NHS
Pan Mersey
Area Prescribing Committee

PAN MERSEY AREA PRESCRIBING COMMITTEE MEETING

Minutes of the Meeting held on Wednesday 5 November 2014 in The Gallery Room, at The Venue, Civic Way, off Poplar Bank, Huyton L36 9GD

Present:

MEMBERS		Present	Apologies
Dr M G Semple (Chair)	Senior Lecturer in Child Health – Alder Hey Children's NHS Foundation Trust		x
Isam Badhawi	Senior Pharmacist – Liverpool Women's NHS Foundation Trust		x
Catrin Barker	Chief Pharmacist – Alder Hey Children's NHS Foundation Trust	x	
Dr Rob Barnett	LMC Representative, Liverpool		x
Nicola Baxter	Head of Medicines Optimisation – West Lancs CCG		x
Alison Butt	Joint Head of Medicines Management - Liverpool Community Health		x
Dr Catherine Doyle	Clinical Lead Medicines Management – Warrington CCG		x
Dr Janice Eldridge	GP Medicines Management Lead – Southport & Formby CCG	x	
Alison Ewing	Clinical Director Pharmacy – The Royal Liverpool & Broadgreen University Hospitals NHS Trust		x
Dr Anna Ferguson	GP Clinical Lead – South Sefton CCG		x
Dr Claire Forde	CCG Governing Body Member, Prescribing Lead – Halton CCG	x	
Simon Gelder	Chief Pharmacist – St Helens & Knowsley Teaching Hospitals NHS Trust	x	
Margaret Geoghegan	Head of Medicines Management – St Helens CCG	x	
Donna Gillespie-Greene	Deputy Head of Meds Management – Cheshire and Merseyside Commissioning Support Unit	x	
Gillian Gow	Chief Pharmacist – Liverpool Heart & Chest Hospital NHS Foundation Trust	x	
Nicola Hayes	Attending on behalf of Diane Matthew	x	
Maureen Hendry	Practice pharmacist/Interface support pharmacist, Liverpool Community Health (representing Alison Butt)	x	
Dr Aftab Hossain	Clinical Lead, Prescribing – Knowsley CCG	x	
Peter Johnstone (Chair)	Prescribing Commissioner – Liverpool CCG	x	
Dr Cecilia Jukka	Consultant Microbiologist/Chair Drug & Therapeutics Committee – Southport & Ormskirk NHS Trust	x	
Dr Tom Kennedy	Consultant at RLBUHT and Chair of D&T	x	
Dr Tom Kinloch	LMC Representative , Mid-Mersey LMC	x	
Lee Knowles	Chief Pharmacist – Merseycare NHS Trust		x
Jenny Lunn	Pharmaceutical Adviser & Team Lead, Medicines Management – Warrington CCG	x	
Susanne Lynch	CCG Lead Medicines Management – South Sefton CCG and Southport & Formby CCG	x	
Diane Matthew (Nicola Hayes attending)	Chief Pharmacist, Warrington & Halton Hospitals NHS Foundation Trust		x
Dr Sid McNulty	Consultant Endocrinologist/Chair Drug & Therapeutics Committee – St Helens & Knowsley Teaching Hospitals NHS Trust	x	

Sarah McParland	Pharmacist – (representing Neil Chilton, 5 Boroughs Partnership NHS Trust)	x	
Dr Neil Mercer	Consultant Anaesthetist/Chair Drug & Therapeutics Committee – Aintree University Hospitals NHS Trust		x
Graham Pimblett	Medicines Management Team Leader – Knowsley CCG	x	
Lucy Reid	Lead Pharmacist – Halton CCG Locality Medicines Management Team	x	
Dr Shamim Rose	GP Prescribing Lead & Board Sponsor – Liverpool CCG	x	
Steve Simpson	Deputy Chief Pharmacist – Southport and Ormskirk NHS Trust	x	
Paul Skipper	Deputy Director of Pharmacy – The Royal Liverpool & Broadgreen University Hospitals NHS Trust (representing Alison Ewing)		x
Dave Thornton	Principal Pharmacist, Clinical Services – Aintree University Hospitals NHS Trust (representing Mags Norval)	x	
Heather Tomlinson	Senior Clinical Pharmacist – Bridgewater Community Trust	x	
Janet Walsh	Medicines Optimisation Pharmacist – West Lancs	x	
Janeth Ward	Prescribing Adviser, Medicines Management Team – Warrington CCG (representing Jenny Lunn)		x
Dr Julie Whittaker	St Helens CCG Governing Body Medicines Management Lead GP	x	
IN ATTENDANCE			
Erika Baker	Senior Pharmacist – Cheshire & Merseyside CSU		x
Anne Henshaw	Senior Pharmacist – Cheshire & Merseyside CSU	x	
Graham Reader	Senior Pharmacist – Cheshire & Merseyside CSU	x	
Helen Stubbs	Senior Pharmacist – Cheshire & Merseyside CSU		x
Nasima Valli	Halton CCG (accompanying Lucy Reid)	x	

1	**APC/14/75 – Welcome and Apologies for Absence** The Chair welcomed the members and accepted the apologies of the following: Dr Calum Semple, Lee Knowles, Dr Anna Ferguson, Alison Butt (Maureen Hendry attending), Alison Ewing, Diane Matthew (Nicola Hayes attending), John Davey, Jenny Jones, Helen Stubbs and Erika Baker.	***Action:***
2	**APC/14/76 – Declarations of Interest and Quoracy Check** A quoracy check confirmed that this meeting was quorate. There were the following declarations of interest at this meeting: Dr Tom Kinloch – unpaid Medical Director of a private company that provides anti-coagulant monitoring services Sarah McParland – provides anti-coagulant monitoring services as part of her NHS role Dave Thornton – has received payments for contribution to educational meetings from manufacturers of apixaban, dabigatran and rivaroxaban.	
3	**APC/14/77 – Minutes of the previous meeting and matters arising.** ***14/77/01 – Minutes from the Previous Meeting*** The Minutes were agreed to be an accurate record of the previous meeting. **Matters Arising:** **14/77/02 – EllaOne Update & Emergency Contraceptive Pathway** DGG reported that we are waiting to hear back from Sue Forster, Assistant Director of Public Health at St Helens Council, and she will follow this up on behalf of the committee.	***DGG***

	14/77/03 – Relvar Ellipta in Asthma The grey statement has been updated and cross-linked to the COPD statement. **14/77/04 – Safety update** Update from EB will be presented next month, as the subgroup meet bimonthly. **14/77/05 – NOAC manufacturer** The draft letter has not been received yet. DGG will liaise with Dr Doyle.	***DGG***
4	**APC/14/78 – New Medicines** ***14/78/01 – Grey Statement Summary*** There have been a number of new product launches and license extensions for products and grey statements have been issued for these. AH ran through the list of products. There were no questions. ***14/78/02 – Removal of statements from legacy websites*** AH gave an update on some of the on-going housekeeping work that is being undertaken. Some of these statements have been removed because the NMSG felt that there is not an on-going need for the statements because they are embedded in clinical practice. They will remain in the formulary but it is not proposed to review any of these statements, as the subgroup does not think it would add any value. This was approved by members. ***14/78/03 – NOACs in Stroke Prevention in Atrial Fibrillation – Green statement + stakeholder feedback*** Dave Thornton explained that the reason the review came through New Medicines was because of a request from Whiston Hospital. The stakeholder feedback forms were well responded to. It raised three questions, related to clinical aspects: 1. The recommendations regarding specific monitoring requirements. The policy statement includes those specified in the individual product SPCs. However, a UKMi document recommends annual monitoring of renal and liver function plus full blood count. The NMSG felt that, due to the nature of patients with AF, that they would have an annual review anyway which would include regular routine monitoring, and so only the SPC recommended monitoring should be included in the policy statement. 2. Apixaban – NICE CG for CKD recommends apixaban over warfarin for patients with a confirmed eGFR of 30–50 ml/min/1.73 m2 and non-valvular AF. The NMSG felt that the wording in the document allowed the prescriber to choose apixaban if they felt it clinically appropriate for an individual patient. 3. AWMSG: In Wales they recommend warfarin first-line for all patients with AF who require anticoagulation. The NMSG felt that this advice was for Wales and so not applicable within England because the NICE TAs specify NOACs as treatment options alongside warfarin. There is also a NICE Consensus document that highlights priority patient groups, and the policy statement reflects both the NICE TA and the Consensus advice. DT asked if the committee are happy with the proposals from NMSG to not include the more specific details raised. It was suggested that it should not be assumed that regular monitoring takes place every year. However, the Committee agreed that only the recommended monitoring from the SPCs should be included in the policy statement. The question was raised as to whether the policy statement should state that apixaban is the first line choice in CKD. The committee agreed that if NICE recommend it then it should be included in the policy statement. DT agreed to add a line to the statement to this effect. The Committee agreed that the All Wales guidance could not be included in the policy statement for the reasons described. There was a discussion around what happens if prescribers at specialist centres such as LHCH follow the local Pan Mersey guidance for patients who reside in Wales where there are different recommendations. The Committee agreed that as NHS in Wales is a separate organisation, any queries would have to be addressed to them. One member suggested that this should also be discussed with the patient as part of the treatment decision process, as GPs in Wales may not continue prescribing of NOACs and so warfarin may be the preferred option.	

5	**APC/14/79 – Formulary and Guidelines** ***14/79/01 – Alprostadil Cream*** This is an alternative to existing alprostadil preparations for erectile dysfunction. This version is easier to use than the alternatives. The cost is comparable to the alternatives. Because it is easier to use there may be more demand for 2nd line (to oral treatmants) so costs may increase to a small extent but that is impossible to calculate accurately. The committee approved its addition to the Formulary as amber. ***14/79/02 – Tocilizumab subcutaneous injection*** Addition of the subcutaneous formulation of tocilizumab for rheumatoid arthritis used as per NICE TA for the iv infusion was considered a minor formulary amendment. GR confirmed this is a red drug as it was stated in error in one place on the document it was amber. It does not require patients to attend hospital for routine administration as the iv infusion version does, so it will be cheaper and more convenient for patients. Although the costings per patient had been provided, the subgroup have not asked hospitals to estimate how many patients would use this to give an overall estimate of cost savings. FGSG felt this could be a time-consuming task and wanted this considered for use now so that benefits from use can begin as soon as possible. If needed the actual cost savings could be looked at post-implementation. The iv infusion would remain on the formulary as this is more suitable for some patients. The committee agreed to subcutaneous tocilizumab being put on the formulary as a red drug. ***14/79/03 – Fentanyl patches statement*** There is no clinical reason why patients should be on one fentanyl patch brand or another, or why they could not be interchanged, apart from potential patient confusion/ safety issues although this can still occur if prescribed generically. However, there is a cost saving to be made by brand prescribing of less expensive brands compared to generic prescription. A number of stakeholder comments have been received regarding confusion if patient receives different brands at different times rather than being prescribed generically. However the CQC recommends that Fentanyl patches are prescribed by brand. If only one brand is put on the statement and prices change or there are supply problems then this is potentially problematic, so the FGSG have recommended a variety of brands that are all similarly priced, which avoids this risk and allows providers and CCGs to choose particular brands at any one time, by local agreement, if they wish. There is no evidence that the subgroup identified, of differing efficacy between brands. All the named brands are on the North West purchasing contract for providers until 2016. The Committee agreed the statement. ***14/79/04 – Imiquimod cream – basal cell carcinoma*** The subgroup felt that this is a minor formulary amendment to the indications for this product already included in the formulary, so this indication should be added as amber. The number of patients is low and it is a short course of treatment so there should be very little increase in cost. The Committee agreed the addition. ***14/79/05 – Colistemethate nebuliser – bronchiectasis*** The majority of colistemethate prescribing used to be carried out in primary care after initiation in secondary care for cystic fibrosis and it was RAG rated as Amber. However when cystic fibrosis services became commissioned by NHS England it was made Red. Subsequently it has become apparent that some patients receive it as part of management of bronchiectasis and the FGSG recommends this use to be returned to Amber in the formulary. The Committee agreed the change to amber for bronchiectasis. ***14/79/06 – Formulary Chapter 10 review*** Chapter 10 has been out for comment. There are a number of comments and most were straight forward and the changes made. It was highlighted baclofen has been changed from amber to green, mefenamic acid for dysmenorrhoea and menorrhagia has been included as green and cannabis spray is included as a black drug following NICE clinical guideline 186 which recommends it should not be offered for spasticity in MS. Where there is a BNFC entry, that will be highlighted in the formulary, and also where there is not, as agreed at October 2014 APC meeting for inclusion of paediatric information. Tocilizumab subcutaneous will be added as per item 14/79/02. The Committee agreed the reviewed Chapter 10.	

14/79/07 – Lactase enzyme drops statement and Infant Formula Feeds guideline

Lactase EnzymeDrops:

The FGSG was asked to look into this because of £50,000 annual cost of prescribing in Pan Mersey area. A lot of prescribing was taking place without the lactase intolerance test being undertaken as required by ACBS regulations for prescribing it on the NHS.

The main comments from consultation were around the testing and impracticability of this, given the condition is usually temporary. The only reliable test requires a stool sample and Alder Hey is the only hospital appearing to offer this test. Because of the difficulties of testing, the subgroup consulted CCGs only and gave them four options to consider: (1) designate black (2) designate green, no test required (against ACBS) (3) designate green and insist that GPs do the testing (4) their suggested alternative option. Most responses were for option (1), unless the patient has long-term lactase intolerance confirmed by testing. Majority of current use should be black.

One member pointed out that most of the pressure to prescribe is from midwives and health visitors who suggest the product to parents. It was agreed that a black statement would need to be effectively communicated within community trusts.
Members agreed to the black statement for Lactase enzyme drops.

Infant Formula Feeds Guidelines:

The Committee requested clarification of the meaning of the 3rd paragraph on page 6 be sought from dieticians as there appears to be a contradiction. It was confirmed the guideline had been written in consultation with dieticians.
It was agreed before the guideline can be approved that i) confirmation should be sought that contributing dieticians at Alder Hey are happy with the final version ii) the organisations contributing locally should be acknowledged and iii) the meaning of the 3rd paragraph on page 6 should be clarified. ***GR***

Once these were done the committee agreed that this could be approved "virtually" following circulation of the document by email.

14/79/08 – Omega 3 Fatty Acids in IgA Nephropathy statement

FGSG did a full evidence review and found that there is insufficient evidence to support this use of omega 3 fatty acids, therefore the subgroup felt that this drug should be classified as black in this use. A question was raised over use with CKD in CVD and it was clarified that there is a separate black statement already for CVD.
The committee were in agreement with the black statement.

14/79/09 – Oral colecalciferol products statement

Consultation on this resulted in a lot of comments. Some stakeholders interpreted this statement as a guideline on Vitamin D but it is not (FGSG is currently updating this guideline). The reason for this statement was to direct prescribers to use licensed colecalciferol products rather than the unlicensed ones, as a number of new licensed products are now available.

Other comments about this statement focussed on it not including unlicensed preparations that are used in daily regimes for rapid administration of loading doses, with the licensed products being licensed instead for longer loading regimes which could affect adherence. However the statement recommends it is preferable to use the licensed products for these rapid loading regimes than using unlicensed preparations, even if this is outside the licensed dosing schedules. The current Vitamin D guideline will remain on the website until it is reviewed but it was agreed to add a paragraph to the front of the guideline indicating changes to recommended oral colecalciferol products and linking to the statement.

The committee agreed the green statement.

14/79/10 – Minor Formulary Amendments

(a) Generic sildenafil prescribing regulation change: Generic sildenafil is now exempt from previous NHS prescribing restrictions regarding which patients can receive treatment for erectile dysfunction on the NHS. This will be noted in the formulary. The cost of treatment was noted and that one treatment a week is only a DH recommendation. Some patients have been having sildenafil treatment on a private prescription because they did not meet the NHS criteria and now they could be getting it generically on the NHS. A member suggested that LMCs need to make the point to GPs that they need

	not write private prescriptions where generic sildenafil is now available on the NHS. (b) Fluoxetine dispersible tablet: Less expensive than oral liquid so will be added to formulary. (c) Minims povidone iodine 5% w/v eye drops: now a licensed product available, so will be added to formulary in place of an unlicensed product. The committee approved the amendments.	
6	**APC/14/80 – Shared Care** ***14/80/01 – Shared Care update*** The revised documentation for Shared Care is currently out for consultation and should be back at the end of this month. The Lithium Shared Care – it is going to be reviewed again because NICE have just updated their guidance on bipolar disease.	
7	**APC/14/81 - Performance Reports** **14/81/01 – APC Prescribing Report October 2014** This report includes up to August ePACT data and a number of tables have now been removed, as discussed at July APC. We are seeing a consistent upward trend of NOAC prescribing and so monitoring of NOAC prescribing will continue in light of the reviewed policy statement. AH asked members to inform her if they have any comments about what they want to see in the report so that it continues to be meaningful and relevant.	
8	**APC/14/82 – Any Other Business** ***14/82/01 – AOB*** **Antibiotics** It is European Antibiotics Awareness Day on the 18th November. One member has seen a report saying that Merseyside is one of the highest prescribers of antibiotics. Some prescribers within the Pan Mersey footprint have very high prescribing figures for antibiotics. A committee member will send a link for ESPAUR to the Medicines Management team so that it can be cascaded to all members. The committee recognised that it would be beneficial for this information to be cascaded through the LPC. **APC Meeting Venue** Members reported a lot of difficulties with parking for the APC Meeting. The Medicines Management team will look at alternative venues and report back to the next meeting. .	***Meds Man Team***
9	**APC/14/83 Date, Time and Venue of the next meeting** November's APC meeting will be on Wednesday 26 November 2014 at 1.30 **–** 3.30pm in The Gallery, The Venue, Civic Way, Poplar bank, Huyton, L36 9GD	

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