NHS BLMK CCG
Milton Keynes
Pharmaceutical Advisers

June 2021

PRESCRIBING NEWS

MK Prescribing Group
May 2021

The May meeting was cancelled. The next meeting will be on July 7th when the 2020-21 Prescribing Incentive Scheme payments to practices will be confirmed.

Representatives of each practice should have attended the action planning meeting across the PCN for the 2021-22 Prescribing Incentive Scheme by 31st July 2021 so if yours isn't booked yet, it is time to do so. Please send in Action Plan template for your practice to Nikki Woodhall by 31st July 2021 as this is the qualifying element to the scheme.

We are delighted that Dr Hari Durairaj from Asplands and Dr Ayesha Zaman (Stonedean) are joining the Group. At the same time, we say goodbye and thank you to Dr Edward Sivills and Bhervi Patel for their time and valuable input to the Prescribing Group. This will also be the last meeting for Janet Corbett – we are all very grateful for her wisdom and leadership over the years and wish her a happy retirement.

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

Milton Keynes Prescribing Advisory Group (MKPAG)
26th May 2021

A virtual meeting was held to discuss several topics:

- Bempedoic acid for lipid lowering was added to the formulary but is currently Red and should only be prescribed by the hospital specialist. This position may change but you will be notified if / when it is approved for continuation prescriptions in primary care.
- Buprenorphine prolonged release injection (Buvidal®) was approved for specialist use only. Please see further information later in the newsletter.
- Progesterone as micronized granules (Utrogestan®) was approved to be used as an option for the management of menopausal symptoms.
- VIZcellose® 0.5% (& 1%) eye drops were added to the formulary as a preservative free carmellose option for adult patients who require a preservative free formulation. The Dry Eye guidance has been updated to include these changes
https://formularymk.nhs.uk/docs/formulary/11/Prescribing%20Guidelines%20for%20Dry%20Eye%20Syndrome%20FINAL-May%202021.pdf.
- Please see important information later about Sodium Valproate Annual Risk Acknowledgement Forms

MHRA Safety Alerts

Polyethylene glycol (PEG) laxatives and starch-based thickeners

The MHRA has warned that the addition of a polyethylene glycol (PEG)-based laxative to a liquid that has been thickened with a starch-based thickener may counteract the thickening action, placing patients with dysphagia at a greater risk of aspiration.

Therefore, patients and carers should be advised to avoid directly mixing together PEG laxatives and starch-based thickeners, especially in patients with dysphagia who are considered at risk of aspiration such as elderly people and people with disabilities that affect swallowing.

Levothyroxine: new prescribing advice for patients who experience symptoms on switching between different levothyroxine products

A very small proportion of patients treated with levothyroxine report symptoms, often consistent with thyroid dysfunction, when their levothyroxine tablets are changed to a different product. In such cases, the MHRA advises that:

- if patients report symptoms after changing their levothyroxine product, consider testing thyroid function
- if a patient is persistently symptomatic after switching levothyroxine products, whether they are biochemically euthyroid or have evidence of abnormal thyroid function, consider consistently prescribing a specific levothyroxine product known to be well tolerated by the patient

Problems only occur in a very small minority of patients. Generic prescribing of levothyroxine remains appropriate for the majority of patients and the licensing of these generic products is supported by bioequivalence testing.

Steroid Emergency Cards

The deadline for implementing the national patient safety alert on steroid emergency cards has passed but practices may wish to confirm that they have identified the appropriate groups of patients who should receive a card.

To support implementation, the Society for Endocrinology, the Specialist Pharmacy Service (SPS), and the British Association of Dermatology (BAD) produced more detailed guidance.
https://www.endocrinology.org/media/4091/spssfe_supporting_sec_-final_10032021-1.pdf

In summary, the following groups were identified as requiring steroid emergency cards:

- Long-term oral glucocorticoids (i.e. 4 weeks or longer) at a dose equivalent to Prednisolone 5mg or more
- Short-term oral glucocorticoids (one-week course or longer and has been on long-term course within the last year or has regular need for repeated courses) at a dose equivalent to Prednisolone 40mg or more
- patients receiving repeated intra-articular glucocorticoid injections, plus additional steroid e.g. via inhalation should be considered
- Inhaled steroids at doses of beclomethasone or equivalent greater than 1000 microgram per day. If patients are also receiving nasal steroids, the threshold is lower at 800 microgram per day.
- Topical high-dose (>/= 200g/ week) potent or very potent glucocorticoids
- used across a large area of skin for 4 weeks or more

Going forward, we have requested the community pharmacies issue the cards for new prescriptions.

Antipsychotics in Dementia

Some information has been cascaded from Public Health England, looking at antipsychotic prescribing in patients with dementia. NICE advice states that a person living with dementia should only try an antipsychotic if they are at risk of harming themselves or others, or if they are severely distressed. The anti-psychotic should be tried alongside other activities to try to help their distress. Risperidone is the only licensed antipsychotic of choice for short-term use and is licensed for 6 weeks use, after which a review should follow.

Prescribing of antipsychotics in dementia will be influenced by the characteristics of practice population and the number of care homes that the practices serve. Not surprisingly, MK has fewer patients on a combination of anti-dementia medicines and antipsychotics than the national average (71 vs 130). Of these, 54 (77%) are found in just 8 practices.

Please remember to consider the appropriateness of antipsychotics when you are undertaking medication reviews. NICE and the MHRA recommend that:

- Prescribers considering continuing antipsychotics should identify and review patients who have dementia and are on antipsychotics, with the purpose of understanding why antipsychotics have been prescribed and carefully consider, after a thorough clinical examination including an assessment for possible psychotic features (such as delusions and hallucinations) whether a prescription for an antipsychotic drug is appropriate. In consultation with the patient, their family, and carers, they should establish whether the continued use of antipsychotics is appropriate; whether it is safe to begin the process of discontinuing their use; and what access to alternative interventions is available.

- Prescribers considering using antipsychotics in patients without a current prescription should carefully consider, after a thorough clinical examination including an assessment for possible psychotic features (such as delusions and hallucinations) whether a prescription for an antipsychotic drug is appropriate.

- It may be appropriate to have a discussion with the specialist memory service, where the patients are under their care, in decisions about discontinuing/ otherwise when a review is carried out.

The Alzheimer's Society has a very useful Best Practice Guide
https://www.alzheimers.org.uk/sites/default/files/2018-08/Optimising%20treatment%20and%20care%20-%20best%20practice%20guide.pdf?downloadID=609

Sodium Valproate Annual Risk Acknowledgement Form

Healthcare professionals who seek to prescribe valproate to their female patients must make sure they are enrolled in the Pregnancy Prevention Programme. This includes the completion of a signed risk acknowledgement form when their treatment is reviewed by a specialist, at least annually.

There has been some debate locally about the use of the term "specialist" on this form, especially in relation to women who have been on sodium valproate for many years and are no longer in contact with a specialist service. There are long waiting times for new patients to be referred to specialist services and there is a risk that the annual review will be delayed or missed.

In order to make sure that women do not fall through the net, MKPAG endorsed the following proposal:

- Specialist services will be responsible for undertaking risk reduction processes for all new initiations and undertake the annual reviews for patients maintained on their case load.

- GPs will be responsible for undertaking the annual risk acknowledgement for patients who have been discharged from specialist services or who have been on valproate for so long that it is not clear in their medical records if they had their treatment initiated in primary or secondary care.

Medicines Optimisation in Milton Keynes

Medicines optimisation looks at the value which medicines deliver, making sure they are clinically effective and cost-effective. It is about ensuring people get the right choice of medicines, at the right time, and are engaged in the process by their clinical team.

The goal of medicines optimisation is to help patients to:

- improve their outcomes.
- take their medicines correctly.
- avoid taking unnecessary medicines.
- reduce wastage of medicines.
- improve medicines safety.

All prescribers will be familiar with their own prescribing habits, but have you ever wondered how you compare to your colleagues and whether prescribing as a whole across Milton Keynes is similar or different to that elsewhere? There is a good source of data, freely available, at https://openprescribing.net/ccg/04F/

The headlines show that the CCG performs well in the following indicators:

- Antibiotic choices https://openprescribing.net/measure/ktt9_cephalosporins_star/ccg/04F/
- Number of average daily quantities (ADQs) per item for anxiolytics and hypnotics https://openprescribing.net/measure/bdzadq/ccg/04F/
- Total DDD of pregabalin + gabapentin per 1000 patients https://openprescribing.net/measure/gabapentinoidsddd/ccg/04F/
- Total items of generic diltiazem modified-release preparations, as a proportion of total items of all diltiazem modified-release items (>60mg) https://openprescribing.net/measure/diltiazem/ccg/04F/
- Total cost per 1,000 registered patients for all NHS England low priority treatments https://openprescribing.net/measure/lpzomnibus/ccg/04F/
- Number of prescription items for all NSAIDs excluding ibuprofen and naproxen as a percentage of the total number of prescription items for all NSAIDs. https://openprescribing.net/measure/ktt13_nsaids_ibuprofen/ccg/04F/
- Prescribing of high dose inhaled corticosteroids compared with prescribing of all inhaled corticosteroids https://openprescribing.net/measure/icsdose/ccg/04F/

The CCG performance is worse than the national average for:

- Opioid items with likely daily dose of ≥120mg morphine equivalence compared with prescribing of all items of these opioids https://openprescribing.net/measure/opioidspercent/ccg/04F/
- Prescribing of methotrexate 10mg tablets as a percentage of prescribing of all methotrexate tablets https://openprescribing.net/measure/methotrexate/ccg/04F/
- Items of low and medium intensity statins as a percentage of items of all statins. https://openprescribing.net/measure/statinintensity/ccg/04F/
- Prescribing of soluble/effervescent forms of paracetamol and co-codamol as a percentage of prescribing of all paracetamol and co-codamol tablets and capsules. https://openprescribing.net/measure/solublepara/ccg/04F/

Areas showing improvement

- Excess spend on ghost-branded generics as a percentage of all spending on generics https://openprescribing.net/measure/ghost_generic_measure/ccg/04F/
- Prescribing of short acting beta agonist (SABA) inhalers - salbutamol and terbutaline compared with prescribing of inhaled corticosteroid inhalers and SABA inhalers https://openprescribing.net/measure/saba/ccg/04F/
- Volume of antibiotics prescribed https://openprescribing.net/measure/ktt9_antibiotics/ccg/04F/
- Trimethoprim as a percentage of prescribing of nitrofurantoin and trimethoprim https://openprescribing.net/measure/trimethoprim/ccg/04F/
- Prescribing of methotrexate 10mg tablets as a percentage of prescribing of all methotrexate tablets https://openprescribing.net/measure/methotrexate/ccg/04F/

Some of these may be surprising and you will recognise that some, where MK is lower than the national average are included in the Prescribing Incentive Scheme or being targeted as specific pieces of work by the Pharmaceutical Advisers. Thank you for all the work that practice teams are doing to ensure patients receive high quality care through good prescribing.

Covid-19 rapid guideline: managing Coivid-19 -last updated 3rd June 2021

This living guideline brings together existing recommendations on managing COVID-19 so that healthcare staff and those planning and delivering services can find and use them more easily and includes new recommendations on therapeutics. https://www.nice.org.uk/guidance/NG191

On 3rd June there was a new recommendation about the use of azithromycin to treat Covid-19. This was a negative recommendation NOT to use azithromycin.

Buprenorphine Prolonged release injection (Buvidal®)

Prolonged-release buprenorphine, Buvidal is a weekly or monthly injection that provides opioid substitution therapy. It is licensed in adults and adolescents aged 16 years or over for the treatment of opioid dependence within a framework of medical, social, and psychological treatment. As such, it will not be prescribed in primary care but practices may have patients who are receiving it via specialist services. It is therefore important to note some potential drug interactions including

- Opioid analgesics (precipitated withdrawal, enhanced central nervous system (CNS) depression, serotonin syndrome with opioids which possess serotogenic properties)
- Opioid antagonists (precipitated withdrawal)
- Gabapentinoids, benzodiazepines (risk of respiratory depression)
- Alcohol and other central nervous depressants (e.g. sedative H1 antagonists, tricyclic antidepressants) (increase sedation)
- CYP3A4 inducers (decreased buprenorphine levels)
- CYP3A4 inhibitors (increased buprenorphine levels)
- Serotonergic medicinal products, such as MAO inhibitors, selective serotonin re-uptake inhibitors (SSRIs), serotonin norepinephrine re-uptake inhibitors (SNRIs) or tricyclic antidepressants (risk of serotonin syndrome)

Due to its extended release properties, management of drug-drug interactions would require additional clinical monitoring and dose adjustments.

It is imperative for specialist services to inform the service user's GP, so that the medication can be added to the service user's summary care record as a hospital administered drug.

More information may be found at:
https://www.sps.nhs.uk/articles/rmoc-buprenorphine-long-acting-injection-guidance/

Interactions with HIV medicines

A recent outpatient letter sent to one of our practices emphasised the importance of recording hospital only medicines on the patient record. The patient was receiving ritonavir and cobicistat which have a major interaction with many corticosteroids including some topical steroids resulting in a possible increase in adrenosuppression.

There is now a SystmOne search. You may wish to set this to run every three months to find HIV patients with no antiretrovirals in their record so that gaps can be identified and filled.

Signing off

I would like to end this edition of Prescribing News with a personal note. We started writing Prescribing News in its current format back in MKPCT days in 2004. The purpose is to inform prescribers and practice teams about developments in medicines, promote safe and cost-effective prescribing and be thought provoking. It has been great to have feedback from our readers over the years.

Many of you will know that I am retiring, and I will be handing on the baton as editor. One of the tools that I have promoted and used to support rational decision-making is by considering all four domains is shown below. Taken together they result in good prescribing for the patient and good value for the NHS.

Efficacy *Benificence*	Safety *Non-malificence*
Cost *Justice*	Patient Factors *Patient autonomy*

From: What constitutes good prescribing?
Barber N. BMJ 1995; 310: 923 - 925.

I am confident that the team will thrive and continue to serve patients and practices in the future, and I wish you and them every success. Janet Corbett.

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