Somerset CCG Medicines Management Newsletter June 2018

Prescribing Formulary and Traffic Lights

Please note that the TLS is available at: http://www.somersetccg.nhs.uk/about-us/how-we-do-things/prescribing-and-medicines-management/

The Formulary is now available as a separate website http://formulary.somersetccg.nhs.uk/

Medicines safety special

We take medicines safety very seriously and have numerous, nationally leading, systems in place to ensure that Somerset patients get as much benefit and as little risk from their medications as possible. We have encouraged deprescribing of unnecessary and potentially harmful medicines, particularly in the frail elderly, via use of innovative tools such as eclipse live Not only does this improve patient outcomes but it also reduces the medico legal risk to the prescriber. This is a fluid situation as patient's ability to tolerate medicines changes constantly based upon their co-morbidities.

We thought we would dedicate this issue to improving medication safety. Medication errors can occur at any stage in the process, and fortunately 75% of incidents result in no harm to the patient. So what do we have in place?

Hunt to crack down on NHS drug errors linked to up to 22,000 deaths

Department of Health & Social Care

The Report of the Short Life Working Group on reducing medication-related harm

About 237m medication errors happen every year, though three-quarters result in no harm to patients

71% of the 237m annual drug errors occur in primary care prescribing, 20% relate to hospital care.

Avoidable adverse drug reactions lead to an estimated 712 deaths in England every year and could be a contributory factor in 1700 to 22,303 deaths a year, concludes a report from the Universities of York, Manchester, and Sheffield.

Initial prescribing- emis has some pop ups and MM have a range available to ensure the correct medication/strength is chosen initially. The MM team will be happy to advise at any time.

Eclipse Live will monitor whether a patient is at risk from a medication (or combination of medicines) based on their ever changing metrics and diagnoses. Below are some examples:

Recent NHSE alerts

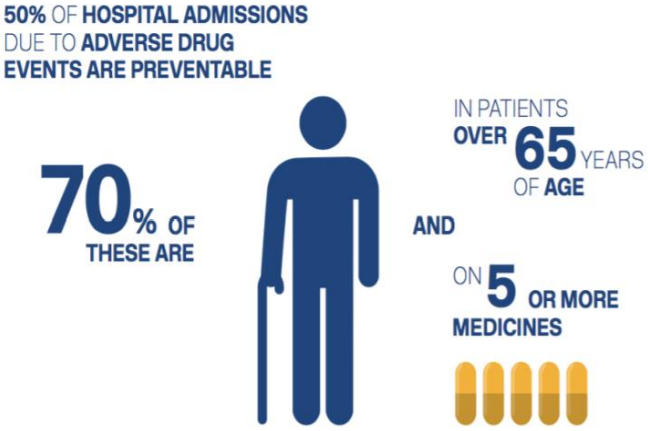
Project	**Ulipristal (Esmya) for uterine fibroids** MHRA warning announced Feb 18. Reports of serious liver injury requiring transplantation.• • Do not initiate new treatment courses of Esmya, including in women who have completed one or more treatment courses previously • • Perform liver function tests at least once a month in all women currently taking Esmya. Stop Esmya treatment in any woman who develops transaminase levels more than 2 times the upper limit of normal, closely monitor and refer for specialist hepatology evaluation as clinically indicated. Liver function tests should be repeated in all women 2 to 4 weeks after stopping treatment. • • Check transaminase levels immediately in current or recent users of Esmya who present with signs or symptoms suggestive of liver injury (such as nausea, vomiting, malaise, right hypochondrial pain, anorexia, asthenia, jaundice). If transaminase levels are more than 2 times the upper limit of normal, stop treatment, closely monitor and refer for specialist hepatology evaluation as clinically indicated.	06/05/2018	12	6
Project	**Valproate in females of child bearing age** MHRA alert April 2017 recommends an action plan to ensure all girls and women of or nearing childbearing age taking valproate are systematically identified so that all relevant resources can be used to plan their care.https://www.gov.uk/government/publications/toolkit-on-the-risks-of-valproate-medicines-in-female-patients	06/05/2018	253	62

Patients at risk of hospital admission

Diabetes	**Patients >=75 year prescribed insulin in last 120 days with latest HbA1c <=58** High risk of hypoglycaemia	06/05/2018	95	9
Diabetes	**Patients >=75 years co-prescribed insulin & sulfonylurea in last 90 days with latest HbA1c <=58** High risk of hypoglycaemia	06/05/2018	4	0
Project	**Severe hyponatraemia** Patients with very low serum sodium <= 125 mmol/L. High risk of falls and hospital admission	06/05/2018	71	17
Project	**Thiazides and hyponatraemia** Patients taking a thiazide diuretic and have sodium <=130. Hyponatraemia is a common side effect of thiazides and can cause confusion and falls in the frail and elderly particularly in renal impairment. Please check if thiazide is still indicated or adjust dose accordingly.	06/05/2018	69	13
Monitoring	**Combined ACE-I, NSAID and thiazide diuretic** Combined ACE-I, NSAID and thiazide diuretic. Triple whammy- can be detrimental to renal health	06/05/2018	280	0

The ***safety spreadsheet*** highlights medicines identified as potential risks by the MHRA (over the last 10 years) and highlights the number of patients per practice taking these medicines. There is a crib sheet to remind us of the reasons behind the caution. Please talk to your practice pharmacist to get an update. Below is an example of the numbers for Somerset

Filter	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
⊞Alfacalcidol	517	554	549	529	578	554	534	564	563	555	478	568
⊞Alimemazine Tartrate	13	30	14	11	14	12	9	14	19	12	11	13
⊞Aliskiren	14	11	11	10	13	17	10	15	10	18	7	13
⊞Arcoxia_Tab 90mg	7	4	5	4	4	3	6	6	3	4	1	2
⊞Brimonidine Tart (Rosacea)		11	8	12	11	9	9	22	10	14	11	16
⊞Bromocriptine	13	12	16	20	12	17	14	12	15	12	14	14
⊞Cabergoline all	46	36	42	32	44			39	43	37	38	44



Of these 50% preventable events, 50% are caused by three categories of drugs- **diuretics, NSAIDS and hypnotics** (and combinations of these). GI Bleed, falls and hyponatraemia figure largely in these admission figures.

Polypharmacy also plays its part in the elderly, so deprescribing and dose optimisation is key.

Below is an excellent resource; we would recommend you save an electronic copy.
http://www.therapeutics.scot.nhs.uk/wp-content/uploads/2018/04/Polypharmacy-Guidance-2018.pdf

A useful page from this document is part of the 7 steps to appropriate polypharmacy, linking 3 tables for a co-ordinated and stepwise approach. The blue hyperlink takes you to the next step. Click the link above to access the full document and access to all the hyperlinks.

Table 2a: An overview of key considerations at each step

Domain	Steps		Process
Aims	1.	What matters to the patient?	**Review diagnoses and identify therapeutic objectives with respect to:** • What matters to me (the patient)? • Understanding of objectives of drug therapy • Management of existing health problems • Prevention of future health problems
Need	2.	Identify essential drug therapy	**Identify essential drugs (not to be stopped without specialist advice):** • Drugs that have essential replacement functions (e.g. levothyroxine) • Drugs to prevent rapid symptomatic decline (e.g. drugs for Parkinson's disease, heart failure)
	3.	Does the patient take unnecessary drug therapy?	**Identify and review the (continued) need for drugs:** • With temporary indications • With higher than usual maintenance doses • With limited benefit in general for the indication they are used for • With limited benefit in the patient under review (See: *Drug Efficacy (NNT)* table)
Effectiveness	4.	Are therapeutic objectives being achieved?	**Identify the need for adding/intensifying drug therapy in order to achieve therapeutic objectives:** • To achieve symptom control • To achieve biochemical/clinical targets • To prevent disease progression/exacerbation
Safety	5.	Does the patient have ADR/Side Effects or is at risk of ADRs/Side Effects? Does the patient know what to do if they're ill?	**Identify patient safety risks by checking for:** • Drug-disease interactions • Drug-drug interactions (see *Cumulative Toxicity* tool) • Robustness of monitoring mechanisms for high-risk drugs • Drug-drug and drug-disease interactions • Risk of accidental overdosing (*Yellow Card Scheme*) **Identify adverse drug effects by checking for** • Specific symptoms/laboratory markers (e.g. hypokalaemia) • Cumulative adverse drug effects (see *Cumulative Toxicity* tool) • Drugs that may be used to treat ADRs caused by other drugs (*Sick Day Rule* guidance can be used to help patients know what do with their medicines if they fall ill)
Cost-effectiveness	6.	Is drug therapy cost-effective?	**Identify unnecessarily costly drug therapy by:** • Consider more cost-effective alternatives (but balance against effectiveness, safety, convenience)
Patient centeredness	7.	Is the patient willing and able to take drug therapy as intended?	**Does the patient understand the outcomes of the review?** • Does the patient understand why they need to take their medication? • Consider Teach back **Ensure drug therapy changes are tailored to patient preferences** • Is the medication in a form the patient can take? • Is the dosing schedule convenient? • Consider what assistance the patient might have and when this is available • Is the patient able to take medicines as intended? **Agree and Communicate Plan** • Discuss with the patient/carer/welfare proxy therapeutic objectives and treatment priorities • Decide with the patient/carer/welfare proxies what medicines have an effect of sufficient magnitude to consider continuation or discontinuation • Inform relevant healthcare and social care carers change in treatments across the care interfaces Add the READ code **88318** to the patients record so that when they move across transitions of care it is clear their medication has been reviewed

Table 2b: An overview of therapeutic groups under each step

Step 2: Essential drug therapy – Only consider stopping following specialist advice

Discuss with expert before stopping	Discuss with expert before altering	
○ Diuretics - in LVSD (7)	○ Anti-epileptics	○ Thyroid hormones
○ ACE inhibitors - in LVSD (17)	○ Antipsychotics	○ Amiodarone
○ Steroids	○ Mood stabilisers	○ Antidiabetics (34)
○ Heart rate controlling drugs	○ Antidepressants	○ Insulin
	○ DMARDs	

Step 3: Potentially unnecessary drug therapy

Check for expired indication	Check for valid indication	Benefit versus Risk
○ PPI (1) /H^2 blocker (2)	○ Anticoagulant (5)	○ Antianginals (12)
○ Laxatives (3)	○ Anticoagulant + antiplatelet (6)	○ BP control (15)
○ Antispasmodics (4)	○ Aspirin (6)	○ Statins (14)
○ Oral steroid (22, 36)	○ Dipyridamole (6)	○ Corticosteroids (20)
○ Hypnotics/anxiolytics (24)	○ Diuretics (7)	○ Dementia drugs (26)
○ H^2 blockers (29)	○ Digoxin (9)	○ Bisphosphonates (37)
○ Metoclopramide (28)	○ Peripheral vasodilators (10)	○ HbA_{1c} control (34)
○ Antibacterials (oral/topical) (32)	○ Quinine (11)	○ Female hormones (42)
○ Antifungals (oral/topical) (33)	○ Antiarrhythmics (13)	○ DMARDs (48)
○ Sodium/potassium supplements (44, 45)	○ Theophylline (21)	*(see Drug Efficacy (NNT) table)*
○ Iron supplements (44)	○ Antipsychotics (25)	
○ Vitamin supplements (44)	○ Tricyclic antidepressants (27)	
○ Calcium/Vitamin D (44)	○ Opioids (30)	
○ Sip feeds (44)	○ Levodopa	
○ NSAIDs (46)	○ Nitrofurantoin (32)	
○ Drops, ointments, sprays etc (49)	○ Alpha-blockers (39)	
	○ Finasteride (40)	
	○ Antimuscarinics (urological) (41)	
	○ Cytotoxics/immunosuppressants (43)	
	○ Muscle relaxants (47)	

4	Antispasmodics		○ Rarely effective, rarely indicated long term ○ CAUTION: Anticholinergic side effects
Cardiovascular System			
5	Anticoagulants		○ Check for expired indications (e.g. temporary loss of mobility that has now resolved) ○ Much more effective for stroke prevention in AF than anti-platelets ○ CAUTION: Bleeding events. Avoid combination of anticoagulants, antiplatelets and NSAIDs ○ Ensure patient adherence to dosing and monitoring regimen ○ Is patient is unfit for anticoagulation (warfarin and DOACs) for cognitive reasons
6	Antiplatelets		○ NOTE: Antiplatelets are no longer indicated for primary prevention of CHD ○ Aspirin plus clopidogrel indicated for maximum 12 months after ACS only ○ CAUTION: Bleeding events. Avoid combination of anticoagulants, antiplatelets and NSAIDs ○ Consider PPI in those with additional GI risk factors (consider lansoprazole or pantoprazole in preference to (es)omeprazole in patients taking clopidogrel) ○ Consider antiplatelets as part of secondary prevention strategy after CVD events ○ First line antiplatelet for secondary stroke prevention is clopidogrel
7	Diuretics		○ Usually essential for symptom control in heart failure ○ Note: Not indicated for dependent ankle oedema (consider medication causes, e.g. CCBs) ○ CAUTION: AKI and electrolyte disturbances ○ Advise patient to stop during intercurrent illness (*Sick Day Rule* guidance); is U&E monitoring robust?

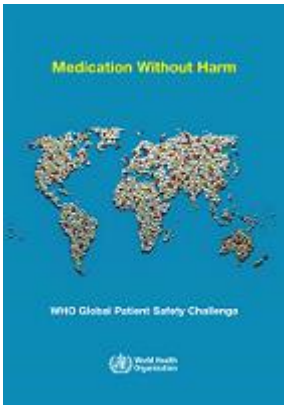
Care homes medicines optimisation.

During the last year our pharmacists and GPs have conducted 3439 medication reviews, identifying 1178 safety risks, and deprescribing £269k of medication.

Federation	No of Care Homes	No of beds	No of Care Homes Reviewed	No of Care Homes Visited 1st Visit	No of Care Homes Visited 2nd Visit	Total hours spent on review	No of Care Home Patients registered	No of Care Home Patients Reviewed 1st Visit	No of Care Home Patients Reviewed 2nd Visit	total number of patient reviews
CLICK	22	488	16	16	0	264.75	392	265	0	265
Bridgwater Bay	19	540	10	10	0	135.00	374	264	0	264
Central Mendip	7	212	6	6	2	233.50	175	123	43	166
East Mendip	11	417	10	10	1	167.50	301	316	52	368
North Sedgemoor & Highbridge	37	810	17	17	1	190.50	562	287	18	305
South Somerset	45	1302	30	30	0	446.65	963	518	0	518
Taunton Deane	61	1857	34	34	10	666.95	1298	688	154	842
West Mendip	18	563	12	12	1	495.25	380	371	12	383
West Somerset	17	446	16	16	1	283.90	355	317	11	328
Total	237	6635	151	151	16	2884.00	4800	3149	290	3439

Safety Risk Assessment Scoring	
1 - Minor	882
2 - Moderate/Significant	278
3 - Major/Serious	18
4 - Catastrophic/Potentially Lethal	0
Total	1178

Intervention Type totals		
1 - Error Codes	1157	-£10,398.95
2 - Switch Codes	1322	-£91,349.99
3 - Stop Codes	1697	-£125,148.88
4 - Start Codes	122	£4,012.78
5 - Allergy Codes	2	n/a
6 - Monitoring	967	n/a
7 - Misc Codes	2418	-£46,626.55
Total	7685	-£269,511.59



The World Health Organisation launched a major initiative to reduce medication errors in three areas:

- High risk situations- such as inpatients, frail elderly, children, care homes
- Polypharmacy- increased with life expectancy, interactions, augmented effects
- Transitions of care- patient moves from one setting to another, usually communication errors

The medicines safety network for Somerset recently met to discuss how to improve medication communication when a patient moves from one setting to another. Discharge summaries are a big concern in terms of timing and quality. Somerset trusts have asked that GPs record late or poor quality discharge summaries on DATIX so that the clinical governance teams can take up the issue with the author of the document. Though this is extra work initially, it will improve the summaries as more individuals are taken to task. GPs should have a DATIX icon on your desktop.

Medication safety dashboard Click here for more

Newly introduced initiative linking medication to admissions and risk of admissions, July-Sept 2017 is latest data. Early stages yet, but practice specific data should be along soon. Looks at GI bleeds risk linked to NSAIDS, antiplatelets, anticoagulants with or without a PPI. Also looks at risk of AKI admissions for patients' prescribed "triple whammy" NSAID, RAS plus diuretic.

We have had this triple therapy alert on ***Eclipse*** for many years, currently:

- 529 patients on all three drugs, but zero patients reviewed. Most patients are above 60 years and taking NSAIDs on repeat prescription.

Also - 1316 total patients on repeat NSAIDs but no GI protection, 900+ of who are over 60 yrs

We have elevated the triple therapy alerts temporarily to red to draw attention to this potential AKI threat. Please can you review any relevant patients ? Please discuss practice data with your pharmacist, or contact [redacted] for practice specific data.

Search	Last Run	Patients	Reviewed
Combined ACE-I, NSAID and thiazide diuretic Combined ACE-I, NSAID and thiazide diuretic. Triple whammy- can be detrimental to renal health	03/06/2018	**308**	**0**
Combined ARB, NSAID and thiazide diuretic Combined ARB, NSAID and thiazide diuretic	03/06/2018	**221**	**0**

Confidential prescribing and patient safety reports on key indicators now available free for GPs

Confidential reports designed to help you improve the quality of your prescribing and patient safety are now available for practices that contribute to the MHRA's Clinical Practice Research Datalink.

The reports provide a list of pseudonymised patients at the practice so that GPs can re-identify and review their care plans. They also show the practice's prescription rate benchmarked against other participating GP practices.

Each report covers a selection of safety indicators. Current indicators are taken from the RCGP patient safety toolkit with input from NICE, including:

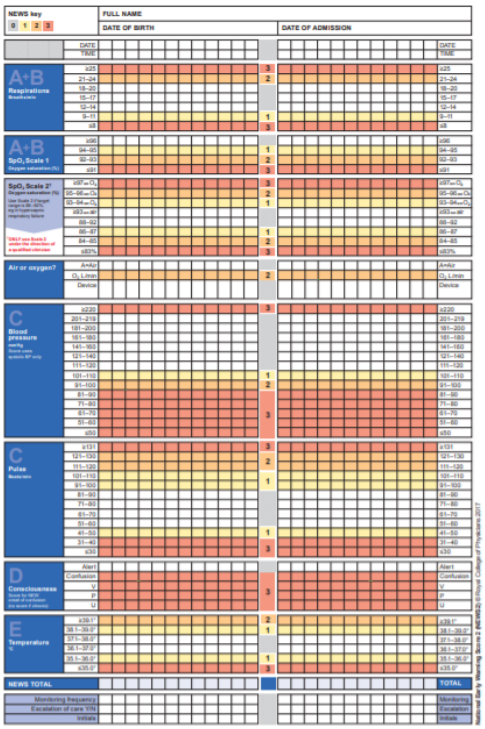
- Prescription of glitazones to patients with heart failure
- Prescription of non-steroidal anti-inflammatory drugs (NSAIDs) to patients with heart failure
- Prescription of NSAIDs to patients with chronic kidney disease (CKD)
- Aspirin monotherapy for stroke prevention in patients with atrial fibrillation

GPs are invited to take an active role in suggesting topics for future reports.

A sample report is available on the CPRD website. Dr Tommy Hunter has written a blog about how he has used the report at his own practice. Unlike much of the performance measurement information that a practice receives, this report is for practice-use only and not in the public domain.

To receive the reports, practices must first join CPRD.

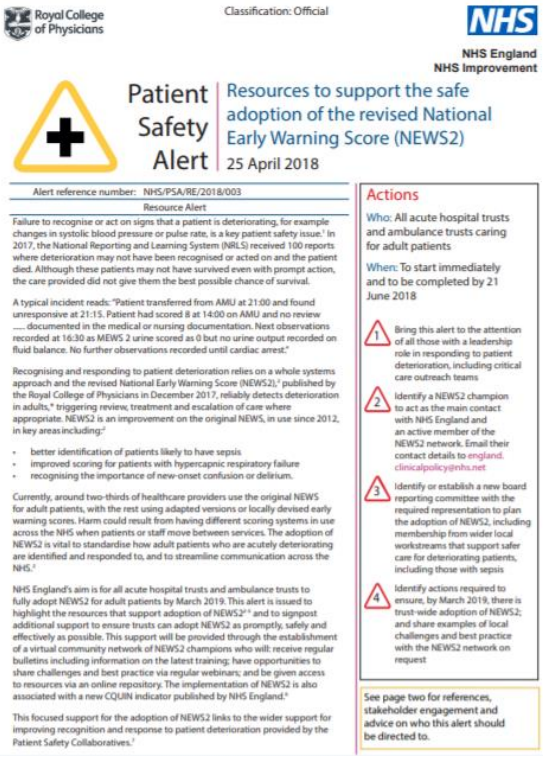
National Early Warning Score (NEWS) 2



NEWS is based on a simple aggregate scoring system in which a score is allocated to physiological measurements, already recorded in routine practice, when patients present to, or are being monitored in hospital. Six simple physiological parameters form the basis of the scoring system:

1. respiration rate
2. oxygen saturation
3. systolic blood pressure
4. pulse rate
5. level of consciousness or new confusion*
6. temperature.

Link to training on NEWS2
Link to RCP website
Link to observation chart



Royal College of Physicians

Classification: Official

NHS England
NHS Improvement

Patient Safety Alert

Resources to support the safe adoption of the revised National Early Warning Score (NEWS2)

25 April 2018

Alert reference number: NHS/PSA/RE/2018/003

Resource Alert

Failure to recognise or act on signs that a patient is deteriorating, for example changes in systolic blood pressure or pulse rate, is a key patient safety issue.[1] In 2017, the National Reporting and Learning System (NRLS) received 100 reports where deterioration may not have been recognised or acted on and the patient died. Although these patients may not have survived even with prompt action, the care provided did not give them the best possible chance of survival.

A typical incident reads: "Patient transferred from AMU at 21:00 and found unresponsive at 21:15. Patient had scored 8 at 14:00 on AMU and no review ..... documented in the medical or nursing documentation. Next observations recorded at 16:30 as MEWS 2 urine scored as 0 but no urine output recorded on fluid balance. No further observations recorded until cardiac arrest."

Recognising and responding to patient deterioration relies on a whole systems approach and the revised National Early Warning Score (NEWS2),[2] published by the Royal College of Physicians in December 2017, reliably detects deterioration in adults,* triggering review, treatment and escalation of care where appropriate. NEWS2 is an improvement on the original NEWS, in use since 2012, in key areas including:[2]

- better identification of patients likely to have sepsis
- improved scoring for patients with hypercapnic respiratory failure
- recognising the importance of new-onset confusion or delirium.

Currently, around two-thirds of healthcare providers use the original NEWS for adult patients, with the rest using adapted versions or locally devised early warning scores. Harm could result from having different scoring systems in use across the NHS when patients or staff move between services. The adoption of NEWS2 is vital to standardise how adult patients who are acutely deteriorating are identified and responded to, and to streamline communication across the NHS.[2]

NHS England's aim is for all acute hospital trusts and ambulance trusts to fully adopt NEWS2 for adult patients by March 2019. This alert is issued to highlight the resources that support adoption of NEWS2[2-4] and to signpost additional support to ensure trusts can adopt NEWS2 as promptly, safely and effectively as possible. This support will be provided through the establishment of a virtual community network of NEWS2 champions who will: receive regular bulletins including information on the latest training; have opportunities to share challenges and best practice via regular webinars; and be given access to resources via an online repository. The implementation of NEWS2 is also associated with a new CQUIN indicator published by NHS England.[4]

This focused support for the adoption of NEWS2 links to the wider support for improving recognition and response to patient deterioration provided by the Patient Safety Collaboratives.[1]

Actions

Who: All acute hospital trusts and ambulance trusts caring for adult patients

When: To start immediately and to be completed by 21 June 2018

1. Bring this alert to the attention of all those with a leadership role in responding to patient deterioration, including critical care outreach teams
2. Identify a NEWS2 champion to act as the main contact with NHS England and an active member of the NEWS2 network. Email their contact details to england.clinicalpolicy@nhs.net
3. Identify or establish a new board reporting committee with the required representation to plan the adoption of NEWS2, including membership from wider local workstreams that support safer care for deteriorating patients, including those with sepsis
4. Identify actions required to ensure, by March 2019, there is trust-wide adoption of NEWS2; and share examples of local challenges and best practice with the NEWS2 network on request

See page two for references, stakeholder engagement and advice on who this alert should be directed to.

Valproate medicines (Epilim ▼ Depakote ▼)contraindicated in women and girls of childbearing potential unless conditions of Pregnancy Prevention Programme are met. **Click here for more**

Further to the valproate warning a few months ago, the MHRA have now reissued a directive that a pregnancy prevention programme must be in place before prescribing, because of the high risk of teratogenicity.

Updated measures for pregnancy prevention during retinoid use. Click here for more

The European Medicines Agency (EMA) has completed its review of retinoid medicines, and confirmed that an update of measures for pregnancy prevention is needed. In addition, a warning on the possibility that neuropsychiatric disorders (such as depression, anxiety and mood changes) may occur will be included in the prescribing information for oral retinoids (those taken by mouth).

Retinoids include the active substances acitretin, adapalene, alitretinoin, bexarotene, isotretinoin, tazarotene and tretinoin. They are taken by mouth or applied as creams or gels to treat several conditions mainly affecting the skin, including severe acne and psoriasis. Some retinoids are also used to treat certain forms of cancer.

Eclipse Live also has alerts on topiramate and pregabalin prescribing and the risks in pregnancy. Patients should be made aware of the risks, and appropriate contraception should be in place whilst taking.

Eclipse have announced that from July 1st: : " As part of our continuous commitment to providing effective patient safety solutions to the NHS, we are delighted to be releasing an updated suite of Radar Admission Avoidance Alerts within your Advice & Guidance (Eclipse Live) interface."
The new interface will give a clear list of alerts as exampled below, together with patient analytics for each practice. Somerset may already have some of these alerts so we will ensure that duplicates are removed as soon as possible.

ANTIPLATELETS

Antiplatelets Alerts

Total number of patients (National) : 10,650,176
Total number of patients on Antiplatelets (National) : 233,918
March 2018

ADMISSION AVOIDANCE (PATIENTS WITH AN ALERT IDENTIFIED FROM RECENT TESTS)

	No. Patients in Alert	Prevalence per 1000 patients who are on Antiplatelet	Reference
Antiplatelet agent detected with severe anaemia (Hb < 9g/dl).	1005	4.30	bnf.nice.org.uk/drug/clopidogrel.html#contraindications
Antiplatelet agent detected with severe thrombocytopenia (Platelet Count < 50).	40	0.17	www.medicines.org.uk/emc/product/5288#CLINICAL_PRECAUTIONS
Multiple antiplatelet agents detected with anaemia (Hb <10g/dl).	295	1.26	bnf.nice.org.uk/interaction/aspirin-2.html
NSAID detected with blood thinning agent in anaemic patient (Hb <10g/dl).	90	0.38	www.medicines.org.uk/emc/medicine/26017
Patient appears to be on both antiplatelet and anticoagulant agents and has significant anaemia (Hb < 9.5g/dl).	110	0.47	bnf.nice.org.uk/interaction/warfarin.html#bnf_I1520219168744
Antiplatelet agent detected with anaemia (Hb ≥9 & < 10g/dl).	2195	9.38	bnf.nice.org.uk/drug/clopidogrel.html#contraindications
Antiplatelet agent detected with thrombocytopenia (Platelet Count ≥50 & < 100).	655	2.80	www.medicines.org.uk/emc/product/5288#CLINICAL_PRECAUTIONS
Aspirin or Clopidogrel detected, with peptic ulcer or GI bleed and no gastroprotection	309	1.32	bnf.nice.org.uk/drug/clopidogrel.html#cautions
Antiplatelet agent detected in thrombocytopenia (Platelet Count ≥100 & <150).	6413	27.42	www.medicines.org.uk/emc/product/5288#CLINICAL_PRECAUTIONS

PRIORITY MONITORING

	No. Patients in Alert	Prevalence per 1000 patients who are on Antiplatelets	Reference
Antiplatelet drug detected with thrombocytopenia (Platelet Count <50) but no recent FBC (Platelets >180 days).	38	0.16	www.medicines.org.uk/emc/product/5288#CLINICAL_PRECAUTIONS
Patient is on multiple antiplatelets, anaemia (Hb <10g/dl) and no recent FBC (Hb >180 days).	121	0.52	www.medicines.org.uk/emc/medicine/24979#INTERACTIONS
Patient on antiplatelet, has anaemia (Hb <9g/dl), needs repeat FBC (Hb >180 days).	342	1.46	bnf.nice.org.uk/drug/clopidogrel.html#contraindications
Antiplatelet drug detected with thrombocytopenia (Platelet Count ≥50 & <100) but no recent FBC (Platelets >365 days).	247	1.06	www.medicines.org.uk/emc/product/5288#CLINICAL_PRECAUTIONS
Patient on antiplatelet, has Anaemia (Hb ≥9 & < 10g/dl), needs repeat FBC (Hb >180 days).	1260	5.39	bnf.nice.org.uk/drug/clopidogrel.html#contraindications
Antiplatelet drug detected with thrombocytopenia (Platelet Count ≥100 & <150) but no recent FBC (Platelets >365 days).	3645	15.58	www.medicines.org.uk/emc/product/5288#CLINICAL_PRECAUTIONS
Patient on antiplatelet, has Anaemia (Hb ≥10 & < 11.5g/dl), needs repeat FBC (Hb >180 days).	9345	39.95	bnf.nice.org.uk/drug/clopidogrel.html#contraindications

MONITORING

	No. Patients in Alert	Prevalence per 1000 patients who are on Antiplatelets	Reference
Patient is on multiple antiplatelets, age > 75 and no recent FBC (Hb >365 days).	1840	7.87	www.medicines.org.uk/emc/medicine/24979#INTERACTIONS
Patient is on multiple antiplatelets and no recent FBC (Hb >365 days).	6556	28.03	www.medicines.org.uk/emc/medicine/24979#INTERACTIONS

ANTIPLATELETS

Patient Analytics

Total number of patients (National) : 10,650,176
Total number of patients on Antiplatelets (National) : 233,918
March 2018

GENDER BREAKDOWN

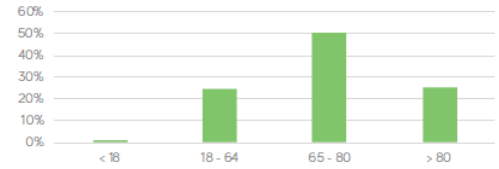
AGE	PATIENTS
Male	59%
Female	41%

HAEMOGLOBIN

HAEMOGLOBIN		DAYS SINCE LAST TESTED	
<9	0.4%	< 92	23.5%
9 -10	4.4%	92-183	17.2%
11 - 13	27.9%	184-365	24.4%
> 13	67.3%	366-730	15.9%
		>730	19.1%

HAEMOGLOBIN DAYS

AGE BREAKDOWN



EGFR

EGFR		DAYS SINCE LAST TESTED	
< 30	2.2%	< 92	27.8%
30-45	7.8%	92-183	18.9%
46-60	29.6%	184-365	25.5%
> 60	60.4%	366-730	13.9%
		>730	13.9%

EGFR DAYS

COMORBIDITY INDEX

Clinical Conditions	Patients
Atrial Fibrillation	5%
COPD / Asthma	17%
Current Smoker	10%
Dementia	4%
Diabetes	27%
Epilepsy	1%
Hypertension	50%
Hypothyroidism	8%
Mental Health	1%
Vascular Disease	40%

ALT

ALT		DAYS SINCE LAST TESTED	
< 50	95.3%	< 92	22.0%
50-99	4.3%	92-183	17.4%
100-149	0.3%	184-365	25.5%
> 150	0.1%	366-730	15.0%
		>730	20.1%

ALT DAYS

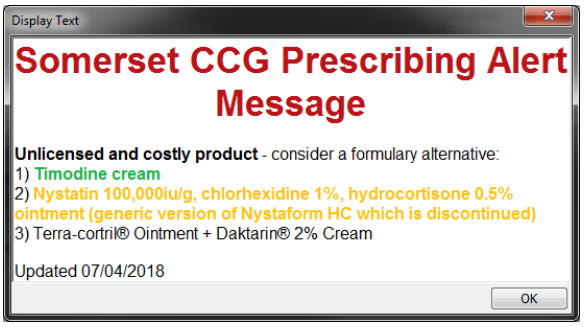
News from Somerset Prescribing and Medicines Management committee (PAMM) and SPF (Somerset Prescribing Forum)

Date Recorded in PAMM minutes	Additions to Formulary	Removed from Formulary
May 2018		**Emollient bath additives for the treatment of eczema in children.** This is being removed following the outcome of this trial: https://www.bmj.com/content/361/bmj.k1332
	Fusacomb Easyhaler DPI (salmeterol/fluticasone) Orion Pharma 50micrograms/250microgram £21.50 x 60 dose 50micrograms/ 500micrograms £26.99 x 60 dose Therapeutic Indications • Asthma in adults and children over 12 years • Chronic Obstructive Pulmonary Disease (COPD) Cost effective equivalent to Seretide in the form of an easyhaler. Reminder that patients with multiple inhalers should only have one type of device.	
	Levosert IUD Contraceptive. Currently has a three year license.	
April 2018	**Testogel (Testosterone) 16.2mg/g gel in a Pump Formulation, Besins Healthcare.** 1x30g pump £31.11	

	Dose adjustments will need to be made as this is not equivalent dose compared to Testogel 50mg gel.	
March 2018	**Enoxaparin Becat® solution for injection pre-filled syringe** 10x 20mg/0.2ml £20.86, 10x 40mg/0.4ml £30.27, 10x 60mg/0.6ml £39.26, 10x 80mg/0.8ml £55.13, 10x 100mg/1ml £72.30 (ROVI Biotech Limited) Brand prescribing of enoxaparin recommended. Guided by secondary care choice not for active switching.	

Cost effective prescribing

Trimovate- this has been relaunched by the manufacturer as a non-licensed product and price has increased 5 fold with a £20 handling charge The formulary has been updated as below, and also we have an emis pop up available to remind us of the possible alternatives. The generic equivalent of what was Nystaform HC is available on emis as 0.5% and 1% HC



Option 1	Timodine® cream	£3.37 (30g)	Contains: nystatin 100,000iu/g, hydrocortisone 0.5%, benzalkonium chloride soln 0.2%, dimeticone 350 10% Potential sensitisers: benzalkonium chloride
Option 2	Nystatin 100,000 units/g/ chlorhexidine acetate 1%/HC 1% oint	£5.29 (30g) Generic version of Nystaform HC which is discontinued	Contains: nystatin 100,000iu/g, chlorhexidine 1%, hydrocortisone 0.5% Potential sensitisers: chlorhexidine acetate
Option 3	If topical triple combination (corticosteroid + antimicrobial + antifungal) is required, consideration can also be given to: Dual formulation of corticosteroid + antimicrobial: Terra-cortril® - Hydrocortisone 1% + Oxytetracycline hydrochloride 3%; Ointment: £5.01 (30g) & Adding miconazole nitrate cream 2% (Daktarin® 2% Cream 30g; £1.82) NB - clotrimazole 1% cream, including Canesten® 1%, contains cetostearyl alcohol which is a potential sensitiser		

Fusacomb Easyhaler

From June 1st there is yet another inhaler to add to the list. Fusacomb Easyhaler is a dry powder inhaler with a salmeterol/fluticasone combination. This is the comparable with Seretide Accuhaler, Aerivio Spiromax and AirFluSal Forspiro but with a price advantage

COPD and asthma in adults and children over 12	50micrograms/250microgram	50micrograms/ 500micrograms
Fusacomb	£21.50	£26.99
Seretide Accuhaler	£35	£40.92
Saving per inhaler	£14.50	£13.30

Seretide is also available at 50/100 at £18 which is low dose asthma (400mcg daily BDP) which is a good step down alternative from above.

News and quality improvement

Oral nutritional supplementation (ONS) in renal patients

Latest update here

Shortage of Hydrocortisone 100 mg/mL or 500mg/5ml Injection

This product contains hydrocortisone sodium phosphate equivalent to 100mg/ml and is formulated as a solution for injection, which permits rapid use in emergency situations. The supplier of hydrocortisone sodium phosphate injection (formerly Efcortesol) is currently out of stock due to an issue with the active pharmaceutical ingredient. Further supplies are not due until late in 2018.

The only other licensed hydrocortisone injectable preparation available is Solu-Cortef®, each vial of which contains the equivalent of 100 mg hydrocortisone as the sodium succinate powder for reconstitution with 2 ml of sterile water for injection. It is licensed for the treatment of any condition in which rapid and intense corticosteroid effect is required and can be administered by the intravenous or intramuscular route.2 However, it is not licensed for the local treatment of soft tissue lesions. It should be noted that the concentration of the solution for injection is 100 mg in 1ml while Solu-cortef® is 100 mg in 2ml.

Shortage of Diamorphine 5mg and 10mg

One of the two manufacturers of diamorphine injection in the UK and are experiencing issues at their manufacturing site which supplies the 5mg and 10mg injections. The higher strengths (30mg, 100mg and 500mg) are currently not affected because these are manufactured at a different site. This memo outlines the considerations that may be needed to manage patients requiring low strength diamorphine. Link

Ever wonder what the CQC is thinking? Nigel's here to help. Nigel's Surgery: Nigel's Surgery: Full list of tips and mythbusters by latest update

Tramadol- manufacturers have added this to SPC

Tolerance, psychic and physical dependence may develop, especially after long-term use. In patients with a tendency to drug abuse or dependence, treatment with tramadol should only be carried out for short periods under strict medical supervision.

When a patient no longer requires therapy with tramadol, it may be advisable to taper the dose gradually to prevent symptoms of withdrawal.

Google When looking for our formulary or traffic lights, or any other documents please don't rely on Google, please use the links at the top of this newsletter. Google can throw up outdated documents.

Controlled Drugs newsletter latest update available. Sedating like Zomorph, but some useful case studies, contacts and FAQs

http://www.somersetccg.nhs.uk/about-us/how-we-do-things/prescribing-and-medicines-management/prescribing/cd-newsletter/

Any feedback? [redacted]