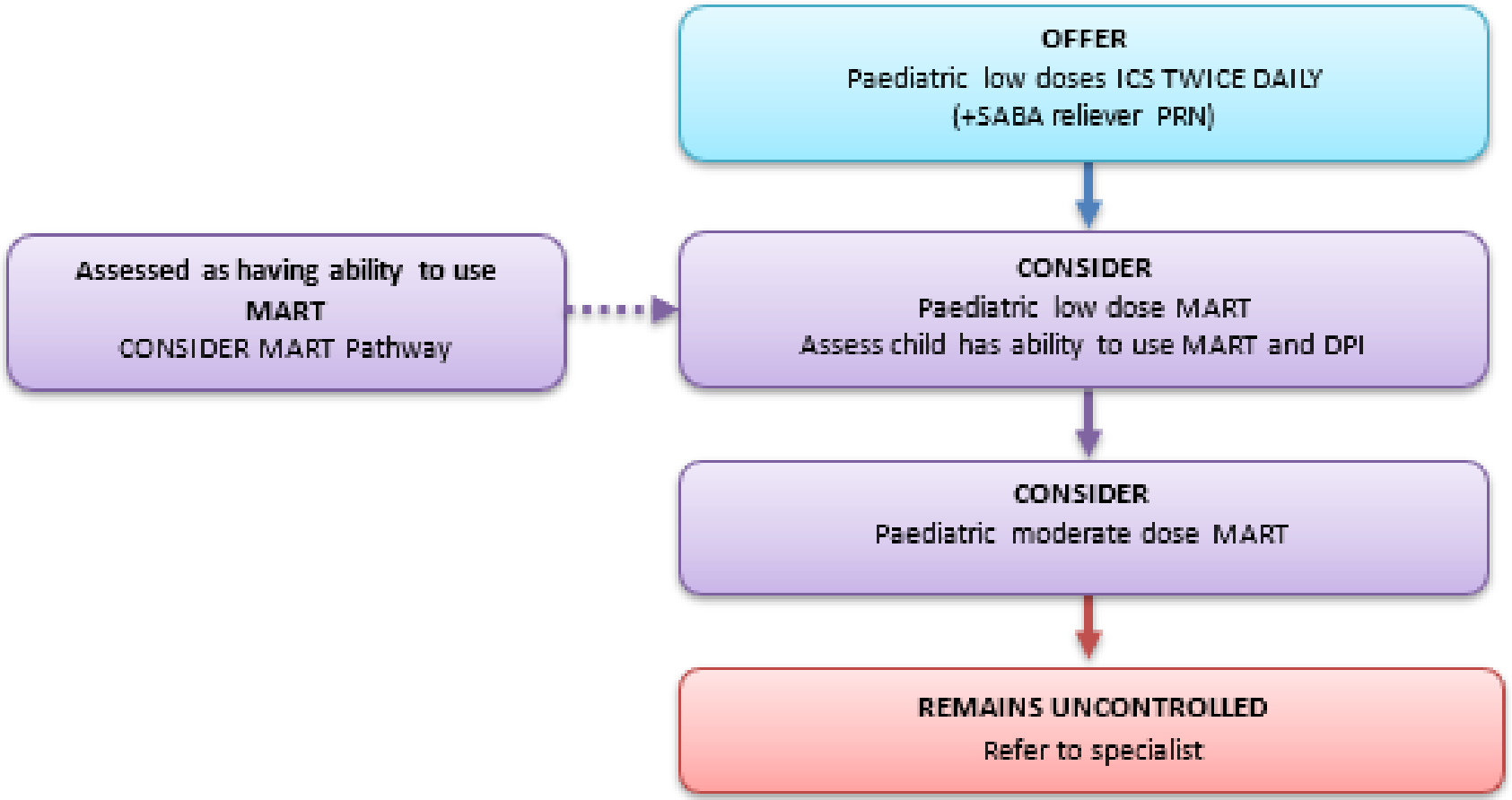

Symptoms at presentation that indicate need for maintenance treatment
or
Severe acute episodes of difficulty breathing and wheeze i.e. hospital admission or 2+ courses of OCS
Suspected (or confirmed) Asthma < 5
CONSIDER
8-12 week trial of paediatric low dose ICS TWICE DAILY (+SABA reliever PRN)
SYMPTOMS NOT RESOLVED
Check inhaler technique
Check environmental source
Check alternative diagnosis
NON-RESPONSE UNEXPLAINED
Refer to specialist
SYMPTOMS RESOLVED
CONSIDER
Stopping ICS and SABA and review 3m
CONSIDER
A further trial without treatment after reviewing within 12 months
SYMPTOMS REOCCUR or ACUTE EPISODE
Restart paediatric low dose ICS TWICE DAILY (+SABA reliever PRN)
Paediatric moderate dose ICS TWICE DAILY (+SABA reliever PRN)
CONSIDER
+ LTRA (Trial 8-12 week stop if no response)
REMAINS UNCONTROLLED
Refer to specialist

Children 5-11 Diagnosed Asthma Conventional Pathway



* MART pathway currently off label for this age group

Children 5-11 Diagnosed Asthma MART Pathway (MART = OFF LABEL)



Paediatric low dose MART?

Budesonide/formoterol 100/6 DPI

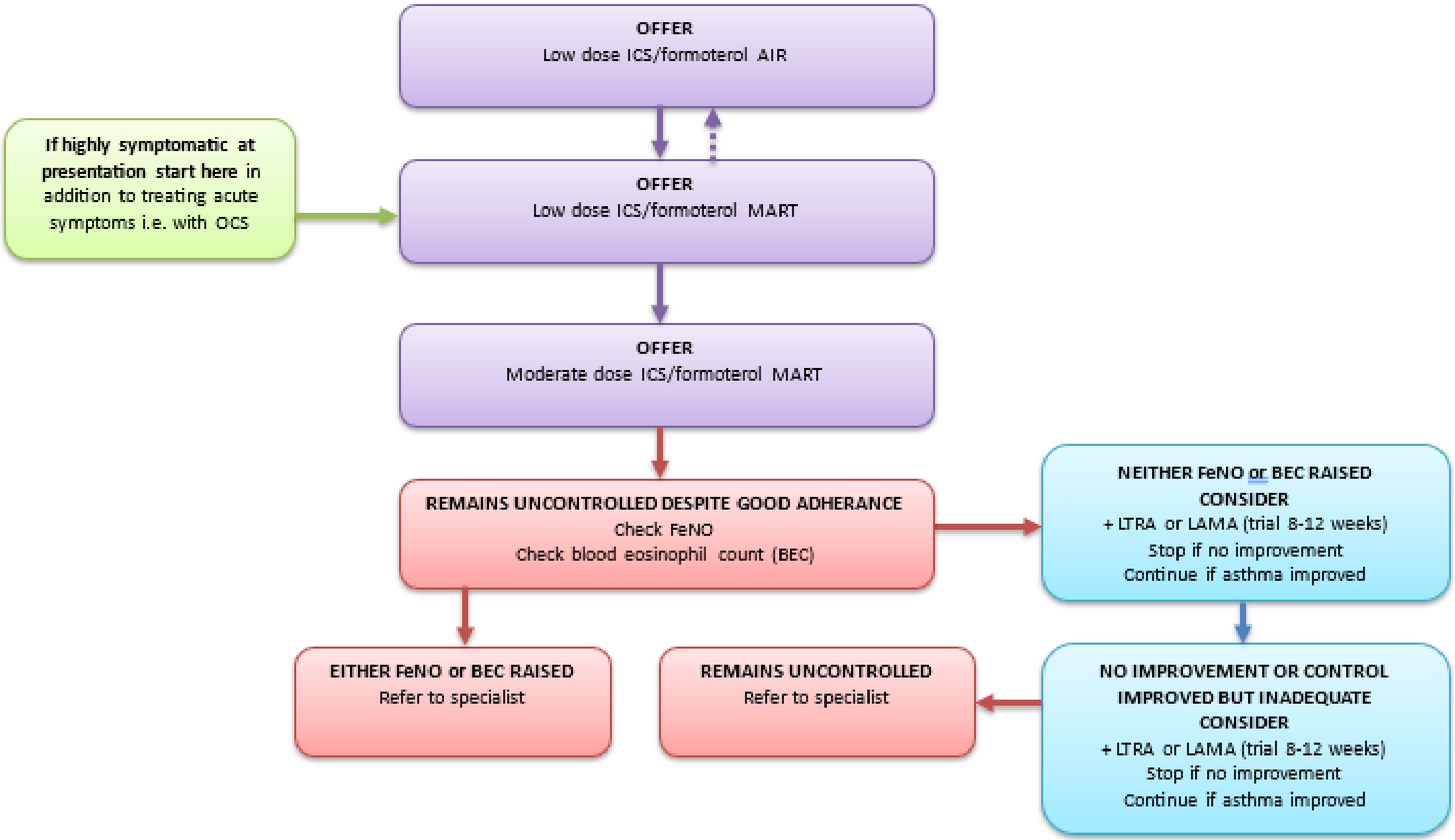
1 puff BD plus 1 additional puff in response to symptoms

Total daily max – 8 puffs (12 inhalations for limited period)

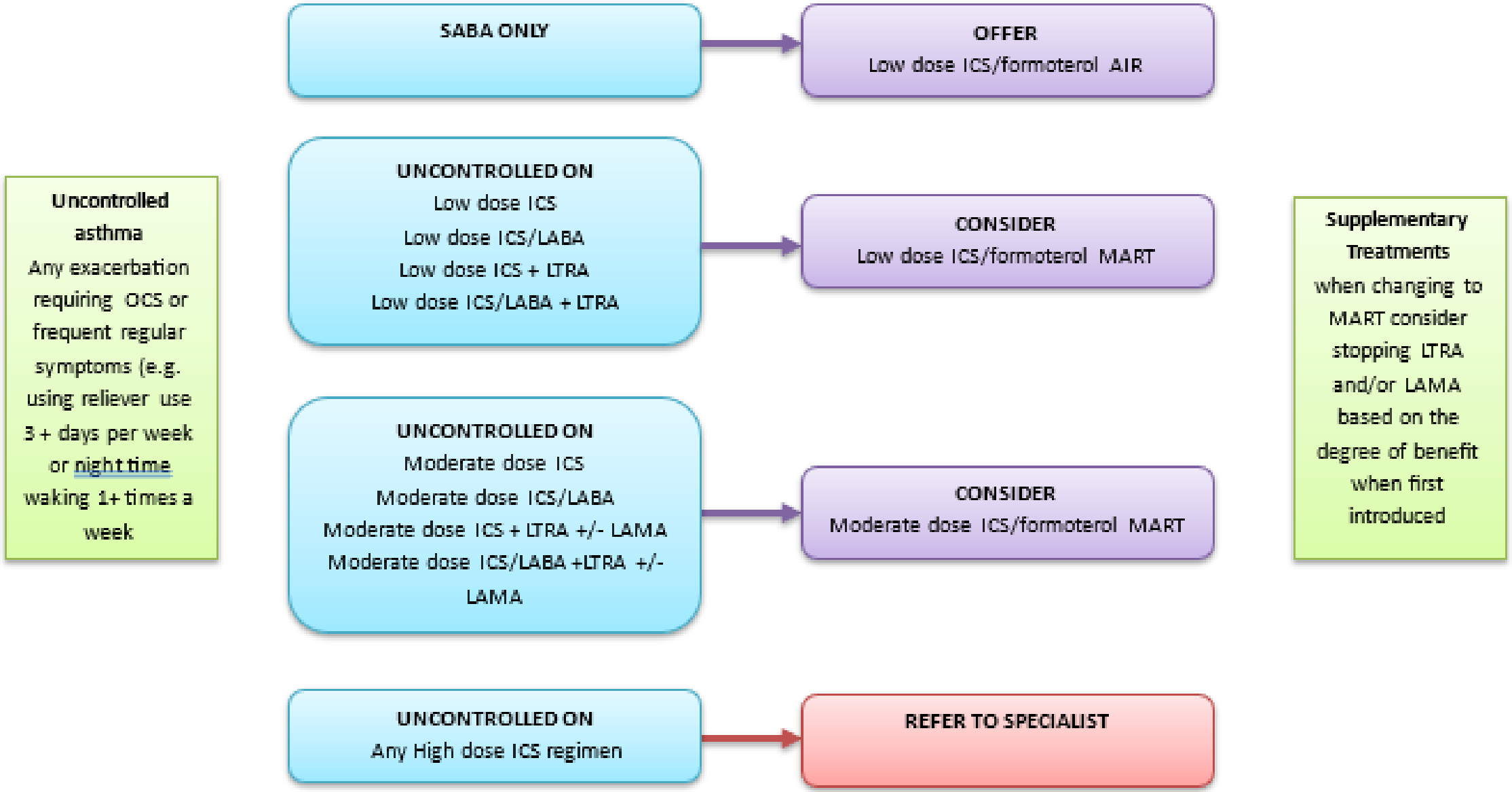
Not more than 6 puffs on a single occasion

Patients using 8 inhalations should be strongly recommended to seek medical advice

Adults and Adolescents 12+

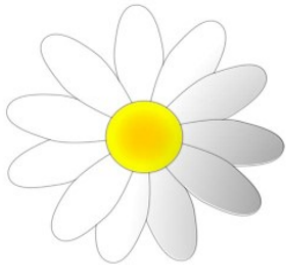


People on an Existing Pathway




OH WOW!
PARADIGM SHIFT!

DAISY Project Barnsley



Signed up or Completed	Engaging	Still to Engage	Other
Hollygreen Practice	BHF Goldthorpe Medical Centre	Lundwood Medical Centre	White Rose/Rose Tree PMS practice (declined)
The Kokoty Practice	Victoria Medical Centre	Dearne Valley Group Medical Practice	The Grove Medical Practice (declined)
Hoyland First	Brierley Medical Centre	Grimethorpe Surgery	
Hoyland Medical Centre	BHF Highgate Surgery	Chapelfield Medical Centre	
Huddersfield Road Surgery	BHF Lundwood	Monk Bretton Health Centre	
Burleigh Medical Centre	The Dove Valley Practice		

NHS
South Yorkshire
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Non-Medical Prescribing Support
Contact Details

NHS
South Yorkshire
Integrated Care Board

Anna Young: a.young@nhs.net
Kel Tyers: kelly.tyers@nhs.net

Non-Medical Prescribing Support Share Point Page

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Resources to Support your Prescribing

[Non-Medical Prescribing (NMP) (sharepoint.com)]