NHS Hastings and Rother Clinical Commissioning Group
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Prescribing Matters

Issue 192 July 2017

Please circulate to all prescribers, including registrars and locums, nurses, paramedics, pharmacists, and pharmacy technicians.
Newsletter can be found here (in the 'communications' section).

In this issue:

Prescribing Support Scheme 2016/17 - key outcomes

Last year local GP practices delivered another incredibly successful Prescribing Support Scheme (PSS), improving cost-effectiveness and quality of prescribing across the CCGs. Every practice across EHS CCG and 23 of 26 practices in HR CCG signed up to deliver the 2016/17 scheme.

As previously reported, over 950 patient-centred ***Pain Management Reviews*** for oxycodone and opioid patches were conducted, reducing the risk to patients of harmful side effects and long-term problems, and delivering over £156K savings to the prescribing budget.

Improving ***repeat prescribing processes*** through the implementation of key standards and delivery of a related training package to 160 practice administration staff formed a key part of the scheme. This resulted in a reduction in the volume of prescriptions and was likely to have contributed significantly to the reduction in prescribing costs observed.

Antibiotic peer review meetings were attended by more than 200 prescribers over 23 meetings. Both CCGs continue to reduce the volume of antibiotics prescribed.

Full details of the outcomes of these parts of the scheme will be reported separately in the coming months.

The majority of GP practices (74%) achieved their cost/ASTRO PU targets and automatically qualified for payment under the scheme. Eleven practices (5 in EHS CCG, 6 in HR CCG) did not meet the required cost/ASTRO PU targets and were eligible to engage the appeals process to receive payment. Nine GP practices fulfilled the requirements of the appeal process.

Thank you for your engagement, hard work and commitment to quality which has led to the delivery of another successful PSS. We look forward to continue working with you. This year's PSS promises great things, with 100% of GP practices signed up for the first time in several years!

Asthma self-management programmes can reduce unscheduled care - National Institute for Health Research

BTS/SIGN asthma guidelines advise that everyone should receive supported self-management in the form of a written personalised action plan that is regularly reviewed by a health professional.
The guidelines emphasise that every asthma consultation is an opportunity to review and reinforce the patient's education and understanding. Brief simple education linked to patient goals is most likely to be acceptable. Self-management programmes aren't always delivered effectively - the 2014 UK National Review of Asthma Deaths (NRAD) study found that self-management training was only reported for 23%.

This extensive overview of systematic reviews included evidence from 270 randomised controlled trials in 27 systematic reviews alongside later randomised trials exploring the effects of asthma self-management on healthcare utilisation and costs.

Results
People with asthma who receive supported self-management are ***less likely to attend A&E or be admitted to hospital***. Self-management programmes were slightly more expensive, but this cost was likely to be offset by reduced unplanned medical visits and improved patient quality of life.
Programmes which included ***written action plans*** supported by ***regular professional review*** were found to be most beneficial.

Implications
These findings are in keeping with current guideline recommendations and emphasise that supported self-management programmes for asthma should be prioritised.
People with asthma, as with other long-term conditions, can be empowered by learning to manage their condition confidently. This can reduce the number of unplanned visits to healthcare services.
The optimal components of self-management support for different population groups needs further study.

Most of our practices appear to be using either the EMIS asthma plan template or the asthma UK plan.

Diabetes – Dr Dashoura advice on insulin initiation in TIIDM

Normally we start with basal insulin at night - NICE guidance suggests most patients should be preferentially started on isophane insulin (NPH); insulin glargine or detemir can be considered if NPH is not appropriate. Day time ***oral antidiabetic drugs should be individually reviewed*** to avoid polypharmacy. Metformin should be continued for CV benefits.
When we have reached good fasting blood glucose but the HbA1c is still higher than 53 mmol/mol (7%) or the patients individualised target, we consider adding prandial insulin for the meal which is responsible of the hyperglycaemia. Ultimately the patient may need full basal bolus regimen with three meal time injections of quick acting insulin like Novorapid (or similar) and one injection of basal insulin at bed time.

The next ***Diabetes LCS updates*** (28 Sept, Hastings; 11th Oct, Eastbourne) will include insulin initiation.
More information can be found in the Right Insulin Right Dose Right Time toolkit which has been adopted for local implementation.
BMJ learning series on initiating insulin may also be helpful.

NHS Urgent Medicine Supply Advanced Service (NUMSAS)

https://www.england.nhs.uk/wp-content/uploads/2016/11/numsas-service-specification.pdf

The DoH and NHSE have commissioned a national pilot of a community pharmacy Urgent Medicine Supply Service, which is now rolling out across some East Sussex community pharmacies. This is an NHS service, whereas the existing 'emergency supply' service is a private service which pharmacies can charge for.

Patients can only access the service by contacting NHS 111; it is not available to patients who 'walk-in' to the pharmacy or are referred by another healthcare professional.

If a community pharmacist makes a supply of a medicine or appliance through NUMSAS they are required to ***notify the patient's GP*** on the day the supply is made or on the following working day; locally this will be through PharmOutcomes.

Please note: Practices are NOT required to issue prescriptions for medicines supplied under the service as pharmacies will be reimbursed directly by NHSE.

Clexane dose change for treatment of DVT/PE

https://assets.publishing.service.gov.uk/media/596f669a40f0b60a400001ba/Clexane_DHPC_300617.pdf

The dosage for treatment of DVT and PE has been standardised across Europe; this means there are now ***two dose schedules to treat DVT/PE*** rather than one in the UK:

- once daily injection of 1.5mg/Kg (150 IU/kg) for uncomplicated patients with low risk of VTE recurrence (the previous UK dosage)
- twice daily injections of 1mg/Kg (100 IU/kg) for all other patients such as those with obesity, with symptomatic PE, cancer, recurrent VTE or proximal (iliac vein) thrombosis (new dosage for the UK)

For patients with severe renal impairment (creatinine clearance 15-30 ml/min) please refer to product literature to check dosing.
Doses and strengths of Clexane are now also expressed as international units and milligrams (previously only as milligrams).

NB there are currently some supply problems with Clexane. If necessary, please use alternative LMWH and refer to BNF for dosing guidance.

Hepatitis A and B supply problems

There are ongoing supply problems with hepatitis vaccines, due to a global supply shortages of hepatitis B and the hepatitis A outbreak in men who have sex with men (MSM); these problems are expected to continue into 2018.
Practice nurses are advised to ensure they keep up to date with the supply situation and advice from PHE on priority groups for vaccination.

Further information can be obtained from:

Query	Contact Details
*General Vaccine Supply Queries, including stock availability and ordering	Contact your regular wholesaler. If unable to obtain supplies, try an alternative wholesaler and if still unable to obtain vaccine, contact the manufacturer directly through their customer services.
Hepatitis A vaccine procurement queries	hepatitisA@phe.gov.uk
Clinical or Public Health Hepatitis A and B queries	Local Health Protection Team or immunisation.lead@phe.gov.uk
Hepatitis A and B Queries from the public	Local Health Protection Team or Screening and Immunisation team
Hepatitis A travel queries	NATHNAC via www.travelhealthpro.org.uk Travax via www.travax.nhs.uk

Area Prescribing Committee update June 17

- **Contact your Medicines Management Advisor for a full copy of the minutes.**
- **Minutes from previous Area Prescribing Committee meetings can be found on the CCG website.**
- **Information on other topics discussed and work in progress can be found in the minutes.**

Shared Care Guidelines and New Monitoring Guidance from the British Society for Rheumatology for azathioprine, ciclosporin, hydroxychloroquine, leflunomide, mercaptopurine, methotrexate, mycophenolate and sulfasalazine.

The guidelines can be found by using a search at this link: http://nww.esht.nhs.uk/corporate/document-search/ .

Key points:-

1) The Specialists Responsibilities, Primary Care Prescriber Responsibilities and the Patient's/ carer's roles are clearly defined in the shared care agreement documents.
2) The Monitoring Schedules are clear and include advice on when to contact the specialist team urgently.
3) Signs of toxicity are summarised.
4) If the practice declines shared care the named consultant should be informed within 14 days of receipt of the specialist's request.

Methotrexate

The methotrexate shared care agreement states that ***only methotrexate 2.5mg tablets should be prescribed*** to eliminate confusion for prescribers and patients. Patients will be counselled by the specialist team on taking the appropriate number of methotrexate 2.5mg tablets.

Prescribing data indicates that there is still a large volume of prescribing of methotrexate 10mg tablets in primary care; patients currently taking 10mg strength tablets should only be switched to 2.5mg tablets if a dose adjustment is being made, where the new dosage will be clearly explained to the patient by the specialist.

Formulary Update - Hypersalivation in adults and children.

First line choice (green) in the formulary- hyoscine hydrobromide tablets and hyoscine patches for treatment of both adults and children.

Second line choice (Blue) –

- glycopyrronium bromide 1mg in 5ml SF oral solution (Colonis Pharma Ltd) for adults
- glycopyrronium bromide 400mcg in 1ml oral solution SF (Sialanar) for the treatment of hypersalivation in children and young adults (up to 25 years) where hyoscine products are contraindicated, ineffective or not tolerated.

Glycopyrronium bromide tablets are not included in the formulary because of their high cost.