# Nottinghamshire Area Prescribing Committee

## Minutes of the meeting held on Thursday 23rd January 2020 2:00pm Boardroom, Duncan MacMillan House

**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 |
| **Tanya Behrendt (TB)** | Associate Chief Pharmacist, Medicines Management | NHS Nottingham City CCG |
| **Laura Catt (LC)** | Prescribing Interface Advisor | Representing County CCGs |
| **Matt Elswood (ME)** | Chief Pharmacist | Nottinghamshire Healthcare Trust |
| **Esther Gladman (EG)** | GP | Nottingham City CCG |
| **Tim Hills (TH)** | Interim Assistant Head of Pharmacy | NUH Trust |
| **David Kellock (DK)** | Chair SFH Drug and Therapeutics Committee | Sherwood Forest Hospitals NHS Foundation Trust |
| **Jenny Moss-Langfield (JML)** | GP | LMC representative |
| **Sarah Northeast (SN)** | Advanced Nurse Practitioner | CityCare |
| **Amanda Roberts (AR)** | Patient representative | |
| **David Wicks (DW)** | GP | Newark and Sherwood CCG |

**In attendance:**

Hannah Godden (HG), Mental Health Pharmacist, Nottinghamshire Healthcare Trust
Shadia Jenner (SJ), Specialist Interface & Formulary Pharmacist
Jill Theobald (JT), Specialist Interface Efficiencies Pharmacist

For item 8 only:
Joan Mercer (JM), Head of Clinical Effectiveness and Alpna Chauhan (AC), palliative care consultant

1. **Apologies**

Khalid Butt (KB), GP, LMC representative
Mark Flanagan (MF), Advanced Podiatrist non-medical prescriber, Local Partnerships, Notts Healthcare Trust
Mike Jones (MJ), Community Pharmacist, Local Pharmaceutical Committee (LPC)
Paramjit Panesar (PP), GP, Nottingham North & East CCG

## 2. Declarations of interest

None declared.

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

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

**Matters arising:**

**Gynaecomastia guideline (Update),** ME felt hyperprolactaemia as a cause of gynaecomastia could be expanded on. It was agreed that Hannah Godden would review this once in post. There was previous concern surrounding bone monitoring which SJ had investigated. As there is no definite guidance on the use of Tamoxifen or Anastrozole, SJ consulted with specialists for opinion. EG suggested the following wording "a course can be repeated after 6 months'' and ''consider seeking specialist advice for further courses". It was agreed that wording around adequate calcium intake and vitamin D supplementation be moved from the Monitoring section to Medicine treatment. This would clarify that this is recommended when prescribing tamoxifen or anastrozole.

**ACTION: SJ to finalise and upload to APC website.**

**Edoxaban** – position statement now published making edoxaban first line DOAC for non-valvular AF unless there is a clinical reason for selecting a different DOAC. NICE due to publish updated AF guidance in September 2020, with consultation document due in April 2020. CCGs have agreed to postpone decision of switching existing patients until consultation published.

**Solar Keratosis** – Published updated guidance. Consultants to monitor excisions and report if squamous cell carcinoma is being excised in error.

**Melatonin** - LC to set up working group to define place on formulary and assess cost impact.

**ACTION: LC to continue to work with the commissioning teams and the trusts to find a solution**

**All other actions were either complete or on the agenda.**

## 4. FOR RATIFICATION – Antimicrobial Guidelines; CAP, Cellulitis

LC presented the updated community acquired pneumonia and cellulitis antimicrobial guidelines which had been updated following comments from JFG. The committee agreed the changes.

JML requested that the GP computer system formulary be updated in a timely way. LC highlighted that this was out of the control of APC, but TB said that CCGs are working towards one practice based formulary across CCG which will help with timely updates.

**ACTION: LC to upload to APC website.**
**LC to liaise with CCGs re SystmOne and EMIS formularies**

## 5. FOR RATIFICATION – Phosphate binders SCP

LC presented the interim update to the SCP. Alu-caps has been removed as this is now discontinued. The alternative product is unlicensed so suggested to be amended to RED. The committee approved the SCP and change of traffic light status. It was noted that a full update was now overdue and this had been raised with NUH renal team.

**ACTION: LC to upload to APC website and update the formulary**

## 6. FOR RATIFICATION – Overactive Bladder Guidelines

LC presented the updated overactive bladder guideline. The committee were presented with two versions, one with just oxybutynin and tolterodine in the first line box and another version with the addition of solifenacin and trospium as equal first line choices. The committee considered the suggestion to remove oxybutynin, however many patients are still on this and it may still be suitable for a cohort. The price of solifenacin has now reduced. GPs were supportive of more first line choices to allow flexibility of choice for individual patients. A warning not to offer oxybutynin or tolterodine to frail elderly patients was suggested and to add cognitive impairment as caution. The committee agreed to use the version with the extended first line options and add a note to try an extra one or two first line options before moving to mirabegron.

**ACTION: LC to amend and send to APC members via email for ratification.**

## 7. FOR RATIFICATION – Male LUTS guideline

LC presented the updated Male LUTS guideline. The committee approved the guideline and agreed to make darifenacin, fesosterodine and propiverine GREY – non formulary as they are rarely used and not cost effective. DW requested that anticholinergic choice with aligned with the updated OAB guidance.

**ACTION: LC to amend and upload to APC website**

## 8. FOR RATIFICATION – End of Life Guidelines

Joan Mercer (JM), Head of Clinical Effectiveness and Alpna Chauhan (AC), palliative care consultant, presented the updated EoL guideline. AC highlighted the changes since last APC.

- Cyclizine oral to subcutaneous conversion was previously 1:1 but now 2:1 ratio. Concern was expressed over the antimuscarinic side effects risk. It was suggested to discuss with the palliative care specialist before increasing the dose if appropriate. DW felt that having to contact specialist would leave GPs exposed out of hours where it could be difficult to get hold of anyone. Cyclizine is not the first line choice, so would only be converting oral cyclizine to subcutaneous if it has been helpful.
- Introduction of ranges for medicine doses (pg. 20, appendix 1b). DW stated that GPs were being asked to prescribe a dose rather than a range, but a range is important to allow for flexibility. DW felt that the ranges were too narrow and may lead to compromised patient care. AC would prefer patients to be reviewed rather than keep increasing doses, especially for opioids. Doses in the guideline are starting doses for opioid naïve patients, patients already on opioids would be converted to equivalent dose for syringe driver. EG suggested inviting discussion about dose ranges at PLT events.
- Introduction of fentanyl rather than alfentanyl for consistency across Nottinghamshire. Alfentanyl still available under specialist direction.

- Introduction of guidance for prescribing in liver disease. EG welcomed this.

Further suggested changes were:

- Change to new CCG name
- Compatibility (Pg. 21) – add to check compatibility if putting more than one medicine in the syringe driver.
- Anticipatory medicines (pg. 15). Discussed the statement "Please note by law it is not possible to write a prescription for Anticipatory Controlled Drugs for utilisation beyond 28 days." Needs to be clarified - CD prescription valid for 28 days and cannot supply more than 28 days duration.
- Review at 4 to 6 weeks. AC felt that reviews were multidisciplinary, not just GP review, and would be happening frequently. To reword to clarify this.
- PCF = Palliative Care Formulary not Forum

AC to present changes at local GP protected learning time (PLT) events over next few months.

Discussion around selecting the correct form for prescribing anticipatory medicines. ME stated that work was ongoing towards one form for whole of Nottinghamshire.

**ACTION: AC and JM to make changes and send to LC. AC to present at PLT events in February. APC Ratification via email.**

## 9. FOR RATIFICATION – Specials Database

JT presented the updated database and agreed the proposed changes. TH requested that the melatonin entry be updated as it currently states that Circadin MR is the only licensed preparation in the UK and other licensed products are now available (although their formulary status is yet to be defined).

**ACTION: JT to make change to melatonin entry and upload to APC website**

## 10. FOR RATIFICATION – DOAC patient alert card

LC presented the updated DOAC alert card. SM suggested to re-word the statement- "No drug means no protection from clots and strokes!" AR would like this to be more specific about what is actually meant. DK noted that the last paragraph was headed with a question, whist rest of the headings are section titles. JML liked the definition of bleeding.

**ACTION: LC to ask MSOs to make changes and send to APC members for ratification.**

## 11. FOR RATIFICATION – Childrens monitoring guidance

The updated ADHD SCP highlighted the need to do blood pressure (BP) and pulse monitoring for children. GPs have requested guidance or training to do this monitoring in children. NUH provided their guidance which is due for review in summer. LC suggested adopting the NUH guidance and reviewing in the summer when the updated guidance is published. EG questioned if the guidance was detailed enough, for example it did not specify how to select the correct size of paediatric cuff. EG - Percentile charts are useful, but hard to read. SN/EG believe there is simpler guidance available.

TB stated that some practices were refusing to accept shared care because of this monitoring. CCGs were unaware that paediatric BP monitoring was rare.

GPs felt that adopting the NUH monitoring guidance was not appropriate. LC to look for more appropriate guidance and feed back to NUH.

**ACTION: LC to look for more appropriate guidance and feed back to NUH.**

**12. FOR RATIFICATION - Headache in adults**

SJ presented further amendments to the Headache in adult guideline. At the last APC meeting, JML queried the use of Naproxen as a treatment option for Medication Overuse Headache, and wondered if alternative NSAIDs could be used. Although Naproxen is used, there is no evidence to support or refute and is an off-license indication. As such, SJ removed this from the guideline. A section on acute migraine in pregnancy was added at the request of the committee. It was raised that in addition to anticholinergic burden, when considering amitriptyline for prophylaxis, prescribers should also consider the risk of serotonin syndrome; this was highlighted in the amended, updated draft of the guideline. SJ provided clarification on the nasal absorption of sumatriptan. Although mainly absorbed via the gut, the data available would indicate some nasal absorption. So this nasal spray has a part to play, in severe nausea, where a patient couldn't swallow a tablet. Other minor wording amendments were suggested but otherwise the document was approved.

**ACTION: SJ to make changes and upload to APC website**

**13. FOR RATIFICATION – Standard Strength paediatric liquids**

JT presented the list of proposed standard strengths for paediatric liquids. The list is based on a position statement from the Royal College of Paediatrics and Child Health (RCPCH) and the Neonatal and Paediatric Pharmacists Group (NPPG). With the exception of omeprazole the committee approved the adoption of these strengths. The omeprazole strength will be agreed once the NUH GORD guidelines are updated.

ME enquired whether fluoxetine had been considered for addition to the list. JT agreed to find out.

**ACTION: JT to update formulary and add links to the guidance.**
**JT to find out why fluoxetine liquid is not included.**

**14. FOR RATIFICATION – Testosterone SCP**

Following the approval of an Amber 1 classification for testosterone for induction of puberty in paediatrics and adolescents LC presented the new shared care protocol and associated guidance. Minor amendments were suggested but otherwise the documents were approved.

**ACTION: LC to make the changes and upload to APC website**

**15. FOR RATIFICATION – Bronchiectasis Self-Management plan**

LC presented the new bronchiectasis self-management plan which was similar to the existing asthma and COPD self-management plans.
Minor changes were suggested but otherwise the document was approved.

**ACTION: LC to make changes and upload to APC website**

## 16. RMOC update

TB and SM gave a brief overview of the recent Midlands and East RMOC.

## 17. Formulary amendments and horizon scanning

### a. Formulary amendments

- **Micronised progesterone 100mg oral capsules (Utrogestan®)** – agreed to remain GREY – no formal submission despite HRT supply issues, because a full review is needed to clarify place in therapy. Interface team requested a submission, but not received one yet.
- **Aqueous cream** – agreed GREY – non formulary as contains sodium lauryl sulphate (irritant) which makes it unsuitable as a leave-on emollient. May be used as a soap-substitute, but other soap-substitutes on formulary (e.g. Zerocream®) that are SLS free and more cost effective. Dermatologists and local GPs support this decision.
- **Ivabradine 2.5mg tablets –** agreed to restrict use of 2.5mg tablets to those unable to halve a 5mg tablet. 5mg tablets are licensed to be divided into equal doses (scored). Committee wanted clarification as to how patients should discard the unused half or if there was any stability data on the use of the second half.

**ACTION: JT to contact company for advice and clarify on formulary.**

- **SodiClor® (sodium chloride liquid 5mmol/5ml) –** agreed GREY as strength preferred locally (and on national standard strength document) is 5mmol/ml. Lower volume helps with compliance.
- **Pyrazinamide 500mg/5ml unlicensed liquid** – agreed RED for paediatric patients where tablets are unsuitable.
- **Hydrocortisone ointment** – agreed to restrict formulary 1% cream and 1% ointment only. Other strengths GREY – non formulary
- **Ibuprofen plasters** – GREY – no formal review
- **Sucralfate suspension** – Currently GREY because it went out of stock and the unlicensed version was very expensive. Tablets are still unavailable. Committee requested input from gastroenterologists.

**ACTION: JT to get opinion from specialists and bring to JFG in February.**

**ACTION: KR/JT to update the formulary**

### b. Horizon scanning

- **Epidyolex® 100mg/ml oral solution (cannabidiol)** – agreed to leave as RED. The committee agreed that no further action was necessary in view of NICE TA 614.
- **Staladex® (leuprorelin acetate) 10.72mg implant** – GREY - no formal assessment. Noted that licensing not as comprehensive as Prostap-3.
- **Voke® (nicotine) inhaler** – GREY no formal assessment
- **Mesalazine 1600mg MR tablet (Octasa®)** – agreed to make this strength GREY due to the large size of the tablet and more cost effective to use lower strength tablets to make up higher doses.

**ACTION: KR/JT to update the formulary**

## 18. New Submissions

### a. Deflazacort

JT presented the submission from NUH for deflazacort (Calcort®) for Duchenne muscular dystrophy (DMD) as an alternative to prednisolone. SFHT were consulted and no objections raised, although their patient numbers were extremely low at 0 to 1 patient per year. Studies show that deflazacort causes less weight gain than prednisolone and may offer an advantage over prednisolone for patients with excessive weight gain, despite a healthy diet, or those with significant pre-morbid obesity. However, the committee heard that available evidence showed that deflazacort offered no advantage over prednisolone in terms of efficacy or side effects (other than weight gain). The reduced weight gain with deflazacort was only seen in early treatment (first 12 months) and was not sustained in later treatment.

Expected patient numbers were low, approximately 4 new patients a year, and the additional cost for 4 patients per year would be in the region of £1300* but this figure would vary depending on dose. DW had experience of a patient request for deflazacort in the past and had been told by a local specialist that the cost could not be justified because the efficacy was the same as prednisolone.

The committee noted that the submitters had requested patient preference as an indication for selecting deflazacort and agreed that this was not appropriate. They also felt that if approved for DMD, it may lead to submissions for other conditions where prednisolone is currently the preferred treatment.

The committee concluded that traffic light classification should be GREY – non formulary on grounds of cost effectiveness.

**ACTION: JT to update the formulary and inform the submitters**

***Post meeting note:** The estimated annual additional cost of using deflazacort for four patients instead of prednisolone was presented as £5000 in the meeting, but it is actually £1300. The committee were informed and agreed that this did not change the decision and that deflazacort should still be GREY on grounds of cost effectiveness.*

### b. Betesil® Plaster

SJ presented the submission for betamethasone valerate (Betesil®) plasters and answers to questions raised by the JFG. The cost comparison requested by the JFG was based on 0.5g of cream as this was estimated by the submitter as the required amount to cover the same surface area as one Betesil® Plaster. It was explained that this would be used as an additional treatment option and not to replace any other product currently being used. The use of the plasters was discussed and JML raised a concern about the surrounding, unaffected skin being exposed to treatment that wasn't necessary. Several committee members raised questions about the practicalities of using the plasters and felt that the submitter would be better placed to answer questions on the use of the plasters.

**ACTION: SJ to invite the submitter to the next JFG meeting.**

### c. Pentosan NICE TA610

JT presented NICE TA610 for pentosan sodium (Elmiron®) for bladder pain syndrome in adults. APC agreed that the traffic light classification should be RED because the TA states that it should only be used in secondary care and that the patient access scheme is not available in primary care. TH and SM confirmed that the Trusts' DTCs had approved the RED classification.

**ACTION: JT to update the formulary.**

**19. APC forward work plan**

Noted

**20. Declaration of compliance with NICE TAs**

Noted

**21. Dates of Future Meeting**

****Note change of room for next meeting****

19th March 2020 – Duncan Macmillan House, **Meeting Room 3**

**22. Any Other Business**

**Meeting closed at 17:00 hrs.**