

**The Northern Lincolnshire Area Prescribing Committee**

**M I N U T E S**

**8 June 2017**

**2.00 pm – 4.00 pm. Main Meeting Room, Freshney Green, Grimsby**

1. **In Attendance**

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

Dr Chathley, General Practitioner (North East Lincs)

Janet Clark (JC) – LPC Pharmacist Representative

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

Paulash Haider (PH) - Procurement Pharmacist (NLaG)

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

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

Gemma McNally (GM) – Strategic Lead Pharmacist (NECS)

Dr Ramesh, General Practitioner (North East Lincs)

Sarah Spooner (SS) – Clinical Lead Care Plus Group

Rachel Staniforth (RS) – Senior Pharmacist, North East Lincolnshire (NECS)

Mrs Aliya Turk (AT) – Professional Secretary APC

**In Attendance**:

Joanne Rowson, Pharmacy Secretary (NLaG)

**2 Apologies**

Apologies were received from:

Elizabeth Barron (EB) – RDash

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

Dr Kasaraneni (KK) – Local Medical Committee

Miss G Kaur (GK) – Consultant Surgeon

Dr Neveen Samuel (NS) – Prescribing Lead for North Lincolnshire CCG

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

Simon West (SW) - Finance Manager, Financial Strategy & Assurance (NL CCG)

It was noted that the meeting was not quorate due to the lack of GP representation from North Lincolnshire CCG.

**3 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 11 May 2017 were taken as read and accepted as a true record. It was noted that Perampanel should state ‘Secondary Care Specialist Initiation Only’. This would be an amber indication. It was noted at this point that all future decisions would be given a RAG rating at the point of inclusion in the formulary. It was also noted that Methanimine Hippurate costs approximately £20.

**Action: JR**

**Matters Arising**

1. Primary Care Antimicrobial Guidance – It was agreed that GMc would circulate the final document following the meeting for information.

**Action GMc**

1. Constipation Pathway – This was deferred until next month.

**Action: RS**

1. Trans Anal Irrigation Pathway – A meeting was planned for RS, GMc and Miss Kaur to meet.
2. Review of the use of NOACs – PH had shared data with GMc but as yet Primary Care data had not been shared. They had discussed this and it was noted that a range of novel oral anticoagulants are in use across the health economy. A strategy for the use of NOACs reflecting latest published evidence is required for discussion at a future APC. The action was closed for now.
3. Chapter 11 – It was agreed that the chapter as it stands was approved and any further additions would be considered in the normal way. It was agreed that as Net Formulary would be in existence from tomorrow this would be the first chapter to be populated. First choice and second choice listings, decided by Primary Care and replicated in Secondary Care. It was noted that some products are expected to be used in Hospital and were on contract at special prices. All decisions to be made by APC as the decision making body. Some of the work with Chapters 1-4 recently brought to the APC by RS would be revisited for first/second choice. The principals as to how first/choice second choices were made would be decided by GMc, AT and RS outside of the meeting to be brought back to APC for approval.

Action: GMc, AT & RS

1. Lurasidone – RS had met with NAVIGO and it has been agreed is that this product should remain specialist only and be RAG rated Red.
2. NEL Continence formulary – this had been shared with the APC for information.
3. Colostomy Bags - It was noted that HT will be sending an email to all who attended the meeting. SS stated that there was a supply issue with nephrostomy bags. Currently the problems that were know about were with North East Lincolnshire. It was noted that there was a problem with peripheral products and the ongoing supply of these. Some of the products were not available on an FP10. In terms of supplies this was not really an APC issue: a contracting meeting would be required to resolve. The item was closed on the APC agenda.
4. Formulary annotation for Cinacalcet/Specialist Endocrinology Services - This could be removed from the agenda as this has now been resolved- as confirmed, GPs should not be asked to prescribe this. Discussions are on-going regarding who should be prescribing this ie Secondary Care with NHSE agreement or a specialist endocrinology centre ie Hull. Item closed. Formulary annotation to be made as RED.

**Action: AT**

1. Shared Care Guidelines for Rheumatololgy DMARDS contractual discussions required – accepted and closed on this agenda.

1. Enstilir – Dr Butt accepted the decision not to put this on the formulary. With regard to Ivermectin he would resubmit with more evidence. It was agreed that resubmissions would not be permitted within the year and this would be fed through M&T also.
2. NOACS- HT informed the committee via email that he had asked the Trust’s clinical lead in Haematology whether NOACs could be prescribed instead of LMWH for patients who are receiving chemotherapy, and is awaiting a response which will be forwarded on once received.

**5 APC Working Arrangements**

1. NICE TA & NG Updates (May 2017). NICE guidance discussed:

See below.

1. Net.formulary – 9 June training to take place at SGH Pharmacy.

**6 Formulary Requests, Amendments and Actions**

1. Entresto– reviewing the draft guideline within Cardiology. At the moment AT has met with Dr Thackery and he has concluded that it will be initiated and initially monitored by Secondary Care and he has narrowed down the focus of which patients will be treated. It will, therefore, be Amber. The shared care/guidance document would come in when a patient is at a stable point and the GP is able to take over the prescribing of this. This has a positive NICE TA and we do have some patients that would qualify for this. It had previously come to the APC when it had a positive NICE TA. It was noted that it was already on the formulary but would change to Specialist Initiation only.
2. Abasaglar – RS circulated this document during the meeting. Initial discussions took place. It was noted that currently we use a lot of Lantus Vials within the Trust. Brand prescribing was required as this was a biosimilar. This would be discussed further at the July meeting. JR would circulate for comments following today’s meeting.

**Action: JR**

1. Guanfacine (Intuniv) – fourth line treatment for North Lincolnshire treatment of ADHD for patients up to the age of 18 years. There is then a transition clinic where patients are then seen within North Lincolnshire through RDash. Clinical views from NL GPs would be required. It was agreed that until there was more evidence of a net saving or a NICE TA then this could not be approved in the current financial climate. It was agreed that Dr Nelapatla would probably like to come and speak regarding this when NL GP representation was present and also at a Brigg meeting.

**Action: JR/AT**

As an aside AT had produced a chart on how decisions are made within APC as a starting point for further discussions.

1. Braltus – clinical effectiveness agreed. APC happy to approve and NL had GP support for this. Pharmacists would need to be aware of this switch and any future of this nature. It was noted that the APC newsletter would assist with this. Within NLaG PH was getting the Braltus rep in to give some training.

**Action: PF/AT**

1. Evolocumab for treating primary hypercholesterolaemia and mixed dyslipididaemia– late item sent out this morning – PH has been made aware of this drug that received NICE guidance last year but is not currently on the formulary. It was noted that this was very expensive for the treatment of patients. Dr Thackery would be asked for a view on both of these products. It will be made available on the formulary in line with NICE TA.

**Action: AT**

**7 Items for General Notice**

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

**8 Items by Prior Notice**

1. Deferasirox (Exjade) - change in formulation from Dispersible Tablets to film coated – currently it is on the formulary as dispersible tablets and these are to be discontinued so the formulary would need amendment to specific film coated tablets.

**Action: AT**

1. Prednisolone Oral Solution – already in use in NLaG but could be used in Primary Care.
2. Perioperative Prescribing – issue raised by Dr Chathley – It was noted that GPs are being asked to prescribe anticoagulants for patients perioperatively for such as endoscopy procedures and cardiac inversions with very little information given. PF could take this back to NLaG but felt that this could cause issues with pre-op appointments as the clinics were not always run by a prescriber. It was agreed that he would take this issue back to Radiology Services but it was felt that this was a commission pathway/service design issue and would need to be discussed outside of the APC. The LMC view had been given stating that the responsibility lies with Secondary Care and it was felt therefore that they may have come across the issue before and it would be worth finding out what happens in Hull. RS would investigate with Karen Balaney outside of the APC.

**Action: RS**

1. Gender ID Clinic – prescribing for hormonal treatments for patients who are undergoing gender change – national guidelines state that there should be a shared care agreements in place. GPs do not see any of these patients they are seen at the Gender Identity Clinic and issues arise when they are discharged from Leeds. PF agreed to write to Liz Kay the Chief Pharmacist, at Leeds, to see if shared care was in place for other areas and we could ask to look at this with a view to further discussions at the APC.

**Action: PF**

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

Thursday 20 July 2017, 2 pm to 4 pm, Health Place, Brigg.

Following the ‘survey monkey’ and the revision of the schedule it was agreed to keep the next meeting as 20 July 2017, at Health Place, Brigg, but from August onwards revert back to the second Thursday of the month.

**NICE guidance (April 2017)** [**http://www.nice.org.uk**](http://www.nice.org.uk)

***Technology appraisals***

| **Title** | **Summary** | **Potential cost impact** |
| --- | --- | --- |
| [TA440](https://www.nice.org.uk/guidance/ta440): Pegylated liposomal irinotecan for treating pancreatic cancer after gemcitabine**Approved not added to the formulary** | Pegylated liposomal irinotecan, in combination with 5‑fluorouracil and leucovorin, is not recommended, within its marketing authorisation, for treating metastatic adenocarcinoma of the pancreas in adults whose disease has progressed after gemcitabine-based therapy. | No impact anticipated. |
| [TA441](https://www.nice.org.uk/guidance/ta441): Daclizumab for treating relapsing-remitting multiple sclerosis**Specialist Commissioning outside of APC remit** | Daclizumab is recommended as an option for treating multiple sclerosis in adults, only if:* the person has active relapsing–remitting multiple sclerosis previously treated with disease-modifying therapy, or rapidly evolving severe relapsing–remitting multiple sclerosis (that is, at least 2 relapses in the previous year and at least 1 gadolinium-enhancing lesion at baseline MRI) and
* alemtuzumab is contraindicated or otherwise unsuitable and
* the company provides the drug with the discount agreed in the patient access scheme.
 | It is estimated that 3,700 people with active relapsing–remitting multiple sclerosis previously treated with disease-modifying therapy or untreated rapidly-evolving severe relapsing–remitting multiple sclerosis are eligible for treatment with daclizumab. It is estimated that around 1,100 people will have daclizumab from year 2021/22 onwards. There may be savings resulting from reduced administration costs associated with daclizumab compared with natalizumab, which needs infusion inpatient visits. Daclizumab is an additional treatment option. This technology is supported by a resource impact template which requires the commercial in confidence discounted price of daclizumab to be input into the template in order to estimate the resource impact.Commissioning: NHS England. Assess cost locally.  |
| [TA442](https://www.nice.org.uk/guidance/ta442): Ixekizumab for treating moderate to severe plaque psoriasis**Adding in line with NICE guidance** | Ixekizumab is recommended as an option for treating plaque psoriasis in adults, only if:* the disease is severe, as defined by a total Psoriasis Area and Severity Index (PASI) of 10 or more and a Dermatology Life Quality Index (DLQI) of more than 10
* the disease has not responded to standard systemic therapies, for example, ciclosporin, methotrexate and PUVA (psoralen and long-wave ultraviolet radiation), or these treatments are contraindicated or the person cannot tolerate them, and
* the company provides the drug with the discount agreed in the patient access scheme.

Stop ixekizumab treatment at 12 weeks if the psoriasis has not responded adequately. An adequate response is defined as:* a 75% reduction in the PASI score (PASI 75) from when treatment started or
* a 50% reduction in the PASI score (PASI 50) and a 5‑point reduction in DLQI from when treatment started.
 | Around 17,300 people with plaque psoriasis who are eligible for biological treatments are eligible for treatment with ixekizumab. An estimated 1,700 people will have treatment with ixekizumab from year 2021/22 onwards.Ixekizumab is an additional biological treatment option for people with plaque psoriasis. This technology is supported by a resource impact template which requires the commercial in confidence discounted price of ixekizumab to be input into the template in order to estimate the resource impact.Commissioning: CCGs. Assess cost locally. |
| [TA443](https://www.nice.org.uk/guidance/ta443): Obeticholic acid for treating primary biliary cholangitis | Obeticholic acid is recommended, within its marketing authorisation, as an option for treating primary biliary cholangitis in combination with ursodeoxycholic acid for people whose disease has responded inadequately to ursodeoxycholic acid or as monotherapy for people who cannot tolerate ursodeoxycholic acid. Obeticholic acid is recommended only if the company provides it with the discount agreed in the patient access scheme.Assess the response to obeticholic acid after 12 months. Only continue if there is evidence of clinical benefit. | It is estimated that around 2,700 people with primary biliary cholangitis will be eligible for treatment with obeticholic acid each year. It is estimated that around 1,600 people will have obeticholic acid from year 5 onwards.The company has agreed a patient access scheme with the Department of Health. This scheme provides a simple discount to the list price of obeticholic acid, with the discount applied at the point of purchase or invoice. The level of the discount is commercial in confidence.Commissioning: NHS England. Assess cost locally.  |

***NICE guidance***

| **Title** | **Summary** | **Potential cost impact** |
| --- | --- | --- |
| [NG68](https://www.nice.org.uk/guidance/ng68): Sexually transmitted infections: condom distribution schemes**Noted by APC** | This guideline covers condom distribution schemes. The aim is to reduce the risk of sexually transmitted infections (STIs). In addition, these schemes can provide a good introduction to broader sexual and reproductive health services, especially for younger people, and help prevent unplanned pregnancies. | It is anticipated that this guideline will be cost saving where the recommendations are not current practice. Organisations are encouraged to evaluate their own practices against the recommendations in the NICE guideline and assess costs and savings locally using the local resource impact template.The guideline will be supported by a local resource impact template to allow organisations to assess costs at a local level. Commissioning: NHS England and local authorities. Assess costs locally.  |
| [CG61](https://www.nice.org.uk/guidance/cg61): Irritable bowel syndrome in adults: diagnosis and management (update)**Noted by APC** | Recommendation 1.1.1.2 updated in line with recent guidance on recognition and referral for suspected cancer.  | n/a |
| [CG100](https://www.nice.org.uk/guidance/cg100): Alcohol-use disorders: diagnosis and management of physical complications (update)**Noted by APC** | Recommendation 1.3.3.1 on use of corticosteroid treatment for people with severe alcohol-related hepatitis updated.  | No significant cost impact anticipated. Commissioning: CCGs.  |