NHS
Pan Mersey
Area Prescribing Committee

PAN MERSEY AREA PRESCRIBING COMMITTEE MEETING

Minutes of the Meeting held on Wednesday 27 September 2017 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
Nicola Baxter	Head of Meds Optimisation at West Lancs CCG		X
Dr Ivan Camphor	Mid-Mersey LMC Representative		X
Nicola Cartwright	Head of Medicines Management – St Helens CCG	X	
Vicki Caton	Pharmacy Clinical Services Manager – Southport & Ormskirk Hospital NHS Trust	X	
Neil Chilton	Medicine Man Clinical Services Manager – North West Boroughs Healthcare NHS Foundation Trust	X	
Dr Patricia Cunningham	Consultant Acute Physician and Medication Governance Group member, RLBUHT		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
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	
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	
Julie MacAngus	Bridgewater Community Healthcare NHS Foundation Trust	X	
Dr Neil Mercer	Consultant Anaesthetist/Chair Drug & Therapeutics Committee –Aintree University Hospitals NHS Trust	X	
Paul Mooney	Medicines Management Lead, RLBUHT	X	
Agatha Munyika	Mersey Care NHS Trust	X	
Mark Pilling	Chief Pharmacist & Assistant Director of Primary Care – 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	
Debra Walker	Alder Hey Children's NHS Foundation Trust	X	
Janet Walsh	Meds Optimisation Pharmacist – West Lancs CCG	X	
Mike Welsby	Pharmacist – St Helens & Knowsley Teaching Hospitals NHS Trust	X	
IN ATTENDANCE			
Helen Dingle	Senior Prescribing Advisor, MLCSU	X	
Anne Henshaw	Senior Medicines Commissioning Pharmacist, MLCSU	X	
Joanne McEntee	Senior Medicines Information Pharmacist, North West Medicines Information Centre	X	
Graham Reader	Senior Medicines Commissioning Pharmacist, MLCSU	X	
Catherine Witter	Medicines Information Pharmacist Southport & Ormskirk Hospital NHS Trust	X	
See Mun Wong	Formulary & Procurement Pharmacist Alder Hey Children's NHS Foundation Trust	X	

1	**APC/17/56 – Welcome and Apologies for Absence** The Chair welcomed members and accepted apologies from the following: Dr Patricia Cunningham, Dr Claire Forde, Catherine Harding, Dr Jamie Hampson, Lee Knowles**,** Dr Tom Kennedy and Nicola Baxter (Janet Walsh attending).	***Action:***
2	**APC/17/57 – Declarations of Interest and Quoracy Check** A quoracy check confirmed that this meeting was not quorate. There were no declarations of interest for items on the agenda.	
3	**APC/17/58 – Minutes of the previous meeting and matters arising.** ***17/58/01 – Minutes from the Previous Meeting*** The Minutes were agreed to be an accurate record of the previous meeting on 26 July 2017. ***17/58/02 – Matters Arising*** ***Appointment of a new APC Chair*** Peter Johnstone has now completed 12 months as APC Chair and the committee members were asked if anyone would be happy to put their name forward, to be Chair or Deputy Chair for the next 12 months. There were no volunteers. When asked, there were no objections to Peter Johnstone continuing as Chair for a further 12 months and Dr Sid McNulty continuing as Deputy Chair for a further 12 months.	
4	**APC/17/59 – New Medicines** ***17/59/01 – Grey Statement Summary*** Dimethyl fumarate: A grey 'holding' statement was produced for this treatment for plaque psoriasis. The NICE TA was expected in November but it has been published in September and so the Red statement on the agenda will supersede this grey statement. Beclometasone/Formoterol/Glycopyrronium inhaler: This is the first triple inhaler to the UK market. This will be reviewed within 6 months by the FGSG as part of the COPD guideline review. Abatacept injection: This is a licence extension for psoriatic arthritis. It will be reviewed when the NICE TA is published (expected July 2018). Brodalumab injection: This treatment for plaque psoriasis will be reviewed when the NICE TA is published (expected May 2018). Sarilumab injection: This is a treatment for rheumatoid arthritis and the NICE TA is expected January 2018, when it will be reviewed by the New Medicines subgroup.	

FreeStyle Libre: This flash glucose monitoring system will be available to prescribe on FP10 prescription on 1st November 2017. It will be reviewed by the Formulary and Guidelines subgroup within 6 months of becoming available on NHS prescription.

The Committee approved the grey statements for the above 6 treatments.

17/59/02 – In-year application prioritisation summary

The NMSG received two in-year applications for drugs not identified at horizon scanning. The prioritisation process was undertaken for both with the following results:

Pitolisant (Wakix) for narcolepsy: Having looked at the information the NMSG concluded that although there was some evidence, it was limited. However, there may be benefits to using pitolisant instead of sodium oxybate, therefore it was given intermediate priority and it will be reviewed by the NMSG in the next financial year.

Ferric Maltol (Ferracru): An in-year application was received from gastroenterologists at RLBUHT and StHKH. Ferracru is the only oral iron preparation specifically licensed for the treatment of iron deficiency anaemia in inflammatory bowel disease. Having discussed the evidence, the subgroup assigned a 'high' priority to this treatment as there are potential clinical and cost benefits to an alternative to intravenous iron, and so it will be added to the NMSG workplan for review within the current financial year.

The APC supported the above prioritisation outcomes.

17/59/03 – Roflumilast (COPD, NICE TA461)

Details of this statement were outlined to the committee. This amber recommended statement, in line with the NICE TA, will replace the current black position on the formulary. A question was raised about the statement in the Safety Box 'Roflumilast is subject to additional monitoring for weight loss' and it was explained that there is no further advice in the NICE TA over frequency of monitoring but clinicians should be aware that roflumilast can cause significant weight loss in some patients and so should monitor patient weight as appropriate. The APC approved this statement.

17/59/04 – Bisphosphonates (Osteoporosis, NICE TA464)

NICE TA464 partially updates TA160 and TA161 and based on TA464 the NMSG have produced two statements, one for the oral treatment and one for the intravenous treatment. The oral statement has a green RAG rating. If patients cannot take the oral bisphosphonates then they may be given the intravenous treatment (red RAG rating).

It was requested that information around drug holidays should be included on the green statement so AH agreed to add relevant information before the statement is uploaded to the website. The APC approved both statements once the requested information has been added. They do not need to come back to APC.

17/59/05 – Eluxadoline (Irritable bowel disease, NICE TA471)

A summary of the statement was given to members. With reference to the sentence on page 1 about stopping eluxadoline at 4 weeks, one member asked who would be responsible for reviewing and stopping treatment. AH advised that the NMSG had already discussed this and felt that these patients will have been through all the other standard treatment options before being referred to secondary care. It was felt the initiating clinician should undertake the review at 4 weeks because these are difficult to manage patients and the GP would not be able to advise on further management if eluxadoline was not successful. It is also part of the amber initiated RAG rating that patients should be stabilised before prescribing is passed to the GP. AH to add wording similar to that on the rifaximin statement to clarify when prescribing can be passed to the GP.

The APC approved the statement subject to this amendment and it does not need to come back to APC.

17/59/06 – Dimethyl fumarate (Plaque psoriasis, NICE TA475)

A summary of the main points of this red statement was given to the meeting. Some providers have already been treating patients with unlicensed Fumaderm, but will have already changed to the new licensed product within current commissioning arrangements. Dimethyl fumarate is PBRe so all use for plaque psoriasis will now be recharged to CCGs There were no questions and the APC approved the statement.

	17/59/07 – Collagenase clostridium histolyticum (Dupuytren's contracture,NICE TA459) NICE recommends that patients who meet the inclusion criteria for the ongoing clinical trial should be encouraged to participate in the study. However, the trial centres are not local to Pan Mersey, so are unlikely to be readily accessible for patients. For patients who do not take part in the trial one injection is given per treatment session by a hand surgeon in an outpatient setting (see bullet point 4). After several attempts to get clarification from NICE, they have confirmed verbally that by 'one treatment session' they mean only one injection ever, per patient. This NICE TA has been under appeal on and off for 3 years. Previously, this treatment was approved in Pan Mersey 4 years ago. A link will be kept to the archived legacy statement for those patients already started on this treatment. Patients who were started on this treatment before TA459 can continue to be treated. It was suggested that clarification over the NICE intention for 'treatment session' should be added to the statement. The APC agreed but did not want the statement to come back to a future meeting with the minor amendment. The statement was approved. ***17/59/08 – Dexamethasone intravitreal implant (Uveitis, NICE TA460)*** Main points of the red statement were outlined. There were no objections or questions. The current statement that this supersedes will be archived. The APC approved the statement. ***17/59/09 – Ranibizumab (Choroidal neovascularisation)*** This statement is not in response to a TA, it was identified and prioritised at last year's horizon scanning to address those patients where choroidal neovascularisation (CNV) was caused by a condition not covered by NICE TAs. NICE did not consider this at the time of the TA as ranibizumab was only licensed for CNV associated with pathologican myopia. Ranibizumab has since received a license extension for CNV from any cause. The statement was discussed along with details of the trial. There were no objections and this statement was approved by the APC. ***17/59/10 – Baricitinib (Rheumatoid arthritis, NICE TA466)*** The author of the statement ran through the details. The committee were informed that the RA Biologics pathway is currently being revised to include the oral JAK inhibitors approved by NICE. The APC approved the statement. ***17/59/11 – Nalmefene (Alcohol dependence, statement review)*** Nalmefene is a treatment for reducing alcohol consumption. This is a routine review of an expiring amber statement (in line with NICE TA325) that was originally accepted by all CCGs except West Lancashire. There are different alcohol pathways across the area. In all areas psycho-social support is to be provided by the local commissioned alcohol service. Local commissioning arrangements would decide how it is managed in each area, including local prescribing arrangements. This will be included in the Netformulary entry for nalmefene, detailing the exact RAG status for each CCG. Following on from the meeting discussion, where concerns were raised around the statement being amber recommended but that not applying to individual CCGs, AH asked if the solution could be for the statement to have no RAG rating but it directs users to the formulary for the RAG rating for each CCG The APC agreed with this proposal. It was agreed that a sentence along the lines of "Please see netformulary for individual CCG RAG ratings" to be added to statement.	
5	**APC/17/60 – Shared Care** ***17/60/01 – Disease Modifying Drugs Shared Care Frameworks*** The Shared Care Subgroup awaited publication of updated monitoring guidance from the BSR earlier this year and all the frameworks follow that guidance. There are now 9 frameworks, one for each drug to support the principle that shared care focuses on the drug rather than the condition. Each framework includes all the licensed indications and locally agreed off-label use for that specific drug. Although penicillamine is no longer initiated, a shared care framework has been developed for existing patients. This framework does not include the appendices that are used to agree shared care.	

	Some late feedback has been received this week. A rheumatologist has said that it would be helpful if CRP and ESR could be monitored at the same time as the BSR-recommended monitoring. This is disease monitoring rather than drug monitoring so the shared care frameworks would probably not be the best place to put this information. The subgroup will look into this separately. A member commented that Box 9 "Significant drug interactions" is light and needs further information. HD informed the committee that the subgroup agreed to simply refer to the SPC in each framework as there would be a vast quantity of information to include otherwise and the documents would become too large. HD asked the committee if they want a link to the SPC in the framework. There was concern expressed that serious interactions such as methotrexate and trimethoprim might be missed if it is not specifically noted and several members agreed. The GPs were consulted as these documents are aimed at Primary Care. One GP suggested adding the sentence "Please note MHRA warning" and members agreed. It is planned to include links to the MHRA warnings, where available. There was discussion at the meeting and approaching consultants was suggested, but it was not accepted.	***HD***
	A GP asked if there could be a statement in the framework about stopping the drug if patients are not complying and coming back for monitoring? This does not just apply to the disease monitoring drugs. It was agreed that a policy statement should be developed as a separate piece of work about the importance of patient monitoring and supporting clinicians to stop prescribing of drugs if patients fail to present for blood monitoring. The APC approved the shared care frameworks.	***Shared CareSG***
	The Consultation Feedback has indicated that hydroxychloroquine does not require routine monitoring but patients who take it for more than 5 years require annual eye examinations. It was suggested it should not be formal shared care. The subgroup therefore agreed that a RAG rating of Amber Retained would be more appropriate and Prescribing Support Information will subsequently be developed that would be likely to come to APC in January 2018. To ensure continuity of care for patients, the committee were asked if they could agree that it will be Amber Retained, pending production of prescribing support information. Several members disagreed with this proposal so it will remain Purple for now and the proposed RAG rating change will be sent out for consultation in October. ***17/60/02 – Chapter 4 RAG review*** The final part of the chapter 4 Amber review. This was held back while the subgroups sought to clarify the commissioning arrangements for the alcohol dependence services. The RAG ratings in the attached document do their best to reflect local arrangements but it is recognised that there will be some local variation and this has also been reflected in the consultation feedback. When the APC Report is sent out, each CCG will be asked how their service operates. Another issue in the feedback is that by leaving Vitamin B Co Forte Green it could potentially increase prescribing so the wording in the drug entry will be strengthened to help ensure that only people with a risk of deficiency due to poor nutrition should be considered for prescribing. A member stated that GPs feel that they would not discontinue unnecessary prescribing on their own; they would need some advice. A discussion then ensued and refeeding syndrome was also discussed. The opinion was that refeeding syndrome would never be Green as it was a 10 day course initiated by specialists. It was noted that this group of patients are likely to have poor nutrition. Members could not agree on the use of vitamin B Co Forte. This will be discussed further outside the meeting. Chapter 4.10 was not approved by APC. ***17/60/03 – Eplerenone and spironolactone RAG review*** Currently eplerenone is RAG rated as Amber Initiated and spironolactone as Green in Chapter 2. The NMSG and FGSG propose that these treatments, when used in the	

	treatment of heart failure, should have a consistent RAG rating. NICE recommends that specialist advice should be sought before an aldosterone antagonist is prescribed so a RAG rating of Amber Recommended would meet this recommendation. Spironolactone would remain Green for other indications. The existing eplerenone statement could then be archived. A consultant expressed his concern at this proposal as he felt it would confuse people and cause problems initiating the drugs. It was pointed out that this is for heart failure only and patients would be seeing a specialist at this point. A discussion ensued and GPs agreed they were comfortable initiating spironolactone. APC agreed the RAG rating should not be aligned for spironolactone and eplerenone. However, it was agreed that the RAG rating for eplerenone should change from Amber Initiated to Amber Recommended. Spironolactone remains Green for all indications. ***17/60/04 – Hydroxycarbamide RAG rating*** Hydroxycarbamide is currently only on the formulary for sickle cell anaemia for which it has been categorised Red. There is some prescribing in primary care so the Shared Care Supgroup investigated this prescribing. Primary care prescribing is principally in Warrington and Halton CCGs for myeloproliferative disorders. The vast majority of hydroxycarbamide across Pan Mersey is in secondary care. Therefore it was decided to give this a Red rating. Consultation Feedback was straight forward with no objections. Warrington and Halton Hospitals have said newly started patients will receive their prescriptions from the hospital and existing patients will be gradually brought back to hospital prescribing. The APC agreed to this amendment. ***17/60/05 – Riluzole Shared Care Framework*** Recently categorised as Purple but there are about 30-40 patients prescribed Riluzole in primary care who were initiated while it had the Amber rating. Riluzole is NICE-approved for amyotrophic lateral sclerosis which is a variant of motor neurone disease. Consultation feedback was discussed and has been addressed. The APC approved this shared care framework. ***17/60/06 – Glyceryl Trinitrate Patch Paediatric Prescribing Support Information*** This was categorised as Amber Initiated in the recent Chapter 2 Amber review which came to June APC and, as it is an off-label use of the glyceryl trinitrate patch, prescribing support information has been developed to support this. GTN patch would be used for children who cannot swallow nifedipine capsules and it is more cost effective and appropriate for children than unlicensed nifedipine liquid. The consultation feedback was discussed. If the GP feels it is not appropriate to take on prescribing, then it will remain with the specialist and the GP should give a reason why to the consultant. Contact phone numbers have been added to the last page of the document so it should be easy for a practice to contact the rheumatology team with any queries or concerns. The APC approved this prescribing support information.	
6	**APC/17/61 – Formulary and Guidelines** ***17/61/01 – Chapter 13 formulary paediatric review*** Chapter 13 has been reviewed to produce paediatric drug RAG designations and additional paediatric information. Stakeholder feedback was discussed and had been addressed. The FGSG will be producing guidelines on emollient use at a future date following on from comments. The APC approved the paediatric amendments. ***17/61/02 – Chapter 12 formulary paediatric review*** Chapter 12 has been reviewed to produce paediatric drug RAG designations and additional paediatric information. Stakeholder feedback was discussed and had been addressed. Agreed off-label nasal steroids to be designated as amber recommended. The APC approved the paediatric amendments. ***17/61/03 – Azithromycin paediatric statement*** The main points of this statement were outlined to the committee and stakeholder feedback had been addressed. The APC approved the statement. ***17/61/04 – Paediatric chronic pain guideline*** The main points of this guideline were outlined to the committee and stakeholder feedback	

	was discussed. All the drugs in the guideline except lidocaine plaster were previously agreed as amber initiated in paediatrics. After a discussion it was agreed to change the rating for lidocaine plaster from amber recommended to amber initiated. There was a discussion about whether the APC is consistent with its use of the terms 'off-licence' and 'off label'. It was agreed to use the term "off-label" in future for all unlicensed indications/use of a licensed product. The guideline is approved by the APC with the above changes. ***17/61/05 – Sucralfate RAG change*** Deferred at request of APC Chair. ***17/61/06 – Quetiapine liquid*** This was previously only available as an unlicensed special. The FGSG proposed the addition of licensed quetiapine oral liquid 20mg/ml to the formulary as Amber Initiated. Consultation feedback was in agreement. This would result in a small additional cost (£4500 across Pan Mersey). This was approved by the APC. ***17/61/07 – Alternative brands of inhaled corticosteroid + long-acting beta-agonist inhalers*** The FGSG proposed the addition of AirFluSal MDI and Sereflo MDI (fluticasone + salmeterol) to the formulary (Fobumix had been consulted on but the manufacturer has delayed the product launch). Consultation feedback comments received were in agreement; but some made the point about adding more brands to the formulary, however, these allow cost savings if CCGs wish to switch patients from Seretide Evohaler. The Formulary and Guidelines Subgroup will review the preferred brands in COPD and asthma guidelines when they are reviewed in the near future. The APC approved the addition of these brands to the formulary. ***17/61/08 – Glycopyrronium injection RAG*** This is currently amber recommended and it is proposed to change it to green for palliative care use. The APC approved this change in RAG rating. ***17/61/09 – Colesevelam bile acid malabsorption statement review*** This statement had reached its review-by date. No significant changes were required and it was proposed that this statement is put on the static list. This was approved. ***17/61/10 – Fiasp*** The FGSG proposed the addition of Fiasp brand of insulin aspart 100units/ml to the formulary, as an alternative brand to Novorapid. Fiasp has a faster onset of action than Novorapid so may be more suitable for some patients although there is no evidence of significant additional clinical benefit. EPAR data had been provided for APC members for information to show the differences in speed of action. It is the same cost as Novorapid. The APC approved the addition of Fiasp to the formulary.	
7	**APC/17/62 – APC Reports** ***17/62/01 – NICE TA Adherence Checklist August 2017*** Noted by APC. This has been updated to include all NICE TAs up to end of August 2017 and it will be uploaded to the Pan Mersey website.	
8	**APC/17/63 – Any Other Business** ***17/63/01 – AOB*** <u>UK Medicines Information Service</u> Joanne McEntee explained to the APC meeting that the UK Medicines Information Service is currently in the process of setting up a prioritisation panel to direct the work undertaken by the regional RMOCs. She asked if any members would be willing to pilot the form on the website to suggest topics for possible RMOC review. For example, following discussions earlier in the meeting, Vitamin B Co Strong may be a topic to suggest as it is likely a national issue.	***ALL***

9	**APC/17/64 Date, Time and Venue of the next meeting** Date and time of next APC meeting: Wednesday 1 November 2017 at 2.00-4.00pm Venue: The Community Room, River Alt Resource Centre, Woolfall Heath Avenue, Huyton, L36 3YE	

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