MINUTES

Area Prescribing Committee, Birmingham, Sandwell, Solihull and environs

10th July 2014 – 2:00 pm – 4:00 pm

SOLIHULL CCG• FRIARS GATE•1011 STRATFORD ROAD • SHIRLEY • SOLIHULL • B90 4BN

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Attendees:	Dr Paul Dudley, Birmingham CrossCity CCG - Chair	(PD)
	Dr Lisa Brownell, BSMHFT – Vice Chair	(LB)
	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)
	Peter Cooke, Sandwell & West Birmingham Hospitals NHST	(PC)
	Professor Robin Ferner, Sandwell & West Birmingham Hospitals NHST	(RF)
	Christine Gunner, HEFT NHS FT	(TC)
	Urmila Tandon, UHB NHSFT	(UT)
	John Wilkinson, Solihull CCG	(JW)
	Maureen Milligan, ROHFT	(MM)
	Patricia James, Midlands and Lancashire CSU	(PJ)
	Bola Ogunremi, Midlands and Lancashire CSU	(BO)
	Jonathan Horgan, Midlands and Lancashire CSU	(JH)
	Sumaira Tabassum, SWB CCG	(ST)
	Timothy Priest, HEFT NHS FT	(TP)
	Dr Waris Ahmad, Birmingham SC CCG	(WA)
	Mandy Matthews, NHS England representative	(MM)
	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)
Administration	Minutes produced by Patricia James, Midlands and Lancashire CSU, APC Secretary cmcsu.medicines-management@nhs.net

Item	Discussion	Action
0714/1. Welcome and Introductions	The Chair, Dr Paul Dudley, (PD) welcomed the committee to the Area Prescribing meeting.	
0714/2. Apologies	Were documented.	
0714/3. Declarations of Interest	The committee were asked to disclose any interest they may have, direct or indirect, in any of the items to be considered during the course of the meeting and to note that those members declaring an interest would not be allowed to take part in the consideration or discussion or vote on any questions relation to that item. There were no declarations of interest made at this meeting.	
0714/4. Minutes and Actions	The minutes of the meeting held on 12th June 2014 were agreed with the exception of: 0614/6 Principles for Harmonisation (bullet point 3) - RF questioned the sentence around the "majority decision". It was agreed that further clarification is required and paragraph needs to be rephrased. Old wording • Where two of the 3 formularies are consistent then the APC will assess the majority view, considering any local reasons for a difference before adopting the majority decision. Where more information is required, the APC will consult with the relevant Trusts before making a decision. New wording • Where two of the 3 formularies are consistent then the APC will assess the majority view, consider any local reasons for a difference and consult with relevant Trusts if more information is required, before agreeing an acceptable decision.	

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	0614/6 6.7 - RF highlighted that different arrangements are in place for the management of amber drugs within Sandwell and West Birmingham. RF suggested that the last paragraph be reworded. The Chair suggested that a broader statement may be needed here to encapsulate and cover all trusts and KA highlighted that this could be an exception for S&WB. **ACTION: New wording: Principles for Harmonisations to be approved and signed off** **New wording: Policy to be approved and signed off-**	**BO & CCG Leads**
0714/5. NICE Technology Appraisals	5.1 BO tabled NICE Technology Appraisals 2013-14 and 2014-15 checklists for discussion These are standing agenda items at each APC. They ensure the APC is sited on the latest technology appraisals to support implementation through the formulary and development of work plans. 5.2 JC mentioned that NHS bodies are obliged to make drugs with positive TAs available with 90 days of the TA release but could choose whether to use them or not. 5.3 JH stated that the NICE TAs still require local guidance and advice to ensure that the local use of drugs is clarified. 5.4 There was debate around the local interpretation of NICE. The group was informed at HEFT, drugs with positive TAs were added to the formulary as RED until their place is therapy was clarified. 5.5 JC suggested that a new colour could be used to indicate a drug which has been added to the formulary following a NICE TA but which has not been reviewed by the APC. 5.6 Following discussion, it was agreed that drugs with positive NICE TAs would be adopted as grey whilst local clarification on their place in therapy is confirmed to the APC **ACTION: NICE Good Practice Guidance on Developing and updating local formularies to be submitted for cascading to the committee** 5.7 A positive NICE TA for canagliflozin was issued on July 25. Advice will be sought from diabetes leads to identify its place in therapy locally.	**KA**

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	ACTION: Contact Diabetes leads in relation to canagliflozin	**BO**
0714/6. Website Update	Covered under any other business.	
0714/7. New Drug Applications	7.1 Dr Alex Richter attended the meeting to present 2 new drug applications: Azelastine hydrochloride/Fluticasone propionate **Dymista®** and Fluticasone Furoate (**Avamys®) – (Encs 1, 2 and 3)** for the treatment of allergic rhinitis. She presented both drugs together. Allergic rhinitis affects 20% of population. The usual treatment options in primary care are oral/topical non-sedative antihistamines and intranasal corticosteroids as recommended in the national (BSACI) and international (ARIA) guidelines. Azelastine/ fluticasone (Dymista®) nasal spray is a combination suspension which contains two drugs which are already used to treat symptoms of rhinitis. The drugs are delivered as a mist and the recommended dose is one actuation in each nostril twice daily. It is indicated for relief of symptoms of moderate to severe seasonal or perennial allergic rhinitis if monotherapy with either antihistamine or corticosteroid alone is not sufficient. It is not licensed for use in children under 12 years. Fluticasone furoate (Avamys®) nasal spray is also delivered as a mist preparation. Each spray actuation delivers 27.5 micrograms of fluticasone furoate. It is indicated in adults, adolescents and children (six years and over) for the treatment of the symptoms of allergic rhinitis. The recommended starting dose is two spray actuations in each nostril once daily. Once adequate symptom control is achieved, dose reduction to one spray actuation in each nostril may be effective for maintenance. Dr Richter also presented a treatment pathway which she developed to support the use of medicines in allergic rhinitis. This included a step up step down treatment approach similar to the BTS Asthma guidelines. Fluticasone furoate and azelastine/ fluticasone nasal sprays are listed as Tier 2 and Tier 3 drugs	

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respectively.

Dr Richter stated that a few trials have demonstrated that combined antihistamine/ corticosteroid (Dymista®) nasal spray was more effective than the individual component drugs. She suggested that use of the spray in primary care may prevent disease progression in some patients thereby preventing the need for more specialist intervention requiring Immunotherapy.

With regard to fluticasone furoate (Avamys®) nasal spray, Dr Richter advised the group that the efficacy of fluticasone furoate in reducing the symptoms of rhinitis was comparable to that of mometasone furoate and the studies have shown that fluticasone furoate is non-inferior to fluticasone propionate at reducing at reducing the Total Nasal Symptom Score (rTNSS) (defined as the sum of three individual 4-point symptom scores for sneezing, rhinorrhoea and nasal congestion).

She also mentioned that these nasal sprays were better tolerated by some patients because of mist formulations.

The following questions and comments were raised.

- Concerns were raised around the risks of nasal septal perforation with the nasal sprays. It was confirmed that this was a rare side effect which could occur with a range of nasal sprays.
- It was highlighted that HEFT D&T and Scottish Medicines Consortium have rejected azelastine/ fluticasone nasal spray in relation to cost effectiveness.
- Dr Alex Richter advised that The All Wales Medicines Strategy Group have accepted the combination spay. She reiterated that once patients are controlled with azelastine/ fluticasone, treatment could be stepped down to a cost effective nasal corticosteroid. It was agreed that the chars should be amended to highlight the step down recommendation more clearly.

7.2 The Chair thanked Dr Richter for her time. The committee discussed the evidence and following a vote the following as agreed:

Azelastine/ fluticasone (Dymista®)
Application Reference No: **APCBSSE/00001**
Application Outcome: **Rejected**
RAG Status: **Non formulary**
Azelastine/ fluticasone was rejected by the committee because it did

	not offer any significant clinical advantage or cost effective benefit over current treatment options. At £18.91 per month, it is considerably more expensive than other options. It was also noted that it had been considered and rejected at the HEFT D&T. **Fluticasone Furoate (Avamys®)** Application Reference No: **APCBSSE/00002** Outcome: **Rejected** RAG Status **Non formulary** The committee agreed that fluticasone furoate could have a place in therapy for some patient groups because patient compliance could be improved with its once-daily dosing and dose delivery system. However, it is more expensive than the first line treatment option (beclometasone dipropionate) and there is a lack of evidence demonstrating superiority over other intranasal corticosteroids. It has been shown to be similar in efficacy to mometasone furoate in reducing the symptoms of rhinitis. It was also noted that the license for fluticasone furoate Avamys® is restricted to patients aged over 6 years and does not include nasal polyps. 7.3 The committee recognised that these were the first applications and discussed the process for new drug applications. MD queried whether attendance by a consultant to present a completed application form which had already been circulated to members was required to reach a decision. 7.4 After discussion, the committee agreed that consultants should be given the opportunity to attend but this is not mandatory.	
0714/8. Updated Chapter 1 and ESCAs	8.1 The Chair asked for approval from the committee with the Final paper on Formulary Chapter 1 – (**Encs 4)** **<u>Resolution:</u>** ***Chapter 1 was approved with the exception of the ESCAs which are to be presented at the August meeting*** 8.2 JC pointed out that on Page 3 – 1.9 of Chapter 1 "Drugs affecting intestinal secretions" the word "specialist" was incorrectly spelt. 8.3 RF requested a review and amendment for accuracy of sentence in	

	relation to licensing in second paragraph on Page 11. **ACTION:** **Amend Page 3 – 1.9 to show correct spelling** **Review the paragraph within the ESCA in relation to licensing** 8.4 It was established that ESCAs should have a uniformed statement documented and relevant information appertaining to various trusts need to be adopted. One version should be drawn up taking into consideration local variations. **ACTION:** **One version of ESCAs to be considered by the committee** **ESCA statement to be submitted at August meeting**	**SN** **SN** **JH** **JH**
0714/9. Harmonised Joint Formulary Paper 2	9.1 Formulary Paper 2 was discussed and updated by SN – **(Encs 5)** 9.2 There was discussion around RAG definitions and a suggestion that a "black" category could be added for drugs reviewed and rejected by the committee. LB remarked that this category would need to be clearly defined. **ACTION:** **RAG definitions to be brought to the August meeting** 9.3 ***FOR RATIFICATION:*** ***1. What should be included in the formulary*** ***2. How are less used drugs are managed and documented***	**JH/PJ**
0714/10. Effect of Hospice Formulary on primary care prescribing HEFT NHS FT	10.1 Christine Gunner presented in the absence of Tania Carruthers. 10.2 HEFT has 2 hospices providing palliative care. It was felt that the majority of patients come from primary care setting. 10.3 The Palliative care formulary is not aligned with local formularies and currently generates administrative problems for prescribers particularly in terms of cost effectiveness of prescribed medicines. 10.4 The formulary was drawn up based on an agreed SLA. There is a need to align the palliative care formulary with local formularies. 10.6 This was thought to be a very relevant issue and RF suggested possibly bringing both formularies together. It was highlighted that a choice of opiates which may have limited evidence base are used in palliative care to achieve pain control in patients. It was also	

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	mentioned that although this is important, the committee should focus on the formulary harmonisation task. The group agreed that the palliative care formulary work would be addressed in the future.	
0714/11. Royal College of Ophthalmologists and UK Ophthalmic Pharmacy guidance on "special" eye products Kate Arnold	KA presented a paper around "Ophthalmic Special Order Products, General Principles" for discussion. She pointed out that this was not a formulary statement but guidance around specials. The group agreed to adopt it and circulate to relevant parties for information **ACTION: Circulate guidance to colleagues as appropriate**	**ALL**
0714/12. AOB	12.1 The question was asked around what happens to the old formularies on the website when the chapters are update. 12.2 BO asked whether Trust formularies would need to be amended in light of APC joint formulary reviews. 12.3 MD indicated that decisions agreed in the APC meeting are equally binding going forward. 12.4 CG asked if the agenda could be referenced with numbers to make it easier to match up actions with agenda items. **ACTION: Incorporate Minute reference numbers into the Agenda** 12.5 APC related Freedom of Information requests JH advised that all FOI requests are collated centrally through the CSU via the FOI leads who will process. The website will provide more details. Contact details for the APC secretary will also be listed for any queries around membership. 12.6 Due to IT issues, BO was unable to give provide a live update on the website to the committee, however, details will be provided on how committee can access this. She will arrange for members to have a password to login to view. The site is still in early stages of development but Chapter 1 can now be uploaded. **ACTION: Passwords to be set up and email link to committee**	**PJ** **BO**

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	Committee to suggest new website name if required	**ALL**
	12.7 Committee concerns around the website name were still expressed. BO advised that James Turton can change the URL to read: www:birminghamsandwellsolihullandenvironsformulary It was suggested that the 5 CCG Leads should be consulted before any amendment is made.	
	12.8 The Chair asked if the APC could provide guidance on the prescribing of NOACs in light of the new NICE guidelines on Atrial Fibrillation and its prescribing responsibility for all CCGs. The Chair also suggested that a Lead Haematologist from each Trust should be invited to discuss the benefits and limitations of these drugs in relation to warfarin and to agree local guidance. Thrombosis leads for the 3 main trusts should be contacted.	
	12.9 MD proposed that endorsement of the current cardiac guidelines and suggested that a document should be produced for the committee to sanction.	
	ACTION: Present cardiac guidelines around NOACs Haematologists/Thrombosis leads to be contacted	**MD CCG leads**
	12.10 The Chair confirmed the August meeting would still go ahead as the committee felt it was important in order to sign off Paper 2 and start work on Paper 3.	
	12.11 Talk around the Venue for the APC was discussed. Friars Gate has been secured until January 2015 however, the location is not suitable for some committee members. Alternative venues will be considered.	
	ACTION: Alternative venues to be emailed to the APC Secretary for consideration	**ALL**
Close	Meeting closed @ 16:25 pm	
Next Meeting	**Thursday 14th August – 14:00 – 16:00 – Friars Gate, Solihull**	

NHFT