NHS
Bassetlaw
Clinical Commissioning Group

NHS
Doncaster
Clinical Commissioning Group

DONCASTER & BASSETLAW AREA PRESCRIBING COMMITTEE (APC)

Action Notes and Log

Thursday 26th November 2020 12 Noon start

Meeting held over Microsoft Teams

Present:	Dr David Crichton	Chair, APC Chair DCCG
	Mrs V-Lin Cheong	Deputy Head of Medicines Management DCCG
	Mr Rob Wise	Head of Medicines Management, Deputy APC Chair BCCG
	Mr Stephen Davies	Chief Pharmacist RDaSHFT
	Dr Rumit Shah	Local Medical Committee Representative
	Mr Lee Wilson	Consultant Pharmacist DBTHFT
	Dr Rachel Hubbard	Doncaster GP
	Miss Amanda Hemmings	Senior Medicines Management Technician DCCG (Secretary)
In attendance:		
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
11/20/1	**Apologies for Absence:** Dr Lucy Peart Acute Physician DBTHFT Mr Alex Molyneux Head of Medicines Management DCCG Mr Andrew Shakesby FCMS Representative Mr Munashe Mvududu Local Pharmaceutical Committee Representative			
11/20/2	**Declarations of Interest:** None were declared			
11/20/2.1	**Fire Alarm Procedure:** N/A Meeting online			
11/20/2.2	**Notification of Any Other Business:** LW asked to discuss Mesalazine preparations which are listed in the TLS. RS wished to discuss Methotrexate bloods test recording and the Arden's system.			
11/20/3	**Notes of the Meeting Held On:** Thursday 29th October 2020 were agreed as a true and accurate record and will be made available on the Medicines Management website.			
11/20/4	**Matters Arising not on the Agenda:** SD gave the committee a further update about Priadel. Both the FCA and Essential pharma have confirmed that the brand will be available for the next 5 years.			
10/20/4.4	**Sucralfate:** LW gave an update about Sucralfate; this has previously been discussed by the committee and has recently also been to the MMG meeting for discussion there. Sucralfate is being prescribed more frequently by secondary care due to ongoing issues obtaining ranitidine. It was put forward by the committee at a previous meeting that other H2R antagonists such as famotidine or cimetidine along with a PPI should be tried first line before sucralfate is given. Sucralfate does carry high cost implications when prescribed in primary care; while cost is not the main issue it was noted that this was a factor. It was thought there was also a lack of evidence for the benefits of prescribing the drug but it is also to be noted that there was no evidence of harm either. DC did however	**DBTHFT-LW**	**Jan-21**	

	bring the committee's attention to the fact that sucralfate is a BNF listed drug indicated for gastric and duodenal ulcers and chronic gastritis. Currently as the drug is not traffic-lighted for our area, it could be prescribed by primary care in the first instance. Sucralfate is currently being used infrequently by the DBTHFT but they would like to see continued prescribing of the drug in a small number of patients for certain listed indications. This would mean prescribing responsibilities would move to primary care once patients are discharged by the hospital. There was a concern by the committee that this would be expected to continue longer term and also that patients already on the drug were not being reviewed or taken off it. LW suggested if the data for patients taking the drug could be run in the community, the hospital would then flag these patients for a review. RS said prescribing of sucralfate should be stopped at the point of initiation in primary care if H2RAs and PPIs had not already been tried and this would need to be clear in any guidance written. The consensus of the committee's was that sucralfate be recommended for an Amber G status; should only be for 8-12 weeks in line with the BNF and highlight that the patient had already tried H2RAs/PPIs and clarity on when the drug should be stopped or reviewed. LW will feedback to the meeting once the guidance has been drafted for approval and the drug will be given an Amber G recommendation at that point.			
2/20/4.2	**Modafinil Updated SCP:** RW addressed the committee to seek approval for the modafinil shared care protocol that he has been working on with input from AM who was not present at today's meeting. The document was an adaptation of the Sheffield SCP but with amendments previously discussed by the committee to localise it for Doncaster and Bassetlaw. In the Sheffield document unlicensed indications are listed for reference which the committee felt were misleading and did not need to be in the document if they were for information only. RW discussed how these had been removed to make it clear that unlicensed prescribing of the drug was not supported in our area, and had also removed anything that had reference to this within the document. RW asked for specific feedback on page 2 of the new document where there is a hyperlink which states 'Recording Specialist Issued Drugs'; this however does not link straight to that document but rather straight to a page on the medicines	**BCCG-RW**		

	management website where the document is hosted. This was originally done in this way so that if the document concerned is updated or reviewed then it won't provide a broken link within the shared care document. It was thought by the committee that the link did not need to be there, it was more confusing as it did not link to the actual resource needed. Also it was noted that once the drug is part of shared care that it won't need to be recorded as a specialist drug and will be inputted onto the clinical systems in a different way. RW asked if a sentence stating 'for medication supplied by another provider, prescribers are require to ensure this is recorded appropriately on their clinical systems' would be a better way to ask clinicians to do this once the link is removed. The committee agreed that this would make more sense and were happy for him to do this. It was also thought that the costings should be removed from the document and it was noted that generics are available as well as branded products. With these slight amendments to the document the committee was happy to accept the localised version of the shared care. There will be no change to the modafinil TLS of Amber for its licensed indications.			
8/20/4.2	**Fidaxomicin & Fosfomycin guidance review and suggested updates:** A discussion was brought regarding the fidaxomicin and fosfomycin guidance which is currently under review and which has previously been discussed at APC as there were various issues raised about the processes in the previous document. ETP phase 4 means that electronic prescriptions are the default method for generating prescriptions in primary care. Under the current arrangements stated in the document, a prescription is to be generated by a GP under the instructions of a consultant microbiologist at DBTHFT, and the prescription to be taken to the main DRI dispensary for dispensing. This currently means that patients or their representatives/carers will need to travel to their practice and then to the hospital to collect these drugs as the hospital does not have a delivery service to patients. A change that was previously put forward has now been agreed. This is to remove fosfomycin from the document; this drug is now easily sourced in community pharmacies and the protocol can be changed so FP10 prescriptions can be issued and dispensed by the community pharmacy of the patients	**DCCG-DC/VLC**	**May-21**	

	choosing, these can then be delivered out to the patient if needed. There are still issues with the process of obtaining and dispensing of fidaxomicin. The community pharmacies can source it within a reasonable timeframe but it is a high cost drug and not something they would hold as stock, there is also a reluctance for them to order it in advance of a prescription in case the patient decides to go elsewhere and they are left with a high cost drug which they are not reimbursed for. As there is currently no solution to make the process for getting the fidaxomicin any easier and only a very small number of patients are prescribed the drug, it has been decided to extend the current guidance for fidaxomicin for the next 6 months. Work will be continued outside of the meeting for an e-prescribing solution and the guidance will be reviewed again at that time to try to improve the current process.			
2/20/8.3	**Hydroxychloroquine:** DC gave a verbal update about hydroxychloroquine, this has been discussed in previous meetings due to issues with arrangements to perform specific eye monitoring including optical tomography for adults taking the drug for inflammatory arthritis and connective tissue diseases. Baseline assessment within 12 months and annual monitoring is required by all patients who have been on long-term therapy of 5yrs and over. There are local issues with capacity within the ophthalmology department at the acute trust and there is no community optometry solution evident due the equipment required. DC reported that as no solution has been found it has been escalated in a number of forums in particular to the ACQRG and FPIG meetings to be discussed in the next week. RS voiced concerns that there is no robust system in place and it was a patient safety issue. Also that the clinical responsibilities would lie with the prescriber which is currently the GPs. It was suggested that if a solution cannot be found then the committee should look at changing the TLS for the drug to protect patients. DC will feedback from the other meetings to see if a solution can be reached. This will then be discussed again in the next APC meeting and any actions will be dependent on the feedback.	**DCCG-DC**	**Jan-21**	
11/20/4.2	**TLS Considerations – Leger Clinic:** Requests have been submitted by the	**DCCG-VLC**	**Jan-21**	

	Leger Clinic to give a recommended traffic light status for: • Testosterone – treatment of testosterone deficiency (to move to shared care Amber or Amber G status) • Tamoxifen – management of gynecomastia in men (request for Red) • Clomifene – testosterone deficiency in men where preservation of fertility is a high priority (request for Red) The committee discussed the submission and for the testosterone it was noted that this had already been discussed at the LMC. It was felt by the LMC that a LES agreement should be worked up for the prescribing and monitoring of this drug and this is now being considered, if this is approved, and the appropriate wording for monitoring by primary care is received by the Leger Clinic, then the appropriate TLS can be given. However for tamoxifen and clomifene for the off-license indications submitted for TLS, it was felt there was a lack of evidence for the committee to be able to make an informed decision about the drugs at this time. This would mean giving these drugs a TLS of Grey 2 due to lack of evidence. AH will draft a letter for the chair to inform Dr. Savage from the Leger clinic of the committee's views and liaise with Dr. Savage to obtain any supporting evidence to enable the committee to make any further decisions. VLC will liaise with A. Needham (DCCG contracts manager) outside of the meeting to ascertain if the prescribing of these drugs for those indications are in the current contract for the Leger clinic. The APC have not consulted on the contract previously and are unable to support the prescribing of these drugs.			
11/20/4.3	**APC terms of reference:** This item has been deferred until the next meeting as AM could not attend the meeting today.	**DCCG-AM**	**Jan-21**	
11/20/5	**Drugs for Review** **Osimertini**b- indicated for positive non-small-cell lung cancer in adults has a recommended change in status from Grey 2 to Red 1,2,8. **Glatiramer acetate-** indicated for relapsing and remitting Multiple Sclerosis was given the recommendation of Red 1,2,8. **Histamine-** indicated in acute myeloid leukemia (AML) in conjunction with low-dose interleukin-2 has a recommended change in status from Red 1,2,3 to Grey 2,5 as the NICE appraisal was suspended and there is a lack of evidence to support prescribing.	**DCCG-VLC**		

	Pembrolizumab- For all licensed indications was reviewed and was recommended to keep the TLS Red 1,2,3.			
11/20/6	**Officers' Actions** All officers' actions were agreed as proposed with the exception of Niraparib which was recommended to stay Red. The entries will be updated on the traffic light system. There was also no suggestion in column 38 to give an ongoing recommendation of a TLS to Goserelin. It was discussed and the committee decided it should keep the status of Amber G in light of NICE guidance NG131.	**DCCG-VLC**		
11/20/7	**Drugs for Consideration:** **Cefiderocol-** to treat infections due to aerobic Gram-negative organisms was given a recommended TLS of Red 1,2,5. **Glasdegib-** For treatment of newly diagnosed de novo or secondary acute myeloid leukaemia in adult patients was recommended to have a TLS Grey 2. **Polatuzumab (with rituximab and bendamustine)-** To treat relapsed or refractory diffuse large B cell lymphoma in adults was given a recommendation of Red 1,2,8. **Eculizumab-** For delayed haemolytic transfusion reactions and hyperhaemolysis in patients with haemoglobinopathies was recommended the TLS of Red 1,2,8. **Rituximab-** For delayed haemolytic transfusion reactions and hyperhaemolysis in patients with haemoglobinopathies was recommended the TLS Red 1,2,8. **Vonicog alfa-** For treatment and prevention of bleeding in adults with von Willebrand disease was given a recommendation of Red 1,2,8. **Volanesorsen-** To treat genetically confirmed familial chylomicronaemia syndrome in adults was suggested to have a TLS of Red 1,2.	**DCCG-VLC**		
11/20/8	**New Business**			
11/20/9	**DBTHFT D&TC Update** The Committee received minutes from the meeting held March 2020			
11/20/10	**Formulary Liaison Group Update** The Committee received minutes from the meeting held February 2020. It was noted that the group is due to start meeting again			
11/20/11	**Doncaster Prisons Drug & Therapeutic Committee update** No minutes available			

11/20/12	**RDaSH FT Medicines Management Committee update** The Committee received minutes from the meeting held July 2020			
11/20/13	**Barnsley Area Prescribing Committee Update** The Committee received minutes from the meeting held August 2020. Of note was the Lowering Carbon Footprint paper which acknowledged as a good thing to consider in our disucssions			
11/20/14	**Rotherham Medicines Optimisation Group Update** The Committee received minutes from the meeting held August 2020			
11/20/15	**Sheffield Area Prescribing Committee Update** The minutes of the meeting held in Nov2019 were received by the Committee.			
11/20/16	**Nottingham Area Prescribing Committee Update** The minutes of the meeting held in Nov 2019 were received by the Committee.			
11/20/17	**SY& B ICS Medicines Optimisation Work-stream Steering Group** No minutes available			
	Dr Shah had to leave the meeting at this point			
11/20/18	**Northern Regional Medicines Optimisation Committee** No minutes available			
11/20/19	**Any Other Business:** LW discussed that there had been an issue with the prescribing of mesalazine. Not every branded and branded generic product is currently listed in on the TLS. As a result a prescriber refused to issue a mesalazine preparation as it was not listed on the entry. The committee discussed that the products brands were just for reference and not a reflection of what should be prescribed. DC suggested that a sentence be added to the current TLS entry to say 'preparations listed are for example only and are not the only products that are able to be prescribed'. RS had previously mentioned as an AOB an issue with methotrexate and the 'Ardens' system that many of the local practice clinical systems are using and explained that when a patient's blood test is not present in the system there is a safety prompt that comes up for some drugs. The issue being that blood results are not showing or received back to the practice from DMARD monitoring and this then becomes an issue to give patients their prescription other than to override the system. He suggested that it would be better if ICE could integrate	**DBTHFT-LW** **DCCG-DC** **RDaSH-SD**		

	with the clinical systems and then the blood results would always be updated. DC mentioned in other geographical areas there is the option to import the results directly from ICE and this would be beneficial in the Doncaster and Bassetlaw area. The committee said as this is a technological problem and not a specific TLS issues, it was felt that this should be picked up by DC and RS outside of this meeting as it is more a question of functionality than a drug related issue. It can be picked up in the PCN directors' meeting. SD told the committee of an upcoming clinical trial that RDaSH are taking part in over the next few weeks. This is to trial hydroxychloroquine in the prevention of Covid-19. He will feedback to the committee again once things are underway.			
11/20/19.1	**Date and Time of Next Meeting:** 12 noon prompt Thursday 28th January 2021 Meeting via Microsoft Teams			

KEY

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