NHS
Milton Keynes Clinical Commissioning Group

PRESCRIBING NEWS

May 2014

Latest News

- **Prescribing Incentive Scheme for 2014/15** has finally been approved and paperwork sent out to practice managers. There are two qualifying elements to the scheme – one is to book a practice visit with the Pharmacy advisers. **Book your visit before 30th September 2014.**
- The CCG **Prescribing Group** March meeting was cancelled. The next meeting is scheduled for 7th May.
- A **Dietician** has recently been appointed into the Pharmacy team to help practices ensure prescribing of Oral Nutrition in Milton Keynes is appropriate.
- We have had some requests for **Souvenaid®** (a nutrition formulation, presented as a drink). Souvenaid is not on the joint formulary and we would therefore not support GPs in prescribing it. Please see below for further information.
- **Triptorelin** is our first line LHRH of choice.
- **Metformin Sachets** have been discontinued. There is a licensed oral solution 500mg in 5ml but is significantly more expensive.

Milton Keynes Prescribing Advisory Group (MKPAG) – 26th March 2014

NOACs (New Oral Anticoagulants e.g. Dabigatran) bulletins are still being reviewed so VDVT/PE indication is hospital only at the moment.

Mirabegron was added to formulary but only in line with approved flow-chart which places it as third line therapy.

A range of **eye drops** have been added to formulary at request of new glaucoma consultant. Preservative-free drops should only be initiated by consultants to keep control on costs.

Insulin Degludec – A decision on this was deferred for clarification of placement of therapy from Dr Chandran. Therefore it is currently not approved for use.

Buccolam switch from Epistatus for children's seizures – this switch is being supported by Teresa Wood (Community Paediatric Matron) – see attached information.

The minutes of MKPAG meetings can be seen on the formulary website.
http://www.formularymk.nhs.uk/

Fostair has now been licensed for use in COPD patients.
Dose recommendations for adults 18 years and above:
Two inhalations twice daily.
http://www.medicines.org.uk/emc/medicine/21006/SPC/Fostair%20100%206%20inhalation%20solution/

Vaccine update

New cohorts for the flu vaccination for 2014/15

Next winter sees the addition of two more age groups of children to those introduced in winter 2013/14. These are planned for eligible four-year-olds, and in several pilot programmes around the country to 11- to 13-year-olds in school years 7 and 8. ***GP practices should note that flu vaccine will be provided centrally for all children in the extended programme, and those of all ages in clinical risk groups, up to and including those aged 17 years.***

Change to the HPV vaccination schedule

From September 2014, the number of doses of HPV vaccine that is given to teenage girls will be reduced from three to two.

Shingles vaccination – first year and reminder about expiry dates

The first year of the shingles vaccination programme ends on 31 August 2014. GPs can therefore continue to offer and vaccinate all those aged 70 or 79 on 1 September 2013, until this date.
Please note that the expiry date of some of the earliest distributed stock is 30 September 2014, however it is likely that this has already been used. Subsequent batches of distributed stock have expiry dates ranging between October 2014 and April 2015. Please note that centrally supplied Zostavax is for the national programme only.

Souvenaid

We have had some requests for Souvenaid®. This may have very modest benefit in patients with early Alzheimer's Disease in terms of improving memory; however there is no evidence that it improves the ability of patients to carry out daily activities. It is also unclear whether it has any additional benefit over a healthy diet.

The main trial followed participants for 24 weeks, so the longer term benefits or disadvantages of the product are unknown.

Souvenaid® is not a licensed medicinal and is not on the Advisory Committee on Borderline Substances (ACBS) list (Appendix 2 of BNF). ***Patients may buy Souvenaid® if they wish – please do not prescribe.***
The Alzheimer's Society suggests that regular exercise is a far more effective way of reducing cognitive decline.

http://www.alzheimers.org.uk/site/scripts/press_article.php?pressReleaseID=886

MPS highlights prescribing as one of the top risks in general practice

http://www.medicalprotection.org/uk/press-releases/MPS-highlights-prescribing-as-one-of-the-top-risks-in-general-practice

Prescribing continues to be one of the top five risks in general practice based on Clinical Risk Self Assessments (CRSAs) conducted by the Medical Protection Society (MPS) at more than 150 practices across the UK and Ireland in 2013.Data from assessments conducted in 2013 revealed that 95.4% of practices visited had risks relating to the prescribing system. Common specific examples include uncollected scripts, repeat prescribing systems, and administrative staff changing medications on the computer. Uncollected scripts accounted for 53% of prescribing risks.

- MPS advises practices to consider making a note on patients' records when they have not collected their prescription. This would alert the doctor to possible non-compliance and highlight to patients that a control mechanism is in place.
- Repeat prescribing protocol accounted for 50% of prescribing risks. On poor prescribing protocols, the MPS said:
  "Some of the practices we visited did not have a written repeat prescribing protocol, or if they did, it contained insufficient detail of the process. The CQC will be looking to see whether a practice has suitable arrangements to ensure that patients have their medicines when they need them, and in a safe way. It is important that practices draw up a comprehensive and robust repeat prescribing protocol that formalises prescribing systems, ensuring that all staff are trained in the procedure and have access to the protocol."
- MPS noted in a small number of practices doctors ask administrative staff to make changes to the repeat prescription screen after hospital discharges. This is risky practice which can lead to errors. Advising on best practice, the MPS said:

  "To avoid errors, ideally the responsible doctor should add the medication to the prescription list. If administrative staff need to change or add medications, it must be closely checked by the doctor afterwards. Considerable care needs to be taken to ensure that all the details are correct and that it has been added to the correct patient record. Ultimately the doctor has responsibility for the prescriptions they sign."

Prescribing risk issues

1. Uncollected scripts
2. Repeat prescribing policy
3. Anticoagulant management
4. Prescription errors
5. Administration staff changing medications on computer

2014/15 Prescribing Incentive Scheme – Prescribing Update Session (Date to be announced)

For the second qualifying element to the Prescribing Incentive Scheme the Pharmaceutical Advisers will be hosting a Prescribing Update Session and will include a clinical element as well as a process session to deal with issues discussed above. The session should be attended by at least 1 GP and 1 Repeat Prescribing Clerk / Receptionist from each practice. They will then need to share the learning with the rest of the practice at a meeting and prepare an action plan and submit a template with details of actions taken before 31st May 2015.

Drug Safety update

http://www.mhra.gov.uk/Safetyinformation/DrugSafetyUpdate/DrugSafetyUpdatePDFarchive/index.htm

Domperidone: risk of cardiac side effects - restricted indication, new contraindications, and reduced dose and duration of use

Domperidone is associated with a small increased risk of serious cardiac side effects. Its use is now restricted to the relief of symptoms of nausea and vomiting and the dosage and duration of use have been reduced. Domperidone is now contraindicated in those with underlying cardiac conditions and other risk factors.
A higher risk was observed in patients older than 60 years, adults taking daily oral doses of more than 30mg, and those taking QT-prolonging medicines or CYP3A4 inhibitors concomitantly.

http://www.ema.europa.eu/ema/index.jsp?curl=pages/news_and_events/news/2014/04/news_detail_002083.jsp&mid=WC0b01ac058004d5c1).
Please review patient's long term need for domperidone and discontinue if possible.

Accu-Chek:

Roche Diabetes Care has become aware of a limitation of Accu-Chek® compact test strips and Mobile tests, which may lead to erroneously lowered blood glucose readings in patients undergoing **ceftriaxone therapy** (e.g. Rocephin® or Cefotrix®). Patients with diabetes who are receiving this specific therapy should stop using both affected blood glucose monitoring (bGM) systems and obtain an alternative system for the duration of this therapy.

Optimise Rx – update

The launch of Optimise Rx has unfortunately been delayed due to a few technical difficulties. The company has put a plan together and we will be in touch with practices soon to do a phased roll-out. One practice has managed to launch the system and is currently feeding back anything on the profile that needs reviewing.

Antibiotics

Fosfomycin

Guidance on the use of Oral Fosfomycin can be found on the formulary website

http://www.formularymk.nhs.uk/includes/documents/Prescribing-Guidance-on-the-use-of-fosfomycin-July13.pdf

Carbapenamase Producing Enterobacteriacae: Killer UTIs are here

Public Health England has taken the unusual step of writing to all CEOs across the NHS to ask for support in tackling Carbapenamse producing bacteria. The CDC in the US has also graded these organisms as an urgent threat (the highest level used). These bacteria have become resistant to most antibiotics in our arsenal including the Carbapenem antibiotics; these IV antibiotics include Meropenem, Imipenem and Ertapenem. They are traditionally used as a last resort to tackle infections needing broad spectrum cover eg abdominal sepsis, or where bacteria are resistant to other types of antibiotics eg ESBL UTIs. NHS England has also released a Stage 2 Patient Safety Alert highlighting this issue.

The reason for this concern is the increasing trends of number of infections, outbreaks and clusters, both internationally and in the UK in Greater Manchester and London. A particular worry is that carbapenem resistance is increasing among Enterobacteriacae (including E coli, Klebsiellaspp and Enterobacterspp) that although live harmlessly in the gut are the most common causes of UTIs, intra-abdominal and bloodstream infections. These bacteria produce an enzyme that is capable of breaking down carbapenem antibiotics, however as this mechanism of resistance is often plasmid borne; these bacteria are also resistant to many other antibiotics. This makes them very difficult to treat and results in complex treatments for patients, increased need for isolation and protracted hospital stays, ward closures and increased morbidity and high mortality.

Suspicion of these infections is highest in the following groups of patients:

- Someone who in the last 12 months has been an inpatient in a hospital abroad
- Someone who in the last 12 months has been an inpatient in a hospital in the UK which has had problems with spread of carbapenamase producing Enterobacteriaceae
- Someone who is a previously positive case (they may carry a card/information to this effect).

Other patients particularly at risk include:

- Cancer /immunosuppressed/transplant patients
- Those receiving prior treatment from private hospitals

However, this is not only a hospital issue, there has been transmission of these infections to second cases, some community acquired cases, cases in children and some cases with no contact with foreign medical institutions. If a case is suspected, contact the IPC teams and microbiologist for advice, reinforce strict hygiene precautions with the patient and their family and follow strict IPC standard precautions as clinicians.

An acute trust toolkit has been released and a community based toolkit is expected shortly to detect manage and control the spread of Carbapenemase producing bacteria. We have a limited time to implement these changes effectively; failure to act promptly has the potential to paralyse healthcare delivery. Please look out for any further information as it becomes available.

Antibiotics for UTIs

Nitrofurantoin

The manufacturer Mercurypharma are discontinuing nitrofurantoin (Macrodantin) capsules 50mg (£3.66 for 30 capsules) with immediate effect and replacing them with a generic nitrofurantoin 50mg capsule (£13.92 for 30 capsules) – an almost four-fold increase in price. There are no other generic capsules on the market.

In Milton Keynes we currently advise prescribers to use nitrofurantoin capsules rather than tablets, as the latter cost £24.35 for 28. However, the increased price of the capsules, whilst remaining less expensive than the tablets, will create a cost pressure unless we take some actions to try to mitigate this effect, which is unwelcome in the current financial environment.

The following nitrofurantoin products are therefore now available:

- Nitrofurantoin 50mg capsules (£13.92 per 30)
- Nitrofurantoin 50mg tablets (£24.35 per 28)
- Nitrofurantoin tablets 100mg (£7.07 per 28)
- Nitrofurantoin 100mg MR (Macrobid £9.50 per 14)
- Nitrofurantoin suspension 25mg/5ml (£195.83 per 300ml)

Factors for prescribers to consider when making treatment choices are outlined below:

http://www.formularymk.nhs.uk/includes/documents/Empirical-Guidance-on-the-Management-of-Infection-in-Primary-Care-in-adults-Mar13-1.pdf

Choice of Antibiotic:

In simple UTIs in women our current antimicrobial prescribing guidance recommends 3 days treatment with **either** trimethoprim 200mg bd or nitrofurantoin 50mg qds (joint 1st line options). 2nd Line depends on susceptibility of organism isolated. Pivmecillinam/Mecillinam may be recommended if no history of penicillin allergy. Avoid cephalosporins and quinolones, especially in the over 60s. If necessary seek advice from the Microbiology Laboratory.

3 days of trimethoprim 200mg bd costs 39p whereas 3 days of nitrofurantoin 50mg capsules qds will now cost £5.57. 3 days of nitrofurantoin 100mg m/r bd costs £4.07.

7 days treatment is **only** required for complicated UTIs (e.g. men, pregnancy and patients with a catheter). Over the last 3 months in Milton Keynes approximately 44% of trimethoprim scripts were for 3 days, whereas only 25% of nitrofurantoin scripts were for 3 days' supply.

Renal Impairment:

Nitrofurantoin is contra-indicated if eGFR< 60 ml/minute **as it will be ineffective** due to inadequate urine concentrations. Healthcare professionals should be aware of a patient's current renal function when prescribing, especially for elderly patients. See MHRA advice from August 2013
http://www.mhra.gov.uk/Safetyinformation/DrugSafetyUpdate/CON300402

With trimethoprim, use half the normal dose after 3 days if eGFR 15-30 ml/minute and use half the normal dose from day 1 if eGFR< 15 ml/minute

Antibiotic sensitivity will of course dictate treatment choice where an MSU has been tested

Pivmecillinam

For pivmecillinam (Selexid) there is no difference in recommended administration for men or women for treatment of UTIs. The recommended dose is 2 tablets (400mg) stat followed by 1 tablet (200mg) three times a day for 3 days (10 tablets). Please see link below for SPC for Selexid®

https://www.medicines.org.uk/emc/medicine/2566/SPC/Selexid+Tablets/

In the past 11 months in MK there have been just over 600 scripts for pivmecillinam with a range of quantities from 5 to 100 tablets. Approximately 52% of scripts were for 10 tablets (3 day course). 10 tablets of 200mg costs £4.50. The tablets must be taken with at least half a glass of water, and preferably taken with or immediately after a meal. Pivmecillinam should not be given to patients with a penicillin allergy.

The way GPs access practice data is changing

In April 2014 the NHS Business Services Authority (NHSBSA) decommissioned the Electronic Prescribing & Financial Information for Practices (ePFIP) system used by GPs to monitor their prescribing activity, particularly to reconcile personally administered items and to extract prescribing data for GP appraisals. The information has been migrated to the Information Services Portal.

The NHSBSA has carried out an exercise to contact all GPs and other prescribing organisations to advise that access to the Information Services Portal is required to enable them to continue to view these reports.

A fact sheet has been produced and is published on the NHSBSA website which provides advice on how to sign up for access to the portal.

http://www.nhsbsa.nhs.uk/PrescriptionServices/3165.aspx

Practices should email **NHSBSA.GPData@nhs.net** if they want to ensure there is no interruption to service in receiving practice information.

The Information Services Portal is already a live system which hosts a variety of reports relating to prescribing activity. Practices can access the system via the NHSBSA website as a guest user to see a limited view of the information currently available at the following link: https://apps.nhsbsa.nhs.uk/infosystems/welcome.

The Pharmaceutical Advisers can be contacted on 01908 278713 / 278744