Minutes

Meeting	**Pan Mersey Area Prescribing Committee**
Venue	Microsoft Teams online meeting
Date and time	Wednesday 23 February 2022, 2.00-4.00pm

Members	Organisation	Present
AL-JAFFAR, Hannah	Southport and Ormskirk Hospital NHS Trust	Y
ATHERTON, Diane Dr	NHS Wirral CCG	N
AZAR, Mo	Alder Hey Children's NHS Foundation Trust	N
BARTON, Carolyn	NHS Knowsley CCG	Y
BIRCHALL, Becky	NHS Halton CCG	Y
CARTWRIGHT, Nicola	NHS St Helens CCG	Y
CHARLTON, Marianne	Wirral University Teaching Hospital NHS Foundation Trust	Y
CHEUNG, Jimmy	Bridgewater Community Healthcare NHS Foundation Trust	N
CHILTON, Neil	Mersey Care NHS Foundation Trust	N
CROSBY, John Dr	Mersey Care NHS Foundation Trust	Y
DOYLE, Catherine Dr	NHS Warrington CCG	Y
FITZGERALD, Richard Dr	Liverpool University Hospitals NHS Foundation Trust	N
FORDE, Claire Dr	NHS Halton CCG	N
FORREST, Danny	Liverpool Heart and Chest Hospital NHS Foundation Trust	Y
GILLESPIE-GREENE, Donna	NHS Wirral CCG	Y
HAWCUTT, Dan Dr	Alder Hey Children's NHS Foundation Trust	N
HENSHAW, Anne	Midlands and Lancashire Commissioning Support Unit	Y
HUNTER, Anna Dr	NHS South Sefton CCG, NHS Southport and Formby CCG	Y
JAIN, Adit Dr (Chair)	NHS Knowsley CCG	Y
JOHNSTON, Jenny	NHS South Sefton CCG, NHS Southport and Formby CCG	Y
JOHNSTONE, Peter	NHS Liverpool CCG	Y

Members	Organisation	Present
KNIGHT, Lisa	Wirral Community Health and Care NHS Foundation Trust	N
LLOYD, Barry	NHS West Lancashire CCG	Y
LUNN, Jenny	NHS Warrington CCG	Y
LYNCH, Susanne	NHS South Sefton CCG, NHS Southport and Formby CCG	N
McKERRELL, Geraldine	Mersey Care NHS FT, Community Services Division	N
McNULTY, Sid Dr	St Helens and Knowsley Teaching Hospitals NHS Trust	Y
PARKER, James	Warrington and Halton Hospitals NHS Foundation Trust	N
PHILLIPS, Kathryn	Bridgewater Community Healthcare NHS Foundation Trust	Y
SKIPPER, Paul	Liverpool University Hospitals NHS Foundation Trust (Royal)	Y
THORNTON, Dave	Liverpool University Hospitals NHS Foundation Trust (Aintree)	Y
VAN MIERT, Matthew Dr	Wirral University Teaching Hospital NHS Foundation Trust	Y
WELSBY, Mike	St Helens and Knowsley Teaching Hospitals NHS Trust	Y
WILLIAMS, John	Southport and Ormskirk Hospital NHS Trust	N
Non-voting members		
BARNETT, Rob Dr	Liverpool Local Medical Committee	Y
CAMPHOR, Ivan Dr	Mid-Mersey Local Medical Committee	N
CULLUMBINE, Ann Dr	Wirral Local Medical Committee	N
HALL, Gareth	APC lay member	N
IRVINE, Adam	Cheshire and Merseyside Local Pharmaceutical Committee	N
In attendance		
DINGLE, Helen	Midlands and Lancashire Commissioning Support Unit	Y
JAEGER, Emma	Midlands and Lancashire Commissioning Support Unit	Y
MARSDEN, Ashley	North West Medicines Information Centre	Y
MORONEY, Tamsin	Midlands and Lancashire Commissioning Support Unit	Y
READER, Graham	Midlands and Lancashire Commissioning Support Unit	Y
WILSON, Paula	Midlands and Lancashire Commissioning Support Unit	Y

1	**Welcome and apologies**	
	The Chair welcomed members. Apologies were accepted from: Geraldine McKerrell, Susanne Lynch (Jenny Johnston attending), Jimmy Cheung (Kathryn Phillips attending), Sarah Quinn, Gareth Hall, and Dr Claire Forde.	

2	**Declarations of interest and quoracy**	
	There were no declarations of interest for items on the agenda. A quoracy check confirmed that this meeting was quorate.	
3	**Minutes of the last meeting**	
	The Minutes of the APC meeting on 26 January 2022 were agreed to be an accurate record of the meeting and formally ratified.	
4	**Matters arising**	
	There were no matters arising.	
5	**New Medicines**	
5.1	**Grey statement summary – for noting** The following grey 'holding' statements have been produced for the APC website: FILGOTINIB tablets (Jyseleca®▼): For ulcerative colitis. To be reviewed when the NICE TA is published (currently expected 08 June 2022). ICOSAPENT EHYL capsules (Vazkepa®▼) for reducing the risk of cardiovascular events: To be reviewed when the NICE TA is published (currently date TBC). MEPOLIZUMAB injection (Nucala®) for chronic rhinosinusitis with nasal polyps: To be reviewed when the NICE TA is published (currently expected 20 July 2022). These were noted by the APC.	
5.2	**Palforzia for peanut allergy in children and young people – NICE TA 769** This is not a PbRE (tariff-excluded) high cost drug, however NMSG agreed that this should be for specialist use only, and a red statement has been produced in line with NICE TA769. CBa went through the details. Costs from the NICE Resource Impact Statement are included. However, it is expected that providing Palforzia within allergy clinics may require additional investment, particularly in clinic capacity and training of staff and additional local costs are not known. RB asked how many patients would be eligible for this and whether there is capacity in the system to manage these patients. The NMSG does not have the information about patient numbers at this stage. It could be difficult for the patients to access this treatment and NICE acknowledges that there may be issues with clinic capacity. The first dose of each new up-dosing level needs to be administered in a healthcare setting and additional resource will be required for clinic review compared to current practice for this group of patients. It was noted that there is likely to be a lot of interest from patients and their families. NMSG felt it may be very motivated patients and their families who request it because there are a lot of cautions and restrictions around when and how patients should take it. Therefore, patient numbers may not be large initially. Wording has been added on the statement to explain that efficacy data are currently only available for up to 24 months of treatment and the SPC advises that no recommendation	

	can be made about the duration of treatment beyond 24 months. It is not known how long patients will remain on treatment and NICE states 87% of children are expected to have discontinued treatment after 24 months based on trial data. Concern was expressed about the potential workload that may impact general practice, and the overall pressure to the healthcare system. However, it was acknowledged that this is outside the remit of this committee. The APC approved the statement.	
5.3	**Upadacitinib for psoriatic arthritis – NICE TA 768** This is a PbRE (tariff-excluded) high cost drug and is specialist use only, therefore a red statement has been produced in line with NICE TA768. TM went through the details of the statement. Standard wording from the NICE Resource Impact Statement has been used for the costs. NICE does not expect implementing this guidance to have a significant impact on resources because upadacitinib is a further treatment option and is available at a similar price to the current treatment options. The APC approved the statement.	
5.4	**Rivaroxaban for prevention of atherothrombotic events in coronary or peripheral artery disease – routine review at expiry, for inclusion on static list** This is a routine review of an existing green statement at expiry. The NMSG proposes that it is added to the static list due to no new evidence or significant changes within the document. Minor updates include costs and adverse reactions, contraindications, and patient factors in accordance with the SPC. When this statement was originally brought to APC in 2019, the APC identified several concerns and points to clarify with NICE regarding patient selection. NICE confirmed that a decision support tool to accompany the TA was in the process of being produced, however this is not yet available. NICE TA607 is due to be reviewed by NICE in 2022 but does not specify a timescale. The NMSG agreed to proceed with the review of the current statement, for inclusion on the static list. If NICE updates the TA with new information, it would be picked up by NMSG and the statement will be reviewed again. Consultation feedback from Knowsley CCG suggested that it would be a secondary care decision to prescribe rivaroxaban for this indication. However, NMSG felt that this feedback should not change the APC position as there was no new evidence to warrant a change in RAG status from green to amber. It was noted that Bridgewater Community Healthcare Trust also submitted feedback suggesting that administration for swallowing difficulties is added to the statement. This was not recorded on the consultation feedback sheet due to an oversight. Although the statement does currently reference administration via gastric tubes, NMSG have previously agreed that administration for swallowing difficulties and feeding tubes would not be routinely added to statements. Therefore, to keep consistent, TM suggested that the current wording should be removed from the statement around gastric tube administration and that the information regarding swallowing difficulties is not added. A discussion was had regarding whether information for swallowing difficulties and feeding tube administration should be added to NMSG statements. It was acknowledged that this	

	information is helpful to primary care, however there is a concern that information from NEWT guidelines may go out of date as new recommendations are published each year and NEWT also includes off-label usage. It was agreed that information from the product SPC should be included in statements where it is available, but NMSG would not include information from other sources, such as NEWT. The information from the SPC regarding administration in swallowing difficulties will be added to the rivaroxaban statement and the information regarding gastric tube administration retained in the document. General consensus was that GPs would be unlikely to proactively initiate treatment but would be happy to continue prescribing. The APC approved this document for inclusion on the static list (after the addition of the SPC information regarding swallowing difficulties and gastric tube administration has been made), and to carry forward existing CCG approvals.	TM
5.5	**NICE TA process** TM presented a proposal for a process to deal with terminated, suspended, and withdrawn NICE TAs. The process for terminated NICE TAs has already been agreed at APC and adopted by NMSG, but this process has now been updated to include how NMSG will deal with suspended and withdrawn TAs. In circumstances where the NICE TA has been suspended and the drug is already launched, wording on the grey statements will be amended to reflect that the TA has been suspended and the recommendation will be reviewed when further information is available on the NICE website. For non-launched drugs, NMSG propose that these are archived off the NMSG workplan and would be revisited at the point of launch or if the NICE TA is updated. Each withdrawn TA would need to be reviewed on a case-by-case basis. However, where a NICE TA is withdrawn due to withdrawal of a product license by the manufacturer there will be insufficient evidence to recommend its use within the NHS and the NMSG proposes that the drug/indication becomes BLACK in the formulary with a link to the withdrawn TA. This is how the withdrawn TA and withdrawn product license for dapagliflozin for use in type 1 diabetes was managed by the NMSG. No feedback was received at consultation for this item. SMc questioned whether the lack of feedback for this item and others is because the proposal was felt to be right, or because of a lack of engagement. GR and AH confirmed that they would not have expected feedback for non-contentious items such as this, or a routine review of a statement at expiry, but they reassured members that they continue to monitor that feedback is being received where they would expect it to be. The APC approved the proposed process.	
6	**Formulary and Guidelines**	
6.1	**Bevespi Aerosphere MDI in COPD** The FGSG proposed the addition of Bevespi 7.2mcg/5mcg Aerosphere (glycopyrronium 7.2mcg /formoterol 5 mcg) metered dose inhaler for COPD, with a green RAG designation, to formulary section 3.1.2. Bevespi Aerosphere is currently the only available LAMA/LABA pressurised metered dose inhaler (MDI) and provides a treatment option for patients who need to use a spacer device. The dose is 2 puffs twice daily. The	

	feedback was largely supportive but there were queries about the high carbon footprint for this inhaler. HD assured members that, as the COPD guidelines will be reviewed later this year, the carbon footprint will be considered at that point. Members commented that the carbon footprint is clearly important, but a balance needed to be found between that, and what is best for the patient. New guidelines will be welcomed as there are now so many inhalers on the formulary. The APC approved the addition to the formulary.	
6.2	**Trimbow MDI in asthma** The APC was asked to approve the addition to formulary section 3.2 of Trimbow (beclometasone 87mcg/ formoterol 5mcg/ glycopyrronium 9mcg) pressurised MDI for asthma indication in adults, with a green RAG designation. Trimbow is currently the only triple (ICS/LABA/LAMA) device licensed for the maintenance treatment of asthma. HD explained that it is currently on the formulary for use in COPD and the license has been extended to include asthma. This will be useful for patients who struggle to use tiotropium and others will benefit from using one inhaler rather than two. There will be another triple inhaler coming to the next APC (Enerzair). Some of the feedback had queried the high carbon footprint of this inhaler. The subgroup is currently reviewing the draft Pan Mersey asthma guideline, and the carbon footprint of each inhaler is being highlighted in the guideline. There was a discussion, during which several points were noted. Some patients will benefit from using two inhalers so that the doses can be tailored. Treatments should not be chosen based on carbon footprints, but this will be an important consideration for some patients. If there is an option, you can give the patient the choice but if there is no option then you prescribe what is the most clinically suitable for the patient. As educated health professionals we should be guiding the patient as to what is best for them and, secondly, for the environment. It was pointed out that while it is necessary to consider the impact and the carbon footprint, the question is “Is there a clinical need for this inhaler?” and the consultants at LUHFT believe there is a clinical need in this case. Access to the product has a place, based on clinical need. It was noted that there is a Cheshire and Merseyside “lower carbon footprint” group looking at inhalers and this will increasingly be on the agenda, so APC needs to acknowledge that. A member queried the discrepancy between the APC asthma guideline and the green designation of Trimbow, as the guideline states anticholinergic therapies are commenced under the guidance of a specialist. NICE and the British Thoracic Society (BTS) differ on this aspect also and the Committee previously discussed at length whether to base the guideline on NICE or BTS, deciding on BTS as a basis. The Formulary and Guidelines subgroup has identified this difference and will address this as part of the review of the Pan Mersey asthma guideline that is currently being undertaken. The APC approved the addition of Trimbow to the formulary.	
6.3	**Trixeo Aerosphere MDI in COPD** This is the third triple therapy inhaler for COPD and the second triple therapy pressurised MDI – it is the same price as the other two and it is another treatment option, with a green	

	RAG designation. While Trimbow and Trixeo are clinically similar, there is slightly better documented evidence for Trixeo. The APC approved the addition of Trixeo to section 3.2 of the formulary.	
6.4	**Psoriasis in adults, sequential use of biological agents** The current guideline has been updated with the addition of bimekizumab, in line with the recent NICE TA723, as Class 3: IL 17 agent. There were no consultation feedback comments received. The omission of non-response definition for some biologics was pointed out and it was agreed these would be added. The CCG representatives also confirmed that the CCG approvals could be carried over to the updated guideline. The APC approved the updated guideline.	GR
6.5	**Flash glucose monitoring, Pan Mersey policy and RAG designation – draft NICE Type 1 and Type 2 diabetes guidelines** NICE is consulting on guidelines covering use of continuous glucose monitoring and flash glucose monitoring in adults and children with type 1 and 2 diabetes, due for publication on 31 March. All three draft guidelines are currently proposing to extend the use of flash glucose monitoring, so there will be a need to review the RAG designation and all of the paperwork that needs to be provided for the GPs when they are asked to prescribe, if the published guideline is in line with the draft. The subgroup is working on the assumption that the draft guidelines are likely to appear as the final versions but will not send any proposals out for consultation until the NICE guidelines are published in case there are any changes. GR wanted to make the APC aware of the action being taken by the subgroup and that the current APC position cannot be updated immediately following publication by NICE, as proposals will need to follow APC process. It was suggested that members communicate that message to the specialists in their organisations to confirm what the subgroup is working on and that there will be a necessary delay before the APC adopts any new position regarding use of flash glucose monitoring so that due process can be followed.	**All**
7	**Safety**	
7.1	**DEXAMETHASONE injection – different injection strengths** This is a routine review of the statement at its expiry date, for inclusion on the static list. There are no significant changes within the document, only minor updates. The base dose equivalence table has been updated to include 3.3mg and 4mg and the Noriderm brand has been added. No consultation feedback was received. The APC approved this statement for inclusion on the static list and agreed to carry forward existing CCG approvals.	
8	**Antimicrobials**	
8.1	**Managing Common Infections in Children – Respiratory Tract** This guidance is based on NICE and Public Health England information where applicable. A few amendments were made as a result of the consultation feedback including the addition of Centor diagnosis aide for acute sore throat and the wording “with antibiotics”	

	for when treatment is not required, to ensure non-antibiotic treatment is still given when needed. RB asked about length of treatment course for acute sore throat due to emerging new evidence that a 10-day course is not required and increases risk of resistance. This was discussed amongst members and EJ confirmed that this had also been raised within the Antimicrobial Review Group. Microbiologists were keen to stay with current guidance and other areas have not adopted a shorter course, so the subgroup decided to adhere to what NICE says for now (NICE summary table states 5-10 days) and review as appropriate. AHu directed attention to a couple of sections in the guidance which she thinks are not clear. This included the wording around the use of treatment for otitis externa which can be purchased but with advice for under 12's. It was agreed to clarify this further. It was agreed that the immediate antibiotic sentence under the sinusitis section should be removed to avoid confusion. AHu disagreed with the lack of guidance/treatment for lymphadenitis/parotitis and expressed concern relating to a patient who needed emergency treatment but system pressures and hospital waiting times could mean that not giving treatment in primary care is more detrimental. It was therefore agreed by the APC that the guideline will not be accepted and should be revised by the subgroup, taking into consideration the concerns raised. The guidance will then need to go back out for consultation before bringing back to APC.	
9	**APC reports**	
9.1	**NICE TA Adherence Checklist (January 2022) – for noting** Pan Mersey APC is compliant up to the end of January 2022. The report will be uploaded to the APC website.	
9.2	**RMOC update** There has been no further meeting since last month's APC meeting. RMOC North has now been disbanded into RMOC North West and RMOC North East. AJ was invited to be RMOC Chair but, as he does not have the capacity, AH will continue to be the APC representative. The first meeting will be in April and AH will update the Committee after that.	
10	**Any other business**	
	None.	
11	**Next meeting**	
	Wednesday 23 March 2022 at 2.00 – 4.00 pm Online meeting via Microsoft Teams.	