AREA PRESCRIBING COMMITTEE MEETING
Birmingham, Sandwell, Solihull and Environs
Minutes of the meeting held on Thursday 14th August 2014
Board Room: Solihull CCG HQ, Friars Gate, 1011 Stratford Road Shirley, Solihull, B90 4BN

PRESENT:

Dr Lisa Brownell, BSMHFT (Chair)	(LB)
Dr Paul Dudley, Birmingham CrossCity CCG	(PD)
Tony Green, Patient and Public Representative	(TG)
Mark Dasgupta, Birmingham CrossCity CCG	(MD)
Satnaam Nandra, Birmingham CrossCity CCG	(SN)
Kate Arnold, Solihull CCG	(KA)
Dr Jamie Coleman, UHB NHSFT	(JC)
Alima Batchelor, Birmingham SC CCG	(AB)
Alan Pollard, Birmingham Women's NHS FT	(AP)
Professor Robin Ferner, Sandwell & West Birmingham Hospitals NHST	(RF)
Dr John Wilkinson, Solihull CCG	(JW)
Maureen Milligan, ROHFT	(MM)
Timothy Priest, HEFT NHS FT	(TP)
Elizabeth Walker, SWB CCG	(EW)
David Harris, Birmingham Community Healthcare NHST	(DH)
Mahesh Mistry, South East Staffs & Seisdon CCG	(MM)
Inderjit Singh, UHB NHSFT	(IS)
Nigel Barnes, BSMHFT	(NB)
Tania Carruthers, HEFT NHS FT	(TC)
Patricia James, Midlands & Lancashire CSU APC Secretary and minute taker	(PJ)
Bola Ogunremi, Midlands & Lancashire CSU	(BO)
Carol Evans, HEFT NHSFT	(CE)

0814/01 **Apologies**
Dr William Rae, ROH NHS FT
Jonathan Horgan, Midlands & Lancashire CSU
Peter Cooke, Sandwell & West Birmingham Hospitals NHST
Mandy Matthews, NHS England

0814/02 **Items of business not on the agenda**
Professor Ferner's letter
JC pointed out that members need to discuss the timing and circulation of the minutes
MD asked the chair if Chapter 3 could be deferred to the September meeting. The members agreed.

The chair confirmed that the members were in agreement with the recording of the APC meetings on the understanding that the recording, once agreed, would be deleted. The APC Secretary confirmed this would be adhered to. The Chair confirmed that this did not have to be documented in the Terms of Reference.

0814/03 Declarations of interest

There were no declarations of interest. A register was circulated round the table to highlight outstanding declarations. The Chair stated that it is the expectation from members that any new or relevant interests should be declared before each meeting. All outstanding declaration forms should be completed and handed to the APC Secretary.

0814/04 Welcome and Introductions

Introductions went round the table

0814/05 Minutes of the meeting held On Thursday 10 July 2014

The minutes of the meeting held on Thursday 10 July 2014 were accepted as a true record, with the following exception:

Page 5; Dr Richter did not say The Welsh Medicines Consortium accepted the combination spray, but The All Wales Medicines Strategy Group. ***APC Secretary to amend***

Once the above amendment is made the minutes can be accepted as final.

0814/06 Matters Arising and Actions

Action table was not cascaded to the group for comment. Chair went through actions from the July meeting:

Action 0701/4 – New Policy wording for principles of harmonisation to be signed off.
MD advised the new wording has been cascaded and there were no objections from the members around the new wording.

***Action**: Action now complete*

Action: 0714/5.1/5.6 - Nice good practice guidance on developing and updating local formularies
BO advised that KA had emailed a document to the APC Secretary which was cascaded to the committee.

***Action:** Action now complete*

Action: 0714/5.9 - Contact Diabetes leads
BO presented a hand out to the members advising that she had contacted the 3 diabetes leads. She had replies from HEFT and S&WBH NHST. The HEFT and S&WBH NHST Diabetes Leads agreed with the option presented to them that canagliflozin should be an amber drug initiated by specialists and transferred to primary care as appropriate and that it should be prescribed within NICE indications. The Leads recommended that the differences between canagliflozin and dapagliflozin should be highlighted in any guidance produced and that GP training should be provided as required.

S&WBH NHST Lead advised that local guidelines around the use of canagliflozin are needed to facilitate usage. The CSU confirmed that it would help develop these and this would be emailed for comment and brought back to the next meeting for agreement. JC stated that a modified RICaD used in line with NICE guidance would be sufficient to support the use of canagliflozin. It was suggested that its status could be amber with RiCaD.

The Chair pointed out that an amber drug is one which is recommended or initiated by secondary care and that in some cases; prescriptions are also initially issued from secondary care.

DH stated that amber drugs may be prescribed by GPs with Specialist Interest (GPwSI) and so should not be referred to as drugs for secondary care recommendation and initiation. It was confirmed that the amber drugs are for specialist initiation and could be initiated by GPwSI.

RF pointed out that the NICE recommendation did not stipulate that canagliflozin should be started in secondary care and by making it an amber drug and requesting specialist initiation; an extra hurdle was being placed between the patient and the NICE recommended drug.

There were discussions around the appropriate RAG status of canagliflozin. The Chair confirmed her understanding that the drug had been appraised by NICE and deemed suitable for use. She asked members if there were any clinical reasons why canagliflozin should not be green. Following a lengthy discussion, it was agreed that NICE did not state that specialist initiation was required and that what was required is for GPs to know where it sits in the treatment algorithm.

The chair summarised that Diabetic Leads would be contacted again and asked if there is any reason why canagliflozin cannot be initiated in primary care and if they would support a green RAG status.

ACTION: ***BO to contact diabetes leads to clarify canagliflozin RAG status***

JC pointed out that Page 6 does not hold an action for the outcome of the drug applications submitted by Dr Richter and queried whether the outcome had been communicated to her. PD advised that his understanding was that we firstly share the decision making tool with the group members to make sure everyone agreed that the information supporting the decisions made were robust before relaying to Dr Richter.

BO advised that she emailed this information out to the joint chairs. However, the requirement was to email to all members to ensure that all were in agreement with response.

ACTION: ***cascade the two decision making tools to members with feedback collated by BO so the decision can be communicated to Dr Richter by PD.***

Action: 0714/8.2/8.4 *ESCAs*
The chair confirmed this will be discussed as part of the agenda

Action: 0714/9.2 *RAG Definitions*
Defer to the next meeting

Action: 0714/11 *Circulate guidance to colleagues as appropriate around "Ophthalmic Special Order Products, General Principles"*
Action now complete

Action: 0714/12.4 *Incorporate reference numbers into the Agenda*
Action now complete

Action: 0714/12.6 *Passwords to be set up for the APC Website*

BO advised that she was unable to send out because all passwords generated for the site whilst in maintenance mode have administrator rights to access. However, she would present at this meeting.

ACTION: **defer to the next meeting**

Action: 0714/12.9 Cardiac Guidelines around NOACs

BO advised that she took advice from KA on the basis of the email KA sent around NICE guidance. Both decided that all NOACs have to be made available in line with NICE guidance and so decided to not to contact the haematologists about the place of NOACs in the therapy until this had been discussed again at the APC.

IS stated that UHB required guidance from the haematologists for governance and patient safety reasons because A &E staff have raised safety concerns related to the current use of all available NOACs. Guidance is required on preferred NOAC, its mechanism of actions and drug-drug interaction profile especially as a potential NOAC specific antidote may become available in the not too far distance.

KA mentioned that it was her understanding that we were contacting haematologists with a view to deciding which NOACs should be used and where. She stated that according to NICE guidance the entire decision around which NOAC is used should be a joint decision between the patient and clinician.

MD noted that if the A&E consultants are saying that the mixed use of the NOACs are creating clinical safety issues, then specialist recommendation is required and this should be presented to the group**.**

KA agreed with MD's comments and circulated the guidance paper which NICE have published on the web in response to queries from a variety of people. She pointed out that in line with the NICE guidance, no funding restrictions should be placed on the use of NOACs and that the drugs must be available to everyone who needs them as jointly agreed by the clinician and patient.

AB stated that if there are variations in the safety and clinical outcomes from the different drugs that there should be appropriate guidance on which NOAC is safe and appropriate for different groups of patients.

TP commented that the document was not entirely clear; NICE does not state how the drug should be made available and who should be responsible for prescribing. It has only stated that NOACs should be made available by CCGs. Health economies have to decide how to implement the NOACs locally and to agree their local guidelines.

The Chair summarised that it is important to update the APC position on the NOACs. All drugs will be available on the formulary and local recommendations for use as provided from the haematologists will be cascaded to primary care colleagues.

ACTION: reinstate action for the next meeting and go back to the haematologists and ask where the drugs sit in the pathway to obtain clear guidance

The Chair summarised a letter from RF querying the differences in philosophy of the various APC commissioners to the formulary.

He stated that the APC needs to decide how inclusive the Formulary will be and suggested that currently some Commissioners perhaps saw only three possibilities:

A Formulary drug is used (for the purpose specified in the Formulary);
A patient is 'exceptional'—that is, so unusual that he or she requires treatment that almost no other patient requires, where 'no other patient' means at most a few each year nationally;
A patient is one of a cohort and Commissioners will decide whether such cohorts of patients should be funded.

He noted that the Committee needs to agree what proportion of patients will be covered by the Formulary, and therefore have treatment funded by the Commissioners. He stated that a very extensive formulary that covered every possible circumstance would be less useful than a rather focussed formulary.

RF further cited the SWBH–Sandwell CCG formulary approach where a mechanism is available which allows clinicians to use medicines outside their formulary if there are legitimate clinical reasons to do so as a model worth considering by the APC. He commented that if the APC plan is to have a Formulary that accommodates the needs of an extremely large proportion of the population then SWBH will be keen to ensure that all those medicines that have been agreed through its 'non-Formulary' process are included in the Formulary.

There was extensive discussion. The Chair summarised the discussion.

The APC reviewed the process of allocating drugs to different RAG ratings thereby clarifying the position of the formulary. The Formulary will be broad even to include all drugs that are likely to be initiated in primary care. The APC acknowledged that in some cases and for some conditions, this may be broad range and where that is the case at some point guidance to primary care to stratify and personalise the use of these drugs will be provided.

There may be some amber and red RAG rated drugs which are so infrequently used that they will need to be presented to the Trust's D&T Committee for approval. This approach will result in greater restrictions being applied within Trusts so that the formulary is more focussed without preventing individuals who would benefit from such drugs from receiving them because they are non-formulary. It was thought that this might apply to about 5% of the population.

ACTION: trust representatives to share their DTC Chairman actions on use of non-formulary drugs with APC to raise awareness of use of such drugs used within the area

0714/12.11 Alternate venues for the APC meetings
The chair confirmed this will be discussed as part of the agenda

0814/07 NICE Technology Appraisal (TAGs) (Enclosure 1)
Papers were distributed to members

0814/08 Website Update
BO presented the website to the members. There is some trouble uploading to the links however BO is in contact with James Turton to sort out.

0814/09 Harmonised Joint Formulary Paper 2 (Enclosure 2)

PD agreed that this paper was agreed and signed off up to section 2.5 at July meeting.

The remainder of the paper was discussed and updated by SN.

The members agreed to undertake a 'brand rationalisation exercise to agree preferred brands for the following drugs: isosorbide mononitrate, diltiazem, verapamil, felodipine and nifedipine.

ACTION: bring last 2 pages of Chapter 2 back to the next meeting

0814/010 ESCAs
The Chair confirmed this would be deferred and discussed at the next meeting including the paper and comments from RF.

ACTION: carry forward to the next APC meeting

0814/11 Harmonised Joint Formulary Paper 3 (Enclosure 6)
The Chair confirmed this would be deferred and discussed at the next meeting

ACTION: carry forward to the next APC meeting

0814/12 Communication template – Decision to decline prescribing of medicines recommended by hospital specialist (Enclosure 7)
The Chair confirmed this would be deferred and discussed at the next meeting

ACTION: carry forward to the next APC meeting

0814/13 Black Country Partnership NHS Trust – managed entry of drugs policy (formulary policy) (Enclosure 8)
The Chair confirmed this would be deferred and discussed at the next meeting

ACTION: carry forward to the next APC meeting

0814/14 – AOB

The chair advised she would look at the next agenda to see what is appropriate. She will then come back to the APC secretary.

PD stated that 2 members had suggested the possibility of an away day to help get through 2 or 3 chapters to prevent members from developing inertia to the formulary harmonisation work. The members agreed that will was a sensible approach to move things forward.

It was pointed out that the committee had been unable to get through the agenda items at the last two meetings. A proposal to increase the meeting time to three hours was not favourably received. It was felt that the reason the chapters were taking so long to get through was because of very important questions around processes which had to be addressed.

An away day would help members focus solely on working through the chapters more quickly. The success of such an away day relies on members ensuring that necessary preliminary work is undertaken with relevant members of their trusts and emails with suggested timescale acted on promptly. Suggested chapters to work on were Chapters 4 and 10.

The away day is planned for November and will be held in addition to the November APC meeting.

The Chair advised the group around the change of venue for the September APC meeting. Details have been emailed by the APC Secretary.

DATE NEXT MEETING:
Thursday 11th September 2014 – Birmingham Medical Institute
Meeting closed at 16:50 pm