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NHS Sheffield Clinical Commissioning Group

Report of the audit in Sheffield primary care of the implementation of the Valproate Pregnancy Prevention Programme (Prevent)

October 2019

In April 2018, the MHRA released new prescribing and dispensing requirements for all valproate containing medicines. They must not be used in women and girls of childbearing potential, irrespective of indication, unless there is a pregnancy prevention programme (Prevent) in place (MHRA, 2018). The aim of the audit therefore was to determine compliance with the MHRA's requirements with regards to the 'actions for general practitioners' set out in the 'Guide for Healthcare Professionals' Prevent booklet.

Method

The audit was conducted in Sheffield GP practices by the CCG Medicines Optimisation Team (MOT) as part of the quality workstream for 18/19. The audit commenced in Jan 2019 and data collection was complete in most practices by end March and all practices by July 2019. The audit was carried out in women and girls of childbearing potential, hereafter referred to as females of childbearing potential, with a current repeat prescription for any valproate medicine. The searches set up by the GP clinical systems (SystmOne and EMIS Web) were used to identify the patient cohort; the age range in these searches is 12 to 49 years inclusive. The MHRA defines 'women of childbearing potential as a pre-menopausal female who is capable of getting pregnant'. Therefore, where documented in the clinical record, it was advised that the following were excluded from the data collection: women with a history of hysterectomy, bilateral oophorectomy, bilateral salpingectomy, bilateral salpingo-oophorectomy or menopause; and girls who are pre-pubertal. Women with a history of infertility were included.

The criteria are shown in the Table 1; the standard was set at 100% for each.

Additional data was collected including the indication, whether the patient was on the learning disabilities (LD) register and which Sheffield hospital they were currently under, if any.

Results

Total number of practices: 80

Total number of patients: 173 (range 0 to 8); 16 practices had no patients and these practices were excluded from the data analysis.

The standards achieved are shown in Table 1; the range was from 0 to 100% for each but, as the numbers of patients at practices were small, this has limited value.

Analysis of the additional data collected is shown in Table 2 (appendix). This analysis was conducted on 165 patients for whom the data collection was complete. The analysis was by indication, whether the patient was under a Sheffield hospital, and for criteria 3, 4 and 6. Valproate preparations are only licensed for epilepsy and mania in bipolar disorders. Of the 165 patients: 115 (70%) had an epilepsy indication of which 37 (32%) were on the LD register; 10 (6%) had another neurological diagnosis of which 1 was on the LD register; 24 (15%) had an indication of bipolar disorder of which

no patients were on the LD register; and 16 (10%) had another mental health diagnosis of which 2 were on the LD register. In total 40 (25%) of patients were on the LD register. As the majority of the patients with LD had an epilepsy diagnosis, results are tabulated for this group separately.

Table 1: Criteria and standards

Criterion		**Standard**	**Standard achieved**
1	Females of childbearing potential being prescribed valproate have had a review or been recalled for a review with their GP since April 2018 [1]	100%	75%
2	Females of childbearing potential being prescribed valproate have been referred for a review with the specialist since April 2018 (where the patient was taking valproate prior to April 2018)	100%	42%
3	Females of childbearing potential being prescribed valproate have had a review with the specialist since April 2018 [2]	100%	35%
4	Females of childbearing potential being prescribed valproate have an up-to-date, risk acknowledgement form on the GP record that is signed by the specialist and the patient/responsible person	100%	16%
5	There is evidence on the GP clinical system that females of childbearing potential being prescribed valproate have received the current version of the patient guide	100%	20%
6	Females of childbearing potential being prescribed valproate are on highly effective contraception (as defined by FSRH Clinical Effectiveness Unit, 2018)	100%	29%

Notes:

[1]patients started by the specialist after April 2018, following the introduction of Prevent, were included in criterion 1 as they should have a review with the GP after initiation; 5 females of childbearing potential commenced treatment with valproate since the introduction Prevent, only 1 for epilepsy. It is not known whether this is indicative of a change in prescribing by the specialist.

[2]where the patient was initiated on valproate after April 2018, this consultation was included in criterion 3 as the specialist review.

Limitations: the source of data was the patient record in the GP clinical system. There may be errors in coding, lack of detail in the recording of consultations and other omissions. There may also be errors in completion of the data collection form by the MOT member.

Discussion

None of the criteria reached the standard of 100%. The highest standard achieved was in the number who had had a review with the GP since April 2018 (75%). The lowest standard was in the number of patients who had the signed annual risk acknowledgement form (RAF) on the GP clinical record (16%). This low number may be partly because the form had not been sent to or received by the GP or not scanned onto the patient record. It also reflects embedding of the process by the specialist. The standard for the number of females of childbearing potential being prescribed valproate who are on highly effective contraception was also low at 29%.

During the data collection, queries from the MOT indicated uncertainty regarding patients with severe LD and the need for highly effective contraception and completion of the RAF. In some cases of LD, the communication from the specialist indicated that the RAF had not been completed as there was no risk of pregnancy as the patient was unable to consent to sexual intercourse. The MHRA has since modified the RAF (April 2019) and this now has a section for the specialist to complete if they consider that there are compelling reasons that the patient is not at risk of pregnancy. This section is applicable to other females e.g. those pre-pubertal as well as those with LD.

There were queries regarding whether the GP could complete the RAF where this hadn't been completed by the specialist. The MHRA states that it is the specialist who must complete the form at each year's annual review; the GP was therefore advised not to complete this but to clearly document in the patient record why there was no RAF. From the analysis of the data collection forms, there is an indication that in some cases the GP had completed the form themselves.

The low compliance with criterion 5 – the patient having a copy of the patient guide - may be due to this not being documented in the patient record. GPs should be encouraged to ensure that the patient has a copy of the guide at their review and record this.

There was also low compliance with the patient being on highly effective contraception (29%). However, the definition of this by FSRH Clinical Effectiveness Unit is narrow e.g. with patients on injectable medroxyprogesterone actetate (DMPA) only included if they are on additional barrier protection; this is because the patient may not attend regularly for their 12 week injection. Some of the patients were on DMPA and receiving their injections regularly but without additional barrier method. Of the 165 patients who were analysed separately, a total of 117 patients (71%) were either on highly effective contraception, or any form of contraception or it was documented in the notes that the patient had declined contraception or was not sexually active.

Other reasons for non-compliance with the criteria were that the patient did not respond to invitations to come for a review with the GP or did not want to be referred to secondary care or subsequently did not attend (DNA) their specialist appointment. Some patients refused to be referred as they did not want their medication changed as they were happy with the control achieved with valproate or considered that they were not at risk of pregnancy (e.g. in same sex relationship) and did not want highly effective contraception.

Respecting patient preference is sometimes difficult to reconcile with the conditions of Prevent. However, if the GP is not following the requirements of Prevent then they are prescribing 'off licence' with the attendant responsibilities. Advice was given that that this is discussed in a MDT meeting in the practice and guidance sought from the specialist, where possible. Any decision not to refer or prescribe highly effective contraception needs to be documented clearly in the notes and a robust method put in place to ensure this is reviewed annually or if the patient circumstances change. Subsequent guidance has also been issued by the MHRA (Mar 2019) referring to the summary of the pregnancy testing advice for the most common contraceptive methods for patients receiving teratogenic medicines.

In April 2019, the updated MHRA alert referred to guidance produced by 13 UK healthcare bodies who collaborated to produce pragmatic guidance. This includes a section on women who DNA specialist appointment (5.9) and women who decline highly effective contraception (5.7).

Recommendations

Only 1 data collection cycle was completed; a re-audit was to be considered for the team's 19/20 quality workstream. However, in April 19, the 19/20 GMS contract Quality and Outcomes Framework (QoF) was issued. This introduced a QOF Quality Improvement domain, with one module on prescribing safety. This module requires the GP practice to demonstrate quality improvement in 3 areas, one of which is the prescribing of valproate to women and girls of childbearing age in line with the pregnancy prevention programme. This indicator should encourage improvement and compliance; under delegated commissioning, the CCG is able to ask for written evidence from practices that the quality improvement activity has been undertaken.

The following actions are recommended:

1. Summary of the audit report to be prepared and distributed in the GP practice bulletin with recommended actions for practices. These include:

    i. GP practices to ensure they have robust recall systems for female patients of childbearing potential prescribed valproate to review and refer to specialist for completion of the annual RAF, where applicable.

    ii. GPs to ensure that when the patient has been reviewed by the specialist that they receive a copy of the annual RAF; where this is not received and no reason given, the specialist should be contacted.

    iii. GPs should document on the clinical record that the patient has a copy of the current patient guide.

    iv. GPs to ensure that female patients of childbearing potential prescribed valproate are offered highly effective contraception. Where this is not used, the practice has procedures to consider the need for pregnancy testing, in line with the MHRA recommendations.

    v. Where GPs are prescribing valproate to female patients of childbearing potential and the condition of Prevent are not fulfilled, the reasons for this are documented fully in the patient's clinical record.

2. MSG to submit the report or summary to APG.

3. The audit report to be shared with the CCG quality managers for the secondary care trusts.

4. The audit report to be shared with the neurologists at STH, STH Medicines Safety Committee, the psychiatrists at SHSC and the neurologists at SCH. The specialists to be asked to review their procedures for ensuring that an annual RAF is completed and sent to the GP.

5. Update the epilepsy and bipolar shared care protocols with details of new annual RAF.
6. Consider re-audit if less than 40% of practices submit feedback on the QOF quality improvement domain.
7. Review outcomes from recommendations in May/June 2020

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Appendix

Table 2 analysis of data collection forms for 165 female patients of childbearing potential receiving valproate

Indication	No. of patients	No. under Sheffield hospital trust	No. reviewed by a specialist since April 2018	No. with an up to date risk acknowledgement form (RAF) on the GP record	No. on a highly effective form of contraception	If not on highly effective, no. on any other method of contraception	No. not on any other contraceptive that have declined contraception or are not sexually active
Epilepsy (total)	115	54 (47%) STH: 43 SCH: 7 SHSC: 4 None of above: 61	42 (37%) STH: 31 SCH: 6 SHSC: 2 None of above: 3	19 (17%) STH: 13 SCH: 1 SHSC: 0 None of above: 5	33 (29%)	22 (of 82)	26 (of 58)
Epilepsy and on LD register	37	22 (60%) STH: 14 SCH: 4 SHSC: 4 None of above: 15	19 (51%) STH: 13 SCH: 3 SHSC: 2 None of above: 1	6 (16%) STH: 5 SCH: 0 SHSCT: 0 None of above: 1	5 (14%)	9 (of 32)	10 (of 23)
Neurology (other)*	10 1 on LD register	4 (40%) STH: 4 (2 pain clinic) None of above: 6	3 STH: 3 (1 pain clinic)	0	5 (50%)	1 (of 5)	0 (of 4)

*Neurology (other) includes migraine, Meniere's disease; multiple sclerosis; myoclonus, sciatica

Indication	No. of patients	No. under Sheffield hospital trust	No. reviewed by a specialist since April 2018	No. with an up to date risk acknowledgement form (RAF) on the GP record	No. on a highly effective form of contraception	If not on highly effective, no. on any other method of contraception	No. not on any other contraceptive that have declined contraception or are not sexually active
Bipolar	24 0 on LD register	17 (71%) STH: 1 SCH: 1 SHSC: 15 None of the above: 7	16 (67%) STH: 1 SCH: 1 SHSC: 11 None of the above: 3	4 (17%) STH: 0 SCH: 0 SHSC: 3 None of the above: 1	11 (46%)	5 (of 13)	4 (of 8)
Mental health (other)**	16 2 on LD register	9 (56%) STH:0 SCH:0 SHSC: 9 None of the above: 7	5 (31%) STH:0 SCH:0 SHSC: 5 None of the above: 0	5 (31%) STH:0 SCH:0 SHSC: 3 None of the above: 2	4 (25%)	0 (of 12)	5 (of 11)

**Mental health (other) includes anxiety, borderline personality disorder, depression, mental and behavioural issues, obsessive-compulsive disorder, schizophrenia, schizoaffective disorder