

**Medicines Optimisation Newsletter**

**[October 2024] (Issue No.63)**

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**Kent and Medway ICB Updates**

 **Topiramate - Implementing MHRA Safety Measures in Kent & Medway**

**New: Topiramate Kent and Medway Guidance**

**Link:** [**Topiramate (Topamax): introduction of new safety measures, including a Pregnancy Prevention Programme - GOV.UK (www.gov.uk)**](https://www.gov.uk/drug-safety-update/topiramate-topamax-introduction-of-new-safety-measures-including-a-pregnancy-prevention-programme)

In June 2024, the Medicines and Healthcare products Regulatory Agency (MHRA) published a [**Drug Safety Update**](https://www.gov.uk/drug-safety-update/topiramate-topamax-introduction-of-new-safety-measures-including-a-pregnancy-prevention-programme) for Topiramate (Topamax) which includes information and advice for healthcare professionals and patients. This follows a review by the MHRA which concluded that the use of topiramate during pregnancy is associated with significant harm to the unborn child.

In response to this, the Medicines Optimisation team have created a guidance document *“Topiramate – Implementing MHRA Safety Measures in Kent & Medway”* to clearly outline the requirements necessary to implement the MHRA Topiramate guidance across NHS Kent & Medway (primary and secondary care), for newly initiated and existing female patients of childbearing potential on Topiramate.

The document also contains information on Topiramate’s interaction with Hormonal Contraception.

The guidance document can be found [(here)](https://www.eastkentformulary.nhs.uk/media/1895/topiramate-implementing-mhra-safety-measures-in-kent-medway.pdf) .

**Antimicrobial Prescribing Guidance**

The Kent and Medway Supplementary information page, which details any relevant local information, considerations, or adaptations to subsections of the NICE summary table guidance, has been updated. Please access antimicrobial prescribing guidance at the following locations:

East Kent [Antimicrobial guide (Primary care) (eastkentformulary.nhs.uk)](https://www.eastkentformulary.nhs.uk/therapeutic-sections/5-infection/antimicrobial-guide-primary-care/)

West Kent [https://www.formularywkccgmtw.co.uk/prescribing-guidelines/antimcrobial-guidelines/primary-care-antimicrobial-prescribing-guidelines/](https://www.formularywkccgmtw.co.uk/prescribing-guidelines/antimicrobial-guidelines/primary-care-antimicrobial-prescribing-guidelines/)

DGS [dgsdvhformulary.nhs.uk/kent-and-medway-guidance/5-infections/](https://www.dgsdvhformulary.nhs.uk/kent-and-medway-guidance/5-infections/)

Medway / Swale [5. Infection (medwayswaleformulary.co.uk)](https://www.medwayswaleformulary.co.uk/therapeutic-sections/5-infection/)

**Reporting a Controlled Drug Issue**

All controlled drug incidents should be reported via the CD reporting portal - [Signin (cdreporting.co.uk)](https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.cdreporting.co.uk%2Fnhs%2Faccount%2Fsignin&data=05%7C02%7Clindsey.williamson%40nhs.net%7Cc8b38b92823c4ac0973408dce920af5e%7C37c354b285b047f5b22207b48d774ee3%7C0%7C0%7C638641573792127146%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C0%7C%7C%7C&sdata=u3RE3TrdrU1XDGHwi3HAfmpCZGoaexd4BIKwsAYIeQw%3D&reserved=0). The portal should be used to:

* Report a concern relating to controlled drugs (this can be patient, staff, provider concerns)
* Apply to be a temporary authorised witness to witness the destruction of controlled drugs
* Record controlled drugs that have been destroyed

Reports are reviewed nationally, and practices/reporters will be approached should further actions be required.

Should the national team deem that the incident requires circulation of generic patient descriptors in the case of drug seeking behaviour they will circulate this information via the nationally agreed dissemination routes.

The portal may also be used by providers who have their own CDAO (CD accountable officer) to:

* Complete a controlled drug quarterly occurrence report
* Complete a controlled drug declaration

**Home Use of Nebulised asthma rescue therapy in children**

Home use of nebulisers in paediatric asthma MUST be initiated and managed only by specialists.

Use of a nebuliser purchased independently of medical advice for use in the home to deliver nebulised asthma rescue medications to children can mask a deterioration in the underlying disease and may increase the risk of potentially fatal delays in seeking medical attention if asthma deteriorates.

Clinical guidance from NICE recommends use of nebulised rescue medicines only in severe or life-threatening acute exacerbations of paediatric asthma, or, on a regular basis, only in patients with severe asthma when they are unable to use other inhalational devices.

***Use of a nebuliser under these circumstances must be strictly under medical supervision***

If home use of a nebuliser for the acute treatment of asthma in children under 18 years of age is considered necessary, ***this MUST be initiated and managed by an appropriate specialist***.

**Advice for healthcare professionals:**

* Use of nebuliser devices at home to deliver asthma rescue medication to children and adolescents, without adequate medical supervision, can mask a deterioration in the underlying disease, which could result in delays in seeking medical attention and have fatal or serious consequences.
* Only specialists in asthma should initiate and clinically manage use of nebulisers and associated nebulised medicines at home for acute treatment of asthma in children and adolescents
* Independent purchase of nebuliser devices outside of specialist medical advice for children or adolescents with asthma is not recommended in any circumstance.
* Pharmacists are asked to advise people seeking to purchase a nebuliser for this purpose that such home use of nebulisers is not recommended without specialist clinical management
* continue to report suspected adverse reactions to nebulised medications and adverse incidents involving nebulisers on a Yellow Card.

Please see [Nebulised asthma rescue therapy in children: home use of nebulisers in paediatric asthma should be initiated and managed only by specialists - GOV.UK (www.gov.uk)](https://www.gov.uk/drug-safety-update/nebulised-asthma-rescue-therapy-in-children-home-use-of-nebulisers-in-paediatric-asthma-should-be-initiated-and-managed-only-by-specialists) for more information.

**Salbutamol SPC update**

Some of the manufacturers of salbutamol products ([Ventolin](https://www.medicines.org.uk/emc/product/850/smpc), [Salamol](https://www.medicines.org.uk/emc/product/12983/smpc#about-medicine)[, Easyhaler Salbutamol](https://www.medicines.org.uk/emc/product/6339/smpc) and [Asthalin](https://www.medicines.org.uk/emc/product/15454/smpc)) have updated their SPCs to advise on the risks of mortality with salbutamol overuse with the information below:

“Overuse of short-acting beta-agonists may mask the progression of the underlying disease and contribute to deteriorating asthma control, leading to an increased risk of severe asthma exacerbations and mortality.

Patients who take more than twice a week “as needed” salbutamol, not counting prophylactic use prior to exercise, should be re-evaluated (i.e., daytime symptoms, night-time awakening, and activity limitation due to asthma) for proper treatment adjustment as these patients are at risk for overuse of salbutamol.”

“Cardiovascular effects may be seen with sympathomimetic drugs, including salbutamol. There is some evidence from post-marketing data and published literature of rare occurrences of myocardial ischaemia associated with salbutamol. Patients with underlying severe heart disease (e.g. ischaemic heart disease, arrhythmias or severe heart failure) who are receiving salbutamol should be warned to seek medical advice if they experience chest pain or other symptoms of worsening heart disease.”

Please see special warnings and precautions for use on individual SPCs (linked above).

**The adult attention deficit hyperactivity disorder (ADHD) and autism spectrum disorder (ASD) service**

October Is ADHD Awareness month. The aim of the global campaign is to provide reliable information and resources to help people thrive with ADHD.

During a recent review of the existing pathway, it was noted that incomplete referrals led to poor triaging and, consequently, poorer patient experience and outcomes.

The review also highlighted that this has contributed to the longer waiting times for the patients as documents needed to be chased. This again led to poorer experience for patients, and everyone involved.

We have worked closely with GP practices and clinicians and based on their feedback we have developed this guidance [[Link to document](#Article00) – see page below] to help improve the patient journey.

The update is to help you make sure that all relevant documents are included, and that baseline clinical readings and medication are present along with the patient history. This allows for efficient triaging of the patient and a better patient experience.

**Shared care**

If you already have a shared care agreement in place with a provider for your patient and require clinical advice you can contact the provider directly. You do not need to go through KCHFTs single point of access.

 

**Referral guidance: The adult attention deficit hyperactivity disorder (ADHD) and autism spectrum disorder (ASD) service**

The following information is needed in order to progress all adult ADHD/ASD referrals:

|  |  |
| --- | --- |
|  | **Information needed for referral** |
| **Reason for referral:** | **Practice to complete:** | **Patient to complete (Must be sent with referral form):** |
| ADHD diagnostic assessment | Referral Form | * Adult ADHD Self-Report Scale (ASRS) v5\*
 |
| ADHD review to initiate or review current medication (Existing diagnosis with no current shared care agreement) | Referral form (including GP medical summary) | * ASRS v5
* Cardiac questionnaire
* Evidence of diagnosis (diagnostic report/relevant ADHD clinical letter that confirms diagnosis)
 |
| Autism diagnostic assessment | Referral form | * Autism Spectrum Quotient tool

(AQ50) |

\*Please note that to align with DSM-5 ADHD diagnostic criteria, the service is phasing out the use of ASRS v1.1 and replacing with ASRS v.5. The service will still accept v1.1 up to the end of October 2024.

A reminder that the online referral form can be found on the Kent Community Health NHS Foundation Trust website. ([https://www.kentcht.nhs.uk/forms/autism-and-adhd-service-diagnostic-assessment-and-medication-review-referral-form/](https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.kentcht.nhs.uk%2Fforms%2Fautism-and-adhd-service-diagnostic-assessment-and-medication-review-referral-form%2F&data=05%7C02%7Cmark.luetchford%40nhs.net%7C78733f63065845c50ed508dcb24a0a42%7C37c354b285b047f5b22207b48d774ee3%7C0%7C0%7C638581278290191810%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C0%7C%7C%7C&sdata=jrt0B6qlJHDqAhkEllHp1zg2tMdFaOGnr7PoeezW5xw%3D&reserved=0))

For further information please contact: kentchft.adultsndreferral@nhs.net

**REMINDER: Prescribe Apixaban generically**

Please continue to prescribe Apixaban generically. It has been added to the No Cheaper Stock Obtainable (NCSO) list for September 2024 [(here)](https://mailchi.mp/cpe/september-2024-price-concessions-final-update?e=22811ce111) . The Community Pharmacy England website gives the following description of an NCSO price concession:

“When community pharmacies cannot source a drug at or below the reimbursement price as set out in the Drug Tariff, the Department of Health and Social Care (DHSC) can introduce a price concession at the request of Community Pharmacy England. A price concession can be requested for any drugs listed in Part VIIIA, Part VIIIB and Part VIIID of the Drug Tariff. For any drugs granted price concessions, contractors are automatically reimbursed at the new prices for that month.” ([Price Concessions - Community Pharmacy England (cpe.org.uk)](https://cpe.org.uk/funding-and-reimbursement/reimbursement/price-concessions/) )

**ScriptSwitch® Prescribing - GP Prescriber Knowledge Centre**

We are pleased to share that a new ScriptSwitch® Prescribing Knowledge Centre has been launched, which is a repository for Learning Materials, Manuals, Bulletins and Release note. It contains training resources for primary care.

[ScriptSwitch Prescribing Knowledge Centre for GPs (optum.co.uk)](https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Finfo.optum.co.uk%2FGP_ScriptSwitch_Knowledge_Centre%3FelqTrackId%3DCD4AB43038CC5BA9BFDE58B37655BC63%26elq%3D00000000000000000000000000000000%26elqaid%3D238%26elqat%3D2%26elqCampaignId%3D%26elqak%3D8AF5DF56A1021DA33B3D116F446CBE53D5A6BBA84EFBAC1D60B272CDF029356C39EB&data=05%7C02%7Ccaroline.mensah1%40nhs.net%7C09e8eb23289744c7ce7308dce3c11214%7C37c354b285b047f5b22207b48d774ee3%7C0%7C0%7C638635665566406247%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C0%7C%7C%7C&sdata=Kb5lNa7iRUijmIV9txTCjHYcjWKgojeVEi80n3s8gzQ%3D&reserved=0)



**Chlordiazepoxide possible genotoxicity risk and KMPT Alcohol Detox policy update**

We would like to advise practices that in May 2022, changes were made to the Summary of Product Characteristics (SPC) of Librium® (chlordiazepoxide) regarding a possible genotoxicity risk. The updated SPC states “Due to the genotoxic potential of chlordiazepoxide, women of childbearing potential should use effective contraceptive measures while being treated with Librium and for 7 months following completion of treatment. If the patient suspects to be pregnant or intends to become pregnant, she should be warned to contact her physician to discuss discontinuation of Librium. Men are recommended to use effective contraceptive measures and to not father a child while receiving Librium and for 4 months following completion of treatment.”

More information can be found on the UKTIS website:

[Librium SPC Updates Opinion Statement (medicinesinpregnancy.org)](https://uktis.org/wp-content/uploads/2022/09/Librium-SPC-Updates-Opinion-Statement.pdf)

Kent and Medway NHS and Social Care Partnership Trust (KMPT), have also updated their alcohol detoxification policy. Diazepam has now replaced chlordiazepoxide as the drug of choice for alcohol detoxification.



**Update on the Supply of Semaglutide Injections (Ozempic®) & Prescribing of Tirzepatide Injections (Mounjaro®)**

An updated medicine supply notification (MSN) for the management of the national supply issues of glucagon-like peptide-1 receptor agonists (GLP-1 RAs) used in the management of type 2 diabetes was released on the 18th of March 2024.

**On the 3rd of October 2024 the Specialist Pharmacy Service (SPS) updated the** [**supply summary**](https://www.sps.nhs.uk/shortages/shortage-of-semaglutide-ozempic-1mg-0-74ml-and-0-5mg-0-37ml-solution-for-injection-pre-filled-disposable-device/) **to reflect the current supply picture of the GLP-1 RA Ozempic (semaglutide injections) and the GIP/GLP RA Mounjaro (tirzepatide injections).**

**The current anticipated re-supply dates of Ozempic have changed and can be found on the SPS supply summary link above.**

**The** [**Specialist Pharmacy Service (SPS) medicines supply tool**](https://www.sps.nhs.uk/shortages/shortage-of-glp-1-receptor-agonists-semaglutide-dulaglutide-liraglutide-exenatide/) **should be used for up-to-date information on supply and re-supply dates for all individual GLP-1 RAs** (free subscription required).

**Mounjaro**

**All strengths of tirzepatide** (Mounjaro KwikPens), including the higher strengths that were not available initially when the drug became commercially available in the UK earlier this year (7.5mg/0.6ml, 10mg/0.6ml, 12.5mg/0.6ml and 15mg/0.6ml solution for injection 2.4ml pre-filled pens), **are now available** (as well as the 2.5mg/0.6ml and 5mg/0.6ml which were already available).

We would like to remind colleagues that:

* The **maximum dose** of Mounjaro of 15mg once a week is not a “target” dose, but doses can be increased only if necessary/clinically indicated to achieve individual patients’ treatment goals (depending upon glucose control). Please see the “Dosing & Administration” section on the [tirzepatide-mounjaro-factsheet](https://www.eastkentformulary.nhs.uk/media/1872/tirzepatide-mounjaro-factsheet.pdf) for more information and guidance on dosing tirzepatide.
* Tirzepatide (Mounjaro®) must only be prescribed for the treatment type 2 diabetes in adults. Prescribing outside of this is not supported in Kent and Medway. Prescribing off-label solely for **weight loss** (in the absence of a type 2 diabetes diagnosis) is not clinically supported or funded by Kent and Medway ICB currently, until NICE have evaluated its use for this indication.

Please continue to ensure that all staff, especially those involved in the management of diabetes and prescribing, continue to follow the actions and the guidance within the [MSN](https://www.eastkentformulary.nhs.uk/media/1866/msn_2024_031-semaglutide-dulaglutide-and-liraglutide-pre-filled-pens-1.pdf) (and in the information sent out previously by the ICB Medicines Optimisation Team) to manage adult patients with type 2 diabetes who are on GLP-1 RAs, whilst the supply issues continue until the end of 2024. This includes **not prescribing more than one month’s supply** for patients.

**Ardens Resources for SGLT2i**

Ardens now have a range of resources for prescribing sodium-glucose cotransporter-2 inhibitors (SGLT2i), including searches, patient information leaflets, and templates to support the safe initiation and prescribing of SGLT2i. Information on how to access these on Ardens can be found below:

**Searches**

Ardens searches are available to help with SGLT2i prescribing and can be used to identify patients on SGLT2i, including identifying patients who may not have had templates completed or leaflets/counselling and side effect information given previously. Searches will find all patients without a “Education about Fournier’s gangrene” SNOMED code. It is recommended to run these searches every 3-6 months

* Ardens folder: 2.22 Prescribing Alerts – Diabetes
* Ardens folder: 2.22 Prescribing Alerts – Cardiovascular

There are various searches under each SGLT2i as well, to highlight patients to review such as those requiring their SGLT2i doses to be reduced or even stopped depending on eGFR, and those which should be stopped if also on a GLP-1 RA.

**Templates**

There is a Template Runner available for prescribing/initiating SGLT2i, including prescribing considerations, patient counselling and follow-up/monitoring. This can be found in the template section within EMIS under Ardens folders

* Ardens main - Ardens Live national content – Pharmacy - SGLT-2i initiation

**Patient Information Leaflets**

Information leaflets/letters to be given to patients can be found in the Ardens document library

* Document called “Sodium-glucose co transporter 2 inhibitors letter to patient” – includes advice on relevant MHRA alerts to be given to patients
* Document called “Sick day rules” – can be given to patients on SGLT2i as well as patients on other medication who require sick day rules

**Hydroxycarbamide with Continuous Glucose Monitoring Systems**

There has been variation to the terms of the Marketing Authorisation(s) for products containing hydroxycarbamide. These changes will be implemented by the Marketing Authorisation holders in due course. Amendments to the Product Information include:

**Summary of Product Characteristics**

* Interference with Continuous Glucose Monitoring (CGM) Systems
* Hydroxycarbamide may falsely elevate sensor glucose results from certain CGM systems which may lead to hypoglycaemia if sensor glucose results are relied upon to dose insulin
* If CGM systems are to be used concurrently with hydroxycarbamide treatment, consult with the CGM prescriber about the need to consider alternative glucose monitoring methods.

**Package Leaflet (Patient Information Leaflet (PIL)**

“What you need to know before you take”

Warnings and precautions

* If you have diabetes and are using a continuous glucose monitor (CGM) to test your blood glucose. Hydroxycarbamide (also known as hydroxyurea) may cause falsely high sensor glucose readings from certain sensors. This could result in using more insulin than needed, leading to low blood sugar (hypoglycaemia). Talk to the physician that prescribed your CGM about whether it is safe to use while you are taking X.

**National Updates**

**New RPS and RCGP Repeat Prescribing Toolkit will improve safety and efficiency**

*Toolkit aims to streamline repeat prescribing systems and reduce medicines waste*

The Royal Pharmaceutical Society (RPS) and the Royal College of GPs (RCGP) have developed a practical toolkit designed to improve the consistency, safety and efficiency of repeat prescribing systems in general practices in England.

The [RPS/RCGP Repeat prescribing toolkit](https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.rpharms.com%2Fresources%2Frepeat-prescribing-toolkit&data=05%7C02%7Clindsey.williamson%40nhs.net%7C7643394a7be74789c38408dcea0ca2e4%7C37c354b285b047f5b22207b48d774ee3%7C0%7C0%7C638642587205787022%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C0%7C%7C%7C&sdata=xVLnRb%2Bj6fmOzF2wBN%2FHyDa069%2Bx318X7Gs7S2d4wcI%3D&reserved=0) was commissioned by NHS England and is a recommendation from the 2021 National Overprescribing Review, which recognised the impact that poorly operated repeat prescribing can have on over prescribing and problematic polypharmacy.

The toolkit is the first national good practice guidance on repeat prescribing in 20 years.

With [over 1 billion prescriptions](https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.nhsbsa.nhs.uk%2Fstatistical-collections%2Fprescription-cost-analysis-england%2Fprescription-cost-analysis-england-2022-23&data=05%7C02%7Clindsey.williamson%40nhs.net%7C7643394a7be74789c38408dcea0ca2e4%7C37c354b285b047f5b22207b48d774ee3%7C0%7C0%7C638642587205801171%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C0%7C%7C%7C&sdata=SfpJk4n7tHMfl8Dz0wNwIvzMgO%2Fw5xoka6VxUeAkv9E%3D&reserved=0) dispensed annually in England, [77% of which are repeat prescriptions](https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fbradscholars.brad.ac.uk%2Fhandle%2F10454%2F10516&data=05%7C02%7Clindsey.williamson%40nhs.net%7C7643394a7be74789c38408dcea0ca2e4%7C37c354b285b047f5b22207b48d774ee3%7C0%7C0%7C638642587205814532%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C0%7C%7C%7C&sdata=MSyu2F2hXW0uPwDIYO63ART8tFnFLvX3KKQWhWWP1RA%3D&reserved=0), the need for efficiency and safety is paramount.

Repeat prescriptions account for nearly [80% of NHS medicine costs for primary care](https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.england.nhs.uk%2Flong-read%2Felectronic-repeat-dispensing-erd%2F&data=05%7C02%7Clindsey.williamson%40nhs.net%7C7643394a7be74789c38408dcea0ca2e4%7C37c354b285b047f5b22207b48d774ee3%7C0%7C0%7C638642587205827893%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C0%7C%7C%7C&sdata=jiaobZb306gpRVj7oohNt2HZ2XWP%2FZmJMiSWxF54pYg%3D&reserved=0). The significant workload caused by repeat prescriptions necessitates streamlining and improvement, which is recognised with resources provided by NHS England on [aligning capacity and demand in general practice](https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.england.nhs.uk%2Fpublication%2Fhow-to-align-capacity-with-demand-in-general-practice%2F&data=05%7C02%7Clindsey.williamson%40nhs.net%7C7643394a7be74789c38408dcea0ca2e4%7C37c354b285b047f5b22207b48d774ee3%7C0%7C0%7C638642587205841956%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C0%7C%7C%7C&sdata=GWXR3U6nVLrWc0QI8P38%2FbHRkLUVLSUZT12O8HcdeGM%3D&reserved=0).

The RPS/RCGP Repeat Prescribing Toolkit allows GP practice teams and primary care networks, working in collaboration with community pharmacies and patients, to evaluate their local arrangements against a framework and work together to identify areas for safety and efficiency improvements.

By streamlining repeat prescribing systems, the toolkit aims to improve patient care, addressing inconsistencies and potential oversupply, whilst reducing unnecessary medicines waste, saving NHS resources.

The toolkit also includes practical guidance on improving communication with patients about repeat prescribing, supported by good practice case studies, flow charts, action plan templates, and useful resources.

Alongside the toolkit, a new NHS dashboard is available, highlighting the scale of potential oversupply of medicines for a range of prescribing areas. Oversupply is when more medication is dispensed than is typically needed or wanted by the patient. The dashboard will support improvement initiatives, particularly around addressing inconsistencies with repeat prescribing processes, to help to minimise avoidable waste or the risk of harm to patients.

The oversupply dashboard is accessible through ePACT2, an online business intelligence platform provided by the NHS Business Services Authority (NHSBSA). ePACT2 improves access to quality prescribing data and is available to authorised users only. To register, visit the [NHSBSA website.](https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.nhsbsa.nhs.uk%2Faccess-our-data-products%2Fepact2%2Fregistering-epact2&data=05%7C02%7Clindsey.williamson%40nhs.net%7C7643394a7be74789c38408dcea0ca2e4%7C37c354b285b047f5b22207b48d774ee3%7C0%7C0%7C638642587205855333%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C0%7C%7C%7C&sdata=Jh3R2rDwYyHYPWgObMNX91liIxZifABb%2F8Wi3PVz6rc%3D&reserved=0) If you are already registered, [access the dashboard](https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fidcs-5e48a6c7d2ea4150bcdcdc847318d62b.identity.oraclecloud.com%2Fui%2Fv1%2Fsignin&data=05%7C02%7Clindsey.williamson%40nhs.net%7C7643394a7be74789c38408dcea0ca2e4%7C37c354b285b047f5b22207b48d774ee3%7C0%7C0%7C638642587205868348%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C0%7C%7C%7C&sdata=g1JCRFSSVuMgp%2Bs79hU7lwlvoSSXouap7brRJ8svEZA%3D&reserved=0).

**MHRA Drug Safety Update**

**Medicines Optimisation MHRA Drug Safety Update – September 2024**

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.

**The September Drug Safety Update includes:**

[**Valproate use in men: as a precaution, men and their partners should use effective contraception - GOV.UK (www.gov.uk)**](https://www.gov.uk/drug-safety-update/valproate-use-in-men-as-a-precaution-men-and-their-partners-should-use-effective-contraception)

Included in the September edition of our newsletter.

[**Letters and medicine recalls sent to healthcare professionals in August 2024 - GOV.UK (www.gov.uk)**](https://www.gov.uk/drug-safety-update/letters-and-medicine-recalls-sent-to-healthcare-professionals-in-august-2024)

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

**NATIONAL CAS ALERTS (National Patient Safety Alerts and CMO Messages):**

**The MHRA Central Alerting System alerts can be accessed at** [**CAS - Home (mhra.gov.uk)**](https://www.cas.mhra.gov.uk/Home.aspx)

24.9.24 NatPSA- Risk of oxytocin overdose during labour and childbirth[**CAS-ViewAlert (mhra.gov.uk)**](https://www.cas.mhra.gov.uk/ViewandAcknowledgment/ViewAlert.aspx?AlertID=103256)

**Shortages Summary**

From February 2024 onwards, the monthly Medicines Optimisation newsletter will no longer contain the medicines shortages update document, which was compiled each month from the shortages listed on the SPS (Specialist Pharmacy Services) Medicines Supply tool. The information published on the SPS Medicines Supply tool is provided by DHSC and NHSEI Medicines Supply Teams and was not formally reviewed by the NHS Kent and Medway Medicines Optimisation team.

During the time that the shortages update was compiled and included in the Medicines Optimisation newsletter, practices and healthcare professionals were still encouraged to register for free access to the SPS website and to access the [SPS Medicines Supply Tool](https://www.sps.nhs.uk/category/medicines-tools/medicines-supply/) directly in real time, to have access to the most up-to-date and complete information and advice available. Now that the shortages update will no longer be compiled by the Medicines Optimisation team for inclusion in the newsletter, healthcare professionals will be required to access the SPS Medicines Supply tool to access information on the latest shortages. Serious Shortage Protocols (SPPs) can be found on the NHS BSA website [(here)](https://www.nhsbsa.nhs.uk/pharmacies-gp-practices-and-appliance-contractors/serious-shortage-protocols-ssps) .

**NICE News Bimonthly – Oct 2024**

**NHS Kent & Medway Medicines Optimisation Team**

**FOR INFORMATION**

**NICE Publications**

**NICE clinical guidelines**

[**Adrenal insufficiency: identification and management**](https://www.nice.org.uk/guidance/ng243) **(Published 28/08/2024)**

This guideline covers identifying and managing adrenal insufficiency (hypoadrenalism) in babies, children, young people and adults. It aims to improve the treatment of primary, secondary and tertiary adrenal insufficiency, and the prevention and management of adrenal crisis.

**Updated NICE Clinical Guidelines**

No new updated NICE clinical guidelines