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

NHS Brighton and Hove Clinical Commissioning Group

NHS High Weald Lewes Havens Clinical Commissioning Group

CITY SCRIPTS

May - June 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.

MPORTANT - 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:

The following articles are relevant to HWLHCCG only:

FDA safety concerns over saxagliptin and alogliptin'

The FDA has issued a safety alert regarding **saxagliptin** (*Onglyza*®) and **alogliptin** (*Vipidia*®). More information is available in the FDA safety announcement.

A safety review found that type 2 diabetes medicines containing saxagliptin and alogliptin (including combinations containing metformin) **may increase the risk of heart failure**, particularly in patients who already have heart or kidney disease.

The FDA alert advises that healthcare professionals should **consider discontinuing** medications containing saxagliptin and alogliptin in patients who **develop heart failure** and monitor their diabetes control.

The review included data from **two large clinical trials** (SAVOR and EXAMINE). In the saxagliptin trial, 3.5% of patients who received the drug were admitted to hospital for heart failure versus 2.8% of patients who received a placebo. In the alogliptin trial, 3.9% of alogliptin treated patients were admitted to hospital for heart failure versus 3.3% in the placebo group. The trials ran for different durations but these data indicate that for approximately **1 in every 150 patients treated** with either of these drugs for **around 2 years** would be expected to be admitted to hospital with heart failure.

Patients taking these medicines should be advised to **contact a healthcare professional** if they develop **signs and symptoms** of heart failure such as:

- Unusual shortness of breath during daily activities
- Trouble breathing when lying down
- Tiredness, weakness, or fatigue
- Weight gain with swelling in the ankles, feet, legs, or stomach

Action:

Patients who are prescribed alogliptin and saxagliptin should be **monitored** for signs of heart failure and these medicines stopped should signs develop.

This warning highlights the need that (as per NICE) if these newer drugs are started they should be reviewed at six months for efficacy and only continued if a 5-6 mmol / mol improvement in HbA1c. As long as they meet this continuation of therapy criteria, the benefits are likely to still outweigh the harms.

Locally, the Joint Formulary gliptin is sitagliptin

www.prescriber.org.uk/2016/04/fda-safety-concerns-over-saxagliptin-and-alogliptin/

Canagliflozin and risk of lower limb amputation

A signal of increased lower limb amputation (primarily of the toe) in people taking canagliflozin compared with placebo is currently under investigation, post results of the CANVAS clinical trial in high cardiovascular risk patients.

MHRA Advice for healthcare professionals:

- As a precaution, consider stopping canagliflozin if a patient develops a significant lower limb complication (eg, skin ulcer, osteomyelitis, or gangrene), at least until the condition has resolved, and continue to monitor the patient closely
- carefully monitor patients receiving canagliflozin who have risk factors for amputation (eg, previous amputations, existing peripheral vascular disease, or neuropathy)
- monitor all patients for signs and symptoms of water or salt loss; ensure patients stay sufficiently hydrated to prevent volume depletion in line with recommendations in the product information; note that diuretics can exacerbate dehydration
- advise patients to:
    - stay well hydrated
    - carry out routine preventive foot care
    - seek medical advice promptly if they develop skin ulceration, discolouration, or new pain or tenderness
- start treatment for foot problems (eg, ulceration, infection, or new pain or tenderness) as early as possible
- continue to follow standard treatment guidelines for routine preventive foot care for people with diabetes

Local Specialist Comment:
We don't know whether the canaglifozin data is a statistical artefact or true, and if true whether it is a class effect or not. However, clinicians should be **aware** of this new safety information. **Risk factors** for amputation should be **considered** before starting new treatment and consideration given to stopping treatment if complications develop during treatment.
This warning highlights the need that (as per NICE) if these newer drugs are started they should be reviewed at six months for efficacy and only continued if a 5-6 mmol / mol improvement in HbA1c. As long as they meet this continuation of therapy criteria, the benefits are likely to still outweigh the harms.

www.gov.uk/government/uploads/system/uploads/attachment_data/file/529618/DSU_pdf_June_2016.pdf

NON - FORMULARY Blood Glucose Testing Strips

We have been made aware of a number of blood glucose meter companies who have been contacting patients, advising them that they can "upgrade" their meter for free. Patient's subsequently request the associated test strips from their GP (usually via a pre-printed slip provided by the company), which are invariably more costly to the NHS.

One particular instance sees the price of the test strips increase from **£9.50 / 50 strips** to more than **£15 / 50 strips**.

*If all strips prescribed were at this higher price, this would be an **extra cost pressure** to the NHS of nearly **£90,000 per year** in Brighton and Hove CCG alone.*

The Medicines Management Team will be following up this unsavoury practice directly with the blood glucose meter companies however, we would like to remind prescribers that the meters listed on the formulary are suitable for most patients. Those with specialist needs i.e. carbohydrate counting, insulin pump users, ketone testing, patients with gestational diabetes or those with severe dexterity problems are permitted to use a non-formulary meter that meets their requirements.

ACTION: Please decline any requests to prescribe non-formulary blood glucose test strips *unless there is a valid clinical reason*.
Patients can be advised to purchase blood glucose testing strips if they wish to continue to use a meter which has advanced functions, over and above their testing requirements.

Nitrofurantoin Toxicity

Pulmonary toxicity with nitrofurantoin is a recognised side effect and prescribers are reminded to ensure appropriate on-going monitoring. It is recommended that liver and kidney function and pulmonary symptoms should be monitored for all patients on long-term therapy with nitrofurantoin, especially for the elderly.

Nitrofurantoin should be discontinued if lung function deteriorates due to the risk of pulmonary toxicity. Acute pulmonary reactions are usually reversible but chronic pulmonary reactions may cause permanent

Opioids Aware

In 2014 the Faculty of Pain Medicine issued a letter highlighting the sharp and sustained increase in the prescription of opioid painkillers in recent years. Almost all the rise in prescribing has been for treatment of long term pain, although opioid medicines are often ineffective for this condition.

Once opioids are started they are difficult to stop. The risk of harm from opioids increases substantially at doses above an oral morphine equivalent of 120mg/day, but there is no increase in benefit. If a patient is using opioids and is still in pain, the opioids are not effective and

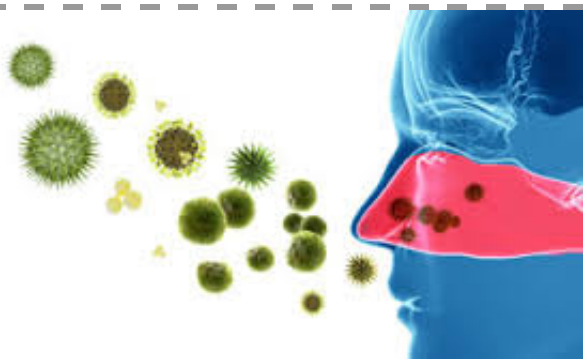
impairment of lung function. Acute pulmonary reactions may occur within the first week of treatment and symptoms may resolve within a few days of stopping nitrofurantoin. Symptoms include fever, dyspnoea, chest pain, cough, rash and sometimes pulmonary oedema.

Chronic pulmonary reactions are rare but are more likely to occur in the elderly or in patients who have received continuous therapy for six months or more. Onset is insidious over months or years. Typical symptoms are dyspnoea, dry cough and fatigue. If unrecognised, there may be progression to pulmonary fibrosis. The fibrosis is not usually reversible, particularly if diagnosed late, and is potentially avoidable.

should be discontinued even if no other treatment is available.

Opioids Aware is a web based resource for patients and healthcare professionals to support prescribing of opioid medicines for pain. Information on the website includes dose equivalents and changing opioids, repeat prescribing and tapering and stopping.

http://www.fpm.ac.uk/faculty-of-pain-medicine/opioids-aware



Hayfever season: the importance of promoting self care

Written by Rachel Cornish

Hayfever; the ‘common cold’ equivalent during the summer months can cause a soar in the number of GP visits. In order to optimise patient outcomes, it is important to promote self-care tips, including adoption of some basic precautions to prevent the symptoms of hayfever. Self care tips that should be recommended to patients may include the following:

- Prevention of pollen getting into eyes by using wraparound sunglasses
- Removing pollen after being outdoors by taking a shower and changing clothes
- Remaining indoors when the pollen count is high (over 50 grains per cubic metre of air)
- Closing windows and doors when indoors to prevent pollen entry

These self care tips are imperative as although they take up time during consultations they may serve to prevent patients returning with poor hayfever control. It is important that patients are aware that before going to see the GP, they need to visit their Pharmacist and treat hayfever symptoms initially with over-the-counter medications. Over-the-counter medications targeted to hayfever can come in a range of forms e.g. eye drops, nasal sprays and antihistamine tablets. As a result, over-the-counter hayfever medications can be tailored to the patient's needs upon advice from the Pharmacist. Thus, patients should be encouraged to speak to their Pharmacist and purchase over-the-counter hayfever remedies themselves as oppose to obtaining them on prescription and using up a GP appointment. It is important to note, the newer second generation antihistamines such as Loratadine and Cetirizine are known as the 'non-sedating' antihistamines in comparison to the first generation such as Diphenhydramine and Chlorphenamine. This is due to their lesser ability to cross the blood brain barrier. However, there are concerns that they can still cause some level of drowsiness and this should be discussed with the patient.

Action: Clinicians should be aware of the self-care advice that should be provided to patients, in addition they should be able to advise patients on the various treatment options available.

SUNSCREEN: protection and prevention

Written by Rachel Cornish

Although the risks of sunbathing are well established, it does not stop individuals from sunbathing without the appropriate sun protection. There are three UV subgroups: UVC, UVB and UVA. UVA contributes to 95% of UV rays from the sun and is a known powerful carcinogen due to its ability to damage skin cells.

In terms of public health, the use of sunscreens is driven by the desire to prevent sunburn and to protect against skin cancer. The ideal sunscreen should have the following properties:

- Broad spectrum (UVA-UVB)
- 30-50 sun protection factor (SPF)
- high UVA index

Education on the application of sunscreens is imperative as although an individual may

use a high SPF sunscreen, they may still burn due to multiple reasons. Various reasons for this are shown below:

- People may apply less sunscreen than the quantities used in the experiments to determine the products SPF.
- The timing of sunscreen application has an effect on the level of protection achieved
- Uniformity of sunscreen application is often not achieved.
- Allergy to that sunscreen

The importance of self care when it comes to sun protection is very important. Individuals need to use appropriate sunscreens, cover up and not spend extreme hours in the direct sunlight and must stay hydrated. It is the individual's responsibility to purchase sunscreens to protect themselves and their family from the sun's harmful rays. Good quality sunscreens (with the above properties) are available to purchase from pharmacies and supermarkets at reasonable prices. However, there is a small cohort of patients who, if deemed appropriate by the prescriber are able to obtain certain sunscreens on prescription. These include patients with abnormal cutaneous photosensitivity resulting from the following:

- Genetic disorders
- Photodermatoses
- Vitiligo
- Radiotherapy
- Chronic or recurrent herpes simplex labialis

Preparations with SPF less than 30 should not normally be prescribed. The following sunscreens are listed on the Joint formulary and are approved for use in the above cohorts:

- Sunsense Ultra ACBS
- Anthelios ACBS
- Uvistat ACBS

Further information on when to prescribe sunscreens can be found under chapter 13 of the Joint Formulary: http://www.gp.brightonandhoveccg.nhs.uk/file/256

'ACBS' stands for the Advisory Committee on Borderline Substances, the above sunscreens are labelled with ACBS as these preparations are regarded as drugs when prescribed for skin protection against ultraviolet radiation in abnormal cutaneous photosensitivity.

For more information on ACBS sunscreen preparations go to the following link: https://www.evidence.nhs.uk/formulary/bnf/current/13-skin/138-sunscreens-and-camouflagers/1381-sunscreen-preparations

Action: Clinicians should ensure that all patients receiving prescription for sunscreen meet the ACBS criteria.

Epipen®-change in dose for children

Following approval from the MHRA, there has been a change in the EpiPen® and EpiPen® Jr body weight classification. EpiPen® comes in two dosage strengths - EpiPen® 0.3mg, and EpiPen® Jr 0.15mg. Selection of the appropriate dosage strength for the patient is determined by the prescribing physician according to patient body weight.

- EpiPen® auto injector 0.3mg is recommended for adults weighing >25kg.
- EpiPen® Jr auto injector 0.15mg is recommended for children weighing between 7.5kg -25kg. For children weighing more than 25kg, EpiPen® auto injector 0.3mg (adult formulation) is recommended.

Please note that the dosage recommendations for the alternative adrenaline autoinjectors Jext® and Emerade® are different so product literature should always be consulted.

ACTION: It is recommended that the child's weight should always be requested and recorded on the clinical system when a new prescription is requested.

Safe Lithium Prescribing

Further to shared learning resultant from two significant events in one of our neighbouring CCGs, the following is a timely reminder of key issues concerning safe Lithium prescribing.

Lithium prescribing is covered by the Lithium Shared Care Guideline, which provides full details of roles and responsibilities together with useful supporting information

Lithium shared care guideline

Safer Lithium Prescribing Tools

● Everyone involved (GPs, Specialists, Dispensing Pharmacists, Patients and Carers) should be aware of their responsibilities.

● **If a patient is transferred to another prescriber, then the new prescriber must be made aware of the shared care guideline.**

● Make use of the patient's lithium treatment monitoring booklet to appropriately document monitoring results and any changes to treatment.

● Be alert to the need for monitoring of adverse effects throughout treatment, and be vigilant for signs of lithium toxicity.

● Be mindful that dose reduction or discontinuation may be necessary during concurrent illness, e.g. diarrhoea, vomiting or infection.

● Ensure that patients are fully aware of their responsibilities, including what to do if they become ill.

● Check for drug interactions when initiating new treatments.

● Do not allow exceptions to the necessity for appropriate monitoring and vigilance when prescribing lithium.

Haloperidol Injection Safety

Prescriptions for haloperidol 50mg/1ml ampoules (depot injection for schizophrenia) have been generated in error, when it has been intended for haloperidol 5mg/1ml solution ampoules (for nausea and vomiting) to be prescribed.

There has been an ongoing manufacturing shortage of haloperidol 5mg/1ml ampoules for many months, and currently practice clinical systems do not have the haloperidol 5mg/1ml ampoules listed (they have been greyed out as if the product has been discontinued rather than out of stock).

This has been raised as an issue with system suppliers but currently it is not known when this will be resolved. It has also been flagged as a risk to the Patient Safety Team at NHS Improvement.

Prescribers are advised to take extra care when prescribing haloperidol injection.

Humalog 200iu/ml KwikPen

A Dear Healthcare Professional letter has been issued to highlight and reduce the risk of medication errors from incorrect use of Humalog® (insulin lispro) 200iu/ml KwikPen.

Humalog® 200iu/ml is twice the concentration of standard 100iu/ml mealtime insulin and should only be administered using its own pre-filled KwikPen.

Patients must be instructed never to transfer it to a different delivery system, as this can lead to overdose and serious hypoglycaemia.

Drug Safety Update

MHRA

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

April 2016 advises:

SGLT2 inhibitors: updated advice on the risk of diabetic ketoacidosis.

Test for raised ketones in patients with ketoacidosis symptoms, even if plasma glucose levels are near-normal. **Advice for healthcare professionals:**

When treating patients who are taking a sodium-glucose co-transporter 2 (SGLT2) inhibitor (canagliflozin, dapagliflozin, or empagliflozin):

- inform them of the signs and symptoms of diabetic ketoacidosis (DKA) and advise them to seek immediate medical advice if they develop any of these
- discuss the risk factors for DKA with patients
- discontinue treatment with the SGLT2 inhibitor immediately if DKA is suspected or diagnosed
- do not restart treatment with any SGLT2 inhibitor in patients who experienced DKA during use, unless another cause for DKA was identified and resolved
- interrupt treatment with the SGLT2 inhibitor in patients who are hospitalised for major surgery or acute serious illnesses; treatment may be restarted once the patient's condition has stabilised
- report suspected side effects to SGLT2 inhibitors or any other medicines on a Yellow Card

Natalizumab (Tysabri▼): progressive multifocal leukoencephalopathy— updated advice to support early detection.

Perform a quantitative serum anti-JCV antibody test—including index value—to support risk stratification for progressive multifocal leukoencephalopathy. For high-risk patients, consider more frequent MRI screening.

Dimethyl fumarate (Tecfidera): updated advice on risk of progressive multifocal leukoencephalopathy.

Cases of progressive multifocal leukoencephalopathy have been reported in patients taking dimethyl fumarate for multiple sclerosis, who all had prolonged lymphopenia.

Fingolimod (Gilenya▼): risks of progressive multifocal leukoencephalopathy, basal-cell carcinoma, and opportunistic infections.

Fingolimod (Gilenya) is authorised to treat relapsing-remitting multiple sclerosis in patients whose disease has failed to respond to beta-interferon or is severe and getting worse rapidly.

Apomorphine with domperidone: minimising risk of cardiac side effects.

Patients receiving apomorphine and domperidone require an assessment of cardiac risk factors and ECG monitoring to reduce the risk of serious arrhythmia related to QT-prolongation. **Advice for healthcare professionals:**

- Before starting treatment, carefully consider whether the benefits of concomitant apomorphine and domperidone treatment outweigh the small increased risk of cardiac side effects
- Discuss the benefits and risks of apomorphine with patients and carers and advise them to contact their doctor immediately if they develop palpitations or syncopal symptoms during

treatment

- Check the QT-interval before starting domperidone, during the apomorphine initiation phase and if clinically indicated thereafter (eg if a QT-prolonging or interacting drug is started or if symptoms of cardiac side effects are reported)
- Regularly review domperidone treatment to ensure patients take the lowest effective dose for the shortest duration
- Advise patients to inform their doctor of any changes that could increase their risk of arrhythmia, such as:
    - symptoms of cardiac or hepatic disorders
    - conditions that could cause electrolyte disturbances (eg gastroenteritis or starting a diuretic)
    - starting any other medicines
- Please continue to report suspected side effects to apomorphine, domperidone, or any other medicine on a Yellow Card

Aflibercept (Zaltrap▼): minimising the risk of osteonecrosis of the jaw.

Dental examination and appropriate preventive dentistry should be considered before treatment, especially for patients also treated with an intravenous bisphosphonate.

Live attenuated vaccines: avoid use in those who are clinically immunosuppressed.

Healthcare professionals working in primary and secondary care should ensure that clinically significant immunosuppression in a patient is identified before administration of a live attenuated vaccine.

Reminder for healthcare professionals:

- Live attenuated vaccines should not routinely be given to people who are clinically immunosuppressed (either due to drug treatment or underlying illness)
- It is important for healthcare professionals who are administering a particular vaccine to be familiar with the contraindications and special precautions before proceeding with immunisation
- Specialists with responsibility for an immunosuppressed patient who may be in a group eligible for a live attenuated vaccine should include in their correspondence with primary care a statement of their opinion on the patient's suitability for the vaccine
- If primary care professionals are in any doubt as to whether a person due to receive a live attenuated vaccine may be immunosuppressed at the time, immunisation should be deferred until secondary care specialist advice has been sought, including advice from an immunologist if required
- Remember that close contacts of immunosuppressed individuals should be fully immunised to minimise the risk of infection of vaccine-preventable diseases in immunosuppressed individuals

Meprobamate: licence to be cancelled.

Following an EU wide review of meprobamate, the remaining licence holder in the UK has ceased manufacturing and the licence will be cancelled by the end of 2016. **Advice for healthcare professionals:**

- Prescribers should review the treatment of any patient who is currently receiving a meprobamate-containing medicine with a view to switching them to an alternative treatment
- Prescribers should not start any new patients on medicines that contain meprobamate

Paraffin-based skin emollients on dressings or clothing: fire risk.
Smoking or a naked flame could cause patients' dressings or clothing to catch fire when being treated with paraffin-based emollient that is in contact with the dressing or clothing. **Reminder for healthcare professionals:**

- Advise patients not to: smoke; use naked flames (or be near people who are smoking or using naked flames); or go near anything that may cause a fire while emollients are in contact with their medical dressings or clothing
- Change patient clothing and bedding regularly—preferably daily—because emollients soak into fabric and can become a fire hazard
- Incidents should be reported to NHS England's Serious Incident Framework (includes Wales), Healthcare Improvement Scotland, or to the Health and Social Care Boards in Northern Ireland

May 2016 advises:

BCR-ABL tyrosine kinase inhibitors: risk of hepatitis B reactivation.
Patients should be tested for hepatitis B virus before starting treatment with BCR-ABL tyrosine kinase inhibitors.

Pomalidomide (Imnovid▼): risk of hepatitis B reactivation.
Before starting treatment with pomalidomide, establish hepatitis B virus status in all patients.

Idelalisib (Zydelig▼): interim measures following signal of serious infection and deaths related to infection found in clinical trials.

June 2016 advises:

Canagliflozin (Invokana▼, Vokanamet▼): signal of increased risk of lower extremity amputations observed in trial in high cardiovascular risk patients. A signal of increased lower limb amputation (primarily of the toe) in people taking canagliflozin compared with placebo in a clinical trial in high cardiovascular risk patients is currently under investigation. See above article for more information.

Nexplanon (etonogestrel) contraceptive implants: reports of device in vasculature and lung.
There have been rare reports of Nexplanon implants having reached the lung via the pulmonary artery. An implant that cannot be palpated at its insertion site in the arm should be located as soon as possible and removed at the earliest opportunity. If an implant cannot be located within the arm, perform chest imaging. Correct subdermal insertion reduces the risk of these events. **Updated advice for healthcare professionals:**

- An implant should only be inserted subdermally and by a healthcare professional who has been appropriately trained and accredited
- Do not insert over the sulcus (groove) between the biceps and triceps.
- Take care to avoid insertion close to any blood vessels or nerve bundles eg the ulnar nerve
- Immediately after insertion, verify the presence of the implant by palpation
- Show the woman how to locate the implant and advise her to do this frequently for the first few months; if she has any concerns she should return to the clinic for advice
- Locate an implant that cannot be palpated (eg, using imaging of the arm) and remove it at the earliest opportunity
- If an implant cannot be located in the arm by palpation or imaging, perform chest imaging
- Surgical or endovascular procedures may be required to remove an implant from the chest
- Review the updated instructions on how to correctly insert the implant, including an amended diagram that illustrates:
    - the correct angle on the arm for insertion
    - how to view the needle to avoid deep insertion

Topical miconazole, including oral gel: reminder of potential for serious interactions with warfarin. In view of reports of serious bleeding events in patients taking miconazole and warfarin, we are considering further measures to minimise the risk of potentially serious interactions between miconazole and warfarin. **Reminder for healthcare professionals:**

- Miconazole, including the topical gel formulation, can enhance the anticoagulant effect of warfarin—if miconazole and warfarin are used concurrently, the anticoagulant effect should be carefully monitored and, if necessary, the dose of warfarin reduced
- Patients should be advised to tell their doctor or pharmacist if they are receiving warfarin before using products that contain miconazole (including those available without prescription), and to seek medical advice if they notice signs of over-anticoagulation during treatment, such as sudden unexplained bruising, nosebleeds or blood in the urine

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 in April and May 2016:

Octasa MR tablets: **BLUE** for new and existing patients. Octasa is the prefered brand of mesalazine and the APC supports a switching programme to take place in primary care.
Vensir XL capsules: **GREEN** for new and existing patients. Vensir XL is the preferred brand on venlafaxine MR and the APC supports a switching programme to take place in primary care.
Ruxolitinub: **RED** for treating disease-related splenomegaly or symptoms in adults with myelofibrosis as per NICE TA386.
Temozolomide: **RED** for the treatment of recurrent malignant glioma (brain cancer) as

per NICE TA23.

The APC approved a new wound management and elasticated garments formulary. Minor changes have been made to the previous formulary which include:

- Honey - Some Algivon products have been replaced with Manuka Dress products
- Cavilion barrier products have been replaced with products from the Medi Derma - S range.

The local TVNs have trialled these products and deemed them to be as effective whilst being cost effective and not compromising on patient care.

- Topical negative pressure therapy has been added to the formulary. This is only for use on patients in joint care with the Tissue Viability Nurse (TVN) Service.
- Hospital only products have been added to the formulary. Primary care alternatives have been noted in the left hand column in most instances.

Sacubitril valsartan: **BLUE** for treating symptomatic chronic heart failure with reduced ejection fraction as per NICE TA388.
Rosuvastatin: **GREEN** (was previously blue, specialist initiated). The lipid pathway states rosuvastatin as an option after 2 other statins at maximum tolerated dose must have been trialled first.
Remsima: **RED** Preferred biosimilar of infliximab.
Esomeprazole IV: **RED** for use in children with feeding tubes.
Abiraterone: **RED** for treating metastatic hormone-relapsed prostate cancer before chemotherapy is indicated as per NICE TA387.
Topotecan, pegylated liposomal doxorubicin hydrochloride, paclitaxel, trabectedin and gemcitabine: **RED** for treating recurrent ovarian cancer as per NICE TA389.

The Respiratory Joint Formulary Chapter (3) was reviewed at the May APC. The following changes have been made:

- Spacer devices have been added to the formulary
- A note encouraging patients to self-care and purchase "Over The Counter" has been added to: simple linctus, pseudoephedrine, pholcodine and menthol and eucalyptus.

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

March 2016

QS120: Medicines optimisation
TA386: Ruxolitinib for treating disease-related splenomegaly or symptoms in adults with myelofibrosis
TA23: Guidance on the use of temozolomide for the treatment of recurrent malignant glioma (brain cancer)
QS118: Food allergy

QS119: Anaphylaxis

NG44: Community engagement: improving health and wellbeing and reducing health inequalities

QS117:Preventing excess winter deaths and illness associated with cold homes

NG13: Updated Workplace health: management practices

CG62: Updated Antenatal care for uncomplicated pregnancies

NICE BITES March 2016 includes:

- Care of dying adults in the last days of life NICE NG31; 2015

April 2016

TA387:Abiraterone for treating metastatic hormone-relapsed prostate cancer before chemotherapy is indicated

TA388:Sacubitril valsartan for treating symptomatic chronic heart failure with reduced ejection fraction

TA389:Topotecan, pegylated liposomal doxorubicin hydrochloride, paclitaxel, trabectedin and gemcitabine for treating recurrent ovarian cancer

QS121: Antimicrobial stewardship

NG46: Controlled drugs: safe use and management

NG45: Routine preoperative tests for elective surgery

QS29:Updated Venous thromboembolism in adults: diagnosis and management

QS22: Updated Antenatal care

QS2: Updated Stroke in adults

CG90: Updated Depression in adults: recognition and management

NICE BITES April 2016 includes:

- Motor Neurone Disease NICE NG42; 2016

Better Health For Our City

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

Medicines Management Team Update

"A few more hellos...!"

Brighton and Hove CCG

This Summer sees lots of new faces in the Medicines Management Team.

Sephora Shaw has joined us full time as a **Pharmaceutical Advisor** to cover Fionnuala Plumart's maternity leave. She will be covering Fionnuala's workstreams of respiratory, antibiotics, PGDs and clinical education.
Stacey Nelson joins us on 7th July for 2 days a week as a **Pharmaceutical Advisor** and will be supporting the QIPP workstreams of continence and nutrition. Stacey will be in the office on Thursdays and Fridays.

Due to the new team members, your practice's allocated Pharmaceutical Advisor may have changed. Please see HERE for an updated list.

Jenny Williams is joining the team as a **Prescribing Support Stoma Nurse** and will be with us for a year to lead on a stoma prescribing savings project. She will be working Wednesday to Friday as a joint post with BSUH Digestive Diseases Department.
David Broadbent is a **Prescribing Support Dietitian** who will be working on a SIP feed prescribing savings project for one year on secondment from BSUH. He will be working Tuesday to Friday.
Katie Clarke is a **Prescribing Support Dietitian** who will be working one day a week on an infant feeds prescribing savings project, on secondment from the Royal Alexandra Children's Hospital, Brighton.
Alison Warren is a **Consultant Cardiac Pharmacist** who will be setting up cluster based cardiac clinics across the city, starting in cluster one, this builds on her successful hypertension clinics in Brighton and AF clinics in Crawley.

All of these people will be contacting you in the near future to introduce themselves, outline their roles and advise how they can support you in achieving high quality medicines optimisation and patient outcomes.

Prescribing Incentive Scheme (PIS) 2016-17

Detail of this current year's PIS 2016-17 is available on the CCG website. Domains covered within the scheme include:

1. Routine Review of High Cost Prescriptions and Specials Prescribing
2. Safe prescribing module
3. AKI – eLearning and Audit (to follow)
4. Reviewing patients with COPD on high dose ICS with a view to reducing steroid load and promote use of a spacer to increase drug deposition in the lungs
5. Pioglitazone Diabetes Review
6. Benzodiazepine Receptor Drugs

The Centre of Excellence is in the process of producing standardised searches for EMIS and System One practices for the last 4 domains. These should be available by July.

Benzodiazepine Receptor Drugs

As part of this year's Prescribing Incentive Scheme (PIS) for the city we're asking

practices to look at their benzodiazepine and Z-drug prescribing and reduce it as much as possible.

NICE Clinical Knowledge Summaries (CKS) have produced a **fantastic** online guide for surgeries on withdrawing patients on BZDs and Z-drugs, http://cks.nice.org.uk/benzodiazepine-and-z-drug-withdrawal. It pulls together a wide variety of information including template withdrawal schedules, how to swap patients to diazepam from other BZDs / Z-drugs where required for slow / managed dose down-titration, and how to manage withdrawal symptoms. To get to these sections click on Management, then Scenario: Benzodiazepine and z-drug withdrawal, then either scroll through the page or click the heading you're interested in.

Pavilions also have a section on their website http://www.pavilions.org.uk/information-professionals/ and the doctors there have very kindly agreed to be contactable by GPs to discuss and offer any advice needed around any specific patient's on benzodiazepines. The best time for consultation is between 9am – 10am, phone number: 01273 731900.

For any queries relating to this section of the PIS then please don't hesitate to contact Kathryn Steele (Pharmaceutical Advisor) on 01273 574796 or email kathryn.steele2@nhs.net. Kathryn normally works Tuesdays and Fridays.

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.

Practice Nutrition Champions

For the past 2 years oral nutritional supplements (sip feeds) reviews have formed part of the Medicines Management work programme. Working with our prescribers we have supported review of patients in order to both optimise prescribing and improve patient outcomes in this area.

We have identified that many patients do not have sufficient information provided by carers/nursing homes to allow prescribers to make an informed decision on whether to prescribe a supplement or not. Prescribers often err on the side of caution and issue a

prescription. Patients discharged from hospital, with no indication of the duration of their supplement, is another issue that our prescribers have to deal with.

Our team will be providing dedicated training sessions during 2016 -17 for practice staff (non-clinical) who will become practice nutrition champions for their practice. The training will enable the champion to:

- **Develop an understanding of MUST and malnutrition.**
- **Ensure that all patients identified as being at risk of malnutrition have appropriate BMI and MUST assessments carried out, and that they are assessed / treated in accordance with local pathways.**
- **Direct appropriate patients for dietician review.**
- **Provide nutritional information to patients / carers for patients with a MUST score less than 2 (preventing inappropriate use of sip feeds).**
- **Liaise with dietitians and other healthcare professionals (such as district nurses/community matrons) on behalf of prescribers.**

Our aim is that this training and on-going support provided by our team will **reduce prescriber time**, in addition to optimising both prescribing and patient outcomes associated with this area.

If your practice wishes to be an early adopter, or would like more information, for this piece of work, please contact Pauline Martin Paulinemartin4@nhs.net

HWLH CCG Prescribing performance update for improving antibiotic prescribing in Primary Care.

As you know, we are measured on 2 targets.

Part a) reduction in the number of antibiotics prescribed in primary care.

Part b) reduction in the proportion of broad spectrum antibiotics prescribed in primary care.

The following graphs show the CCG trends (in red) compared to the Surrey-Sussex Area team (in light blue) and National average (in bright blue).

PART A

PART B

As before, we are not high in terms of volume of antibiotics being prescribed. It is our choice of antibiotic that makes us different. We are higher than average for use of cephalosporins, quinolones and co-amoxiclav, however, it is pleasing to see that we are moving in the right direction.
In order to better understand whether our higher than average use of these broader spectrum agents is justified, the Medicines Management Team has started to audit prescribing within a number of practices. Watch this space for progress and outcomes.

Contact the HWLH medicines management team

Feedback to the author of this newsletter

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