NHS Berkshire West Area Prescribing Committee
Minutes of Meeting held on 7th May 2014
Room G30, 57/59 Bath Road, Reading, RG30 2BA

Attendance:

[redacted]

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1. Chairman's Introduction

[redacted] welcomed everyone to the meeting.

2. Apologies

[redacted]

3. Pecuniary Interests

No declarations received.

4. Minutes of the APC meeting held on 5th March 2014

The minutes were agreed as accurate.

5. Matters Arising from Meeting on 5th March 2014 not Included in Main Items

TA280 and the pending rheumatology paper: [redacted] met with Consultant Rheumatologists [redacted] and [redacted] to discuss formulating a rheumatology pathway for anti-TNF agents. During the meeting it was felt that there was a more pressing need to address ankylosing spondylitis over rheumatoid arthritis (RA) .RBH are following NICE guidance for anti-TNFs in RA and using the DAWN database to ensure patients are adequately monitored and clinically reviewed whilst on treatment. [redacted] to work with [redacted]

[redacted] to produce a paper on ankylosing spondylitis.

The Prescribing of Melatonin in Primary Care: [redacted] is working on shared care for adult ADHD patients requiring melatonin and will bring to the APC once complete.

NOAC monitoring: [redacted] gave an update on the NOAC monitoring service informing the group that RBFT had written to the CSU/CCG stating their dissatisfaction over the lack of support for a monitoring service. [redacted] also informed the group that there had been an error involving a GP who switched a patient from warfarin to dabigatran without first taking an INR. A further mistake was made by the community pharmacist dispensing the prescription and a box of 75mg capsules was issued instead of a box of 110mg. The patient's relative informed the anticoagulant clinic who brought the patient in for an INR and were able to offer advice and reassurance to the patient as well as support the GP and address some learning points.

[redacted] informed the group that a 4th NOAC is expected in 2015 and the use of NOACs is set to grow. [redacted] proposed building in safety systems at different tiers to ensure optimum patient safety. This would involve the following areas:

- Education of GPs: Each practice would be asked to nominate a cardiovascular (CV) lead who would be up skilled with the support of secondary care. The CV lead would be responsible for educating other GPs in his practice and/or for the prescribing of NOACs.
- Identification of suitable patients for NOACs: Using the GRASP audit tool, patients suitable for NOACs would be better identified. The GRASP audit tool can also assist with ensuring patient diagnoses are properly coded.
- Initiation of treatment: Patient treatment initiation could be improved by using the support of community pharmacists through the New Medicines Service or targeted medicines use reviews (MURs). Alternatively a dedicated service could be commissioned from community pharmacists. Additional material like the HeartMind program initiated by Boeringher Ingleheim could be used to support patients. This program features a nurse led telephone welcoming service, daily text message reminders and other features.
- Follow-up: This would involve community pharmacists but also systems built in to allow the GP to recall the patient for a review of treatment at specified intervals.

The APC were interested to know more about this proposal and have asked for a scoping paper to be submitted to the GPs Medicines Optimisation

Committee.

Lithium Shared Care Guidelines – [redacted] informed the group that the ECG requirement would remain in the document.

The changes to the shared care proforma for hydroxycarbamide, colomycin and tobramycin were approved.

Out Patient Proformas – [redacted] updated the group on the meeting with [redacted] to outline concerns regarding the current outpatient proforma process and discuss solutions. In attendance were [redacted] (Wokingham CCG), [redacted], [redacted], [redacted] and [redacted]. It was a productive meeting and minutes are available for the meeting. Separate minutes are available for this meeting held on 1st April 2014.

6. Update on existing and expired EPC topics

The policy for ropinirole has expired and is presented as item 10.1

7. Horizon Scanning / NICE Update

No update.

8. Expanding the membership of the APC

[redacted] informed the group about proposals to expand the membership of the APC to include

- Private hospitals providing NHS services through choose and book
- Local Medical Committee (LMC) Chair
- University

The APC were in favour of private providers gaining access to papers and given an opportunity to comment. Their recommendation is that the LMC chair be invited to attend the GP MOC and if any objections to APC decisions are voiced at GP MOC the paper can be brought back to the APC for reconsideration. It was also decided that [redacted] would be the link between Reading University and the CCGs.

9 Midlands Therapeutic Review and Advisory Committee (MTRAC)

[redacted] presented the MTRAC model of presenting evidence for policy submissions and asked if BWAPC should adopt this approach. This would include the addition to policy statements of a four compartment box indicating a new treatment's place in therapy plotted against the strength of evidence for efficacy. Whilst the committee agreed it was a good idea, they noted that it would complicate the current process by making it difficult to create a reproducible and reliable way of viewing the evidence. The decision

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was made to stay with existing process.

10 Papers

10.1 **APC 14/11 What priority should be given to the prescribing of generic ropinirole for restless leg syndrome (RLS)?**

- The previous low priority statement for ropinirole has expired.
- There are currently no licensed treatments for RLS although there are several unlicensed treatments.
- Branded ropinirole (Adartel) would cost between £204 and £1023 for 52 weeks treatment. Generic ropinirole is now available and would cost between £7.28 and £22.16 for the same duration of treatment.
- In the past requests for ropinirole or pramipexole have come through the individual funding request (IFR) route and would normally be approved for patients who have explored several options and have a RLS symptom score of ≥ 24.
- Local consultant neurologists are in favour of having the option of at least one licensed treatment for patients with moderate to severe RLS who have failed on conservative and other treatments.
- Based on the limited evidence of benefit in patients with a baseline score of 24, the APC agreed to approve ropinirole as an option for patients failing conservative and first line treatments.

Recommendation
Generic ropinirole is recommended for use within Berkshire West for the treatment of RLS in patients with a baseline score of 24 who have not gained sufficient benefit from other treatment. It was agreed that information on the scoring for RLS should be included within the pathway.

Action: [redacted] to update pathway to reflect RLS severity scores and incorporate into generic ropinirole policy. This should be taken to GP's MOC for ratification and then published on Netformulary and websites.

10 .2 APC 14/12
RLS treatment pathway
The APC were satisfied with the RLS treatment pathway and felt it should be included with the above policy statement for ropinirole as it helps to clarify the cohorts of patients eligible for treatment with generic ropinirole.

Action: [redacted] to include RLS treatment pathway within the generic ropinirole policy statement.

10.3 APC 14/13
Nalmefene for the reduction of alcohol consumption in adult patients with alcohol dependence with a high drinking risk level.

The summary of product characteristics (SPC) recommends that nalmefene may only be prescribed in conjunction with continuous psychosocial support

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focused on treatment adherence and reducing alcohol consumption. Based on the above licensed indication the APC did not feel that this was suitable treatment for a GP to initiate. This treatment should come as a package of care with a heavy emphasis on psychosocial support. The committee asked that the local Drug and alcohol action team [redacted] be allowed to comment on the paper. The APC also noted that the evidence for efficacy and effectiveness was only marginally superior to treatment with placebo and asked for this fact to be communicated to the [redacted] team.

Recommendation:
[redacted] to update document and circulate to the Joint Commissioner for Berkshire DAAT.

Action: Document to be updated and brought to next meeting.

10.4 APC 14/14

The use of Relvar Elllipta for COPD and asthma

- Relvar is a new once daily combination inhaler licensed for COPD and asthma.
- It contains fluticasone fuorate and vilanterol.
- The pricing of Relvar means there would be significant cost saving implications for prescribing in COPD.
- The available evidence shows Relvar to be non-inferior to current treatment (compared against vilanterol in COPD and Seretide Accuhaler in asthma).
- There are concerns around the dosing as all inhalers are equivalent of high dose inhaled steroid. Without a proper understanding of the equivalence of the steroid doses this could lead to excessive steroid prescribing.
- There is a risk of pneumonia with treatment and further longer term data is warranted.
- There are also additional concerns which have been voiced nationally by a group of well-regarded respiratory pharmacists. These centre around the blue colour; in the UK associated with reliever treatment and also concerns that the name Relvar sounds like reliever.
- The APC were also informed that [redacted] and [redacted] will be leading a piece of work around pathways and prescribing in COPD/asthma.

Based on the above points, the APC were in unanimous agreement not to recommend treatment until the respiratory working group had an opportunity to meet and discuss treatment prescribing/pathways.

Recommendation:
The use of Relvar is not recommended at this present time and will be reviewed once the respiratory working group has decided upon the most suitable treatments for patients in Berkshire West.

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Action: Policy to be taken to GP's MOC for ratification and then published on Netformulary and websites.

10.5 APC 14/15
Guidelines for Appropriate Prescribing of Specialist Paediatric Formulas in Berkshire Primary Care.
The Medicines Optimisation Team Dietician has taken over work initiated by Public Health prior to the abolition of primary care trusts. The guidelines require further consultation with the health visitors and the APC were invited to comment on the document. There was a discussion centred on whether CCGs should be paying for these formulas in the first instance. The APC were invited to submit any further thoughts or comments to [redacted].

Recommendation:
Policy to be discussed at July APC.

11 NICE Technology Appraisals
TA 305: Aflibercept for retinal vein occlusion (RVO)
[redacted] informed the group that the priorities committee had recently produced a treatment pathway for RVO with dexamethasone implant recommended as first line (unless contraindicated) and the anti-VEGFs (ranibizumab/aflibercept) as second line treatment.

12 Ketamine shared care
- The APC agreed for some minor amendments to the existing document produced by [redacted] (a draft version of the document has been in use since 2010).
- These changes include removing references to the Liverpool pathway and replacing this with the term integrated care pathway.
- Other changes include updating the document with the new controlled drug status once this is known.
- [redacted] confirmed that the pain Consultant [redacted] is happy to lead on the completion of this document.

Recommendation:
[redacted] to update the policy and return the document to the APC once complete

Action: [redacted] to lead on ketamine shared care.

13 Minor amendment to the LUTS pathway
The amendment will be discussed at the July APC once [redacted] has finalised the pathway with [redacted] noted that there was no indication for combining an antimuscarinic and an alpha blocker.
[redacted] also asked that the APC consider allowing the prescribing of

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Vesomni in patients already stabilised on treatment with solifenacin and tamsulosin as this would lessen the pill burden for patients and result in savings on the cost of tamsulosin (as Vesomni is a similar price to solifenacin).
The APC discussed this but were not in favour of a switch program and wished for Vesomni to remain as low priority across all patient groups.

14. Any Other Business
None

Dates of Future Meetings

Date of Meeting	Venue
Wed 2nd July 2014	Rooms G29/30, 57/59 Bath Road, Reading, RG30 2BA
Wed 3rd September 2014	Rooms G29/30, 57/59 Bath Road, Reading, RG30 2BA
Wed 5th November 2014	Rooms G29/30, 57/59 Bath Road, Reading, RG30 2BA

All Meetings 10.00am – 12.00pm

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