Oxfordshire
Cinical Commissioning Group

Prescribing Points

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This newsletter is written by the Medicines Optimisation Team, Oxfordshire CCG (OCCG), Jubilee House, Oxford Business Park South, Oxford, OX4 2LH. It is for all health professionals in Oxfordshire and is uploaded to the OCCG website. For queries, contact OCCG.medicines@nhs.net .
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Inside this issue:

Adverse outcomes in older patients using trimethoprim for urinary tract infection

Reducing the inappropriate prescribing of antibiotics for urinary tract infections (UTI) in primary care has been identified as an area for medicines optimisation. For example, the NHS England Quality Premium (QP) scheme aims to reduce the use of **trimethoprim** in older people, due to high levels of resistance to this antibiotic.
In addition, adverse outcomes associated with trimethoprim have been investigated in a recently published UK cohort study of more than 178,000 people aged over 65 years with a UTI. Whilst there are some limitations to this study, it was found that trimethoprim, of all the antibiotics studied, was associated with the greatest risk of acute kidney injury (AKI) and hyperkalaemia.

What do we know already?

- Trimethoprim is a commonly used antibiotic, particularly for UTIs. However, in England, trimethoprim is no longer the first-choice treatment for UTIs in many areas of the country, as resistance is now very common, with 34% of laboratory-processed urine samples showing resistance. The current first-line treatment recommended by Public Health England is **nitrofurantoin** if a patient's estimated glomerular filtration rate (eGFR) is over 45 ml/min/1.73m2. Resistance to this antibiotic remains relatively low, present in 3% of samples. If nitrofurantoin is unsuitable, or if eGFR is less than 45 ml/min/1.73m2, **pivmecillinam** is recommended as the alternative first-line option. Trimethoprim is only recommended as a first-choice if there is a low risk of resistance, as based on local resistance patterns
- The current national and local target for the 2018/19 financial year is a 30% (or greater) reduction in the number of trimethoprim items prescribed to patients aged 70 years or greater.
- Co-trimoxazole, a combination antibiotic containing trimethoprim and sulfamethoxazole, has been associated with an increased risk of sudden death, which may be mediated by increased serum potassium. Although the sulphonamide component of sulfamethoxazole has long been associated with a substantial risk of AKI, it is not known if the risks for trimethoprim alone are similar to those for co-trimoxazole.

So what?
Prescribers are requested to reduce the inappropriate prescribing of trimethoprim in older people and take into account the recent findings about adverse outcomes such as AKI. If nitrofurantoin is unsuitable, or if eGFR is less than 45 ml/min/1.73m2, **pivmecillinam** is recommended as the alternative option. For patients with penicillin allergy or where pivmecillinam is not suitable, **fosfomycin** may be used.
Antibiotic prescribing guidelines are currently being reviewed and will be published in due course.

Rivaroxaban 2.5mg tablets for prophylaxis of atherothrombotic events following an acute coronary syndrome

A reminder that rivaroxaban 2.5mg twice daily dose regime is ONLY licensed for prophylaxis of atherothrombotic events following an acute coronary syndrome with elevated cardiac biomarkers in line with NICE TA335. The 2.5mg strength should **NOT** be initiated in primary care or used for other indications such as, atrial fibrillation, deep vein thrombosis, pulmonary embolism, or prophylaxis of venous thromboembolism. There has been some local prescribing of this strength recently and further investigations have shown some to be prescribing errors. OUHFT have indicated that they will not routinely be using rivaroxaban 2.5mg for prophylaxis of atherothrombotic events following an acute coronary syndrome.

So What?
Prescribers in primary care are requested not to initiate rivaroxaban 2.5mg.
Please see local guidelines for prescribing DOACs in atrial fibrillation and DVT/PE:
Primary Care Prescriber Decision Support for DOACs in Atrial Fibrillation.
Guidelines for DOACs for Treatment and Secondary Prevention of VTE

Supply issues

Discontinuation of Zafirlukast

The manufacturer of **zafirlukast** (*Accolate*®) has **discontinued** this product with effect from the end of March 2018. No further supplies are being made and it is predicted that minimal supplies will be available within the supply chain. **Commercial reasons** are cited for this decision and it is stressed that there were **no safety concerns** with this medicine. Zafirlukast is a leukotriene receptor antagonist and as such the closest available **alternative** is **montelukast**.

So what?
Clinicians should be aware of this product being discontinued. It would be prudent to run clinical system searches to identify any patients who are currently prescribed this product to allow a review and arrangements made to identify a suitable alternative.

Diamorphine supply issues

The Department of Health and Social Care (DHSC) have advised of a manufacturing issue with one of the suppliers of **diamorphine 5mg** and **10mg injection.**
DHSC and NHSE have since been working with Accord and their supplier in Germany and the manufacture of diamorphine 5mg and 10mg injection will soon resume with an anticipated resupply date of beginning of September 2018. DHSC and NHSE have also been working with the remaining supplier, Wockhardt, to support the supply issue. Wockhardt have been able to increase their production of diamorphine 5mg and 10mg but are unable to support the entire market in July and August. A management plan has been developed to manage the supply issue during July and August 2018.

Management plan from 1st July 2018:

- Primary care and drug misuse centres will be able to continue to order diamorphine in line with historical demand.
- Secondary care will have access to restricted supplies of diamorphine

Recommended Local Action- Primary care and drug misuse centres

- Although you will be able to access diamorphine as per historical demand, we would encourage prescribers to be aware of the supply issues and reduce prescribing where appropriate
- Please order responsibly during this time, in line with historical demand and do not stock pile to avoid lengthening the out of stock period.
- In the case that diamorphine cannot be accessed, please refer to the clinical guidance issued by UKMI which provides more information on suggested alternatives to diamorphine: https://www.sps.nhs.uk/articles/shortage-of-diamorphine-5mg-10mg/ . The first-choice is morphine which is given in detail in this link. If you require clinical guidance locally – please liaise with secondary care prescribing partners in substance misuse services or pain specialist services
- Further information which you may wish to review include the Patient Safety Alert on high dose morphine and diamorphine http://www.nrls.npsa.nhs.uk/resources/?entryid45=59803

Distribution Arrangements (From 1st July)

- Diamorphine 5mg and 10mg will only be available to order from Alliance. No minimum surcharges will be levied
- Morphine 10mg injection (Martindale) available to order from AAH only.
- Diamorphine 30mg injection (Wockhardt), diamorphine 100mg (Accord) and diamorphine 500mg (Accord and Wockhardt) – usual wholesalers.

For further information on ordering processes please contact:

Alliance
Phone Number: 0330 1000 448
customerservice@alliance-healthcare.co.uk

AAH
Phone Number: 0344 561 8899

Safety alerts

COPD formulary alert

There have been reports that a few patients are being changed from tiotropium respimat to Spiolto but are already taking Fostair. Patients should not be having LAMA/LABA combination together with a LABA/ICS.

So what?
Prescibers and community pharmacies are to be on the alert to make sure COPD patients are not prescribed LAMA/LABA combination together with a LABA/ICS

Blood Glucose Monitoring System Alert

Blood Glucose Monitoring System: Accu-Chek Aviva, Accu-Chek Performa and Accu-Chek Inform II test strips – risk of strip error messages and false high and low blood glucose results
Affected test strips, manufactured by Roche Diabetes Care, may give increased strip error messages prior to dosing with blood and in some cases may give false high or low readings, which may be hard to detect. Practices should identify patients using these strips and follow the MHRA advice.

So what?
•Advise patients to discontinue use of Accu-Chek Aviva and Accu-Chek Performa blood glucose test strips with affected lot numbers, see FSN.
•Return affected test strips to the pharmacy where they were dispensed or purchased from for replacements.
•Ensure that patients are aware of this information and that they have an alternative testing means, if required.
•Ensure the patient can continue to monitor their blood glucose effectively.
•If patients are concerned about their blood glucose readings when using this meter, advise them to contact their healthcare professional.

Risk of mix-ups between Insulin Fiasp® (fast-acting insulin aspart) and Tresiba® (basal insulin degludec)

Cases have been reported where patients have mistakenly administered the mealtime insulin Fiasp® (currently available as yellow pens) instead of the basal insulin Tresiba® (available as light green pens) or vice versa. Such mix-ups can have serious clinical consequences, specifically hypo- or hyperglycaemia. Clinicians should advise patients using both products to be extra vigilant and always check the name of the insulin before each injection to make sure that they administer the correct insulin.
To strengthen the differentiation between the products, from 01 June 2018 Fiasp® will be available as red and yellow cartridges, pre-filled pens and vials.

So What?
- Check if the patient also uses both Fiasp® and Tresiba®.
- If so, remind the patient of the risk of mix-ups and the need for extra vigilance.
- Advise them to check the name of the insulin before each injection and to take extra care if preparing injections in poor light.
- Advise patients to contact their diabetes nurse or doctor or their GP immediately if they do mix up injections

For more information, including images of the old and new pen colours:
https://www.medicines.org.uk/emc/rmm/1168/Document

Omacor – revised SPC

Summary product characteristic (SPC) now highlights that Omacor contains soya oil, and those with allergy to soya or Peanut oil should not take this product.

Prescribers are reminded **not to** prescribe omega-3 –acid ethyl esters in line with Thames Valley Priorities Committee Comissioning Policy No 281

Valproate medicines (Epilim▼, Depakote▼): Pregnancy Prevention Programme materials online

Prescribers are reminded to use materials online and hardcopies arriving over the coming weeks by post to ensure women and girls of childbearing potential on valproate medicines meet the requirements of the Pregnancy Prevention Programme. For more information please see here

Guidelines update

Glaucoma and Ocular Hypertension Treatment Guidelines (Topical products)

New guidelines for Glaucoma and Ocular Hypertension Treatment are now available.
The guideline was developed in conjunction with OUHFT and therefore secondary care should only be requesting topical products for glaucoma and ocular hypertension within the guidelines. The guidelines note that all prescriptions should be written generically, e.g. Latanoprost not Xalatan®. There is no evidence to suggest that a branded product is more effective than a generic product.
Please note that the combination product Latanoprost 50micrograms/ml plus timolol 5mg/ml is not recommended within the guidelines. Patients should be switched to either:

- latanoprost 50 micrograms/ml 1 drop affected eye at night PLUS timolol 0.25% 1 drop into the affected eye in the morning

OR

- If compliance is an issue switch to travoprost 40 micrograms/ml plus timolol 5mg/ml fixed combination 1 drop affected eye daily.

This switch can be done in primary care

Please note that Timolol Unit Dose 0.5% ophthalmic solution 0.2ml unit dose (Timoptol®) has been discontinued. This was originally included in the guidelines, and there are a number of patients on this in primary care. The ophthalmology consultants are happy for patients who require preservative free eye drops to be switched in primary care by GPs to Timolol 1mg/g eye gel 0.4g unit dose (Tiopex®).

So what?
Prescribers are requested to review patients in line with updated guidelines and patients on Xalatan should be switched to generic latanoprost.

COPD Guideline update – Triple therapy

Please note that the COPD guideline has been updated to include the new single inhaler 'triple therapy' devices – Trimbow ® (beclometasone/formoterol/ glycopyrronium) metered dose inhaler and Trelegy Ellipta ® (fluticasone furoate/umeclidinium/vilanterol) dry powder inhaler . This is available on the CCG website here
Please note these are only to be used in line with the guidance for patients with severe COPD not controlled on dual therapy

Osteoporosis - Guidance for Fracture Risk Assessment and Prevention in Primary Care

The updated Osteoporosis guidance is now available on the CCG website here. It incorporates several previous guidelines on osteoporosis and covers assessing when to treat in both primary and secondary prevention as well as patients taking aromatase Inhibitors, GnRH analogues and corticosteroids, the treatment pathway, duration of treatment, risks and calcium and vitamin D supplementation.
There has also been a minor amendment to the guidelines for initiating treatment of denosumab to include some information about the risk of vertebral fractures following discontinuation. This is available here

So what?
Prescribers should be aware of the updated guidance available and use it when assessing fracture risk and making treatment decisions

Management and control of prescription forms

A guide for prescribers and health organisations on management and control of prescription forms has been published in March 18 by NHS Counter Fraud Authority. Full document can be found here

Guaranteed Provision of Palliative Care Drugs in the Community

Community Palliative Care teams often experience difficulties in obtaining emergency drugs eg. for use in syringe drivers. This can be due to local pharmacies either not holding the required drugs or not stocking sufficient quantities to complete the prescription. For a number of years, the Oxfordshire Clinical Commissioning Group (OCCG) has arranged with some Pharmacy Contractors to guarantee stocking an agreed selection of routine palliative care drugs in order to overcome such difficulties.
To view the list of participating pharmacies and the list of palliative care drugs that these pharmacies are *guaranteed* to stock, please click on the link here. **It is recommended to call the pharmacy ahead to check if there are any issues.**

Please note, that carers and healthcare professionals are not restricted to obtaining palliative care drugs only from the pharmacies taking part in this scheme. Prescriptions for palliative care drugs can be fulfilled by any other community pharmacy.

Referrals to DVT clinic

Practices are asked to ensure that all patients referred to the OUH DVT clinic during 'out of hours' must take a pre-anticoagulated blood sample with them to the appointment.
If an appointment is delayed until the next day, the GP should take a D-dimer blood sample (for patient to take to clinic appointment) and the patient should be given therapeutic anticoagulation. NICE Quality Standard (QS29) states that people with suspected deep vein thrombosis are offered an interim therapeutic dose of anticoagulation therapy if diagnostic investigations are expected to take longer than 4 hours from the time of first clinical suspicion. Current guidelines will be updated shortly to clarify requirements.

- Direct Oral Anticoagulants 'DOACs' for Treatment and Secondary Prevention of Deep Vein Thrombosis (DVT) and Pulmonary Embolism (PE) in Primary Care
- Dalteparin – Guideline and Shared Care Protocol for Prescribing in Primary Care

Oxfordshire LARC (intra-uterine system) service

Further to the article in GP Weekly Bulletin 21, March 2018, OCCG and OCC are pleased to report that an arrangement has been agreed to maintain the current local LARC service in Primary Care with the additional inclusion of fitting IUS for women with gynaecological/medical conditions (with or without contraception).
This will include a variation to the Council's LARC Call-off Contract Specification to no longer exclude these patients. As such, please continue to fit devices from 1st July 2018 (Quarter 2) in the knowledge that you will be reimbursed for the service provided.

In order for both the Council and the CCG to monitor IUS activity by indication moving forward, the IUS section of the LARC clinical system template has been reviewed as part of the much broader Primary Care Commissioned Services Dataset edit. This was approved by the Clinical Ratification Group (CRG) on 4th July 2018 and should be available over the next few weeks. Use of this template will be mandated to ensure accurate coding and reimbursement.

If not done so already, please also encourage your staff that are trained IUS fitters to familiarise themselves with the APCO formulary changes from March 2018. Levosert is now the first choice for women requiring a device for up to 4 years, and Mirena remains available for women requiring a device for 5 years or when HRT is also indicated.

New Standards for Thickening Food and Drink for Patients with Dysphagia

International Dysphagia Diet Standardisation Committee (IDDSI) has been working to develop international standards for thickening food and drinks for patients with dysphagia, for several years.

Dysphagia is the medical term for swallowing difficulties.
Some people with dysphagia have problems swallowing certain foods or liquids, while others are unable to swallow at all.

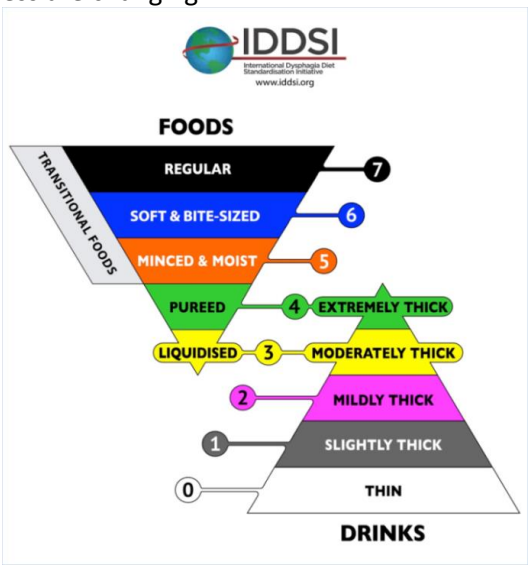
Other signs of dysphagia include:

- coughing or choking when eating or drinking
- bringing food back up, sometimes through the nose
- a sensation that food is stuck in the throat or chest
- persistent drooling of saliva
- being unable to chew food properly
- a 'gurgly' wet sounding voice when eating or drinking

Over time, dysphagia can also cause symptoms such as weight loss and repeated chest infections. For more information go to https://www.nhs.uk/conditions/swallowing-problems-dysphagia/

Thickeners
Thickeners can help people with dysphagia to swallow fluids and eat foods safely. Fluids are thickened to varying consistencies as suggested by Speech and Language Therapists. A systematic review of the literature was conducted to examine the impact of drink thickness and food texture on swallowing behavior across the age spectrum. The systematic review was peer-reviewed and published Open Access in the Dysphagia Journal (Steele et al., 2015 Dysphagia, (30)1: 2-26 ;).

New framework
The descriptors for the levels of thickness are changing:



The framework will be translated into a number of languages as part of worldwide implementation. The standards are being adopted in the UK between April 2018 and April 2019. Some of the thickener companies have already changed their packaging to reflect the new descriptors.
Methods have been developed to standardise the process of thickening to ensure consistency when working with patients. These are outlined below:

Food Testing Methods
http://iddsi.org/framework/food-testing-methods/
Drink Testing Methods
http://iddsi.org/framework/drink-testing-methods/

Below is a comparison between the old and the new descriptors for fluids:

Current Fluid Descriptor	New IDDSI Fluid Descriptor
Normal Fluids	Level 0 – Thin Fluids
Slightly Thick	Level 1 – Slightly Thick
Stage 1 – Syrup	Level 2 – Mildly Thick
Stage 2 – Custard	Level 3 – Moderately Thick
Stage 3 – Pudding	Level 4 – Extremely Thick

Thickeners are classed as "yellow" on Oxfordshire CCG Formulary and should only be recommended by SLTs.
In Oxfordshire the Speech and Language therapists started using the terminology from May 7th 2018 and the change over to the new food descriptors is planned to take place later in the year, likely to be around August time.
The Speech and Language Therapists (SLTs) have been raising awareness of the changes throughout Oxfordshire and will involve the Care Home Support Service (CHSS). The CHSS has been supporting Care Homes, as they have an ongoing relationship with them.
Any concerns should be raised with the Community SLTs at adultSLT@oxfordhealth.nhs.uk

So What?

- Advise patients and carers to **REFER TO THE INDIVIDUAL PRODUCT TIN** e.g. Resource Thicken Up Clear, Thick and Easy, Nutilis Clear, for the manufacturer's instructions to make up each consistency, using the correct number of scoops per volume of fluid, and the correct scoop for the product.
- For **Resource Thicken Up Clear**, the dosage on the new tins is now described per 200mls fluid rather than 100mls (no change in scoop size).
- The scoop size and number of scoops per 200mls is changing for **Nutilis Clear** also.
- It is important to highlight this to patients/carers who are already on these products before the new framework comes in to place.
- Any queries please contact Suzanne Bradshaw, Prescribing Support Dietitian, OCCG, occg.dietitian@nhs.net