



Buckinghamshire, Oxfordshire
and Berkshire West
Integrated Care Board

BOB Medicines Optimisation Bulletin



This monthly newsletter is written by the Medicines Optimisation Team of the BOB Integrated Care Board and is intended for healthcare professionals and practice staff. If you have any questions or feedback, please contact the team via the email address: bobicb.medicines@nhs.net

Past editions of the bulletin can be found on the [SharePoint](#) website.

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National updates

Valproate use in men – Updated MHRA advice

On 5th September the [MHRA published further precautionary advice](#) regarding valproate use in men. A retrospective observational study has indicated a possible association between valproate use by men around the time of conception and an increased risk of neurodevelopmental disorders in their children. This risk is much lower than the up to 30-40% risk of neurodevelopmental disorders in children born to mothers taking valproate during pregnancy.

See the full advice for MHRA guidance, key points for healthcare professionals:

- **Inform male patients (of any age) who may father children** of the possible risk at initiation of valproate or at their next regular treatment review – this counselling should be given irrespective of the indication for valproate and also after intravenous use of valproate
- As a precaution, recommend that **male patients use effective contraception (condoms, plus contraception used by the female sexual partner)** throughout the valproate treatment period and for 3 months after stopping valproate, to allow for one completed sperm cycle not exposed to valproate
- At the next regular treatment review, discuss with men on oral valproate treatment whether they are planning a family in the next year and if they are, refer to a specialist to discuss alternative treatment options

The updated advice will be added to the valproate patient guide in the meantime see MHRA's [Advice for male patients on valproate to use contraception](#) and [visual risk communication diagram to be used by a healthcare professional when counselling on the risks](#).

The MHRA update will also be reviewed by the BOB ICS Valproate Task and Finish Group in due course. In addition, resources to support have been put together by the national Valproate Integrated Quality Improvement (VIQI) Programme that may be helpful, including a [Valproate Q&A paternal risk document](#) and [General Practice responses to paternal valproate risk flowchart](#)

Healthcare professionals are welcome to join the VIQI via their collaboration space at [Medicines Safety Improvement Programme - FutureNHS Collaboration Platform](#) or request

invites to group meetings and workshops at
england.medicinesafetyimprovementprogramme@nhs.net

So what?

- Read the full safety update and recommended actions for healthcare professionals and information that should be provided to patients.
- Male patients who may father children should be informed of the possible increased risk of neurodevelopmental disorders in their children. Men and their partners are being recommended to use effective contraception during valproate treatment and for at least 3 months after stopping valproate.
- No one should stop taking valproate unless they are advised by a specialist to do so because of the importance of keeping their condition under control.
- The BOB [valproate shared care protocol](#) will shortly be updated to reflect this update.



BOB System updates



Updates from Area Prescribing Committee

BOB ICB Asthma Guideline Development – Expression of Interests from Practice nurse/primary care pharmacist

The BOB ICB Integrated Respiratory Delivery Network is about to start working to produce Asthma Guidance which will align treatment across the organisation. A small working group made up of local consultants, GPs, specialist nurses, and pharmacist is being convened to support this work.

The group is looking for a Practice nurse or Practice Pharmacist who is involved in the management of patients with Asthma, to assist in the development of these guidelines. The group meets for approximately 1 hour per month, on a Tuesday afternoon.

If you would like to be involved or would like more information, contact jillian.powell@nhs.net

Prescribing Quality Scheme

PQS 2023-24 achievements summary report

The BOB ICB Medicines Optimisation Prescribing Quality Scheme for 2023 – 24 has now been finalised and closed off. The PQS ran from 1st May 2023 to 31st March 2024 and the MOT would like to share the outcomes of the scheme.

Thank you for all the hard work carried out through the PQS which demonstrates some of the significant achievements, towards the aim of improving the quality and safety of prescribing across Primary Care, and potential impact to the wider NHS and social care system.

The summary report can be found here:

[Prescribing Quality Scheme 2023-24 report - FINAL-R .docx](#)

Medication Safety

Topiramate Annual Risk Awareness Form for patients with epilepsy on current therapy

As per the [topiramate new MHRA safety measures](#) this includes a Pregnancy Prevention Programme (PPP). Patients who are currently taking topiramate for epilepsy requires the specialist prescriber to discuss and complete an [Annual Risk Awareness Form \(ARAF\)](#) with the patient (or responsible person).

For patients already under regular review with the secondary care services ARAFs will be completed at their next review with the specialist as there is no capacity to expedite appointments.

Please only expediate a review with the specialist team where they are **not** under regular follow up with a specialist or it is deemed that the absence of risk may have changed.

So what?

- Where topiramate is prescribed for epilepsy the ARAF will be completed at their next review with the specialist. Further information on the new safety measures and the supporting materials can be found on [topiramate Drug Safety Update](#).

Valproate Prescribing Guide for Primary Care

A Primary Care prescribing guide to support the 'Safer prescribing of valproate containing medicines in patients (with childbearing potential) has been developed for EMIS and SystmOne systems. The guide identified clinical searches, clinical safety alert pop-ups, clinical review templates, SNOMED read codes and audit template which can be used to support the safer prescribing of this high-risk medicine.

This document must be read in conjunction with the BOB '[Oral Valproate Medicines Shared Care Protocol for all patients \(male and female\) under the age of 55 and those over 55 who are planning to have children](#)'.

[Valproate prescribing guide primary care for EMIS system FINAL.docx](#)

[Valproate prescribing guide primary care for SystmOne clinical system FINAL.docx](#)

So what?

- Oral valproate containing medicines are classed by the CQC as high-risk medicines and the prescribing management processes for valproate maybe included in the CQC inspection reviews carried out.
- Using the available Ardens clinical review templates will automatically ensure the correct SNOMED read codes are applied to the patient records.
- All practices should have a process for safe prescribing and reviewing patients on valproate in accordance with current national guidance. If practices don't use Ardens this should be through EMIS and TPP/SystmOne, or others.

Safe anticoagulant prescribing – update

Following on from the article that was published in [BOB Medicines Optimisation Bulletin - August 2024 Volume 3 Issue 8 - Safe anticoagulant prescribing](#) which highlighted that Primary Care prescribing data has identified a number of BOB ICB patients who may have received two or more anticoagulant drugs in the same month, or in two consecutive months.

The MOT would like to highlight to all clinicians that there is a [Prescribing alerts Ardens search](#) available, see image below, for its file location on Emis Enterprise.

Name	Population Count	%	Last Run
On OAC ?stop DOAC or warfarin as on two anticoagulants			
Query stop DOAC or warfarin as on two anticoagulants			Hidden
On OAC ?stop or anticoag review as no licensed indication recorded			
Query stop or anticoag review as no licensed indication recorded			Hidden
On OAC ?stop or anticoag review as not done in last 1y + AF + latest ...			
Query stop or anticoag review as not done in last 1y + AF + latest OR			Hidden
On OAC ?stop or anticoag review as single DVT >6m ago + no other i...			
Query stop or anticoag review as single DVT 6m+ ago + no other i...			Hidden
On OAC ?stop or anticoag review as single PE >1y ago + no other ind...			
Query stop or anticoag review as single PE 1y+ ago + no other ind...			Hidden

Community pharmacists are well placed to optimise the safe use of anticoagulants and to help ensure a safe transition between therapies as well as promote and encourage patients to return any medication no longer needed. The [Community pharmacy oral anticoagulant safety audit 2021/22](#) highlights the importance of good communication and recommends community pharmacists proactively discuss the anticoagulant medicine with the patient or representative to ensure safe and effective use, including the signs of over-anticoagulation and the need to check with a doctor or pharmacist prior to starting any OTC medicines.

So what?

- There is a [Prescribing alerts Ardens search](#) available, it would be good practice to run the search on a regular basis to help identify any potential medicines safety issues that need to be reviewed
- Community pharmacists should be proactively discussing the anticoagulant medicine with the patient or representative ensure safe and effective use
- Any changes in anticoagulant therapy need to be clearly communicated to patients/carers and check patients have understood

Excess quantities of semaglutide and tirzepatide

Semaglutide injection is administered once a week and is only available as a multidose pre-filled pen, which contains four doses so **one multidose pen will last for one month**.

Tirzepatide is also administered weekly and is available in both a single-use and a multidose pre-filled pen form. The tirzepatide multidose pen contains four doses so **one multidose pen will last for one month**.

[Open Prescribing data](#) indicates that BOB prescribers are requesting four multidose pens per month in error. This is unlikely to be required and likely to be caused by the dose and quantity being confused on a picking list.

Due to the ongoing national [shortage](#) of these products, prescribers should check that the correct quantity of the multidose pen is prescribed

Table showing differences between KwikPen® and auto-injector pre-filled pens

Mounjaro® pre-filled pens	Volume of injection	Number of pens per pack
KwikPen®	2.4ml	1 pen contains 4 doses (each dose is 0.6ml). One pen is sufficient for 4 weeks treatment
Auto-injector	0.5ml	4 single dose pens each containing 0.5ml . One pack of four pens provides 4 weeks treatment.

Please note that Mounjaro is a [black triangle](#) medicine which identifies newly licensed medicines that require additional monitoring. Local guidance can be found [here](#).

So what?

- Please take care when prescribing and ensure if requesting a multidose pen only one pen per month is issued.

Yellow Card Biobank: call to contribute to study of genetic links to side effects associated with direct-acting oral anticoagulants (DOACs) and allopurinol

The [Yellow Card Biobank](#) is a collaboration between the MHRA and Genomics England.

Adverse drug reactions, or side effects, continue to be a significant burden on the NHS and account for one in 6 hospital admissions. This initiative is part of the long-term vision for more personalised medicine approaches, by improving the understanding of how a patient's genetic makeup may increase their risk of experiencing harmful side effects to medicines.

Side effects covered in this pilot study are:

- severe bleeding events with a DOAC - apixaban, dabigatran, edoxaban, rivaroxaban – see [Drug Safety Update](#) for a reminder on this risk
- rare severe skin reactions with [allopurinol](#), including Stevens-Johnson Syndrome (SJS), Toxic Epidermal Necrolysis (TEN), and Drug Reaction with Eosinophilia and Systemic Symptoms (DRESS) syndrome

So what?

- Suspected side effects to medicines or vaccines and medical device incidents can be reported via the [MHRA Yellow Card reporting site](#).
- Support this initiative to explore whether there is a genetic basis of side effects associated with DOACs and allopurinol.

Medication Safety Searches - ACE (angiotensin converting enzyme) inhibitors or ARB (angiotensin receptor blockers)

To improve medicines safety, in each edition of the Medicines Optimisation Bulletin, we will be highlighting a medication search which can be undertaken in practices to help ensure patient safety. These searches often include high risk medications which require monitoring and certain parameters which may be investigated by [CQC](#).

This month we are focusing on **ACE (angiotensin converting enzyme) inhibitors or ARB (angiotensin receptor blockers)**

ACE inhibitors or ARB's can be prescribed for various indications, but the main ones are heart failure, hypertension, prophylaxis of cardiovascular events and diabetic neuropathy.

Both ACE inhibitors and ARB's work in the renin-angiotensin pathway. ACE inhibitors are usually prescribed first, with ARBs as an alternative due to intolerance with ACE inhibitors.

The following monitoring is recommended to be undertaken in patients prescribed these medications:

Creatinine and Electrolytes & Blood pressure

Frequency

Prior to initiation: A baseline blood test for creatinine and electrolytes and blood pressure monitoring.

During treatment: After initiation and at dose changes a repeat blood test for creatinine and electrolytes will be needed after 1-2 weeks depending on the indication. Blood pressure should also be reviewed between 2-4 weeks of starting these medications or changing the dosage.

Once stable: A blood test for creatinine and electrolytes should be performed 6-12 months depending on the indication.

Please see the following link from [Specialist Pharmacist Service](#) and [NICE CKS](#) for further detail on monitoring ACE inhibitors or ARB's in different conditions.

Please, report any adverse effects of the medication via the [MHRA Yellow Card](#) reporting scheme.

So what?

- We advise running a search to identify the number of patients within your practice who are prescribed ACE inhibitors or ARB's and have blood tests due.
- Set up a method of reviewing and monitoring patients prescribed these drugs regularly
- If you have any examples of good practice where you have undertaken this audit, we would like you to share these with the Medicines Optimisation Team via email: bobicb.medicines@nhs.net

Miscellaneous

Medicines Compliance Aids (MCAs) and 7 day Prescription Requests

It has been brought to our attention recently that several community pharmacies are requesting 7-day prescriptions from GP practices in order to provide patients with Medicines Compliance Aids (MCAs) (also known as blister packs, dosette boxes or MDS) and are not prepared to provide the MCA without a 7-day prescription.

This is not in line with the Community Pharmacy Contractual Framework, since pharmacies cannot ask a prescriber to amend prescription quantities unless agreed with the prescriber that the patient would benefit clinically from weekly supplies due to patient issues such as risk of taking excess medications if more than 7-days medication is supplied or if a patient's medication regime changes frequently.

It is the responsibility of the community pharmacists under the Equality Act to make any reasonable adjustments to help patients take their medications such as large font labels, easy open caps or provide reminder charts.

Pharmacies are permitted to provide MCAs as a private arrangement with the patient, but this does not involve the pharmacist to be supplied with 7-day prescriptions.

This issue has now been brought to the attention of the South East Pharmacy and Optometry and Dentistry Commissioning Hub who have sent out a regional email on the 17/07/2024 to all community pharmacies reminding them of this. If any GP

practice continues to experience this issue with any community pharmacies, please send the details to Frimleyicb.southeastcommunitypharmacy@nhs.net

Some useful information can be found on the websites listed below:

[Multi-compartment compliance aids \(MCAs\) | RPS \(rpharms.com\)](#)

[Usage of Medicines in Compliance Aids – SPS - Specialist Pharmacy Service – The first stop for professional medicines advice](#)

[The Equality Act 2010 - PSNC Website](#)

[Helping patients take their medicines safely: reasonable adjustments - West of England Academic Health Science Network \(weahsn.net\)](#)



Training, upcoming meeting and Resources

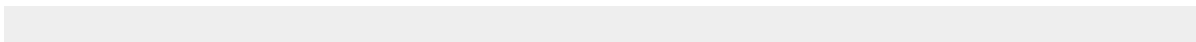


“Pharmacy Workforce Conference” on Tuesday 1st Oct’24 from 9am – 5pm, at the Oxford Belfry Hotel, just off junction 7 of M40.

BOB ICB is hosting its “**Pharmacy Workforce Conference**” on **Tuesday 1st Oct’24** from **9am – 5pm**, at the *Oxford Belfry Hotel, just off junction 7 of M40*. We hope that you will support the whole-day event, which is free of charge, by permitting your relevant staff to attend. The conference is primarily aimed at pharmacy professionals (pharmacists and pharmacy technicians) working within Primary Care. Attendees will be able to hear from both national and local speakers on many important and topical subjects and they will also have the opportunity to network with colleagues and share ideas and experiences.

Kindly register by clicking [here](#).

Deadline for registrations is Fri 20th Sep’24.



NICE topic priorities

Are you interested in which guidelines NICE maybe reviewing?

NICE has a new [centralised approach to prioritising our guidance topics](#). You can see NICE's [priorities for 2024 to 2025](#) and their [Forward view](#). Health and social care staff, patients and the public can suggest a topic for guidance development [using this form](#).

BOB ICB Repeat Prescribing Training

Just a reminder regarding the Repeat Prescribing training for GP practice staff which will be held on **Microsoft Teams**.

Training sessions are scheduled for the following dates The following dates below are focused on staff involved in the preparation of repeat prescriptions (**non-clinical staff**):

Wednesday 18th September 09:30-11:00 & Thursday 17th October 11:00-12:30

Clinical staff, especially **prescribers & pharmacists** may choose to attend the session on **Wednesday 23rd October 13.00-14:00**. This will focus on the clinical implications and process development of Repeat Prescribing systems.

To register interest, please complete the Microsoft Form individually for each staff member attending via the following link: [Repeat Prescribing Training Sessions - Registration Form](#)

If you have multiple members of staff who would like to attend, and would prefer Face to Face training, please contact bobicb.medicines@nhs.net to discuss your requirements.

Centre for Pharmacy Postgraduate Education (CPPE) 'Valproate: the hard conversations – focal point' online workshop

The CPPE have an online workshop aimed at developing learner's skills and confidence in using a person-centred approach to help manage the risks associated with valproate. This workshop is intended for pharmacists, pharmacy technicians and trainee pharmacists. This can be booked via the [CPPE website](#).

Diabetes Information and Resources

The BOB Integrated Diabetes Delivery Network (IDDN) have created a ClinOx webpage to host diabetes resources relating to pathways and guidance to support your management of people with diabetes. For the latest information from BOB IDDN, please see the newsletters on this [link](#).

Other news and information

Medicines Supply Information

Information on long-term supply issues can be found on the [Medicines Supply Tool](#) on the SPS website. Please note this is not an exhaustive list.

Serious Shortage Protocols

Serious Shortage Protocols (SSPs), which enable community pharmacists to supply patients with specific alternative medicines, are available to view on the NHS Business Service Authority (BSA)'s [dedicated SSP web page](#), along with supporting guidance. Questions regarding the SSPs should be directed to the NHS Prescription Service:

Email: nhsbsa.prescriptionservices@nhsbsa.nhs.uk

Telephone: 0300 330 1349. Textphone: 18001 0300 330 1349

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