Prescribing Newsletter

Making the most of medicines

November 2025

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Melatonin – improving access and support for prescribing in autism

Sleep disorders in children with neurodevelopmental difficulties such as autism (ASD) and ADHD are more common than the typically developed population.

- In ASD, insomnia can occur in 40-80% of children and adolescents (Cortesi et al, 2010).
- In ADHD, 25-50% are reported to have sleep problems (Corkum et al, 1998; Gau et al 2007; Fisher et al, 2014).

Clinical experience suggests that melatonin may be of value for treating sleep onset insomnia and delayed sleep phase syndrome in these young people. The formulary position for melatonin in children and young people has traditionally been **AMBER**, ie, GPs will usually agree to prescribe melatonin to young people, where sleep hygiene measures have proved insufficient, on the advice of a specialist /paediatrician.

GPs commonly face the situation where a young person has received a diagnosis of autism, and suffers sleep problems, however the service has not been able to make recommendation for melatonin. Often this is because the service has not been commissioned to advise on sleep, and/or clinicians working in this space are not prescribers.

To bridge this gap NHS Frimley have produced Guidance for the Primary Care for Prescribing of Melatonin and have agreed a change in formulary status to **GREEN** for patients with a diagnosis of autism (via an NHS provider; we have no way of assuring the many private services).

It is recommended that behavioural sleep therapies are continued alongside medication for at least four weeks, but preferably ongoing, as the combination has been found to be more effective than medication alone. The aim is to establish healthy sleep patterns with the lowest effective dose.

For those GPs who prefer to seek advice and guidance from community paediatrics, rather than initiate themselves, this route remains available.

Formulary updates

- Flexitol 25% heel balm added to formulary as **GREEN**. Restricted to use in the prevention of foot ulcers in people with diabetes. Flexitol 10% made **non-formulary**.
- Relugolix tablets for treating hormone-sensitive prostate cancer changed to **AMBER WITHOUT SHARED CARE**

New or updated prescribing position statements.

- High-cost drugs for adults with juvenile idiopathic arthritis (JIA)
- Inflammatory bowel disease (IBD) high cost drug pathway for adults
- Over the counter (OTC) prescribing guidance
- Anti-CGRP and botulinum toxin type A migraine prevention pathway
- High-cost immunomodulator drug pathway for adults with psoriatic arthritis

Public libraries supporting digital inclusion opportunity

NHS England is expanding its partnership with public libraries to help people access high-quality health information and use the NHS App. Over 1,400 libraries supported this in wave 1, which focused on digital inclusion for deprived and marginalised communities. **Wave 2 will launch during Health Information Week (19 –25 January 2026)** and will include refreshed guidance, knowledge exchange, and NHS App drop-in sessions

Libraries in your area have expressed interest in participating.
Contact **england.nhseimplementation@nhs.net** with any queries.

New clinical guide from the British Geriatrics Society

Pragmatic prescribing to reduce harm for older people with moderate to severe frailty

British Geriatrics Society
Improving healthcare for older people

Key aims		• Use shared decision-making to establish patient goals. • More lenient therapeutic targets may better balance medication harms and benefits.	• Symptom control.
Common conditions	**Potential harm from medicines**	**Moderate frailty (CFS 6)** Individual needs help with some aspects of personal care (e.g. washing or dressing), may struggle on stairs, may no longer go out alone **Adjustment**	**Severe frailty (CFS 7-9)** Individual needs help will all personal care or receiving palliative care **Adjustment**
Hypertension	• Falls Fractures • Electrolyte imbalance • Acute kidney injury	More lenient target – average systolic BP in range 140-160 mmHg.[1] Measure BP when sitting and one minute after standing – use lower value for therapeutic decisions.[2]	No BP target – harms likely to exceed benefits. Deprescribing advised.
Type 2 Diabetes	• Hypoglycaemia, leading to cognitive decline/falls	HbA1c target 60 to 75 mmol/mol.[3]	Avoid symptomatic hyper/hypoglycaemia. Simplify prescription.
Cholesterol	• Myalgia • Sarcopenia • Functional decline	Primary prevention: deprescribing advised. Secondary prevention: NNT likely to exceed 100/year to prevent one cardiovascular event – discuss stopping.[4]	Harms likely to exceed benefits. Deprescribing advised.
Heart failure with reduced ejection fraction	• Hypotension • Volume depletion • Falls	Limiting prescribing to fewer than the 'four pillars' may be a better balance of risks and benefits.[5] **ARNI/ACEi** Hypotension, hyperkalaemia. **Beta-blocker** Orthostatic hypotension. **MRA** Dehydration, hyperkalaemia. **SGLT2i** Dehydration, urinary tract infection, thrush.	Continue loop diuretics for fluid overload only.
Osteoporosis	• Therapeutic burden	If on bisphosphonate >3 years, then little evidence of benefit of continuation for next 3 years - discuss stopping.[6]	Treatment unlikely to be beneficial if immobile or in last year of life.
Cognitive impairment	• Accelerated cognitive decline • Falls • Fractures	Minimise exposure to anticholinergic medicines.[7] Evaluate ongoing risk/benefit of any antipsychotic or sedative medications, favouring deprescribing if possible.	Continue anti-dementia drugs if ongoing symptomatic benefit.

This guide provides more lenient therapeutic targets than standard guidelines; balancing potential benefits and harms of medicines in this population.

It is designed for all prescribers involved in medicines optimisation across primary and secondary care settings.

Find the full guidance here.

* Reminder Levemir™ (insulin detemir) has been discontinued *

For further guidance please see our recent article (page 2) and also the ABCD/PCDO Joint Guidance here (which is also available on DXS).

Generic dapagliflozin is the first line SGLT-2 inhibitor on the Frimley formulary

The UK patent for dapagliflozin recently expired, as a result generic dapagliflozin is now available at a much-reduced cost compared with other SGLT2 inhibitors. The majority of local dapagliflozin prescribing is already as generic so financial benefits are realised immediately. However is a significant number of patients with type 2 diabetes (T2D) on other SGLT2 inhibitors. Please may we request that clinicians consider;

- Using generic dapagliflozin as the first-line SGLT2i for all diabetes related indications
- Accepting the Scriptswitch message, where clinically appropriate, suggesting use of dapagliflozin (unless the SGL2i is treating patients with CKD without T2D).
- At T2D annual review consider switching patients from other SGLT-2 inhibitors to dapagliflozin.

Other info/ resources

- You can view your practice's prescribing rates of non-generic dapagliflozin as a proportion all SGLT-2 inhibitors here
- NHS Frimley PIL SGLT-2 inhibitors and rare side effects

We appreciate your continued efforts to improve outcomes and value in medicines optimisation. Please cascade this information to relevant team members in your practice.

Local polypharmacy training - evaluation and impact

Managing the health of older people with multiple health conditions and polypharmacy has become increasingly complex and much of this care occurs in primary care. Polypharmacy presents medication management challenges for older people, their family carers, and healthcare services. Problematic polypharmacy is associated with adverse clinical outcomes including adverse drug events, falls, hospitalisations, and even death. Although Structured Medication Reviews were introduced to reduce polypharmacy and over-prescribing, clinicians are not always confident in identifying and managing problematic polypharmacy.

In November 2023, a local polypharmacy training programme was developed for Frimley, BOB, and BLMK Integrated Care Systems (ICSs) in collaboration with the Health Innovation Network (HIN) Oxford Thames Valley. This training was based on the national HIN Polypharmacy Programme Action Learning Sets and was adapted for multidisciplinary teams, including social care staff working closely with older people susceptible to problematic polypharmacy.

A total of 509 health and social care professionals attended 11 training sessions held between April 2024 and March 2025. All participants received a certificate of attendance, which contributed toward the requirements for local prescribing incentive schemes. Post-training evaluations showed an improvement in average confidence scores from 6.5 to 7.9 out of 10, reflecting greater assurance and practical application of learning. This increased confidence has been supported by positive trends in local polypharmacy comparator data, suggesting that the training has contributed to enhanced medication review quality and safer prescribing practices. Notably, data indicates that prescribing has fallen below forecasted projections, indicating a positive shift in prescribing behaviour.

MHRA alerts

MHRA Safety Roundup November 2025

Reducing harm from psychotropic medicines used for behaviour that challenges in people with a learning disability programme

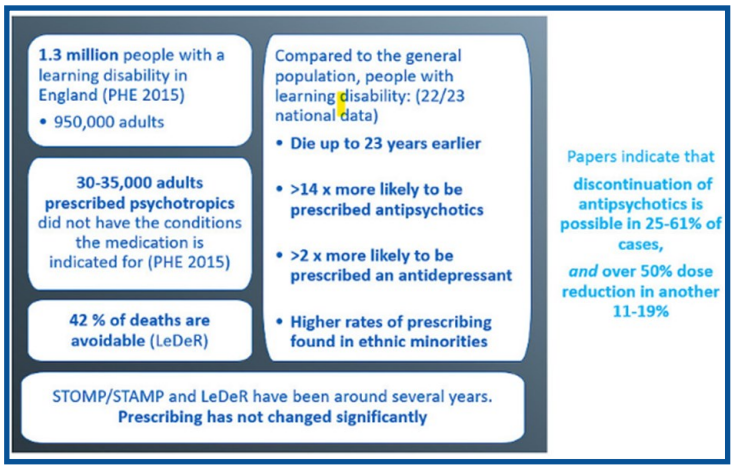
The National Medicines Safety Improvement Programme (MedSIP) is part of the National Patient Safety Strategy. The programme aims to address the most important causes of severe harm associated with medicines, that continue to challenge the health and care systems in England. Behaviour that challenges is not a diagnosis, it describes a range of behaviour that some people with learning disability may display when their needs are not being met.

Where possible psychotropic medicines should be avoided for behaviour that challenges

If needed, prescribing should be

- at the lowest dose
- be reviewed regularly
- stopped as soon as possible.

There are about 1.3 million people with a learning disability in England. Approximately 14% of people with a learning disability are prescribed antipsychotic medicines (compared to 1% of people without a learning disability).



Psychotropic medications include antipsychotics, antidepressants, anxiolytics (benzodiazepines), anti-seizure medication (antiepileptics), sedatives (including hypnotics) and stimulants. They affect the working of the brain and impact on a person's mood, thoughts, perceptions and behaviour. These medications can often have side-effects and can also affect a person's quality of life, so should only be used if there is a clear clinical indication.

The MOT will be working with Oxford Healthcare Innovation Network to take a systems approach to bring together NHS providers, social care, voluntary sector and lived experience to tackle reducing harm from psychotropics used for behaviour that challenges in people with a learning disability.

We hope to bring you more information over the coming months. If you are interested in joining our stakeholder event please contact frimleyicb.prescribing@nhs.net

MOSCCH Corner

After a hospital stay Mr E was discharged from hospital back to his care home with new analgesia. While in hospital his morphine had been changed to oxycodone due to poor renal function. The oxycodone was added to Mr E's hospital electronic medication record as a NEW (and additional medication), but NOT as a replacement medication. Mr E's discharge letter was not available. The patient was given both the old (morphine) and the new (oxycodone). He was readmitted; treated for opioid overdose (successfully) but succumbed to influenza A while in hospital.

Our Good Practice Guidance (GPG) for Care Homes for Queries or Concerns with Discharge Prescriptions will be updated in light of the subsequent Prevention of future deaths report to state:

> *When a resident is discharged back to a care home, or transferred between care homes,* ***a senior staff member with responsibility for medication should review their discharge medication****.*

Additional information in 'discrepancies to particularly look for' to include:

- is a similar type of medicine to another medication the resident is already taking,
- one or more medicines altered (stopped, started or changed), but medicines reconciliation on admission to hospital appears incorrect or not to have taken place

Frimley ICB Learning from Patient Safety Events (LFPSE) lessons and feedback

Recently we received a LFPSE report that a patient had been started on "AREDS2," (a lutein and antioxidant supplement) by a consultant in secondary care, prescribing was then continued by the GP practice. These items are included in NHSE's list of Items which should not routinely be prescribed in primary care. In addition to lutein and antioxidants this list also includes.

- co-proxamol
- glucosamine and chondroitin
- herbal treatments and other natural products
- homeopathy
- minocycline for acne
- omega-3 fatty acid compounds (excluding icosapent ethyl [Vazkepa®])
- silk garments
- aliskerin
- bath and shower preparations for dry and pruritic skin conditions
- dosulepin
- doxazosin (prolonged release)
- oxycodone and naloxone combination product
- paracetamol and tramadol combination product
- perindopril arginine
- rubefacients, benzydamine, mucopolysaccharide and cooling products (excluding NSAIDs and capsaicin)
- trimipramine

Other items such as amiodarone, dronedarone, IR fentanyl, lidocaine plasters, liothyronine, needles for pre-filled and reusable insulin pens and certain travel vaccines also have a place on this list – with various caveats. Please see the Frimley ICB Medicines Optimisation position statement for full information on the safe and effective use of these items in primary care.

Look Alike Sound Alike (LASA) errors

Incidents reported recently have highlighted mis-selection errors made in prescribing or dispensing the following drugs:

⇒ atorvastatin/ amitryptylline
⇒ rotigotine/ rivastigmine
⇒ atorvastatin/amlodipine
⇒ trimipramine/ trimethoprim

Please take care when selecting to prevent LASA errors.

Gabapentin dose and renal function

A recent LFPSE report detailed how a patient was prescribed gabapentin 300mg OD increasing up to 300mg TDS based on CrCl using Actual Body Weight (ABW). The BNF states ;

> *Ideal body weight should be used to calculate the CrCl. Where the patient's actual body weight is* ***less*** *than their ideal body weight, actual body weight should be used instead.*

In this case the patient's ABW was **more** than their Ideal Body Weight (IBW), so IBW should have been used. This meant the patient should have received a lower dose. The patient was admitted to hospital with suspected gabapentin toxicity Please find further guidance on considerations with body weight when estimating renal function Prescribing in renal impairment | Medicines guidance | BNF | NICE or the individual SPCs here

NHS Frimley Medicines Optimisation team may be contacted on frimleyicb.prescribing@nhs.net
National Medicines Advice Service
Healthcare professionals in primary care across England may contact this service on 0300 770 8564 or asksps.nhs@sps.direct