

**The Northern Lincolnshire Area Prescribing Committee**

**M I N U T E S**

**12 October 2017**

**2.00 pm – 4.00 pm. Seminar Room 2, Ground Floor, Freshney Green, Grimsby**

1. **In Attendance**

Paul Fieldhouse (PF) - Chief Pharmacist & Clinical Lead for Medicines Optimisation (NLaG) (Chair)

Dr Pratik Basu (PB) – Prescribing Lead (North Lincs)

Dr Chathley, General Practitioner (North East Lincs)

Margaret Henry (MH) - North East Lincolnshire Community Representative for Prescribing

Geeta Kaur (GK) – Consultant Surgeon

Alex Molyneux (AM) – Medicines Optimisation Pharmacist (NECS)

Eddie McCabe (EMc) – Assistant Director of Finance, Contracts & Procurement (NEL CCG)

Abayomi Olusanya (AO) – Locality Pharmacist North East Lincolnshire (NECS)

Dr Ramesh - General Practitioner (North East Lincs)

Rachel Staniforth (RS) – Medicines Optimisation Pharmacist (NECS)

Sara Spooner (SS) – Clinical Lead Care Plus Group

Mrs Aliya Turk (AT) – Professional Secretary APC

Hazel Tait (HT) - Assistant Contracts Manager (NLaG)

Simon West (SW) – Finance Manager (NEL CCG)

**In Attendance**:

Joanne Rowson, Pharmacy Secretary (JR)

Caroline Andrews, Diabetes Specialist Nurse (CA) – for item 6vi

Donna Redhead (DR), Service Manager – for item 4ii and 4iii

**2 Apologies**

Apologies were received from:

Jim Devlin (JD) – Medicines and Therapeutics Committee Chairman (NLaG)

Paulash Haider (PH) - Procurement Pharmacist (NLaG)

Andy Karvot (AK) – Consultant Pharmacist Antimicrobials (NLaG)

**The meeting was declared as not quorate and email approval of all decisions will be sought following the meeting.**

**Action : JR**

**Declarations of Pecuniary Interest**

There were no declarations of financial interest.

**4 Minutes of Previous Meeting and Matters Arising**

The minutes of the previous meeting held on 14 September 2017 were taken as read and accepted as a true record. It was noted that RS had submitted some minor changes to JR via email this week and the updated minutes would be circulated to all members.

**Action: JR**

**Matters Arising**

1. Primary Care Antimicrobial Guidance – RS circulated this at the meeting and asked for comments via email. All changes from previous document are highlighted. The updated Antimicrobial guidelines will be approved by email agreement with APC members.

**Action: JR**

1. Constipation Pathway – Circulated at short notice this morning. Miss Kaur, Consultant Surgeon (NLaG) attended for this item. PF commented on the pathway and challenged the need ‘if one laxative has not worked refer to Secondary Care’ – red flag needs adding and also note that this is Adult Only pathway. AM commented it did not follow standard flow chart layout and streamlining of this was agreed with colour coding to be changed to reflect RAG ratings as used in the formulary. It was agreed that suggested amendments would be made, circulated for comments and approval at next meeting.

**Action: AO**

1. Trans Anal Irrigation Pathway – At the last meeting where this had been discussed there had been discussions regarding treatment at a weekend and this pathway cleared up the discussions. It was noted that currently Secondary Care would have to ‘bear the brunt’ of the consultations as the Community Incontinence Service was not currently up and running properly. RS was hoping today for agreement in terms of the pathway but that the service commissioned would have to be looked at further. Monitoring requirements would be identified through the Trusts and Care Plus Group. General approval was given but due to not being quorate decisions would be ratified via email.

**Action: RS/JR**

1. Review of the use of NOACs (pathway for low molecular weight heparins) – Dr Jalihal has agreed to chair and JR will arrange a meeting. It was agreed that the best location for this would be at Health Place, in Brigg and a Thursday would suit the GPs best (representatives from Pharmacy Paul Fieldhouse or Deputy). It was noted that RS had contacted Paul Towmey, as per her action who had agreed that this was up to CCGs to commission.

**Action: JR**

1. Sodium Valproate – PF had contacted RDash and the LMC with regard to this as requested.
2. Shared Care Guidelines Update – NE Lincs meeting held with NAVIGO and documents being prepared. Wider remit of shared care perse between both CCGs is required.
3. Methocarbamol and Nefopam – Information from NLaG on usage was shared Methocarbamol – 34 packs of 100 over last 12 months, Nefopam – 49 packs of 90 over last 12 months. RS had provided a prescribing positioning statement on both products. Discussion took place regarding the need for these to remain on the formulary. The general agreement was that there was no place in therapy for Methocarbamol or Nefopam and it was agreed to give a 3 month notice period prior to removal of both products (grey = non formulary) this would give prescribers the opportunity to be transfer patients. AT would notify prescribers on 1 November and both products would be withdrawn from the formulary on 1 February 2018. If any objections were received prior to removal further discussions would take place at the APC.

**Action: AT**

1. Anticipatory Medication Charts – **Post meeting note: JR had sent information from the last meeting to Dr Adcock who had attended for the discussions. He would update the chart as per the discussions, seek approval from the Multidisciplinary End of Life Group and then return the document to APC and M&T for final approval before leading on the communications for this when everything was in place. This would remain on the agenda until final approval.**

**Action: JR**

**5 APC Working Arrangements**

* NICE TA & NG Updates (September 2017)

[TA463](https://www.nice.org.uk/guidance/ta463) – Cabozantinib for previously treated advanced renal cell carcinoma – formulary red- Specialist Supply Only

[TA464](https://www.nice.org.uk/guidance/ta464) – Bisphosphonates for treating osteoporosis – Add link to formulary as some recommendations in [TA160](https://www.nice.org.uk/guidance/ta160) and [TA161](https://www.nice.org.uk/guidance/ta161): have been superseded.

[TA465](https://www.nice.org.uk/guidance/ta465) – Olaratumab in combination with doxorubicin for treating advanced soft tissue sarcoma - It was noted that treatment of advanced soft tissue sarcoma is Specialist Commissioning and NLaG are not commissioned to treat, therefore, formulary marked as red and restricted to specialist centre only.

[TA466](https://www.nice.org.uk/guidance/ta466) – Baricitinib for moderate to severe rheumatoid arthritis Added, as per NICE recommendations following 90 days, RAG rated red, noted that this was a Patient Access Scheme

[TA467](https://www.nice.org.uk/guidance/ta467) – Holoclar for treating limbal stem cell deficiency after eye burns Specialist Centre only NLaG not commissioned for this treatment

[TA468](https://www.nice.org.uk/guidance/ta468) – Methylnaltrexone bromide for treating opioid-induced constipation

[TA469](https://www.nice.org.uk/guidance/ta469) – Idelalisib with ofatumumab for treating chronic lymphocytic leukaemia

[TA470](https://www.nice.org.uk/guidance/ta470) – Ofatumumab for treating chronic lymphocytic leukaemia

All the above products are already on the formulary for other indications. NICE were unable to make a recommendation about the use in these instances in the NHS and therefore no changes would be made to the formulary

[TA471](https://www.nice.org.uk/guidance/ta471) – Eluxadoline for treating irritable bowel syndrome with diarrhoea would need to be added in line with NICE but it was noted that this would have massive resource implications in Primary and Secondary Care. AT shared information that indicated that the costs would be £18,000 initially for NE Lincs. It was agreed to add to the formulary as Amber with shared care, initiated in Secondary Care, patients stabilised in Secondary Care with Primary Care taking over, pathway to be developed, Specialist initiation in line with NICE with ongoing prescribing in Primary Care once patients are stable and all other options exhausted.

[TA472](https://www.nice.org.uk/guidance/ta472) – Obinutuzumab with bendamustine for treating follicular lymphoma refractory to rituximab Added as per nice recommendations following 90 days.

[TA473](https://www.nice.org.uk/guidance/ta473) – Cetuximab for treating recurrent or metastatic squamous cell cancer of the head and neck Add to formulary noting Patients would be referred to Tertiary Centre only for this treatment (Hull)

* Net.formulary Update – AT gave an update, explaining proposed changes to Chapter 2 that had been circulated. She noted the comments made by the group. It was noted that this chapter had been been agreed with the Associate Medical Directors AMDs and CCGs and had been RAG rated. Nothing had been added but some items had been removed due to very limited usage shown on Ascribe (Secondary Care) and Epact data (Primary Care). APC concurred with the following items that were proposed to be removed:

Chlortalidone tablets

Triamterene capsules

Co-amilozide tablets

Triamterene with furosemide tablets

Furosemide with potassium tablets

Spironoloactone with furosemide capsules

Co-tenidone

Oxprenolol

Terazosin

Olmesartan

Valsartan with hydrochlorthiazide

Felodipine MR tablets

Rutosides (Paroven) capsules

Cilostazol tablets

Inositol nicotinate tablets

Etamsylate tablets

Ezetimibe tablets

Fish Oils (Maxepa)

Gemfibrozil tablets / capsules

Nicotinic Acid tablets

* The proposed RAG ratings were also approved.
* The following were discussed by the APC and further consultation is required with the Cardiology Team:

Indapamide MR Tablets 1.5 mg – possibly used for patients following a stroke (GPs state they receive requests for this drug to be prescribed) – AT to clarify with Dr Banerjee

Glyceryl Trinitrate Ointment – to be removed from Chapter 2 but the use is more prevalent in Chapter 1 (not to be removed from the Formulary)

Nicardipine MR Tablets – proposed to be removed but query with Renal Lead Consultant if there is scope to use this for patients with renal impairment

Pentoxifyline 400 mg MR Tablets – need to clarify the commissioning round this and if Consultants are still using this for Bechet’s

Sacubutril with valsartan, Entresto – to be changed to Hospital Only until there is a pathway agreed

As per previous agreement it was agreed that 3 month notice would be issued for any items that it had been agreed to remove from the formulary.

**Action: AT**

**6 Formulary Requests, Amendments and Actions**

1. Entresto - discussed as part of Chapter 2 discussions above.
2. Abasaglar insulin glargine biosimilar – from a Primary Care perspective should not be an issue as patients only supplied pen devices or cartridges for insulin therapy, CA stated this was also the case in NE Lincs. It was agreed that this would be added to the formulary as ‘green’.

**Action: AT**

1. Guanfacine (Intuniv) – Dr Nelapatla due to attend the November meeting at Brigg.

**Action: AT**

1. Biosimilars – PH had provided the following information: Filgrastim, Infliximab, Etanercept and Rituximab IV are the only biosimilars used in NLaG.
2. Trimbow – new line request circulated but not discussed. Carried forward to November meeting.

**Action: JR**

1. Freestyle Libre – Caroline Andrews (CA), Diabetes Specialist Nurse attended for this item. She introduced herself and explained her reason for attending. Patients had been commenced on this device in trial sessions. Patients were initially self funding themselves for this but following on from a NICE innovation briefing funding needed to be considered locally. CA explained how the device works and that certain patients benefit from the use of this but not all patients. She suggested the initiation of the device in Secondary Care and following patients up diligently to see whether device is useful as was happening with the trials. The trials had shown that patients who are diligent with their diabetes and tested diligently, carbohydrate counting, insulin adjustment and those on pump therapy etc benefited from this device. She gave examples of patients stories demonstrating those who were finding this device useful. It was noted that it is suitable for pre-conceptial women, pregnant patients, pump therapy patients etc. The devices last for 14 days, therefore, 24 devices a year are required by a patient. At present patients are selected into trials, the company representative attends for the initial demonstration appointment, they are offered the device for 2 weeks but the self funding is explained at this stage.

RS had asked for this item to go on the agenda as it was noted that from 1 November 2017 there is an expectation that this will be available on an FP10 so discussions were required around which patients and whether the specialist service or GPs will pick up the ongoing prescribing of this and whether patients who do not self fund go down the IFR route or is there enough information to decide where patients fit.

AM asked from the trial group of patients so far if there had been any end point changes, ie reductions in admissions etc. CA stated that improvements in day to day average glucose were shown (cloud based software used but there were issues with this that IT were trying to remedy). Enough data is not given to note any end point changes particularly. It was noted that strip testing in addition to this device was required therefore, there was no cost reduction on strips used. EMc noted that this is a lifestyle type product and consideration should be given to patients selected for use due to FP10 usage getting into Primary Care as the IFR process and STP will say not routinely commissioned through Primary Care. RS noted a paper that gives costs and cost effectiveness, NICE have summarised and shown patients who would benefit from this device.

To summarise:

Recommendation is that it is not for general use and should not be initiated in Primary Care. It was noted that Leeds have commissioned this routinely for use in Secondary Care (red) and IFRs for use in Primary Care. HT felt that an internal conversation was required before a decision is made across the whole patch NL are sending IFRs to HT currently. Hull and East Riding have criteria for patient selection but still have the IFR route in place. It was therefore, agreed that this was not for routine use in Primary Care but would be Secondary Care only with IFRs. A summary of the evidence would be circulated to see how a pathway can fit into this. It was noted that CA has a narrow criteria for patients she felt suitable for this treatment and patients are made aware of the situation

1. Pregabalin – Humberside Police have sent a letter to state this has been linked to drug related deaths. A response had been sent. It was noted that Pregabalin is to be considered through a DH consultation to be reclassified as a Schedule 3 Controlled drug to make it harder for people to access this. Conversations would need to take place regarding a pathway. The APC newsletter could include information regarding this.

**Action: AT**

1. Skilarence – new line request circulated – Dr Mohungoo to attend the next meeting to discuss this.

**Action: AT/JR**

**7 Items for General Notice**

1. MHRA Drug Safety Update – The APC noted the contents of the alert for September 2017.

**8 Items by Prior Notice**

1. Request from Dispensing Appliance contractors for practices to issue prescriptions for items requested by the hospital – RS explained that patients are being initiated in hospital with a device and then the request goes to a dispensing appliance contractor who is then requesting that the GP practice provide the prescription for this and she provided examples of this. The first the GP practice knows about this is when they get it from Dispensing Appliance Contractor. PF agreed to investigate this further within NLaG.

**Action: PF**

1. Adrenaline AutoInjectors in Schools – information has been shared by PF (this referred to Item 7i of September 2017 minutes – see below):

*Discussions took place regarding the number of adrenaline auto-injector pens that should be prescribed, currently NLaG are issuing 2 as their first prescription from hospital and it was agreed that this would be the APC recommendation. Patients should be advised to carry these with them at all times.*

1. Sharing Information with the GPs re vaccinations – Sarah Wise, Consultant Midwife wished to share some information so that the GP’s are aware that they are offering Flu and Pertussis vaccines to the pregnant women attending  Ante Natal Clinic appointments at SGH and DPOW and possibly Goole. She wished to know if they would be happy with the information being shared with them via email following their vaccination, and was assuming that they would just need to know the women’s demographics and what vaccine she had received for her record. The template they intended to use had been shared with the group. This was agreed. **Post meeting note PF has contacted Sarah Wise re the approval of this.**

**Date, Time and Place of Next Meeting**

Thursday 9 November 2017

2 pm

Health Place Brigg