

# Medicines Optimisation Newsletter

## [November 2023] (Issue No. 52)



- [Kent & Medway Medicines Sustainability Re-Hale Project](#)
- [Direct Oral Anticoagulants \(DOACs\) – A Change to Improve Patient Safety](#)
- [Emollients and fire safety](#)
- [New Melatonin Guidelines in Kent and Medway](#)
- [Gastro-intestinal Anti-spasmodic Prescribing](#)
- [New Position Statement: Safe Prescribing of Injectable Medicines in Primary Care](#)
- [Addition of Actimorph orodispersible morphine to formularies and new Morphine Sulfate Liquid Guidance](#)
- [Addition of Methenamine Hippurate to the Kent and Medway Formulary](#)
- [Nitrofurantoin MHRA Drug Safety Update – New Supporting guidance for patients and prescribers](#)
- [Wegovy and risks of inadvertent prescribing and dispensing of injectable semaglutide](#)
- [Kent and Medway guidance on Emollient Prescribing](#)
- [MHRA Drug Safety Update](#)
- [Shortages Summary](#)

## Kent and Medway ICB Updates

### Safety and Improvement

#### **Kent & Medway Medicines Sustainability Re-Hale Project**

In the UK, a staggering 60 million inhalers are distributed annually, contributing to 3% of the NHS's carbon footprint. Until now, there has been no efficient method for inhaler recycling. Patients have been encouraged to return them to pharmacies, but unfortunately, they are typically mixed with other medical waste and ultimately incinerated rather than recycled.

Cath Cooksey from Kent & Medway ICB Medicine Optimisation and Sam Coombes from East Kent Hospitals University Hospital Trust have worked incredibly hard to pull a successful, collaborative project together. NHS Kent and Medway in collaboration with Chiesi Ltd have developed a pilot programme aimed at demonstrating that inhalers can be recycled. This pilot initiative will span the entirety of East Kent for a duration of 12 months. It will enable patients to drop off their unwanted or used inhalers at multiple convenient locations, including East Kent Hospitals University Hospital Trust, community pharmacies, and dispensing GP practices. Using already established transportation infrastructure these inhalers will be collected at the same time as the community pharmacy receives a medicines wholesale delivery. This comes from an agreement we have with Alliance Healthcare to use their expertise and infrastructure to drastically limit any environmental impact from collecting the inhalers.

The programme will include the recovery of inhalers, recycling the inhaler components and repurposing the gases through collaboration with a specialist waste management company.

*Every effort is made to ensure that the information contained in this newsletter is accurate and up to date at the time of publication. Please be aware that information about medicines and therapeutics will change over time, and that information may not be current after the initial date of publication. Please take note of the publication date and seek further advice if in any doubt about the accuracy of the information. The information contained in this newsletter is the best available from the resources at our disposal at the time. Acronyms used are standard formulary. This newsletter is produced by the NHS Kent and Medway Medicines Optimisation Team on behalf of the Kent & Medway ICB. For all correspondence including any queries, please contact the Medicines Optimisation team email: [kmicb.medicinesoptimisation@nhs.net](mailto:kmicb.medicinesoptimisation@nhs.net)*

This is an exciting initiative, and the biggest of its kind in the UK. It is hoped that this will assist in the development of a much-needed national inhaler recycling programme. More information, including the locations of ReHale collection sites can be found at <http://www.kentandmedway.icb.nhs.uk/east-kent-inhaler-recycling> . The pilot project is currently operating in East Kent.

## Direct Oral Anticoagulants (DOACs) – A Change to Improve Patient Safety

**Intelligence from the National Reporting and Learning System (NRLS)** suggests that anticoagulants are linked to more deaths and severe harm errors than any other medicine. The use of anticoagulants is widespread with 18 million prescriptions issued in 2018. (Ref: NHS Futures – MedSIP workspace)

**The Community Pharmacy National Audit 2021/22** ([here](#)) found that:

4.4% (4,940) of patients were not aware they were prescribed an anticoagulant.

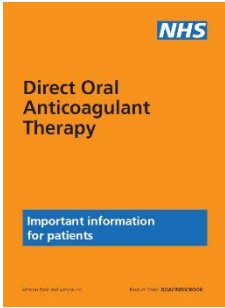

23.5% of all patients audited could not describe the symptoms of over-anticoagulation.

19.8% of patients were unaware of the need to speak to a doctor or pharmacist before taking over the counter (OTC) medicines.

78.2% of patients were not carrying their yellow anticoagulant card in the pharmacy at the time of consultation. This card is intended to always be carried by all patients taking anticoagulant.

### What can GP Practices do?

**As part of a wider Kent and Medway strategy to improve the education given to people on DOACs, we are encouraging all Practices to issue all patients on DOACs with a DOAC booklet and an Anticoagulant Alert Card. We advise that practices introduce processes to ensure that these are issued to all patients currently on DOACs and thereafter to all patients at initiation. This will contribute to meeting the prescriber's responsibility to ensure that patients for whom they prescribe have the necessary information.**

	<p><b>Direct Oral Anticoagulant Therapy Information Book</b>  <b>Order code: DOAC THERAPY BOOK</b>  <b>Published October 2022</b></p>
	<p><b>Anticoagulant Alert Card</b>  <b>Order code: OATALERTCARD</b>  <b>Updated October 2022</b></p>
<p><b><i>In Primary Care these NHS England Resources can be ordered from <a href="#">PCSE Online</a>.</i></b>  <b>The NHS England DOAC booklet is available to providers at a cost of £16.20 (includes VAT) for 50 booklets (min order). (Price Sept 2023)</b></p>	
<p><b>Additional on- line materials</b></p>	
<p>Manufacturer specific alert cards</p>	<p>These are available in the <a href="#">risk minimisation material directory</a> on the <a href="#">electronic medicines compendium</a>.</p>
<p>Further Information</p>	<p><a href="http://www.nhs.uk">www.nhs.uk</a></p>

*Practices, please contact your local ICB Medicines Optimisation Team by email if you have any questions.*

*Every effort is made to ensure that the information contained in this newsletter is accurate and up to date at the time of publication. Please be aware that information about medicines and therapeutics will change over time, and that information may not be current after the initial date of publication. Please take note of the publication date and seek further advice if in any doubt about the accuracy of the information. The information contained in this newsletter is the best available from the resources at our disposal at the time. Acronyms used are standard formulary. This newsletter is produced by the NHS Kent and Medway Medicines Optimisation Team on behalf of the Kent & Medway ICB. For all correspondence including any queries, please contact the Medicines Optimisation team email: [kmicb.medicinesoptimisation@nhs.net](mailto:kmicb.medicinesoptimisation@nhs.net)*

## Emollients and fire safety

A recent CQC report for an organisation in Kent and Medway highlighted the importance of considering the fire risk with emollients. This is [MHRA drug safety update](#) that was released in August 2020. This article is to serve as a reminder of the advice given in the alert.

There is a fire risk with all emollients that contain paraffin, regardless of the concentration of paraffin. There is also a risk with paraffin-free emollients. A similar risk may apply for other products that are applied to the skin over large body areas, or in large volumes for repeated use for more than a few days.

The MHRA drug safety update contains useful information and resources for healthcare professionals, particularly a [MHRA and NFCC emollients toolkit presentation pack](#) from which the following important points are taken:

Advice for healthcare professionals

- **Ensure patients and their carers understand the fire risk** associated with the build-up of dried emollient residue on clothing and bedding and can take action to minimise the risk
- When prescribing, recommending, dispensing, selling, or applying an emollient, **instruct patients not to smoke, cook or go near any naked flames or heat source (gas, halogen, electric bar or open fire) whilst wearing clothing or dressings that have been in contact with emollients.** If the patient cannot do this advise on measures to do so safely (e.g., use safety lighters or e-cigarettes; remove long sleeved or loose clothing before cooking; put on a thick uncontaminated shirt, overalls or apron, move chairs further away from the open fire or other heat source)
- Be aware that **washing clothing or bedding** at a high temperature may reduce emollient build up **but does not totally remove it** – it is important to minimise risk in additional other ways (as above)
- For complex cases **contact the local fire and rescue service** for advice and support

## Formulary and Guidance

### New Melatonin Guidelines in Kent and Medway

In October 2023, Melatonin guidelines were approved at IMOC (Integrated Medicines Optimisation Committee) for use across Kent & Medway.

This guideline has been designed to support clinicians within primary and secondary care with the management of melatonin prescribing for adults and children with sleep disorders within NHS Kent and Medway.

This guideline also provides recommendations on the cost-effective prescribing of melatonin by considering product formulations and brand, groups of patients for whom melatonin is indicated, and information around review and discontinuation. Information on drug holidays will also be included. NB: The use of other hypnotics (e.g. benzodiazepines) are not covered within this guideline.

Please find the approved guideline embedded below, which can now be used and shared.

The guidelines will be uploaded to all formulary websites in due course.

Along with the guidelines being approved and updated, the formulary websites will also be updated in due course to reflect this, for now please use the products listed within the guidelines for formulary choices.

[issue-52-melatonin-management-of-sleep-disorders.pdf \(medwayswaleformulary.co.uk\)](#)

*Every effort is made to ensure that the information contained in this newsletter is accurate and up to date at the time of publication. Please be aware that information about medicines and therapeutics will change over time, and that information may not be current after the initial date of publication. Please take note of the publication date and seek further advice if in any doubt about the accuracy of the information. The information contained in this newsletter is the best available from the resources at our disposal at the time. Acronyms used are standard formulary. This newsletter is produced by the NHS Kent and Medway Medicines Optimisation Team on behalf of the Kent & Medway ICB. For all correspondence including any queries, please contact the Medicines Optimisation team email: [kmicb.medicinesoptimisation@nhs.net](mailto:kmicb.medicinesoptimisation@nhs.net)*

## Gastro-intestinal Anti-spasmodic Prescribing

Kent and Medway ICB does not support the prescribing of dicycloverine (or propantheline for GI smooth muscle spasm).

Dicycloverine and propantheline are NON-FORMULARY and not recommended for prescribing. Dicycloverine is poorly selective and both drugs are more likely to cause antimuscarinic effects. There are lower cost alternatives with relatively fewer adverse effects. There is also insufficient evidence to demonstrate a significant difference in effectiveness between the anti-spasmodics. Consider alternative safer, more cost-effective options.

Recommendations for prescribers:

- Review existing dicycloverine and propantheline prescribing. Consider STOPP criteria listed in BNF dicycloverine monograph, anticholinergic burden and manufacturer's SmPC cautions and contraindications.
- Comprehensive trials of the other formulary antispasmodics should be attempted and if necessary, refer to a specialist to exclude underlying disease and advise on anti-spasmodic choice.
- Formulary status of GI Anti-spasmodics:

1st line – mebeverine, alverine

2nd line – hyoscine butylbromide, peppermint oil capsules.

Dicycloverine and propantheline are 'not recommended' and NON FORMULARY" in Kent and Medway ICB. Please see the full position statement on your local HCP Guidance platform or formulary website.

## New Position Statement: Safe Prescribing of Injectable Medicines in Primary Care

The Integrated Medicines Optimisation Committee (IMOC) have recently approved a new Kent and Medway position statement on the safe prescribing of injectable medicines. This statement includes key prescribing recommendations to improve the safety of prescribing and minimise any potential harm associated with prescribing injectable medicines and is available on your local formulary website.

[issue-52-safe-prescribing-of-injectable-meds-in-primary-care.pdf \(medwayswaleformulary.co.uk\)](https://www.medwayswaleformulary.co.uk/issue-52-safe-prescribing-of-injectable-meds-in-primary-care.pdf)

## Addition of Actimorph orodispersible morphine to formularies and new Morphine Sulfate Liquid Guidance

Oral morphine sulfate liquid has been directly linked to the cause of death in 13 'prevention of future death reports' issued by coroners since 2013, the majority of which related to its use for treating chronic pain. There are a variety of reasons given for this including people 'swigging' from the bottle rather than measuring the dose, people being supplied large quantities over a long period of time, illicit use, self-harm, interactions between the morphine and other prescribed and illicit medication, and a lack of documentation of who collected the supply (Wickaware, 2021; NHS South Region South West, 2016).

Actimorph is a new orodispersible morphine formulation that is available in smaller doses; 1mg, 2.5mg, 5mg and 10mg. It offers several safety advantages to liquid morphine for patients who may be at risk when using the liquid formulation, examples of these patients are outlined in the new liquid morphine position statement available [here](#). These safety advantages include:

- It is an orodispersible tablet formulation. This would prevent patients at risk of swigging from the bottle from doing so and is easier to measure the dose than using a syringe to draw up the required volume. This is especially beneficial for patients with poor eyesight or poor manual dexterity that are unable to measure their dose of liquid appropriately.
- Is classified as a scheduled 2 CD drug and therefore subject to the additional controlled drug requirements and documentation of who collects the supply. Oramorph 10mg/5ml is a CD5 which gives the illusion that it is 'safer' which is not the case.
- As it is an orodispersible formulation the bottle can't be spilled or dropped.

*Every effort is made to ensure that the information contained in this newsletter is accurate and up to date at the time of publication. Please be aware that information about medicines and therapeutics will change over time, and that information may not be current after the initial date of publication. Please take note of the publication date and seek further advice if in any doubt about the accuracy of the information. The information contained in this newsletter is the best available from the resources at our disposal at the time. Acronyms used are standard formulary. This newsletter is produced by the NHS Kent and Medway Medicines Optimisation Team on behalf of the Kent & Medway ICB. For all correspondence including any queries, please contact the Medicines Optimisation team email: [kmicb.medicinesoptimisation@nhs.net](mailto:kmicb.medicinesoptimisation@nhs.net)*

- Actimorph is available in a wide range of strengths starting from 1mg that allow for precise titration to the minimum effective dose and personalised tapering.
- The orodispersible tablet may be placed on a spoon with a small quantity of water to allow it to be given to patients with swallowing difficulties.

For patients where it is appropriate to use the liquid, in order to support clinicians to prescribe morphine sulfate liquid safely, new guidance on the appropriate use of the liquid has also been approved. This includes information regarding the risks and support to help prescribing teams to recognise when their patients may be accidentally or intentionally up-titrating their dose of liquid morphine.

#### **Addition of Methenamine Hippurate to the Kent and Medway Formulary**

Please note that in October 2023 Methenamine Hippurate (Hiprex) was approved by IMOC for inclusion in the Kent and Medway Formulary for use in recurrent lower urinary tract infections (rUTIs) in **women** aged 18-80 years of age.

This has been approved for specialist initiation via hospital urology specialist with continuation of prescribing in primary care following an initial supply by the hospital, and is second line to the initial measures outlined in local antimicrobial guidance available [here](#).

#### **Nitrofurantoin MHRA Drug Safety Update – New Supporting guidance for patients and prescribers**

On the 26th April 2023 the MHRA issued a drug safety update for Nitrofurantoin to remind clinicians of the risks of pulmonary and hepatic adverse drug reactions ([here](#)). Since then, two supporting pieces of guidance have been approved: a patient information leaflet and new monitoring guidance for prescribers. The guidance for prescribers includes advice from the MHRA, recommended monitoring for patients prescribed long term Nitrofurantoin and how to review Nitrofurantoin in the long term.

#### **Wegovy and risks of inadvertent prescribing and dispensing of injectable semaglutide**

[NICE TA875](#) was published in September 2023 on **Wegovy (injectable semaglutide)** for managing overweight and obesity:

- Wegovy is now available in limited supply for the NHS, and in line with the NICE TA **available only via tier 3 services within Kent and Medway** for managing overweight and obesity. Pathways are being developed for the tier 3 services. More information is available [here](#).
- In Kent and Medway, Wegovy has a formulary status of **“Specialist Only”** - only commissioned obesity tier 3 services can undertake the prescribing of Wegovy. **Wegovy should not be prescribed in primary care.**

It is imperative that all glucagon-like peptide-1 receptor agonists (GLP-1 RAs) are **only prescribed for their licensed indications**:

- GLP-1 RAs are licensed for the treatment and management of type 2 diabetes, except Wegovy, and Saxenda (liraglutide), are licensed for managing overweight and obesity.
- The prescribing of GLP-1 RAs, other than Wegovy and Saxenda, for solely managing overweight and obesity (off-label) is not supported within Kent and Medway.

The [National Patient Safety Alert \(NPSA\)](#) from the DHSC issued on the national supply issues of all GLP-1 RAs, was issued and cascaded in July 2023 (does not include Wegovy):

- We would like to remind colleagues involved in the prescribing and dispensing of GLP-1 RAs that **the mandatory actions within the NPSA are to remain in place until supply issues have resolved**. Supplies are currently not expected to stabilise to meet full market demand until **at least mid-2024**.

**Please note that as well as Wegovy, there is another brand of injectable semaglutide available:**

- **Ozempic**, which is licensed in the UK for use in **type 2 diabetes only**.

*Every effort is made to ensure that the information contained in this newsletter is accurate and up to date at the time of publication. Please be aware that information about medicines and therapeutics will change over time, and that information may not be current after the initial date of publication. Please take note of the publication date and seek further advice if in any doubt about the accuracy of the information. The information contained in this newsletter is the best available from the resources at our disposal at the time. Acronyms used are standard formulary. This newsletter is produced by the NHS Kent and Medway Medicines Optimisation Team on behalf of the Kent & Medway ICB. For all correspondence including any queries, please contact the Medicines Optimisation team email: [kmicb.medicinesoptimisation@nhs.net](mailto:kmicb.medicinesoptimisation@nhs.net)*



There is a **risk of inadvertent prescribing and dispensing of injectable semaglutide in primary care** due to the **similar strengths/concentrations** of the available **Wegovy and Ozempic products**:

- It is recommended that all GLP-1 RAs are **prescribed by brand**.
  - There are ScriptSwitch messages in place, which we advise are adopted, to support this.
- In the table below, please find a **comparison of the available Wegovy and Ozempic products**, highlighting the **differences/similarities in the strengths/concentrations** of the products available:

<b>Wegovy (semaglutide) preparation</b> (For managing overweight and obesity)	<b>Ozempic (semaglutide) preparation</b> (For treatment of type 2 diabetes mellitus in adults)
Wegovy FlexTouch <b>0.25mg/0.37ml</b> solution for injection 1.5ml pre-filled pens	Ozempic <b>0.25mg/0.19ml</b> solution for injection 1.5ml pre-filled pens
Wegovy FlexTouch <b>0.5mg/0.37ml</b> solution for injection 1.5ml pre-filled pens	Ozempic <b>0.5mg/0.37ml</b> solution for injection 1.5ml pre-filled pens
Wegovy FlexTouch <b>1mg/0.75ml</b> solution for injection 3ml pre-filled pens	Ozempic <b>1mg/0.74ml</b> solution for injection 3ml pre-filled pens
Wegovy FlexTouch <b>1.7mg/0.75ml</b> solution for injection 3ml pre-filled pens	N/A – no 1.7mg strength of Ozempic available
Wegovy FlexTouch <b>2.4mg/0.75ml</b> solution for injection 3ml pre-filled pens	N/A – no 2.4mg strength of Ozempic available

**Red** = different strengths/concentrations of similar Wegovy and Ozempic preparations.

**Amber** = same strengths/concentrations of Wegovy and Ozempic preparations.

**Green** = Wegovy preparation available only, no equivalent/similar Ozempic preparation available.

### Kent and Medway guidance on Emollient Prescribing

IMOC have recently approved guidance on Emollient Prescribing in Adults and Children. The guidance has been attached below, and it will be uploaded to each individual formulary websites in due course.

The main changes include:

- Bath and shower products should not be routinely prescribed.
- Patients who do not have a diagnosed dermatological condition or significant risk to skin integrity (maintenance) should no longer receive emollients on an NHS prescription and be advised to purchase emollients over the counter (OTC).
- For patients who have been reviewed by secondary care/specialist and require an emollient not listed in this guideline, written rationale should be provided including why other first line products are unsuitable, and the request respected.
- If the rationale for deviation from products listed in this guideline is not recorded in communication from specialist/secondary care, then primary care prescriber should switch to the most suitable cost-effective alternative.
- Emollients should be reviewed frequently (at least annually) by the initiating clinician (GP or specialist) and stopped where continued use is not justified.
- There has been a change with the preferred choice in emollient preparations as highlighted in the guidance below.

[issue-52-emollient-prescribing.pdf \(medwayswaleformulary.co.uk\)](https://www.medwayswaleformulary.co.uk/issue-52-emollient-prescribing.pdf)

## National Updates

### MHRA Drug Safety Update

The latest MHRA Drug Safety Updates can be accessed at [Drug Safety Update - GOV.UK \(www.gov.uk\)](https://www.gov.uk/drug-safety-update). This includes links to alerts, recalls and safety information and to the monthly Drug Safety Update PDF newsletter.

*Every effort is made to ensure that the information contained in this newsletter is accurate and up to date at the time of publication. Please be aware that information about medicines and therapeutics will change over time, and that information may not be current after the initial date of publication. Please take note of the publication date and seek further advice if in any doubt about the accuracy of the information. The information contained in this newsletter is the best available from the resources at our disposal at the time. Acronyms used are standard formulary. This newsletter is produced by the NHS Kent and Medway Medicines Optimisation Team on behalf of the Kent & Medway ICB. For all correspondence including any queries, please contact the Medicines Optimisation team email: [kmicb.medicinesoptimisation@nhs.net](mailto:kmicb.medicinesoptimisation@nhs.net)*

**The October 2023 Drug Safety Update includes:**

**[Valproate: dispense full packs of valproate-containing medicines - GOV.UK \(www.gov.uk\)](#)**

NB. FAO Dispensing practices – please see full article (link in title)

Following a consultation, the Government has amended the Human Medicines Regulations 2012 (HMRs) to require manufacturer's original full pack dispensing of valproate-containing medicines.

Unless there are exceptional circumstances, valproate-containing medicines must always be dispensed in the manufacturer's original full pack from 11 October 2023.

**[Isotretinoin \(Roaccutane ▼\): introduction of new safety measures, including additional oversight of the initiation of treatment for patients under 18 years of age - GOV.UK \(www.gov.uk\)](#)**

NB. Dispensing practices – please see full article (link in title) and [Pharmacist Checklist.pdf \(publishing.service.gov.uk\)](#)

The MHRA have strengthened the safe use of isotretinoin through the introduction of additional oversight of the initiation of isotretinoin in patients under 18 years and through improved assessment and monitoring of mental health and sexual function issues. They ask healthcare professionals to review these new measures and supporting materials and integrate them into their clinical practice when referring patients and when prescribing or dispensing isotretinoin.

**[MedSafetyWeek November 2023: your Yellow Card report helps to improve patient safety - GOV.UK \(www.gov.uk\)](#)**

**[Letters and medicine recalls sent to healthcare professionals in September 2023 - GOV.UK \(www.gov.uk\)](#)**

**Please follow the link in the titles above for more information and resources.**

**The MHRA Central Alerting System alerts can be accessed at <https://www.cas.mhra.gov.uk/Home.aspx>**

### **Shortages Summary**

Please find the medicines shortages update (up until 13<sup>th</sup> November 2023) attached. Practices are encouraged to register for access to the SPS website <https://www.sps.nhs.uk/> and access the full medicines supply tool directly in real time.

**[shortages-summary-issue-52-nov-23.pdf \(medwayswaleformulary.co.uk\)](#)**