Milton Keynes Clinical Commissioning Group

PRESCRIBING NEWS

February 2019

CCG Prescribing Group January 9th 2019

The Group discussed the following key points:-

- Ideas for Prescribing Incentive Scheme 2019-20
- Antimicrobial Prescribing Guidance (please look out for revised guidance soon)
- New OptimiseRx message for adrenaline auto injectors (please see more information later)
- NHS England new Consultation on items that should not be routinely prescribed in Primary Care. See https://www.england.nhs.uk/wp-content/uploads/2018/11/06i-pb-28-11-2018-lpp-gff-annex-a-items-not-routinely-prescribed-update.pdf

Milton Keynes Prescribing Advisory Group (MKPAG) January 23rd 2019

- The revised NOAC Guidance was agreed. **Edoxaban is the most cost effective NOAC** and therefore is our first line formulary choice for many patients. Please see the guidance (already circulated)https://www.formularymk.nhs.uk/includes/documents/Anticoagulation-guidance-Jan-2019.pdf
- The DMARD Shared Care Protocol has been updated and is available on the formulary website
- There was a discussion about medicine supplies if there is a No Deal Brexit. Reminder: not to stockpile.
- MHRA safety messages regarding sodium valproate and emollients were noted – see below

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

Sodium Valproate Pregnancy Prevention Messages

The MHRA has reported that compliance by healthcare professionals with the new valproate safety measures for pregnancy prevention appears patchy despite a lot of publicity. Women continue to report instances when they have not received patient information with their dispensed valproate medicine. All healthcare professionals must continue to identify and review all female patients on valproate, including when it is used outside the licensed indications (off-label use) and provide them with the patient information materials every time they attend their appointments or receive their medicines (including the Patient Information Leaflet at dispensing).

One of the medicines Management Team came across a patient newly registered at an MK surgery who has been on Epilim for years but there was nothing documented in the patient's notes/letters to confirm that the safety information has been shared. The patient had been at two different MK surgeries before this. The Epilim is on repeat in non dm+d format so none of the warnings triggered when the prescriptions were issued. The Pharmacist raised this with the GP who has now given the patient the information and the repeat template has been updated. Luckily this particular patient has a contraceptive implant so had effective contraception.

Although there are published national searches for Valproate medicines on S1 they do not include any non dm+d issues so would not have picked up this patient. The Pharmaceutical Advisers have developed a search to identify women prescribed sodium valproate in non dm+d format (i.e. not within the NHS Drug Dictionary) so please ask for their help to identify any patients who may still be at risk.
For further information, please see https://www.gov.uk/drug-safety-update/valproate-medicines-are-you-in-acting-in-compliance-with-the-pregnancy-prevention-measures

Emollients – New information about risk of severe and fatal burns with paraffin containing and paraffin free emollients

Warnings about the risk of severe and fatal burns from emollient usage have been extended to paraffin-free products as well as those containing paraffin. The emollient products are not flammable in themselves. However they act as an accelerant, increasing the speed of ignition and intensity of the fire when fabric with residue is ignited. Therefore, clinicians are asked to advise patients using emollients not to smoke or go near naked flames and warn about the easy ignition of clothing, bedding and dressings which may have dried residue of emollient on them. Washing clothing or fabric at high temperature may reduce emollient build up but may not totally remove it.

For further information, please see https://www.gov.uk/drug-safety-update/emollients-new-information-about-risk-of-severe-and-fatal-burns-with-paraffin-containing-and-paraffin-free-emollients

Methotrexate quantities

Prescribing data shows that some large quantities of methotrexate 10mg and 2.5mg tablets are being prescribed. In line with good practice, patients should be started on 2.5mg tablets regardless of their dose to avoid confusion between the two strengths. In addition, supplies should be restricted to 2 months at a time to make sure that patients are coming in for monitoring regularly. CQC looks at high risk medicines so a review of quantities and strengths will help.

Colleagues from Rheumatology have undertaken an audit and expressed their concern about the number of patients still receiving a mix of 10mg and 2.5mg tablets and that Milton Keynes seems to be an outlier nationally. Twenty six patients have been identified. Please review patients on the combination of strengths. We strongly recommend that they are switched over to multiples of 2.5mg to avoid confusion and errors, in line with national safety guidance.

STOMP: Stopping Over Medication of People with a learning disability or autism or both

Background

In 2015, NHS England led a 'call to action' after reports from Public Health England, NHS Improving Quality and the Care Quality Commission showed that:

- There is a much higher rate of prescribing of medicines used for mental illness amongst people with a learning disability than the general population, often more than one medicine in the same class, and in the majority of cases with no clear justification;
- Medicines are often used for long periods without adequate review, and there is poor communication with parents and carers, and between different healthcare providers.

The call to action led to the setting up of the STOMP project led by NHS England and other partners.

What it means for Primary Care

The goal of STOMP is to improve the quality of life of people with a learning disability, autism or both by reducing the potential harm of inappropriate psychotropic drugs this includes being used wholly inappropriately, as a "chemical restraint" to control challenging behaviour, or in place of other more appropriate treatment options.

Public Health England have estimated that on an average day in England, between 30,000 and 35,000 adults with a learning disability, autism or both are taking a prescribed antipsychotic, an antidepressant or both without appropriate clinical indications (psychosis or affective/anxiety disorder). A substantial proportion of people with a learning disability, autism or both who are prescribed psychotropic drugs for behavioural purposes can safely have their drugs reduced or withdrawn.

Research has shown that among adults known to their GP to have a learning disability, (excluding only those in hospital as inpatients) on any average day:

17.0% were taking prescribed antipsychotic drugs
16.9% antidepressants
7.1% drugs used in mania and hypomania
4.2% anxiolytics
2.7% hypnotics

NICE advises that specialists consider prescribing antipsychotic medication to manage behaviour that challenges only if:

- Psychological or other interventions alone do not produce change within an agreed time or
- Treatment for any coexisting mental or physical health problem has not led to a reduction in the behaviour or
- The risk to the person or others is very severe (for example, because of violence, aggression or self-injury)

If there is a positive result the specialist needs to conduct a full multidisciplinary review after three months and then at least every six months covering all prescribed medication (including effectiveness, side effects and plans for stopping).

A person-centred approach is necessary when reducing or withdrawing psychotropic drugs. If prescribed for behaviours that challenge there is the expectation that the drugs will stop unless:

- There is evidence that the person with a learning disability, autism or both has gained significant benefit from the use of the psychotropic drug(s) and recent attempts to withdraw the drug(s) has resulted in a deterioration
- The nature of the behaviours experienced prior to prescribing psychotropic drug(s) was so severe that withdrawal is considered clinically inappropriate by the carers and others

NHS England has suggested some steps for GP practices to take. These include:

1. Identifying people with a learning disability or autism who are prescribed psychotropic medication
2. Develop a programme for reviews in conjunction with annual physical health checks
3. Undertake a drug review and find out when and why each drug was started. Try to find out what were the indications and/or behaviours and concerns that prompted the start of each drug
4. Check with the person, family and their carers. Ensure accessible information and any necessary communication support is available
5. If behaviour is part of a mental illness or autistic spectrum disorder/ADHD (Neurodevelopmental Disorder) then discuss with a learning disability psychiatrist.
6. Check whether previous attempts at drug reduction and withdrawal have been tried, how it was undertaken and what was the outcome. Remember that sudden withdrawal of psychotropic drugs may result in discontinuation effects.
7. Achieve a consensus amongst carers, family, the person (if possible) and involved professionals that there is scope to reduce or stop psychotropic drug use and it is in the person's best interest.

Principles of dose reduction and drug discontinuation

1. Make reductions stepwise and realistic, keeping specialists involved. Generally withdraw or reduce one drug at time. Choose the drug with the least evidence of benefit first.
2. The rate of reduction should depend on an agreement between the carers, and if possible the person and the prescriber. This should be informed by the level of concern of the carers, the history of the behaviours associated with the introduction of the drugs, the duration of exposure, dose of drug, half-life of drug, previous response to such reduction / discontinuation and the availability of other strategies and support for the carers to deal with re-emergent behaviours
3. For drugs with a long half-life (e.g. fluoxetine) or delivered as long acting injections withdrawal will take longer. For drugs with significant drug-drug interactions (carbamazepine) withdrawal may impact on the effects of the other drugs.

Potential problems

1. Sometimes if behaviour deteriorates it can be difficult to judge whether it is a withdrawal effect (usually occurs within the first week), the person adapting to the absence of the drug (usually in the first month), a return of the behaviours for which the drug(s) was prescribed. Sometimes the person may just be more alert and the carers may have difficulties with the impact of this on their usual working practice. Observe PRN usage in these circumstances.
2. It is better to slow down the rate of reduction rather than sticking to a rigid plan if there are concerns about the person's behaviour.
3. Be aware of drug discontinuation effects (see table below). These are usually mild and self-limiting but may be difficult to elicit in people with a learning disability, autism or both.

Class of medication	Discontinuation effects	Management
Antipsychotics	No consensus about whether there are discontinuation problems. Some older antipsychotics worsen tardive dyskinesia	Slow down rate of reduction
Antidepressants	Most SSRIs and other antidepressants are associated with discontinuation effects. Flu-like symptoms, dizziness, insomnia and irritability are common	If mild – reassurance If severe – reintroduce antidepressant
Benzodiazepines and Z drugs	At least 1/3 of long term users suffer discontinuation problems – stiffness, weakness and flu-like symptoms	Minimal intervention and reduce slowly Consider switch to diazepam
Mood stabilisers	Rapid withdrawal of anticonvulsants has been associated with seizures	Slow down rate of reduction

Golden rule - Accept that the reduction may take some time and will be difficult from time to time. However it is a worthwhile aim.

The RCGP has updated and published a Step by Step Guide for annual health checks which includes advice on medication reviews and the need to reduce psychotropic medication.
https://www.rcgp.org.uk/clinical-and-research/resources/toolkits/health-check-toolkit.aspx

There are also professional resources at https://www.england.nhs.uk/learning-disabilities/improving-health/stomp/professionals/ and resources for patients and carers at https://medication.challengingbehaviour.org.uk/

Our Care Home Pharmacist, Jas Janjuha has started to work with the LD team to review patients in care homes with learning disabilities and may be in touch with your practices about this important work stream.

Barrier Creams

Reminder to practices and pharmacies that Proshield Plus is no longer on the formulary and our cost effective barrier cream is Medi Derma (S and Pro) for appropriate patients. Our team has been doing some switches in practices but we are finding that patients are being switched back to Proshield as the care homes and carers are still requesting. We kindly ask that you review your repeat prescribing policy and remind your receptionists/ repeat prescribing clerks not to choose medicines from the acute screen and be aware of the changes made to most cost effective products.
https://www.formularymk.nhs.uk/131-Dry-and-scaling-skin-disorders/

Telephone requests for analgesia

One of our neighbouring CCGs has shared details of an incident relating to a telephone request for tramadol.

A GP practice received a telephone call from a "patient" requesting urgent analgesia. At the same time the "patient" informed the receptionist that the mobile phone number on "their" patient record needed to be updated. When the return phone call was made, the "patient" provided the correct name, address and date of birth, and the consultation resulted in a prescription for tramadol. Further prescriptions for tramadol were subsequently requested and issued since it was listed within the medication history. It was subsequently found that the actual patient had not been requesting or receiving the tramadol.

In response to this incident NHS England's Controlled Drug Team have recommended that:

- CDs should not be prescribed via telephone consultations if there is no history of this medication on the patient's records. If there is a history of prescribing a CD, check to see if the consultations were face-to-face or via telephone or out-of-hours.
- Do not change any patient contact details over the phone, ask them to visit the surgery and complete a change form, and ask for ID to confirm details.
- All incidents involving CDs must be reported NHS England NHS England's Controlled Drug on www.cdreporting.co.uk

Please pass on this information to your prescription clerks and receptionists.

Falsified Medicines Directive

The European Union Falsified Medicines Directive is due to come into force in February 2019. The Directive introduces tougher rules to ensure medicines are safe and that the trade in medicines is rigorously controlled. This is a reaction to a reported significant increase of false medicinal products detected within the legal supply chain of the Member States. Counterfeiting high-price medicines is perceived as a growing illegal business and a threat to public health worldwide.

The legislation will require all prescription medicines for sale to carry a unique and randomised serial number encoded in a 2D-barcode and a visible anti-tampering device. The unique identifier comprises:

- a product code, which allows the identification of at least the name of the medicine, the common name, the pharmaceutical form, the strength, the pack size and the pack type
- a serial number which is a numeric or alphanumeric sequence of a maximum of 20 characters randomly generated
- a batch number and an expiry date

It will be the responsibility of manufacturers to upload the serial numbers to a system of national databases linked by a European hub (although only 15% of products are expected to be compliant from February), while country-based national data repositories will allow verification at different times and final decommissioning when each pack is dispensed to a patient.

At each stage of the supply chain, the product will be inspected to ensure it has not been tampered with, has not previously been dispensed and that the packaging remains intact. Additionally, the individual product must be scanned to record the batch number and expiry date. This check will indicate whether the product is authentic. On supply to the patient, the unique identifier must be 'decommissioned' via a scan from the FMD system, to prevent any duplication of a legitimate identifier for use on a falsified medicine. This will be checked against data in the national repository.

The GPC is working on guidance for GPs and has advised that for now GPs do not invest in any equipment. There is a long lead-in time for FMD and the medicines you are likely to have to decommission are those that are being administered to patients - so largely vaccines but also anything else that is personally administered.

Medicines produced before February 2019 are not covered by the directive and so there is no need to decommission these ... so the impact is unlikely to be felt until 2019/20 'flu season. Practices will need to record the batch and expiry date of personally administered medicines by barcode scan and this will trigger the decommission message. We understand this facility is being built into GP IT systems, ideally by September 2019 to capture the flu data.

The positon in the event of the UK leaving the EU is unclear.

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