NHS Bassetlaw Clinical Commissioning Group

NHS Doncaster Clinical Commissioning Group

DONCASTER & BASSETLAW AREA PRESCRIBING COMMITTEE (APC)

Action Notes and Log

Thursday 24th September 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
	Mrs Rachel Wilson	Deputy Chief Pharmacist, DBTHFT
	Dr Dean Eggitt	Local Medical Committee Representative
	Dr Sulman Thullimalli	Local Medical Committee Representative
	Miss Amanda Hemmings	Senior Medicines Management Technician DCCG (Secretary)
In attendance:	Sukveer Kaur	Practice Support Technician
	Dr Robert Stevens	Consultant Rheumatologist 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
9/20/1	**Apologies for Absence:** Dr Lucy Peart Acute Physician DBTHFT Mr Lee Wilson Consultant Pharmacist DBTHFT Mr Munashe Mvududu Local Pharmaceutical Committee Representative Dr Rumit Shah Local Medical Committee Representative Mr Andrew Shakesby FCMS Representative Mr Stephen Davies Chief Pharmacist RDaSHFT			
9/20/2	**Declarations of Interest:** None were declared			
9/20/2.1	**Fire Alarm Procedure:** N/A Meeting online			
9/20/2.2	**Notification of Any Other Business:** None			
9/20/3	**Notes of the Meeting Held On:** Thursday 27th August 2020 were agreed as a true and accurate record and will be made available on the Medicines Management website.			
9/20/4	**Matters Arising not on the Agenda:** None			
9/20/4.1	**Matters Arising:** None			
9/20/4.2	**Prescribing of Heel Balms:** VLC opened a discussion regarding prescribing of Heel Balms within Primary Care. The matter had previously been discussed at DCCG MMG meeting due to the large quantity of heel balms prescribed it was asked if the APC would consider giving these products a TLS? There has been some research done but there is a lack of clinical evidence to prove that they are effective on a long-term basis. There are no safety concerns to highlight. By updating a TLS, it is thought that this may support more appropriate prescribing.	**DCCG – VLC/AM**	**Nov - 20**	

	Most of the prescribing of heel balms followed advice from the Podiatry Services. The Committee concluded the TLS for heel balms should be Amber G, that some guidance should be worked up with a proposal that patients initiated on a 25% strength Urea product would be stepped down to a 5 or 10% product for ongoing treatment. Urea 5 -10% products are already included on the formulary, which are cost effective and provide the same benefit. It was agreed this should be flagged up on the clinical prescribing systems to make prescribers aware and alert them to step down the product strength.			
8/20/4.2	**Fidaxomicin & Fosfomycin guidance review and suggested updates:** The fidaxomicin and fosfomycin guidance has previously been discussed at APC and there were issues raised about some of the processes in the previous document. The roll out of EPS4 nationally means that electronic prescriptions are the default in primary care. Under the current arrangements in the document, the consultant microbiologists at DBTHFT contact the GP for a prescription to be collected and 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 was to remove fosfomycin from the document as this drug is now easily sourced in community pharmacies and the protocol to be changed so FP10 prescriptions can be issued and dispensed by the community pharmacy of the patients choosing, these can then be delivered out to the patient. (Historically there was an issue obtaining the drug from anywhere outside of the hospital). There is still an issue with the obtaining and dispensing of fidaxomycin. RH as an action from the last APC meeting looked into the possibility of whether Well - the outpatient pharmacy contractor of DRI could accept an electronic prescription for fidaxomycin. She notified the Committee that ETP prescriptions for this drug were not able to be sent to that particular pharmacy as they did not show up as active on the Primary Care clinical systems. The dispensing pharmacy must have a contract to be able to accept and issue prescriptions			

	according to its licensed agreement. RW noted that there could be a possibility to send a FP10 prescription for fidaxomycin via email to the DRI inpatients dispensary. The original prescription can then be posted on to the department. The dispensary also operates an out of hour's service; but it would still mean the patient/carer would have to physically attend to collect the prescription. AM noted that fidaxomycin was now easier to obtain within community pharmacies; however it was an expensive item for them to carry as stock and there could be a delay in obtaining once ordered by them. RH asked if there was a possibility that one of these pharmacies could act as a wholesaler and if fidaxomycin could be obtained from a hub pharmacy as and when needed. DC suggested that the CCG would need to look at the financial impact and update flow charts within the document. AM would look at the possibilities around which community pharmacies would be able to facilitate acting as wholesalers/hubs for fidaxomycin and the locality of these to make it easier to get the drug to patients throughout the Doncaster area. It was decided that this would come back to a future meeting once further checks had been made. It was also previously suggested that linezolid be considered as part of these processes as it would be subject to the same kind of arrangements. This was not agreed at this time as it would face the same prescription issues.	**DCCG-AM**	**Nov-20**	
7/20/4.2	**Guidance for vitamin supplementation post bariatric surgery:** AM gave the Committee an update regarding the guidance that he had agreed to work on alongside LW (who was not in attendance of the meeting today). He had taken the discussion to MMG who were in agreement of the APC recommendations. Previously the Committee had heard from Mr Balchandra DBTHFT Consultant Upper GI and Bariatric Surgeon. It was decided by the Committee with the help of Mr Balchandra that there would be exceptions for certain patients who had undergone medical procedures and would have a vitamin or mineral deficiency due to this. Such as sleeve gastrectomy and gastric bypass procedures being linked to higher risk of a long term deficiency. It was agreed that a suitable cost effective product be selected to allow for	**DCCG-AM/LW**	**Oct-20**	

	continued prescribing once patients were discharged back into Primary Care. The guidance would also give information of what to do with out of range blood tests and contact information of the DBTHFT Dieticians. Once the guidance is in place a TLS of Amber G will be given. AM will liaise with LW again outside of the meeting and will bring the guidance back for update once it is complete.			
8/20/4.3	**Denosumab:** The Committee had previously discussed the SCP for denosumab and how service arrangement in DBTHFT differs with that of Sheffield's Metabolic Bone Unit. Dr R Stevens from DBTHFT addressed the Committee as it was felt some specialist input would help the Committee reach a decision about whether Doncaster can adopt an altered protocol. This was to help the Committee to understand more about the differences with current arrangements; the impact this may have on patients and make a more informed decision. There are currently differences in the pathways for Primary Care to continue to prescribe on stabilisation from the hospital between Sheffield and DBTHFT. Sheffield agreed 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 - 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 initiated by metabolic bone unit in Sheffield remaining with secondary care until month 12. The main issue with the earlier discharge from metabolic bone unit (STH) was that the P1NP blood test was undertaken prior to the second injection of denosumab; meaning a discharge could not be done at month 6. This blood test was not available in primary care so only secondary care has the facility to do this and understand the relevance of the result prior to decision being made to continue with the treatment. Dr Stevens confirmed that the P1NP blood test was not necessary for use in denosumab patients and was used more as a guide alongside the DEXA scans in Sheffield. He confirmed that it was useful but not mandatory. With the main blood test needed being a serum calcium monitoring due to a small chance of	**DCCG- DC**	**Nov-20**	

	hypocalcaemia. denosumab can be continued if calcium levels are not outside the lower laboratory range. (hypocalcaemia). DC asked Dr Stevens about the risk of patients not being given their denosumab injections on time in relation their risk for fracture given the MRHA alert issued? Dr Stevens replied that there was the risk of an osteoclastic storm if delayed and that once patients were put on to denosumab that this would have to be considered a long-term treatment due to that risk. If people do need to stop then Zolendronic acid has been trialled in other areas to stop an Osteoclastic storm occurring, this is only being trialled at research level at present. DC also asked about the review process. Dr Stevens replied that anyone on parenteral treatment of denosumab would be reviewed by secondary care on an outpatient basis with planned DEXA scans and potentially P1NPs. This would be in 5 yearly cycles. VLC asked about anticipated patient numbers per year for denosumab for treatment of osteoporosis. Also about the criteria for starting denosumab opposed to a bisphosphonate. Dr Stevens did not have exact numbers at this time but stated that there were far less denosumab patients than those on bisphosphonates ?up to 100 people. Also that bisphosphonates were given as first line treatment with the exception of there being a contra-indication. Patients unless contra-indicated would be given intravenous zolendronic acid before denosumab is trialled. A benefit for denosumab being that it could be used in renal dysfunction with close monitoring where bisphosphonates are not recommended. If three or more bisphosphonates have been tried and a patient continues to suffer side effects then the patient may be offered denosumab instead. DC also queried from Sheffield APG minutes whether wholesaler licenses were needed to supply denosumab. AM was tasked with checking into this as it may carry a financial impact. DC stated that the Committee would need to work through the points raised today and would come to a decision once the queries had been answered. FPIG will need to be given the patient data/numbers to consider. This will be sent on by Dr Stevens for consideration. He thanks Dr Stevens for his attendance today.			
2/20/4.2	**Modafinil Updated SCP:** VLC addressed the committee to give an update	**DCCG-AM/**	**Oct-20**	

	regarding the modafinil SCP that Sheffield CCG has produced. Previously the document had come to the APC meeting for comments and the Committee had raised some points with regards to the unlicensed indications of modafinil. Within the document there had been listed unlicensed indications for the drug which also carry an EMA warning. The Committee had asked for feedback about this. The response from Sheffield had been that only the licensed indications were approved by Sheffield APG and the other indications within the document were for information only. The rationale was that it was additional guidance to Primary Care to support prescribing decisions made by GPs. The Committee agreed that it was misleading to have this information within the document and could lead to errors in interpreting. The TLS for the drug in Doncaster and Bassetlaw is Amber G and it was thought that this information should be adapted for Doncaster and Bassetlaw by removing the unlicensed indications or highlighting them to make prescribers aware that they are not endorsed. AM and RW have agreed to revise the document and make it local to Doncaster and Bassetlaw with the suggested alterations.	**BCCG-RW**		
9/20/4.4	**Highest prescribed GREY drugs by PCN:** The committee reviewed the prescribing of grey listed drugs between April – July 2020. The top items were Movelat cream and gel, Tadalafil 5mg tablets, Dosulepin 25mg and 75mg tablets, there were also high numbers of Sodium Fluoride toothpastes and Blephaclean wipes. It was felt that most of these items with the exception of dosulepin could stopped when patients were reviewed. There was a risk that these items were being added onto prescriptions after discharge from various services by staff other than GPs. It was then difficult for the GPs to pick up each item on aprescription at the point of signing without knowing if the patient had the items added recently or had been given the same item on a long-term basis, without the patient being there at the time to conduct a review. It was understood that the dosulepin prescriptions would remain for long standing stable patients. However this is expected to decrease over time and the prescribing trend of this drug had not increased which shows that there were unlikely to be any new initiations.	**DCCG-VLC**		

	It was discussed that Medicines Management Team would work together with the GP practices to help reduce the numbers of grey drugs prescribed. There is a financial impact and NHSE OTC guidance is relevant to several items that continue to be prescribed. There will be communication to prescribers via the MMG to try and re-inforce the message about grey drug prescribing and using the TLS correctly.			
9/20/5	**Drugs for Review** There are currently no drugs for review at this time.	**DCCG-VLC**		
9/20/6	**Officers' Actions** All officers' actions were agreed as proposed and will be updated on the traffic light system.	**DCCG-VLC**		
9/20/7	**Drugs for Consideration:** **Insulin lispro (Lyumjev)** for the indication of Diabetes Mellitus was given a recommended TLS of **GREEN G.** **Turoctocog alfa pegol (Esperoct)** indicated for the treatment and prophylaxis of bleeding in patients 12 years and above with Haemophilia A was recommended to have a TLS of **RED 1,2,3.** **Isatuximab (Sarclisa)** with the indication to treat relapsed and refractory Multiple Myeloma in adults was recommended to have a TLS of **Red 1,2,3.** **Heel Balm (Flexitol, Dermatonics)** indicated for the treatment of Dry Heels was recommended a TLS of **AMBER G.** **Avatrombopag** for the indication of Thrombocytopenia (chronic liver disease needing a procedure) was given the TLS of **RED 1,2.** **Osilodrostat (Isturisa)** indication for Endogenous Cushing's syndrome was recommended to have a TLS of **GREY.** **Remdesivir (Veklury)** for the indication of Coronavirus disease 2019 (COVID-19) was given the recommendation for a TLS of **RED 1,5**	**DCCG-VLC**		
9/20/8	**New Business**			

9/20/9	**DBTHFT D&TC Update** The Committee received minutes from the meeting held March 2020			
9/20/10	**Formulary Liaison Group Update** The Committee received minutes from the meeting held February 2020			
9/20/11	**Doncaster Prisons Drug & Therapeutic Committee update** No minutes available			
9/20/12	**RDaSH FT Medicines Management Committee update** The Committee received minutes from the meeting held July 2020			
9/20/13	**Barnsley Area Prescribing Committee Update** The Committee received minutes from the meeting held August 2020			
9/20/14	**Rotherham Medicines Optimisation Group Update** The Committee received minutes from the meeting held August 2020			
9/20/15	**Sheffield Area Prescribing Committee Update** The minutes of the meeting held in Nov2019 were received by the Committee.			
9/20/16	**Nottingham Area Prescribing Committee Update** The minutes of the meeting held in Nov 2019 were received by the Committee.			
9/20/17	**SY& B ICS Medicines Optimisation Work-stream Steering Group** No minutes available			
9/20/18	**Northern Regional Medicines Optimisation Committee** No minutes available			
9/20/19	**Any Other Business:** DC raised that he would not be able to attend the next scheduled APC meeting on the 29th October 2020. This falls over the half term period for schools and also other Committee members may struggle to attend. He asked if there was the option to move the meeting forward by one week. Various other Committee members had commitments around the new proposed meeting date. It was decided to keep the original time and date and RW as deputy chair would step in for DC to chair the meeting on the 29th October 2020. DE discussed an issue with patients taking warfarin with sub-optimal INR levels. These patients are sent to DRI and the Medical Assessment unit to be assessed and usually given treatment with enoxaparin to stabilise them. He asked if this was the best course of action and if it would be a possibility for primary care to do a bridging prescription for the enoxaparin and if there was a possibility to change the TLS to facilitate this. This would essentially stop a hospital		**Oct-20 - LW**	

	admission, be easier for patient and more cost effective. DC agreed that there was work to be done with this as dalteparin not enoxaparin was the first line choice within our current shared care agreement. There was a supply/stock issue with dalteparin for certain doses and that is why enoxaparin was being used as a second line alternative. AM mentioned as enoxaparin is Amber on the current TLS this should not require a change in status; it also fits with protocol if GP and specialist monitoring is taking place. An amendment to the current dalteparin shared care document could be made and the document is now due for a review. DE mentioned that patients may not be on a shared care pathway so the TLS may need to be looked at. LW is currently working on the new shared care guidance. RWilson will feed this information back to him and it will be discussed further once the document is ready for comment.			
9/20/19.1	**Date and Time of Next Meeting:** 12 noon prompt Thursday 29th October 2020 Meeting via Microsoft Teams			

KEY

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