NHS South Yorkshire Integrated Care Board Doncaster Place

NHS Nottingham and Nottinghamshire Bassetlaw Place-Based Partnership

DONCASTER & BASSETLAW AREA PRESCRIBING COMMITTEE (APC)
Action Notes and Log
Thursday 27th July 2023 at 12 Noon,
Meeting Held over Microsoft Teams

Present:		
	Mr Rob Wise	Senior Pharmacist NNICB - Bassetlaw Place Partnership, APC chair
	Dr Rachel Hubbard	Clinical lead for Doncaster Place
	Mr Lee Wilson	Consultant Pharmacist DBTHFT
	Mrs Ashley Hill	NHS SYICB Doncaster Place Senior Medicines Optimisation Technician (Secretary)
	Mr Steve Davies	Chief Pharmacist RDaSH
	Miss Faiza Ali	Pharmacist NHS SYICB Doncaster Place Locality Lead Pharmacist
	Dr Rumit Shah	Local Medical Committee Representative
In attendance:		
	Dr Rupert Suckling	DMBC Representatives
	Mr Victor Joseph	
Minutes only:		

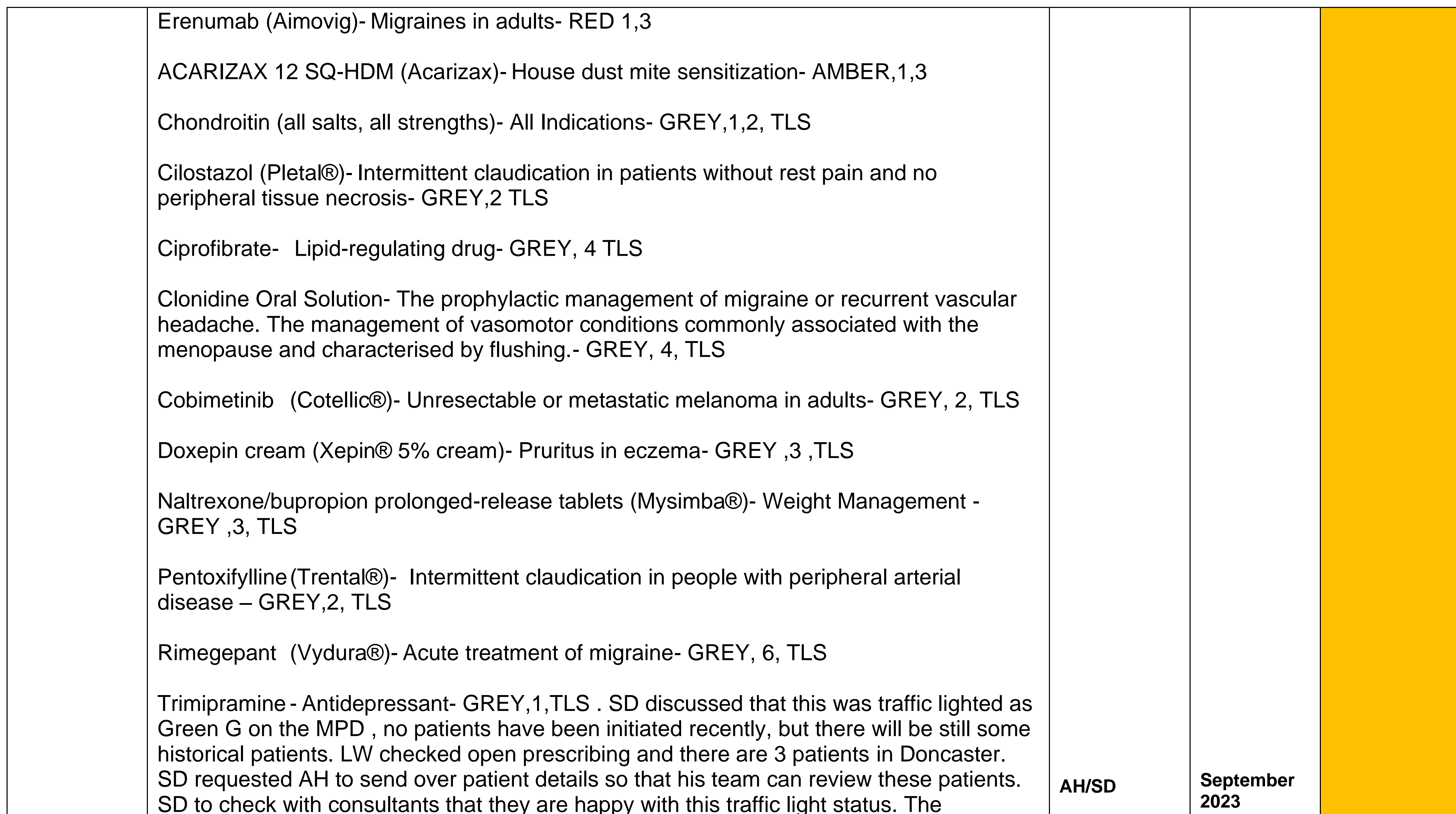
Agenda Ref	Subject / Action Required	Action Required By	Timescale	Status of Action (RAG) and Date
07/23/1	**Apologies for Absence:** Mrs Charlotte McMurray- NHS SYICB Doncaster Place Interim Chief Pharmacist, Deputy APC chair Rachel Wilson – DBTHFT Chief Pharmacist Lucy Peart– Consultant DBTHFT Dr Mallicka Chakrabarty- Bassetlaw GP Representative			
07/23/2	**Declarations of Interest**:			
07/23/2.1	**Fire Alarm Procedure:** NA meeting held online			
07/23/2.2	**Notification of Any Other Business**: LW to discuss DOAC indications			
07/23/3	**Notes of the Meeting held on:** The Thursday 29th June 2023 actions log was agreed as a true and accurate record and will be made available on the medicines management website.			
07/23/4	**Matters Arising not on the agenda**			
03/23/05	**Tiagabine (Gabitril)** AH informed the committee that Sheffield are currently reviewing the epilepsy in adults shared care protocol and adding some amendments. They will also add in the addition regarding Tiagabine in the final document. The document will be discussed at IMOC when ready for approval. The committee agreed that this action could be closed.			
05/23/20.2	**Monitoring of DMARDs& Rheumatology** RS asked the committee whether there were any further updates regarding blood monitoring. The Chair explained that APC was not the committee that could address this but there is dialogue between Doncaster Place and DBTH. RS stated that if Rheumatology decommissioned monitoring in Doncaster this would have implications on traffic light status of medication. RH informed the committee that Nabeel has been in contact with Tim Noble at DBTH, as this was not on DBTH radar. Rheumatology will need to put a business case forward which would include what the ramifications would be if they		**update when available**	

	stopped blood monitoring. No confirmation that this has happened Nabeel has made it clear that Primary care needs to be involved if monitoring was coming back to primary care. RS wanted to be assured that Primary care are kept aware of any decision. The chair agreed that this would be a standing agenda item and the committee would be kept updated. LW will contact Dr Chee-Seng Yee consultant Rheumatologist to discuss with Tim Noble regarding plans.	**LW**		
07/23/4.1	**Matters Arising**			
10/22/7.2	**Goserelin (Zoladex)- Breast Cancer & Endometriosis** FA discussed with the committee she has emailed several DBTH specialists and had no response. The chair suggested that FA could arrange a team's meeting which would allow for two-way dialogue and may be more convenient than email. The committee commented that all that was required was a simple short word document to support the use of Goserelin over the 6 months licensed indication, including supporting documents. This would provide assurance and guidance to prescribing primary care clinicians. LW enquired if there were any other places who had a similar document that could be used/ amended, FA responded that none were found. LW will try to obtain receive a response for FA from a DBTH specialist. FA explained that there was also another query regarding Goserelin which is traffic lighted grey for Endometrial thinning due to lack of evidence, which is causing confusion as it has been confused with endometriosis which are two different indications. FA has contacted a specialist who confirmed that they are not using Goserelin for Endometrial thinning at DBTH and was happy for this indication to be removed from the MPD to stop confusion. The committee agreed that the grey listing for Goserelin and Leuprorelin for Endometrial thinning to be removed from the MPD as there is no evidence to support the use and is not being used by DBTH confirmed by specialist and will avoid potential for future confusion concerning different traffic light listed indications	**FA/ LW**	**September 2023**	
04/23/20	**Hydroxychloroquine prescribing** RH gave the committee an update that there are ongoing conversations with contracting with regards to a provider who is going to be taking over the retinal screening. The Medicines Management Team is providing searches on patients:	**RH/CM**	**update when available**	

	• 1: On hydroxychloroquine more than 5 years of treatment (No retinal screening on record) • 2: On hydroxychloroquine more than 1 year if additional risk factors are present. Risk factors include concomitant tamoxifen use, impaired renal function (eGFR <60mL/min/1.73m2) and a high dose of hydroxychloroquine (>5mg/kg/day) • 3: On for 4 years • 4: On for 3 years • 5: On for 2 years group • 6: On for 1 year. • 7: New patients (less than 1 year at time of search) Currently DBTH systems do not allow them to identify patients who are on Hydroxycholoquine, which is a sticking point at the moment. RH discussed they are looking at ways that practices can share that information with DBTH and there is still some contracting to be finalised. LW suggested looking at patients who are on 300mg or 400mg doses instead of trying to find weights of patients; RH will inform Karen Jenninson who is producing the searches. The chair reported that Bassetlaw & Doncaster commissioning managers have been in joint discussions with DBTH, as Bassetlaw are looking at the same solution. The Bassetlaw numbers from 2021 showed that there were 136 patients who have been Hydroxycholoquine for over 5 years at the time. Bassetlaw are looking at a joint approach with Doncaster, which is ongoing. RH stated that there is going to be a SY ICB project in the future which was discussed at IMOC. RS expressed concerns about the time that has taken to get this service provided. LMC have sent out communications to prescribers previously regarding referring patients back to secondary care. LW responded that Rheumatology have been receiving referrals for patients to be reviewed. It was established that it has been difficult to find a provider who is able to offer the retinal screening required. The committee agreed that this is moving forward and will return with any further updates in due course.			
05/23/8.3	**Shared Care Prescribing of subcutaneous methotrexate for the treatment of rheumatological conditions**		**September 2023**	

	The chair has contacted Bassetlaw council, which confirmed that they do not collect cytotoxic waste from patients' homes. Enquiries are being made to NHS England regarding community pharmacy contracting, as some patients may be returning methotrexate tablets to them which should be disposed in a cytotoxic bin. LW suggested involving LPC if it is in the contract as the issue for community pharmacy may be around the increase in volume if methotrexate injections are to be collected as well. The chair to report back at next meeting with reply.	**RW**		
07/23/5	**Drug's approved at June's IMOC meeting** The following drugs were approved at APC and will go to MOG for information: Bulevirtide (Hepcludex®)- Treatment of chronic hepatitis delta virus (HDV) infection in plasma (or serum) HDV-RNA positive adults with compensated liver disease – RED ,1,6 TLS Voclosporin (Lupkynis®)- Use in combination with mycophenolate mofetil for the treatment of adults with active class III, IV or V (including mixed class III/V and IV/V) lupus nephritis- RED,1,6 TLS Clobetasol propionate/neomycin sulphate/nystatin 0.5mg/5mg/100,000 IU/g Cream/ointment-Topical corticosteroid- GREY,4 TLS Aceclofenac- Non-steroidal anti-inflammatory- GREY,4 TLS Agomelatine- Major Depression-GREY 3 TLS Aliskiren (Rasilez)- Hypertension- GREY,2 TLS Almotriptan (Almogran)- Treatment of acute migraine- GREY 4 TLS Amantadine- Influenza- GREY 2 TLS Amifampridine (3,4 diaminopyridine phosphate)(Firdapse)- Lambert-Eaton Myasthenic Syndrome (LEMS) in adults- GREY 1 TLS			

	Anakinra- Rheumatoid arthritis in adults- GREY 2 TLS Armour thyroid – Hypothyroidism- GREY 1 TLS Atorvastatin 30mg and 60mg tablets- Lipid modification- GREY 4 TLS Baloxavir marboxil (Xofluza)- Uncomplicated influenza and post exposure prophylaxis of influenza in patients aged 12 years and above- GREY 2 TLS Belzutifan (Welireg)- von Hippel-Lindau (VHL) disease- GREY 6 TLS Bemiparin (Zibor)- All licensed indications- GREY 6 TLS Co-Proxamol - All licensed indications- GREY 6 TLS Dosulepin- Depressive illness, particularly where sedation is required- GREY 1 TLS Doxazosin MR preparations- Hypertension- GREY 1 TLS "Self-care medicines - All Conditions for which over the counter items should not routinely be prescribed in primary care"- GREY 5 TLS Adalimumab (Humira)- As per licensed appropriate NICE TA- RED,1,2,6 TLS Afibercept (Eylea)- "Eye Conditions As per licensed appropriate NICE TA"- RED 1,2 Avelumab (Bavencio)- As per licensed appropriate NICE TA- RED 1,6 Bevacizumab- As per licensed appropriate NICE TA- RED 1,6			



	Erenumab (Aimovig)- Migraines in adults- RED 1,3 ACARIZAX 12 SQ-HDM (Acarizax)- House dust mite sensitization- AMBER,1,3 Chondroitin (all salts, all strengths)- All Indications- GREY,1,2, TLS Cilostazol (Pletal®)- Intermittent claudication in patients without rest pain and no peripheral tissue necrosis- GREY,2 TLS Ciprofibrate- Lipid-regulating drug- GREY, 4 TLS Clonidine Oral Solution- The prophylactic management of migraine or recurrent vascular headache. The management of vasomotor conditions commonly associated with the menopause and characterised by flushing.- GREY, 4, TLS Cobimetinib (Cotellic®)- Unresectable or metastatic melanoma in adults- GREY, 2, TLS Doxepin cream (Xepin® 5% cream)- Pruritus in eczema- GREY ,3 ,TLS Naltrexone/bupropion prolonged-release tablets (Mysimba®)- Weight Management - GREY ,3, TLS Pentoxifylline (Trental®)- Intermittent claudication in people with peripheral arterial disease – GREY,2, TLS Rimegepant (Vydura®)- Acute treatment of migraine- GREY, 6, TLS Trimipramine - Antidepressant- GREY,1,TLS . SD discussed that this was traffic lighted as Green G on the MPD , no patients have been initiated recently, but there will be still some historical patients. LW checked open prescribing and there are 3 patients in Doncaster. SD requested AH to send over patient details so that his team can review these patients. SD to check with consultants that they are happy with this traffic light status. The	**AH/SD**	**September 2023**	

	committee discussed the impact of historical patients when changing traffic light status as patients would need to be referred to secondary care could cause big impact. AH explained that new grey and red drugs are added to the quarterly drug reports and should be reviewed by the medicines optimisation team who would contact the GP and if the GP was happy to continue to prescribe this would be noted in their notes. It was discussed that an optimise RX message could be used to inform prescribers of the change or a read code could be used to say that patient has been reviewed for that drug. AH to check with Jen Cox. The chair discussed that there is no supportive information for prescribers when a medication has been changed to grey and with some medications this could cause problems for prescribers is there is no supporting information, e.g. a note to say, "except for legacy patients, whereby it's been determined that there's not a suitable alternative". RH discussed that clinicians would want to know why has a drug that has been green changed to grey. The chair requested that this point is discussed at the next IMOC meeting. Unfortunately, the chair is not present at IMOCs September's meeting and asked that CM is informed/ listened to recording and to discuss this on behalf of Doncaster and Bassetlaw APC. Co-careldopa intestinal gel (Duodopa®)- Parkinson's Disease- RED,1,6, TLS Relugolix–estradiol–norethisterone acetate (Ryeqo®)- Uterine Fibroids- RED,3,TLS Brexucabtagene autoleucel (Tecartus)- Refractory B-cell acute lymphoblastic leukaemia- RED,1,6, TLS Axicabtagene ciloleucel (Yescarta)- Refractory follicular lymphoma- GREY,2, TLS Axicabtagene ciloleucel (Yescarta)- Refractory diffuse large B-cell lymphoma after first-line chemoimmunotherapy- RED,1,6, TLS Daratumumab with bortezomib and dexamethasone (Darzalex)- Multiple myeloma- RED,1,6, TLS	**CM**		

	Dabrafenib plus trametinib (Tafinlar & Mekinist)- BRAF V600 mutation-positive advanced non-small-cell lung cancer in adults- RED,1,6, TLS Esketamine (Spravato)- Major depressive disorder in adults at imminent risk of suicide- GREY, 2, TLS Tixagevimab plus cilgavimab (Evusheld)- Preventing COVID-19- GREY, 2, TLS Cemiplimab (Libtayo)- Metastatic cervical cancer- GREY,2,TLS Darolutamide with androgen deprivation therapy and docetaxel (Nubeqa)- Hormone-sensitive metastatic prostate cancer- RED,1,6 Pembrolizumab with lenvatinib (Keytruda & Lenvima)- Endometrial cancer- RED,1,6, TLS Upadacitinib (Rinvoq)- Crohn's disease- RED,1,6, TLS **The following drugs were not approved and are required to be re discussed at the next IMOC meeting:** Eflornithine cream (Vaniqa®)- Treatment of facial hirsutism in women- AMBER G,1,2 The committee discussed in detail that the drug itself is safe enough to prescribe i.e. monitoring requirements and GPs. RS and RH explained that they would be happy to prescribe it for a patient to try before referring to dermatology. The committee discussed that it was perhaps traffic lighted as Amber G for the indication rather than the drug itself. It is currently traffic lighted as Green G non formulary on the MPD. Making it Amber G would mean that the patient would have to be initiated by a specialist first before a GP could prescribe. The committee also discussed the ramifications in general regarding traffic lighting, as this could potentially increase referrals to secondary care, as prescribers and non-prescribers are looking at traffic light status for prescribing guidance. The committee did discuss that the traffic light status is only a guide, but many prescribers will prescribe what is supported on the MPD. RH asked for the rationale for it being Amber G.	**CM**		

	It was agreed that this should be taken back to IMOC for further discussions, with a green traffic light status with referral to NICE hirsutism guidance. Unfortunately, the chair is not present at IMOC's September's meeting and asked that CM is informed/ listened to recording and to discuss this on behalf of Doncaster and Bassetlaw APC.			
07/23/6	**Returning Drugs from MOG** All drugs have been accepted by MOG from July's APC meeting.			
07/23/8	**New Business**			
07/23/8.1	**Traffic Light drugs for approval** Tibolone traffic light application was discussed to be traffic lighted by the committee as an add-back therapy for endometriosis. It originally came from a query from a practice as it has not been traffic lighted on the MPD. The committee agreed to the Amber G status IMOC rational as 2C. FA had checked with Dr Thomas Barani and had email correspondence to confirm this. FA to seek approval from lead gynaecologist at DBTHFT to be able to add their details under "Does this application have the support of the division head/lead clinician" in the application form. To be completed before going to September's IMOC for final approval. Pigmanorn cream traffic light application was discussed to be traffic lighted by the committee as a query had come through from a practice. It was recommended from a dermatologist and a community pharmacy was able to obtain this special cream that is imported from Germany. The committee were informed that a patient should trial it for 3 months to see if this is effective. Another dermatologist had replied that they would prefer to use Manchester cream and Pharmacist Melissa had completed a form for Manchester cream as well. The committee discussed in detail that more background information is required for both creams, including what happens after 3 months? LW will discuss with Dr Desai that the creams will remain red. The committee agreed that both creams will be traffic lighted as red and will not go to IMOC.	**FA** **LW**		
07/23/8.2	**IMOC TLDL Green Clause** AH requested if the discussion regarding the TLDL green clause could come back to the September's meeting as there is work going on in the background and will be discussed at September's IMOC. The chair also discussed that it was decided that the TLDL subgroup			

	work would go straight to IMOC for approval and then then go to place, and if there was anything to be discussed from place it would be re discussed at the next IMOC meeting.			
07/23/8.3	**Melatonin** AH shared with the committee a letter which was received by the medicines optimisation team from a GP requesting guidance on a patient that is seen at Sheffield Ophthalmology department. They would like the patient's GP to continue to prescribe Melatonin as part of management of diurnal hormone, that would help the patient. The patient has had improvements with using melatonin prescribed by them. The letter was originally going to be discussed at IMOC but due to time restraints it was not discussed, and a response is required before September. Currently on the MPD, melatonin is traffic lighted as Grey, but the specialist requested due to the exceptional circumstances of this patient for it to be prescribed. The committee discussed this in depth, noting that there is no long term use data or safety data that they are aware of. Committee acknowledged that this was an exceptional circumstance, however that it must be for the prescriber to determine whether they are willing to prescribe. APC also commented that if the prescriber did choose to prescribe then it would be recommended that a management plan be written detailing review intervals, possible treatment breaks/de-escalation. RH will draft a letter back to the GP to be co-signed by the chair and sent to the clinician.	**RH/RW**		
07/23/9	**DBTHFT D&TC Update** The committee received minutes from the meeting held in July 2023			
07/23/10	**Formulary Liaison Group Update** There were no recent minutes received			
07/23/11	**Doncaster Place MOG** The Committee received minutes from the meeting held in July 2023			
07/23/12	**RDaSH FT Medicines Management Committee update** There were no minutes received			
07/23/13	**Barnsley Area Prescribing Committee Update** There were no minutes received			
07/23/14	**Rotherham Medicines Optimisation Group Update** The committee received draft minutes from the meeting held in July 2023			

07/23/15	**Sheffield Area Prescribing Committee Update** There were no minutes received			
07/23/16	**Nottingham Area Prescribing Committee Update** There were no minutes received			
07/23/17	**SY& B ICS Medicines Optimisation Work-stream Steering Group** There were no recent minutes received			
07/23/18	**Northern Regional Medicines Optimisation Committee** There were no recent minutes received			
07/23/19	**IMOC meeting** The committee received minutes from the meeting held in July 2023			
07/23/20	**Any Other Business**			
	DOACs Indications -LW LW shared with the committee some guidance that is from the British Committee for Standards in Hematology. LW had recently received an enquiry from a practice Pharmacist who could not prescribe a DOAC for a patient who has cerebral venous sinus thrombosis because it is off-license. LW enquired if something could be added to the MPD or formulary for unusual thrombosis, similar to what is in place for how DBTH use DOAC in DVT and PE. They are treated in the same way but usually warfarin is used. This particular patient had already been tried with a high dose of warfarin and the INR was still not in range, so the specialist suggested that a DOAC should be used. The committee recognised that for this indication DOACS will not be licensed as will only be used in a small number of patients. The committee agreed that a statement could be put under DOAC to indicate that management of venous thrombosis at unusual sites is occasionally undertaken and agents other than warfarin can be used, see guidance. LW to circulate a draft statement to committee members for approval. This will be added to the MPD when agreed.	**LW**		
07/23/21	**Date and Time of Next Meeting**			

	12 noon prompt Thursday 28th September 2023 Meeting to be held Via Microsoft Teams			

KEY

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