NHS
Milton Keynes Clinical Commissioning Group

PRESCRIBING NEWS

February 2021

CCG Prescribing Group 13th January 2021

A virtual meeting was held to discuss several topics:

- Practices were congratulated on their progress with Covid-19 vaccinations
- The first meeting of the BLMK Prescribing Committee has taken place with Dr Fagan representing MK GPs. It will be the decision making committee with the local Prescribing Group acting in an advisory role.
- Targets for the 2021-22 Prescribing Incentive Scheme were discussed. This will now go to BLMK Prescribing Committee for sign off before being sent out to practices.
- It was confirmed that payments for the 2020-21 Prescribing Incentive Scheme will be protected with practices receiving the same level of payment as last year (unless their score has risen, then they will receive the appropriate payment for the number of points).
- The Group discussed the opportunity for external support to review patients with Atrial Fibrillation. More information for practices will be available at a later date.

Milton Keynes Prescribing Advisory Group (MKPAG) 27th January 2021

The meeting was cancelled but decisions are being made via email consultation.

- Addition to the formulary – Invicorp for erectile dysfunction – second line to oral ED medicines and on the recommendation of a consultant with initiation undertaken in secondary care and used within licensed indication. Amber 3
- Addition to the formulary – Visuxl eye gel – Amber 2 in line with local guidance.
- An application for wider use of Entresto was not approved at this stage and requires further discussion.
- The Primary Care Antimicrobial Guidance has been updated in line with the most recent NICE Guidance. The document will be circulated to practices shortly and placed on the formulary website.
- A policy was approved to support shared care for children on complex medicines such as antiepileptics.

Minutes of MKPAG and CCG Prescribing Group meetings can be found on the formulary website
https://www.formularymk.nhs.uk/Default.asp

MHRA Safety Alerts

Erythromycin – two cautions

https://www.gov.uk/drug-safety-update/erythromycin-caution-required-due-to-cardiac-risks-qt-interval-prolongation-drug-interaction-with-rivaroxaban

The MHRA has warned that erythromycin has been associated with events secondary to QT interval prolongation such as cardiac arrest and ventricular fibrillation. Erythromycin should not be given to patients with a history of QT interval prolongation or ventricular cardiac arrhythmia, including torsades de pointes, or patients with electrolyte disturbances. The product information for clarithromycin also includes warnings regarding the risk of QT interval prolongation and fatal arrhythmia.

In addition, a potential drug interaction between rivaroxaban and erythromycin resulting in increased risk of bleeding has also been identified.

Erythromycin and clarithromycin inhibit CYP3A4 and P-gp and can lead to an increase in the maximum blood concentration of rivaroxaban. The product information for rivaroxaban advises that the interaction with erythromycin can lead to potential increased bleeding risk in high-risk patients, especially in those with mild or moderate renal impairment.

Rivaroxaban is not the only direct-acting oral anticoagulant (DOAC) to interact with macrolides such as erythromycin. For edoxaban, the product information recommends a reduced dose of 30mg a day for patients on concomitant erythromycin. For dabigatran and apixaban the product information states that concomitant administration of P-gp inhibitors (and for apixaban, also CYP3A4 inhibitors) is expected to result in increased plasma concentrations and that blood concentrations were raised when used concomitantly with another macrolide, clarithromycin.

All patients prescribed DOACs, including those also on macrolides, should be informed of the signs and symptoms of bleeding and be advised to seek medical advice should they occur (see Drug Safety Update from June 2020). Follow guidance on dosing of DOACs in patients with renal impairment and monitor renal function during treatment to ensure dose remains appropriate.

Prescribing Safely – a reminder

Ticagrelor and simvastatin

Please note that if **Ticagrelor** is co-administered with **simvastatin,** the maximum dose of simvastatin should be 40mg as plasma concentrations of simvastatin are moderately increased by ticagrelor. Please advise people to report any unexplained muscle pain, tenderness or weakness.

Decline messages on OptimiseRx

OptimiseRx messages include logic algorithms based on coding within the patient record meaning that messages appear when specified criteria are met. Wherever possible and in particular, when prescribing antibiotics for acute infections, it is advised that the presenting complaint is entered into the record before prescribing. This will help to ensure that OptimiseRx messages only appear when relevant to a specific patient/scenario and thus reduce the number of messages that the prescriber sees.

For example, we have noticed that in response to the following message '*Review use of co-amoxiclav; consider a first-line antibiotic'*, a number of prescribers have entered rejection reasons to indicate they are using for indications such as 'animal bites' or 'pyelonephritis'. This message contains logic exclusions for valid first-line indications (community acquired pneumonia, pyelonephritis, facial or unspecified cellulitis, acute exacerbation of COPD and previously prescribed antibiotics for COPD within 3 months, rhinosinusitis, diverticular disease, human bite, cat or dog bite within 1 month, or infective exacerbation of bronchiectasis) so if any of these are coded before prescribing co-amoxiclav, the OptimiseRx message will not appear.

The majority of prescribers are selecting one of the TPP default reasons for rejecting messages, which does not provide us with much useful information to gauge why the messages are being declined. Whilst we understand the reason for this may be speed, if we have more information about the reason, it is likely that the messages could be disabled or additional patient criteria added to stop the message firing so often. However, some information is better than none.

Homely Remedies Toolkit

In support of the self-care agenda, the BLMK Care Home Pharmacy Teams have updated guidance on Homely Remedies.

A homely remedy is a medicinal preparation used to treat minor ailments, which can be bought over the counter and does not require a prescription. These "homely remedy" products are kept in a Care Home to allow access to products which would commonly be available in any household. CQC and NICE both support the use of homely remedies.

Homely remedies fall into two legal categories, GSL (General Sales List), which are available widely from supermarkets, pharmacies and other stores; and P (Pharmacy Only Medicines) which are available only from a pharmacy.

Homely remedies allow a person to access medication to relieve the symptoms of a self-limiting condition without delay and without the need to contact the GP just as they would if they were living in their own home. Homely remedies should not be used for more than 48 hours without consulting the resident's GP. Medicines falling into these categories may also be prescribed at the discretion of the resident's GP for longer term use.

The approved list of minor ailments and medicines:

AILMENT	**MEDICINE**
Indigestion	• Gaviscon® Advance • Peptac®
Pain (mild to moderate)	• Paracetamol NB: Other medicines containing paracetamol may have been prescribed for some residents and this must be carefully checked
Constipation	• Senna tablets or syrup
Diarrhoea	• Oral rehydration therapy, e.g. Dioralyte®
Dry Cough	• Simple Linctus (Sugar-free)
Insect bites and stings	• Hydrocortisone cream 1%

The toolkit has been approved by Bedfordshire, Luton and Milton Keynes (BLMK) Clinical Commissioning Group (CCG) to be used by suitably trained staff, and as such represents the GPs within the organisation. **It is not necessary for a Care Home to write to each resident's GP for homely remedies to be approved or 'signed off', provided only the CCG list of products is stocked.** However, it would be useful for the GP Practice supporting the home to know that stocks of homely remedies are available for their patients. A GP does NOT need to be contacted to ask for permission to start using a homely remedy as decisions are supported by flow charts within the toolkit. If the person repeatedly needs a homely remedy in the same month for the same symptoms the GP should be contacted to report the frequency and a review would be needed.

Further information may be found at https://medicines.blmkccg.nhs.uk/wp-content/uploads/2020/12/BLMK-CCG-Homely-Remedies-Toolkit-Dec-2020.pdf or by contacting the CCG Care Home Team - Hazel Gervais and Kasia Wolska via Mkccg.carehomespharmacy@nhs.net

BLMK Respiratory Project

The BLMK Respiratory Group led by Dr Chirag Bakhai has been engaging with the National Services for Health Improvement (NSHI), an independent service provider, to provide additional capacity for delivering clinical reviews for people with asthma and COPD. This service is well established in Bedfordshire and has been highly successful. We wish to expand the service and offer support to practices in Milton Keynes and Luton as well as further widening provision in Bedfordshire. Whilst NSHI work in collaboration with pharmaceutical companies, it has no affiliation to any one pharmaceutical company nor does it promote any pharmaceutical company's products in the provision of services.

The COPD+ service aims to standardise clinical care, implement national and local guidelines and provide cost effective care to improve patient outcomes. The service provides additional clinical capacity to practices with a respiratory specialist nurse delivering the following:

- Patient identification and therapeutic review
- Clinical review of people with COPD in line with NICE guidelines/GOLD Report/Locality guidelines
- F2F consultations (where clinically necessary and safe to do so)
- Lifestyle counselling
- Education (incorporating RCGP accredited modules) and Nurse mentorship
- An optional decision support software package for COPD

The REACT Respiratory Asthma Service will similarly provide a respiratory specialist nurse to deliver the following:

- Patient identification and therapeutic review
- Clinical review of patient cohorts identified / prioritised by the practice
- Education (incorporating RCGP accredited modules) and Nurse mentorship
- A status report of current asthma treatment, for each patient.

Headline outcomes from the work that has been undertaken in Bedfordshire include:

- Improved identification - a fifth of those on the COPD register did not have COPD when reassessed
- Improved medical management - inhaler therapy was rationalised and treatment stepped down when appropriate
- Improved referral rate and attendance relating to pulmonary rehabilitation
- Improved supported self-management - proportion of people with asthma who had adequate written asthma plans rose from 68% to 95%

We recognise the immense pressure facing practices at this time and would encourage practices to take up the offer of additional capacity to support you and your population with respiratory disease. Please get in touch with the Pharmaceutical Advisers in the first instance.

Take WITHOUT a pinch of salt!

Have you ever considered that the medication you are prescribing for your hypertensive patients may be contributing to their condition? It is easy to give patients advice on a low sodium diet but what about the *content* of their medicines?

Generic Name	Sodium Content per tablet across range of manufacturers		Per maximum daily dose of analgesic
	mg	mmol	
Paracetamol Soluble	388-392mg	16.9-17.0mmol	130-136mmol
Paracetamol effervescent	419-439mg	18.2-19.0mmol	146-152mmol
Co-codamol 8/500 soluble, dispersible, effervescent	388-438mg	16.6-19mmol	135-150mmol
Co-codamol 30/500 soluble, dispersible, effervescent	388-438mg	16.6-19mmol	135-150mmol

Prescribing soluble preparations may impose an unnecessary increased risk for patients - especially those with hypertension, heart disease or renal failure. **If a patient takes 8 co-codamol soluble tablets a day, they will be taking the equivalent of 8.8g salt - much more than the recommended maximum daily intake of 6g (2g sodium).** Their use should be reserved for patients with genuine swallowing difficulties.

Antacids also often contain a high amount of sodium and a low sodium antacid should be selected. The formulary product of choice is **Co-magaldrox** (Mucogel®). However NHS England guidance lists antacids as suitable for self-care.

Please consult the BNF or Summary of Product Characteristics to find out the sodium content of other preparations or see https://www.sps.nhs.uk/wp-content/uploads/2019/03/UKMi_QA_Sodium-content-of-medicines-update_Jan-2019.pdf

Latest updates on Vitamin D

1. Supplements for care home residents and those who are clinically extremely vulnerable

In response to a question about when patients registered to get vitamin D supplies will receive them we have had the following response from the DHSC:

Production of the supplements has started, the distribution company will receive their first batches this week, and deliveries will start on Monday (W/C 18th of January).

Emails will be going out shortly to those who opted in and have been confirmed on the CEV list. The opt-in process was due to close on the 4th of January but this has now been extended to the 21st of February in line with the Prime Minister's announcement last week regarding shielding.

They have emphasised that deliveries will **take several weeks.**

2. NICE NG 187 Published 17th December 2020

This guideline covers vitamin D use in the context of COVID-19. The recommendations are:

Encourage people to follow UK government advice on taking a vitamin D supplement to maintain bone and muscle health. The advice is that:

Adults (including women who are pregnant or breastfeeding), young people and children over 4 years should consider taking a daily supplement containing 10 micrograms (400 units; also called international units [IU]) of vitamin D between October and early March because people do not make enough vitamin D from sunlight in these months.

Adults, young people and children over 4 years should consider taking a daily supplement containing 10 micrograms (400 units) of vitamin D throughout the year:
if they have little or no sunshine exposure including because they:

- are not often outdoors, for example, if they are frail, housebound or living in a care home
- usually wear clothes that cover up most of their skin when outdoors
- are spending most of their time indoors because of the COVID-19 pandemic
- if they have dark skin, for example, if they are of African, African-Caribbean or south Asian family origin,

Babies from birth to 1 year should have a daily supplement containing 8.5 micrograms (340 units) to 10 micrograms (400 units) of vitamin D throughout the year if they are breastfed or formula-fed and are having less than 500 ml of infant formula a day

Children aged 1 year to 4 years should have a daily supplement containing 10 micrograms (400 units) of vitamin D throughout the year.

Vitamin D supplements should be purchased over the counter, not prescribed.

Vitamin D supplement should not be offered to people solely to ***prevent*** COVID-19, except as part of a clinical trial.

Vitamin D supplement should not be offered to people solely to ***treat*** COVID-19, except as part of a clinical trial.

Denosumab (Prolia) – how to claim back.

We have had a couple of follow up queries from our previous Newsletter which reminded practices to buy in Denosumab and claim back via completing a FP34PD form. Confirmation from the NHSBSA that these forms should be submitted at the end of each month along with an FP10 for each patient you have administered the Denosumab to in order to reclaim the cost of the injection as well as a personally administered fee.

GP who is not a dispensing doctor	**A personally administered item (such as a vitamin B12 injection)**	**FP34PD Submission**	**Peach**

The importance of stopping, thinking and finding the relevant information

Thank you to Emma Hooton for sharing this reflection on a seemingly straightforward query that she was asked about.

Question – What antibiotic can be used for a UTI in a patient already on metronidazole?

Review of patient record - a young female, not pregnant, no allergies, no previous UTI - so usually nitrofurantoin would be first choice. However, when nitrofurantoin is co-prescribed with metronidazole there is an increased risk of peripheral neuropathy so the second choice would be trimethoprim. Oh but the patient is also receiving ciclosporin from the hospital. When ciclosporin & trimethoprim are co-prescribed, there is an increased risk of nephrotoxicity so that combination isn't a good idea either. Therefore the choice has to be the third line treatment option i.e. pivmecillinam.

Moral of the story – always look in detail at the patient record and always record externally prescribed medicines. Not doing so may compromise patient safety.

The Pharmaceutical Advisers can be contacted on 01908 278744 or 278713 or speak to your CCG practice pharmacist