Nottinghamshire Area Prescribing Committee

Minutes of the meeting held on Thursday 18th January at 2:00pm Room A01, Duncan MacMillan House, Porchester Road, Nottingham, NG3 6AA

All attendees should be aware that public authorities are legally required to comply with the Freedom of Information Act 2000. The minutes and papers from this meeting could be published on the Publication Scheme or internet with all names included, unless notified to the Chair before the meeting commences or included in a pre-agreed confidential section due to the sensitive nature of the topic.

Present:

Steve May (SM) Chair	Chief Pharmacist	Sherwood Forest Hospitals NHS Foundation Trust
Khalid Butt (KB)	GP	LMC representative
Jenny Moss-Langfield (JML)	GP	LMC representative
Tanya Berendt (TB)	Deputy AD Medicines Management	NHS Nottingham City CCG
David Wicks	GP Prescribing Lead	Representing Mid-Notts CCGs
Judith Gregory (JG)	Assistant Head of Pharmacy	Nottingham University Hospitals NHS Trust
Esther Gladman (EG)	GP Prescribing Lead	NHS Nottingham City CCG
Laura Catt (LC)	Prescribing Interface Advisor	Representing County CCGs
Paramjit Panesar (PP)	GP	Representing Greater Notts CCGs
Matthew Prior (MP)	Chief Pharmacist	Nottingham Treatment Centre
Matt Elswood (ME)	Chief Pharmacist	Nottinghamshire Healthcare Trust

In attendance:

Nick Sherwood (NS), Mental Health Efficiencies Pharmacist, Greater Notts CCGs (for Item 4 only)
Jill Theobald (JT), Interface Efficiencies Pharmacist, Greater Notts CCGs
Lynne Kennell (LK), Specialist Interface and Formulary Pharmacist, Sherwood Forest Hospitals NHS Foundation Trust

Apologies:

Sachin Jadhav (SJ), Chair NUH Drug and Therapeutics Committee, Nottingham University Hospitals NHS Trust
Amanda Roberts (AR), Patient representative
Sarah Northeast (SN), Advanced Nurse Practitioner CityCare
Ankish Patel (AP) Community Pharmacist Local Pharmaceutical Committee
David Kellock (DK), Chair SFH Drug and Therapeutics Committee, Sherwood Forest Hospitals NHS Foundation Trust
Irina Varlan (IV), Specialist Interface & Formulary Pharmacist, Nottingham University Hospitals NHS Trust

1. **Apologies**

Noted

2. **Declarations of interest**

ME declared that a family member was receiving treatment with ferric maltol. He did not participate in discussions surrounding item 12b.

3. **Minutes of the last meeting/matters arising**

The minutes from the previous meeting were reviewed and agreed as being accurate.

Adult ADHD Shared Care Protocol

No further update.

Action: NottsHC trust to provide update at March meeting

Colesevelam – Bile Acid Malabsorption

LK had circulated the proposed criteria for colesevelam treatment via email and had received one response which was in agreement with the suggested points. Gastroenterologists had been invited to the meeting as requested previously, but were unavailable for attendance in person. After discussion it was felt that there were clinical questions that remained and that a face to face discussion with a clinician was required.

Action: LK to bring back papers and invite gastroenterologist to JFG/ APC meeting

4. **New Greater Nottingham Interface Efficiencies Pharmacists**

JT and NS introduced themselves to the committee and outlined their new roles.

5. **FOR RATIFICATION – Restless legs treatment algorithm (Update)**

The restless legs treatment algorithm had been updated due to it reaching its review date. Changes included increasing the threshold for iron treatment, addition of a warning regarding augmentation with dopamine agonists and the addition of rotigotine, pregabalin, gabapentin and codeine as treatment options.

It was highlighted that some of the medications now listed in the guideline are not currently on the formulary for this indication.

Action: Formulary treatment options for restless legs to be reviewed at JFG

6. **FOR RATIFICATION – Antimicrobial guidelines (Interim Update)**

The Antimicrobial Prescribing Guidelines for Primary Care had been updated due to the publication of updated NHS England guidance. The updated guideline was ratified.

It was highlighted that due to supply problems with mupirocin nasal ointment, the MRSA decolonisation section may require amendment as Octenisan nasal gel is now in use in the acute trusts for patients unable to use Naseptin cream due to peanut allergy.

Actions: IV to confirm suitability of Octenisan Nasal Gel for use in Primary Care with Infection control
IV to finalise guideline and upload to APC website.
IV to produce bulletin summarising changes for distribution to primary care

7. FOR RATIFICATION - Inflammatory Bowel Disease, Azathioprine and mercaptopurine information sheets (update)

The information sheets that support the Inflammatory Bowel Disease Shared Care Protocol had been reviewed and minimal updates made. The clinical relevance of some of the interactions listed had been questioned by clinicians so require further research.

Subject to the correction of typographical errors the documents were ratified by the committee.

Action: LC to research interactions and reconsider the need for their inclusion
LC to finalise documents and upload to APC website.

8. FOR RATIFICATION- Apomorphine prescribing information sheet and Parkinsons' Disease SCP (Update)

The SCP for apomorphine had been updated in line with NICE NG71 and additional safety information regarding domperidone had been added. The updated document was ratified subject to the confirmation of current pricing and the correction of typographical errors.

Actions: LC to check pricing and finalise document for uploading to APC website.

9. FOR DISCUSSION – Omega 3 for hypertriglycerideamia

Omega 3 fatty acids are classified as Amber 3 for hypertriglyceridaemia for use in line with a local guideline. NHS England have recently published a document detailing medications that are not recommended to be prescribed in primary care and omega 3 fatty acids are included in this. However it is understood that this recommendation is based on the NICE do not do recommendations for cardiovascular disease and it is unclear whether the hypertriglyceridaemia indication has been considered. Specialists have indicated a desire for continued use locally and the committee was requested to consider how this should be managed. TB had queried the use in hypertriglyceridaemia with NHSE and NICE but hadn't gained any further clarity. Other areas locally were keeping access to Omega 3 for this indication. After discussion it was concluded that use of Omega 3 fatty acids for the treatment of hypertiglyceridaemia was accepted as long as the defined criteria was satisfied regarding triglyceride levels and risk factors for pancreatitis. However it was requested that lipidologist opinion be sought regarding the potential consequences of raising the threshold for treatment

to TG levels > 10. It was felt that the NHS England guidance offered an opportunity to ensure that current primary care prescribing is reviewed and that de-prescribing occurs for indications other than hypertriglyceridaemia.

ME informed the committee that there is use within his trust of omega 3 fatty acids for the treatment of refractory schizophrenia which similarly is not covered by the NHS England guidance.

Actions: TB to discuss with lipidologists clinical consequences if treatment threshold was raised to TG levels>10.

10. FOR DICUSSION – Prescribing Policy (Update)

LC presented an updated Prescribing Policy which is used in Provider contracts. Amendments included a set duration of medication at discharge of at least 10 days and the home oxygen section had been updated following advice from specialist teams.

It was questioned whether a similar document exists regarding expectations of primary care and it was suggested that specific problems are fed into the interface team. The relevance of inclusion of information regarding private providers was questioned, but it was agreed that this should be incorporated into this policy rather than creating a separate document as a point of reference.

Actions: LC to make suggested amendments and recirculate to members for comments
JG to take to NUH DTC

11. Formulary amendments and horizon scanning

All suggested amendments were accepted with the exception of LBF barrier cream. A barrier cream formulary is in development and it was unclear whether this preparation will be included.

Actions: Interface team to ascertain whether LBF cream will be included in the barrier cream formulary
Interface team to update formulary

12. NEW SUBMISSIONS

a) Trimbow® (Formoterol fumarate, beclometasone dipropionate and glycopyrronium bromide, Chiesi ltd) for COPD patients

A formulary submission for Trimbow had been discussed at the JFG. Evidence suggested that it was non inferior to formoterol/ beclomethasone plus tiotropium and it offered a cost saving when compared to these medications being given via separate inhalers. The JFG had expressed some concerns regarding inappropriate use of triple therapy being encouraged, but it was felt that for appropriate patients it may offer cost and compliance benefits. Opinion of respiratory specialists involved in the local COPD guideline had been sought and views received so far echoed concerns over the use of the triple inhaler detracting from appropriate patient review and step down. It had been suggested that it may be appropriate to defer until the updated NICE guideline on COPD which is expected in November 2018.

The APC discussed the lack of compelling clinical reasons to add Trimbow to the formulary, but accepted that it may have a place for patients with compliance issues and offered a cost saving. It was highlighted that any potential therapy changes would be resource heavy, reducing any QIPP saving, but if it was to be available, respiratory nurse specialists should be involved in its initiation and patients should receive appropriate counselling to ensure that no inadvertent treatment duplication occurs. It was agreed to seek commissioner opinion on the potential missed QIPP opportunity from not adding Trimbow to the formulary.

Action: LC/ TB to seek commissioner opinion on the potential QIPP savings from the introduction of Trimbow, with note to the resource required to implement any change.

Post meeting note- Opinion from Dr Charlotte Bolton (co-author of Nottinghamshire COPD guideline) had been received after the meeting. This echoed concerns about inappropriate use of triple therapy and it was felt that there should be no switching of devices unless there was a specific issue with current devices for individual patients. If Trimbow was to be added to the formulary for appropriate patients, its role should be clear.

b) Ferric Maltol (Ferracru, Shield TX) for iron deficiency anaemia

The JFG had discussed a formulary submission for ferric maltol for the treatment of iron deficiency anaemia in IBD patients. Evidence is limited to placebo controlled studies, but it is hypothesized that it may be better tolerated than conventional iron salts and therefore may be an alternative to day case attendance for IV iron infusions. Although the medicine cost would be a cost pressure to GP prescribing budgets, efficiency savings could be released due to decreased activity costs.

The APC supported the use of ferric maltol with an Amber 2 classification for patients that would otherwise have received IV iron subject to strict inclusion criteria including intolerance to at least two conventional iron products and a trial at twice daily rather than three times daily administration. Clear treatment durations would need to be specified to ensure that treatment does not continue indefinitely.

Actions: LK to liaise with submitting clinicans to produce a flowchart detailing the criteria for initiation and responsibilities for review.

c) Freestyle Libre (Abbott Diabetes Care)

The JFG had discussed a formulary submission for Freestyle Libre for patients with Type 1 diabetes meeting defined criteria as follows:

- Already performing ≥ 8 fingerpick blood glucose tests per day; FGS is cost equivalent at 8 fingerpick tests per day.
- Women who are currently pregnant or trying to conceive; 7 or more tests a day are recommended by NICE (NG3 Feb 2015) in pregnancy (to include women with gestational or type 2 diabetes on multiple daily injections).
- Children who have significant fear or anxieties of multiple fingerprick testing.

- People with frequent admissions or paramedic attendances (> 2 per year) with DKA or hypoglycaemia requiring external support where a trial of FGS might reasonably be expected to prevent or reduce future admissions.
- Those who meet current NICE criteria for insulin pump therapy (HbA1c ≥8.5% or disabling hypoglycaemia as described in NICE TA151) where a successful trial of FGS may avoid the need for pump therapy and so avoiding the significant cost of a pump and consumables.
- Those who have recently developed impaired awareness of hypoglycaemia. A trial of FGS can reduce hypoglycaemia and may prevent future need for Continuous Glucose Monitoring (CGM), demonstrating cost saving. It is noted that for persistent hypoglycaemia unawareness, NICE recommend CGM with alarms, not FGS.
- Those with occupations or circumstances where regular fingerprick glucose testing is not practicable and overall glycaemic control is suboptimal as a consequence – working as a mechanic, when scrubbed in operating theatres or where there is a physical or mental impairment which prevents fingerpick testing for example.

This device had received a large amount of attention from patients with clinician engaging with patients regarding this. It is anticipated that use of the device would aid tighter diabetes control and reduction in HbA1c with subsequent reductions in short and long term diabetes complications. However published evidence to support a reduction in diabetes complications is currently limited.

The proposal appeared to exceed the >£10K per CCG financial threshold and had therefore been highlighted to CCGs.
Discussion about the criteria for initiation and continuation ensued and it was requested that patients should have a clinical requirement to test x8 per day in addition to meeting another criterion. It was also suggested that a decrease in test strip usage should be quantified in the continuation criteria.

A FAQ document is currently being produced and this will be available on the APC website. It was requested that in addition, a standard template letter for clinicians is created to use at initiation and review and that this includes details of the system codes that are used to prescribe the product and information about a need for the continuation of test strips despite use of the device.

The APC were in support of adding the device to the formulary, with an Amber 2 classification, but requested that the amended criteria for initiation and continuation and the costings be circulated for further consideration. Patients should be reviewed at 6 months and should understand that prescriptions for the sensor will only continue if the criteria is satisfied. Use of the device should be audited after 12 months.

Actions: LC to circulate amended criteria for initiation and continuation
LC to circulate costings
LC to seek approval from individual CCGs

13. <u>FOR INFORMATION: APC forward work plan</u>

Noted. The following items were discussed specifically:

NICE guidance on asthma management- The committee was informed that discussions with specialists had occurred and it was felt that no change to the local guidance should be undertaken currently, but the situation should be reviewed when the BTS guidance was updated at the end of the year.

Prescribing to transgender patients practice policy- This was being reviewed by the Equality Lead at City CCG.

Emollient formulary- it was highlighted that some non-formulary requests are being received from the Treatment Centre.

COPD Exacerbation Rescue Medication Guidance- this had been reviewed and received minor updates and would be circulated via email.

14. FOR INFORMATION: Declaration of compliance with NICA TA's

Noted

15. Meeting Minutes from SFH DTC and NUH DTC

These were noted.

16. Future Dates of Meetings 2018

15th March 2018
17th May 2018
19th July 2018
20th September 2018
15th November 2018

17. Any Other Business (AOB)

Ocular lubricant guideline- some minor amendments had been made to products that would be highlighted in bulletin. It was raised that some of the non- preferred products had been made non-formulary which was causing some problems at NUH.
Action: LK to review formulary entries; list as generics but with preferred brands in the text

Issues with use of multiple opiates and gabapentin/ pregabalin- ME raised that this issue was growing and was causing particular problems in prisons. Some discussions with Roger Knaggs had occurred and it was felt that the APC guidelines could be reviewed and re-promoted to highlight the issue.
Action: LC to add guideline review to the workplan

RMOC- A meeting had occurred and had discussed antimicrobial resistance, care homes and polypharmacy but no decisions or recommendations made. This will be added to future APC agendas as a standing item.

Liothyronine- It was raised that some GPs had requested that secondary care should be responsible for prescribing this for patients that had been reviewed and deemed acceptable to continue. After discussions it was felt that this was inappropriate and the grey classification should remain with primary care prescribing for exceptional patients that remained on the medication after appropriate review.

Meeting closed at 16:55