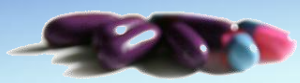
LOTHIAN PRESCRIBING BULLETIN

Supporting prescribing excellence - informing colleagues in primary and secondary care

In this issue …



Issue No. 93 **September 2018**

Introducing Peer Approved Clinical System Tier Two (PACS2)

The Scottish Government have issued guidance on the implementation of PACS2, which replaces some of the processes previously covered by the Individual Patient Treatment Request (IPTR) policy. This is now implemented in NHS Lothian.

The aim of the policy is to enhance the consistency of approach across all NHS Boards when considering medicines that have not been accepted for routine use in NHS Scotland.

The responsibility for making a request through the PACS2 process rests with the clinician who wishes to prescribe the requested medicine. There are no clinicians (including non-medical prescribers) exempt.

As part of best practice and in order to strengthen the case being made, the requesting clinician must seek peer support for their application from another NHS clinician with suitable experience in treating the condition for which the medicine is being requested.

This policy is applicable to patients being treated within primary care and secondary care across NHS Lothian. The process will apply to new patients. Submissions will not be required for patients who have already been initiated on a medicine through the NHS, although submissions will be required if treatment is initiated in private health sector.

PACS2 process is designed to provide an opportunity on a case by case basis to request the use of a licensed medicine that

- *is a medicine for an indication that has been considered and not recommended for use in NHS Scotland by the Scottish Medicines Consortium (SMC); or*
- *is a medicine accepted for restricted use by SMC but the intended use is outwith SMC restrictions; or*
- *is a medicine which has been submitted to and is awaiting/undergoing evaluation by the SMC*.

Currently, the existing IPTR process still applies for medicines that are not recommended by the SMC due to non-submission.

Decisions on medicines, including those not recommended by the SMC and therefore not routinely available in NHS Lothian, are published on the Lothian Joint Formulary website at www.ljf.scot.nhs.uk/FormularyCommittee/NewDrugDecisions/Pages/default.aspx

Full information of this process is available on the LJF website at http://www.ljf.scot.nhs.uk/FormularyCommittee/Procedures/Pages/default.aspx

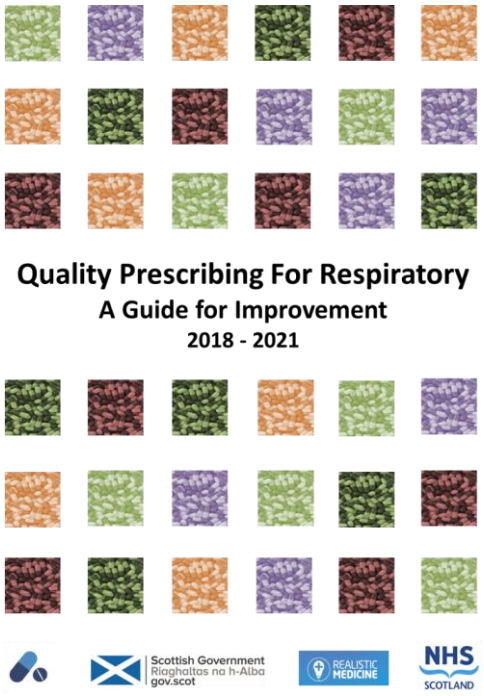
eLJF-CLINICAL update - now version 4.57 - six years of prescribing support

eLJF-CLINICAL has been guiding clinicians to make clinically appropriate LJF prescribing decisions for over six years and continues to improve thanks to user feedback. The next version 4.57 is currently being installed in Vision practices. The asthma and COPD sections of the respiratory chapter have been significantly updated and include links to the revised inhaler posters. The drug misuse section was well overdue a review and this has now been completed and includes a section on take home naloxone, with guidance regarding clinically appropriate use. Finally, the children's chapter is 75% through a complete rebuild which is due for completion with the next version.

A pause for breath – quality prescribing for respiratory

Since the introduction of the *High Strength Corticosteroid Inhaler* National Therapeutic Indicator (NTI) in 2012 and the *Respiratory Prescribing Strategy 2014-16* there has been a significant reduction (equivalent to £14 million per annum) in the prescribing of high strength inhaled corticosteroid. This has been achieved by front line clinicians reviewing patients and stepping down the steroid burden, whilst being supported by better local formulary choices.

The Effective Prescribing & Therapeutics Branch of the Scottish Government has worked in collaboration with the Scottish Practice Pharmacist and Prescribing Advisers Association (SP3AA) and respiratory MCN to produce the updated strategy ***Quality Prescribing For Respiratory – A Guide for Improvement 2018-2021***.



The key intervention of the previous strategy was to promote a holistic review of patients with a view to checking inhaler suitability and specifically to reduce inappropriate steroid burden where this was clinically appropriate. Over the last four years a range of clinical evidence and data analysis developments have shaped a number of additional quality improvement interventions, for practices and clusters to consider.

The National Review of Asthma Deaths was published in 2014, after the earlier strategy. The review identifies the group of patients with asthma at greatest risk of emergency admission and death, namely those who are prescribed more than 12 short acting beta agonist (SABA) inhalers in 12 months. Strictly speaking a well-controlled asthmatic should only use one or two SABA inhalers a year as a maximum of three doses a week is defined as optimal control. However those receiving greater than 12 SABAs are at much greater risk of an adverse clinical event. An NTI has been introduced to highlight this issue and patient identifier searches have been built into the Scottish Therapeutics Utility (STU), to support targeted review and quality improvement. It is important to note that this measure should **not** be applied to patients with COPD.

Review of all patients on high strength inhaled corticosteroids remains a priority, but the NTI for *Children under 12 years old prescribed high strength ICS* provides a means of targeting patients at significant risk of the side-effects from high steroid burden.

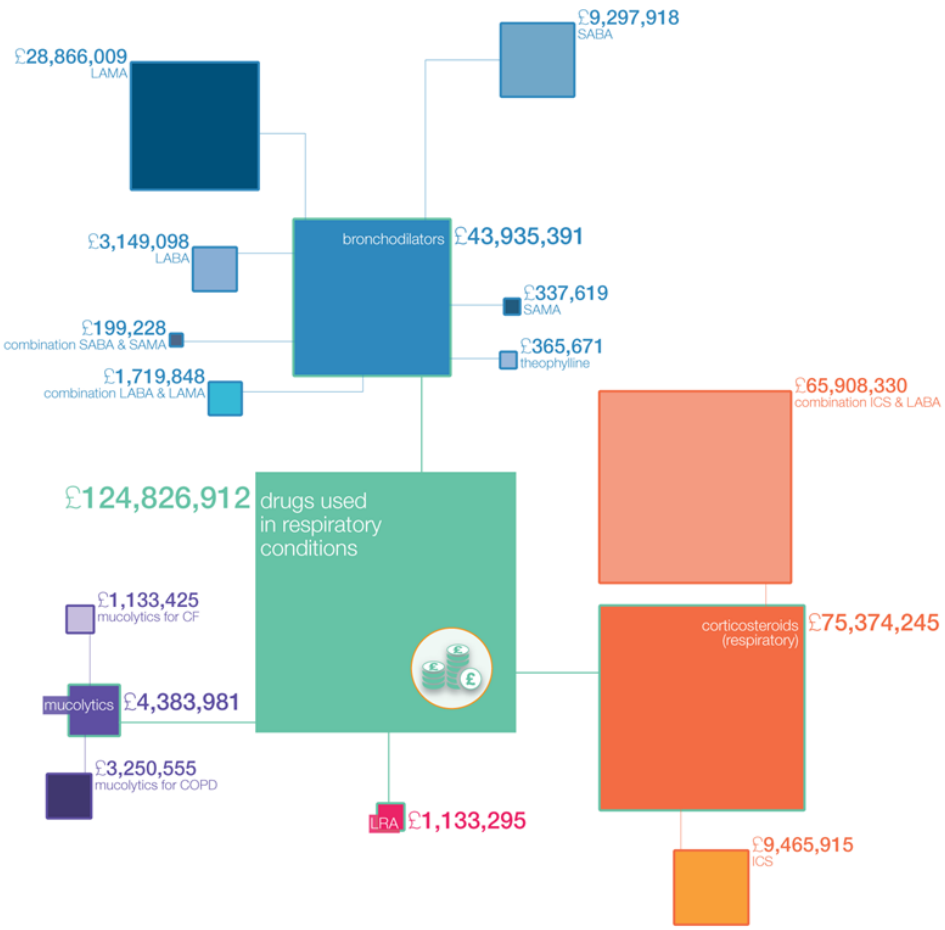
For patients with COPD the main quality improvement is to review the appropriateness of inhaled corticosteroid use for the individual patient. The new strategy utilises the GOLD Guideline (2017) as the main source for clinical evidence and advice. GOLD divides COPD patients into four groups and Group A and B are of particular interest, as they should probably not be treated with an inhaled corticosteroid as the increased risks of developing community acquired pneumonia outweigh the benefits. In essence if a patient with COPD has never required a course of systemic corticosteroids for an exacerbation then they should probably not be using an inhaled corticosteroid. This is another group of patients for targeted intervention, where the focus of treatment should be around optimising the use of SABA, long acting muscarinic agonists and long acting beta agonists.

Finally, this document introduces ways of identifying patients prescribed excessive inhaled corticosteroids, equivalent to greater than 14 months' worth in 12 months. This is included as an NTI and again patients for review can be identified using the respiratory searches in STU (see article on page 3.) The new strategy provides a range of evidence based quality improvement interventions for consideration by individual GPs and clusters. Case studies from across Scotland are provided as examples of best practice.

Key messages:

- *Think 12 and 12*. Patients with asthma who are prescribed more than 12 SABA inhalers in 12 months are at greatest risk of emergency admission and death.
- If a patient with COPD has never required a course of systemic corticosteroids for an exacerbation then they should probably not be using an inhaled corticosteroid.
- STU is able to help you identify these patient groups, so that you can target interventions to improve health outcomes.

This graphic illustrates the prescribing spend in NHS Scotland in relation to respiratory conditions.



Inhaling correctly?

Drug Safety Update Vol11 Issue10 May 2018 included an article about reports of patients incorrectly using an inhaler resulting in them inhaling a capsule into the throat. This highlights the need to ensure that patients know how to use the inhaler.

The case reports were with the Braltus® (tiotropium) device. This has capsules that need to be inserted in the device not the mouthpiece as happened in the cases discussed. It should never be assumed that patients know how to use a device.

Healthcare professionals should ensure that patients have been trained to use the inhalers they are prescribed. We highlighted some useful websites in the last issue of the LPB. Here they are again. The websites include videos showing how to use different devices and how to support patients.

- www.prescqipp.info/projects/respiratory-care#inhaler-technique-assessment-videos-and-leaflets
- www.rightbreathe.com

STU supporting prescribers

STU (Scottish Therapeutics Utility) is a computer programme available for installation in all practices which is capable of interrogating practice clinical systems to provide intelligence on both repeat and high-risk prescribing. The recent addition of a respiratory report aims to complement the new respiratory prescribing strategy.

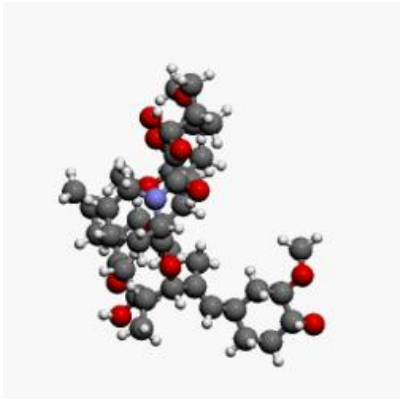
There are five new reports within the Respiratory section which will identify cohorts of patients in the following categories:-

- patients issued >12 SABA in last 12 months
- patients issued >14 Inhaled Corticosteroids over the last 12 months (separate reports for adult or child)
- patients receiving high-dose inhaled corticosteroid (separate reports for adult or child).

For further information on STU, including installation guides and technical support, please contact the Prescribing Efficiency and Analysis Team on peatteam@nhslothian.scot.nhs.uk

Edinburgh Transplant Units: tacrolimus switch in new patients

Tacrolimus, a calcineurin inhibitor, is an essential drug used for the prophylaxis of graft rejection following solid organ transplantation. The MHRA/CHM advises that tacrolimus should be prescribed and dispensed by brand name to minimise the risk of toxicity and graft rejection.



To date, Prograf® has been the first line immediate-release tacrolimus formulation of choice in Edinburgh for transplant patients. The renal and liver transplant teams recently examined the evidence supporting the safety and clinical effectiveness of Adoport®, a new brand of immediate release tacrolimus. It was recognised that there is potential for significant long-term cost savings to be made by switching patients from Prograf® to Adoport®. Previous switches undertaken in other health boards demonstrate this switch to be safe and cost effective. Doses are equivalent, 1mg Adoport® = 1mg Prograf®.

From August 2018 onwards, the transplant teams in Edinburgh will begin to use Adoport® as the first line tacrolimus agent in newly transplanted patients only. The role of the GP will remain the same and is reflected in the shared care agreement which has been updated to reflect this change in practice.

While patients who are currently on Prograf® should remain on this, there are plans to switch these patients to Adoport® in the future. Any switch will happen in outpatient clinics co-ordinated by the transplant unit, under the care of specialist consultants and pharmacists. Letters will be sent to the GP, community pharmacy and the patient to inform them when this switch occurs**.**

Under no circumstances should a switch be carried out in the community and GPs are not to initiate a switch.

Change to Mircera® shared care agreement

Mircera® (methoxy polyethylene glycol-epoetin beta) is an erythropoiesis stimulating agent licensed for the treatment of symptomatic anaemia associated with chronic renal failure. Erythropoietin is a hormone that is produced by the kidneys. In patients with chronic renal failure there may be lower levels of erythropoietin which can lead to anaemia.

Mircera® is prescribed for patients on peritoneal dialysis, patients who have not yet commenced dialysis and for some transplant patients. It should be administered subcutaneously once every two weeks until the 12-week establishment period has been completed and a haemoglobin level greater than 105g/L is achieved. The dose can then be administered monthly at double the previous fortnightly dose or as advised by the renal unit.

Once removed from cold storage the expiry date is now reduced to 30 days due to updated advice. Previously the first 12 weeks would have been supplied by secondary care and administered in primary care after the patient received their first dose from the anaemia co-ordinator. However due to the cold storage restrictions it has been agreed by the GPPC that secondary care now will supply the first 4 weeks of treatment and primary care will take over the prescribing thereafter.

As in the previous shared care agreement (SCA) the patient's full blood count (FBC) should be taken in primary care every two weeks during the establishment period and this will be monitored by the anaemia co-ordinator. After this time the FBC should be taken and monitored in primary care and any abnormal results discussed with the renal team if required.

Key messages:

- The SCA has been changed to reflect the cold storage issue and GPs are requested to prescribe Mircera® from 4 weeks instead of 12 weeks. No other additional monitoring is required.
- The new SCA will be effective from Monday 1st October 2018.

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