Minutes of the meeting of the AREA PRESCRIBING COMMITTEE held on Wednesday 12th August 2015 in the Boardroom at Hillder House

MEMBERS:

Mr T Bisset	**Community Pharmacist (LPC)**
Dr M Ghani (Chair)	**Medical Director (Barnsley CCG)**
Ms S Hudson	**Lead Pharmacist (SWYPFT)**
Ms C Lawson	**Head of Medicines Optimisation (Barnsley CCG)**
Ms K Martin	**Head of Quality for Primary Care (Barnsley CCG)**
Dr A Munzar	**General Practitioner (LMC)**
Dr K Sands (up to item 15/144)	**Associate Medical Director (SWYPFT)**
Ms G Turrell	**Lead Pharmacist, Medicines Information (BHNFT)**
Joy Waldock	**Palliative Care Consultant, Barnsley Hospice**

ATTENDEES:

Ms N Brazier	**Administration Officer (Barnsley CCG)**
Ms D Cooke	**Lead Pharmacist (Barnsley CCG)**
Dr Mahdi (for item 15/143)	**Consultant Physician in Respiratory Medicine (BHNFT)**
Ms A Meer	**Specialist Interface Pharmacist (BHNFT)**

APOLOGIES:

Mrs C Applebee	**Medicines Management Pharmacist (Barnsley CCG)**
Dr R Jenkins	**Medical Director (BHNFT)**
Dr K Kapur	**Consultant Gastroenterology**
Dr J Maters	**General Practitioner (LMC)**
Mr M Smith	**Chief Pharmacist (BHNFT)**

ACTION

APC 15/133 DECLARATIONS OF INTEREST

Enclosure A1 was shared with the Committee. The letter from NHS England was seeking assurance from CCG Accountable Officers that appropriate systems and processes were in place to ensure that conflicts of interest or potential conflicts of interest were declared and mitigated.

The Head of Medicines Optimisation noted that currently declarations of interest are routinely submitted on an annual basis and it was acknowledged that members of the Committee would submit declarations to their own organisations. The Chair however asked if the Committee felt that additional procedures should be in place to provide a more robust process for APC members and those invited to attend APC meetings. The Chair felt that more than the register of interests should be in place to document pharma contact especially as decision makers and that this should apply to those that talk to the Committee and those that submit an application to the Committee in order to establish if there is any involvement or interest with the company.

The Lead Pharmacist, Barnsley CCG noted that the New Product

Application template form included a declarations of interest section but it was agreed that this needed to be given more prominence. It was noted that when applications were submitted to the Committee for new products, the company is not always known at the decision making stage and therefore a section would be included to document the manufacturer details. **DC** **DC**

It was acknowledged that members would come into contact with pharma representatives in their roles and various scenarios were discussed giving examples of when to declare an interest.

The APC acknowledged sight of the letter from NHS England and its contents and were able to provide assurance that a comprehensive review of systems and processes would be carried out to ensure compliance with all the requirements listed in the letter. All providers gave assurance to the Chair that they had policies in place for dealing with pharmaceutical companies.

It was agreed that the Head of Medicines Optimisation would liaise with Richard Walker, Head of Assurance, Barnsley CCG to confirm the necessary information expected to be recorded from members and others attending the meeting. This would be brought back to the Committee. **CL**

It was agreed that APC member declarations of interest would be updated and the Chair proposed, and it was agreed, to hold declared information on the register for 2 years from the date declared. **ALL**

It was agreed that up to date information would be obtained from Lynne Richards, Governance, Assurance & Engagement Facilitator for those signed up to the GP Federation in order to keep the register up to date. **NB**

APC 15/134 MINUTES OF THE PREVIOUS MEETING

The minutes of the meeting held on 8th July 2015 were agreed as an accurate record of the meeting.

APC 15/135 MATTERS ARISING AND APC ACTION PLAN

135.1 Magnesium Supplementation

The Lead Pharmacist, BHNFT informed the Committee that magnesium aspartate was on the Sheffield formulary. In terms of renal prescribing, a consultation was currently taking place and therefore there was no decision about switching to magnesium aspartate. The Lead Pharmacist, BHNFT would continue to follow this up and would report back in September 2015. **GT**

135.2 Guidelines for the treatment of nausea and vomiting in pregnancy

The Lead Pharmacist, BHNFT presented Enclosure C. The Committee accepted the guidelines.

It was agreed that an information sheet with key information extracted from the guidelines, relevant to primary care, would be produced and sent to LMC. **DC**

135.3 Rivaroxaban – Antiplatelet Guidance
Use of Aspirin in Primary Prevention

Following the last APC meeting, the Specialist Interface Pharmacist presented Enclosure D to clarify the use of aspirin in primary prevention. The 2 studies presented concluded that low dose aspirin should not be used as primary prevention as the risk of a bleed was too high.

The studies also showed that use of aspirin in diabetic patients should only be used in primary prevention if there was a high risk of a cardiovascular event, however the Chair and Associate Medical Director noted that it wasn't recommended to use aspirin in diabetic patients and this was stated the NICE guidance.

It was acknowledged that more information was available but the information presented was around the licensing and it was noted that the evidence for use of aspirin in primary prevention was not there.

Clarification for primary and secondary care around when aspirin should be used can be found in the diabetes guidelines and it was agreed that the relevant section would be included in the medicines management newsletter following the issue of the updated NICE guidance next month. The Community Pharmacist also felt this would be a useful article to include in the new pharmacy newsletter. **DC TB**

Rivaroxaban inclusion in Antiplatelet Guidance

Following the last APC meeting, the Specialist Interface Pharmacist updated the antiplatelet guidance to include rivaroxaban for acute coronary syndrome (ACS) in line with the NICE TA. The Specialist Interface Pharmacist informed the Committee that she has since come across conflicting evidence in the draft SIGN guidance for ACS which states that patients with ACS should not be offered rivaroxaban (or apixaban or dabigatran) in addition to dual antiplatelet therapy. It was noted that NICE still recommend its use but have indicated 3 times greater risk of a bleed.

The APC were asked if this should be included in the guidelines.

The Specialist Interface Pharmacist noted that no feedback had been received from the cardiologists with a decision following this evidence but would follow this up with them and provide feedback to the APC.

Following discussion, the APC agreed that as there was a NICE TA recommending its use, the guidance would be updated to include information on the increased risk of bleeding and the recommended duration of therapy. This would be reviewed following feedback from the cardiologist. **AM GT**

Post meeting note: It was agreed at the 9th September 2015 APC meeting to include in the guidance, as part of the bleed risk assessment, that any prescriber would be advised to contact their relevant medicines information team before they prescribe Rivaroxaban in ACS. **AM**

Action Plan – Other Areas

135.4 Fitness for Purpose

The Head of Medicines Optimisation has updated the communication plan with information from BHNFT. This was now with the Lead Pharmacist, BHNFT for approval. Once approved, the resource pack would be published. **GT/CL**

135.5 LHRH Analogues

The Head of Medicines Optimisation had met with the Contracting Team and noted that there was an issue with the service contract as the specification had not yet been finalised. The Head of Medicines Optimisation would follow this up. **CL**

135.6 Interface Group – D1s

The Head of Medicines Optimisation noted that responses had been received from all providers and she was in the process of populating the report. It was noted that initial action plans for providers were in place and work was ongoing and it was agreed that the report would be presented at the October 2015 meeting. **CL**

135.7 Implementation of antimicrobial stewardship

The Head of Medicines Optimisation noted that as part of the Antimicrobial Quality Premium and Antimicrobial CQUIN, all providers had agreed to share information around what activities they were undertaking in order to produce a joint report. SWYPFT had shared their Antibiotic Stewardship Action Plan but The Head of Medicines Optimisation was awaiting a submission from BHNFT. The Lead Pharmacist, BHNFT would follow this up. **GT**

135.8 Co-amoxiclav secondary care guidance

The Lead Pharmacist, BHNFT informed the Committee that BHNFT are using Define© data which looks at regional prescribing and has shown BHNFT as an outlier. Primary Care colleagues felt that they had been flagging this for some time but the issue hasn't yet been resolved in secondary care. It was agreed that the Lead Pharmacist, BHNFT would share the Define© data with the Chair who would follow this up with the Medical Director, BHNFT. **GT** **MG**

135.9 NICE TA339 and TA340

The Lead Pharmacist, BHNFT would confirm if these were applicable to BHNFT after their meeting on 13 August 2015. **GT**

Post meeting note: The Lead Pharmacist, BHNFT confirmed that both NICE TA339 and NICE TA340 are applicable to BHNFT.

APC 15/136 DISCHARGE LETTER AUDIT, BHNFT ACTION PLAN

The Committee received the action plan, produced by Pat McLaren in collaboration with the Medical Director, BHNFT. Unfortunately Pat McLaren was unable to attend the meeting to support this agenda item therefore the Chair asked The Lead Pharmacist, BHNFT if the action plan presented would provide assurance to the Governing Body that the next audit undertaken would provide better outcomes in terms of

correct information being provided on the D1's, particularly around medicines on admission and discharge and full completion of the medication section.

The Lead Pharmacist, BHNFT was only able to provide assurance about some of the plan areas as many were Trust wide issues. The Lead Pharmacist, BHNFT was able to confirm that lots of work streams were now in place to improve quality of medicines reconciliation and that she and the Interface Pharmacist had been involved with introducing new process changes (discharge changes, a new treatment chart including medicines reconciliation and updated policy) and as a result felt confident that these changes would provide better outcomes following a re-audit.

The Lead Pharmacist, BHNFT would take issues back to the Medical Director to provide the Chair with the assurance required that the action plan would improve results following a re-audit. **GT**

The Head of Quality for Primary Care noted that no end dates had been provided on the action plan and these would need to be specified. It was felt that this could be achieved quite easily in collaboration with the contracting team as issues would be discussed and actions closed down at the contracting meetings. This would provide assurance to the Chair of the Area Prescribing Committee and Quality & Patient Safety Committee. **GT**

The Lead Pharmacist, BNHFT would speak with Pat McLaren and the Medical Director, BHNFT about including the end dates and would send a revised action plan to the Chair, to then share with the Committee. **GT** **MG**

The Lead Pharmacist, BHNFT noted that lots of work had recently been undertaken with training the new junior doctors using the new D1 documentation and improvements had been seen.

The Head of Medicines Optimisation asked if it would be possible to see the system populated as agreed in previous meetings attended with BHNFT colleagues in order to confirm that what had been agreed in meetings with BHNFT and approved at the Membership Council was being implemented. The Lead Pharmacist, BNHFT would look into arranging this. **GT**

The Head of Quality for Primary Care asked that the revised action plan be shared with Brigid Reid, Chief Nurse, Barnsley CCG who was establishing a new Quality Board where progress against plans would be discussed. It would also be helpful if she was kept informed of APC discussions around the action plan. **NB**

In terms of timescales for the re-audit, the Lead Pharmacist, Barnsley CCG would need to assess capacity within the Medicines Management Team before confirming when a re-audit would take place. In the meantime, the Lead Pharmacist, BHNFT noted that internal spot checks would be undertaken. **DC**

Following a suggestion to use Pharm Outcomes to collect the data

when undertaking the re-audit, it was agreed that the Head of Medicines Optimisation. Barnsley CCG and the LPC representative would discuss this further outside of the meeting. **CL/TB**

APC 15/137 GUIDANCE ON UNLICENSED USE OF MEDICINES IN MENTAL HEALTH

The Lead Pharmacist, SWYPFT presented Enclosure G as requested by the Committee which listed the groups of drugs with reference to the evidence base.

Following feedback from the Committee, it was agreed that the guidance would be amended to include details at the front of the document explaining what Maudsley and Bazire are and how to access them. **SH**

The Lead Pharmacist, Barnsley CCG noted that given that a number of APC reports had been received previously for antipsychotics being used for acute psychosis, could this be included. SH agreed to include this for completeness. **SH**

It was agreed that the guidance would be sent to LMC. **SH**

Subject to the above amendments, the Committee accepted the guidance.

APC 15/138 SHARED CARE GUIDELINES

138.1 Shared Care Guidelines for Dermatology

The Lead Pharmacist, BHNFT had not yet met with the Dermatologists to endorse the guidelines, therefore it was agreed to bring the guidelines back to the October 2015 meeting. **GT**

138.2 Shared Care Guidelines for ADHD

The Lead Pharmacist, SWYPFT presented Enclosure H2 to highlight a change to the monitoring requirements. NICE guidance recommended that pulse and blood pressure be measured every 3 months. It was noted in the guidelines that the Adult ADHD service would check this at the 6 monthly appointment but GPs should measure in between i.e. twice a year. Due to the impact this would have on primary care, this needed to be highlighted in the letter to the GP and a prompt on Scriptswitch was also suggested. **DC**

The Committee approved the changes.

APC 15/139 NOAC ALERT CARD INITIATIVE

The Lead Pharmacist, SWYPFT shared the national template with the Committee and asked if the Committee were happy for orders to be placed.

It was agreed that the CCG, BHNFT and SWYPFT would order supplies of the NOAC alert cards with individual logos added. **DC/GT/ SH**

APC 15/140 DICLOFENAC USE WITHIN BHNFT

The Lead Pharmacist, BHNFT presented Enclosure J which showed that usage was going down but noted that diclofenac was still being

used in obstetrics and gynaecology. The Lead Pharmacist, BHNFT was to pick this up again with obstetrics and gynaecology and the Chair agreed to email the Medical Director, BHNFT to raise the APC's concern. **GT** **MG**

APC 15/141 SOLUBLE PREDNISOLONE QIPP DETAIL AID

The Lead Pharmacist, Barnsley CCG presented Enclosure K, Medicines Information QIPP Detail Aid which has been adapted to highlight how expensive soluble prednisolone tablets are.

It was noted that soluble tablets accounted for less than 5% of prednisolone prescriptions but 43% of the total spend on oral prednisolone and therefore it was to highlight that should soluble tablets be required then standard tablets can be prescribed and dispersed in water, even though it is off license.

It was clarified that the oral solution, 5mg/5ml could be prescribed for children as this was the more cost effective option.

The evidence was noted and the Lead Pharmacist, Barnsley CCG said that she had been in touch with Trent Medicines Information Service who had confirmed that they do follow this aid and have used it in children as well with no reported problems.

The Community Pharmacist raised some concerns with issuing standard tablets to be dispersed in water (in the community as opposed to being issued in the controlled environment of an Acute Trust). As this was national guidance, the Chair felt assured with the anecdotal evidence presented and known usage across the country, that we should endorse this and accepted that if individuals didn't wish to dispense then that was their professional responsibility/choice.

The Lead Pharmacist, BHNFT noted that the majority of Acute Trusts were following the aid and issuing standard tablets to be dissolved and noted that BHNFT were looking to endorse this.

APC 15/142 FORMULARY REVIEW

142.1 <u>CNS</u>

The Lead Pharmacist, Barnsley CCG took the Committee through the review highlighting changes to both the traffic light list and formulary.

- On page 2 – zolmitriptan to be added to the formulary with a green classification and add to the grey list the branded products on patent.

- On page 4 – capsaicin – add the patches to the grey list

Pages 7 onwards were presented for information only but the Committee were asked to highlight any issues.

It was noted that there was Ketamine guidance at the Hospice and Joy Waldock agreed to review the guidance to see if it was current. **JW**

The Committee accepted the formulary review.

142.2 Musculoskeletal

The Specialist Interface took the Committee through the review highlighting areas requiring clarification.

- Page 3, Hydroxychloroquine and Chloroquine: there was reference in the Shared Care guidance to use lean body weight opposed to actual body weight so this needed to be changed. **CA**
- Page 4 Ibuprofen gel: should read 5%. It was noted that in primary care it was more cost effective to prescribe Fenbid gel 100g and it was agreed that this would be added. **AM**

- Page 5, Piroxicam: it was agreed to give the oral preparation a grey classification on the traffic light list.

- The Lead Pharmacist, SWYPFT referred to page 5, Baclofen, and noted that Tizanidine (red classification) was occasionally used. It was agreed that this would be classified Amber G and the Lead Pharmacist, SWYPFT agreed to produce a supporting information sheet. **SH**

The Committee accepted the formulary review.

142.3 Eye

It was agreed that this would be deferred to the September 2015 meeting to allow for some of the queries highlighted being resolved. **AM**

APC 15/143 NEW PRODUCT APPLICATIONS

Following a lengthy discussion at the July 2015 meeting, it was felt that the Independent Reviews presented for the 3 applications would be taken back for additional information to be provided to fully inform the decision making process.

Additional information was provided in a tabled paper to the Committee showing the comparative advantages and disadvantages of the new LABA/LAMA inhalers: Ultibro Breezhaler®, Anoro Ellipta® and Duaklir Genuair® and Dr Mahdi was in attendance to support these applications.

Dr Mahdi noted that Sheffield had agreed for all 3 products to be added to their formulary and Dr Mahdi asked for all 3 products to be added to the Barnsley formulary for greater patient choice.

It was confirmed that these applications would not alter the information in the COPD algorithm and FEV1>50% LAMA/LABA would still be used first line.

The Committee discussed the information presented and agreed that the products were very similar but from the comparative evidence presented it was agreed that only Duaklir Genuair® would be added to the formulary. The Chair asked the Committee members present if they had any conflicts of interest with the manufacturer of Duaklir Genuair® before it was added to the formulary. There were no conflicts of interest declared.

Ultibro Breezhaler® and Anoro Ellipta® were rejected and this decision would be communicated to Dr Mahdi. These would be classified grey. **AM/GT**

It was agreed that the algorithm would be updated. **AM/GT**

APC 15/144 NEW PRODUCT APPLICATION LOG

There were no new product applications to note.

APC 15/145 BARNSLEYAPCREPORT@NHS.NET FEEDBACK

The report was received and noted by the Committee.

APC 15/146 NEW NICE TECHNOLOGY APPRAISALS – JULY 2015

It was agreed that these would be discussed at the September meeting. **GT/SH**

APC 15/147 FEEDBACK FROM THE MEDICINES MANAGEMENT GROUPS

126.1 Primary Care Quality & Cost Effective Prescribing Group

There were no issues to report.

126.2 BHNFT

There was nothing to report.

126.3 SWYPFT Drugs & Therapeutics Committee

No meeting had taken place therefore there was nothing to report.

APC 15/148 ISSUES FOR ESCALATION TO THE QUALITY & PATIENT SAFETY COMMITTEE

There were no issues to escalate to the Quality & Patient Safety Committee.

APC 15/149 HORIZON SCANNING DOCUMENT – JULY 2015

The Committee agreed to classify the new products as follows: -

Insulin glargine (biosimilar), 100 units/mL solution for injection in cartridge & pre-filled pen, (Abasaglar®▼, Eli Lilly) – **PROVISIONAL RED**

Naloxegol, 12.5 mg & 25 mg film-coated tablets, (Moventig®▼, AstraZeneca) – **PROVISIONAL RED - AWAITING FEEDBACK**

Tiotropium/olodaterol, 2.5 microgram/2.5 microgram inhalation solution, (Spiolto® Respimat®, Boehringer Ingelheim) - **PROVISIONAL GREY**

Pregabalin (generic), 25 mg, 50 mg, 75 mg, 100mg, 150 mg, 200 mg, 225 mg, 300 mg hard capsules, (Pregabalin Sandoz, Sandoz) – **already listed on the traffic light list**

Duloxetine (generic), 20 mg & 40 mg gastro-resistant capsules, (Duloxetine, Consilient) - **already listed on the traffic light list**

Colecalciferol, 2,740 IU per mL/200 IU per 3 drops oral solution, (Fultium-D3® Drops, Internis Pharmaceuticals) – **PROVISIONAL GREY**

Colecalciferol, 2,400 IU per mL/67 IU per drop oral solution, (Invita D3® oral drops, Consilient) - **PROVISIONAL GREY**

Amlodipine, 1 mg/mL & 2 mg/mL oral solution (Amlodipine, Rosemont Pharmaceuticals) **- already listed on the traffic light list**

Rivastigmine, 2 mg/mL oral solution (Rivastigmine Rosemont, Rosemont Pharmaceuticals) **- already listed on the traffic light list**
Tolvaptan, 15 mg, 30 mg, 45 mg, 60 mg & 90 mg tablets (Jinarc®▼, Otsuka Pharmaceuticals) **- already listed on the traffic light list**
Lenvatinib, 4 mg & 10 mg hard capsules (Lenvima®▼, Eisai) – **PROVISIONAL RED**
Somatropin, 15 mg/1.5 mL solution for injection cartridges (Omnitrope SurePal® 15, Sandoz) - **already listed on the traffic light list**
Follitropin alfa, 75 IU/0.125 mL, 150 IU/0.25 mL, 225 IU/0.375 mL, 300IU/ 0.50 mL & 450 IU/0.75 mL solution for injection (Bemfola®, Finox Biotech) – **PROVISIONAL RED**
Raloxifene (generic), 60 mg film-coated tablets (Raloxifene, Actavis) - **already listed on the traffic light list**
Temozolomide, 5 mg, 20 mg, 100 mg, 140 mg, 180 mg & 250 mg hard capsules (Temozolomide Accord, Accord) - **already listed on the traffic light list**
Nivolumab,10 mg/mL concentrate for solution for infusion (Opdivo®, BMS) – **PROVISIONAL RED**

APC 15/150 MHRA DRUG SAFETY UPDATE – JULY 2015

The Committee received and noted the July 2015 MHRA Drug Safety Update which included advice for medicines users summarised below: -

1 Denosumab (Xgeva▼, Prolia); intravenous bisphosphonates: osteonecrosis of the jaw - further measures to minimise risk
Patient reminder cards about the risk of osteonecrosis of the jaw are being introduced; denosumab 120 mg is now contraindicated in patients with unhealed lesions from dental or oral surgery.

2 Latanoprost (Xalatan): increased reporting of eye irritation since reformulation
Advise patients to tell their health professional if they experience severe eye irritation.

APC 15/151 SOUTH YORKSHIRE AREA PRESCRIBING COMMITTEE MINUTES

The minutes from NHS Rotherham CCG (13 May 2015), NHS Sheffield CCG (21 May 2015) and NHS Doncaster & Bassetlaw CCG (25 June 2015) Area Prescribing Committee meetings were received and noted.

APC 15/152 ANY OTHER BUSINESS

152.1 NHS England Guidance for Hepatitis C

The Lead Pharmacist, BHNFT informed the Committee that NHS England had produced guidance for the Treatment of Chronic Hepatitis C in patients with Cirrhosis. The APC were asked if this would go onto the formulary given that there was currently no NICE TA.

Sheffield's position was not yet known therefore it was agreed to bring the guidance to the next Committee. This would be classified red but it was noted that BHNFT would have to supply the drugs (red classification) should any prescriptions be received in the meantime. **GS**

152.2 Flu Vaccine

The Community Pharmacist noted that discrepancies had been identified with the number of flu vaccines given out and the number

reported from GP surgeries particularly around midwifery services and wanted to make practices aware.

152.3 APC Terms of Reference

The Head of Medicines Optimisation noted that the APC Terms of Reference went to the August 2015 Quality & Patient Safety Committee meeting. Minor amendments were made to the membership section and these would be brought back to the next meeting for information. **CL**

APC 15/153 DATE AND TIME OF THE NEXT MEETING

The time and date of the next meeting was confirmed as Wednesday, 9th September 2015 at 12.30 pm in the Boardroom, Hillder House.