NHS Bassetlaw Clinical Commissioning Group

NHS Doncaster Clinical Commissioning Group

DONCASTER & BASSETLAW AREA PRESCRIBING COMMITTEE (APC)

Action Notes and Log

Thursday 29th October 2020 12 Noon start

Meeting held over Microsoft Teams

Present:	Mr Rob Wise (RW)	Deputy APC Chair , BCCG Head of Medicines Management
	Mrs V-Lin Cheong (VLC)	Deputy Head of Medicines Management DCCG
	Dr Rachel Hubbard (RH)	Doncaster GP
	Mr Andrew Houston (AHO)	Deputy Chief Pharmacist RDaSHFT
	Dr Rumit Shah (RS)	Local Medical Committee Representative
	Mr Munashe Mvududu (MM)	Local Pharmaceutical Committee Representative
	Dr Lucy Peart (LP)	Acute Physician DBTHFT
	Miss Amanda Hemmings (AH)	Senior Medicines Management Technician DCCG (Secretary)
	Andrew Shakesby (AS)	FCMS Representative
In attendance:		
	Dr Douglas Savage (DS)	Sexual Health Lead Doctor (Leger Clinic)
	Amanda Needham (AN)	Strategy and Delivery Manager DCCG
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
10/20/1	**Apologies for Absence:** Dr David Crichton Chair, APC Chair DCCG Mr Alex Molyneux Head of Medicines Management DCCG Mr Lee Wilson Consultant Pharmacist DBTHFT Mr Stephen Davies Chief Pharmacist RDaSHFT			
10/20/2	**Declarations of Interest:** None were declared			
10/20/2.1	**Fire Alarm Procedure:** N/A Meeting online			
10/20/2.2	**Notification of Any Other Business:** None			
10/20/3	**Notes of the Meeting Held On**: Thursday 24th September 2020 were agreed as a true and accurate record with a minor alteration and will be made available on the Medicines Management website.			
10/20/4	**Matters Arising not on the Agenda:** None			
10/20/4.1	**Matters Arising:** None			
10/20/4.2	**Low back pain and sciatica – NICE guidance:** VLC addressed the committee regarding the topic of low back pain and sciatica due to an update of NICE guidance. The guidance covers assessing and managing low back pain and sciatica in people aged 16 and over. It was discussed as to whether the committee should think about giving a Grey TLS to drugs previously used for these conditions which are no longer advised. The pharmacological treatment for low back pain and sciatica within the guidance was discussed, including medications that are recommended, and those that are not recommended.	**DCCG– VLC**	**Jan-21**	

	RS raised concerns about the NICE guidance for these conditions as it often takes time for things such as physiotherapy appointments to be arranged and there are often waiting lists for other non-pharmacological therapy outlined in the guidance. VLC informed the committee that this is a change in practice, and that there is another NICE guidance for chronic pain due to be published earlier next year. VLC also talked about how DCCG medicines management team are reviewing pain guidance currently. RS felt that it would be beneficial to see this guidance before giving a consideration of a TLS for certain drugs for these conditions. RH also noted that sciatica was neuropathic and that such as gabapentinoids are in fact licenced for this type of pain. VLC agreed that this was the case but pointed out that NICE made their recommendations based on the evidence of harm for this group of medicines, rather than the lack of effectiveness. RS felt that this decision could not be taken in isolation and that commissioning arrangements would need to support primary care to work towards this guidance. It was felt that it was important to have a joint multi stakeholder approach to work towards NICE guidance but further consideration was needed before any TLS for the drugs currently used for these conditions could be agreed upon. Further considerations will be given to this once the new NICE guidance has been published.			
10/20/4.3	**Testosterone- The Leger Clinic:** The committee welcomed guest speaker Dr D Savage from the Leger Clinic. Also A.Needham from DCCG Strategy and Delivery eam was welcomed to the meeting. Dr Savage is an expert in sexual health medicine and wanted to gain the committee's views about whether an Amber TLS and shared care document for testosterone would be suitable. Currently Dr Savage sees all male patients at the Leger clinic from the Doncaster and Bassetlaw area that are prescribed testosterone for the indication of testosterone deficiency. The shared care Dr Savage would be looking to produce aims to pass the prescribing and monitoring back to primary care after 12 months or upon the patient being stabilised if this is longer than the 12 month period. The reason for this is because he cannot see new cohorts of patients until existing patients are discharged from his service. Amanda Needham DCCG, also kindly attended today's meeting to give the committee context to the current and proposed commissioning arrangement for	**The Leger Clinic- DS**	**Nov-20**	

	the sexual health service which Dr Savage leads. AN discussed that the service had undergone a contract review and confirmed that until a time that patients are discharged from the service, new patients cannot access the service as needed. This has caused an impact with growing waiting lists and patients unable to be seen. With the review highlighting this issue, AN was working with Dr Savage to try to support him to discharge testosterone patients who are stable from his clinic. They wanted to ensure that what the service did now would be future-proof to enable Dr Savage to be able to see new patients going forward. It was raised by the committee that if prescribing and monitoring were to pass to primary care after 12 months and the patients discharged from specialist care, that this would not qualify as shared care. A shared care arrangement would look to see at least annual monitoring being undertaken by the specialist. It was thought that the TLS for testosterone for this condition would need to be Amber G with clear guidance and an option to be able to refer the patients back to the specialist quickly if the need arose, dependant on what the monitor requirements were and whether these were able to be carried out by primary care. The committee asked about the appropriateness of this and what monitoring requirement would be expected. Dr Savage said that he would do a PSA test and DRE before the patient started testosterone therapy and review patients at 3, 6, and then 12 months before discharging to primary care and only then if the patient was stabilised on therapy. At that point the patient would then require annual blood tests (including PSA) to be undertaken. Dr Savage did mention that if the patient had a raised PSA that they should then be referred to urology. When questioned if the patient should be referred back to him if they have an elevated PSA, he explained that he currently contacts the patients own GP for a referral to urology and that he would be unable to fast track this as he doesn't have the capacity to be able to refer them directly. He also maintained that the testosterone should be continued until the urologist had assessed the patient. Another question asked was if this therapy was a lifelong commitment for the patient or if there was a point where this should be stopped. Dr Savage answered that this would be expected to be lifelong treatment except in rare circumstances, e.g co-morbidity which is then resolved. One example being in some overweight patients, where the excess weight is lost and testosterone levels then return to normal. The committee felt that Dr Savage should draft a guidance document with the			

	monitoring requirements outlined and what to do with out of range tests, the referral process and any further information needed. RS then agreed to take this to the LMC meeting. The guidance once drafted will also then come back to APC for further discussion. There are also other drugs which Dr Savage on occasion prescribes for other indications; these are clomifene for male testosterone deficiency and tamoxifen for gynecomastia. Dr Savage wishes to continue to prescribe these drugs for the conditions mentioned and will submit TLS entry forms so these can be considered for a status at a future meeting.			
10/20/4.4	**Sucralfate:** LP brought forward a discussion regarding sucralfate tablets. The drug is currently unlicenced in the UK and is an expensive drug. Sucralfate is sometimes initiated by the gastroenterology department within secondary care as an alternative to ranitidine. This is because currently there is a supply issue with ranitidine. On that basis it was asked if prescribing of the drug could be taken on by primary care if it was needed to be continued for the patient once discharged. It was suggested that the drug be given the status of Green on the TLS. VLC talked about this drug previously not been regularly prescribed within primary care due to availability as well as cost. The community pharmacies previously were thought to have struggled to source stock of sucralfate as it is imported which also carries additional charges as the pharmacies have to order it in as a special. Whilst it was accepted that it may now be easier to obtain a supply in the community; the pharmacies themselves would not be subject to the same contracting to enable them to source the drug cheaply; prices for a supply of 112 tablets ranging from between £85 to almost £800. It was thought that there was not enough clinical evidence to support the prescribing of the drug as it was not included in any NICE guidance as a treatment option. VLC mentioned that H2 receptor antagonists should be first line treatment and that famotidine was able to be sourced by both hospitals and community pharmacies. There is also the option to look at prescribing cimetidine. LP asked whether some guidance could be undertaken to look at prescribing sucralfate second line with PPIs as the first line choice. This would then mean giving sucralfate a TLS status of Amber G. Patients would be discharged from DRI with a 4 week supply of sucralfate only after a PPI had been tried. LP discussed that some patients may not necessarily need to continue sucralfate beyond the 28 days. However there would sometimes be a need for further	**DBTHFT- LP**	**Nov-20**	

	courses. It was felt by the committee that this was then more of a formulary decision and would be better discussed at FLG. However as the FLG is currently not meeting it was thought that this should be taken to the MMG meeting. This is also as there is a financial element that needs to be considered. AH will liaise with KJ (secretary of the MMG) outside of the meeting to ask for arrangements to be made for representation of DBTHFT at the next meeting to further discuss this.			
10/20/4.5	**Priadel – Supply/withdrawl information:** AHO gave the committee an update regarding a previous discussion in July's AOB; It was believed at the time that the Priadel brand of lithium was to be withdrawn from the market. RDaSH were going to look producing a document to support the switch of patients from the priadel brand to camcolit another brand of lithium which is not available in the same strength. It has since come to light however that Essential Pharma who produces priadel have decided to reverse its decision to withdraw the brand from the market. AHO confirmed that due to this RDaSH would not be looking to switch patients to a different brand. Clinicians across all healthcare settings are advised that there is no longer a need to implement system-wide switching of patients from priadel tablets to an alternative lithium carbonate preparation until further notice. Essential Pharma has confirmed supplies of priadel 200mg and 400mg tablets are sufficient to meet current UK demand and is working to ensure further stocks are available to maintain supply after April 2021. AHO confirmed that priadel manufacturer, Essential Pharma, has provided reassurance that if any community pharmacy is in need of urgent stock of priadel, it can be obtained through their direct distributor Movianto. MM raised an issue that some community pharmacies would not be able to order directly without setting up an account with the distributor if stock could not be obtained in the usual way; he noted that it was not always down to the individual pharmacy itself but their head office who would decide if the pharmacy could proceed to do this. AHO stated that as this was likely to be a national supply problem and so both independent and chain pharmacies would be likely to have the same issues across the country. With this in mind he thought it feasible that the pharmacies would look at opening up an account if the need arose. If they were not able to do so then it would be appropriate to signpost the patient elsewhere to ensure	**RDaSHFT-AHO**		

	the continued supply.			
10/20/4.6	**Evolutio TLS requests (specialist eye service):** The committee discussed the proposed eye preparations put forward for TLS consideration by Evolutio**.** The following was decided: **Ofloxacin 0.3% eye drops** indicated for local treatment of infections was given the proposed TLS of Red 1. The committee agreed this would require specialist assessment to enable patient selection initiation and on-going treatment. **Levofloxacin 5 mg/ml eye drops** indicated for local treatment of infections was given the proposed TLS of Red 1. This would also require specialist assessment to enable patient selection initiation and on-going treatment. .**Dexametasone 0.1% eye drops 1mg/ml** indicated for local treatment of inflammation (short-term) and short term local treatment of inflammation (severe conditions) was suggested to have a TLS of Amber G. This was agreed by the committee for short term courses only and they wanted clear advice and the guidance to mention long-term risks with the use of steroids. **Ganciclovir 0.15% eye gel 1.5 mg/1** indicated for acute herpetic keratitis was requested to have the TLS Amber G. However it was the committee's view that a TLS of Red 1 was more appropriate as it will require specialist assessment to enable patient selection initiation and on-going treatment. It was felt that primary care would not wish to continue treatment of this. Keratitis requires follow up and it was felt there may be a risk if the patient was given a continued supply and was not followed up in a timely manner. It could be detrimental as patients with this condition can deteriorate quickly. It was also noted that the dispensing pack of this product should last for 28 days. Initial treatment was expected to be for around 8 days with treatment being extended up to 21 days and it is thought that the product should last without the need for resupply.	**DCCG-VLC**		
10/20/5	**Drugs for Review** The list of drugs the committee reviewed were as follows: **Pasireotide** for the indication of Cushing's disease this was given the continued recommendation of **RED 1, 2.** **Alprostadil cream** indicated for erectile dysfunction previously **Green G** is now recommended to be **GREY 5** as it is not for routine prescribing in primary care.	**DCCG-VLC**		

	Cannabis oromucosal spray for the indication of MS - Spasticity has moved from **GREY** to **RED 1, 2, 8** as NICE guidance recommends prescribing for this condition.			
10/20/6	**Officers' Actions** All officers' actions were agreed as proposed and will be updated on the traffic light system.	**DCCG-VLC**		
10/20/7	**Drugs for Consideration:** **Treosulfan** for the new indication of treatment before allogeneic haematopoietic stem cell transplant for people with malignant diseases was given a recommended TLS of **RED 5, 8.** **Carbimazole** indicated for hyperthyroidism was recommended to have a TLS of **GREEN G.** **Entrectinib** indicated to treat NTRK fusion +ve solid tumours in adults and children 12 years and older was recommended to have a TLS of **RED 1,2,8.** **Entrectinib** indication to treat ROS1-positive advanced non-small-cell lung cancer in adults was recommended to have a TLS of **RED 1,2,8.** **Gilteritinib** indicated for the treatment of relapsed or refractory FLT3-mutation +ve AML in adults was recommended a TLS of **RED 1,2,8.** **Avelumab** indicated for untreated advanced Renal cell was given the TLS of **GREY 2.** **Naldemedine** indication for opioid induced constipation was recommended to have a TLS of **AMBER G.** **Fentanyl Transdermal Patches** for all indications with the exception of non-cancer pain was given the recommendation for a TLS of **Green G.** **TLS Considerations put forward by Evolutio for the specialist eye service:** **Ofloxacin 0.3% eye drops** indicated for local treatment of infections was given the proposed TLS of **RED 1.** **Levofloxacin 5 mg/ml eye drops** indicated for local treatment of infections was given the proposed TLS of **RED 1.** **Dexametasone 0.1% eye drops 1mg/ml** indicated for local treatment of inflammation (short-term) and short term local treatment of inflammation (severe conditions) was given the suggest TLS of **AMBER G.**	**DCCG-VLC**		

	Ganciclovir 0.15% eye gel 1.5 mg/1 indicated for acute herpetic keratitis was given the TLS of **RED 1.**			
10/20/8	**New Business**			
10/20/9	**DBTHFT D&TC Update** The Committee received minutes from the meeting held October 2020			
10/20/10	**DCCG Medicines Management Group** The committee received minutes for the meeting held October 2020			
10/20/11	**Formulary Liaison Group Update** No minutes available			
10/20/12	**Doncaster Prisons Drug & Therapeutic Committee update** No minutes available			
10/20/13	**RDaSH FT Medicines Management Committee update** No minutes available			
10/20/14	**Barnsley Area Prescribing Committee Update** The Committee received minutes from the meeting held September 2020			
10/20/15	**Rotherham Medicines Optimisation Group Update** No minutes available			
10/20/16	**Sheffield Area Prescribing Committee Update** No minutes available			
10/20/17	**Nottingham Area Prescribing Committee Update** No minutes available			
10/20/18	**SY& B ICS Medicines Optimisation Work-stream Steering Group** No minutes available			
10/20/19	**Northern Regional Medicines Optimisation Committee** No minutes available			
10/20/20	**Any Other Business:** RW and VLC discussed that the November APC meeting was at present planned to go ahead. However there would be no APC meeting in December as this would fall over the Christmas period. Going forward and due to additional work pressures people may have in response to the Covid –19 pandemic; the meeting will be assessed as to its suitability to continue on a rolling basis. Committee members were asked to feedback if attendance was likely to be a problem at the time.			

10/20/19.1	**Date and Time of Next Meeting:** 12 noon prompt Thursday 26th November 2020 Meeting via Microsoft Teams			

KEY

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