Nottinghamshire Area Prescribing Committee
Meeting minutes

APC meeting 25th February 2021, due to the COVID-19 Pandemic the meeting took place as a web conference using Microsoft Teams.

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)	**Senior Medicines Optimisation Pharmacist**	**NHS Nottingham & Nottinghamshire CCG**
David Wicks (DW)	**GP – Mid Notts ICP**	**NHS Nottingham & Nottinghamshire CCG**
Laura Catt (LC)	**Prescribing Interface Advisor**	**NHS Nottingham & Nottinghamshire CCG**
Matt Elswood (ME)	**Chief Pharmacist**	**Nottinghamshire Healthcare NHS Foundation Trust**
Tim Hills (TH)	**Assistant Head of Pharmacy**	**Nottingham University Hospitals NHS Trust**
David Kellock (DK)	**Chair SFH Drug and Therapeutics Committee**	**Sherwood Forest Hospitals NHS Foundation Trust**
Esther Gladman (EG)	**GP – City ICP**	**NHS Nottingham & Nottinghamshire CCG**
Amanda Roberts (AR)	**Patient representative**	
Jennifer MossLangfield (JML)	**GP**	**LMC representative**
Sarah Northeast (SN)	**Advanced non-medical prescriber**	**Nottingham CityCare**
Asifa Akhtar (AA)	**GP – South Notts, ICP**	**NHS Nottingham & Nottinghamshire CCG**
Kuljit Nandhara (KN)	**Divisional pharmacist lead for Mental Health Services**	**Nottinghamshire Healthcare NHS Foundation Trust**

Interface support:
Lynne Kennell (LK), Specialist Interface & Formulary Pharmacist for SFH
Shary Walker (SW), Specialist Interface & Formulary Pharmacist for NUH
Hannah Godden (HG), Specialist Mental Health Interface and Efficiencies Pharmacist
Irina Varlan (IV), Specialist Interface Efficiencies Pharmacist
Jill Theobald (JT), Specialist Interface Efficiencies Pharmacist
Karen Robinson (KR), APC Interface Technician

Apologies:

Khalid Butt (KB), GP – LMC Representative

Declarations of interest (DOI)

None declared.

Minutes of the last meeting/matters arising

The minutes from the previous meeting were reviewed and accepted as being accurate except one minor amendment to remove the hyphen from Jenny Moss Langfield's surname.

ACTION: Interface team to finalise and upload to APC website

ME introduced Kuljit Nandhara to the group. Kuljit is one of three Deputy Divisional Pharmacist leads employed by Nottinghamshire Healthcare NHS Foundation Trust.

Ibandronic acid for adjuvant treatment of breast cancer
Ibandronic acid for adjuvant treatment of breast cancer was approved clinically at July's APC, but due to the significant cost associated with the intervention, further commissioning approval needed to be sought as it exceeded the threshold for the APC's financial mandate. No further progress has been made to date. TB and TH will discuss possible options for moving forward outside of this meeting and bring options for possible resolution to the next JFG.

ACTION: TB and TH to continue to seek resolution

End stage heart failure pocket book
LC had fed back to the ICS EoL group all of the previous comments offered by APC members. No further progress has been made so far.

Amiodarone
At the November APC meeting, while reviewing the Limited clinical value medicines list, it was highlighted that NHS England recommends prescribing amiodarone only under shared care due to the monitoring requirements. The APC committee decided we needed input from the MSO group before changing the formulary classification from Amber2. Following the MSO Network meeting in December 2020, there was a consensus to make amiodarone Amber 1 in line with NHS England guidance and align with changes implemented with neighbouring CCGs. The MSO group acknowledged that a bigger piece of work around reviewing existing patients is required, but classification should change to Amber1 for new patients for now and a SCP needs to be developed; so new prescribing is in line with NHS England. .
There are approximately five hundred patients on amiodarone across Nottinghamshire. The MSO representatives are already in discussions with the Specialist Cardiology Pharmacist at NUH to establish the safest way to review and refer the patients currently taking amiodarone.
The committee agreed that amiodarone should be classified as Amber 1 for new patients and that existing patients should be reviewed. A shared care protocol will be developed and the traffic light change will be made at the next APC meeting once the supporting documents had been written. A review plan for existing patients needs to be agreed with cardiology.

ACTION: IV to develop SCP for amiodarone and bring to the next APC for approval.

FOR RATIFICATION – Vitamin D Guidelines for Adults and Children (update)

JT highlighted a number of changes to the Vitamin D guidelines in response to the CCG publishing an updated vitamin D position statement that includes stronger wording about the need for people to purchase their own vitamin D supplements for maintenance and prevention of deficiency. Repeat

prescriptions will be reviewed with the aim of changing to self-care. If prescribing needs to continue then it should be prescribed as the food supplement, ValuPak. Legal advice has been sought by the CCG prior to making this recommendation.

Changes to the adult and children's guidelines included:

- Updated the links to the local position statement
- Removed preferred brand (Stexerol) from flow chart and added note that 1000 unit tablets are most cost effective. No change to recommended dose.
- Removed statements about not prescribing unlicensed products.
- Updated prices and removed statements about preferred brands. Added information about gelatin content of ValuPak (food supplement).
- Removed info about peanut/soya allergy and added link to SPS document that covers this instead.
- Added standard header & version control.

ME questioned if it was appropriate for those in long term residential care, prison inmates and those that are housebound to purchase their own vitamin D. JT agreed to discuss with the CCG and feed back.

EG asked that children's dosing be reviewed to bring in line with commonly available pack sizes. It was agreed that this would be addressed when the guideline was next reviewed fully.

ACTION: JT to make changes and upload to the APC website.

FOR RATIFICATION – Adult ADHD SCP (New)

There is currently an interim service at NHCT that provides a commissioned pathway for adults with ADHD; this went live on 1st September 2020. The longer-term plan (phase 2) is the development of the Neurodevelopmental Specialist Service (NeSS) and shared care for adults with ADHD across Nottingham and Nottinghamshire. The plan is for shared care to start in April 2021.

The main principles of the shared care protocol:

- Prescribing responsibility will only be transferred when it is agreed by the specialist and the patient's primary care prescriber that the patient's condition and medication is stable.
- The specialist will conduct an annual review.
- The GP will be responsible for prescribing and monitoring maintenance therapy.
- Monitoring is 6 monthly and includes: blood pressure, heart rate, weight, assessment for side effects and risk of misuse/abuse or diversion.

The documents have been reviewed and approved by the NHCT Neurodevelopmental Specialist Service Leadership Group. The GP mental health leads feed into this group and therefore have had oversight of the documents also.

Regarding patient and carer roles and responsibilities, points 4 and 5 on the Shared Care Protocol, AR asked how patients would identify a suspected adverse reaction and how is safe and secure storage is decided? HG clarified that it is the specialist's responsibility to provide verbal and written medication information to the patient and this would include information about potential adverse effects. HG also clarified that, for patients, there is no additional storage security requirements for these medications above and beyond other prescription only medicines.

There was a discussion around which monitoring results should be sent to the specialist by GPs. It was agreed that it wasn't realistic or appropriate to send all results and only abnormal monitoring

results need to be fed back to Secondary Care. HG will request secondary care to include baseline and most recent results of monitoring in letters to GPs when requesting shared care. DW queried the meaning of 'systolic blood pressure greater than the 95th percentile' as a criteria for review / discontinuation of the medicines. After a discussion it was agreed that the wording be changed to 'a clinically significant increase in blood pressure' as it isn't possible to define exactly what a clinically significant increase would be across this adult population who may have varying degrees of underlying conditions.

EG queried about the treatment of co-existing mental health conditions (e.g. depression, anxiety) in this patient cohort and whether this should be discussed with the specialist. HG confirmed this decision should be made on a case-by-case basis if concerned that a psychiatric condition has been caused / worsened by the medication prescribed for ADHD. Also to take into account medicine interactions. ME highlighted the importance of considering psychological therapies in this patient cohort. JML queried about an OptimiseRx message for interactions between ADHD medication and antidepressants – highlighted that GPs can often override warnings about interactions with SSRIs due to the frequency and often low severity.

ME mentioned a Protected Learning Time (PLT) event was in the planning process and he would highlight to the organiser key areas that members had raised in order for them to be addressed at PLT

ACTION: HG to make the changes and upload. HG / JT to explore possibility of an OptimiseRx message. ME to feed information back to the PLT organisers

FOR RATIFICATION – Guideline on the Management of Sleeping Difficulties in Childhood (New)

LC presented the updated sleep and melatonin guideline which the committee had reviewed previously. It was noted that the document would mainly be used within secondary care as that is where prescribing should take place, however as some of the cost of melatonin is passed through to the CCG, assurance is required that restrictions are being followed. A few minor adjustments were suggested, introduction of colour to the flow chart and the addition of a non-referral box. DK has also returned some further suggestions such on format and grammar. Subject to these changes the document was approved.

ACTION: LC to feed back to the authors and upload the final version

FOR RATIFICATION- Nottinghamshire Adult Asthma Treatment Summary (Update)

LK presented the updated guidance which is based on NICE NG80: Asthma: diagnosis, monitoring and chronic asthma management, BTS/ SIGN guidelines 2019 and the Global Initiative for Asthma (GINA) guidelines. The guideline had been updated with input from a Nottinghamshire-wide working group. The main changes were:

- A regular preventer was now promoted as first line therapy. SABA only treatment should be for use in limited numbers of patients in line with national guidance.
- Montelukast had been added as an option at step 3a in line with NICE guidance.
- MART regimens were promoted as an option at step 3a.
- Treatment options had been rationalised and Duoresp® and Flutiform® had been removed from the guideline due to limited use locally. These will remain on the formulary and switching of current patients is not advised unless clinically necessary. Fobumix® had been added as a cost effective option.

It had been emphasised that step 4 options are for use on specialist advice only. Traffic light

symbols had been added to reinforce this.
Relvar® had been added to the guidance in line with recent APC approval.
Oral steroids had been removed as a treatment option at step 5 and omalizumab had been expanded to include other specialist therapies at step 5.
A table of potencies had been added into the treatment notes (based on the table in BTS guidance).
Link to the Right Breathe website for inhaler videos had been added into the treatment notes.
The recommendation to use an MDI as first line device had been removed and now it is advised that patients should be prescribed a device that they can and want to use.
Formatting changes had been made to include as much relevant information from the treatment notes in the main part of the guideline.
A DPI beclomethasone device will be added to the guidance in line with current formulary choices to provide a DPI product choice at step 1.

Environmental factors had been considered during the update, but there was some reluctance to promote dry powder inhalers as first line option as specialists were concerned that this may result in otherwise stable patients being switched to devices without sufficient inhaler technique training. Hence the current recommendation being a device that the patient can and wants to use. Keeping patients well and decreasing wastage was most desirable. It was highlighted that some CCGs have statements regarding environmental considerations of inhaler devices and it was suggested that something similar should be added to the notes to increase awareness and allow patients to make an informed decision.

Other suggestions made by members included the addition of other product ingredients to the inhaler potency table and clarifying the annual 12 SABA inhaler limit with specialists.

ACTION: LK to action the above points, finalise guidance and upload.

FOR RATIFICATION - COPD antimicrobial guideline for acute exacerbation (Update)

SW presented the updated guideline
The main change was increasing the dose of amoxicillin from 250mg to 500mg TDS (in line with the NUH guideline) in addition to the co-amoxiclav in patients with *Haemophilus influenzae* with sensitivity reported as “I” (susceptible at higher doses).

The EUCAST guideline dosing for the combination of amoxicillin and co-amoxiclav is somewhere in the middle and doesn’t reflect UK dosing, therefore, it has been decided to go with using the higher dose of amoxicillin 500mg TDS to align to NUH and avoid confusion with pneumonia.

The amendment was due to the lab reporting changes introduced in August 2020 by the EUCAST for reporting sensitivity results, more specifically against *Haemophilus influenzae.*

SFHT microbiology consultants were also consulted.

ACTION: A small amount of re-wording will be made to offer more clarity as well as adding the definition of I. SW will email the amended document to members for final ratification

Formulary Amendments and Horizon Scanning

Formulary amendments.
LK gave a brief overview of the medications considered at JFG that warranted further discussion and those that had not been discussed at JFG as below. All other formulary amendments carried

forward from JFG were agreed.

>Aminophylline tablets discontinued. Low level of prescribing across Nottinghamshire. Stock exhaustion is likely to occur in April.
ACTION: LK to highlight to the Medicines Optimisation teams and added to the APC bulletin
>Modafanil for paediatric patients. JFG recommended a traffic light classification of RED for this cohort of patients, but had requested prescribing data. There are approximately 5 patients in Nottinghamshire, but it was acknowledged that this is a tertiary service.
ACTION: LK to check if there is a service specification before any classification changes are made
>Haloperidol – discontinuation of 0.5mg capsules. NHCT will be using 0.5mg tablets but these are more expensive compared to other formulations and strengths, particularly in primary care. Consideration given to using liquid instead, but concerns raised about the feasibility of measuring such small volumes (0.25ml) and potential for error. It was suggested that 0.5mg and 1mg doses could be 6ationalized to 0.75mg or 1.5mg so that 1.5mg tablets could be used, reserving the 0.5mg tablets patients who could not halve tablets or use liquid. The committee felt that this was not practical due to prescriber habits and the recommendation of 0.5mg and 1mg doses in various guidelines (e.g. APC guidelines for the behavioural and psychological symptoms of dementia). An alternative suggestion was that the liquid could be used first line for new patients (community pharmacies to supply 1ml syringe) and 0.5mg tablets second line. HG highlighted that there are no current plans to switch existing patients in primary care due to the risk assessments that would need to take place and current capacity of the Medicines Optimisation team to support a switch.
ACTION: HG to discuss with Beth Carney
>Zonisamide – new liquid formulation. Currently only capsules are on the formulary, classified as Amber 2. A request had been made by Andrew Wignell, paediatric pharmacist at NUH, for the liquid formulation for a small patient cohort. It was agreed to add this to the formulary and monitor prescribing.
ACTION: IV to update formulary and add to workplan to monitor prescribing
>Polycal® – Polycal® is prescribed to top up calories in paediatric renal patients who are fluid restricted. The formulary only has Maxijul® listed and restricted to use under dietician advice. It was noted that there are age restrictions within the license for Polycal®, whereas Maxijul® has no age restrictions and it was questioned why Polycal is used in preference.
ACTION: IV to investigate

Horizon scanning:
>Enerzair® Breezhaler® (indacaterol / glycopyrronium): New medication - Grey no formal assessment.
>Atectura® Breezhaler® (indacaterol / mometasone): New medication - Grey no formal assessment.
>Symbicort® (budesonide 100micrograms / formoterol 3micrograms) MDI: Now licensed for asthma, remove the reference to COPD only.
>Buprenorphine transdermal patches, new brand Rebrikel®, 5mcg, 10mcg and 20mcg. Grey pending further feedback from Medicines Optimisation teams.
>Otigo® (phenazone 40 mg / lidocaine 10 mg/g) ear drops: New medication - Grey no formal assessment.
>Zeposia® (ozanimod) capsules: New medication - Grey no formal assessment.
>Fycompa® (perampanel): Licence change - Remove reference to age range from formulary entry.
>Dyzantil® (sodium valproate MR) tablets: New brand - Grey no formal assessment.

ACTION: KR to update the formulary

New Applications

Semaglutide (Rybelsus® 3mg, 7mg and 14mg tablets, Novo Nordisk Ltd) for the treatment of Type 2 Diabetes Mellitus

SW presented the submission for (Semaglutide (Rybelsus®). Oral semaglutide (Rybelsus®) the first oral GLP-1 receptor agonist option for patients who need treatment intensification for T2DM. The availability of oral semaglutide increases patient choice with respect to GLP-1 RA therapy. Rybelsus® is cost-neutral to other GLP-1 RA, with a cost per day of £2.62, and has an adverse event profile consistent with the GLP-1 RA class.

The APC has emphasized the importance of review in 6-12 months, requested a clearer picture of the patient cohort, and to define the criteria a bit tighter (e.g. use of injection). It was suggested that the submitter should provide prescribing audit data in 9-12 months' time and that during this time initiation is on consultant recommendation only.

ACTION: SW to confirm patient cohort and criteria with submitters and gain ratification by email

Liraglutide (Saxenda®, Novo Nordisk Ltd) for managing overweight and obesity- NICE TA664.

SW presented a brief summary of the NICE TA.
There is no Tier 3 Weight Management service in Nottinghamshire, and therefore a RED traffic light classification is appropriate with a recommendation that the patient be referred to Derby. APC felt it was not appropriate for prescribing within Primary Care and if possible an optimise message should be developed.

ACTION: SW to update the formulary. LC to feed back to commissioners to review the agreement that the CCG have with Derby weight management service to ensure this is included as an option.

FOR INFORMATION - APC forward work plan

It was noted that some work streams were out of date due to the team's focus being prioritised onto the COVID vaccination delivery. Meeting dates had also been changed and members were urged to check these new dates.

AOB

Carbamazepine

EG asked if routine monitoring was required following a query from a GP colleague. The group confirmed that there is no requirement for routine monitoring but this may be helpful in some circumstances (and is available locally) under specialist request.

DOACs in DVT/PE guideline update

NICE is due to publish on the 26th March 2021 new guidance on Venous thromboembolic diseases: diagnosis, management and thrombophilia testing (NICE NG 158). Dr Hermans, Consultant Haematologist at NUH, has kindly updated the APC guideline DOACs in VTE or PE to be in line with the NICE recommendations but wanted to ask the committee if his presence is required when the guideline is ratified. The updated version gives the option for DOACs to be prescribed in primary care for suspected DVT or PE, before the patient has come to secondary care.

The committee agreed that his presence would be well received to help clarify some of the new recommendations.

Date of next meeting – 22nd April 2021

Meeting ended at 16:16hrs