NHS
Bassetlaw
Clinical Commissioning Group

NHS
Doncaster
Clinical Commissioning Group

DONCASTER & BASSETLAW AREA PRESCRIBING COMMITTEE (APC)

Action Notes and Log

Thursday 23rd July 2020 12 Noon start

Meeting held over Microsoft Teams

Present:	Dr David Crichton	Chair, APC Chair DCCG
	Mr Alex Molyneux	Head of Medicines Management DCCG
	Mrs V-Lin Cheong	Deputy Head of Medicines Management DCCG
	Mr Rob Wise	Head of Medicines Management, Deputy APC Chair BCCG
	Dr Rachel Hubbard	Doncaster GP
	Mr Stephen Davies	Chief Pharmacist RDaSHFT
	Dr Rumit Shah	Local Medical Committee Representative
	Mr Lee Wilson	Consultant Pharmacist DBTHFT
	Miss Amanda Hemmings	Senior Medicines Management Technician DCCG (Secretary)
	Mrs Ashley Hill	DCCG MMT Practice Support Technician
In attendance:	Dr Rao Kolusu	DCCG Prescribing Lead
	Mr S Balchandra	Consultant GI and Bariatric surgeon DBTHFT
Minutes only:		
	Dr Rupert Suckling & Dr Victor Joseph	DMBC Representatives

Agenda Ref	Subject / Action Required	Action Required By	Timescale	Status of Action (RAG) and Date
7/20/1	**Apologies for Absence:** Dr. Lucy Peart (Acute Physician DBTHFT) Mr Munashe Mvududu (LPC Representative)			
7/20/2	**Declarations of Interest:** VLC declared to the committee that she has acquired shares in GSK pharmaceuticals. No agenda items were in conflict or reference to this in today's meeting.			
7/20/2.1	**Fire Alarm Procedure:** N/A Meeting online			
7/20/2.2	**Notification of Any Other Business:** None			
7/20/3	**Notes of the Meeting Held On:** Thursday 27th Feb 2020 were agreed as a true and accurate record and will be made available on the Medicines Management website.			
7/20/4	**Matters Arising not on the Agenda:** **Ciclosporin** – LW discussed briefly about issues with the poor uptake of prescribing in primary care of Ciclosporin eye drops. This is in relation to a recent shared care arrangement for ciclosporin eye drops. The issue stemmed from a delay in TLS status update and relevant shared care protocol onto the DCCG website for prescribers to refer to. This has now been rectified and no further issues are expected.			
7/20/4.1	**Matters Arising:** None			
11/19/8.2	**Management of Children with a Growth Hormone Disorder SCP** LW brought back the revised SCP for final comment. The Committee agreed that the document was ready to be disseminated subject to revisions, in respect of: providing clarity in relation to when growth hormones can be stopped; and the prescribers' monitoring responsibilities. The committee also suggested minor formatting changes to the document. The TLS remains the same in relation to the medication discussed in the document. LW to finalise the document, which will be added to the website. **Post meeting note – the suggested revisions and minor formatting changes have been made and the document has now been published on the DCCG website. (08/10/2020)**	**DBTHFT-LW**		

7/20/4.2	**Guidance for vitamin supplementation post bariatric surgery** – Guest speaker - Mr.S.Balchandra (DBTHFT Consultant Upper GI and Bariatric Surgeon) addressed the Committee regarding the prescribing of vitamins and minerals in patients who received bariatric surgery. There were inconsistencies in the BOMSS guidance, NHSE self-care guidance and guidance issued by neighbouring CCGs around the prescribing of vitamins and minerals in the post-bariatric patient cohort. Mr Balchandra pointed out that from a post-bariatric surgery viewpoint, the prescribing of certain vitamins and minerals was mandatory; emphasising the potential for long-term deficiencies and complications if patients did not take these supplements. The continuous prescribing of supplements to this cohort of patients was felt to be a duty of care in a medico-legal context. Mr Balchandra highlighted recent legal challenges in relation to this matter. He felt strongly that he and his team would continue to prescribe for patients whilst they were under secondary care; but thought this should continue once discharged into primary care with monitoring. LW pointed out that he had received emails from the bariatric and GI team sharing the same stance and they did not wish to veer from their own guidance. Currently, bariatric patients were discharged to primary care after two years; although Mr Balchandra said they would be happy for these patients to be referred back again if there were issues. Primary care along with DCCG Medicines Management Team will be looking at stopping the prescribing of certain items as outlined in the NHSE OTC document. Within the document there are recommendations of items not to be routinely prescribed of which vitamins and minerals are noted; the document states that these supplements are thought to have limited evidence of clinical effectiveness. However it does list certain exceptions which refer to patients that have been medically diagnosed with malabsorption due to surgery and lifetime or chronic conditions. Patients are able to buy most supplements OTC and could be directed to do so once they had been discharged back into the care of their GP. However it was felt that the monitoring of the patient could lapse and there were no assurances that the patient would continue to purchase the supplements they needed. RH discussed some concerns around how it was difficult for the GPs to monitor levels of micronutrients; they would need to have specialist bottles for pathology. Further concerns were also raised about knowing what actions to take if the micronutrient levels were out of range. She suggested the use of a passport for	**DBTHFT-SB**	**Oct - 20**	

	the patient which contains information such as treatment, latest blood tests and results. SB responded that patients were discharged with detailed letters with what treatment and future monitoring was required. He also mentioned the routine blood tests would only need to be done annually. RS also asked for clear guidance for primary care, which should contain information about actions to take in the event of micronutrient deficiency, whether a patient would be expected to buy supplements over the counter, and if prescribed, the appropriate products to select. RW also noted that the BOMSS guidance pre-dated the NHSE OTC guidance and discussed certain exemptions. The point that remains unclear is whether vitamins and minerals for this cohort of patients is considered preventative or treatment of a chronic condition. He had looked at what neighboring APCs had decided and discovered that some were asking patients to buy OTC. He did however accept there were exceptions to consider and also wanted the committee to make a decision which was clear and documented. DC talked about the NHSE OTC exceptions and how it was feasible for primary care to prescribe supplements taking into account patients who'd had bariatric or gastric surgery. He felt however, that different bariatric procedures have different vitamins and minerals requirement: with sleeve gastrectomy and gastric bypass procedures being linked to higher risk of long term deficiency. AM asked if Mr. Balchandra would provide input into a guidance document to detail the cases where patients should be exempt and where a supplement could be continued in primary care. Mr Balchandra said he would be happy to do so. It was further discussed and was suggested that the TLS for specific vitamins and minerals for certain indications only, be classified as AMBER G once the guidance document was in place. The guidance document should contain a list of products which are cost effective and clinically appropriate; and information about what to do in relation to out of range blood tests; and a direct contact link to the dieticians dealing with bariatric cases. The committee agreed that once this had been finalised and it has been to other relevant meetings within the organisation ensuring the financial implications have been taken into account, this would need to come back to APC for formalisation of the TLS only.			

1/20/8.1	**Gender Dysphoria** DC updated the committee regarding the service specification for the non-surgical element for transgender services that came into effect in April 2020. It was discussed about what the commissioning expectations on Primary Care were. The document talks about a trans health service and future MDT approach, which is thought to be similar to a GP who has a special interest or acquires some specialist knowledge in the matter. The document talks about working on a phased approach over time with an addendum to the service specification due in 2021/22. The document clarifies that patients can self-refer which is different to the current service. It was also mentioned about the conclusion of the contract provider. This is when the individual and the lead clinician agree that the treatment for gender dysphoria is complete; not less than six month after completion of the last planned intervention for the purposes of follow up. This is also to assess longer term impact. DC discussed how the current shared care arrangement isn't as updated as the updated document. He also mentioned about Rotherham CCG leading on the original shared care document which Doncaster and Bassetlaw had not fully signed up and it was felt this will need to be reviewed in line with the updated specification. DC discussed liaising with the CCG Primary Care team to look at considering a local LES type arrangement now the updated document has come into effect. There is still pressure from the Porterbrook clinic, previously based on an assumption around the 18 week RTT with patients still being discharging into primary care at this point; however the updated document does clarify that it is a longer term shared care arrangement that is required. AM mentioned making the DCCG communications team aware in relation to publishing the updated document. The committee will further discuss things once a formal shared care document has been worked up.	**DCCG - DC**	**Oct-20**	
2/20/4.2	**Modafinil updated SCP –** VLC gave an update about the Modafinil SCP that STHFT have produced. Modafinil is currently classified AMBER on the DCCG TLS list when indicated for excessive sleepiness caused by narcolepsy. The document has been to Sheffield's Area Prescribing Group for approval. DBTHFT have historically always based their guidance on the Sheffield document for this drug as most of the Doncaster patients are seen in STHFT sleep clinic. A	**DCCG-VLC**	**Oct - 20**	

	change to the document notes interactions between Modafinil and Hormonal Contraception. Also new unlicensed indications which Sheffield had specified. VLC asked the committee's views regarding traffic lighting Modafinil for the proposed new indications. SD asked if there was any other guidance about the drug being used for the unlicensed indications that Sheffield had listed. VLC told the committee that Sheffield is set to produce a different set of pathways with drugs used for sleep disorders. RW mentioned that the document acknowledges that Modafinil is being used for unlicensed indications as approved by the STHFT drug safety committee but doesn't expand on how this decision was reached. He had also found that the EMA had opposing views to what the Sheffield document had and thought this required further explanation. Modafinil remains a first line choice of drug for its indicated use but there is currently no other evidence to support its use in the unlicensed indications at this time. It is currently AMBER for the licensed indication on Sheffield's TLS list but shows as RED for the unlicensed indications. The committee feel this needs further clarification as to why and if it will only be prescribed by secondary care for the unlicensed indications as discussed. VLC will liaise with Sheffield and this will come back to APC at a future date.			
7/20/4.3	**Pre-emptive Prescribing (Palliative Care) Guidance** – The Committee had a discussion about Palliative Care and the on-going issues with the end of life pre-emptive prescribing instruction to administer letters. RS had concerns surrounding when patients are being discharged from the acute trust with a black box and the paperwork including an end of life care fast track form. The discharge letter states information regarding doses and instructions of how the pre-emptive medication should be used. However there is a step requiring practices to transcribe the instructions from discharge letters onto a "Dear Sister" letter for use in the community. Some practices use a pre-populated template for the transcribing but not all will. RS stated that it was an extra burden for practices to have to do this and asked if there was any update on whether DBTHFT could provide a template which was raised previously. LW explained that DBTHFT may not have the IT capacity to support this. AM asked if there could perhaps be a liaison between RDaSH's IT department and DRI to see if they could find a way forward. As DRI use a different system (JAC) to what the GP practices use it was thought this could be difficult to facilitate. The CCG do publish documents and templates on both EMIS and Systm1 for	**RDaSH-SD** **DBTHFT-LW**	**Oct-20**	

	prescribers as a matter of course and this is what is expected by the stakeholders. RDaSH also use Systm1 and SD discussed how the trust would like to work towards putting letters of instruction straight into the patient record, which could be viewed at the interface. It was also noted that since publication of the palliative care document that there was a change to the dosage instructions set out in the guidance. LW advised the committee of a recent change in policy which now affects the doses listed in the document. The recommended doses have been changed/set on the JAC system but the community document has yet to be changed to reflect this. The document was not yet due for review, however in light of these changes it will need to be reworked. SD also asked for there to be a clearer guidance of titration of these particular drugs. The current document discusses maximum dosages and some of the patients will not require anywhere near these amounts. It was felt the document could benefit from some guidance around smaller doses and titration of these when necessary. LW talked about specifying a maximum of six doses per day being worked into document also. If the patient requires over this amount then a review to assess suitability for a syringe driver should be carried out. SD and LW agreed to work with the palliative care teams and bring the new guidance back to a future meeting on completion to be discussed. DC raised a proposal supported by RDaSH to facilitate patients and/or their carers/relatives to self-administer palliative care drugs. SD explained that RDaSH had been approached by patients and their relatives/carers over a number of years to enable them to be able to administer or have relatives be able to administer palliative care drugs for them by S/C injection. An out of policy agreement was devised between SD and Dr Nav Ahluwalia (Executive Medical Director RDaSH) to support this. Prior to Covid-19, RDaSH had been working on a policy to support the administration by patient/relatives. It was in response to patients requiring stat doses of pre-emptive drugs in the middle of the night. The need for this policy was prompted by the timing and sometimes the locality for district nurse visits. SD mentioned the feedback had been positive in these cases and that RDaSH now wanted to continue to work on a policy. The committee did have some concerns in regards to risks and safety of this; work to expand this has not been supported in response to the CCG queries.			

	The arrangement has been discussed by both APC and in the MMG meeting. There are also plans for SD to attend an LMC meeting along with Dr. Dean Eggitt to continue discussions and gain the committee members' opinion. It was also felt that examples from other areas who already have policies in place for administration of palliative care drugs by patients/carers would be valuable to see if there were any issues or longer term problems that would need to be considered. SD confirmed that RDaSH will continue to support the out of policy arrangement at present should they need to use it with the prescribers backing. This will be brought back for update at a later date.			
7/20/4.4	**Minocycline requests for Prescribing in Primary Care** – VLC brought this issue for discussion due to issues raised by a general practice who was asked to prescribe Minocycline for the treatment of Acne which is a GREY listed drug when used for that specific condition. The TLS of Minocycline was recently changed to GREY on the back of NHSE guidance and it was thought this may not have been fully realised by a certain prescriber. Minocycline has low quality evidence when prescribed for Acne vulgaris which is GREY on the TLS; also a Cochrane review found that it also has poor quality evidence when prescribed for Acne rosacea. It was decided to add the condition of Acne rosacea onto the TLS with the same status of GREY. It was felt that Doxycycline or other tetracycline's would be alternatives with proven track records and be considered more cost effective treatment. LW was going to speak to the prescriber in question and pass on the information discussed today.	**DCCG-VLC**		
1/20/8.2	**Glycopyrronium for Hyperhidrosis Prescribing Enquiry Letter** – VLC updated the Committee regarding the Glycopyrronium query that had been previously discussed at APC. A surgery had been asked to prescribe the drug to treat the condition of hyperhidrosis. On further investigation it appears that the request for Glycopyrronium was not to be used for Iontophoresis as previously thought; which is a last resort type of treatment using this drug. There are several preparations of the drug available but all are off-label in the treatment of this condition. It was thought that if all other medications for treatment of this condition had been tried then it could have been a reasonable request to use this but it did carry cost implications without much evidence of success. LW had liaised with the prescriber from DBTHFT who had asked for primary	**DCCG-VLC**		

	care to prescribe and the request was withdrawn to the best of the prescribers knowledge. It was thought that another medication was being trialled instead. However this did prompt the committee to discuss giving Glycopyrronium a TLS of RED for use in hyperhidrosis and it was agreed that this should be the required action to take.			
11/19/4.6	**SCP's for update- Denosumab** – LW and VLC gave updates regarding the Denosumab SCP. STH produce the guidance and DBTHFT adopt the policy but there are differences in the pathways for primary care to continue to prescribe on stabilisation from the hospital between Sheffield and DBTHFT. Sheffield agree this at 6 months but in Doncaster it's currently 12 months. Sheffield and Doncaster differ in service arrangements with STH using P1NP with a DEXA scan at 5yrs. DRI is instead a DEXA only based service doing these scans at 2yrs and 5yrs respectively. There have been discussions whether the DBTHFT shared care protocol could be tweaked to have a DRI discharge with primary care picking up prescribing from month 6; with patients still being seen at the metabolic bone unit at month 12. The committee discussed cost effectiveness and better service arrangement in the DBTHFT area to allow this to happen however still felt some specialist input would be welcome to help them reach a decision. LW agreed to ask Dr Rob Stevens to a future meeting to help the committee understand more about the differences with current arrangements; the impact this may have on patients and make a more informed decision.	**DCCG-LW**	**Oct-20**	
7/20/4.8	**Letter to Medicines Management and CCG Chair** – A letter has been received addressed to the Chair by a local Doncaster practice and North LMC representative. The letter talks about SCPs and guidance not always being clear or present across regional boundaries for Doncaster patients. The letter stated it was felt that there were no clear monitoring arrangements with Secondary Care on transfer of patients to Primary Care once asked to take on prescribing responsibilities. The letter also asked about funding to provide Shared Care in complex matters and to enable additional training. It was stressed in the letter that the LMC felt there was a lack of adequate information regarding monitoring from DBHTFT and when this was scheduled to take place; although this did not include the Warfarin Clinic Monitoring. The letter mentioned Gastroenterology and Rheumatology as being considered a problem in this matter by a straw poll			

	undertaken at PCN level. The letter also stated that the LMC had written directly to the Hospitals but had received no feedback and this was in part the reason they wished the matter be discussed by the APC. The letter was noted as requiring a response. DC responded that this was raised at the LMC meeting and he had been given a verbal response. However he was happy to clarify and will provide a written response also. DC went on to say that we endevour to align shared care protocols across SYB ICS. One area that had not been picked up in the previous response was in relation to the funding of shared care. DC specified that we do have a LES arrangement for shared care prescribing in Doncaster to allow remuneration for the prescribing of certain drugs. He did acknowledge that the adherence to shared care was not always followed by specialists. It is the committee's view however that once that shared care has been agreed across organisations and DBTHFT that we expect both primary and secondary care to adhere to the arrangements. RMOCs were being developed to try to align prescribing decisions across regions; however it is difficult to facilitate these. RW mentioned we had to be realistic and that unless we have national agreements, these types of issues would always arise. Unfortunately anything out of area would be impossible to control. Different areas may have differing guidance to DBTHFT due to different commissioning arrangements in that area and they would therefore be following their own protocols and agreements. AM re-inforced that by saying as the NHS is commissioned into small local units each would be bound to develop and follow their own arrangements so there will always be differences between areas. AM also mentioned that the CCG medicines management team would be happy to advise on a case by case basis if further guidance was needed. While we expect the vast majority of cases to fit within the guidance set out, we understand that not all will and can assist when patient may fall out of these guidelines. While NICE guidance is taken into account in all areas the interpretation can often be different. We are working to further standadise shared care and eliminate as many of these issues as we can by working across the ISC which may help on a more regional level. In relation to the queries about monitoring and blood work and the problems surrounding specific departments, AM and LW would like to find out more information and they will then liaise with these departments to understand what these issues are and try to work towards resolving these. A letter will be sent to			

	the LMC in response.			
7/20/4.9	**APC Annual Report** – The Annual Report was presented to the Committee. This was a re-cap of the matters that had arisen and of the work that has been done over the past 12 months. The committee accepted this was a true reflection of the work undertaken and with a slight change to the attendance percentages requiring alteration; agreed this was fine to publish on the DCCG website.			
7/20/5	**Drugs for Review** **Peginterferon beta-1a** – Indication/treating relapsing–remitting multiple sclerosis in adults in classified as **RED** **Saxagliptin/ Dapagliflozin**- Indication/Diabetes Mellitus Type 2 requiring extra monitoring was classified as **GREEN G** **Quetiapine (Standard & XL formulation)** – Indication/Generalised anxiety disorder(GAD)(unlicensed use) classified as **RED** **Quetiapine (Standard & XL formulation)** – Indication/ Antipsychotic - patients on the SMI register/Antipsychotic use in dementia classified as **AMBER G**. New brand to be added to TLS with recent SPC warnings. **Buserelin** – Indication/Endometriosis previously only considered for prostate cancer was given the classification of **AMBER G.** **5-aminolevulinic acid hydrochloride** – Indication/treatment of actinic keratoses for the treatment of body regions other than face and scalp was given the classification of **RED** **Fluorouracil injection and oral** – Indication/Common malignancies with new testing and treatment recommendations was classified as **RED**. **Capecitabine** – Indication/colon and breast cancers with new testing and treatment recommendations was classified as **RED**. **Tegafur/gimeracil/oteracil** – Indication/advanced gastric cancer with new testing and treatment recommendations was classified as **RED**. **Pramipexole** – Indication/restless leg syndrome was classified as **GREEN G** in response to latest safety information. **Pramipexole** – Indication/Parkinson's Disease was classified as **AMBER G** in response to latest safety information. **Dexrazoxane** – Indication/Cardiotoxicity (prevention of) caused by doxorubicin or epirubicin to now include use in children and young people under 25 years was classified as **RED**.	**DCCG-VLC**		

7/20/6	**Officers' Actions** All officers' actions were agreed as proposed and will be updated on the traffic light system.	**DCCG-VLC**		
7/20/7	**Drugs for Consideration** **Sotagliflozin** – NICE recommendation of drug sotagliflozin with insulin as an option for treating type 1 diabetes in adults with a BMI of at least 27 kg/m2, when insulin alone does not provide adequate glycemic control despite optimal insulin therapy, only if certain criteria are met**.** The classification of this drug is currently delayed due to it being as yet unavailable. The committee felt that the drug should be available before a TLS could be given.	**DCCG-VLC**		
7/20/8	**New Business** – No new business was brought at this time.			
7/20/9	**DBTHFT D&TC Update** No minutes available			
7/20/10	**Formulary Liaison Group Update** No minutes available			
7/20/11	**Doncaster Prisons Drug & Therapeutic Committee update** No minutes available			
7/20/12	**RDaSH FT Medicines Management Committee update** No minutes available			
7/20/13	**Barnsley Area Prescribing Committee Update** The minutes of the meeting held in Jan 2020 were received by the Committee.			
7/20/14	**Rotherham Medicines Optimisation Group Update** No minutes available.			
7/20/15	**Sheffield Area Prescribing Committee Update** The minutes of the meeting held in Nov2019 were received by the Committee.			
7/20/16	**Nottingham Area Prescribing Committee Update** The minutes of the meeting held in Nov 2019 were received by the Committee.			
7/20/17	**SY& B ICS Medicines Optimisation Work-stream Steering Group** No minutes available			
7/20/18	**Northern Regional Medicines Optimisation Committee** No minutes available			
7/20/19	**Any Other Business:**			

7/20/19.1	**Date and Time of Next Meeting:** 12 noon prompt Thursday 27th August 2020 Meeting via Microsoft Teams			

KEY

Completed / Closed	**To Action**
In Progress	**To be actioned but date not yet due**