Minutes

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

Attendance		
AL-JAFFAR, Hannah	Southport and Ormskirk Hospital NHS Trust	Y
ATHERTON, Diane Dr	NHS Cheshire and Merseyside, Wirral Place	N
BARK-JONES, Jo	Bridgewater Community Healthcare NHS Foundation Trust	Y
BARTON, Carolyn	NHS Cheshire and Merseyside, Knowsley Place	Y
BIRCHALL, Becky	NHS Cheshire and Merseyside, Halton Place	Y
CARTWRIGHT, Nicola	NHS Cheshire and Merseyside, St Helens Place	N
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	N
DOYLE, Catherine Dr	NHS Cheshire and Merseyside, Warrington Place	Y
FITZGERALD, Richard Dr	Liverpool University Hospitals NHS Foundation Trust	Y
FORREST, Danny	Liverpool Heart and Chest Hospital NHS Foundation Trust	Y
GILLESPIE-GREENE, Donna	NHS Cheshire and Merseyside, Wirral Place	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 Cheshire and Merseyside, Sefton Place	Y
JAIN, Adit Dr (Chair)	NHS Cheshire and Merseyside, Knowsley Place	Y
JOHNSTONE, Peter	NHS Cheshire and Merseyside, Liverpool Place	Y
JOSEPH, Smitha Dr	NHS Cheshire and Merseyside, Halton Place	Y
KNIGHT, Lisa	Wirral Community Health and Care NHS Foundation Trust	N
LLOYD, Barry	NHS Lancashire and South Cumbria, West Lancashire Place	N

Attendance		
LUNN, Jenny	NHS Cheshire and Merseyside, Warrington Place	N
LYNCH, Susanne	NHS Cheshire and Merseyside, Sefton Place	Y
McKERRELL, Geraldine	Mersey Care NHS FT, Community Services Division	Y
McNULTY, Sid Dr	St Helens and Knowsley Teaching Hospitals NHS Trust	Y
MOONEY, Paul	Warrington and Halton Hospitals NHS Foundation Trust	N
PARKER, James	Warrington and Halton Hospitals NHS Foundation Trust	Y
SANDERSON, Paul	Alder Hey Children's NHS Foundation Trust	Y
SAWERS, Claire	NHS Cheshire and Merseyside, Warrington Place	Y
SKIPPER, Paul	Liverpool University Hospitals NHS Foundation Trust (Royal)	Y
THORNTON, Dave	Liverpool University Hospitals NHS Foundation Trust (Aintree)	N
VAN MIERT, Matthew Dr	Wirral University Teaching Hospital NHS Foundation Trust	N
WELSBY, Mike	St Helens and Knowsley Teaching Hospitals NHS Trust	Y
ZAMAN, Asif	NHS Cheshire and Merseyside, Wirral Place	N
Non-voting		
BARNETT, Rob Dr	Liverpool Local Medical Committee	N
CAMPHOR, Ivan Dr	Mid-Mersey Local Medical Committee	Y
CULLUMBINE, Ann Dr	Wirral Local Medical Committee	Y
HALL, Gareth	APC lay member	Y
IRVINE, Adam	Cheshire and Merseyside Local Pharmaceutical Committee	N
MANNING, Lisa	Cheshire and Merseyside Local Pharmaceutical Committee	Y
In attendance		
DINGLE, Helen	Midlands and Lancashire Commissioning Support Unit	Y
LONSDALE, Julie	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

1	Welcome and apologies	
	The Chair welcomed members and accepted apologies from Jenny Lunn (Claire Sawers attending), Nicola Cartwright, Adam Irvine (Lisa Manning attending), Dr Rob Barnett, Dave Thornton, Colin Brennan, Asif Zaman (Donna Gillespie-Greene attending), and Dr John Crosby.	

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, matters arising, APC report**	
	The Minutes of the APC meetings on 28 September 2022 and 26 October 2022 were agreed to be accurate records of those meetings and were formally ratified. This is the last Pan Mersey APC meeting and therefore today's minutes cannot be ratified at a subsequent meeting. A vote was taken, and it was agreed that the minutes from today's meeting will be circulated and, if agreed, ratified by email.	
4	**Matters arising**	
4.1	**Biologics dose escalation in IBD – update on formal ICB position** SL provided clarification over the ICB position regarding biologics dose escalation in inflammatory bowel disease, which has not been approved by the ICB. LUHFT clinicians raised a concern with the ICB Medical Director following the Pan Mersey APC proposal for biologic dose escalation not being able to be sent for ratification by the ICB Executive Group because Cheshire had not agreed to it. Rowan Pritchard-Jones confirmed that those patients awaiting treatment could be treated in the interim, but a business case will need to be developed for further Cheshire and Merseyside discussion via the Interim APG arrangements then for ICB consideration. SL has been tasked with progressing this work on behalf of the ICB. PS confirmed that, in the interim, the LUHFT consultants are treating the patients, but they understand that it will need to be discussed further at the ICB and any issues resolved. SL and AH will continue to work on this and will contact PS and LUHFT clinicians if more information is needed.	SL/AH
5	**APC and the ICS (STANDING ITEM)**	
5.1	SL provided an update and information regarding the next steps for APC following the initial engagement exercise. The ICB Medical Director request was for a single Cheshire and Merseyside APC, and MLCSU has been asked to facilitate this. Continuing the arrangements of two separate APCs was not working as the recommendations from each may be different. Currently APC recommendations go to the ICB Executive Group for approval, but only items which have been agreed by both Cheshire APG and Pan Mersey APC can be put forward for approval because the ICB wants a harmonised approach. Therefore, it was established that there was a need for an Interim APC arrangement for January to March 2023 to shape the development of the new APC and address urgent business, with the new Cheshire and Merseyside APC established from April 2023. SL attended the Cheshire APG last week and it was agreed to continue with the scheduled Pan Mersey dates for APC and subgroups for the interim period and Cheshire will be onboarded into these meetings.	

	There have been conversations about where the APC recommendations will go and it has been confirmed that APC recommendations will need to go to ICB for approval, not to individual Places, so there will be a single Cheshire and Merseyside decision. SL acknowledged that there is a need to look at what Clinical Leads are available to attend APC and wants to get opinions as to how to make it work. Individuals can email SL directly with any suggestions or concerns. On behalf of Mid-Mersey LMC, IC explained that they had an executive meeting yesterday and discussed the possible impact of this merger and its implications for GPs. They have ongoing concerns around shared care and the impact of medication being transferred into general practice and the associated additional workload. He asked what impact this merger will have on GPs. SL acknowledged these concerns and responded that it is important moving forward to look at workload for all parts of the system. The key part of the APC process is subgroups and consultation for any concerns to be raised. SL will also be linking in with the ICB Primary Care Committee around commissioning in primary care. As a system, everyone is looking to move towards the Consensus on the Primary and Secondary Care Interface recommendations. IC reminded the committee that LMC is the only statutory representative body for general practice and as such needs to be involved in discussions. SL confirmed that she supports the approach of involving the LMC, as she has been doing in Sefton, and that the roles and responsibilities of APC members will need to be clear, so individuals know who they are there to represent. She is happy to attend any LMC meetings if that would be helpful. AJ suggested that there is a need to be sensitive to GP Prescribing Leads who have represented their respective CCGs at APC but are no longer being retained at Place; as prescribing leads they have presented GP contributions to what has been discussed at APC. AJ asked what the future GP representation will be to ensure a continued balance between primary and secondary care? This is a real concern for the interim APC as there may be no GPs present to provide their opinion. SL will pick this up with Dr Fiona Lemmens to address this and agrees that having 'jobbing' GPs will add to the success of the committee.	SL
6	**Formulary and Guidelines**	
6.1	**Primary care prescribed glucose monitoring decision aids and GP letter** Following the publication of updated NICE guidance for people with type 1 diabetes and type 2 diabetes in March 2022, NHS Cheshire and Merseyside has decided to withdraw the legacy Continuous Glucose Monitoring (CGM) policy and to follow the recommendations in NICE NG17, NG18 and NG28. Many more patients with type 1 and type 2 diabetes are now eligible to receive CGM, both by primary care and secondary care. To support primary care, two decision aids have been developed with the support of diabetologists, and a letter template which would be used when a specialist makes a recommendation for a GP practice to prescribe one of these devices. The ICB decision was made on 27th October, and it was subsequently agreed the documents should go for Fast-track consultation across Cheshire and Merseyside. Significant feedback was received and, as a result, a number of changes were made. HD gave a summary of the changes that had been made. Many stakeholders fed back concerns about the need for training and support both for health care professionals and for patients and around choice of the most appropriate	

	device for each patient. Training and implementation are beyond the scope of these documents, but HD has spoken to diabetes specialist nurses in two Merseyside trusts to find out how patients with type 1 diabetes have been trained and started on FreeStyle Libre. She has also spoken to the companies that manufacture the four primary care prescribed devices to find out about training and supply of starter kits. Other concerns expressed in the feedback were around being able to choose the most suitable device for each patient. Diabetologists have suggested that, for the first 6 months, FreeStyle Libre is the first-choice device, recognising that practices have experience in prescribing this device. For some patients, this will not be suitable, for example if the patient does not scan the sensor regularly or does not like the device on their arm. These patients could start any one of the other three devices with suitable training. These documents were presented at the Cheshire APG meeting last week and SL updated the committee on the outcome of that meeting. They were concerned about the proposed RAG rating, and they felt it should be amber initiated. After further discussions with the Chair of the group, to understand their concerns, it came down to the assurance that if a request came through, the prescriber would be clear as to what exactly had taken place with the patient up to that point. SL and AH have today put in some additional wording to the GP letter, to add that clarity. SL pointed out the amendment which should now make it clear what has and what has not been done (e.g. the patient has been counselled and given the relevant information), and whether the patient has been given the initial supply or not. SL has been led to believe that this will enable Cheshire to support the amber recommended criteria. SMc believes this should be designated green as this is the future of continuous glucose monitoring. The technology is here and there is help for people. With the NICE guidance/criteria, it should be easy to see if the patient meets the criteria. He has read all the feedback and agrees with Dr Ooi. SMc queried why there was no feedback from his trust, and it was confirmed that none was received by the CSU or the formulary and guidelines subgroup. Up to now, these devices have been started in secondary care and GPs have then taken over prescribing. It cannot be assumed that all GPs will feel competent to initiate these devices with no prior training. One GP fed back that we should recognise that GPs have a varying amount of knowledge about diabetes but not always enough and so there is a gap. If it was green now then many GPs would not have sufficient knowledge at this stage and may cause inappropriate usage, resulting in both wastage of money and lack of patient outcomes. If a practice does not have the expertise, then SMc would be happy for the patients to be referred to the trust. The committee was reminded that amber recommendation is for any GP who is comfortable initiating prescribing and also includes community diabetes services, not just secondary care diabetes services. In the interim GPs need to be trained to become competent. AH pointed out that Cheshire has indicated they will move from amber initiated to amber recommended and this is not intended to be a long-term RAG rating, but this is to help the early stages of implementation. She suggested this could be reviewed in 6-12 months' time. HD proposed that the APC agrees to the documents with an amber recommended RAG rating now, in view of the fact that primary care is not skilled up just yet, and we commit to a review in 6 months. AJ agreed.	

	There are a number of ICBs across the country that have not yet agreed to follow NICE. When asked why we find ourselves in this situation, with a training issue, when NICE produced this guidance months ago, SL explained that we could have finalised these documents sooner, but there was no guarantee of a positive ICB decision. Cheshire and Merseyside have committed to the large amount of funding needed but that decision was not guaranteed. It was acknowledged that it is not ideal that it had to go for fast-track consultation. SL thanked HD, for the enormous amount of work and effort that has gone into getting everything ready. It was noted that education and training for primary care needs to be addressed but sits outside APC and CSU remit. A vote was taken on whether to approve as amber recommended, with the amendment to the GP letter, and with the caveat that it is reviewed in 6 months' time. The APC approved this, with a review and wider consultation in 6 months' time.	
6.2	**Primary care prescribed glucose monitoring RAG rating for Type 2 diabetes** The FGSG brought the following proposals to the APC: 1) Change RAG designation of flash glucose monitoring from Amber Initiated to Amber Recommended for Type 1 diabetes and for people with Type 2 diabetes when the NICE criteria are met. 2) Withdraw current Pan Mersey statement, and supporting templates for specialist initiation, continuation, and patient contract. 3) Add links to NICE guidance in the formulary entry for primary care prescribed glucose monitoring. 4) Add the primary care prescribed real-time CGM brands to the formulary with the same RAG designation as for flash glucose monitoring. 5) Addition of secondary care prescribed real-time CGM brands to the formulary as Red, for information. HD went through the background information and the reasoning behind the above proposals. SMc wanted it to be recorded that he felt the RAG designation should be green. There were no further comments. The APC approved the above proposals.	
6.3	**Addition of three primary care prescribed real-time continuous glucose monitoring devices to the formulary** The following three new brands have been launched since the NICE guidance was published. The costing information is included in the accompanying agenda document. The current brand on the formulary is Freestyle Libre / Freestyle Libre 2 (licensed for age 4 years and older). 1. GlucoRx Aidex Sensor – to be added to the formulary for adults with type 2 diabetes only. 2. Dexcom One – licensed for age 2 years and older. 3. Glucomen Day – licensed for age 6 years and older. The APC voted to approve the addition of these 3 brands.	

	For information, secondary care prescribed monitoring will be added to the formulary with a Red RAG designation.	
6.4	**Metolazone - licensed formulation (Xaqua®)** The subgroup proposed the addition of Xaqua® brand of metolazone 5mg to the current formulary entry with a red RAG designation and the following additional wording: "Two brands of metolazone tablets are currently available, Xaqua® 5mg (licensed) and Zaroxolyn® 2.5mg and 5mg (unlicensed). Xaqua® has up to two-fold increased bioavailabilty compared to Zaroxolyn® and therefore the brands are not interchangeable. Metolazone must therefore be prescribed by brand name as patients unintentionally switched between products may experience toxicity or subtherapeutic effects as a result of the difference in bioavailability." A link to the Specialist Pharmacy Services (SPS) background information will also be included in the formulary. This proposal is currently out for consultation, but after discussion with Place Leads it has been brought to this meeting because of the potential safety issue around the different bioavailabilities that needs highlighting and there is no December APC meeting. For information of secondary care colleagues, a member confirmed that Xaqua® stock may all be directed to secondary care at the moment and is not available in primary care. The APC approved this proposal.	
7	**New Medicines**	
7.1	**Grey statement summary** A grey 'holding' statement has been produced by the New Medicines Subgroup for the following drugs and has been uploaded onto the APC website: DROSPIRENONE 3mg / ESTETROL 14.2mg tablet (Drovelis®▼) for Oral contraception: Grey statement has been produced, pending application for use. TIRZEPATIDE (Mounjaro®▼) injection (Type 2 diabetes mellitus in adults): Will be reviewed when the NICE TA is published (expected 25 April 2023). The APC noted the grey statements produced and the proposed timescales for review.	
7.2	**Fostamatinib for ITP (NICE TA835)** NICE TA835 was published on 19 October 2022, and updates and replaces NICE TA759. Fostamatinib is recommended as an option for treating refractory chronic immune thrombocytopenia (ITP) in adults, only if certain criteria are met and the company provides it according to the commercial arrangement. This is a tariff-excluded high cost drug and is for specialist use only, therefore a red statement has been produced. This replaces the existing black statement in line with NICE TA759. Fostamatinib is a further treatment option for patients who have not had a suitable response to prior therapy including a thrombopoietin receptor agonist (TPO-RA), or	

	where use of a TPO-RA is not appropriate, and the overall cost of treatment will be similar to the current treatment options. The APC approved this red statement.	
7.3	**Relugolix–estradiol–norethisterone acetate for uterine fibroids (NICE TA832)** NICE TA832 was published on 19 October 2022 and recommends relugolix-estradiol-norethisterone acetate as an option for treating moderate to severe symptoms of uterine fibroids in adults of reproductive age. Relugolix-estradiol-norethisterone acetate is a further treatment option and is available at a similar price to the current treatment options. The annual treatment cost per patient is £939.00. The NMSG assigned an amber retained RAG as patients would require referral to secondary care for this treatment and it was considered that patients would remain under the care of the specialist. A DXA scan is recommended after the first year of treatment and NMSG agreed that it would be the responsibility of the specialist to request the scan and to action the results, in line with the Cheshire and Merseyside HCP interface document. AHu queried whether breast cancer risk should also be included in the statement. TM advised that the wording of the statement is taken directly from the NICE TA, with additional information from the product SPC. Unless a specific caution is included in the TA or SPC it would not be added. After a discussion, the APC agreed that TM will add "e.g. of the genital organs or the breasts" after "known or suspected sex-steroid malignancies" in the safety section to make it clearer, as this wording is used in the SPC. TM explained that the draft statement was forwarded to Cheshire APG, and while Primary Care are in agreement with the amber retained RAG designation, one Cheshire trust had concerns that patients would be retained by the specialist service indefinitely. Therefore, the amber retained RAG is not supported by Cheshire. In order to get an agreement across Cheshire and Merseyside and take a single recommendation to the ICB, TM asked whether it would be necessary for APC to reconsider the proposed RAG rating. A discussion took place regarding the rationale for the amber retained RAG designation. One of the main factors for this was the requirement for the specialist to determine continuation of treatment after the 12-month DXA scan. Having considered the RAG rating further, it was agreed that an amber initiated RAG would be appropriate if a caveat is included that the patient will remain under the specialist for 12 months until the DEXA scan results have been actioned. TM will update the statement accordingly. Upon the basis that the amendment regarding breast cancer will be made and the RAG rating is changed to amber initiated with the above caveat, the APC confirmed their approval of this amber initiated statement. SL and AH to raise this with the Cheshire APG Chair to seek agreement for the amber initiated RAG designation with the above caveat, so that this can go to the ICB Executive Group for approval.	TM TM SL/AH

7.4	**Eltrombopag olamine and romiplostim for ITP** It was agreed at the APC meeting on 25 May 2022 that the expiry dates for these two statements would be extended until NHS England had reviewed the Interim Clinical Commissioning Policy implemented during the COVID-19 Pandemic. NHS England have now withdrawn the Interim Clinical Commissioning Policy and NMSG has considered whether further review of these statements is necessary. As the NMSG considers that the NICE TA recommendations for these drugs are now established into clinical practice, it is proposed that the two statements are archived and the links to the NICE TAs will be retained in the relevant formulary entries. Review and update of the policy statements was not considered to add any further benefit. There were no questions, and the APC confirmed support of this proposal.	
8	**APC reports**	
8.1	**NICE TA Adherence Checklist (October 2022) – for noting** Pan Mersey APC is compliant up to the end of October 2022. NICE TA832 for relugolix-estradiol-norethisterone acetate will be amended to amber initiated RAG, as agreed at this meeting, and then the report will be uploaded to the APC website.	
9	**Any other business**	
	The Chair thanked all members for their input and contributions to the Area Prescribing Committee during the years it has been operating and wished the new APC every success. As APC Professional Secretary, AH thanked all members for their help and support over the years and, in particular, thanked Dr Adit Jain as Chair, Peter Johnstone as Vice Chair, and Dr Anna Hunter as Deputy Chair. She also thanked the MLCSU team who support her with organising these meetings each month.	
10	**Next meeting**	
	The November 2022 meeting is the last meeting of the Pan Mersey Area Prescribing Committee. It will be superseded by the Cheshire and Merseyside Interim Area Prescribing Group. The first meeting of the Interim APG will be on Wednesday 25 January 2023 at 14.00 - 16.00 hours Online meeting via Microsoft Teams	