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

MOP UP

Medicines Optimisation Update Issue January 2026

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 additions to BSWformulary and Change in Traffic Light Status (TLS)

- **Budesonide Respules** – Added with **AMBER** traffic light for initiation by ENT specialist for severe eosinophilic nasal polyposis or sino-nasal aspirin-exacerbated respiratory disease.
- **Droperidol** – added to formulary with a **RED** traffic light for off-label use for Acute Behavioural Disturbance (ABD)/Rapid tranquilisation, with each trust to follow internal procedures for use.
- **Chewable methylephenidate (Tuzulby®)** – added to formulary with **AMBER SC** traffic light. Added to BSW shared care agreement as a treatment option for children aged 6-17 years who do not tolerate 1st line branded generic preparations.
- **QV wash and cream** – added with **RED** traffic light for use within trusts only, not to be prescribed in primary care.

New and Updated Prescribing Guidelines and Shared Care Agreements

- **Sodium Zirconium Cyclosilicate Shared Care Agreement**–approved for publication alongside inclusion in the LCS. Guidance is available from specialist teams and monitoring to be carried out in primary care.
- **BSW-Insulin Formulary update-** minor updates to remove discontinued products and wording updated to reflect changes in NICE guidance.
- **GLP1-RAs-Nutritional considerations for prescribers–** this document pulls together information for clinicians on nutritional issues that can present in individuals prescribed GLP-1s specifically for weight management.

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

Precautionary Recall of SMA Infant Formula Products by the (FSA), and Nestlé

Full details of the affected products and batch numbers can be found at: FSA: Nestlé recall Nestlé: Recall Notice: SMA Infant Formula and Follow-On Formula
Information from the UKHSA on the issue can be found here Briefing note template
BSW Paediatric Dietitians advise **immediate prescription changes** for infants currently prescribed the SMA products outlined below-
SMA Alfamino-The manufacturer has confirmed that the majority of batches currently in circulation are affected, with no unaffected stock currently available. **Therefore, do not initiate new patients on SMA Alfamino.**

For patients currently prescribed SMA Alfamino:

- End SMA Alfamino prescription(s)
- Prescribe **Neocate LCP 420g tin** as the alternative amino acid formula, Formulary
- **Do not switch to an extensively hydrolysed formula** unless specifically advised by a dietitian.

If a patient can only tolerate SMA Alfamino, practices must:

- Contact the **managing paediatric dietitian**, or
- **Re-refer** if the patient is no longer on the dietetic caseload. The dietitian will provide individualised clinical advice.

For patients currently prescribed SMA LF or Sma Anti-reflux:

- End SMA LF or SMA Anti-reflux prescription(s).
- Advise carers to purchase an over-the-counter equivalent.
- Do not switch to: Extensively hydrolysed formula, or Amino acid formula.
- If CMPA is suspected, refer to: BSW CMPA Guidelines – Version 2.0 (August 2025)

Advice to Carers (as per FSA Guidance)

- Immediately discontinue use of the affected SMA product.
- Return the product to the place of purchase or dispensing pharmacy.
- An appropriate alternative feeding option must be arranged promptly.

System Support and Alerts
Ardens is developing a **prescribing search** to assist practices in identifying patients currently prescribed affected SMA products.
Optimise is implementing a **clinical system alert** advising against the initiation of SMA infant formula during the recall period.

Dietetic Support and Contact Details- Where further clinical advice is required, Paediatric Dietitians can be contacted as follows:
Royal United Hospital (RUH): ruh-tr.paediatricdieteticreferrals@nhs.net, **Great Western Hospital (GWH):** gwh.paediatricdieteticreferrals@nhs.net, **HCRG (Wiltshire & Swindon Community):** wilts.dietetics@hcrgcaregroup.com

National Patient Safety Alert: Preventing Harm from Incorrect Recording of a Penicillin Allergy as a Penicillamine Allergy

Ensure that you have used the CORRECT method to identify patients who require review.

The National Patient Safety Alert (NatPSA) found here has highlighted a critical issue where patients' **penicillin allergy** has been **incorrectly recorded as a penicillamine allergy** in electronic prescribing systems. This look-alike, sound-alike error poses a serious risk of **patients receiving penicillin-based antibiotics, potentially leading to life-threatening anaphylaxis**. GP Practices have received an email about this NatPSA and we issued a newsletter article in December MOP UP– December 2025
It has come to our attention that some GP Practices have used the wrong search method when attempting to identify patients who have an incorrect recording of penicillamine allergy.
This is because allergies recorded in the clinical system must be identified using both a '**sensitivity**' and '**clinical coding**' to ensure all possible patients are captured in the report. Searching for a clinical code in the traditional way will not necessarily identify **ALL** your patient list.
Ensure you have **run the Arden's report** for penicillamine allergy to identify an accurate list of patients to review according to the actions of the NatPSA. The report can be found here **Arden's Ltd > Prescribing Alerts > Allergies or Arden's Ltd > Alerts | CAS and MHRA > b. 2025.**

Tamoxifen: QT Prolongation and monitoring recommendations for high-risk patients

Following MHRA assessment of post-marketing safety data and clinical trial ECG results, healthcare professionals are advised to monitor ECG and electrolytes before and during tamoxifen treatment in patients with risk factors for QT prolongation, including those with cardiac comorbidities or taking QT-prolonging medicines.
Patients should be informed of this potential risk and advised to report symptoms such as **palpitations, dizziness, or fainting**.

Safer Psychotropic Prescribing for People with a Learning Disability and/or Autism (STOMP)

People with a learning disability and autistic people remain significantly more likely to be prescribed psychotropic medicines, often for extended periods and without regular review. National data **consistently highlights**:
A 16-fold increased likelihood of antipsychotic prescribing in people with a learning disability.
A 7-fold increase in autistic people, frequently in the absence of a diagnosed mental health condition

Key Actions for Practices

1 Implement a robust and consistent psychotropic medicines review process.
Ensure patients with a learning disability or autism are prioritised for psychotropic medication review within routine structured medication review (SMR) processes.
2. Record medication duration and planned review dates
Accurate documentation helps prevent unintentional long-term prescribing and supports continuity of care across clinicians.
3. Use the correct STOMP recording code
Utilise Ardens STOMP review code: **Y2E64.**This ensures activity is captured, auditable, and visible across the MDT**.**
4. Identify your patients using **SystmOne searches- Reporting → *Clinical Reporting → BSW General Practice → Medicines Optimisation Team → Safety → Reduce risk of overmedication harm (STOMP)***
This enables practices to:

- **Identify patients prescribed psychotropics**
- **Monitor those requiring review**
- **Track progress against STOMP priorities**

Working Together to Reduce Harm

Effective STOMP implementation helps primary care teams:

- Reduce unnecessary psychotropic burden.
- Improve physical and mental health outcomes through regular monitoring.
- Strengthen personalised care and shared decision-making.

Align with national quality and safety priorities, including LeDeR recommendations.
Every review counts. Even small adjustments can significantly improve safety, wellbeing, and quality of life.

£££££££ Cost Saving drug switch of the month -Duoresp Spiromax DPI inhaler to Fobumix Easyhaler/WockAIR £££££££

In the past 12 months, **over £613k** has been spent on Duoresp Spiromax inhalers. **Duoresp Spiromax is no longer a preferred formulary choice** in asthma or COPD. At least **£156k could be saved** across BSW by prescribing either Fobumix Easyhaler or WockAIR.
NB
- **Fobumix Easyhaler is first-line** ICS/LABA DPI option **for COPD.**
- **Symbicort Turbohaler is a first line** option **for asthma**, however, is **more costly than Fobumix Easyhaler and Wockair**.
- The inhaler devices differ in their design; therefore, patients' ability to use the device effectively should be considered. Please refer to the individual SPCs and PILs and ensure **appropriate patient counselling**.

Product	Pack size	Cost
Fobumix Easyhaler 160micrograms/dose / 4.5micrograms/dose dry powder inhaler	**120**	**£21.50**
Fobumix Easyhaler 320micrograms/dose / 9micrograms/dose dry powder inhaler	**60**	**£21.50**
WockAIR 160micrograms/dose / 4.5micrograms/dose dry powder inhaler	**120**	**£19.00**
WockAIR 320micrograms/dose / 9micrograms/dose dry powder inhaler	**60**	**£19.00**
Symbicort 200/6 Turbohaler	120	£28.00
Symbicort 400/12 Turbohaler	60	£28.00
DuoResp Spiromax 160micrograms/dose / 4.5micrograms/dose dry powder inhaler	120	£27.97
DuoResp Spiromax 320micrograms/dose / 9micrograms/dose dry powder inhaler	60	£27.97

A **search** to identify patients can be located on SystemOne - **Clinical Reporting > BSW General Practice > Medicine Optimisation Team > Cost Savings**

Action Required
Please do not delay in sending cost savings that that your practice has completed so far to bswicb.prescribing@nhs.net , as this will contribute towards your Prescribing Quality Scheme (PQS) target. Please refer to your practice quarterly report for 25/26 which includes the target for your practice.

***Important Notice*-**Switches which have been undertaken **for Alogliptin or Linagliptin > Sitagliptin cannot be included within your practice savings,** as they are incentivised separately in the PQS under the "DPP4 switch programme" and do not contribute towards the calculated savings target. Please refer to the PQS Service Specification 25-26.

Patient safety Focus:

- **The under-recognised risk of toxicity of propranolol in overdose.** Following several Prevention of Future Death Reports, the General Pharmaceutical Council (GPhC) has produced patient safety spotlight information, exploring the **risks of harm from propranolol**, in particular the risk of toxicity in overdose. In 2022-2023 the National Poisons Information Service (NPIS), received 358 enquiries involving intentional propranolol overdose. In 12 cases the overdose resulted in death. Read about the recommendations for safer prescribing of propranolol, especially in patients that may be more at risk of intentional overdose, on the. GPhC website
- **Levetiracetam (Keppra®) oral solution: risk of errors with change to oral syringe.** A new 5mL dosing syringe (delivering up to 500mg) will replace the 3mL syringe (up to 300mg) for Keppra® oral solution 100mg/5ml – used in children aged 6 months to 4 years. When prescribing or dispensing, healthcare professionals should appropriately counsel caregivers about the change from 3ml to 5ml syringe and how to measure the dose using the new 5mL syringe. Both sizes may be available at the same time, increasing the risk of incorrect doses being administered. For more information refer to the, healthcare professional letter from UCB Pharma which contains illustrations of the change to the syringe markings.
- **Keep the warmth, lose the risk: MHRA and National Fire Chiefs warning** -As colder weather arrives, the MHRA and the National Fire Chiefs Council (NFCC) are urging the public to be aware of fire **risks linked to emollient skin creams**. To help keep people safe this winter, the MHRA and NFCC are highlighting three simple precautions: 1. **Keep away from flames Avoid smoking**, candles and other naked flames and open fires if fabrics have dried on emollient products. Contaminated fabrics can catch fire quickly and cause a fire to spread quickly. 2. **Keep warm safely** Sit at least 1 metre away from open fires and heaters, sitting too close could set light to fabrics. 3. **Wash bedding and clothing regularly** Wash items at the highest temperature recommended on the care label to help reduce cream build-up. Washing does not remove residue completely, so continued caution is important. Read more on the. Gov.uk website