NHS
Pan Mersey
Area Prescribing Committee

PAN MERSEY AREA PRESCRIBING COMMITTEE MEETING

Minutes of the Meeting held on Wednesday 29 June 2016 in The Education Centre, Kent Lodge, Broadgreen Hospital. L14 3LB

Present:

MEMBERS		Present	Apologies
Peter Johnstone (Chair)	Prescribing Commissioner – Liverpool CCG		X
Dr Sid McNulty (Deputy Chair)	Consultant Endocrinologist/Chair Drug & Therapeutics Committee – St Helens & Knowsley Teaching Hospitals NHS 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
Becky Birchall	Senior Pharmacist, NHS Halton CCG		X
Colin Brennan	Pharmacist, University Hospital Aintree (representing Dave Thornton)	X	
Dr Ivan Camphor	Mid-Mersey LMC Representative	X	
Nigel Cosford	Senior Meds Man Pharmacist, St Helens CCG (representing Nicola Cartwright)	X	
Dr Anna Ferguson	GP Clinical Lead – South Sefton CCG	X	
Dr Claire Forde	CCG Governing Body Member, Prescribing Lead – Halton CCG	X	
Danny Forrest	Liverpool Heart & Chest Hospital Foundation Trust (representing Gillian Gow)	X	
Simon Gelder	Chief Pharmacist – St Helens & Knowsley Teaching Hospitals NHS Trust	X	
Donna Gillespie-Greene	Head of Medicines Commissioning - Midlands & Lancashire Commissioning Support Unit	X	
Matt Harvey	Liverpool LPC Representative		X
Dr Dan Hawcutt	Consultant Paediatrician and Chair of D&T Alder Hey Children's NHS FT	X	
Maureen Hendry	Practice pharmacist/Interface support pharmacist, L'pool Community Health (representing Alison Butt & Marie Buckley)	X	
Dr Aftab Hossain	Clinical Lead, Prescribing – Knowsley CCG		X
Jenny Jones	Principal Pharmacist Meds Management – Warrington & Halton Hospitals NHS FT	X	
Dr Tom Kennedy	Consultant at RLBUHT and Chair of D&T		X
Lee Knowles	Chief Pharmacist – Mersey Care 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	
Dr Neil Mercer	Consultant Anaesthetist/Chair Drug & Therapeutics Committee –Aintree University Hospitals NHS Trust	X	
Kath Phillips	Pharmacist – Southport and Ormskirk NHS Trust	X	
Mark Pilling	Interim Head of Medicines Management – Knowsley CCG	X	
Sarah Quinn	Head of Meds Man, Bridgewater Community Healthcare NHS Foundation Trust	X	

Lucy Reid	Lead Pharmacist – Halton CCG Locality Medicines Management Team	X	
Barry Robertson	5 Boroughs Partnership Mental Health Trust (attending of behalf of Neil Chilton)	X	
Paul Skipper	Deputy Director of Pharmacy – The Royal Liverpool & Broadgreen University Hospitals NHS Trust (representing Alison Ewing)	X	
Dr Octavia Stevens	GP, Southport & Formby CCG		X
Dr Tree	GP, St Helens CCG	X	
Janet Walsh	Pharmacist – West Lancs CCG	X	
IN ATTENDANCE			
Anne Henshaw	Senior Pharmacist – Midlands & Lancs CSU	X	
Joanne McEntee	UK Specialist Pharmacy Service (UK Medicines Information)	X	
Agatha Munyika	Pharmacist – Mersey Care NHS Trust	X	
Graham Reader	Senior Pharmacist – Midlands & Lancs CSU	X	
Helen Stubbs	Senior Pharmacist – Midlands & Lancs CSU	X	
See Mun Wong	Pharmacist – Alder Hey Children's NHS FT	X	

1	**APC/16/34 – Welcome and Apologies for Absence** The Deputy Chair welcomed members and accepted the apologies from the following: Peter Johnstone, Nicola Baxter, Dave Thornton, Alison Butt & Marie Buckley (Maureen Hendry attending), Imran Chohan, Matt Harvey, Dr Lisa Manning and Dr Octavia Stevens.	***Action:***
2	**APC/16/35 – Declarations of Interest and Quoracy Check** A quoracy check confirmed that this meeting was quorate. There was one declaration of interest – see item 16/37/05.	
3	**APC/16/36 – Minutes of the previous meeting and matters arising.** ***16/36/01 – Minutes from the Previous Meeting*** The Minutes were agreed to be an accurate record of the previous meeting on 4 May 2016. Item 6: Dr Ivan Camphor expressed concern about dementia drugs no longer being Shared Care but now being amber initiated. At the last meeting supporting documents to help GPs were presented and approved with minor amendments. Dr Camphor was reminded that Mid-Mersey LMC has been involved throughout the whole process. HS confirmed that she had emailed Dr Kinloch, chair of the LMC and he had responded and acknowledged that the agreed amendments had been made and he was happy for the documents to go ahead. 5 Boroughs confirmed they are keen to work alongside the CCGs and GPs to ensure a smooth transition. A member referred IC to the top of page 6 where the minutes record that any difficult patients can be referred back to secondary care. Secondary Care are keen to be involved as early as possible if there are any problems so they can be dealt with in a timely manner. ***16/36/02 – Matters Arising*** ***Chair Letter to NICE re 30 days turnaround (e.g. Sacubitril/Valsartan)*** This letter has been written to NICE but no reply has been received yet.	
4	**APC/16/37 – New Medicines** ***16/37/01 – Grey Statement Summary*** <u>Romiplostim</u>: A grey statement has been produced for the licence extension for use in ITP where splenectomy is not contra-indicated, which NICE has confirmed is not covered by the existing TA. This will be reviewed when NICE review and update their existing guidance, or if a formal application for use in this cohort of patients is received and prioritised for in-year review. <u>Ixekizumab</u>: For treatment of plaque psoriasis. This will not be reviewed prior to the NICE TA, which is due April 2017. <u>Safinamide</u>: The Walton Centre are leading on this drug for Parkinson's disease. It will be	

reviewed within 6 months of the UK product launch, following a full assessment of the evidence.

The Committee agreed to the above.

16/37/02 – Non-renewal of expiring NMSG statements July-September 2016

Roflumilast; Lubiprostone; Prasugrel: The NICE TA recommendations for these drugs are now established into clinical practice and it is considered that these statements do not add any further additional benefit. The APC agreed to the non-renewal of these statements and links to the NICE TAs will be retained in the formulary.

Fluticasone furoate with vilanterol inhaler (Relvar Ellipta®) for COPD / Fluticasone furoate with vilanterol inhaler for asthma: These statements have been superseded by the COPD guidelines and the asthma guidelines. The APC agreed that both statements may be archived when the statement for COPD expires as the two statements cross reference to each other.

Olodaterol: A grey statement has been in existence for 2 years and no expression of interest has been received, therefore it is proposed that the statement is archived and the drug will remain as grey on the formulary long-term. The APC agreed to this course of action.

16/37/03 – Collagenase for Dupuytren's Contracture – update

The APC approved a red policy statement in May 2013. This statement was due for review in May 2015 but a FAD2 produced by NICE in Sept 2015 has been under appeal and the NMSG has been waiting for the outcome of the appeal. The APC agreed to an initial extension to the statement expiry date to May 2016. NICE has now published the outcome of the appeal and it has been referred back to the appraisal committee. The subgroup propose waiting for the NICE TA and therefore request approval to extend the statement expiry date for a further 6 months. There were no objections so the APC supported this.

16/37/04 – Canagliflozin, Dapagliflozin and Empagliflozin as monotherapies for type 2 diabetes

This statement has been produced on the back of a NICE multiple TA. The NMSG felt it was preferable to adopt the multiple-style policy statement to enable the prescribing information to be included for each of the three drugs. There was a discussion about the clarity of the positioning of these drugs as they are not first-line, and the wording in the statement. AH clarified that it is normal practice for the NMSG to adopt the NICE TA wording within policy statements as they had been advised that organisations should not be seen to be 'interpreting' the NICE TA recommendations. It was agreed to amend the title box to clarify that these drugs are third-line options for treating type 2 diabetes in adults in accordance with NICE TA390.

The APC Committee agreed to this change and agreed the statement.

16/37/05 – Sacubitril valsartan for chronic heart failure

(DF declared an interest in Novartis Pharmaceuticals UK Ltd)

A task and finish group was convened to look at how the NICE TA should be implemented across Cheshire & Merseyside and members were invited from as wide a range of relevant clinical backgrounds as possible. The APC approved a temporary Red statement on 4 May 2016 to enable this work to be completed. The drug has been RAG rated as 'amber following specialist initiation'. DF explained that this treatment replaces established ACE inhibitor or angiotensin II receptor blocker (ARB) treatment, it is not in addition to.

The cost is quite high and therefore individual CCG costing reports have been produced for each CCG and sent out to the Medicines Management Leads. Safety concerns are listed and the implementation recommendations aim to minimise the risks. The last page consists of bullet points, that outline the implementation recommendations from the task and finish group, with hyperlinks to the relevant documents.

Attention was drawn by a GP to page 3, third bullet point from the bottom, and there followed a discussion with GPs about the implication for primary care. The specialist would write to the GP when the patient is stabilised on optimum dose of sacubitril/valsartan and has been reviewed, for the GP to take on prescribing. On-going monitoring was discussed. DF explained the process. Prescribing and monitoring of the drug must be retained by the heart

	failure team during dose titration. On its own without inclusion of the further implementation information, the statement would not be robust enough but with the implementation information and access to the task and finish group documents, it is believed that it will be robust enough. The APC members agreed to this statement.	
5	**APC/16/38 – Formulary and Guidelines** ***16/38/01 – Chapter 3 formulary – paediatric review*** The chapter has been reviewed in order to include information on paediatric uses, including RAG designations that apply to paediatrics. Key points, and how stakeholder feedback had been addressed were summarised. The reviewed chapter was agreed. ***16/38/02 – Adult-Onset Still's Disease (AOSD) pathway*** The proposed pathway describes use of biological agents in patients where conventional treatments have been insufficiently effective. AOSD is a rare disease and NICE will not be issuing guidance in the foreseeable future. However IFR application is not appropriate as it is a defined cohort of patients, hence the need for a business case / treatment pathway for commissioners to decide if this may be routinely commissioned. No biologicals are specifically licensed in AOSD. There are currently 12 patients across the Pan Mersey area who are being treated for AOSD with biologicals, although there are no records of recent IFR approvals, so likely they have been categorised incorrectly or are historical cases (>3 years ago). When asked if there was information on the 12 patients broken down by CCG it was stated this was not currently available but GR could ask rheumatology departments if they had this information. How stakeholder feedback had been addressed was summarised. There was a question regarding a consultation feedback comment concerning affordability of commissioning this, and although CCGs ideally try to avoid post code prescribing, there will be situations where some CCGs will not be able to offer treatment. This is outside the remit of the APC because it gives guidance to commissioners and cannot make commissioning decisions. Due to the rarity of AOSD, evidence for the drugs requested in the application (etanercept, infliximab, anakinra and tocilizumab) is limited to individual case reports and series. There are case reports/series citing patients who have failed treatment with anti-TNF agents and have subsequently responded to alternative anti-TNF agents or anakinra, patients who have failed treatment with anakinra who have subsequently responded to tocilizumab, and a very limited number who have failed treatment with both anti-TNF agents and anakinra who have subsequently responded to tocilizumab. The pathway proposed use of a biological agent in patients failing to respond adequately to conventional treatment, and allows the use of a second biological agent if there is insufficient response to the first. If a third agent is thought necessary then this would need to be applied for on an IFR basis as this would be so rare as to likely fit exceptionality criteria. It was confirmed the business cases were supported by a consultant rheumatologist at St Helens & Knowsley Hospitals NHS Trust and had been approved by its Drug & Therapeutics Committee, although this was not recorded on the business case paperwork at the meeting. There were no objections to the business case and pathway, and these were agreed. ***16/38/03 – Nortriptyline RAG status*** The FGSG considered the position of this for migraine, neuropathic pain and depression. Nortriptyline is currently on the formulary as a green or amber drug for different indications but it has recently become very expensive compared to amitriptyline. The subgroup reviewed the evidence and found there is no evidence to say it is more effective than alternatives or better tolerated. However there had been significant consultation feedback saying it may not be any more effective but it is often better tolerated, and although more expensive than amitriptyline it is comparable in cost to some other alternative treatments. Therefore FGSG had recommended it remained on formulary as 2nd line to amitriptyline for use only as an option where amitriptyline has been tried and has been effective, but has not been tolerated. It was felt that GPs would be able to make the decision regarding amitriptyline intolerance and therefore it was inappropriate to make it amber which would lead to referral to specialist unnecessarily, and so the recommendation was for a green designation. It was reported to	***Action: GR*** ***Action:***

	the meeting that it is being prescribed widely by some consultants without trying amitriptyline first, but this was likely because they had not realised the increase in price. The FGSG will discuss the price with the Walton Centre so that it is used in line with the above recommendation. The second line use and green designation was agreed by the APC. ***16/38/04 – Gastro-oesophageal reflux disease (GORD) – paediatric guideline*** The FGSG felt there was a significant need to provide local guidance in addition to NICE guidance on this issue, and the guideline was developed by Alder Hey Hospital to be used both in primary and secondary care. One of the main challenges is the reassurance of parents that GORD is common in young children or babies. As part of this it was proposed to change the RAG rating of ranitidine in <12 years old from amber initiated to green. How stakeholder feedback had been addressed was summarised, and a number of minor amendments agreed by the APC. The guideline and ranitidine formulary amendment were agreed by the APC. ***16/38/05 – Melatonin in adults statement – updated*** This statement was reviewed relatively recently by APC but it was realised it did not cover use in adults with learning difficulties with sleep problems, as recommended in NICE NG11. The statement has been updated to include this. The updated statement was agreed. ***16/38/06 – Nadolol discontinuation*** Manufacturer has discontinued nadolol in the UK for commercial reasons. The FGSG propose changing the formulary to say it is now only available as an imported product from abroad – the imported product is licensed in its country of origin but not in the UK. It is important existing patients continue treatment for arrhythmias. Many new patients can be treated with bisoprolol but a minority will require nadolol to control their condition in future. The APC noted this and agreed to the formulary amendment. ***16/38/07 – Statement non-renewal*** ***Dutasteride*** The Formulary and Guidelines subgroup propose that this Black statement is not renewed as there is sufficient information included in the formulary entry. ***Fentanyl immediate release formulation*** The FGSG propose that this Amber statement is not renewed at its expiry date as there is sufficient information included in the formulary entry. The APC Committee agreed that the two statements are not renewed and are archived. ***16/38/08 – Minor formulary amendments*** ***Nicorandil*** The FGSG sought APC approval to amend the formulary entry to read that Nicorandil is to be used only after other classes of drug were not suitable and to add a link to the Drug Safety Update regarding the risk of ulcer complications. ***Actikerall*** It is proposed to add Actikerall as Green to section 13.8.1 for hyperkeratotic actinic keratosis. ***Butrans*** The FGSG proposed the addition of Butrans (buprenorphine) 15microgram/hour transdermal patch as Green to section 4.7.2 of the formulary. The above proposals were agreed by the APC.	***GR***
6	**APC/16/39 – Shared Care** ***16/39/01 – Amber RAG re-classification of specified sections of CNS formulary chapter*** The Shared Care subgroup have started to look at the CNS chapter in the formulary. <u>4.1 Hypnotics</u>: Melatonin RAG status as Amber Patient Retained was agreed, although it was acknowledged that this is not necessarily the opinion of the mental health trusts. Prescribing support documents will be written to help GPs in prescribing melatonin in ADHD. Changes have been made following feedback from stakeholders.	

	Promethazine has been re-categorised as green. This status was agreed. 4.2.1.Antipsychotic Drugs (oral): These are proposed as amber initiated. Representatives from both Mid-Mersey and Liverpool LMCs would prefer the oral anti-psychotics to be Amber Patient Retained based on concerns about the lack of certainty if a patient was to be discharged, that there would be reliable rapid access back into the specialist service. It was confirmed by 5 Boroughs that such a service was indeed in place for patients in their catchment area. Mersey Care confirmed that a great deal of work is being undertaken to ensure robust services are in place to deliver such a service in their area. It was agreed that because the drugs themselves do not satisfy the criteria for Amber Patient Retained, they should be classified as Amber Initiated, but that there should be an agreed statement on the website which reflected that implementation was dependent on local commissioning arrangements. This statement was to be agreed by email before any changes to the website are made. It was also agreed that a suite of prescribing support documents should be drawn up to support the process of implementation. It was agreed that the SCSG will bring this back in 6 months' time to review. 4.2.2 Antipsychotic depot injections: There was some concern that these drugs should be Amber Patient Retained but the status was agreed as Amber Initiated subject to a strong statement that these drugs are subject to local commissioning arrangements and may be supplied and administered by the specialist service (CPNs) in the community. DGG will liaise with LK over the wording. 4.2.3 Anti-mania drugs: Although there was concern from the Mid-Mersey representative that these drugs should be Amber Retained, it was agreed that the practice of GPs prescribing on specialist advice was widely practised and so the suggested category of Amber Initiated was agreed for carbamazepine, lamotrigine and semi-sodium valproate. Lithium remains Shared Care. 4.3 Antidepressants: The suggested categories were all agreed. 4.4 ADHD: All agreed as Shared care. The CNS stimulant modafinil for narcolepsy was agreed as Amber Patient Retained. 4.11 Drugs for Dementia: Already agreed previously.	***Action DGG/ LK*** ***Action: DGG/ LK***
7	**APC/16/40 – Performance Report** **16/40/01 – APC Prescribing Report May 2016** The quarterly report was presented to the committee. It was proposed to bring this report to the APC twice a year, at the end of May and the end of November, instead of 4 times a year because then changes in patterns and trends will be clearer to see. The APC agreed to this proposal. **16/40/02 – NICE TA Adherence Checklist May 2016** It was proposed that this checklist is brought as a standard agenda item each month in order that all NICE TAs are noted by the APC. The APC committee agreed.	
8	**APC/16/41 – Any Other Business** ***16/41/01 – AOB*** Sodium Valproate Dr Hawcutt announced that there is now a sodium valproate information leaflet that is relevant to paediatrics, available from the Medicines for Children website.	
9	**APC/16/42 Date, Time and Venue of the next meeting** Date and time of next APC meeting: Wednesday 27 July 2016 at 1.30-3.30pm Venue: River Alt Resource Centre, Woolfall Heath Avenue, Huyton, L36 3YE.	

10	**Post Meeting Note** **Addendum to June Minutes** Dr Camphor expressed concerns regarding dementia drugs and the need for clear shared care agreements across the region. As the spokesperson for Mid Mersey LMC, Dr Camphor said it was felt that all dementia drugs should be classed as amber retained.	

The agenda and minutes of this meeting may be made available to public and persons outside of The Pan Mersey Area Prescribing Committee Health Community in order to comply with requests made under the Freedom of Information Act 2000.