NHS
Kent and Medway

Medicines Optimisation updates – November 2022

Reminder on the Prescribing of Sodium Valproate safely in Women and Girls

Children born to women who take valproate during pregnancy are at significant risk of birth defects and persistent developmental disorders. As such, we would like to remind all practices (particularly dispensing practices) that it is vital that women and girls are dispensed valproate safely.

The GPhC have issued an update on the importance of safely dispensing sodium valproate.

Supplying valproate safely to women and girls

Pharmacy professionals have a key role in supplying valproate safely. Valproate must not be used in any woman or girl able to have children unless there is a pregnancy prevention programme (PPP) in place.

Watch this video created by Central & North West London NHS Trust, in which a pharmacist talks to a patient about the risks of valproate which explains the Pregnancy Prevention Programme.

For women and girls, when they are dispensed valproate, they should expect:

- to be provided with a **patient card** every time valproate is dispensed
- for valproate to be dispensed with a copy of the **patient information leaflet**, and if repackaged, with a **warning on the container** supplied
- to be reminded of the risks in pregnancy and **the need for highly effective contraception**, and a reminder of **the need for annual specialist review**
- to be asked if they have received the **patient guide**

For more information please refer to the MHRA Guidance on Valproate use by women and girls

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Notification of product name change: Carefine Insulin Pen Needles to Greenfine Insulin Pen Needles

As of 1st November 2022 Neon Diagnostics Ltd will be changing the product name CareFine Insulin Pen needles to the new name of GreenFine Insulin Pen Needles.

This is a product name change only. The product, composition and quality control of the pen needles will remain unchanged.

All computer systems and pharmacy shelves will be updated to ensure a smooth transition for all current CareFine users.

For any further queries regarding this please contact Neon Diagnostics.
info@neondiagnostics.co.uk / www.neondiagnostics.co.uk
Freephone Helpline: 0800 009 3379

SPS Medicines Advice Service Information

Listed below are useful SPS Medicines Advice service helpline contact details, that can be used for Medicines Information by all healthcare professionals in primary care and may be particularly helpful to those in the team supporting with queries. Please note that queries can take up to 5 working days (or longer) to receive an answer.

Tel: 0300 770 8564.

Email: asksps.nhs@sps.direct

Further details can be found below:

https://specialistpharmacyservice.cmail20.com/t/j-l-vhthjjy-jdthdlhkty-h/

Healthcare professionals working in hospitals/Trusts should continue to contact their local Trust medicines advice service including for advice on local guidelines and formularies.

Healthcare professionals working in Primary care are also able to contact their local Medicines Optimisation Team.

Medicines Optimisation MHRA Drug Safety Update – Oct 2022

The latest MHRA Drug Safety Updates can be accessed at 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 October 2022 Drug Safety Update includes:
MedSafetyWeek November 2022: Every Yellow Card report helps to improve patient safety - GOV.UK (www.gov.uk)

The seventh annual #MedSafetyWeek social media campaign took place 7 to 13 November 2022 and this year's focus was the importance of reporting suspected adverse reactions to medicines and vaccines. The MHRA are also encouraging the reporting of suspected problems with medical devices or other healthcare products to the Yellow Card scheme. We ask healthcare

professionals to support the campaign and talk to their patients and colleagues about side effects and how they can report suspected problems to the Yellow Card scheme.

The Yellow Card scheme helps the MHRA to monitor the safety of healthcare products once they are on the market. Reporting to the scheme allows the MHRA to identify new adverse effects and gain more information about known adverse effects. By completing a Yellow Card report, you can help contribute to the safe use of healthcare products for patients and contribute to the safety information of a product and how it is used.

The Yellow Card scheme has helped to identify numerous safety issues, many of which were not previously linked to a particular healthcare product until Yellow Card reports were received by the MHRA. You can read some case studies where Yellow Card reports have contributed to patient safety.

Please follow the link in the title above for more information and resources.
COVID-19 vaccines and medicines: updates for October 2022
Letters and medicine recalls sent to healthcare professionals in September 2022

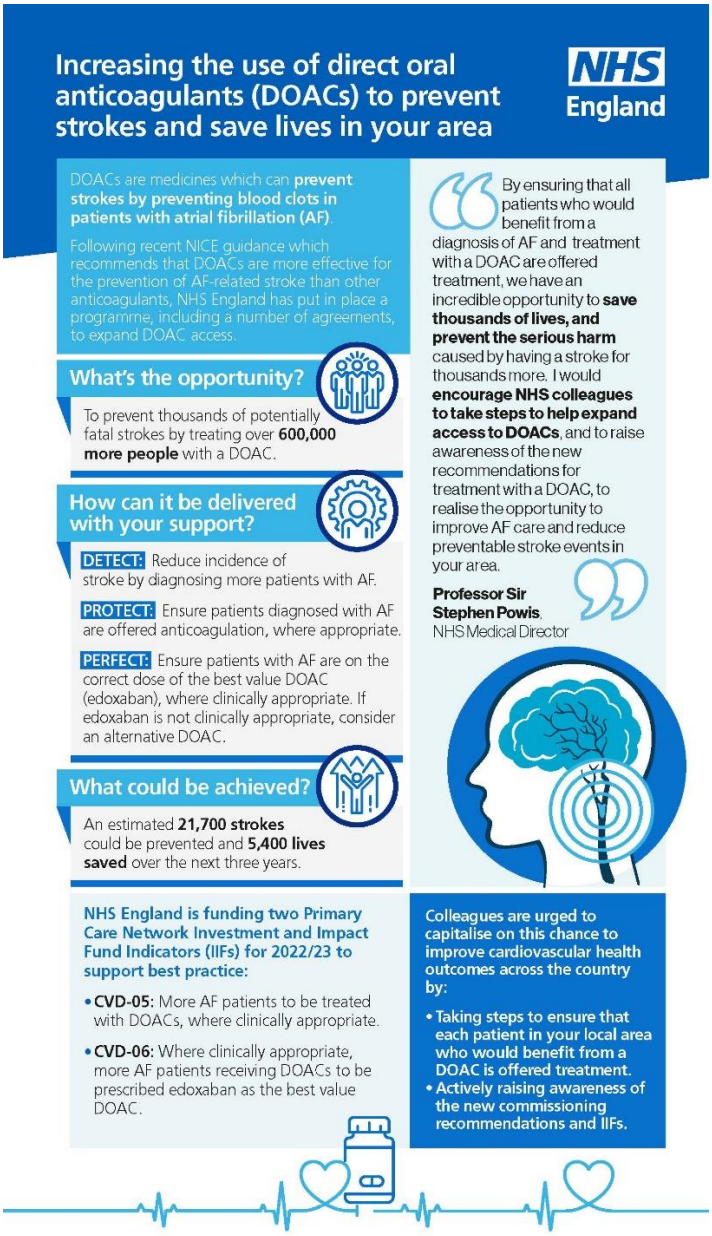
The MHRA Central Alerting System alerts can be accessed at https://www.cas.mhra.gov.uk/Home.aspx .

National Patient Safety Alerts can be accessed at https://www.england.nhs.uk/patient-safety/patient-safety-alerts/ .
We are reviewing our response to MHRA and National Patient Safety Alerts to include local advice. In the meantime, we have included a summary of the MHRA Drug Safety Update.
This update is prepared by the NHS Kent and Medway Medicines Optimisation Team.

Direct oral anticoagulants (DOAC) infographic

NHS England has developed a new infographic in support of the national initiative to expand the use of direct oral anticoagulants (DOACs), accelerating treatment and improving atrial fibrillation (AF)-related outcomes in England.

The ‘Detect, Protect, Perfect’ initiative, with the support of NHS colleagues can be delivered in line with the NHS Long Term Plan, to prevent more strokes and improve cardiovascular disease outcomes.



DOAC Infographic (england.nhs.uk)

Please note this DOAC infographic supports our current Kent and Medway position statement on anticoagulant prescribing. jpc-anticoagulant-position-statement-risk-mitigation-v3.pdf (medwayswaleformulary.co.uk).

Product Discontinuation: FreeStyle Libre 1

Abbott have confirmed that by the 31st December 2022 the original FreeStyle Libre flash glucose monitoring system will be discontinued in the UK. This is part of Abbott's product improvement plans. Please note that this discontinuation does **not** impact FreeStyle Libre 2 sensors.

The FreeStyle Libre 2 system is available and suitable for diabetic patients who qualified for the original FreeStyle Libre system. The benefits of the original FreeStyle Libre system remain with the FreeStyle Libre 2 system, with the main differences between the two systems being that the FreeStyle Libre 2 system has three optional real-time glucose alarms (low glucose, high glucose, and signal loss), and no finger prick tests (unless glucose readings and alarms do not match symptoms or expectations).

In the October Drug Tariff, the FreeStyle Libre sensor was flagged with a 3-month notice of deletion. It will be deleted from Part IX of the January 2023 Drug Tariff. This means that pharmacies will no longer be able to dispense the original FreeStyle Libre sensors from NHS prescriptions and receive payment after submission of their December bundle. The PSNC have more information on the submission of these prescriptions and advice for contractors, which can be found here: FreeStyle Libre Sensor to be deleted from Part IX of the January 2023 Drug Tariff - PSNC Website

Actions for prescribers:

- For patients currently prescribed original FreeStyle Libre sensors, prescriptions should be changed from the original FreeStyle Libre sensors to the FreeStyle Libre 2 sensors. Please note that the original FreeStyle Libre system should be stopped on the repeat template
- When appropriate, patients should be informed that they will be changed from the original FreeStyle Libre sensors to the FreeStyle Libre 2 sensors, and reassured that the FreeStyle Libre 2 system provides the same benefits as the original FreeStyle Libre system

Information for patients:

- Patients who are registered with the manufacturer, Abbott, should receive an email from Abbott letting them know what to do should they have opted into communication from Abbott
- Patients can use the FreeStyle LibreLink smartphone app to get the most out of the FreeStyle Libre 2 system. If patients are still using a reader, this is the ideal time for them to switch to the app. Please note that alarms cannot be received on multiple devices. Patients must start the FreeStyle Libre 2 sensor with the device they want to receive alarms on (either FreeStyle Libre 2 reader, or a compatible phone with FreeStyle LibreLink app):
- **Using the FreeStyle LibreLink app:**
    - For patients who already have the app, no action is required. Patients do not need to download a new app. Patients can continue to use their current app straight away to scan FreeStyle Libre 2 sensors, making sure they have updated the app to the latest version
    - For patients who do not currently use but would like to start using the FreeStyle LibreLink app, they can download the app for free on the Apple App Store or Google Play store

    - More information, including device compatibility, can be found at: https://www.freestylelibre.co.uk/libre/
- **Using a FreeStyle Libre 2 reader:**
    - Patients who require a reader for the FreeStyle Libre system will require a replacement reader for the FreeStyle Libre 2 system if they wish to continue using a reader
    - Patients can order a free of charge FreeStyle Libre 2 reader from Abbott directly by calling Abbott Customer Careline on 0800 170 1177 or they can order online by visiting: https://www.freestylelibre.co.uk/libre/FSL2Replacement.html
    - To order a new reader, patients will require their current FreeStyle Libre reader serial number (found in the grey square on the back of the reader). Patients do not have to send their old FreeStyle Libre black reader back. A new FreeStyle Libre 2 blue reader will be delivered directly to them

For **further support/advice and information for patients**, on this discontinuation of the original FreeStyle Libre system and about the FreeStyle Libre 2 system, patients should contact Abbott directly:

- Patients can visit the FreeStyle Libre **website** here: https://www.freestylelibre.co.uk/libre/
    - Abbott's website includes user-friendly information and free online training on the FreeStyle Libre 2 system to help patients get the most from it, including updating the app, alarm functionality and activating the Bluetooth alarm function etc. Patients can visit: https://progress.freestylediabetes.co.uk/
    - The website has an FAQ section and a list of their contact channels, including an Online Sensor Support Service and Live Chat, which can be found here: https://www.freestylelibre.co.uk/libre/help/contact-us.html
- If patients wish to contact Abbott via **telephone**, Abbott Customer Careline can be contacted on 0800 170 1177

For further information regarding this discontinuation please contact the Abbott Customer Service Team on 0800 032 1016

November Shortages

Please find the medicines shortages update (14th November 2022) Practices are encouraged to register for access to the SPS website https://www.sps.nhs.uk/ and access the full medicines supply tool directly in real time.


Nov 22 shortages.docx

Serious Shortage Protocols: Estraderm MX® 50mcg and 75mcg patches

On behalf of the Department of Health and Social Care (DHSC), the Kent and Medway ICB MO team would like to inform you that Serious Shortage Protocols (SSPs) have been issued for Estraderm MX® 50 microgram and 75 microgram patches (SSPs 037 and 038).

The SSPs will enable community pharmacists across the UK to supply patients with Evorel® 50 microgram patches or Evorel® 75 microgram patches respectively.

The SSPs are now available to view here on the NHS Business Service Authority (NHSBSA)'s dedicated SSP web page, along with supporting guidance and other active SSPs.

These SSPs came into effect on the 15 November 2022 and are currently due to expire on the 13 January 2023. Should this change, the SSPs will be updated accordingly and published on the NHSBSA web page.

If you have any questions regarding the SSPs please contact the NHS Prescription Service:
Email: nhsbsa.prescriptionservices@nhsbsa.nhs.uk
Telephone: 0300 330 1349
Textphone: 18001 0300 330 1349

Discontinuation of Stemetil 5mg/5ml Syrup

A recall notice has been issued for all batches of Stemetil 5mg/5ml Syrup as a precautionary measure due to the identification of N-nitrosomethylphenylamine (NMPA) above the acceptable limit.

There will be no further production of Stemetil 5mg/5ml syrup, so this is in effect a product discontinuation and supplies are no longer available.

For advice regarding alternatives, considerations and background, and clinical information please see the following link and the SPS Medicines Supply Tool.

MHRA Class 4 Medicines Defect Information: Venlafaxine XL 300 mg prolonged-release tablets

Martindale Pharma has made the MHRA aware that the GTIN in the 2D barcode and the printed variable data represents the branded version of the product (Venlalic® XL 300 mg prolonged-release tablets). It should instead reflect the generic name: Venlafaxine XL 300 mg prolonged-release tablets. The code for the printed barcode is correct. Please see the following link for further details.