NHS
Bath and North East Somerset, Swindon and Wiltshire
Integrated Care Board

MOP UP.

Medicines Optimisation Update Issue
OCTOBER 2023

To contact NHS BSW ICB Medicines Optimisation Team:
✉ bswicb.prescribing@nhs.net
Website: https://bswtogether.org.uk/medicines/

BSW Area Prescribing Committee (APC) Updates (see all recent decisions in full here)

APC meetings in Aug/Sep were cancelled due to holiday season and industrial action. Minutes from the October meeting are awaiting ratification.

The BSW formulary remains under construction and is designed to be an evolving, dynamic resource. We are working to ensure the messages on GP prescribing systems and Optimise Profiles are in line with the BSW formulary. If you discover information you believe to be inaccurate or misleading, or for further information, email bswicb.formulary@nhs.net

MHRA Drug Safety Updates (Valproate containing medicines)

New legislation came into force on 11th October 2023 meaning that dispensing of all valproate containing medicines must now be in the manufacturer's original pack. This will apply to all dispensing entities. Considering the known medication safety challenges around valproate containing medications, this enforcement will require an ongoing collaborative way of working to ensure continued patient safety. The guidance provides information on the reasons for the change and outlines what needs to be done differently accordingly.

The MHRA information and guidance on the legislative change can be found here. Please ensure to read this in full.

Community Pharmacy England have also issued information here and some practical guidance and FAQs can be found here.

Managing GLP-1 analogues shortage

Local diabetes teams have raised concerns around GLP-1 analogue prescribing patterns as a result of shortages. A fluctuation in people's blood glucose levels have been observed, with some significant rises in blood glucose where a person's GLP-1 analogue has been stopped and re-started inappropriately at high dose because of the intermittent GLP-1 stock supplies.

In order to minimise confusion, once a Diabetes GLP-1 review is complete, we would encourage clinicians to **update the patient's repeat template** and consider **removing any stopped medication, if appropriate.** If a re-start of a GLP-1 analogue is considered appropriate, GLP-1 analogue doses should be titrated from the recommended starting dose as per SmPc or BNF.

For further national guidance on managing GLP-1 analogue shortages, please consult Joint PCDS and ABCD Guidance: GLP-1 Receptor Agonist National Shortage, which can be found linked to the full National Patient Safety Alert here.

Resources to support GP practices with this shortage can be found here https://bswtogether.org.uk/medicines/stock-shortages/

Updates from the AHSN

England's Academic Health Science Networks (AHSN) have changed their names, to better reflect their role as the innovation arm of the NHS.

Our local AHSNs will now be known as Health Innovation Wessex and Health Innovation West of England.

Polypharmacy Training – various dates

As part of the national AHSN/Health Innovation polypharmacy programme, **Action Learning Sets** for GPs and prescribers are being run through to March 2024. The aim is to help healthcare professionals who undertake prescribing, medication reviews and de-prescribing on a regular basis understand the complex issues surrounding stopping inappropriate medicines safely.

Register your interest here and you will be contacted with available dates.

Medicines Optimisation website

New documents

- Resources to support patients having a Structured Medication Review
- Presentation - Integrated Care Record - Benefits to your Surgery
- Presentation - Incentive Scheme Eclipse Deprescribing Project
- Presentation - Eclipse webinar PIS and frailty
- Website – List of rebates

Updated document

- Emergency Access to Medicines Scheme – list of medications (Oct 23)

ADHD Medicine Shortages guidance and resources

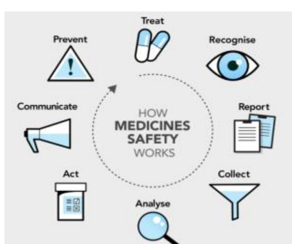
In response to the CAS/NatPSA for ADHD Medicine shortages, AWP have kindly produced detailed guidance to support local GP practices with the shortage. Please note this guidance is in relation to treatment of ADULTs. You can access the guidance here it can also be found on our shortages webpage alongside other useful information(see link below)

CAMHs has also produced guidance and resources to support GP practices with the shortage in relation to CHILDREN AND YOUNG PEOPLE. this has been added to our shortages webpage https://bswtogether.org.uk/medicines/stock-shortages/ This includes leaflets for patients and contact details for local services.

Please note, the guidance recommends that 'GP surgeries and specialist teams should promptly and proactively identify patients prescribed guanfacine and refer them back to their specialist team – These patients should be referred to the specialist team outlined on the shared care agreement. Abrupt cessation of guanfacine can result in rebound hypertension, therefore patients need to be weaned off the medicine where possible and will require *specialist* input.'

MedSafetyWeek 2023 (6th – 12th of November)

This year's campaign will focus on **who can report**. Patients, doctors, nurses and pharmacists all have a key role in the cycle of medicines safety. It aims to explore the different perspectives that come from these groups and how the information they provide can help make medicines safer.



In the UK, the focus is on the importance of reporting suspected adverse reactions to medicines and vaccines, but also encouraging the reporting of suspected problems with medical devices or other healthcare products to the Yellow Card scheme. Find out more about the campaign https://yellowcard.mhra.gov.uk/MedSafetyWeek This includes posters, campaign materials and e-learning for healthcare professionals. There is a useful visual summary of 'How Medication Safety Works' here.

Shared Learning from Medication Safety Events – Propranolol Toxicity in Overdose

Locally, there have been several incidents of **overdose** involving young people prescribed propranolol for anxiety symptoms. To help reduce further harm from this under recognised medication safety risk, the Oxford Health Team that provides mental health services to children and young people within BSW would like to raise awareness of this safety theme.

The clinical evidence for using propranolol in treatment of physical symptoms related to anxiety such as palpitations, sweating and tremor in children and young people is yet to be established. Propranolol isn't included in the Children's BNF for this indication. When taken in overdose it is severely toxic and difficult to treat.

Hereford GP Education have produced a brief webinar, available here which highlights the issue and supports GPs to find an alternative approach. This focuses on adults not children and young people but many of the same principles apply.

Although local concerns are primarily in relation to young people, the same issues apply in the general adult population. A report by the Health Safety Investigation Branch (HSIB) in 2020 highlighted the potentially under-recognised risks of harm from toxicity of propranolol in overdose.

In line with the HSIB report, to mitigate risks, prescribers should consider the measures below for existing prescribing and avoid initiating new prescriptions.

- Check patient's history for evidence of suicidal thoughts and self-harm (particularly overdosing).
- Review regularly.
- Prescribe the lowest effective dose.
- Limit the quantity of tablets prescribed.
- Audit prescribing to understand current practice.
- Review people prescribed propranolol who have increased risk factors for example those co-prescribed antidepressants and be aware of the high prevalence of psychiatric co-morbidities associated with a diagnosis of migraine which is another common indication for prescription of propranolol. It is thought that people with depression and migraine could be at an increased risk of using propranolol for self-harm, and co-prescribing of an antidepressant may increase the risk of toxicity in cases of overdose and cardiac side effects.

When anxiety presents the first line intervention, in any age group, should always be psychological. In children and young people, if anxiety is very severe and functionally impairing then refer to CAMHS for CBT. If it is less severe but still needing intervention, then the options are:

- Self-help. Use online resources e.g., happymaps.co.uk onyourmind.org.uk For *adults* Useful links and resources from AWP and AWP talking therapies Wiltshire Swindon BaNES
- CBT or brief CBT-informed work via therapeutic provision in schools/colleges (e.g., refer to the schools Mental Health Support Team)

Specialists may consider medication for children and young people and there is some evidence that an SSRI should be the first line (usually Sertraline) https://pubmed.ncbi.nlm.nih.gov/Ipser et al 2009/ **If GPs feel the patient cannot wait for referral for specialist assessment and a prescription is needed urgently, *please phone the local CAMHS duty psychiatrist for advice on prescribing*.** There are significant risks associated with propranolol and benzodiazepines which should be avoided.

CAMHS are developing some local guidance to support this pathway.

GPs can initiate and prescribe SSRIs for *adults* in line with **NICE** Escitalopram, paroxetine, and sertraline | Prescribing information | Generalized anxiety disorder | CKS | NICE

The **RCGP** have produced a 5-minute 'change your practice' video which can be found here Video RCGP 5 minute change your practice - Propranolol Toxicity requires registration (free) to access

PrescQIPP have produced resources to support audit which can be found here https://www.prescqipp.info/our-resources/webkits/hot-topics/ requires registration (free) to access.

Shared Learning from Medication Safety Events: Tresiba FlexTouch® (Insulin degludec) 100units/mL Pre-filled Pens

Locally, several incidents have been identified related to the switching of Tresiba FlexTouch® (Insulin degludec) 100units/mL Pre-filled Pens to **Tresiba Penfill® (Insulin degludec) 100units/mL solution for injection 3mL Cartridges**.

Tresiba FlexTouch® (Insulin degludec) 100units/mL Pre-filled Pens are out of stock and may be out of stock until January 2024 – See the MSN for further information. Tresiba® (Insulin degludec) 100units/mL solution for injection 3mL cartridges remain available and can support increased demand.

When prescribing Tresiba Penfill® (Insulin degludec) 100units/mL solution for injection 3mL *cartridges*, ensure that the patient is supplied with a suitable insulin delivery system/Pen and appropriate needles and *that the patient is thoroughly counselled on how to use this device*.

It should be noted that Tresiba® FlexTouch® (Insulin degludec) 100units/mL Prefilled Pens are calibrated to adjust the dose in 1-unit increments and hence the combination of **Tresiba Penfill® (Insulin degludec) 100units/mL solution for injection 3mL *cartridges* with NovoPen 6® device (dials in 1-unit increments)** is a practically appropriate alternative for most patients influenced by the MSN out of stock issue.

The NovoPen Echo Plus® device dials in ½ unit increments, is **not appropriate** for most patients and could lead to dosing errors.

Local pharmacies can order NovoPens as normal from the wholesaler, Alliance. The PIP codes for the NovoPens are as follows:
NovoPen 6 Grey: 419-6689
NovoPen 6 Blue: 419-6697
Or alternatively contact **0330 100 0448 Alliance wholesalers** direct number for urgent supply.
To support practices in locating patients with a view to switching **Ardens** have created a search. The search can be located here - Reporting> Clinical Reporting> Ardens Ltd> Alerts Other> CAS and MHRA 2023 > Tresiba FlexTouch on repeat- Out of stock.
See MSN and Formulary for further details.

Please **Share Learning from Medication Safety Events** you Identify. Sharing learning from medication safety events and recording events on the national Learn from Patient Safety Events (LFPSE) service helps improve patient safety by raising awareness and prompting local and national actions/alerts to mitigate the risks identified. If you'd like to share your learning from a medication safety event, get in touch via bswicb.prescribing@nhs.net and mark for the attention of the **Medication Safety Team**.

This newsletter represents what is known at the time of writing so information may be subsequently superseded. Please contact the Medicines Optimisation Teams with comments/feedback or information for inclusion. This newsletter is aimed at healthcare professionals working within BSW.