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

# MOP UP

Medicines Optimisation Update Issue August 2024

**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)

**New guideline additions to BSWformulary**

**New - Guidance on Prescribing of Low Molecular Weight Heparin (LMWH) in adults**– this local guide summarises key safety considerations when using **LMWH in primary care**. **Dalteparin** remains LMWH formulary choice in BSW. The guideline outlines prescribing and monitoring responsibilities across primary/secondary care interface for various indications. Note that while traffic light status is assigned for individual indications, there may be occasions where the usual arrangements for provision are not possible and a pragmatic approach may be required, depending on the situation to ensure that the patient receives supplies of LMWH in a timely manner. Please continue to email bswicb.prescribing@nhs.net for advice if required.

**New - Management of Subtherapeutic INRs in Patients on Warfarin** – guidance for managing adults on oral vitamin K antagonists (e.g. warfarin), with an International Normalised Ratio result below their target range.

**Other amendments**
**Update – BSW guidelines for use of melatonin in children –** updated to reflect licence changes in melatonin liquid formulations. On FP10, Ceyesto melatonin 1mg/ml oral solution is a cost-effective choice where a liquid formulation is necessary (liquid is second line if crushed Adaflex tablets are unsuitable). **Melatonin liquid should therefore be prescribed by brand name Ceyesto**. Use of melatonin in paediatrics is assigned a RED traffic light status (TLS) and prescribing is usually retained by community paediatric services for treatment of ADHD. TLS for melatonin in ADULTS depends on indication, read more here Formulary (bswformulary.nhs.uk)
**Update – BSW prescribing guidelines for dry eye -** minor update includes the addition of **Viscotears HA eye drops** (sodium hyaluronate 0.1%) and Sodium hyaluronate 0.2% 10ml (Aactive HA PF®).as preservative-free options for mild-moderate disease.

**Traffic Light Status (TLS) and Shared care Agreement (SCA) updates**
**Dementia drugs** – the formal SCA for Donepezil, Rivastigmine, Galantamine and Memantine for treating Alzheimer's disease has been retired. When used within their license, these drugs are now assigned as Amber TLS, [*considered suitable for prescribing in primary care following specialist recommendation*]. Further work is required about the use of dementia drugs in off-label indications. For prescribers in Wiltshire, donepezil retains a green TLS as part of the Wiltshire dementia LES, which is currently under discussions as part of wider BSW LES review work.

*The BSW joint 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 joint formulary. If you discover information you believe to be inaccurate or misleading, or for further information, email bswicb.formulary@nhs.net*

## STOMP Audit: Stopping over medication of people with a learning disability or autism

**Call for an Expressions of Interest:**
Are you passionate about prescribing quality improvement work? What is your current psychotropic medication prescribing pattern for patients with Learning Disability and/or autism?
We invite you to express your interest in joining our exciting **new** local project, **BSW Audit: STOMP – Stopping over medication of people with learning disability or autism.**

**About the Project:** BSW STOMP Audit is an innovative initiative **lead by BSW Meds Op colleagues who will conduct an audit for your practice/PCN.**

**Objective**: The Medicines Optimisation team is planning to conduct local audit work with GP practices, aimed to raise practice awareness of STOMP and gain an insight into how LD health check, medication reviews and clinical indications for psychotropic medication in patients with LD and/or autism are currently documented in clinical systems. Non PID-audit data & theme will inform future BSW Medicine Safety Action Plan and paper to ICB LD Health board and ICS partner organisation.

**Scope:** BSW Med Op colleagues will conduct an audit on "Adults with a LD and /or autism who have antipsychotics on repeat". We are NOT changing any medicines or making any specialist review referrals, merely collecting the data set and providing a "what good looks like" summary for the practice/PCN team. Caldicott Guardian for the practice can grant us access to their SystmOne if they would like to take up the offer of completing the audit. Participation is not mandatory. Audit template does not collect patient identifiable data and it is unlikely others would be able to identify the patient from the information.

If you are interested in a member of our team conducting a practice/PCN STOMP audit or would like to share any focused STOMP work that has been undertaken locally, please email bswicb.prescribing@nhs.net by **1st October 2024**, please **title email - STOMP Quality Improvement Work.**

## Dexcom One -withdrawal

Dexcom One is being withdrawn later this year and is being replaced by Dexcom One Plus.
A transition guide is available here. Dexcom ONE Plus is an all-in-one sensor and transmitter (so no need for a separate transmitter) and includes upgrades to interactivity and connectivity. The user must **download a new App** or **obtain a replacement reader** (if they do not have smartphone access) to be able to use Dexcom One Plus.
The new sensors can be prescribed now, and we encourage practices to **start the process of *switching*** *patients over to the upgraded sensors.*

## BNF app

The BNF has produced a series of short videos on the use of the BNF app. The library currently includes simple topics such as how to download and update the app but will become more extensive with new complex topics due to be added. Please share with your colleagues, particularly those who may feel the loss of the paper copy in September.

## Have you seen?

The British College of Dermatology have launched six education modules to support and educate pharmacists in dermatology care. The courses provide essential information on skin examinations and managing common conditions like acne vulgaris, psoriasis, atopic eczema, and sun safety, as well as managing skin infections, including those featured in the Pharmacy First service. Interactive learning and case studies offer practical insights, supporting learners to confidently assist and advise patients. Read more here

## Promethazine 5mg/5mL solution (Phenergan) product licensing changes

The manufacturer has informed us that there will be a letter sent to UK Healthcare Professionals about this **new contraindication** but have not yet shared the details of this letter or the detail of the reason for the change, although they do state that the change was made following thorough review of safety data. The Children's BNF has yet to be updated BUT the manufacturers *have* changed their product licence/summary or product characteristics (SPC) here

The SPC now states promethazine is contraindicated and **must not be used in children less than six years of age** due to the potential for fatal respiratory depression, psychiatric and CNS events.

An article from Medication Safety authorities in New Zealand highlights the reason for this change in licensing as a potential link between promethazine and psychiatric and central nervous system side effects in children in children under 6 years of age and can be found here

## 3M Inadine- changes to licensing and contraindications

Inadine Customer letter - New IFU.pdf

Following a Medical Device Regulation Review, 3M have made some changes to the instructions for use on their Inadine Dressing Range. Notably, the existing *precautions* have been upgraded to **contraindications**. Please refer to the **customer letter PDF** (double click to access) and ensure this is shared with any colleagues who may use or prescribe Inadine dressings.

## Medicines Optimisation website

**Updated 'stock shortages' page section**

(Prescribing available GLP-1 receptor agonists during national shortages):-
https://bswtogether.org.uk/medicines/stock-shortages/

**New documents**

Safe Valproate Prescribing Role and Responsibility Flowchart
https://bswtogether.org.uk/medicines/wp-content/uploads/sites/3/2024/08/Safe-Valproate-Prescribing-Flowchart-Version-1.0-Jul-2024.pdf

## Community Pharmacy Incident Reporting

Approved Particulars have now been published and are available on **NHS England's website**.

The clinical governance requirements of the community pharmacy contractual framework (CPCF) include *an approved incident reporting system, together with arrangements for analysing and responding to critical incidents*. The approved incident reporting system is set out in this Approved Particulars.

Broadly, the updated Incident Reporting Approved Particulars will confirm existing expectations and practice, including that:

- Pharmacies must have a patient safety incident log for all incidents, which captures the information set out in the Approved Particulars.
- Pharmacies must report to the Learn from Patient Safety Events Service (LFPSE) relevant incidents (but not near misses) and when reporting use the defined levels of physical and psychological harm grades in LFPSE.
- Pharmacies must notify a referring external organisation of the incident with appropriate details, where the incident is related to a referral from that organisation,
- Only relevant staff involved in providing NHS services should be involved in the analyses of patient safety incidents.
- The pharmacy owner must participate in any reasonable activities associated with patient safety incidents including engaging in review and root cause analysis where requested to do so by the relevant service commissioner, or other referring organisation where the incident is related to a referral from them.
- Pharmacies may report incidents anonymously if, for example, the error could constitute a criminal offence, or as part of staff 'whistleblowing' in relation to unsafe dispensing practices.

**For further information,** please see NHS England » Incident reporting system

## ££££££££ Cost Saving drug switch of the month -Metformin or Glucophage 500mg tablets switching to Axpinet brand ££££££££

| Product | Pack size | Cost |
|---|---|---|
| Axpinet 500mg tablets | **28** | **50p** |
| Metformin 500mg tablets | 28 | 71p |
| Glucophage 500mg tablets | 84 | £2.88 |

In the past 12 months, practices across BSW ICB have spent £470k on Metformin 500mg tablets. By prescribing as **Axpinet brand**, there are savings available of up to **£140k** each year.

**NB** -remember to submit the cost savings recording template which accompanied your practice quarterly report to bswicb.prescribing@nhs.net. Pharmacy technician support can be offered on a first come first served basis. Please **do not delay making contact** if your practice is wishing for support to achieve 2024-25 cost savings.

## Freestyle Libre 2 Plus sensor

The FreeStyle Libre 2 **Plus** sensor as a replacement for the FreeStyle Libre 2 sensor and has been added to Formulary and has also been added to Systmone

The FreeStyle Libre 2 Plus sensor offers the same easy-to-use glucose sensing experience of the FreeStyle Libre 2 sensor with these differences-

- **15-day wear duration**, compared to 14-day.
- Can be used by children 2 years and over, compared to 4 years and over.

Please note patients do not need to update their apps.

**Community Pharmacy** colleagues -please note you may wish to run down your stocks of Freestyle Libre 2 sensors in readiness for the change in prescribing.