Nottinghamshire Area Prescribing Committee Meeting minutes

APC meeting 21st October 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:

Tanya Behrendt (TB) Chair	**Senior Medicines Optimisation Pharmacist**	**NHS Nottingham & Nottinghamshire CCG**
Laura Catt (LC)	**Prescribing Interface Advisor**	**NHS Nottingham & Nottinghamshire CCG**
Khalid Butt (KB)	**GP – Mid Notts ICP**	**LMC Representative**
Jennifer Moss Langfield (JML)	**GP**	**LMC representative**
Sarah Northeast (SN)	**Advanced non-medical prescriber**	**Nottingham CityCare**
Tim Hills (TH)	**Assistant Head of Pharmacy**	**Nottingham University Hospitals NHS Trust**
Susan Hume (SH)	**Advanced non-medical prescriber**	**Nottinghamshire Healthcare NHS Foundation Trust**
Esther Gladman (EG)	**GP- City ICP**	**NHS Nottingham & Nottinghamshire CCG**
Ann Whitfield (AW)	**Patient representative**	
Katie Sanderson (KS)	**Patient representative**	
Sarah Partridge (SP)	**Clincal Practice Pharmacist NEMS**	**PCN pharmacy workforce representative**

****Due to no representation from Sherwood Forest Hospitals NHS Trust or Nottinghamshire Healthcare Trust the meeting was not quorate. Minutes and actions will be approved by those parties ahead of ratification****

Interface support:
Lynne Kennell (LK), Specialist Interface & Formulary Pharmacist for SFH
Hannah Godden (HG), Specialist Mental Health Interface Pharmacist, NHS Nottingham & Nottinghamshire CCG
Jill Theobald (JT), Specialist Interface Pharmacist, NHS Nottingham & Nottinghamshire CCG
Irina Varlan (IV), Specialist Interface Pharmacist, NHS Nottingham & Nottinghamshire CCG

In attendance:

Arun Gande, PCN pharmacist (observing).

Apologies:
Steve May (SM) Chief Pharmacist Sherwood Forest Hospitals NHS Foundation Trust

David Wicks (DW) GP, Mid Notts ICP, Nottingham & Nottinghamshire CCG
Matt Elswood (ME), Chief Pharmacist, Nottinghamshire Healthcare NHS Foundation Trust
Asifa Akhtar (AA) GP, South Notts ICP, NHS Nottingham & Nottinghamshire CCG
David Kellock (DK), Chair SFH Drug and Therapeutics Committee, Sherwood Forest Hospitals NHS Foundation Trust

2. Declarations of interest (DOI)

None declared.

3. Minutes of the last meeting/matters arising

The minutes from the previous meeting were reviewed and were accepted as an accurate record of the meeting subject to the correction of some minor typographical errors.

Ibandronic acid for adjuvant treatment of breast cancer

TB informed the APC that work on this is progressing. Further feedback will be provided at the next meeting.
ACTION: TB to provide feedback at the December APC.

Amiodarone shared care

The SCP documents had been uploaded as previously agreed. Following an audit conducted by MSOs it had been indentified that there was a significant proportion of patients that had received thyroid monitoring, but had not had T3 or T4 levels monitored as per protocol. It was highlighted that the NUH laboratory does not process these tests if TSH is normal and questioned whether these tests were necessary. It had also been identified that there was a lack of advice about the management of out of range U and Es in the protocol so advice is being sought from secondary care. The recommendation about ophthalmology monitoring will be replaced with an annual Optician visit as per the SPS recommendation. The APC agreed with these changes.

LC informed the APC that NUH will only supply one week of amiodarone for patients that require it in a MDS because of stability issues. It had also been identified that NUH were planning on using the discharge letter as a means to communicate the request for Shared care to primary care. This was not felt to be appropriate and a formal request from the clinician responsible for the ongoing care of the patient would be required.

ACTION: Interface team to ascertain SFH practice for thyroid function testing
TH to feedback to NUH cardiology team requirements for Shared Care initiation

Lithium shared care protocol

There has been no update from ME about clarity from RMOC on expectations regarding shared care guidance implementation.

ACTION: ME to feedback at December APC

PCN pharmacist representation

A review of the ToR is still in progress to incorporate the updated membership.

ACTION: LC to review the ToR for a future APC meeting.

Fentanyl Patches and brand choice

No update to report

ACTION: MO to pursue a switch in primary care to Opiodur®.

Bassetlaw integration into the ICS

LC had met with Rob Wise to discuss this area. It was felt that as patients in Bassetlaw would be treated by Acute trusts in South Yorkshire; the local guidance would continue to be followed. It had been agreed that APC agendas and minutes would be shared and any inconsistencies highlighted.

Phosphate binders for the treatment of hypophosphatemia in adults SCP

A final version is still awaited from the NUH renal service.

ACTION: TH to follow up with NUH renal pharmacist

Agomelatine Information Sheet

It had been confirmed that this patient group would not be included on practice Severe Mental Illness registers unless there is a diagnosis of depression with psychosis. Therefore the APC recommendation for annual LFTs would not be picked up by this recall system.

ACTION: HG to undertake primary care agomelatine prescribing and monitoring audit in 6-12 months

Shared care communication

LC informed the APC that as the RMOC guidance on this is awaited, it had been decided to wait for this before developing a local standard template letter as a national version may be created.

ACTION: LC to await publication of RMOC guidance. Development of a standard template letter to be pursued following this.

Vectura inhalers

TH updated the APC regarding the company takeover of an inhaler manufacturer by a tobacco company. There were differing views on whether this should affect local choice of therapy, but any change is unlikely affect patient treatment. Statements from BTS and the Primary Care Respiratory Society are awaited and the APC agreed to wait for publication of these before making any decisions on future actions.

ACTION: TH to update APC at December meeting.

****Other actions were completed or on the agenda for today's meeting****

4. Toculizumab in pregnancy and neonatal vaccines

LC informed the committee that babies born to mothers who had received toculizumab during pregnancy need to have live vaccines delayed for six months and concerns had been raised with regards ensuring that this happens. It was highlighted that this advice applies to other biologics, but as the monoclonal antibodies for Covid are given acutely in severe illness there is potential for a breakdown in communicating this to those responsible for the baby's care.

ACTION: LC to link JML with MSOs at NUH to discuss a suitable resolution

5. Diabetes Guideline update- options paper

LK reminded the committee of the previous discussions on the update of the local Type 2 diabetes guidelines. A draft update had been clinically endorsed by the APC in March 2020, but as the cost impact exceeded the APC's mandate, a business case had been required. Due to difficulties in producing costing estimates, work had stalled and it had been agreed to wait for NICE guidance, which at that point was expected imminently. NICE guidance had been delayed and local clinicians had requested that this work is now pursued, but issues with estimating the cost impact remain. An options paper had been prepared to assess likely support from the groups that would be required to approve a business case going forward. This had been presented to the Diabetes Steering group, but formal feedback was awaited. NICE guidance was scheduled for publication in February 2022 and a draft had been published in August 2021. This differed from the ADA/ EASD guidance that the draft local guidance was based on, notably around SGLT2 inhibitors and GLP1 agonists. SGLT2 inhibitors were positioned earlier in the treatment pathway, as first line therapy alongside metformin for patients with cardiovascular risk. GLP-1 inhibitors were specifically advised against for cardiovascular risk reduction as they had been found to be not cost effective. LK outlined the options in the paper and asked the APC for their views on the most appropriate way forward.

- Option 1 – do nothing.
  Concerns were expressed about implementing guidance for a short time period and the need to potentially undo prescribing recommendations if imminent NICE guidance differs. However, it was agreed that doing nothing may be offering patients a disservice as growing evidence supports the use of SGLT2s. There was acknowledgement that this will be the case by default over the next several months as change cannot be implemented until a business case for the additional costs had been taken through the system and agreed.

- Option 2 – Proactive management and policing of current guidelines.
  Again it was agreed this was not appropriate and this was the least favourable option.

- Option 3 - Fully implement EASD/ADA Guidelines.
  This option was not accepted by the committee on the grounds that the draft NICE update is currently out for consultation and advised against GLP-1s for cardiovascular risk reduction and states that this is not a cost-effective use of resources. The APC felt that it could not endorse prescribing of agents where NICE have specifically advised against.

- Option 4 - Implement an interim update maintaining prescribing within the restrictions of current NICE guidance.
  This was broadly in line with the APCs preferred option. Although it is unclear exactly where SGLT2s will be placed in therapy by NICE, the direction of travel and evidence

supports their use for cardiovascular risk reduction. It was felt that work on adopting their use for this should commence as the development and approval of a business case will take some time. During this process any further developments from NICE should be noted as they happen.

TH informed the APC that a cross- specialty meeting to discuss SGLT2 usage is scheduled for November which may be relevant to the development of a business case noting the other recommendations for these agents in CKD and heart failure.

ACTION: LK/LC to request that clinicians write a business case for using SGLT2s for cardiovascular risk reduction and take to the Service Change Review Cell.
TH to provide feedback on discussions from within NUH

6. Melatonin prescribing update

HG reminded the APC about previous discussions around melatonin in September 2019 where an options paper was presented. A traffic light reclassification to Amber 2 had been considered for paediatrics, but the cost pressure would have been significant and above the APC mandate.A melatonin prescribing guideline was developed for paediatrics and adopted by SFH and NUH as a way of ensuring prescribing was appropriate. Prescribing levels in secondary care haven't changed significantly since this guidance was implemented in February 2021. The pricing and availability of unlicensed preparations used by secondary care is becoming more unstable and going forward there is a possibility of regulatory challenge if we continue to prescribe unlicensed formulations as licensed formulations are coming onto the market. Some areas are moving towards using licensed preparations and an Amber prescribing status for paediatrics. Options were considered to either watch and wait and reconsider the situation once Circadin is off-patent in 2022 or do some pro-active work to try and decrease melatonin prescribing in paediatrics.

TH presented some NUH data showing that cost per gram of unlicensed melatonin formulations increased due to unavailability from the usual supplier. In terms of number of patients prescribed melatonin, this went down during the COVID19 pandemic but is now increasing again. There is a meeting planned with community paediatrics at NUH to discuss melatonin prescribing.

It was suggested that the combined secondary care and primary care prescribing data be revisited to assess whether Nottinghamshire is an outlier as a region. This should be done by prescribing volume as well as cost. The approach can then be reviewed at the December meeting.

Action: TH to feedback outcome of internal discussions at NUH
HG to review combined secondary care and primary care prescribing data and bring to December APC meeting.

7. Steroid card guidance

LC presented the Steroid Card guidance, which had been developed by Jo Freeman, Medication Safety Officer at SFH in conjunction with the MSO network. The APC had been requested to host the guidance that outlines how emergency steroid cards should be issued by clinicians. Several comments were received including the guidance being unclear as to which card should be given and issues with the practicalities of what patients are being given; giving two separate cards is not ideal. It was questioned whether SystemOne could flag up patients for whom it is necessary to issue a steroid card and whether the guidance could contain advice about the

management of patients that carry a card. Concerns were expressed about potentially diluting the message about steroid suppression so that patients at significant risk of adrenal suppression are put at risk. It was suggested that this information should be available via the NHS app in a similar way to Covid-19 vaccination status and it was requested that this be cascaded back nationally.

ACTION: LC to feedback points raised to Jo Freeman

8. DOAC position statement

IV informed the APC that currently this document states that edoxaban is first line based on significant savings via a rebate scheme. Rebate schemes for rivaroxaban and dabigatran have recently been approved but these aren't as profitable. The most commonly prescribed DOAC locally is rivaroxaban.

The DOAC position statement is due for review, but it had been decided that it should remain as is and then be reviewed once generic pricing is available once patents begin expiring or the DOAC group feel that it is no longer appropriate to recommend edoxaban first line. The APC agreed.

ACTION: IV to extend review date and upload to APC website.

9. DVT/PE Guidance

This guidance had recently been updated to allow primary care initiation of DOACs, but since then there had been recent evidence published to support the use of rivaroxaban and apixaban in obese patients. NUH plan to update their guidance, but will request haematology input for patients greater than 200kg. It felt beneficial for this information to be available for primary care use but wanted to highlight that this is for the DVT/ PE indication only and that there is no evidence to support use of other DOACs. APC agreed that this should be added to the guidance. It was questioned whether Optimise Rx can look at BMI to aid choice of the most appropriate agent.

ACTION: IV to update guidance and upload to APC website
JT to investigate whether Optimise Rx can flag a BMI related message.

10. Patient initiated follow up and shared care monitoring

LC informed the APC that there are plans to introduce patient initiated follow up for a carefully selected group of rheumatology patients at NUH. If these patients are under Shared Care and meet the criteria they would move to patient initiated follow up or would receive a routine follow up after 2 years rather than one year if they hadn't initiated this themselves within that timeframe. The SCP had been updated to reflect this. The APC supported this beneficial patient centred care initiative and requested that it be implemented in other areas once trialled in this patient group.

ACTION: LK to finalise and upload updated SCP to APC website
LK to highlight to SFH clinicians

11. Lithium prescribing information sheet

It had been agreed previously that a Shared Care arrangement for lithium in line with RMOC advice would not be pursued locally in Nottinghamshire. Therefore the lithium prescribing information sheet had been reviewed as an Amber 2 prescribing guideline. The main changes included reducing frequency of lithium serum level monitoring to 6-monthly after the first year for stable patients in line with NICE CG185 recommendations, updated criteria for advice or referral back to secondary care as requested at the August APC meeting and the addition of a section on treatment duration and discontinuation. Specialists recommend that all patients be discussed with them prior to lithium treatment discontinuation, but GP members felt that there were circumstances when this wasn't appropriate, e.g. in a palliative care situation so requested a caveat be added to the prescribing guideline for this.

It was highlighted that the advice on eGFR calculations not being accurate in patients of afro-carribean origin may no longer be correct.

The APC approved the updated prescribing guideline subject to clarification on accuracy of eGFR in patients of afro-caribbean origin.

ACTION: HG to confirm whether it's accurate to continue advising that an adjusted formula for eGFR is required for patients of Afro Caribbean origin.
HG to finalise document and upload to APC website

Post meeting note: NICE CKD guideline, published in August 2021, removed the recommendation to adjust for ethnicity when calculating eGFR in people from black ethnic groups. It was agreed that adjusting eGFR equations for different ethnicities may not be valid or accurate. The lithium prescribing guideline has been updated to reflect NICE recommendation as follows: eGFRcreatinine may be less reliable in certain situations (for example, acute kidney injury, pregnancy, oedematous states, muscle wasting disorders, and in adults who are malnourished, who have higher muscle mass or use protein supplements, or who have had an amputation) and has not been well validated in certain ethnic groups (for example, black, asian and other minority ethnic groups with CKD in the UK.

12. Unlicensed specials prescribing

IV presented the updated Unlicensed Specials list that had been reviewed after reaching its expiry date. It was questioned whether the strengths of liquid medicines stocked in the acute trusts had been considered when recommending strengths in this guidance and it was agreed that the paediatric pharmacists would be contacted to ensure that there were no discrepancies. The APC agreed the update subject to this clarification.

ACTION: IV to contact trust paediatric pharmacists to ensure recommended strengths of liquid medicines are in line with local use.
Interface team to review from a formulary perspective and update formulary with any changes needed

13. Eye lubricant formulary and prescribing advice

This guidance had been reviewed by Umema Adamjee, Medicines Optimisation Pharmacist after reaching its expiry date, with input from ophthalmologists at both trusts. There had been some reformatting of clinical advice with more emphasis on self care and patient education

added. Hyaluronate had been added as an option as there was a significant amount of usage locally and it had been agreed with specialists that primary care would switch patients to the most cost effective brand of a product unless a reason for a specific brand was communicated. Some concerns were expressed about the creation of a text document rather than a flowchart and it was requested that this be re-formatted to become more user friendly. The detailed information from NHS England regarding self care was felt to be superfluous and it was suggested that this be removed and hyperlinked.

ACTION: IV to feedback points raised to Umema Adamjee. Final version to be e mailed to the committee for ratification.

14. Managing Behaviour and Psychological Problems in Patients with Diagnosed or Suspected Dementia

HG had reviewed and updated this guidance in consultation with the original authors and key stakeholders (dementia outreach teams). Key changes included the addition of guidance on physical health monitoring for the minority of patients prescribed longer term antipsychotics and a reminder that antipsychotic medication should only be initiated on specialist advice. Some changes had been made to treatment choices outlined for different dementia types; this was based on local specialist expert opinion and consensus

The updated guidance was ratified by the APC.

ACTION: HG to finalise and upload updated guidance to APC website.

15. RMOC update

This item was deferred and it was agreed that an update would be circulated via email.

16. Formulary amendments and horizon scanning

a) Formulary amendments

All formulary amendments were agreed as per the Joint Formulary Group recommendations on the 16th September 2021.

ACTION: Interface team to update the formulary

b) Horizon scanning

All of the horizon scanning entries were noted as per the Joint Formulary Group recommendations on the 16th September 2021 with the exception of the following which was discussed in more detail:

Trimbow NEXThaler- This was a DPI alternative to the pMDI that is currently on the formulary for COPD patients. It had been confirmed that it was priced equivalent and it was agreed that this should be added to the formulary as an option in line with the green inhaler agenda. It was highlighted that the COPD guidance currently lists devices so this would need to be added before an Amber 3 classification could be assigned.

ACTION: LK to review COPD guidance regarding Trimbow NEXThaler
Interface team to update formulary with horizon scanning changes.

17. New applications

a) Piracetam

The JFG had considered a formulary application for piracetam as an adjunctive treatment of refractory cortical myoclonus with or without additional epilepsy in adult patients. It would be used in severe cases where the burden of myoclonus was high and when at least 2 other first line medications had failed due to lack of efficacy or intolerance. Although the evidence base was limited, efficacy could be assessed on an individual basis and the medication stopped if ineffective. It was generally well tolerated, included in the recommendations in NICE epilepsy guidance and of similar cost to alternative antiepileptics. The APC agreed with the JFG's recommendation of an Amber 2 classification, with prescribing to be retained in secondary care for initial dose titration and demonstration of efficacy and tolerability. Thereafter prescribing could be transferred to primary care, but patients would remain under the care of the neurology team.

ACTION: LK to inform clinicians and update formulary

b) Inclisiran (NICE TA)

LC informed the APC about the requirements to make inclisiran available locally in line with NICE TA 733 within 30 days of its publication. Inclisiran is a novel potent therapy that reduces LDL-C and after an initial dose and another at 3 months, is maintained by two doses a year by subcutaneous injection. Inclisiran had been identified by NHS England and Improvement as a medicine that it wishes to adopt systematically and at scale to help address sub- optimal lipid management in high- risk patient populations. The expectation is that this will be prescribed in primary care and a commercial arrangement had been negotiated with Novartis that supports this and promotes a population health management approach to lipid management.

The cost of inclisiran in primary care is at a discounted price, but the costs in secondary care were expected to be significantly more. The Academic Health Science Network are developing training and implementation tools to support practices, but these were not yet available.

Discussion was had regarding the most appropriate traffic light classification. Ultimately an Amber 3 classification was envisaged, but until national guidance was available this was considered inappropriate. In the interim it was agreed that an Amber 2 classification should be assigned, with prescribing for appropriate patients in primary care being permissible after discussion with a lipidologist for example using Advice and Guidance referral. It was requested that a detailed formulary entry be created to advise primary care prescribers on the practicalities of prescribing and the NHS England expectations of primary care prescribing. It was also suggested that information be added to the next edition of Hints and Tips.

ACTION: Interface team to update formulary and add to Hints and Tips
LC/ TB to update APC with further national developments.

18. APC forward work plan

Noted.

Work on updating the local dronedarone Shared Care protocol had been paused due to the anticipated publication of the RMOC's version. The expiry date will be extended to January 2022.

19. AOB

- Team update and farewells- The APC thanked Amanda Roberts for her dedication and valued input as patient representative and wished Irina Varlan well for her upcoming maternity leave. The new patient reps, AW and KS were welcomed. Recruitment is ongoing for two Specialist Interface Medicines Optimisation pharmacists to further support implementation of APC work.

- Resumption of Face to Face meetings- due to meeting room number restrictions, there are no suitable meeting rooms available in a central location. Therefore meetings will continue via Microsoft Teams for the time being.

- SGLT2 inhibitors and Diabetic Ketoacidosis (DKA)- TB raised that increasing numbers of SGLT2 inhibitor related DKA admissions had been noticed at NUH due to sick day rules not being applied. The MSO group are looking at this area and producing some advice that will be communicated to primary care.

- Sativex- A few enquiries had been received and an update on progress at NUH was requested.
  ACTION: TH to follow up this issue

- Primary Care LES payments- DW had requested that it be raised that cinacalcet and midodrine monitoring is not currently funded appropriately in primary care. LC will raise this with Rachel Harrold.
  ACTION: LC to follow up

- Teamnet- It was raised that Teamnet can be used without a login and this may be a useful platform for other organisations. It was suggested that the website be demonstrated at a future meeting so that members from other organisations can see its functionality.
  ACTION: LC to follow up this issue

- Hypothyroidism in pregnancy- It had been identified that NUH guidance for this condition contained expectations of primary care to monitor and manage these patients, but there was a lack of awareness about this in Primary care.
  ACTION: LC to follow up this issue

- Mental Health requests for prescriptions- There had been some issues in the Mansfield area with the Local Mental Health team asking patients to request prescriptions from their GP and this was not felt to be appropriate. HG will follow up with the pharmacist for that area.

20. Date of next meeting – 16th December 2021

The meeting finished at 17:30 pm