NHS
Pan Mersey
Area Prescribing Committee

PAN MERSEY AREA PRESCRIBING COMMITTEE MEETING

Minutes of the Meeting held on Wednesday 30 November 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	
David Ainscough	Pharmacist, Liverpool Community Health	X	
Catrin Barker	Chief Pharmacist – Alder Hey Children's NHS Foundation Trust		X
Dr Rob Barnett	LMC Representative, Liverpool	X	
Marie Buckley	Joint Head of Medicines Management – Liverpool Community Health		X
Dr Ivan Camphor	Mid-Mersey LMC Representative		X
Nicola Cartwright	Acting Deputy Head of Meds Man – St Helens CCG		X
Vicki Caton	Pharmacy Clinical Services Manager – Southport & Ormskirk Hospital NHS Trust	X	
Neil Chilton	Medicine Management Clinical Services Manager – 5 Boroughs Partnership, Mental Health Trust	X	
Nigel Cosford	Senior Meds Man Pharmacist, St Helens CCG	X	
Dr John Edwards	GP, St Helens CCG	X	
Dr Anna Ferguson	GP Clinical Lead – South Sefton CCG	X	
Dr Claire Forde	CCG Governing Body Member, Prescribing Lead – Halton CCG		X
Donna Gillespie-Greene	Head of Medicines Commissioning - Midlands & Lancashire Commissioning Support Unit	X	
Gillian Gow	Chief Pharmacist – Liverpool Heart and Chest FT	X	
Dr Jamie Hampson	GP, Liverpool CCG	X	
Matt Harvey	Liverpool LPC Representative	X	
Dr Dan Hawcutt	Consultant Paediatrician and Chair of D&T Alder Hey Children's NHS FT		X
Dr Adit Jain	Clinical Lead, Prescribing – Knowsley CCG	X	
Jenny Jones	Principal Pharmacist Meds Management – Warrington & Halton Hospitals NHS FT	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	
Agatha Munyika	Mersey Care NHS Trust	X	
Mark Pilling	Interim Head of Medicines Management – Knowsley CCG	X	
Sarah Quinn	Head of Medicines Management, Bridgewater Community Healthcare NHS Foundation Trust	X	

Lucy Reid	Lead Pharmacist – Halton CCG Locality Medicines Management Team	X	
Paul Skipper	Deputy Director of Pharmacy, The Royal Liverpool & Broadgreen University Hospitals NHS Trust	X	
Dr Octavia Stevens	GP, Southport & Formby CCG	X	
Dave Thornton	Assistant Clinical Director of Pharmacy – University Hospital Aintree	X	
Janet Walsh	Medicines Optimisation Pharmacist – West Lancs	X	
Mike Welsby	Pharmacist – St Helens & Knowsley Teaching Hospitals NHS Trust	X	
IN ATTENDANCE			
Helen Dingle	Senior Prescribing Advisor, MLCSU	X	
Anne Henshaw	Senior Pharmacist – Midlands & Lancs CSU	X	
Dr Evonne Osborne	GP Trainee	X	
Graham Reader	Senior Pharmacist – Midlands & Lancs CSU	X	

1	**APC/16/68 – Welcome and Apologies for Absence** The Chair welcomed members and accepted the apologies from the following: Nicola Cartwright (Nigel Cosford attending), Dr Ivan Camphor, Lee Knowles (Agatha Munyika attending), Dr Dan Hawcutt, Alison Ewing / Isam Badhawi (Paul Skipper attending), Marie Buckley (David Ainscough attending) and Dr Claire Forde.	***Action:***
2	**APC/16/69 – Declarations of Interest and Quoracy Check** A quoracy check confirmed that this meeting was quorate. There was one historical declaration of interest from Peter Johnstone for Astra Zeneca.	
3	**APC/16/70 – Minutes of the previous meeting and matters arising.** ***16/70/01 – Minutes from the Previous Meeting*** DGG drew to the attention of the committee that there had been a slight change to the APC Meeting Frequency item (under Any Other Business) to make it less wordy. It was read out to members and the change agreed. The Minutes were agreed to be an accurate record of the previous meeting on 2 November 2016. ***16/70/02 – Matters Arising*** ***Annual Declaration of Interest Form*** A new annual declaration of interest form will be brought to the next meeting (in January) for members to declare anything within the last 2 years and sign. **Sodium oxybate audit – further information** At the 28 September 2016 APC meeting the committee had considered the updated Red statement on sodium oxybate in narcolepsy with cataplexy, but had requested more information on the audit data of the last 2 years' usage submitted by the Liverpool Sleep Service based at Aintree. This has now been provided. The audit data appears to show that overall sodium oxybate in 30 patients: - approximately halves the number of cataplexy episodes and reduces daytime sleepiness from severe to moderate - results in mean number of cataplexy episodes reducing from 29.2 (range 1 – 350) per week to 12.1 (range 0 – 210) per week, i.e. from approx. 4 per day to approx. 2 per day - results in Epworth Sleepiness Scale reducing from 20.1 (severe) to 13.5 (moderate). The Service states that clinically significant reduction in cataplexy episodes is 10 per week or 50% reduction, and clinically significant reduction in Epworth Sleepiness Scale is 2-3 units (pages 2-3 of audit report) although this appears to be a reflection of the results achieved by sodium oxybate in clinical trials. These measures cannot detect significant functional changes, e.g. severity of cataplexy episode, performance status, quality of life and health economic benefits, for which quantitative assessments are difficult. Several members commented that sodium oxybate appears to be clinically effective when used by the Service and the fact that this would be prescribed by a speciality clinic could provide assurance that it will be used correctly. There was a discussion about whether commissioners would want to pay for this level of benefit. The point was raised that if	***DGG***

	commissioners do decide not to fund sodium oxybate then that could have wider significance for the sleep service at Aintree. A question was raised about continuing treatment if it is not demonstrating enough benefit. Attention was drawn to the sentence on page 1 of the statement saying "If insufficient benefit is seen at this point, sodium oxybate treatment will be discontinued". Two patients were discontinued due to lack of benefit. There were no objections to the updated Red statement, although it was accepted that this may or may not be ratified by each commissioner depending on whether each decided to commission sodium oxybate.	
4	**APC/16/71 – Safety** ***16/71/01 – Insulin Identification Chart*** The Safety Subgroup has produced an insulin identification chart and has had some good feedback. There were some suggestions that the insulin chart should include everything. It was agreed to leave the chart as it is but put a statement on the front page to say "this is not an exhaustive list". A member suggested that the wording in the fourth bullet point on page 1 should read 100 units per ml, 200 units per ml, 300 units per ml. This will be changed. Concern was expressed about the twice daily doses as there was no information about the length of time between doses. The committee was reminded that this was an identification chart, not a guide to administration or prescribing. GPs present thought this will be useful so a link will be put on the website and then GPs can add that link into their practice/CCG bulletin. Liverpool LPC also expressed an interest in bringing this to the attention of their membership. This chart was agreed with the above minor changes.	***Action: DGG***
5	**APC/16/72 – New Medicines** ***16/72/01 – Grey Statement Summary*** <u>Opicapone capsules</u>: This was highlighted at horizon scanning. A grey 'holding' statement has been produced. The NMSG will undertake a full assessment of the evidence for this treatment for Parkinson's Disease. The Committee agreed to the above. ***16/72/02 – Early archive of NMSG documents (COPD)*** The green statements for Umeclinidium bromide inhaler in COPD and for LAMA/LABA combination inhalers in COPD, have been superseded by Pan Mersey COPD Guidelines for Inhaled Therapy. It is proposed that these two statements are archived early in order to avoid any confusion. There were no objections and the Committee agreed to the proposal. ***16/72/03 – Minor update to Brivaracetam statement*** This statement was recently agreed by the APC. However, feedback has been received to say that because it is an anti-epileptic drug it would be useful to have advice around pregnancy. This advice has been taken from the SPC and added to the Safety box. No other changes have been made to the statement. Where appropriate, the NMSG will add this information to future statements. The APC Committee agreed to this minor update and to adding this information to future statements for other treatments where appropriate. ***16/72/04 – Prioritisation outcomes for in-year applications*** Two in-year applications for drugs have been received. <u>Fluocinolone (Iluvien) for cystoid macular oedema</u>: The evidence for use of fluocinolone in CMO is extrapolated from secondary outcomes in trials of a different US fluocinolone implant product which is a much higher strength than Iluvian. Therefore the NMSG could not support the application as there is no direct evidence for the UK product.	

	Insulin degludec for diabetes mellitus: Currently the statement is black because NICE did not consider degludec to be cost-effective. The manufacturer has now reduced the price significantly. All the key issues were considered and the NMSG decided this was of intermediate priority. It will be added to the horizon scanning process for next year's workplan for consideration. The APC Committee agreed to both decisions above. ***16/72/05 – Certolizumab in RA (NICE TA415)*** For patients who have failed one anti-TNF. GR talked the committee through the details. The only change to the Rheumatoid Arthritis Biologics Pathway is the addition of the TA number. The statement was agreed by members.	
6	**APC/16/73 – Formulary and Guidelines** ***16/73/01 – Formulary Chapter 6 paediatric review*** The FGSG has updated Chapter 6 for paediatrics, mainly by designating paediatric RAG ratings where different to adults and also to add in paediatric information if it is considered helpful. The consultation feedback was largely in agreement or 'no comment'. Use of dexamethasone in croup – this was agreed to be added to Ch.3 as a more appropriate section for this indication. Levothyroxine 12.5mcg and 75mcg tablets are new strengths recently available – this minor change was not in the stakeholder consultation document but FGSG felt these could be added at this stage. The reviewed Chapter 6 was agreed by the APC as above. ***16/73/02 – Formulary Chapter 7 paediatric review*** The FGSG has updated Chapter 7 for paediatrics, mainly by designating paediatric RAG ratings where different to adults and also to add in paediatric information if it is considered helpful. The consultation feedback was largely in agreement or 'no comment'. However points were raised regarding mirabegron which requires blood pressure monitoring in primary care – it was stated that practices do not have paediatric blood pressure cuffs and may not have adequate information on what constitutes normal blood pressure (B.P.) at different ages. However most of the children on mirabegron are over 5 years of age and would not need a paediatric blood pressure cuff and they are kept under the care of Alder Hey which checks B.P. as well. FGSG suggested including a link to paediatric blood pressure charts used by Alder Hey in the formulary. The reviewed Chapter 6 was agreed by the APC as above, including link to B.P. charts. ***16/73/03 – Paediatric Overactive Bladder (OAB) prescribing algorithm*** Pan Mersey currently has an adult OAB guideline so FGSG thought it would be useful to have a paediatric version. The drugs are amber initiated in paediatrics. Consultation feedback was mainly in agreement or 'no comment'. However there were comments about unlicensed tolterodine appearing above trospium in the pathway and whether there is an obligation to use licensed over unlicensed drugs. It was suggested that, if the prescriber can justify that the drug is better it is acceptable to use that drug even though it is off-label. One member said that his organisation has a best practice policy for following NICE but where they are presented with a recommendation or expert opinion from Alder Hey, they are happy to follow that advice. A member asked if a comment could be added to say the specialist should inform the GP about the unlicenced status of any drug and confirm the parent/ child had given informed consent, and the GP should also be informed about baseline blood pressure checks. The algorithm was agreed by the APC as above. ***16/73/04 – Symbicort metered dose inhaler*** *Symbicort* 200/6 has been available for some time as a dry powder device (*Turbohaler*) and a 200/6 metered dose inhaler has recently been made available. It is licensed for COPD only (not asthma). It is less expensive than the *Turbohaler*. It is proposed to add this to the formulary as a green drug and add it to the Pan Mersey COPD guideline as an alternative to *Turbohaler* device where *Symbicort* is recommended. This was agreed by the APC.	

	16/73/05 – Minor formulary amendments Matoride XL: The FGSG proposed adding Matoride XL 18mg, 60mg, to formulary section 4.4 to allow greater dose flexibility in existing tablet range. Elvanse: It was proposed to add Elvanse 20mg, 40mg, 60mg to the formulary section 4.4 to allow greater dose flexibility in existing tablet range. The APC agreed to both of these amendments.	
7	**APC/16/74 – Shared Care** **16/74/01 – ADHD** Mid Mersey LMC provided consultation feedback for the Shared Care Frameworks for ADHD and this feedback was discussed by the Shared Care subgroup at the November meeting. Each point was addressed as follows: 1. The subgroup agreed to delete the sentence 'GPs should not decline to take part in shared care on the basis of cost' and this will also not be included in any future shared care frameworks. The suggested sentence 'GPs are not obliged to take part in any Shared Care Agreements unless it is locally commissioned and agreed by the LMC' should not be added to shared care frameworks as that is part of implementation and not the framework itself. 2. The Shared Care subgroup believed that the 21 day timeframe for the agreement of shared care was appropriate and that it was important for the GP to reply with a response even if they refuse as this is helpful for the patient as well as the clinician and the CCG medicines management team. 3. The GMC Guidance does not preclude off label prescribing 4. No issues were raised at the meetings held between the LMC and Halton CCG and subsequently Warrington CCG Point 1 was queried. Does removing that sentence imply that GPs could refuse on the basis of cost? It was agreed that the decision should not be based on the cost of the drug so there should be no reference to cost in the documents. There is space within section 2 of the shared care framework for the GP to record the reason for declining the request. Halton CCG is proposing to run a pilot within the CCG but it will not be for all patients. Warrington CCG are waiting for these documents because they are planning to commission a service. Shared care cannot be commissioned unless there is a framework in place so this is a starting point. Some members expressed the opinion that it is sensible for there to be clinically safe shared care guidelines for people to use and they should be ratified. It was acknowledged that when it comes to implementing the shared care, not all CCGs would ratify the documents. Other members had misgivings about agreeing the shared care frameworks and not all CCGs would adopt them. However, when this work was originally started, the Shared Care subgroup recognised that there would be differences of opinion at this point and the aim was to produce clinically appropriate shared care documents that could be handed to the CCGs for individual implementation, because of the differences in commissioning around the Pan Mersey area. Although several 'tweaks' to the documents were discussed, it was accepted that this would lead to the documents continuing to come back and forth to APC. One CCG Lead felt that this is not being led by CCGs but is being led by secondary care so he encouraged CCGs to take ownership so they 'can drive the process and make things happen'. He felt that this could be a missed opportunity for CCGs to take shared care forward and in the interests of patients they should be allowing more shared care for patients. The documents make up a tool for aiding the commissioning of a service and the Chair asked members if there is anything wrong with the documents. There were no objections to the documents. It was therefore agreed by the APC committee that the documents, as they stand, will go to the CCGs for action, or otherwise. **16/74/02 – Melatonin** Melatonin has been categorised as amber retained and this prescribing support information and patient letter have been drafted.	

	Two main areas of concern were expressed by members. Firstly, if the Alder Hey specialist prescribed unlicensed drugs then the GP could be left prescribing unlicensed drugs long-term. However, the document does state that the specialist will continue to see the patient at 6-monthly intervals and determine ongoing clinical need. Secondly, what happens once the child reaches adulthood? - the development of a management plan to cover adult transition was required. There were no comments on the documents presented at the meeting but they could not be agreed because transition from child to adult services was a major issue. If the drug is amber retained then the APC has an obligation to resolve the transition problem and build something into the guidance; and many members agreed that this needs to be driven by Alder Hey Hospital. It was agreed that this will only be ratified after further commentary has been added. To be brought back to the APC.	***Action: HD***
8	**APC/16/75 – APC Reports** ***16/75/01 – APC Prescribing Report*** Quetiapine: Overall the trend is downwards. It was agreed that CSU should continue to monitor this. Colief: Seems to have an upward trend since May 2016. Will keep monitoring this for a further six months. Doxazosin MR: It was agreed to retire this item. Dutasteride and Finasteride: It was agreed to retire this item. Triptorelin: The graph shows an on-going rise. Sacubitril/Valsartan: Currently prescribing in primary care is very low, but it is anticipated that this could be a considerable cost pressure over time and so this will continue to be monitored. ***16/75/02 – NICE TA Adherence Checklist October 2016*** The October checklist was included on the APC agenda for noting. It has been updated to include all NICE TAs up to end of October. This will go on the Pan Mersey website this week.	
9	**APC/16/76 – Any Other Business** ***16/76/01 – AOB*** Flu Vaccine: A GP brought to the attention of members that an issue will arise regarding flu vaccine for next winter, as there is now a quadrivalent vaccine available in addition to the trivalent vaccine. He has been asking Public Health for the last two weeks if they have a view on which of the two is their preferred vaccine and he has had no answer. GPs are being asked to place orders now. The Chair suggested that the APC write to Public Health to request an answer.	***DGG/ Chair***
10	**APC/16/77 Date, Time and Venue of the next meeting** Date and time of next APC meeting: Wednesday 25 January 2017 at 2.00-4.00pm Venue: The Education Centre, Kent Lodge, Broadgreen Hospital, Thomas Drive, Liverpool. L14 3LB.	

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