COVENTRY & WARWICKSHIRE
AREA PRESCRIBING COMMITTEE

MINUTES OF THE COVENTRY AND WARWICKSHIRE AREA PRESCRIBING COMMITTEE HELD ON FRIDAY 18th JANUARY 2019 AT 12.30 PM IN THE CLINICAL SCIENCES BUILDING (CSB) AT UHC&W NHS TRUST

PRESENT:-
Simon Fletcher – University Hospitals Coventry & Warwickshire NHS Trust (SF) – Chair
Altaz Dhanani – Coventry & Rugby CCG (AD) - APC Secretary
Joe Booker – Coventry LMC (JB)
Jane Smith – Coventry GP (JS)
Claire Keane – Coventry GP (CK)
Nigel Johnson – Warwickshire LMC (NJ)
Helen Edwards – Arden & GEM CSU representing South Warwickshire CCG (HE)
Kim Panting – South Warwickshire GP (KP)
Sumara Parvez – South Warwickshire NHS Trust (SP)
Ashwin Hindocha – Coventry LPC (Ahi)
Satyan Kotecha – Warwickshire LPC (SK)
Hardeep Bagga (Deputy) – University Hospitals Coventry & Warwickshire NHS Trust (HB)
Cath Sansby - University Hospitals Coventry & Warwickshire NHS Trust (CS)
Debra Armstrong – George Eliot Hospital NHS Trust (DA)
Loay David – George Eliot Hospital NHS Trust (LD)
David Tait – Coventry & Warwickshire Partnership Trust (DT)
Ian Bayman – Lay Member (IB)
Zoulikha Zair (FY1 doctor) - University Hospitals Coventry & Warwickshire NHS Trust (ZZ)
Mark Easter - University Hospitals Coventry & Warwickshire NHS Trust (ME)

IN ATTENDANCE: Anita Hunjan (AH), Susan Dhesi (SD)

The meeting started late due to not being quorate with a secondary care clinical representative

1. APOLOGIES

Richard Lambert, Bernhard Usselmann

SF will be arriving late; therefore AD chaired the meeting until his arrival.

2. MINUTES OF THE LAST MEETING

The minutes of the last meeting held 16th November 2018 were agreed as accurate with the exception of few amendments to page 3, additional sentence missing at the end of item 5.3.2 "*Patients would require*

training on how to use it as it looks very similar to existing insulin devices" and a change of wording to the sentence on item *5.3.3 "….there was a major reduction in cardiovascular adverse events"* which were to be amended prior to publication of the minutes.

2.2 - **Action log** – *AD* went through a couple of outstanding actions;

- *September 2018 item 5.1 Netformulary amendment* – CS reported that UHCW specialists have suggested to combine the SCA's of testosterone topical gel and testosterone injection into one, she thought this could be discussed further at the next working group meeting
- *November 2018 item 6.4 MDS & Prescription Ordering Assessment form* – SD confirmed that this was now in progress

AD reminded the committee to complete the declaration of interest form and hand to Susan at the end of the meeting.

3. MATTERS ARISING

There were no matters arising.

4. Drug Positioning Statements

4.1 - **Semaglutide –** A DPS for treatment of adults with insufficiently controlled type 2 diabetes mellitus was brought to the committee for consideration;

4.1.1 - AH summarised the contents of the draft DPS; stating that this was an action from the joint formulary application (UHCW) submission at the last meeting. It is a sixth GLP-1 agonist, a fourth once weekly preparation, which has three different available strengths starting at the lowest strength and moving up to maximum of 1 mg per week. It is licensed for use as monotherapy but also in addition to other medicinal preparations. The trials showed superiority versus dulaglutide, exenatide (Bydureon®▼), sitagliptin and insulin glargine. The side effects are similar to the other GLP-1 preparations. NICE TA is still in development and SMC advice is to be confirmed. The WMSG did recommend for monotherapy but did not recommend with other therapies

4.1.2 - IB spoke about his view from the last meeting's discussions, stating that it was important to consider the cardiovascular risk in treating diabetes mellitus. Other things being equal, liraglutide should be preferred, certainly if established atherosclerotic CVD is present. Otherwise, if frequency of dosing is an issue, semaglutide may be appropriate. He suggested that the DPS verdict statement should include CVD risk and then perhaps use as first-line if appropriate

4.1.3 - LD remarked that he supported IB comments and confirmed that CVD risk was an essential part of controlling diabetes

4.1.4 - AD asked IB to email him a paragraph statement for him to include in the draft DPS verdict which he will send out to the committee for virtual ratification

4.1.5 - AH pointed out that a revised GLP-1 comparison chart should be tabled for March's meeting

The committee agreed that the DPS verdict to read as *'recommended for use in primary care*' and to include CVD criteria.

4.2 - **Roflumilast** – A revised DPS for treatment of severe chronic obstructive pulmonary disease (COPD) was brought to the committee for reconsideration;

4.2.1 - AH informed the committee that the current published verdict states *'not* recommended' but there have been updates on specific recommendations:

- NICE TA recommends it as an add-on to bronchodilator therapy for treating severe chronic obstructive pulmonary disease in adults with chronic bronchitis for those patient who have exacerbations, and that the drug should be initiated by a specialist
- GOLD recommends it for patients on LABA/LAMA with exacerbations (where there is a low beneficial ICS response)
- SMC still state '*not recommended for use'*

AH added that the main side effect was weight loss which needs to be monitored and it should be used in caution in patients with depression or psychiatric or anxiety symptoms

4.2.2 - IB thought it would be better to go with the GOLD recommendation

4.2.3 - The committee wondered if the drug classification should be changed to specialist initiation (SI)

4.2.4 - NJ had concerns around the number of cautions for this drug; primary care needs to be made aware of the monitoring information, he suggested that a specialist initiated drug checklist (SIDC) should be devised

4.2.5 - LD also queried the monitoring process and how would this be implemented

4.2.6 - DA highlighted that all drugs should have better communication between secondary care and primary care

4.2.7 - The committee deliberated on the monitoring review timescale - within 3 or 6 months, whether it would benefit having a drug checklist or should the monitoring be continued at the respiratory clinic

4.2.8 - JB added that most COPD checks would be dealt by the practice nurses not the GP

4.2.9 - SK suggested that the checklist should include the new medicines service (NMS), so that community pharmacist would then have patient interaction

4.2.10 - JS added that the monitoring process was crucial in primary care

4.2.11 - AD concluded that the working group will devise a SIDC, seek appropriate monitoring review advice from the three trust respiratory consultants and bring both items back to the next meeting

The committee agreed for this item to be discussed further with a SIDC at March's meeting.

4.3 - **Binosto® -** A DPS for treatment of postmenopausal osteoporosis was brought to the committee for consideration;

4.3.1 - HE summarised the contents of the draft DPS; stating that this was an action from the joint formulary application (GEH) submission at the last meeting. An effervescent tablet licensed as alternative formulation to Alendronic acid standard release tablets and Alendronic acid oral solution. In terms of the cost comparison the effervescent tablets are 30 times more expensive compared to the standard release tablets for a month's supply and parental preparation will be expensive because of the administration and clinic times. It is marketed to have high buffering capacity. There is no specific place in therapy by NICE, SMC have accepted the tablet for restricted use for those patients who are unable to swallow tablets

HE said that in terms of our local formulary it could be placed as third line option but there appears to be lack of data indicating which cohort of patients this would help

4.3.2 - JB raised concerns about the statement stating '*restricted for those patients who are unable to swallow tablets',* he pointed out that there are lots of patients who do not like to swallow tablets whom might not meet the criteria for Binosto®

4.3.3 - LD favoured the SMC statement but when Alendronic acid is not appropriate the side effects still remain the same for effervescent tablet. JS requested if the side effect statement could be included in the DPS verdict

4.3.4 - SP questioned whether the effervescent tablet could go down PEG feeds, as the liquid formulation is an unlicensed special

4.3.5 - HB read out to the committee the NEWT guidance statement which states for swallowing difficulties use – '*effervescent tablets or the oral solution. Alternatively consider using the once-yearly Zoledronic acid tablet'* and for enteral tubes states *'no information on administrating effervescent or oral solution via enteral tubing feeds has been located'*

The committee agreed that the DPS verdict read as *'recommended for use in primary care*' and to include the SMC statement.

4.4 - **Tapentadol SR** – A decision review application submitted by UHCW Consultant Rheumatologists, requesting the inclusion for rheumatologist to prescribe this drug for chronic pain management was brought to the committee for consideration;

4.4.1 - CS briefly summarised the reason for this request; the drug is currently classified as SI only from the pain clinic team, the rheumatologists would prefer to prescribe under the same conditions stated in the DPS and SIDC which would then not delay tapentadol prescribing for their patients

4.4.2 - LD and SP had concerns that this process could increase the usage of the drug; SP added that at SWFT they do not advocate the use of tapentadol. CS replied the intention is to use the first line agents and only prescribe this drug if there is failure to respond to all other opioid agents

4.4.3 - JS believed that her experience from the rheumatologists is that they do follow the pain pathway

4.4.4 - LD also suggested to include in the verdict *'patients who are already on opioid drug but not responding after dose optimisation'*

4.4.5 - HB explained that it currently leads to disadvantages of the patient journey; referral delays at the pain clinic and delays in next follow-up review. He felt that if there was assurance from the rheumatologists that they would follow the pain clinic process then it would benefit the patient's chronic pain treatment

At this point ME attended the meeting

4.4.6 - The committee debated on the pain management criteria in secondary and primary care and also that the DPS statement should reflect the local agreement at each trust

4.4.7 - AD concluded that he will reword the DPS verdict with the committee comments and send out for virtual ratification

The committee agreed to revise the verdict, then republish the DPS.

Section 4 Decisions		
Code	**Action**	**Action by:**
4A	Email APC office a draft CVD risk statement for Semaglutide DPS verdict	IB
4B	Write Semaglutide DPS verdict & send out for virtual ratification, format document then publish on both websites	AD/SD/ALL
4C	Add Roflumilast item to next meeting agenda, devise and present a SIDC	AH/HE/SD
4D	Write Binosto® DPS verdict & send out for virtual ratification, amend & format document, then publish on both websites	AD/SD/ALL
4E	Re-write Tapentadol SR DPS verdict & send out for virtual ratification, then republish DPS	AD/SD/ALL

5. Specialist Drugs/netFormulary

5.1 - **NetFormulary Amendments** – Nine proposed amendments from ArdenGEM CSU were brought to the committee for consideration;

5.1.1 - HE highlighted that the following new drugs have been issued with a NICE TA and recommended classification as specialist only (SO);
Dabrafenib with trametinib – two indications, Gemtuzumab ozogamicin with danorubicin and cytarabine, Padeliporfin and Tofacitinib for ulcerative colitis

Also for the inclusion of four new drugs that are on the allergic rhinitis pathway which was approved at the last meeting;

Azelastine nasal spray, Fluticasone propionate nasal spray, Fluticasone furoate nasal spray and Mometasone furoate nasal spray

The committee agreed for these proposals to be included on the netFormulary.

5.2 - **Netformulary Amendments** - Five proposed amendments from Coventry and Rugby CCG (CRCCG) were brought to the committee for consideration;

5.2.1 - AH highlighted that this request has come from the COPD specialist because *Azithromycin for prevention of exacerbations in COPD and bronchiectasis in selected high risk patients* is not on the netFormulary. She thought that the drug could be classified as specialist advised (SA) or SI. GOLD and NICE both state that patients should have a regular review by the respiratory specialist. AH thought a drug checklist could be created similar to Roflumilast

5.2.2 - IB pointed out some discrepancies on the reference column of the form

5.2.3 - AH explained that the following twelve new GI drugs amendments were part of the on-going review of the netFormulary chapters;

Recommended as preferred choice are: *Ispaghula husk, sterculia, Methylcellulose tablets, Docusate, Bisacody, Senna, Sodium picosulfate, Glycerol (Glycerin) suppositories, Bisacodyl suppositories, Docusate enema, Sodium citrate compound enema. Co-danthramer sugar free suspension* is licensed for use in terminally ill patients only

AsH pointed out that *Co-danthramer sugar free suspension* is extremely expensive, SK added that this drug should only be prescribed when other palliative care drugs have failed. The committee felt that it should be classified as second line and to include the statement that *'it is only to be used as an optional therapy'*

Arachis oil enema recommended as '*not recommended'* because of the risk of peanut allergy and there are other options available

Orlistat 120 mg capsule recommended as preferred choice for obesity indication and has a NICE clinical guidance

The committee agreed for these proposals to be included on netFormulary, except to bring back Azithromycin amendment form with a SIDC to the next meeting.

Section 5 Decisions		
Code	**Action**	**Action by:**
5A	Publish the agreed specialist drugs to netFormulary	HE/SD
5B	Publish the agreed formulary drugs to netFormulary	HE/SD
5C	Add Azithromycin netFormulary form to next meeting agenda, devise and present a SIDC	AH/HE/SD

6. Guidelines/Resource Documents

6.1 - **Community Antibiotic -** A revised guidance which incorporated UHCW Microbiologist amendments on page 6 for treatment of tonsillitis and sinusitis was brought to the committee for consideration;

6.1.1 - AH explained that the duration of treatment to be changed for phenoxymethylpenicillin 500 mg/1g to 5 – 10 days and insert a FeverPain score in order to find a pathway for treatment

6.1.2 - DA felt that duration was a wide variation, considering the implementation of antimicrobials resistance and antibiotic CQUINS, AH said it was added to give prescribers the option

6.1.3 - LD commented on some changes that were required for *'Genital Tract Infection'* section, he requested to change the Doxycycline 100 mg as first line for Chlamydia trachomatis indication. He suggested adding these minor amendments to the guidance and reviewing GTI section at a later date when there was official consensus

6.1.4 - SK noted a change required to page 2 of the guidance under UTI section '*Nitrofurantoin MR' preparation* cost is cheaper

6.1.5 - AH mentioned that the microbiologist has also agreed to amend the sinusitis section for those antibiotics that are needed after 2 – 3 weeks or more; there are variations to use Penicillin or Co-amoxiclav (second line) in line with NICE CKS

The committee agreed to amended the guidance with the committee comments and bring back to the meeting.

At this point SF joined the meeting.

6.2 - **PPI Step down –** A patient leaflet devised by UHCW Gastroenterologist and CRCCG Medicines Optimisation team was brought to the committee for approval;

6.2.1 - CS explained the purpose for this leaflet was to reduce overuse of the high dose PPIs in both secondary care and primary care. The Medicines Optimisation Practice Support Pharmacists are currently implementing a project whereby they will look at those patients in GP practices that are on a high dose PPI. A similar project will be starting on UHCW wards, starting with Gastroenterology ward then Elderly Care ward, to potentially stop their medication by following the specific criteria. The leaflet will be published in the resource section of the website for GPs to use when they are reviewing patients

6.2.2 - JS thought that this patient leaflet was excellent and felt that GPs do require more assistance on PPIs.

6.2.3 - SK commented on 2 points, page 1 to highlight some clear reasoning *why it is important to step down or stop PPIs',* so that patients do not think it is just about saving costs. On page 2 step 1 paragraph **"How do I stop or reduce my PPI?"** to reword the sentence and

change the dose figures *to 'If you are on a high treatment dose, try to reduce your dose to a lower maintenance dose'*

The committee agreed to amend and then publish the patient leaflet.

Section 6 Decisions		
Code	**Action**	**Action by:**
6A	Amend community antibiotic guidance with committee comments and present again for further discussion	AH/HE
6B	Amend PPI step down – patient leaflet with committee comments and publish in the resource section	CS/SD

7. Shared Care Agreements

AD introduced this section and gave a brief background to why these items presented today, to check that the documents were still fit for purpose, the shared care process and transfer is still being applied. The documents were last written in 2013 and are due for an overall review. AD added that today's discussion was not about the current SCA issues that commissioners and providers are currently facing.

7.1 - **Shared Care Agreement process, Algorithm, SC letter –** this document is a summary description of the process for safe prescribing of the specialist shared care drugs.

7.1.1 - SF requested if the shared care letter could be made more visible on the APC website, AD said that he will look into this to have easy access on the website

7.1.2 - AD went through the following recommended changes and the committee briefly discussed these points;

- To remove the word 'fax' out of the document as this system is not secure whereas NHS.net is a secure system
- Issues occurring in primary care
- Whether a telephone call follow-up should be done as well as SCA and letter sent to the GP
- Should the SCA document be copied to the patient
- The specialist informs the patient at the same time that they request the GP to continue prescribing. LD pointed out that most GPs will accept SC drugs, otherwise it will delay the prescribing process
- Committee deliberated '*when does the shared care treatment discussion* start'
- Questions raised about patient stabilisation

7.1.3 - AD also talked about the NHS England document '*Responsibility for prescribing and transferring care from secondary to primary care'* , which gives key principles for shared care or discharge of patients. The GP would be invited to participate in the shared care process. RMOC will also be looking into this so that it will be a national process. He added that he will disseminate the NHS England document to the committee.

7.1.4 - CK said that in Coventry the shared care system is excellent, the issues and safety concerns occur for those out of area especially (including student patients) that have been seen by their local trust specialists

7.1.5 - DT pointed out that on the NHS England document there is an additional bullet point for if GPs are not willing to participate.. *"They should then discuss that with relevant parties so that additional information or support could be made",* he asked if that statement could be included in the APC documents

The committee agreed for the three documents to be amended with proposal changes, and then republish

Section 7 Decisions		
Code	**Action**	**Action by:**
7A	Email the NHS England principles document to committee	AD
7B	Amend the shared care agreement documents: process, algorithm, letter and republish	AD/SD

8. Drug Checklist

8.1 - **DOACs documents** - Four revised specialist advised checklists: Apixaban, Dabigatran, Edoxaban and Rivaroxaban were brought to the committee for reconsideration;

8.1.1 - HE confirmed that these amended checklists have been reviewed as a result of comments from the 3 hospital trusts' pharmacists and have also been reviewed by a haematologist and cardiology specialist at UHCW. She read out some of the key changes that might require further discussion;

- Renaming of the DOACs checklist as they are classified as SA
- To reformat the final documents with page 1 having the information and page 2 having a checklist form
- Cockcroft and Gault calculator formula explained with the website link
- Information on extreme body weight
- Information to patients – supplying an alert card and booklet

8.1.2 - The committee had a separate discussion on the transfer issues that occur in primary care

8.1.3 - CK mentioned that the GP EMIS system calculates a different version to the Creatinine Clearance (CrCL) >15 mL/min for renal patients. SF confirmed that the Cockcroft and Gault method should be used and is the most accurate

8.1.4 - LD queried why UHCW do not use an accurate eGFR formula, SF said that he will chase the CKD formula clarification

8.1.5 - CS mentioned some discrepancies in the overview section

The committee agreed for the revised checklists to be formatted and then republished

Section 8 Decisions		
Code	**Action**	**Action by:**
8A	Reformat the four DOACS SIDCs and republish on both websites	**HE/SD**

9. APC Development

9.1 - **Prescribing of Liothyronine** - AD added that due to time constraint this item will be presented at the next meeting.

Section 9 Decisions		
Code	**Action**	**Action by:**
9A	Add Liothyronine item to March's agenda	**AD/SD**

10. AOB

10.1 - **Medicines Pathway Committee -** A revised terms of reference (TOR) for the new medicines pathway committee (MPC) was brought back to the committee for reconsideration;

10.1.1 - ME summarised a brief background and explained how the process would work across all three trusts, focus would mainly be looking at the non-tariff High Cost Drugs for all three acute hospitals and the decisions made in the committee will be adapted as a policy in all three Trusts. He stated that the current system and referral access does not work and it will reduce duplication of workload

10.1.2 - LD commented that this TOR was a much improved version, but felt concerns that the high costs drugs already have a NICE TA guidance. He wondered why another new committee should be created and how will it benefit secondary care. ME replied that the plan is to harmonise practice across the whole health economy and to add the new meeting in conjunction with the APC committee because most of the members would already be in attendance

10.1.3 - IB noted that the document has discrepancies in the title name through the TOR, it seems that there are insufficient pathways between the various trusts, if that is the case, then this new committee would be a solution but not to judge whether the drugs are valuable or not

10.1.4 - HE commented on behalf of the ArdenGEM CSU High Cost Pharmacist, there should be a robust process for the non-NICE approved drugs to be funded and used at CCG level; this would need to involve the commissioners . The quoracy does not state a commissioner representative

10.1.5 - NJ said the only issue would be the timings of fitting in another meeting, ME replied that the MPC meeting would not add time but be scheduled within the APC committee time schedule

10.1.6 - DT questioned about the mental health drugs and when would they come into tariffs, he asked for some clarification on this

10.1.7 - AD expressed that it was crucial to have a commissioner representative at the meeting; ME added that focus would be on tariff drugs and NICE TA remits

The committee agreed to commence this new pathway committee.

10.2 - AD stated that as the meeting had come to a close, he will email the other AOB items for a virtual discussion.

Section 10 Decisions		
Code	**Action**	**Action by:**
10A	Set-up the new Medicines Pathway Committee; meeting dates etc	**ME/AD**
10B	AD to email AOB items to committee for a virtual discussion	**ALL**

11. Date of next meeting

The date and time of the next meeting is Friday 15th March 2019 at 12.30pm until 3pm.