All the latest prescribing news from your Medicines Management Team at the CCG.

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NHS Brighton and Hove Clinical Commissioning Group

NHS High Weald Lewes Havens Clinical Commissioning Group

CITY SCRIPTS

March - April 2016

Prescribing Newsletter

Brighton and Hove CCG & High Weald Lewes Havens CCG

This newsletter is produced by the Medicines Management Team at the CCG, and is sent to all local GPs, Practice Nurses and Community Pharmacists. We would welcome any feedback on the content and usefulness of the newsletter and suggestions for future topics.

With many thanks to neighbouring CCGs who have contributed material to this newsletter.

IMPORTANT - PLEASE READ

This edition comes to you jointly from the Medicines Management Teams at Brighton and Hove CCG and High Weald Lewes Havens CCG.
Many of the articles will be of interest to both CCG localities however, please be aware that a few may be CCG specific. In this instance the articles will be clearly highlighted.

IN THIS EDITION:

The following articles are relevant to both BHCCG and HWLHCCG:

The following articles are relevant to BHCCG only:

angiothensin system drugs in heart failure: risk of potentially fatal hyperkalemia
- Oral anti-cancer drugs
- Liothyronine
- Seritide Evohaler and Sirdupla MDI dosing
- Co-proxamol
- Discontinued contraceptives
- SSRIs and NSAIDs
- DKA risk with SGLT2 inhibitors
- Ibuprofen and chickenpox
- Quetiapine... IR or MR?
- MHRA Drug Safety Update
- APC and JF update
- NICE guidance

Scheme Claims

The following articles are relevant to HWLHCCG only:

- Electronic Repeat Dispensing Update

Medicines Management Team Update

Brighton and Hove CCG

The team would like to welcome Kathryn Steele, our new permanent part-time pharmaceutical advisor, whose normal working days are Tuesdays and Fridays. Kathryn's will be looking after: Albion Street, The Avenue, Willow, Whitehawk, Broadway, Warmdene, Beaconsfield and Preston Park surgeries; and clinical areas include: pain, mental health and substance misuse.
Kathryn is contactable on kathryn.steele2@nhs.net.

HANDY TIP: How to print this newsletter

If you wish to print out a copy of this newsletter to share or distribute with your colleagues, the best way to do this is to save and print as a PDF. You can do this by:

1. Hold Ctrl + P on your keyboard
2. Select the printer as "PDFwriter" or press "save as PDF"
3. A "Save As" window should now pop up. Name and save the PDF document on your desktop or in a suitable folder
4. Double click on the file to open the PDF (in adobe reader)
5. Hold Ctrl + P on your keyboard for the second time and select your preferred printer. You may wish to set the printer to print 2 pages per side and double sided to use the paper efficiently.

Pre-surgery suppression therapy for MRSA positive patients

As noted at the February Brighton Area Prescribing Committee,

all patients requiring MRSA suppression therapy before their operation at BSUH will receive supplies at the pre-op assessment clinic from now on. Any requests for primary care to prescribe this should be declined and the patient referred to the BSUH pre-op clinic.
The products that will be supplied by BSUH are:

- Octenisan Nasal Gel
- Chlorhexidine wash

Spironolactone and renin-angiotensin system drugs in heart failure: risk of potentially fatal hyperkalemia[1]

Spironolactone belongs the class of medicine known as a mineralocorticoid receptor antagonist (MRA). This alert reminds prescribers of the potential risk of hyperkalaemia when spironolactone is prescribed with an ACE inhibitor (or an ARB) particularly in patients with renal impairment, and how to avoid this problem.

When can this combination be used?

The RALES trial (2009) was stopped early on the basis of significant mortality benefits seen with spironolactone in patients with moderate to severe heart failure secondary to left ventricular systolic dysfunction (LVSD) and an ejection fraction <35%. Further evidence with eplerenone supports the combined use of an MRA with an ACE inhibitor and beta-blocker in this patient group. This combination is recommended in guidelines for heart failure including NICE and the European Society of Cardiology.

The MHRA Drug Safety Update February 2016 reported an increasing number of spontaneous reports of abnormal blood potassium (mainly hyperkalemia) in patients' co-prescribed spironolactone with an ACE I or ARB, 3 of which had a fatal outcome. The incidence appears to be greater than those reported in the RALES study. This increase may be due to different conditions and baseline patient characteristics between trial and routine clinical practice and / or represent stimulated reporting due to increased awareness of the risks

How to avoid problems [2]

Check baseline renal function and potassium

Many heart failure patients have renal impairment. If baseline renal function is impaired start with lower doses – e.g 25mg on alternate days. In more severe renal impairment (e.g creatinine in > 220 mmol/l or eGFR <30 ml/minute) or deterioration in renal function seek specialist advice from the heart failure teams.

Do not start if baseline potassium is > 5.0 mmol/l.

Monitor potassium and renal function after starting and/or dose changes:

At 1 week, 4 weeks, 8 weeks, 12 weeks then at months 6, 9 and 12, then 4-6 monthly thereafter.

Adjust dose with reference to potassium levels:

Potassium level	**Action**
<5.0 mmol/l	Can increase dose if clinically indicated
5.0-5.4 mmol/l	Maintain current dose
5.5-5.9 mmol/l	Halve dose
≥ 6.0 mmol/l	Withhold

Do not exceed 50mg once a day (lower dose if renal function is impaired)

Avoid combination of ACE inhibitor **and** ARB **and** spironolactone

Avoid potassium sparing diuretics, NSAIDs or trimethoprim.

Use potassium supplements with great care. Avoid salt substitutes.

Would eplerenone be safer?

Although this alert refers to spironolactone the same recommendations apply to the prescribing of eplerenone with an ACE inhibitor (or ARB).

Prescribing Data indicates:

Within BH CCG, over 670 patients are on spironolactone (50mg or less) and 125 patients are on eplerenone and in HWLH CCG, over 540 patients are on spironolactone (50mg or less) and 122 patients are on eplerenone.

Many of these patients will be co-prescribed an ACE inhibitor or ARB.

References

1. Drug Safety Update volume 9 issue 6. February 2016:2

Spironolactone and renin-angiotensin system drugs in heart failure: risk of potentially fatal hyperkalemia https://www.gov.uk/drug-safety-update/spironolactone-and-renin-angiotensin-system-drugs-in-heart-failure-risk-of-potentially-fatal-hyperkalaemia#risk-of-hyperkalaemia-with-spironolactone

2. ESC guidelines for the diagnosis of treatment of acute and chronic heart failure 2012. Practical Guidance in the use of MRAs in patients with systolic heart failure http://www.escardio.org/static_file/Escardio/Guidelines/publications/HFGuidelines-Heart-Failure-Web-Tables.pdf

Reminder: Do not prescribe oral anti-cancer drugs in primary care.

We have recently noticed prescriptions for oral anti-cancer medications prescribed and dispensed in primary care. In 2008, the National Patient Safety Agency (NPSA) issued a Rapid Response Report alerting all healthcare staff of potentially fatal outcomes if incorrect doses of oral anticancer therapy were prescribed, dispensed or administered. In response to this alert, Brighton and Sussex University Hospitals NHS Trust made it a policy that **all oral chemotherapy, including hydroxycarbamide, would be prescribed in-house by the specialist team looking after the patient.**
To see the 2012 letter sent to GPs explaining this and for further information click here HERE.

ACTION for community pharmacists:
We would like to ask that pharmacists support us in this message and do not dispense any prescriptions for oral anti-cancer medications and contact the prescriber to arrange that the patient receives supplies from the specialist as per local policy.

Liothyronine

Levothyroxine (L-T4) is a prodrug and is converted to liothyronine (L-T3).

In 2015 the British Thyroid Association Executive Committee released a statement about Management of primary hypothyroidism. In this statement it is advised that:
"L-T4/T3 combination therapy in patients with hypothyroidism should not be routinely advised, as there is insufficient evidence to show that combination therapy is superior to L-T4 monotherapy."

The statement concludes:
"*Levothyroxine therapy offers a safe, rational and simplified approach to the correction of hypothyroidism, and for the vast majority of patients, treatment results in improved physical and psychological well-being. However, the management of patients with a suboptimal clinical response remains challenging. The benefits of combination therapy with L-T4 and L-T3 are still unproven, and the potential for harm exists with unregulated use of unapproved therapies*"

Liothyronine is not in our local formulary and not recommended to be prescribed in primary care because (i) there is no robust clinical evidence available of any benefit in these patients and (ii) it is not licensed for long term treatment of (uncomplicated)

hypothyroidism.

As with any other unlicensed and un-evidenced therapy; it cannot be justified as a safe nor appropriate use of NHS funds and **we are therefore requesting that any prescribing of liothyronine (L-T3) be reviewed and switched to levothyroxine (L-T4).** Below is guidance for the switchover.

Approximately 100 micrograms levothyroxine equals to 20-25 micrograms liothyronine. Patients will need a repeat thyroid function tests about 8 weeks later to enable levothyroxine dose titration if necessary. Average levothyroxine dose requirements range from 100-150 micrograms daily. Patients usually feel best if their free T4 is in the upper end of the reference range without causing TSH suppression.

Please note the Brighton Joint Formulary does list liothyronine as Red for its licensed indication (for treatment of myxedematous coma and pre radioiodine treatment). Any prescriptions for this indication should be supplied by the patient's specialist.

B&H prescribers

ACTION: Review any patients who are currently being prescribed liothyronine. Currently, 27 practices in the city are prescribing this unlicensed medication to their patients. If you would like any switching guidance please contact the medicines management inbox.

HWLH prescribers

ACTION: The HWLH Medicines Management team would like to offer specific pharmacist support to any practices wishing to review their prescribing of liothyronine. If your practice would like to take up this opportunity please contact Pauline Martin on paulinemartin4@nhs.net or your regular prescribing support technician.

Reminder: Correct dosing for Seretide Evohaler and Sirdupla MDI

It has been noticed that some patients prescribed the above inhaled corticosteroid inhalers are receiving an incorrect dose. We would like to highlight that Seretide Evohaler and Sirdupla MDI must be taken as TWO puffs TWICE a day in order to achieve a therapeutic dose of salmeterol.

If a prescriber wishes to step down the steroid load (which is something that is actively encouraged if suitable) then the inhaler prescribed must be stepped down to a lower strength.

A step down cannot be achieved by reducing the dose to one puff twice a day. (Thus reducing their steroid intake by half but also their LABA dose in half which is

sub-therapeutic.)

ACTION for Prescribers and Pharmacists:
Ensure that a therapeutic dose (two puffs twice a day) is prescribed when signing or dispensing a prescription for Seretide Evohaler or Sirdupla MDI.

Co-proxamol

Co-proxamol was withdrawn from the market on the advice of the Committee on Safety of Medicines (CSM) due to serious safety concerns in January 2005. However, over a decade later, prescribing of co-proxamol is still occurring for a significant number of patients in both CCGs.

There is no robust evidence that co-proxamol is more effective than full strength paracetamol used alone in either acute or chronic use. Clinical data show that dextropropoxyphene (which is what is contained in co-promaxol along with paracetamol), even at normal therapeutic doses, has serious effects on the heart resulting in prolongation of the PR and QT intervals and widening QRS complexes. There are also concerns about potential abuse and suicide (In England and Wales in 1997–1999, 18% of drug-related suicides involved co-proxamol; these constituted 5% of all suicides). The toxic effects of dextropropoxyphene on respiration or cardiac function are usually the cause of death. Death from co-proxamol overdose may occur rapidly, the lethal dose can be relatively low, and the effects are potentiated by alcohol and other CNS depressants. The majority of co-proxamol overdose deaths occur before hospital treatment can be received. The risk of dying after co-proxamol overdose was 2.3 times greater than for tricyclic antidepressants and 28.1 times greater than for paracetamol. Treatment of dextropropoxyphene overdose is complex, dextropropoxyphene has a very long duration of action so, like methadone, patients need to be monitored for a long periods following overdoses.

Apart from the safety concerns there is a significant cost increase in the price of the tablets. Recent local prescribing data showed that the NHS was charged **£350** for 100 tablets. There is no set price for this unlicensed preparation and may well increase in the future.

Based on the current level of prescribing, if all prescriptions for co-proxamol are charged at this inflated price, this would present an additional cost pressure of nearly **£1 million to the local NHS over the next year. This money could be used more efficiently for our patients.**

B&H prescribers
ACTION: Review any patients who are currently being prescribed Co-proxamol and switch to a formulary choice analgesia, if an analgesic is still needed.

Currently, 28 practices in the city are prescribing this unlicensed medication to their patients. If you would like any switching guidance please contact the medicines management inbox.
See the formulary here: http://www.gp.brightonandhoveccg.nhs.uk/file/627

HWLH prescribers
ACTION: The HWLH Medicines Management team would like to offer specific pharmacist support to any practices wishing to review their prescribing of co-proxamol. If your practice would like to take up this opportunity please contact Pauline Martin on paulinemartin4@nhs.net or your regular prescribing support technician.

Discontinued Contraceptives

Binovum® tablets, Ovysmen® tablets and Trinovum® tablets (all ethinylestradiol and norethisterone) are being discontinued in 2016 for commercial reasons.

Action: Women taking these preparations will need to be switched to a formulary alternative. See the Joint Formulary Chapter 7 for approved preparations.

SSRIs and NSAIDs

A NICE Eyes on Evidence (EoE) article reports a large Korean observational study that found antidepressant use with NSAIDs was associated with increased risk of intracranial bleeding within 30 days of first taking the combination. No statistically significant differences were seen between individual antidepressant classes. The EoE concludes that evidence supports current BNF and NICE guidance recommending the combination of SSRIs and NSAIDs be prescribed with caution.
A Medicines Q&A summarises the risk of GI bleeding associated with SSRIs, including in combination with NSAIDs.

Updated advice on the risk of DKA with SGLT2 inhibitors

With agreement with MHRA and EMA, the manufacturers of the three **SGLT2 inhibitors** (canagliflozin, dapagliflozin and empagliflozin) have written to healthcare professionals regarding updated advice on the risk of **diabetic ketoacidosis** (DKA) linked with these treatments. The letter advises that there have been **rare** but serious, sometime **life-threatening** and fatal cases of DKA. Clinicians are encouraged to **continue reporting** suspected adverse reactions through the yellow card system.

The updated advice notes that DKA **must be considered** in the event of **non-specific symptoms** such as nausea, vomiting, anorexia, abdominal pain, excessive thirst, difficulty breathing, confusion, unusual fatigue or sleepiness.

Clinicians should **inform patients of the signs and symptoms** of metabolic acidosis and advised them to seek immediate medical advice if they develop. In patients who develop DKA, treatment with SGLT2 inhibitors should be stopped immediately and only restarted if another clear precipitating factor is identified and resolved.

Additionally, **before starting treatment** it is recommended that **risk factors** that predispose individuals to DKA are considered. These include:
Low insulin-producing capacity in the pancreas, a sudden drop in a patient's insulin dose, increased insulin requirement (due to illness, surgery or alcohol abuse) or conditions that can restrict food intake or lead to severe dehydration.

EMA recommends temporarily stopping SGLT2 inhibitors in patients who are undergoing major surgery or are in hospital due to serious illness.
Healthcare professionals are reminded that SGLT2 inhibitors are not authorised for type 1 diabetes, noting that cases of ketoacidosis have also occurred during off-label use and clinical trials in type 1 diabetes.

Locally, latest 3 month ePACT data indicates;
27 practices have prescribed SGLT2i for around 57 patients within BHCCG
17 practices have prescribed SGLT2i for around 85 patients within HWLHCCG.

Action: Clinicians should be **aware** of the updated advice. Patients should be advised of the signs and symptoms of DKA and clinicians need to remain **vigilant** and react quickly should they arise.

www.prescriber.org.uk/2016/03/updated-advice-on-the-risk-of-dka-with-sglt2-inhibitors/

www.ema.europa.eu/ema/index.jsp?curl=pages/news_and_events/news/2016/02/news_detail_002477.jsp

www.ema.europa.eu/docs/en_GB/document_library/Press_release/2016/02/WC500202388.pdf

Ibuprofen use in patients with chickenpox

There has been a lot of social media and newspaper coverage of the use of Nurofen in a child with chickenpox causing severe reactions.
Its a rare reaction but advice is not to use Ibuprofen to treat pyrexia associated

with chicken pox. (http://www.ncbi.nlm.nih.gov/pubmed/20568491)
Evidence suggests that there are elevated risks of of skin complications in people with varicella when exposed to NSAIDs. These findings have been replicated in several studies [Bijl, 2010; Mikaeloff et al, 2008].
For this reason it is recommended that NSAIDs are avoided in children with varicella.

Quetiapine... Immediate or Modified Release?

Sussex Partnership Foundation Trust (SPFT) have decided to routinely use plain / immediate release quetiapine in preference to modified release (MR) / XL quetiapine.
All prescriptions for quetiapine should be for the plain tablets **unless MR is stated in the patient notes or in clinic letters**.
The Medicines Management Teams are aware of multiple occasions where the patient is meant to be prescribed the plain tablets however, the XL preparation has been selected on the clinical system resulting in the patient receiving the wrong formulation. **This is a very costly error as on average a box of XL tablets cost £200 more than the plain tablets.**

This commonly happens when a 50mg dose of **plain** quetiapine is recommended by the specialist. As there is no 50mg plain tablet, the 50mg modified release tablet inadvertently gets added to the patient's prescription. To make up a 50mg dose, the 25mg plain tablets should be prescribed with the directions written as "Take TWO".

SPFT support and give guidance to patients who are switched from XL tablets to plain tablets. A patient information leaflet can be found here: http://www.sussexpartnership.nhs.uk/sites/default/files/documents/faq_pil_-_switching_from_quetiapine_xl_to_plain_tablets_-_ver_4_-_jul_15_2.pdf

ACTION for prescribers: Ensure that plain / immediate release quetiapine is prescribed unless modified release is the preparation specifically recommended by a specialist. If a modified release preparation is intended, then the joint formulary approved brand is **Mintreleq XL**. Use of this brand is supported by Sussex Partnership Foundation Trust as it is cost effective to the local NHS.

The Medicines and Healthcare products Regulatory Agency (MHRA) has published Drug Safety Update for:

February 2016 advises:

Spironolactone and renin-angiotensin system drugs in heart failure: risk of potentially fatal hyperkalaemia. See above article for further information.

Valproate and of risk of abnormal pregnancy outcomes: new communication materials

In January 2015 we informed you that children exposed to valproate in utero are at high risk of developmental disorders and congenital malformations. To further improve awareness of the risks of valproate in pregnancy we are asking that you use the new communication materials below to support discussion of these risks with women of childbearing potential and girls who take valproate. Hard copies are being sent to relevant healthcare professionals from this week.

Resources to use (see below for more information):

• Booklet for Healthcare Professionals

• Consultation checklist

• Guide to give to patients

• Card to give to patients (see below example)

Later in 2016, the outer packaging for medicines containing valproate will include a warning for women on the risk of adverse pregnancy outcomes.

See the letter that was sent to healthcare professionals regarding valproate for further information.

Actions for prescribers:

• Valproate treatment must be started and supervised by a specialist experienced in managing epilepsy or bipolar disorder.

• Consider the need to arrange treatment reviews with the relevant specialist for women of childbearing potential and girls who are currently taking valproate.

• If a woman who is taking valproate tells you she is pregnant or would like to have a baby, refer her to the specialist responsible for her care.

• Please continue to report any suspected side effects to valproate or any other medicine on a Yellow Card (see also guidance on reporting side effects experienced by the woman or child to medicines taken during pregnancy).

Actions for pharmacists:

• Whenever you dispense a medicine related to valproate for a woman of childbearing potential or girl, give her a patient card, unless she confirms that she already has one.

• Encourage her to read the card (example in figures below) and enter her name and date to reinforce her own accountability to consider the information it contains.

• If you manage dispensing services in your organisation, ensure that processes are in place to

allow these requirements to be met.

• Please continue to report any suspected side effects to valproate or any other medicine on a Yellow Card (see also guidance on reporting side effects experienced by the woman or child to medicines taken during pregnancy).

Key Facts – Valproate▼ and Pregnancy

Name: Date:

- Valproate is an effective medicine used to treat epilepsy and bipolar disorder.
- Valproate can seriously harm an unborn child when taken during pregnancy and should be not taken by women and girls unless nothing else works.
- When taking valproate always use reliable contraception so you do not have an unplanned pregnancy.

▼ This medicine is subject to additional monitoring. This will allow quick identification of new safety information. You can help by reporting any side effects you may get. See www.mhra.gov.uk/yellowcard for how to report side effects.

What you must do

- Speak to your doctor if you are thinking about having a baby, and do **not** stop using contraception until you have done so.
- Tell your doctor at once if you think you may be pregnant or know you are pregnant.
- Never stop taking valproate unless your doctor tells you to as your condition may become worse.

Keep this card safe so you always know what to do.

SAGB.VPA.15.12.1440b January 2016

March 2016 advises:

Trametinib (Mekinist▼): risk of gastrointestinal perforation and colitis

Use trametinib, authorised either as monotherapy or combined with dabrafenib, with caution in patients with risk factors for gastrointestinal perforation.

Also, on 8th February 2016 NHS England issued a Stage One: Warning, Patient Safety Alert.

Risk of severe harm or death when desmopressin is omitted or delayed in patients with cranial diabetes insipidus.

Brighton Area Prescribing Committee and Joint Formulary Update

The Brighton APC makes decisions concerning additions to the Joint Formulary. The following summarises decisions made by the APC February and March 2016:

Ciclosporin (Ikervis) eye drops: **RED** for treating dry eye disease that has not improved despite treatment with artificial tears as per NICE TA369

Vortioxetine: **BLUE** for treating major depressive episodes in adults whose condition has responded inadequately to 2 antidepressants within the current episode as per NICE TA367

Duaklir Genuair 400/12: GREEN

Spiolto Respimat 2.5/2.5: GREEN

AirFluSal Fospiro 50/500: GREEN

Phenelzine: changed to **BLUE** (was previously red)

Olaparib: **RED** as per NICE TA381

Ramucirumab: **BLACK** as per NICE TA378

Enzalutamide: **RED** as per NICE TA377

Radium-223 dichloride: **RED** as per NICE TA376

Nintedanib: **RED** as per NICE TA379

Panobinostat: **RED** as per NICE TA380

Eltrombopag: **BLACK** as per NICE TA382

Adalimumab, etanercept, infliximab, certolizumab pegol, golimumab, tocilizumab and abatacept: **RED** for rheumatoid arthritis not previously treated with DMARDs or after conventional DMARDs only have failed as per NICE TA375.

Octasa MR tablets: **BLUE** Cost effective brand of mesalazine 400mg and 800mg tablets

Nivolumab: **RED** as per NICE TA385

Adalimumab, certolizumab pegol, etanercept, golimumab and infliximab: **RED** as recommended, within their marketing authorisations, as options for treating severe active ankylosing spondylitis in adults whose disease has responded inadequately to, or who cannot tolerate, non-steroidal anti-inflammatory drugs. Infliximab is recommended only if treatment is started with the least expensive infliximab product as per NICE TA383.

A review of Chapter 13 - Skin was completed and as a result there have been multiple changes to the formulary.

See HERE for a list of products that have been added/removed.

That's NICE... https://www.nice.org.uk/guidance

January 2016

QS112: Gastro-oesophageal reflux in children and young people.

TA381: Olaparib for maintenance treatment of relapsed, platinum-sensitive, BRCA mutation-positive ovarian, fallopian tube and peritoneal cancer after response to second-line or subsequent platinum-based chemotherapy.

TA378: Ramucirumab for treating advanced gastric cancer or gastro–oesophageal junction adenocarcinoma previously treated with chemotherapy.

TA377: Enzalutamide for treating metastatic hormone-relapsed prostate cancer before chemotherapy is indicated.

TA376: Radium-223 dichloride for treating hormone-relapsed prostate cancer with bone metastases.

TA379: Nintedanib for treating idiopathic pulmonary fibrosis.

TA380: Panobinostat for treating multiple myeloma after at least 2 previous treatments.

TA382: Eltrombopag for treating severe aplastic anaemia refractory to immunosuppressive therapy (terminated appraisal)

TA375: Adalimumab, etanercept, infliximab, certolizumab pegol, golimumab, tocilizumab and abatacept for rheumatoid arthritis not previously treated with DMARDs or after conventional DMARDs only have failed.

QS109: Diabetes in pregnancy.

QS110: Pneumonia in adults.

QS111: Obesity in adults: prevention and lifestyle weight management programmes.

QS107: Preventing unintentional injury in under 15s.

QS108: Multiple sclerosis.

NG33: Tuberculosis.
NG19: Updated Diabetic foot problems: prevention and management

NICE BITES January 2016 includes:

- Type 2 diabetes NICE NG28; 2015

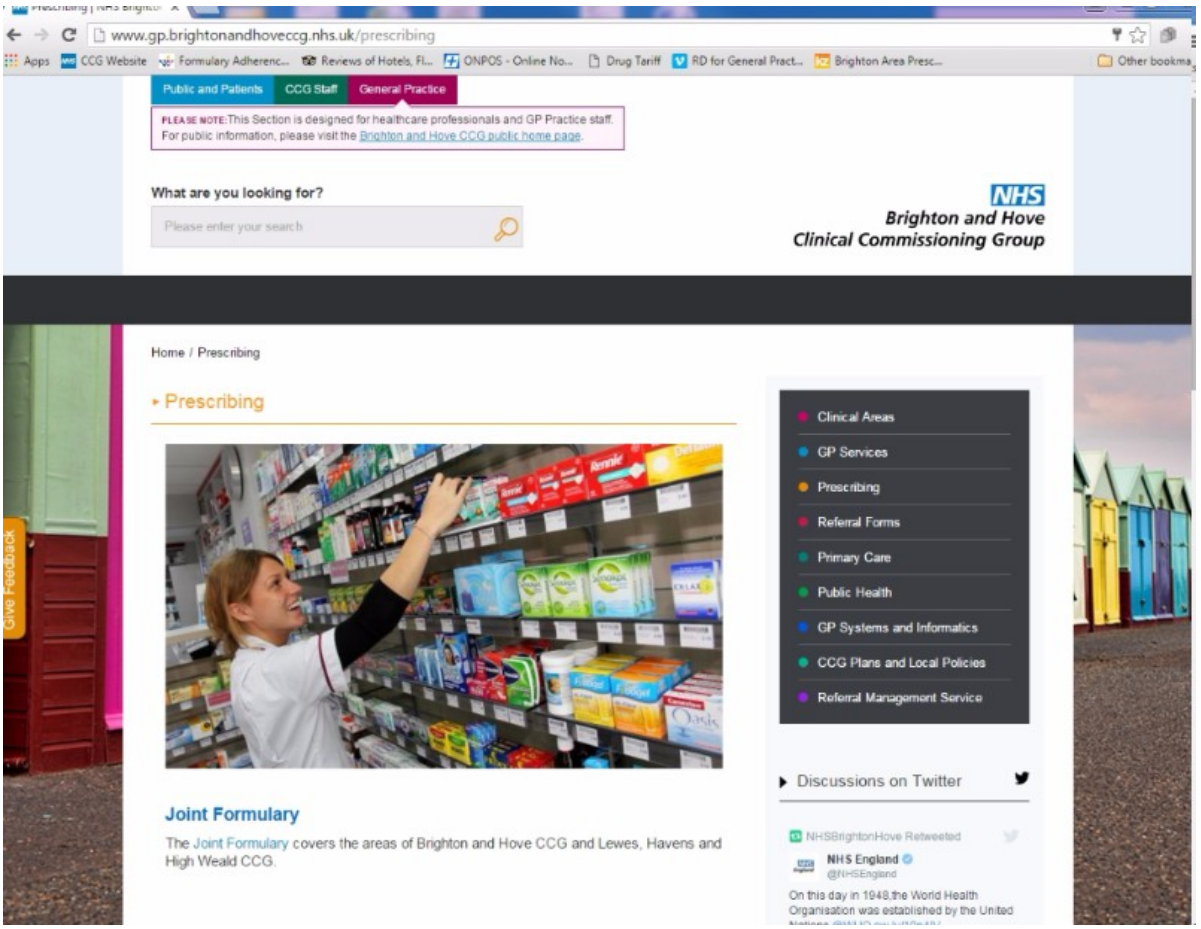
February 2016

NG42: Motor neurone disease: assessment and management
TA385: Ezetimibe for treating primary heterozygous-familial and non-familial hypercholesterolaemia.
TA384: Nivolumab for treating advanced (unresectable or metastatic) melanoma.
QS113: Healthcare-associated infections
QS114: Irritable bowel syndrome in adults
NG35: Myeloma: diagnosis and management
TA383: TNF-alpha inhibitors for ankylosing spondylitis and non-radiographic axial spondyloarthritis
CG185: Updated Bipolar disorder: assessment and management
CG137: Updated Epilepsies: diagnosis and management
QS10: Updated Chronic obstructive pulmonary disease in adults
QS9: Updated Chronic heart failure in adults

NICE BITES February 2016 includes:

- Tuberculosis NICE NG33; 2016

The following is intended for healthcare professionals in the Brighton and Hove CCG locality.



Brighton and Hove CCG Website - Prescribing Pages

The BH CCG website prescribing pages are the GO-TO place to find information regarding locally approved medication and policies, as well as links to other useful resources national websites.

From the prescribing home page you are able to access:

- Joint Formulary (JF) which is list of locally approved medications. 80% of all medications prescribed in the city should be listed on the formulary.
- Shared Care Guidelines (SCGs) and Information Sheets which outline the responsibilities of the specialist who has initiated the medication and the primary care prescriber who is continuing the prescribing.
- Patient Group Directions (PGDs) including national and local PDGs.
- Information on the Brighton Area Prescribing Committee including minutes
- Archive of previous City Scripts newsletters
- Details of the current and past Prescribing Incentive Schemes
- Clinical resources which include local guidance such as lipid management, prescribing of pregabalin, management of infections, self monitoring of blood glucose, erectile dysfunction, vitamin D, dry eye management, overseas travel, plus many more.
- Non-clinical resources include local policies on; the boundaries of NHS and private healthcare and inappropriate or excessive prescribing as well as top 10 tips for prescribers, blister pack FAQs, and resources for non-clinical staff working in practices such as the repeat prescribing pack.

PLEASE NOTE: The website is regularly updated with newly approved medication and new and the latest versions of policies.
We strongly advise against printing anything from the prescribing pages or saving your own local version as these could quickly become out of date.
We recommend that the website is accessed to ensure the most up to date content is being viewed.

Why not save a few of the above links as bookmarks or as a shortcut on your desktop now?

Electronic Repeat Prescribing

If you have any queries regarding EPS, please send these to the medicines management inbox: bhccg.medicinesmanagement@nhs.net.
Someone in the team will then signpost you to the most appropriate organisation to assist you.

Prescribing Incentive Scheme Claims

Cathryn Goodman has now moved on to High Weald Lewes Havens CCG therefore all claims / invoices for owed Prescribing Incentive Scheme monies should be sent to Katarina Ondrusova. Email address: katarina.ondrusova@nhs.net. Katarina currently works in the finance team 2 days a week (Tuesdays and Thursdays).

Contact the BH medicines management team

The following has been written by the medicines management team at High Weald Lewes Havens CCG and is intended for healthcare professionals in this CCG locality.

Electronic Repeat Dispensing Update

Electronic repeat dispensing (eRD) is now available through the EPS2 release and we envisage its implementation to be beneficial to patients, GP's and surgery staff. With this in mind the HWLH medicines management team will be assisting interested GP practices across our CCG with roll out, and a pilot is now underway in Peacehaven.

Following successful engagement with local pharmacies, the first cohort of patients from Rowe Avenue Surgery has been successfully switched to eRD. Once the process is established in Peacehaven our team will be moving onto other practices, who have expressed an interest, helping them to get up and running with the system.
Our target is to get 25% of repeat prescriptions issued using eRD within 24 months. If you would like your practice to be involved in this project, or would like further information, please contact michael.watson7@nhs.net

Contact the HWLH medicines management team

Feedback to the author of this newsletter

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