Medicines Optimisation Monthly Newsletter

Introduction

Welcome to our monthly Medicines Optimisation Team newsletter for GP practices and providers. This aims to highlight current updates, issues and guidelines around medication and to support prescribers and practices, pulling together information from various resources to provide a one-stop summary and useful links.

Items covered in this newsletter include:

- New or updated NICE guidance
- Area Prescribing Group (APG- South) and Area Prescribing Committee (APC-North) update
- Controlled Drug newsletter
- Out of stock bulletin
- DHSC supply disruption alert on ranitidine products
- Transfer of care around medicines (TCAM) - North Staffs
- Vaccine update
- Autumn campaigns - NHS 111 and CCG antibiotic stewardship
- Using eGFR or Cockcroft and Gault to calculate appropriate drug doses
- Team contact details are medopsqueries@stoke.nhs.uk or southstaffs.medsoptimisation@nhs.net

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New or updated NICE guidance

The latest NICE guidance on medicines includes -

- **Fever in under 5s - assessment and initial management NG143**

  Guidance relating to medication includes -

  Use of antibiotics by the non-paediatric practitioner

  1.4.9 Do not prescribe oral antibiotics to children with fever without apparent source. **[2007]**

  Drug interventions to reduce body temperature

  1.6.4 Consider using either paracetamol or ibuprofen in children with fever who appear distressed. **[2013]**

  1.6.5 Do not use antipyretic agents with the sole aim of reducing body temperature in children with fever. **[2013]**

  1.6.6 When using paracetamol or ibuprofen in children with fever:

  - continue only as long as the child appears distressed
  - consider changing to the other agent if the child's distress is not alleviated
  - do not give both agents simultaneously
  - only consider alternating these agents if the distress persists or recurs before the next dose is due. **[2013]**

- **Cannabis-based medicinal products NG144**

  This guideline covers prescribing of cannabis-based medicinal products for people with intractable nausea and vomiting, chronic pain, spasticity and severe treatment-resistant epilepsy.

1.1 Intractable nausea and vomiting

1.1.1 Consider nabilone as an add-on treatment for adults (18 years and over) with chemotherapy-induced nausea and vomiting which persists with optimised conventional antiemetics.

1.1.2 When considering nabilone for adults with chemotherapy-induced nausea and vomiting,

take into account potential adverse drug interactions, for example, with central nervous system depressants and other centrally active drugs.

NB. Nabilone is usually prescribed within secondary care. The SPC recommends that the drug should be used under close medical supervision

1.2 Chronic pain

1.2.1 Do not offer the following to manage chronic pain in adults:

- nabilone
- dronabinol
- THC (delta-9-tetrahydrocannabinol)
- a combination of cannabidiol (CBD) with THC.

1.2.2 Do not offer CBD to manage chronic pain in adults unless as part of a clinical trial.

1.2.3 Adults who started cannabis-based medicinal products to manage chronic pain in the NHS before this guidance was published[1] should be able to continue treatment until they and their NHS clinician think it appropriate to stop.

1.3 Spasticity

1.3.1 Offer a 4-week trial of THC:CBD spray to treat moderate to severe spasticity in adults with multiple sclerosis, if:

- other pharmacological treatments for spasticity are not effective (see the recommendations on spasticity in NICE's guideline on multiple sclerosis in adults)
- the company provides THC:CBD spray according to its pay-for-responders scheme[2].

  After the 4-week trial, continue THC:CBD spray if the person has had at least a 20% reduction in spasticity-related symptoms on a 0 to 10 patient-reported numeric rating scale.

1.3.2 Treatment with THC:CBD spray should be initiated and supervised by a physician with specialist expertise in treating spasticity due to multiple sclerosis, in line with its marketing authorisation.

1.4 Severe treatment-resistant epilepsy

NICE has made research recommendations on the use of cannabis-based medicinal products for severe treatment-resistant epilepsy.

NICE is developing technology appraisal guidance on cannabidiol with clobazam for treating seizures associated with Lennox-Gastaut syndrome and Dravet syndrome.

1.5 Prescribing

Who should prescribe?

1.5.1 **Initial prescription of cannabis-based medicinal products[3] must be made by a specialist medical practitioner (a doctor included in the register of specialist medical practitioners [the Specialist Register]**[4]). They should also have a special interest in the condition being treated[5]. For children and young people under the care of paediatric services, the initiating prescriber should also be a tertiary paediatric specialist.

Shared care arrangements between the initiating specialist and the patients GP may be recommended for ongoing prescribing and monitoring. The Medicines Optimisation team will provide further advice about local arrangements in due course.

- **Diabetic foot problems - prevention and management NG19**
  Treatment

  1.6.6 Start antibiotic treatment for people with suspected diabetic foot infection as soon as possible. Take samples for microbiological testing before, or as close as possible to, the start of antibiotic treatment. **[2019]**

  1.6.7 When choosing an antibiotic for people with a suspected diabetic foot infection (see recommendations 1.6.8 and 1.6.9), take account of:

  - the severity of diabetic foot infection (mild, moderate or severe)
  - the risk of developing complications
  - previous microbiological results
  - previous antibiotic use
  - patient preferences. **[2019]**

- **Gastro-oesophageal reflux in children and young people: diagnosis and management NG1**

- Do not offer acid-suppressing drugs, such as proton pump inhibitors (PPIs) or H_2 receptor antagonists (H_2RAs), to treat overt regurgitation in infants and children occurring as an isolated symptom.
- Do not offer metoclopramide, domperidone or erythromycin[1] to treat GOR or GORD unless all of the following conditions are met:
    - the potential benefits outweigh the risk of adverse events
    - other interventions have been tried
    - there is specialist paediatric healthcare professional agreement for its use.

- **Gastro-oesophageal reflux disease and dyspepsia in adults: investigation and management CG184**

  Interventions for uninvestigated dyspepsia

  - Leave a 2-week washout period after proton pump inhibitor (PPI) use before testing for *Helicobacter pylori* (hereafter referred to as *H pylori*) with a breath test or a stool antigen test. **[2004, amended 2014]**

  Interventions for gastro-oesophageal reflux disease

  - Offer people a full-dose PPI (see table 2 in appendix A) for 8 weeks to heal severe oesophagitis, taking into account the person's preference and clinical circumstances (for example, underlying health conditions and possible interactions with other drugs). **[new 2014]**
  - Offer a full-dose PPI (see table 2 in appendix A) long-term as maintenance treatment for people with severe oesophagitis, taking into account the person's preference and clinical circumstances (for example, tolerability of the PPI, underlying health conditions and possible interactions with other drugs), and the acquisition cost of the PPI. **[new 2014]**
  - Do not routinely offer endoscopy to diagnose Barrett's oesophagus, but consider it if the person has gastro-oesophageal reflux disease (GORD). Discuss the person's preferences and their individual risk factors (for example, long duration of symptoms, increased frequency of symptoms, previous oesophagitis, previous hiatus hernia, oesophageal stricture or oesophageal ulcers, or male gender). **[new 2014]**

Interventions for peptic ulcer disease

- Offer *H pylori* eradication therapy to people who have tested positive for *H pylori* and who have peptic ulcer disease. Also see H pylori testing and eradication. **[2004]**
- For people using NSAIDs with diagnosed peptic ulcer, stop the use of NSAIDs where possible. Offer full-dose PPI (see table 1 in appendix A) or H_2RA therapy for 8 weeks and, if *H pylori* is present, subsequently offer eradication therapy. **[2004]**
- Offer people with peptic ulcer (gastric or duodenal) and *H pylori* retesting for *H pylori* 6 to 8 weeks after beginning treatment, depending on the size of the lesion. **[2004, amended 2014]**

- **Multiple sclerosis in adults - management CG186**

Exercise

1.4.1 Encourage people with MS to exercise. Advise them that regular exercise may have beneficial effects on their MS and does not have any harmful effects on their MS.

Vaccinations

1.4.2 Be aware that live vaccinations may be contraindicated in people with MS who are being treated with disease-modifying therapies.

1.4.3 Discuss with the person with MS:

- the possible benefits of flu vaccination **and**
- the possible risk of relapse after flu vaccination if they have relapsing–remitting MS.

1.4.4 Offer flu vaccinations to people with MS in accordance with national guidelines, which recommend an individualised approach according to the person's needs[3].

Vitamin D

1.8.1 Do not offer vitamin D solely for the purpose of treating MS.

Omega fatty acids compounds

1.8.2 Do not offer omega-3 or omega-6 fatty acid compounds to treat MS. Explain that there is no evidence that they affect relapse frequency or progression of MS.

Full guidance available at https://www.nice.org.uk/

Area Prescribing Group (APG- South Staffs) and Area Prescribing Committee (APC - North Staffs)

Drug	Indication	Formulary classification	Approved by APC	Approved by APG
Droperidol injection	Rescue therapy (3rd line antiemetic) for post-operative nausea and vomiting (PONV) in children and adolescents aged 2 – 18 years old who do not respond adequately to dexamethasone or ondansetron (as monotherapy or in combination)	RED - Restriction: initiation only by specialists in anaesthetics	YES	Awaiting discussion at November meeting

FORMULARY

Mexiletine is now a 'Red' drug on the North Staffs formulary. Prescribing for arrhythmias will be managed by acute trusts locally. Prescribing for symptomatic treatment of myotonia in adult patients with non-dystrophic myotonic disorders falls within NHS England commissioning arrangements. If practices have any patients on mexiletine then please repatriate these to secondary care.

NICE TA updates:

- Risankizumab for treating moderate to severe plaque psoriasis (NICE TA 596) was approved by APC in Sept 2019 for inclusion on the Joint Formulary as a Red drug.
- Fluocinolone acetonide intravitreal implant (Iluvein) for treating recurrent non-infectious uveitis in adults (NICE TA 590) was approved in October 2019 for inclusion on the Joint Formulary as a Red drug.

ESCAs

Updated ESCAs for **Lanthanum** and **Sevelamer-** both used for the **treatment of hyperphosphatemia in pre-dialysis CKD patients** in **North Staffordshire.** Approved by APC in September 2019. These are accessible on the North Staffs netFormulary:

http://www.northstaffordshirejointformulary.nhs.uk/docs/esca/

Hospital specialist clinicians (doctors or NMPs) are expected to initiate and stabilise treatment with sevelamer and lanthanum, prior to requesting shared care with the GPs. Stabilisation will usually take 4 weeks. On-going blood monitoring is expected to be undertaken by the specialist clinician as stipulated in the ESCA

GUIDELINES

Staffordshire and Stoke-on-Trent Asthma Prescribing Guidelines (Adults and Children over 12 years) are now available on netFormulary.

Click here for South Staffordshire.
Click here for North Staffordshire.

These guidelines allow for use of all inhalers that are recommended by both the North Staffordshire Joint Formulary and the South Staffordshire Joint Formulary. Any queries can be directed to the Medicines Optimisation team.

Controlled Drug Newsletter

This latest edition includes -

- **Publication of the NICE Cannabis-based medicinal products guideline**
- **Patient Safety Message - Alfentanil in Palliative Care**
- **CQC Management of controlled drugs update**
- **Unresolved Discrepancy Reports**
- **Report ALL CD incidents, concerns and occurrence reports via the CD on-line reporting site: www.cdreporting.co.uk**

The CD newsletter contains local and national CD information to support safe use and handling of controlled drugs.

You can use the dedicated e-mail to contact the team:

Shropshire & Staffordshire e-mail: england.shropshire-staffs-cd@nhs.net

Derbyshire & Nottinghamshire e-mail: england.nottsderbycontrolleddrugs@nhs.net

New direct contact details for the controlled drugs team are -

Samantha Travis	07920 251 512
Margaret Farrow – Johnson	07730 376 324
Eleanor Carnegie	07730 376 391
Jayne Wood	07714 777 667 (Landline number 0113 8254717 is currently able to receive calls but may be decommissioned shortly)

Please click here to read the full CD newsletter

Disposal of CDs in care homes -

NHS England & NHS Improvement North Midlands CD team have received a few enquiries about how care homes should dispose of controlled drugs (CDs). It is important to note that the disposal of medicines waste is subject to legislation and regulated by the Environment

Agency.

- Care homes with nursing - Must only return medicines to a licensed waste disposal company. Patients' own individually-labelled controlled drugs in schedules 2, 3 and 4 must be denatured in an appropriate CD denaturing kit before handing to the waste disposal company. Good practice involves two staff members (at least one being a registered professional) - one to denature and the other to act as a witness. A nursing home will need to apply for a T28 waste exemption from the Environment Agency, this is free of charge and available at https://www.gov.uk/guidance/waste-exemption-t28-sort-and-denature-controlled-drugs-for-disposal
- Care homes without nursing - All medicines including CDs should be returned to a community pharmacy or dispensing doctor. Unwanted or out-of-date CDs should be stored in the CD cabinet, segregated from current stock and returned promptly. Best practice involves two staff members recording CD returns entries in the care home CD register. This helps to verify that the register is accurate.

You can find further guidance for disposal of medicines in care homes on the CQC website at: https://www.cqc.org.uk/guidance-providers/adult-social-care/disposing-medicines-care-homes-care-homes-nursing

Out of stock bulletin

The latest update from the DHSC on drug shortages (confidential to NHS staff only - login required) is available on **https://www.sps.nhs.uk** under 'Supply Issues Update for Primary and Secondary Care November 2019'. This includes a useful table on HRT shortages.

Key points -

Orals out of stock

Edronax (reboxetine) 4mg tablets
• Pfizer, sole supplier will be out of stock from 20 November to 20 December 2019 due to manufacturing issues.
• Parallel imports are available for pharmacies to order via their usual wholesaler routes.

Ethinylestradiol 10microgram and 50microgram tablets
• UCB, sole supplier is out of stock due to manufacturing issues and currently unable to advise

a resupply date.
• Unlicensed imports are available; lead times vary.

Ongentys (opicapone) 50mg capsules
• Bial Pharma, sole supplier is out of stock until mid-January 2020.
• Very limited supplies of unlicensed opicapone capsules are available from importers.

Seroxat (paroxetine) 10mg tablets
• GSK are out of stock until mid-December 2019 due to regulatory issues.
• Generic supplies of paroxetine 10mg tablets from other suppliers remain available.
• For patients prescribed Seroxat tablets by brand, who do not have sufficient supplies for the out of stock period, clinicians should consider prescribing the generic product.

Adalat (nifedipine) tablets
• There are ongoing supply issues with the Adalat Retard and LA range from Bayer. Alternative nifedipine presentations continue to remain available from generic suppliers.
• Supplies of nifedipine 5mg and 10mg immediate release soft gel capsules are now available from Relonchem.

Eye drops

Phenylephrine 2.5% Minims eye drops solution
• Bausch and Lomb are experiencing supply issues across their phenylephrine Minims range.
• Minims phenylephrine 2.5% eye drops will be out of stock from the end of November 2019 until early January 2020.
• Limited unlicensed imports can be sourced; lead times vary.
• The Royal College of Ophthalmologists (RCOphth) has provided clinical guidance to support local prioritisation of remaining supplies and advice on alternative options where appropriate.
• See link below for the Supply Disruption Alert issued 14 November 2019: https://www.cas.mhra.gov.uk/ViewandAcknowledgment/ViewAlert.aspx?AlertID=102923

Injectables -

Adrenaline Auto-Injectors (AAIs)
• Recent supply issues affecting some brands of AAIs has impacted on all manufacturers, however, there are currently sufficient supplies overall to meet normal patient demand.

Adrenaline 1:1000 ampoules for anaphylaxis kits

• Adrenaline 1:1000 ampoules are currently available in sufficient quantities to meet normal demand.

• Some healthcare professionals may be holding an AAI in preference to adrenaline ampoules, to treat anaphylactic reactions; this should not be necessary.

• All healthcare professionals providing services where anaphylaxis treatment may be required, including but not exclusive to flu vaccination services, should have the competency to draw up and administer intramuscular adrenaline from ampoules with a normal syringe and needle.

• During the current shortage, please use ampoules and not auto-injectors to replenish anaphylaxis kits. Remember to include the relevant dosing charts, syringes and needles.

• The Green Book and Resuscitation Council guidance provides additional advice to healthcare professionals on the use of adrenaline in response to anaphylaxis.

There is an expectation that healthcare professionals should use adrenaline ampoules in preference to Emerade or other AAIs.

Diamorphine 5mg and 10mg injection

• Primary care, private hospitals, hospices and substance misuse treatment centres can continue to order diamorphine, unrestricted, from usual wholesalers.

Discontinuations

Glibenclamide 2.5mg and 5mg tablets (Wockhardt)

• Glibenclamide 2.5mg and 5mg tablets have been discontinued with immediate effect.

Use of glibenclamide has declined over the years because of a significantly greater risk of hypoglycaemia, particularly in the elderly, due to its dependence on renal excretion and tendency to accumulate in people with impaired renal function. The number of patients still treated with glibenclamide is likely to be low.

There are several other sulfonylureas available (gliclazide, glimepiride, glipizide, and tolbutamide).

Sulfonylurea	Daily dose	Dose equivalence to 5mg glibenclamide

Glibenclamide	2.5- 15mg	
Gliclazide	40 to 320mg	80mg[3]
Glipizide	2.5-20mg	5mg[1]
Glimepiride	1-6mg	No data
Tolbutamide	0.5-2g	1g[1]

Blood sugars and hypoglycaemia symptoms should be monitored more closely after a switching treatment and doses titrated accordingly.

If it is not considered appropriate to switch patients, unlicensed imports are available from importers; lead times vary.

• Amglidia, glibenclamide 6mg/ml oral suspension, licensed for neonatal diabetes, remains available for direct order from Amring Pharma.

Please be mindful that unlicensed alternatives can be costly - check with your Medicines Optimisation team representative for any queries

DHSC supply disruption alert on ranitidine products

Summary -

All oral formulations of ranitidine are anticipated to be out of stock, with no date for resupply until further notice.

• An investigation by the Swiss and German regulatory agencies and the US Food and Drug Administration (FDA), has identified a contaminant, N-nitrosodimethylamine (NDMA), in samples of ranitidine active substance.
• All stock manufactured for the UK using the affected ranitidine active substance has been quarantined, whilst Medicines and Healthcare products Regulatory Agency (MHRA) investigations are ongoing.
• Although all oral formulations are expected to be out of stock, **very limited supplies of unaffected oral ranitidine products may remain available and should be reserved for those patients in whom alternatives are not clinically appropriate.**
• All other patients should be reviewed as repeat prescriptions are requested, and if ongoing treatment is required, be switched to clinical alternatives.

Action required -

All healthcare professionals in primary, secondary or specialist healthcare services who prescribe or dispense ranitidine, should for licensed use for gastrointestinal conditions -

• Identify current patients prescribed ranitidine tablets, effervescent tablets and oral solutions, and:

- Review to establish if ongoing treatment is still required.
- If ongoing treatment is still required, then consider switching to an alternative treatment (see table in this link to full document)
  .

Please note:

• It is recommended that **omeprazole is the first-choice proton pump inhibitor** (PPI) where clinically appropriate, as there are currently sufficient supplies to manage an increase in demand.
• It is recommended that patients are not switched to alternative H2-receptor antagonists in the first instance as this may exacerbate a shortage of these products. Sufficient supplies will continue to be available to meet current demand.

Specialist indications
• Consult specialist clinicians who use ranitidine to identify circumstances when ranitidine cannot be substituted with clinical alternatives.
• Reserve any remaining supplies of oral ranitidine for circumstances where specialists consider there are no clinically appropriate alternatives.

Prescribers should work in close collaboration with their community pharmacists to understand if they still have any ranitidine in stock and also which clinical alternatives are available.

Transfer of care around medicines (TCAM) - Staffordshire

MEDICINES SUPPORT (Hospital to Home)

Transfer of Care Around Medicines (TCAM) - this service involves e-referral of high-risk patients to community pharmacy for support on discharge from hospital.

Why is transfer of care around medicines important?

Referring high risk patients to their community pharmacist for a medicines consultation following a stay in hospital has been shown to reduce readmission rates (1).

There is a growing evidence base from across England and Wales that this is the right thing to do to improve patient care and support Medicines Optimisation and thereby hospital reduce readmission rates.

1. **Background**

Research has repeatedly shown that patients often experience errors or unintentional changes to medicines when moving between care providers, presenting significant risk to patient safety (1).
Improving the safe transfer of information about a patient's medicines should therefore reduce the incidence of avoidable harm to patients, and this has become a priority improvement area for our National Health Service.

Community pharmacists are well placed to support patients recently discharged from hospital. Evidence from research into community pharmacy post-discharge medicines services has demonstrated significant increases in medicines adherence, leading to improved health outcomes for patients and fewer admissions and re-admissions to hospital (2). Work from Newcastle showed that community pharmacists were able to contact the majority of patients referred to them and results indicate that patients receiving a follow-up consultation may have lower rates of readmission and shorter hospital stays. (3)

2. **What is happening in Staffordshire and Stoke on Trent STP?**

West Midlands Academic Health Science Network (WMAHSN), the local LPC and CCGs have been working with acute trusts to adopt this project by referring high risk patients to community pharmacy for support across our STP. The following Trusts will be launching their referral to community pharmacy service via the PharmOutcomes™ platform from the middle of November 2019:

• Royal Stoke University Hospital
• County Hospital

The Haywood Hospital and North Staffs Combined NHS Trust are likely to commence referrals in the New Year followed by Burton Hospital later in 2020.

Referred high-risk patients (with their consent) will be contacted by their nominated community pharmacist and offered additional support (either face-to-face or over the telephone) to take their medicines correctly.

3. **What will this mean for GP Practices and Pharmacists working in GP Practices?**

GP surgeries will not receive a copy of these referrals to community pharmacy. However, a small number of patients will be identified as having significant medicines issues following their discharge and communication may be required with their GP. We would expect this to be less than 5% of the average 50-60 completed referrals/week predicted across the entire STP. This communication would be either via nhs.net mail or telephone depending upon urgency. As such, it is not anticipated that GP practices will see any major change when Trusts start to make referrals, in line with experience from the rest of England.

Appendix 1

Statistics linked to medicines when patients are admitted to hospital

• There were roughly 20 million people admitted to into the NHS last year and the majority of these would have been prescribed medicines to improve their care.
• It is estimated that 60% of patients have three or more changes made to their medicines during a hospital stay. The transfer of care process is associated with an increased risk of adverse effects (AEDs) (4)
• 30-70% of patients experience unintentional changes to their treatment or an error is made because of a lack of communication or miscommunication.
• Only 10% of elderly patients will be discharged on the same medication that they were admitted to hospital on. (5)
• 20% of patients have been reported to experience adverse events within 3 weeks of discharge, 60% of which could have been ameliorated or avoided (6).

References

(1) National Patient Safety Agency and National Institute for Health and Clinical Excellence Technical safety solutions, medicines reconciliation 2007 Available from https://www.nice.org.uk/guidance/psg1
(2) Elliott R et al. Department of Health Policy Research Programme Project Understanding and Appraising the New Medicines Service in the NHS in England (029/0124) 2014 http://www.nottingham.ac.uk/~pazmjb/nms/downloads/report/files/assets/basic-html/index.html#1
(3) Nazar H, Brice S, Akhter N, Kasim A, Gunning A, Slight SP, Watson NW (2016) A new Transfer of Care initiative of electronic referral from hospital to community pharmacy in England: A formative service evaluation. BMJ Open 2016;6:e012532. doi:10.1136/bmjopen-2016-012532
(4) Himmel W, Kochen MM, Sorns U et al Drug changes at the interface between primary and secondary care. International Journal of Clinical Pharmacology and Therapeutics 2004:42; 103-109) www.ncbi.nlm.nih.gov/pubmed/15180171
(5) Mansur N Weiss A Beloosesky Y. Relationship of in hospital medication modifications of elderly patients to post discharge medication, adherence and mortality Ann Pharmacotherapy 2008; 42: 783 -789 https://doi.org/10.1345/aph.1L070
(6) Hesselink G, Schoonhoven L, Barach P, Spijker A, Gademan P; Kalkman C, Liefers J, Vernoonji-Dassen M, Wollersheim H. Improving patient handovers from hospital to primary care; A systematic review. Ann Intrn Med 2012; 157: 417-28). DOI: 10.7326/0003-4819-157-6-201209180-00006

Vaccine update

A 'BUG SPECIAL' edition of the Public Health England Vaccine Update was released and updated this month to celebrate the 300th edition since it was launched.

This Bug Special edition features:

- The Vaccine Evaluation unit (VEU)
- The Vaccine Preventable Bacteria Section (VPBS)
- Streptococcus pneumoniae identification and capsular typing
- Culture-independent detection and typing of pneumococcus
- Haemophilus influenzae identification and capsular typing
- Bordetella pertussis
- Diphtheria; identification and toxigenicity testing of potentially toxigenic corynebacterial
- Immunity testing

- Shortage of pneumococcal polysaccharide vaccine (PPV23)
- Vaccination of individuals with uncertain or incomplete immunisation status
- Starting nursery postcard and poster
- Vaccine update Index has now been published
- Vaccine supply for the 2019 to 2020 Flu programme
- Ordering additional Gardasil for the universal HPV immunisation programme
- The EU Falsified Medicines Directive and Delegated Regulation as applicable to PHE supplied vaccines for the national immunisation programme
- Vaccine supply for the non-routine programme

Please click here to read

Autumn campaigns - NHS winter pressures and CCG antibiotic stewardship

'Help Us, Help You' Winter Pressures campaign

This winter NHS England and NHS Improvement and Public Health England is once again running the overarching NHS winter pressures campaign - **'Help Us, Help You'** - to help the public understand how they can stay well this winter and access appropriate services.

The winter months can be challenging for the NHS, especially for urgent care services. The winter pressures campaign is delivered across a range of phases that target different audiences with different calls to action to help reduce these pressures. This includes messages about flu vaccination, contacting NHS 111, seeking advice at the first signs of a winter illness, accessing evening and weekend GP appointments and the advantages of consulting with community pharmacists.

In recent years there has been an increasing emphasis on people taking responsibility for staying healthy and managing their own health and **'Help Us, Help You'** is a powerful way to build on this.

The unifying **'Help Us, Help You'** campaign brand is based on the principle of reciprocity and aims to increase peoples' understanding of the actions they can take to help the NHS to help them. Following the expert advice of NHS staff, people can help the NHS help them stay well; prevent an illness getting worse; take the best course of action; and get well again sooner.

'Help Us, Help You' is an integrated multichannel campaign, involving advertising, partnerships, PR, social media, specific Black, Asian and Minority Ethnic (BAME) and disability groups' communications.

In addition to the new NHS 111 creative that launched in January 2019, there will be new creatives available for the Winter Response and Pharmacy Advice phases.

The 'Help Us, Help You' Winter Pressures campaign phases:

- **Flu vaccination 'Help Us, Help You - Stay Well this Winter' campaign**. Further details here.

- **NHS 111 'Help Us, Help You – Know What to Do' campaign.** Further details here.

- **Winter Response 'Help Us, Help You – Before it Gets Worse' campaign.** Further details here.

- **GP Access 'Help Us, Help You – When You Need It' campaign.** Further details here.

- **Pharmacy Advice 'Help Us, Help You – Get It Seen To' campaign.** Further details coming soon.

Staffordshire CCGs antibiotic stewardship 2019

By now most GP practices in Staffordshire should have received a poster and postcards to encourage appropriate use of antibiotics. Please display these posters in your waiting areas or on clinic room doors to continue to spread the message regarding appropriate use of antibiotics.

The postcards are designed to give to patients who do not require antibiotic treatment and encourage self-care and contain the following messages -

- **Taking ANTIBIOTICS when you don't need them puts you and your family at risk**
- **Colds, most coughs, sinusitis, ear infections, sore throats, and other infections often get better without antibiotics as your body can usually fight these infections on its own.**
- **Many of these conditions can last between 8 days and up to 3 weeks.**

Help us to keep antibiotics working for when you do need them

Antibiotics are not prescribed for infections that are likely to get better on their own.

HOW TO TREAT YOURSELF

- **Have plenty of rest.**
- **Drink enough fluids to avoid feeling thirsty.**
- **Ask your pharmacist what to take to help with your symptoms.**
- **Fever is the body fighting infection. If you or your child are feeling poorly you can take paracetamol.**

If your symptoms get worse or you develop new symptoms, contact your GP practice or phone 111 (England) for advice.

REMEMBER - IT'S OK TO ASK

Using eGFR or Cockcroft and Gault to calculate drug doses

Advice for healthcare professionals:

- MHRA has received reports and queries related to the choice of renal function estimate used when prescribing medicines for patients with renal impairment
- for most drugs and for most adult patients of average build and height, estimated Glomerular Filtration Rate (eGFR) should be used to determine dosage adjustments
- creatinine clearance (CrCl) should be calculated using the **Cockcroft-Gault formula** (see below) to determine dosage adjustments for:

    - **direct-acting oral anticoagulants (DOACs)**
    - **patients taking nephrotoxic drugs (examples include vancomycin and amphotericin B)**
    - **elderly patients (aged 75 years and older)**
    - **patients at extremes of muscle mass (BMI <18 kg/m2 or >40 kg/m2)**
    - **patients taking medicines that are largely renally excreted and have a narrow therapeutic index, such as digoxin and sotalol**
- when dose adjustment based on CrCl is important and no advice is provided in the relevant BNF monograph, consult the Summary of Product Characteristics
- reassess renal function and drug dosing in situations where eGFR and/or CrCl change rapidly, such as in patients with acute kidney injury (AKI)

To read the full article plus other updates on Drug Safety, please go to - https://www.gov.uk/government/publications/drug-safety-update-monthly-newsletter