NHS

AREA PRESCRIBING COMMITTEE MEETING
Birmingham, Sandwell, Solihull and environs
Minutes of the meeting held on
Thursday 13th September 2018
Venue – Birmingham Research Park
Vincent Drive, Birmingham, B15 2SQ

PRESENT:

Dr Lisa Brownell	BSMHFT (Chair)
Dr Paul Dudley	Birmingham and Solihull CCG
Prof Mark DasGupta	Birmingham and Solihull CCG
Satnaam Singh Nandra	Birmingham and Solihull CCG
Dr Nashat Qamar	Birmingham and Solihull CCG
Nilima Rahman-Lais	Birmingham and Solihull CCG
Dr Sonul Bathla	Sandwell & West Birmingham CCG
Katy Davies	UHB NHS FT
Carol Evans	UHB NHS FT/ Birmingham and Solihull CCG
Gurjit Kudhail	UHB NHS FT
Jonathan Boyd	Sandwell & West Birmingham CCG
Jeff Aston	Birmingham Women's & Children's NHS FT
Dr Neil Bugg	Birmingham Women's & Children's NHS FT
Nigel Barnes	BSMHFT
Dr John Wilkinson	Birmingham and Solihull CCG
Ravinder Kalkat	Midlands & Lancashire CSU
Daya Singh	Midlands & Lancashire CSU
Kuldip Soora	Midlands & Lancashire CSU

IN ATTENDANCE:

Adele Linthwaite for item 0918/05	Birmingham and Solihull Mental Health NHS FT
Mark Poyner for item 0918/05	UHB NHS FT

No.	Item	Action
0918/01	**Apologies for absence were received from:** Prof Jamie Coleman, UHB NHS FT Inderjit Singh, UHB NHS FT, deputy attended Dr Sangeeta Ambegaokar, Forward Thinking Birmingham Partnership Dr Angus Mackenzie, Sandwell & West Birmingham Hospital NHST Mary Johnson, SES&S Peninsula CCG Kate Arnold, Birmingham and Solihull CCG It was confirmed that the meeting was quorate.	
0918/02	**Items of business not on agenda** (to be discussed under AOB) • Licensed ciprofloxacin ear drops • Nitazoxanide use within Birmingham Women's and Children's NHS Foundation Trust • Prescribing of anti-depressants in patients aged below 18	
0918/03	**Declaration of Interest (DoI)** The APC secretary has recently requested committee members to complete their annual declarations of interests. There are some outstanding and members were reminded to submit these at the earliest opportunity. There were no interests to declare relating to items on the agenda.	
0918/04	**Welcome and Introductions** The Chair welcomed everyone to the meeting today. The Chair reminded members, that the meeting is digitally recorded for the purpose of accurate minute taking and once the minutes are approved, the recording is deleted by the APC secretary.	
0918/05	**Urgoclean® Wound Care Group recommendation -** Wound product evaluation – Urgo Medical UK It was established that there were no Declarations of Interests for Urgo Medical UK. The wound product evaluation for Urgoclean® was circulated with the papers for the meeting The Chair welcomed Adele Linthwaite, Birmingham and Solihull Mental Health NHS FT and Mark Poyner, UHB NHS FT to the meeting and invited them to present the wound recommendation for Urgoclean®. Adele Linthwaite explained that she has used the product in various Trusts and there is currently no product on the formulary that works as effectively at desloughing wounds and is as pain free as Urgoclean®. Mark added that from experience in diabetic foot clinic, other products such as gel dressings if used can make sloughy wounds too wet. The Chair invited questions or comments from members. Discussion points/concerns raised included: • Urgoclean® can be used on surgical wounds and pressure ulcers.	

- A member asked what the wound care group were using prior to Urgoclean®. Adele responded that it depends on the exudate level of the wound and they have used products such as Aquacel® albeit unsuccessfully. This has meant wounds have taken longer to de slough. Other methods such as surgical debridement and sharp debridement can be used but are not appropriate in all settings. Urgoclean® provides a gentler, non-invasive and faster way to deslough.
- A member asked whether the product was considered at the initial BSSE APC wound formulary review. A fellow APC member responded Urgoclean® was requested to be added to the formulary at that point. It was not on any of the local trust formularies therefore a wound care group evaluation was requested. As a result of that, this application for Urgoclean® is being presented today.
- How many patients do you anticipate treating with Urgoclean® in a 3-month period? Mark responded that possibly 1 to 2 patients may be treated with this dressing in the diabetic foot clinic. Antimicrobial dressings are used more often than Urgoclean® in this setting. The use of this dressing will vary according to setting and the dressing is quite specific to its role in wound management.
- A member asked what is the alternative to this product if APC refuse? The representatives responded that there is no comparable alternative to this on the formulary.
- A member raised concern that if Urgoclean® is approved and is given a Green RAG rating then this may lead to inappropriate prescribing and asked if there are any guidelines for its use. Mark responded that the key marketing of Urgoclean® is that it is used specifically for sloughy wounds.
- A member asked what setting this dressing would be anticipated to be used in. Additionally, whether it is to be used in community by district nurses or practice nurses and if so, would any training be provided. Adele responded that she can envision it to be used quite widely in the community setting and would feed back to the community representative of the Wound care group regarding training and the possibility of clarifying Urgoclean®'s position within the wound management pathway.
- A member raised a point that as there is no contraindications to this dressing and can be used for both sloughy and non-sloughy wounds then this may become the go to dressing for all types of wounds. The representatives responded that this dressing would be clearly marked for de sloughing for each of the local community formularies and would sit in its own category.
- Urgoclean® will fulfill an unmet need as there have been wounds that have deteriorated as this product has not been available on formulary. The wound care group is proposing a RAG status of Green, therefore available to prescribe in primary care or secondary care without making a referral to a tissue viability team.
- There is no cost pressure associated with Urgoclean® and there is not expected to be an increased spend in wound care products if Urgoclean® is approved as this is price equivalent to what is currently being used.

The Chair thanked Adele Linthwaite and Mark Poyner for attending the meeting, for answering all the questions from the APC members and advised them that the decision would be relayed within 5 working days, in line with APC policy.

Further discussion points in the absence of the representatives included:

- A member expressed concerns that if given Green RAG status Urgoclean® may be used inappropriately for all types of wounds.
- It was agreed that the Wound care group amend the pathway/dressing matrix so that Urgoclean® position in wound care is clear.

The Chair directed the members to the Decision Support Tool for completion:

Patient Safety: No issues

Clinical effectiveness: Local evaluation positive

Strength of evidence: Local evaluation

Cost-effectiveness or resource impact: Cost saving compared to current practice

Place of therapy relative to available treatments: 1st line option for sloughy wounds

National guidance and priorities: N/A

Local health priorities: N/A

Equity of access: N/A

Stakeholder views: N/A

Implementation requirements: To clarify where Urgoclean® fits into the current wound algorithm.

Decision Summary: Urgoclean® to be added to the formulary as GREEN.

ACTIONS:

- **Wound care group to define the position of Urgoclean® within the current algorithm.** — **SSN/Wound care group**
- **Relay decision to the Wound Care Group by Thursday 20th September 2018** — **APC sec**
- **Add Urgoclean® to APC formulary as Green** — **APC sec**

0918/06 Wound care products evaluation procedure - for ratification

The Chair directed members to the wound care products evaluation procedure.

Decision Summary: The document was approved.

0918/07 BSol CCG Over the Counter medicines policy

The Chair directed members to the Birmingham and Solihull CCG (BSol CCG) policy that had been circulated with the papers for the meeting.

A BSol CCG representative member explained NHS England in conjunction with NHS Clinical Commissioners produced guidance for CCGs in April this year on conditions for which OTC items should not be routinely prescribed in primary care. BSol CCG has produced a policy in line with this guidance.

The BSol Over the Counter (OTC) medicines policy has been approved and will be implemented. The CCG is bringing the policy to APC for information and a

request for support in implementation. The CCG asks for there to be reference to the policy on the BSSE APC formulary website.

In addition, this is a request to the member Trusts to support the implementation of the policy as OTC medicines are commonly prescribed in both secondary care and primary care. Trusts are requested to ensure their Emergency departments are fully aware of the policy and deliver the same messages as GPs will be delivering. Supporting materials can be made available which can be displayed within Trusts. Trusts should also advise those individual directorates which may make recommendations to GPs to prescribe OTC products as part of a medication regime.

It was added that the document does not signify that OTC medicines should not be used in any circumstances but rather it gives the GP the opportunity to discuss with the patient whether they would be willing to purchase the medication rather than having on prescription.

Members agreed with the policy but felt the timeline given by NHS England is challenging. They felt that it could take several years to change the viewpoint of patients, but it is a good initiative and benefits will be seen over the next couple of years.

A member expressed that it is important everyone supports the policy as this will make patients aware this policy is in effect across the whole region, between secondary and primary care and not solely in certain practices.

A member noted there is very little done nationally in terms of marketing to support the policy and appears to be more of a local awareness campaign.

ACTION:

- **BSol CCG Over the counter policy to be linked on the APC formulary website** — **APC sec**

0918/08 BSSE APC documents - for ratification

The Chair directed members to the final APC ToR, APC Policy, Decision Support Tool (DST) and website wording. The documents had recently been discussed at the June Away day and July APC meeting. These are the final versions for ratification.

There were no further comments regarding these documents. The documents were approved.

ACTION:

- **Publish final ToR, Policy, DST and website wording onto BSSE APC website.** — **APC sec**

0918/09 BSSE APC Feraccru RICaD – for ratification

Feraccru® was approved onto the formulary as AMBER with RICaD following an application in December 2017. The Chair directed members to the revised Feraccru® RICaD.

The Chair invited questions or comments from members. Discussion points/concerns raised included:

- A primary care representative member referred to the continuing monitoring requirement for GPs in the RICaD where it states "*GPs to monitor Hb every 3 months for a year after correction, then 6 monthly".* The member supposed if a patient is requiring regular iron then they are most probably visiting their Inflammatory Bowel Disease (IBD) clinic 6 to 12 monthly and it would be more appropriate for bloods to be tested in this setting if this is the case.
- Another primary care member stated that to fulfill this he would check the system to see if the hospital had been doing regular blood tests and if not would request them. In this members experience, the IBD nurses often follow up with patients via telephone call rather than a face-to-face appointment, so they may not be able to easily take bloods.
- A member stated for safety reasons, whoever issues the prescription should be responsible for the monitoring of the patient. This may be done by accessing the results via a system if they are available. If unavailable, the GP would be expected to request bloods.
- A member clarified according to the monitoring requirements of the RICaD, GPs have to continue to monitor the patient for clinical effect after the treatment has finished after 3 months. GPs do not typically see patients who are stable. However, the clinic may be seeing the patient as a result of other agents the patient is on as a result of their IBD.
- A member queried why the RICaD indicated that specialists do not prescribe the full 3-month course. A member clarified during the initial presentation for Feraccru® this was considered, and the APC concluded for better patient access, specialists to initiate the treatment and for GPs to continue.
- It was raised that the requirement for GP to monitor for clinical effect after 3 months could potentially mean that the GP has the onus to reissue Feraccru® if parameters are out of range.
- Members agreed that the post treatment therapeutic response should not be part of the RICaD and should be part of ongoing clinical care letter. If a patient is being routinely reviewed in IBD clinic then there would be no need for primary care involvement as the clinic would be undertaking the relevant monitoring.
- APC members agreed to return the RICaD back to author for review.

ACTION:

- **Feraccru® RICaD to be updated in collaboration with UHB NHS FT** — **SSN/APC sec/UHB NHSFT**

0918/10 Summaries for decline to prescribe – for information

The Chair directed members to the Summaries for Decline to prescribe (DtP) that had been received from UHB NHS FT QE, Birmingham Women's and Children's NHS FT, Sandwell and West Birmingham NHS FT and UHB NHS FT HGS.

<u>The Chair invited questions or comments from members. Discussion points/concerns raised included:</u>

- It was agreed no significant trends could be observed from the summaries to Decline to Prescribe (DtP) that would impact on services.
- A member observed that from the summaries primary care colleagues have given justifiable reasons for declining to prescribe medication. A

member noted the use of DtPs are embedded within certain Trusts more than others.

- The Chair encouraged Trusts to continue to use the DtP forms in a systematic way which may mean that the Trust request DtPs are filled in or clinicians fill in the form themselves following correspondence from the GP. In addition, CCG members should encourage primary care colleagues to complete DtPs to build a better understanding of any issues surround shared care agreements.
- Local Medical Committee (LMC) have stated that shared care agreements are not compulsory. Overall, there is significant cooperation.
- Feedback was required on which practices are not filling in the DtPs.

0918/11 DTC Chairs Non-formulary approvals – for information

A summary from UHB NHS FT QE, SWB NHS T, BWCH and UHB NHS FT HGS were included in the papers circulated for the meeting. For information; no action required.

0918/12 Regional Medicines Optimisation Committee (RMOC) recommendations – for information

RMOC shared care data capture

The RMOC (Midlands and East) is interested to understand the shared care processes that are currently in place across the Midlands and East, and particularly to be aware of the specific issues and medicines that create difficulties in this region. In order to do this APCs are asked to discuss this issue as an agenda item and respond to three short questions. The APC secretary directed members to the shared care data capture which was circulated with the papers.

The APC members proceeded to agree answers to the questions presented on the RMOC shared care data capture.

- To the question *Does the area operate an effective shared care process? (if yes, please forward an electronic link or a copy)* Members answered yes referring to the Effective Shared Care Agreements (ESCAs). In addition, it was felt that the RICaDs and their purpose should be mentioned. An example of ESCA and RICaD would be included.
- *Does this include a "traffic light" system for specific medicines?* Yes
- *What are the three main issues that create difficulties at care interfaces?* 1. Practicality for example whether the appropriate ESCA/RICaD is being sent and a response received appropriately. 2. Primary care/GP confidence and capacity to participate into shared care arrangements. This varies across the area. 3. Variability in the perception of whether this is core GMC/GP work.
- *What are the five most common medicines or classes that create most difficulties at care interfaces?* Members agreed denosumab, antipsychotics, disease modifying antirheumatic drugs (DMARDs) particularly methotrexate, Attention deficit hyperactivity disorder (ADHD) medicines and Paediatrics in general.

ACTION: Send the completed return to RMOC before the deadline 30th September 2018. **APC sec**

North RMOC Update June 18 and London RMOC Update July 18

The Chair directed members to the North RMOC Update June 18 and London RMOC Update July 18.

It was noted that some APCs have implemented the RMOC recommendation on FreeStyle Libre®. There was discussion amongst members whether the decision around FreeStyle Libre® was an APC decision or a commissioning decision and it was agreed in fact that it was a commissioning decision.

There was no other issues or comments made.

Free of Charge (FOC) Medicines Schemes: RMOC advice for adoption as local policy

The Chair directed members to the RMOC advice concerning what should be in place regarding local policies on compassionate use/free of charge medicines.

The BSSE APC Position Statement on Use of Manufacturers' Free of Charge Medicines Schemes is also due for review.

It was agreed amongst members that a review of the current APC policy on Free of Charge medicines schemes should be carried out in comparison to the RMOC advice.

ACTION:

- **Highlight differences between BSSE APC Position Statement on Use of Manufacturers' Free of Charge Medicines Schemes and the RMOC advice on Free of Charge Medicines and feedback to APC** **APC Sec**

0918/13 Minutes of the meeting held on Thursday 12th July 2018 – for ratification

The minutes of the meeting held on Thursday 12th July 2018 were discussed for accuracy.
No comments were made. It was confirmed that the minutes are approved, can be uploaded to the APC website and the recording deleted.

0918/14 Matters Arising

The APC sec moved onto the action table enclosure for comments and updates. Actions that were not discussed were considered to be closed.

The outstanding actions include:

- 0618/10 – Emollient Bath Additives- Approach dermatologists to comment on the article and summarise their position on the use of bath emollients. Update: Collective response received from UHB NHS FT HGS. Dermatologists inclusive of paediatric dermatologists disagreed with action to remove the bath emollients from formulary based on a study which they believe is limited. Another trust representative received comment from dermatology stating they would like to retain antimicrobial bath oils on the formulary as they have not been assessed but they would not use ordinary

bath emollients routinely. It was decided that the emollient bath additives should remain on the formulary as GREEN.
ACTION: APC secretary to relay decision and thanks to the dermatologists on behalf of APC **APC sec**

- 0518/10 Feedback from Midlands & East Regional Medicines Optimisation Committee – Secondary care representatives to report back re: Ethambutol 400mg in 5ml, Pyrazinamide 500mg in 5ml, Isoniazid 50mg in 5ml Update: HEFT ID department approves. BCH NHS FT supportive. No other comments have been received.
  ACTION: Standardise the strengths of oral liquids for anti-TB medicines on formulary website **APC sec**

- 1017/07 Pan Birmingham Respiratory Clinical Network Asthma Guidelines Update: Guidelines produced and are currently being ratified. Scheduled for upcoming APC meeting.

- 0717/06 Enteral Nutrition – Harmonisation of BNF section 9.4 Update: Scheduled for October 2018 APC meeting

Long standing actions are currently being reviewed by the APC secretariat and members will be contacted regarding these.

0918/15 NICE Technological Appraisals (TAs)

In July 2018, there were 6 TAs published; all 6 are NHSE commissioned.

In August 2018, there were 5 TAs published; of these, 3 are NHSE commissioned, 2 are CCG commissioned. The CCG commissioned are:

- Ixekizumab for treating active psoriatic arthritis after inadequate response to DMARDs (TA537)
- Dupilumab for treating moderate to severe atopic dermatitis (TA534)

Red RAG status was agreed for all TAs.

ACTION: Update APC formulary with decisions on NICE TAs **APC sec**

Any other business:

1. Ciprofloxacin ear drops

Cetraxal® 2mg/ml (0.2%) is licensed for topical treatment for acute otitis externa (AOE). The current APC recommendation is off label use of ciprofloxacin eye drops and this is currently on formulary as AMBER specialist recommendation.

ACTION: Add Cetraxal® to the formulary as AMBER **APC sec**

2. Nitazoxanide use within Birmingham Women's and Children's NHS FT

Nitazoxanide has been added to a member Trust's formulary specifically for the use in treatment of cryptosporidium in immunocompromised patients post liver transplant. The use of this drug will usually account for around 3 patients a year. Patients may be from outside of the region. The representative member explained the importance of this drug in

immunocompromised patients as it prevents further complications such as sclerosing cholangitis. It was clarified that an application would not be required as per APC policy for drugs prescribed within hospital tariff and funded by the hospital. These are considered through internal NHS Trust processes. NHS Trusts need to inform the committee of their decision for RED formulary status drugs that are taken home with patients.

The APC recognise that there is a small number of patients at the Trust that will be prescribed nitozoxanide and the initiating Trust will take on the responsibility if prescribing long term. It is normally a 3 to 10-day course for patients however there is a possibility this could be diagnosed on an outpatient appointment.

APC support the prescribing of the drug within hospital setting only and acknowledge that there may be patients who may take this drug out of the hospital setting.

ACTION: Nitazoxanide to be added as RED on formulary with the wording 'for hospital use only' **APC sec**

3. Prescribing of antidepressants under the age of 18 years in primary care

A member raised that colleagues in Solihull have informed there are several patients on long term antidepressants who are under the age of 18. There is discussion whether a number of these patients can transfer to primary care with a shared care agreement. The member asked if a shared care arrangement would be appropriate.

A member asked whether there are any licensing issues for these antidepressants under the age of 18. The member responded that fluoxetine is licensed for this group of patients whereas sertraline which may occasionally be used, is not licensed.

A member raised that a RICaD may be appropriate which is patient specific for the off-label use of antidepressants in patients under the age of 18.

It was recognised that transferring prescribing into primary care for these patients will ease patient access particularly for those working or studying.

Member to feedback to APC once discussions have taken place with the adult mental health trust and Forward Thinking Birmingham Partnership.

The Chair thanked the members for their input today. The meeting closed at 16:15.
Date of next meeting: Thursday 11th October 2018 14:00 – 16:45
Birmingham Research Park.