Minutes of the meeting of the AREA PRESCRIBING COMMITTEE held on Wednesday 15th April 2015 in the Boardroom at Hillder House

MEMBERS:

Dr M Ghani (Chair)	**Medical Director (Barnsley CCG)**
Ms C Lawson	**Head of Medicines Optimisation (Barnsley CCG)**
Ms K Martin	**Deputy Chief Nurse (Barnsley CCG)**
Mr M Smith	**Chief Pharmacist (BHNFT)**
Mrs S Hudson	**Lead Pharmacist (SWYPFT)**
Dr K Sands	**Associate Medical Director (SWYPFT)**
Dr J Maters	**General Practitioner (LMC)**
Dr A Munzar	**General Practitioner (LMC)**

ATTENDEES:

Mrs C Applebee	**Medicines Management Pharmacist (Barnsley CCG)**
Mr R Staniforth	**Lead Pharmacist (Barnsley CCG)**
Ms D Cooke	**Lead Pharmacist (Barnsley CCG)**
Ms Amina Meer	**Medicines Information Pharmacist (BHNFT)**
Miss Nicola Brazier	**Administration Officer (Barnsley CCG)**

APOLOGIES:

Dr R Hirst	**Palliative Care Consultant (Barnsley Hospice)**
Dr R Jenkins	**Medical Director (BHNFT)**
Ms G Smith	**Specialist Interface Pharmacist (BHNFT)**
Mr T Bisset	**Community Pharmacist (LPC)**

ACTION

APC 15/53 DECLARATIONS OF INTEREST

No declarations of interest were received.

APC 15/54 MINUTES OF THE PREVIOUS MEETINGS

The minutes of the meeting held on 11th March 2015 were agreed as an accurate record.

Actions from the previous meeting were checked and the following feedback was given on outstanding actions: -

39.1 Methotrexate Injections

Mike Smith to provide an update to Karen Martin before the beginning of May to take to the next Quality & Performance meeting. **MS**

51.1 Bridging Protocols

Mike Smith noted that this issue had been escalated internally and confirmed that this had been discussed at the VT Committee where it was confirmed that the activity would stay within the surgical CBU where it currently sits. This issue would also be discussed at the next BHNFT Medicines Committee meeting for complete clarity on where the bridging patients sit

and where the service is delivered from.

Dr Maters asked if there was any guidance available for bridging before the patient goes into hospital and Mike Smith agreed to circulate the Trusts bridging protocol to members which was welcomed by the Committee. **MS**

Deborah Cooke noted that 3 examples had been found at the practice that had raised this issue at the LMC and Deborah agreed to pass these to Mike Smith. **DC**

Richard Staniforth noted that the LMC had requested a contact name within the Trust to raise any future issues. **MS**

APC 15/55 MATTERS ARISING AND APC ACTION PLAN

55.1 Dexamethasone Injection

This item was deferred to the next meeting.

55.2 Testosterone Shared Care Guideline Re-audit in Primary Care

Richard Staniforth noted that the original number of 63 outstanding shared care agreements had reduced to 62. It was confirmed that 49 of the 62 shared care agreements had been returned to Endocrinology signed by both specialist and GP with 13 outstanding.

It was agreed that the 13 outstanding would be taken out to practices by members of the Medicines Management Team to avoid postage delays/issues to ensure that all 62 shared care agreements were returned before the next APC meeting. **RS**

It was confirmed that the fax machine within the Endocrinology Department was working and receiving faxes.

55.3 Inflammatory Bowel Disease Shared Care Guideline

This item was deferred to the next meeting but Deborah Cooke understood that following the agreement to incorporate mycophenolate into the shared care guideline that the hospital would not be asking GPs to pick up prescribing until the monitoring information within the guideline had been clarified. This was agreed.

55.4 Review on inhaled corticosteroids and pneumonia risk

Dr Maters raised at the March APC meeting that based on Canadian population studies there was a suggestion that beclomethasone and budesonide were safer steroids than fluticasone in relation to pneumonia risk.

Amina Meer presented papers that provided different evidence around the risk. Enclosure B2 showed no increased risk. Enclosure B3 which was a more recent study showed fluticasone to have high incidents of pneumonia compared with budesonide and beclomethasone in COPD and asthma.

Following discussion, it was agreed that as there had been no change to national guidelines, no further action would be taken at this time.

55.5 Asthma guidance for practice nurses

Caron Applebee confirmed that the guidance had been circulated to the practice nurses with a request for comments by the end of April. No comments had yet been received. Karen Martin suggested that Caron Applebee also make contact with Andrea Parkin, the new Advanced Nurse Practitioner.

55.6 Action Plan – Other areas

55.6.1 Interface Group – D1s

Richard Staniforth talked to Enclosure C2, the Medicines Interface Action Plan which had updated timeframes. He confirmed that the questionnaire would be issued to the virtual network in the next few weeks in line with the new dates in the plan, with the report of summarised responses being complete for the June APC meeting. **RS**

Mike Smith asked if colleagues were aware of any meetings taking place outside of the virtual network to discuss the content of D1's. Dr Ghani confirmed that Dr Kapur and Dr John Harban had met to go through and to streamline the content of the D1, which is used as an aid to assist primary care GPs to manage patients when they present in practice.

Mike Smith noted the work was underway in pharmacy to establish where the processing delays occurred in the pathway.

It was felt by GP members present that the quality of the letters being received from the hospital had significantly deteriorated since the audit had been undertaken. Dr Ghani agreed and noted that this was to be picked up on the action plan being produced at BHNFT. Mike Smith confirmed that Chris Hunton was leading on producing a Trust action plan and Dr Ghani wanted to chase this up. Mike Smith confirmed that an update should be obtained through Chris Hunton with Richard Staniforth, Dr Kapur and Mike Smith being included in communications. **MG**

Amina Meer informed the Committee that she has attended meetings with communication and pharmacy representatives to produce supporting documents for junior doctors about how to appropriately write the D1 with the required information to inform GPs. It was noted that no BHNFT doctors were members of this group and it was agreed that junior doctors' actions were a key part of the discussions.
Mike Smith noted that he had asked Chris Hunton to link with the work being undertaken by Richard Staniforth and Dr Kapur.

Richard Staniforth stated that Dr Gupta attended the recent LMC as the consultant representative and noted that he was not aware of the D1 audit. Dr Gupta indicated that the Consultant Body would like to be involved and agreed to raise this with his Medical Director.

Mike Smith noted that they were currently working on an electronic version of the immediate discharge letter. It was stressed that the importance of completing the D1 needed to be communicated to the junior doctors.

It was noted that the action plan would come back to the next meeting

and would also be discussed at the Governing Body meeting.

55.6.2 Continence Service Audit

Sarah Hudson confirmed that the audit had been carried out and the information would be presented to the May APC meeting. **SH**

APC 15/56 NOACS

Deborah Cooke reminded the Committee that this issue was originally brought to the APC following feedback that cardiologists occasionally wanted to use a different order of therapy to the guidance, where Apixaban was positioned first line. Since then NICE have produced some guidance on TA's and formularies which was presented at Enclosure N2.

Deborah Cooke referred to question 2 of the frequently asked questions relating to local formularies where it states that …"if there is more than one NICE approved medicine for the condition, providers and commissioners must not recommend that any one of them are used routinely in preference to the others (unless an order of preference is stated in the TAs or HSTs). Providers or commissioners can suggest to healthcare professionals that a particular medicine is preferred locally. However this local recommendation must only be taken into account after a patient and prescriber have discussed all treatment options and only if they have no preference about which medicine they want to use…"

Following a lengthy discussion, it was agreed that the algorithm at Enclosure D2 would be reviewed at the next meeting to provide evidence base behind all 3 therapies (Dabigatran, Apixaban and Rivaroxaban). A decision would then be made about amendments to the policy/preferred statement around suggested order of therapy in line with the NICE guidance at Enclosure N2.

APC 15/57 PRIMARY CARE ASSESSMENT OF SUSPECTED DEEP VEIN THROMBOSIS PATHWAY

Chris Lawson was seeking endorsement from the Committee for the Primary Care Assessment of Suspected Deep Vein Thrombosis Pathway. Chris noted that the pathway was based on the current Rotherham pathway and has been ratified by the VTE Committee at BHNFT, Unplanned Care Programme Board and Governing Body and has been developed to support primary care processes in undertaking a comprehensive initial assessment, Wells score and near patient D-dimer test for suspected DVT at the GP surgery, therefore allowing early exclusion of DVT (VTE) in a primary care setting. If patients are at significant risk of DVT but are unable to get a scan in less than 4 hours in line with NICE guidance, then managing them with a Newer Oral Anticoagulant (NOAC) or Low Molecular Weight Heparin (LMWH) is in line with NICE guidance. The interim management is there until the scan is available and the aim is to reduce the number of referrals which could in turn create better access to scan appointments.

Chris Lawson noted that it was not envisaged that there would be a large increase in primary care patients being treated as the majority will get scanned but there will be a few given a dose of a NOAC and more

rarely less treated with LMWH.

Dr Ghani asked the Committee for comments with a focus on the prescribing aspect.

Chris Lawson acknowledged that NICE are increasingly issuing guidance within supplementary frequently asked questions which supports the use of many therapies and it was noted that we must be mindful of this in terms of what the Committee are recommending. In line with this it was noted that the exclusive reference to using Rivaroxaban in this pathway needed to be reviewed. **CL**

Following feedback to have an electronic template available, Chris Lawson noted that an electronic template was being developed and would be issued when this is launched.

It was agreed to look at the traffic light status for NOACs when this is launched.

APC 15/58 MEDICATION FOR THE MANAGEMENT OF DEPRESSION IN ADULTS IN PRIMARY CARE

Sarah Hudson presented the updated guidelines which had been circulated to consultants. Minor changes had been made. The Committee approved the guidelines and it was agreed that these would be sent out to primary care with the APC memo. The Committee endorsed the change in the traffic light classification of escitalopram tablets from grey to green. **CA/DC**

APC 15/59 PRIMARY CARE ANTIMICROBIAL TREATMENT GUIDELINE

Deborah Cooke presented Enclosure G1 which had been updated in line with Public Health England guidance. The guideline had been circulated for comments and comments received had been incorporated. The guideline is to be used as an electronic document which contains hyperlinks to navigate through the content. It was suggested that this be made clearer on the front page to avoid printing and Deborah Cooke agreed to feed this back. **DC**

Dr Ghani had a query regarding Acute Bronchitis, consider 7 days delayed antibiotic with symptomatic advice/leaflet. This was felt to be in line with Public Health England guidance but Deborah Cooke agreed to check and confirm this with Dr Pang. **DC**

Karen Martin highlighted the link to the Quality Premium Scheme 2015/16 which is intended to reward Clinical Commissioning Groups (CCGs) for improvements in the quality of the services that they commission and for associated improvements in health outcomes and reducing inequalities. One of the key targets is improving antibiotic prescribing in primary and secondary care**.**

Chris Lawson noted that the scoring points within the antibiotic section of the Medicines Optimisation Scheme have been increased as a result of the quality target.

Deborah Cooke noted that as part of the Medicines Optimisation

Scheme, practices have been asked to develop a protocol for the use of back up prescriptions and a resource pack is being produced. Copies of the target information leaflet are also being printed in tear off pads and these will be distributed to GPs and pharmacies. It was requested that an electronic version of the leaflet be made available to GPs.

Dr Ghani added that inappropriate use of antibiotics can be reported through the Barnsley APC reporting mechanism.

Subject to clarification around Dr Ghani's query above, the Committee approved the guideline and it was agreed that this would be circulated for use in primary care and also circulated more widely with the APC memo to increase awareness of the guideline. **DC/CA**

APC 15/60 FITNESS FOR PURPOSE

Chris Lawson presented the resource pack which describes the Committees governance and communication processes. This was circulated at the end of 2014 for feedback particularly around the Guidelines for Clinical and Prescribing Responsibility which clearly identified the criteria around the Committees decision making processes. Chris noted that the communication map was almost complete but was still awaiting feedback form BHNFT and Barnsley Hospice. **GS/RV**

Mike Smith asked for a further week to obtain additional comments from colleagues. **MS**

It was agreed that the terms of reference would be reviewed separately at the May meeting.

Subject to any further comments from Mike Smith, the Committee were happy to endorse the resource pack which would be publicised to primary care practices. **CL**

APC 15/61 SHARED CARE

61.1 <u>ADHD shared care guideline (lisdexamfetamine license extension)</u>

Sarah Hudson informed the Committee that this had been updated to record that lisdexamfetamine now has a license for use in adults.

Following clarification being sought around the dose information also including the frequency information, the Committee accepted the guideline. **SH**

With regards to private prescribers of ADHD, Sarah Hudson noted that SWYPFT had issued some guidance around receiving patients who had previously referred themselves to private prescribers. This stated that they would not pick up treatments recommended by someone else, and that any patient received would start the treatment pathway again with an assessment.

61.2 <u>Shared Care Guideline for the use anticonvulsants as mood stabilisers</u>

Sarah Hudson presented the guidelines for approval. An error was identified in the monitoring section and Sarah Hudson agreed to insert **SH**

the correct information.

Further to this amendment, the guidelines were approved by the Committee.

61.3 Nalmefene shared care guideline for treatment of alcohol use disorders without physical dependency

Sarah Hudson presented the guideline with a treatment algorithm at Enclosure J2.

Following discussion, it was agreed that a mechanism should be in place to ensure patients referred by Phoenix Futures for counselling are monitored to ensure they are engaging with the counselling sessions, with the condition that if non-attendance at sessions then prescriptions would be not be issued.

Chris Lawson highlighted that as reference was made on the algorithm to LDQ then it needed to be referenced in the shared care guideline to link the documents together. **SH**

Dr Ghani asked for it to be made clear what was required from GPs. **SH**

Deborah Cooke referred back to when Nalmefene was originally classified by the Committee. It was classified as Amber G with supporting information and it was therefore agreed that the shared care guideline was not required but the supporting information, algorithm and questionnaire with the links noted above was required.

Caron Applebee suggested creating a template for the supporting information sheet and agreed to pick up with action. **CA**

The revised information would be brought back to the next meeting. **SH**

61.4 Request for new shared care agreement for patients transferred to new GP Practice

The Committee accepted the form to be completed for patients taking a shared care drug who have recently registered with a new GP and this would be sent out to primary care. **CA**

APC 15/62 CABERGOLINE TRAFFIC LIGHT CLASSIFICATION FOR HYPERPROLACTINAEMIA

Deborah Cooke raised a query that Gillian Smith had received from Professor Jones where GP practices were requesting shared care guidelines for Cabergoline for Hyperprolactinaemia.

Deborah Cooke noted that Cabergoline is included as a primary care specialist drug service as it was Amber for Parkinson's Disease and was part of that shared care guideline but was not on the traffic light system for this indication so sought clarity from the Committee about where this should sit.

Deborah Cooke informed the Committee that Professor Jones felt that a shared care guideline was not needed as there was no evidence of valvular problems at this lower dose. The Committee agreed that this

should be given a classification Amber G with an information sheet endorsed by Professor Jones. This would come back to the APC meeting. **DC**

APC 15/63 QUALITY FIRST: MANAGING WORKLOAD TO DELIVER SAFE PATIENT CARE

Chris Lawson presented Enclosure L for information and awareness.

A discussion took place and it was acknowledged that the APC are mindful of the pressures on primary care when they make decisions.

Sarah Hudson noted the difficulties encountered by SWYFT clinicians and patients when GP practices took a blanket decision to decline all requests to prescribe medicines for any "off-label" indications, treating these requests as if they were for "unlicensed" medicines.

APC 15/64 NEW PRODUCT APPLICATIONS

Deborah Cooke noted that one new product application had been received for Naloxone. Signatures were currently being obtained.

APC 15/65 BARNSLEYAPCREPORT@NHS.NET FEEDBACK

The Committee noted the report.

APC 15/66 NEW NICE TECHNOLOGY APPRAISALS – MARCH 2015

66.1 The NICE TA's published in March 2015 were discussed and the following was agreed: -

TA335 (Rivaroxaban for preventing adverse outcomes after acute management of acute coronary syndrome) was relevant for use and Deborah Cooke asked Amina Meer to include this in the antiplatelet guidance. The Committee classified this as Red until it was included in the guidance. **AM**

TA336 (Empagliflozin in combination therapy for treating type 2 diabetes) was relevant for use and it was agreed to be classified as Amber G and included in the Amber G guidance. **CA**

TA337 (Rifaximin for preventing episodes of overt hepatic encephalopathy) was already on the formulary (Amber).

TA338 (Pomalidomide for relapsed and refractory multiple myeloma previously treated with lenalidomide and bortezomib) was not recommended.

Post meeting note*: Pomalidomide has been added to the grey list as NICE TA 338 does not recommend its use.*

Chris Lawson noted that work was underway to review all the medicine areas included within the local Diabetes Guidelines and that Dr Sands would be working with the medicines management team to look at updating the diabetes guidance due to the increased number of approved new drugs since the guidance was issued a year ago.

66.2 Feedback from BHNFT Clinical Guidelines and Policy Group
Mike Smith noted that the February and March NICE TAs were being processed and had been sent to designated leads for comment.

66.3 Feedback from SWYFT NICE Group
Nothing to report back.

APC 15/67 FEEDBACK FROM THE MEDICINES MANAGEMENT GROUPS

67.1 BHNFT
Nothing to report back.

67.2 SWYFT NICE Group
Nothing to report back.

APC 15/68 ISSUES FOR ESCALATION TO THE QUALITY & PATIENT SAFETY COMMITTEE

The Committee agreed to escalate Testosterone Shared Care and Antimicrobial Guidelines to the Quality & Patient Safety Committee. **CL/RS**

APC 15/69 HORIZON SCANNING DOCUMENT – MARCH 2015

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

Infliximab (biosimilar) - 100 mg powder for concentrate for solution for infusion, (Remsima®▼, Napp Pharmaceuticals) – **PROVISIONAL RED**
Infliximab (biosimilar) - 100 mg powder for concentrate for solution for infusion , (Inflectra®▼, Hospira) – **PROVISIONAL RED**
Secukinumab - 150 mg solution for injection in pre-filled pen or syringe (Cosentyx®▼, Novartis) – **PROVISIONAL RED**
Insulin lispro - 200 units/mL solution for injection in pre-filled pen (Humalog®, Eli Lilly) – **PROVISIONAL RED** DUE TO DIFFERENT CONCENTRATION WHICH MAY RESULT IN ERRORS IN PRESCRIBING

The remaining products are already listed on the Barnsley Traffic Light list (by their generic name): -

Pregabalin (generic) - 25 mg, 50 mg, 75 mg, 100mg, 150 mg, 200 mg, 225 mg & 300 mg hard capsules, (Lecaent®, Actavis)
Pregabalin (generic) - 25 mg, 50 mg, 75 mg, 100mg, 150 mg, 200 mg, 225 mg & 300 mg hard capsules, (Rewisca®, Consilient)
Pirfenidone - 267 mg hard capsules, (Esbriet®▼, Roche)
Eplerenone (generic) - 25 mg & 50 mg film-coated tablets (Eplerenone, Zentiva)
Diclofenac/misoprostol - 50 mg/200 micrograms & 75mg/200 micrograms, (Masidemen®, Actavis)
Latanoprost/timolol (generic) - 50 micrograms/mL + 5 mg/mL eye drops (Latanoprost/timolol, FDC International)
Tacrolimus - 0.75 mg, 1 mg & 4 mg prolonged-release tablets (Envarsus®, Chiesi)
Mesalazine - 4g prolonged-release oral granules, (Pentasa®, Ferring Pharmaceuticals)
Mitoxantrone - 2 mg/mL concentrate for solution for infusion (Mitoxantrone, Accord)
Sevelamer carbonate (generic) - 800 mg film-coated tablets

(Sevelamer carbonate Consilient)
Methylphenidate - 18 mg prolonged-release tablets (Matoride XL®, Sandoz)
Paracetamol - 60mg,125mg, 250mg suppositories, (Alvedon®, Intrapharm Laboratories Limited)
Prednislolone acetate - 2.5mg, 5mg, 10mg, 20mg, 25mg tablets (Pevanti, Amdipharm Mercury Company Limited)

Mike Smith raised the issue of the approach to the agreement being reviewied in respect the Infliximab (biosimilar) and the cost pressures being faced. Chris Lawson noted that she was due to attend a regional meeting about biosimilar products and it was agreed that Chris Lawson and Mike Smith would discuss this outside of the APC meeting.

Dr Sands noted that the introduction of insulins at various concentrations was increasing and it was felt that this should be discussed at a future APC meeting. In the meantime Deborah Cooke agreed to check that prompts were on Scriptswitch about the concentration levels being selected to prevent prescribing errors. **DC**

Sarah Hudson noted that some internal discussions at SWYFT would be taking place about a different branded generic of Methylphenidate. **SH**

It was clarified that this new brand would not be added to the traffic light list until feedback was received.

APC 15/70 MHRA DRUG SAFETY UPDATE – MARCH 2015

The Committee received and noted the March 2015 MHRA Drug Safety Update. Deborah Cooke drew attention to the following warning: -

- Dimethyl fumarate (Tecfidera®): fatal PML in an MS patient with severe, prolonged lymphopenia

  Check full blood counts (including lymphocytes) before prescribing dimethyl fumarate and then every 6 to 12 months. Stop treatment immediately if you suspect progressive multifocal leukoencephalopathy.

Dr Ghani had received a request to prescribe this which was red on our system (specialist only). Deborah Cooke agreed to check this. **DC**

***Post meeting note**: Dimethyl fumarate has previously been classified as a non formulary grey drug. NHS England states that it is only available within certain trusts through patient access schemes. As such this drug is not available at BHNFT, but can be prescribed by Specialists at Sheffield Teaching Hospitals. The traffic light classification has been changed to provisional red to reflect that it should only be prescribed by specialists.*

APC 15/71 SOUTH YORKSHIRE AREA PRESCRIBING COMMITTEE MINUTES

The minutes from the South Yorkshire Area Prescribing Committee meetings were received and noted.

Chris Lawson noted that NHS Sheffield CCG had made reference to

the Barnsley CCG generic prescribing statement but noted that they had somehow linked it to prescribing of Pregabalin in error. Chris Lawson would alert NHS Sheffield to this. **CL**

APC 15/72 ANY OTHER BUSINESS

72.1 Community Pharmacy Dispensing

Chris Lawson highlighted one incident where community pharmacy had dispensed a Spiromax inhaler for a generic Turbohaler. As this is a different device, this therefore has an impact on patients as they would require training. Chris Lawson sought approval from the Committee to issue a statement asking community pharmacies, when they receive a generic Turbohaler prescription, to check with the patient what they are receiving before they issue a Spiromax inhaler.

The Committee were happy for Chris to produce and issue a statement. **CL**

APC 15/73 DATE AND TIME OF THE NEXT MEETING

Wednesday, 13 May 2015 at 12.30 pm in the Boardroom, Hillder House.