GMMMG Interface Prescribing Subgroup

Minutes

11th February 2016, 1pm-3pm
Number One Riverside, HMR CCG
Smith Street, Rochdale

Present:

Dr Richard Darling (RD) General Practitioner, Heywood, Middleton and Rochdale CCG *(Chair)*

Lesley Smith (LS) Chief Pharmacist, Pennine Care NHS Foundation Trust

Jason Farrow (JF) Medicines Management Pharmacist, Salford CCG

Robert Hallworth (RH) Specialist Cancer Pharmacist, North of England Area Team, NHS England

Claire Foster (CF) Medicines Management pharmacist, South Manchester CCG

Anna Swift (AS) Medicines Management Pharmacist, Wigan CCG

Dr Heather Procter (JP) General Practitioner, Stockport CCG

Dr Tom Leckie (TL) Consultant, Pennine Acute Hospital Trust

Dr Jane Bradford (JB) General Practitioner, Bolton CCG

Robert Elsey (RE) Specialist Pharmacist, Pennine Acute Hospital Trust

Gary Masterman (GMa) Deputy Chief Pharmacist, Wigan Wrightington and Leigh Foundation Trust

Support:

Gavin Mankin (GM) Principal Pharmacist Medicines Management, RDTC *(Professional Secretary)*

Andrew Martin (AM) Strategic Medicines Optimisation Pharmacist, Greater Manchester Shared Services (part of NW CSU)

In attendance: Nil

Apologies received: David O'Reilly, Hong Thoong, Janette Tilstone

Declarations of Interest

1) Minutes of the meeting on 14th January 2016.

The minutes were accepted as a true and accurate record.

ACTION: RDTC to publish as final.

2) Matters arising

2a) RAG List Recommendations from October 2015 and November 2015 meeting – awaiting GMMMG approval

These are going to the February 2016 meeting of GMMMG for final approval.

2b) RAG List Recommendations from December 2015 meeting

The comments received were circulated to and reviewed by the group.

It was agreed that the following RAG rating be the final recommendation of the group:

Product	Decision		Notes on Decision
	Status Assigned	Deferred	
1) Requests deferred from previous meetings			
None			
2) New Requests from New Therapies Subgroup and Formulary Subgroup			
Apremilast for psoriatic arthritis	RED		Recommended be classified as RED as per other biologics and only to be used as per NTS recommendation.
Edoxaban	GREEN		As per all the other NOACs.
Pembrolizumab	RED		As per all other chemotherapy drugs.
Idelalisib	RED		As per all other chemotherapy drugs.
Tolvaptan for treating autosomal dominant polycystic kidney disease	RED		Recommended by classified as RED for this indication because of complicated dose titration, the hepatic monitoring required, specialist input required in decision to prescribe, and drug only available via a PAS scheme.
3) RAG List Review – products on formulary currently with no RAG status			
None			
4) Changes to current RAG status			
Linaclotide for IBS-C	GREEN		Recommended be changed to GREEN as per NTS recommendation i.e. only if suitable primary care pathway/guidance in place from GREEN (following specialist initiation).
5) No Change to Current RAG status			
None			
6) Miscellaneous Decisions			
None			

ACTION: **GM to send final recommendation on RAG status of these drugs to the March 2016 meeting of GMMMG for approval.**

GM to update RAG list and publish on website once approval received from GMMMG

2c) RAG List Recommendations from January 2016 meeting

These were circulated to Trusts and CCGs for comment with a deadline for comments of the 29th February 2016. Any comments received will be reviewed by the group at the March 2016 meeting.

2d) Process for GPs accepting individual patients for shared care

A discussion paper and with some draft proposals has been sent out to all Trusts/CCGs for wider consultation before any final recommendations were made to GMMMG. This includes a suggested standard form of words to be used in the letter from the specialist to the GP requesting shared care for an individual patient. Any comments will be collated for discussion at the February 2016 IPS meeting.

All the comments received on the discussion paper and draft proposals around the process for GPs accepting individual patients for shared care sent out to all Trusts/CCGs were reviewed by the group.

During the discussion the following points were raised:

- In terms of sending out paper copies of SCPs to GPs or directing prescribers to the website need to do whatever makes the process easiest to ensure the greatest uptake from secondary care, and make the process as streamline for everyone as possible.
- Need reassurance on both sides of interface that if GP does not respond to a request then they are happy to accept.
- Need to get secondary care clinicians to fully understand the principles of shared care.
- GPs should be encouraged to respond promptly of they are not happy.
- New Mental Health CQUIN may facilitate shared care letters for mental health drugs.

After discussion it was agreed that to propose that GMMMG approve the suggested standard form of words to be used in the letter from the specialist to the GP requesting shared care for an individual patient. And that this letter includes an electronic link to the SCP on the GMMMG website rather than sending out paper copies to GPs which each individual patient request.

It was expected that GPs would not routinely be expected to sign acceptance but should be encouraged to actively response of they do not wish to accept shared care. A form would be made available on the GMMMG website to facilitate this, if GPs to use if they wish. The group would keep the process under review and ask for specific examples from CCGs/Trusts where there had been issues/problems.

ACTION:	**GM to finalise suggested standard form of words to be used in the letter from the specialist to the GP requesting shared care with members of the IPS before sending to March 2016 GMMMG for approval.**

2e) Disulfiram Shared Care Protocol

This is going to the February 2016 meeting of GMMMG for final approval.

2f) Nadolol in paediatrics with prolonged QT syndrome

We discussed this at the Interface Subgroup in Jan 2016 but did not reach a decision. The group had a couple of questions around when nadolol would be chosen over propranolol in these patients especially given that propranolol is available in a licensed suspension and has dosing info in BNFC. CMFT had confirmed that Nadolol is their preferred beta blocker for patients with prolonged QT, particularly as it is a once a day preparation. They currently use an unlicensed nadolol 40mg tablet and an unlicensed liquid in paediatric patients with between 5 and 10 patients on it.

After further discussion the group agreed to recommend that Nadolol should be classified as a RED drug for this indication because it is unlicensed, there is no dosing information available in the BNF-C, and the number of patients is small.

ACTION: AM to contact Trusts and CCGs with proposed RAG status.

2g) Omeprazole for GORD in paediatrics
We discussed this at the interface subgroup in Jan 2016 and the feeling was omeprazole should be classed as a GREEN drug on the paediatric RAG list because it is included in the NICE guidance. The group is inclined only to list the MUPS tablets as there is evidence that the suspension should not be used as it is less effective. A number of places in the UK do not list omeprazole suspension for this reason.

With regard to dose rounding to facilitate ease of administration the following responses were received:
North Manchester General Hospital:
We don't normally round the dose to the nearest half tablet as that can cause significant dose changes (the starting dose is 700micrograms/kg which as an example in a 2.4kg baby works out at 1680micrograms). We normally round to one decimal place in mg- the dose mentioned would be 1.7mg.
To be honest we don't use the liquid here and I understand the reasoning behind that, I think it is probably sensible.
Normally recommend dissolving 10mg MUPS tablet in 10ml or 5ml water (for a dispersible tablet they don't disperse very well so smaller volumes are sometimes better).
More often than not it's 10mg in 10ml as that means when doses change it's easier for the parent to change the dose in quite a straightforward way. The manufacturer provides no guidance regarding volume of water to dissolve in so there is specific issue from that point of view.

RMCH:
Paeds gastro pharmacist who confirms that do have a few patients <1 years on a PPI. Generally, for ease of administration, ranitidine liquid would be used first line but if severe GORD they often end up on omeprazole. The gastro team reserve the use of lansoprazole for patients with feeding tubes or in some cases if it is felt a PPI is necessary and patients are refusing omeprazole MUPs orally.
Our neonatal team discharge approximately 1 patient every 1-2 months on oral omeprazole (although some of these patients will end up being transferred back to a DGH). They would only use omeprazole after failure with ranitidine, and they do not routinely use lansoprazole.
Our gastro pharmacist encourages rounding to nearest 5mg, this is both for ease of administration. However, not always appropriate especially in small infants on low doses. Our neonatal team wouldn't routinely round to half a tablet, they would ask parents to disperse a whole tablet in 10ml of water to create a 1mg/mL suspension and give a proportion.
The group noted that both GMMMG and the Formulary Subgroup were looking at this issue and that no further action was required by the IPS at this stage other than to list Omeprazole MUPS tablets as a Green drug on the paediatric RAG list.

2h) Azathioprine in ILD SCP
It was agreed at Jan 2016 IPS to suggest to authors that this indication be added to the existing GMMMG SCP for azathioprine for IBD in adults. This is because it would easier to have just one SCP for a drug covering all the different indications especially as because the monitoring should not differ between indications. UHSM have indicated that they would be ok with adding the ILD indication to the IBD SCP. However, they had a couple of queries:

- The only difference here is that UHSM ILD team do not check Hep B C and TB tests before starting. What is the premise and evidence base for this? It was confirmed these was recommended by NICE in patients who are at risk of Hep B & C or TB infection only.
- Also the GP bloods are three monthly and we ask for monthly. UHSM follow the recommendations in the BSR/BHPR guideline for DMARDs, routinely they monitor monthly, although the guideline does state that it may be reduced to 3 monthly if stable for 6 months at maintenance dose following discussion with the patient. New guidelines on monitoring are expected in 2016 from BSR. – IPS agreed to ask UHSM why stable ILD patients could not be monitored 3 monthly as per BSR guideline.

ACTION:	**GM to confirm with UHSM reasons why stable ILD patients could not be monitored 3 monthly.**

3) Drugs Requiring a Review of RAG status

- Mycophenolate for interstitial lung disease – currently no status – recommended be classified as AMBER and that UHSM be asked to write a shared care protocol to support this.

ACTION: AM to contact Trusts and CCGs with proposed RAG status.

4) New Drugs from NTS and Formulary Subgroup requiring a RAG status

- Ledipasvir – recommended be classified as RED.
- Daclatasvir – recommended be classified as RED.
- Ombitasvir-paritaprevir-ritonavir – recommended be classified as RED.
- Ciclosporin 1mg/ml eye drops for dry eye disease – recommended be classified as GREEN (following specialist initiation) for this indication.
- Elosulfase alfa – recommended be classified as RED.
- Omega-3-acid ethyl ester for triglyceridaemia – recommended be classified as GREEN (following specialist initiation) as per the Grey list recommendation from the Formulary Sub-group.

ACTION: AM to contact Trusts and CCGs with proposed RAG status.

5) Shared Care Protocols – drafts currently out for comment to CCGs/Trusts

- Oral atypical antipsychotics

This is currently out for comment to all Trusts/CCGs by the end of February 2016. All comments received will be discussed at the March 2016 IPS meeting.

6) Shared Care Protocols – 1st draft

- Typical antipsychotics depot injections
- Amiodarone in paediatrics.

This group agreed to send these out for comments all Trusts/CCGs with comments due by the end of March 2016. All comments received will be discussed at the April 2016 IPS meeting.

7) Shared Care Protocols – final drafts to go GMMMG for approval.

- Domperidone

The final draft was presented to and approved by the group subject to the following sentence from the Neonatal & Paediatric Pharmacists Group – The Use of Domperidone in Infants and Children – May 2015 being included in section 4:
"However, the evidence for the long-term efficacy of motility stimulants in the management of GORD in children is limited and unconvincing."

ACTION: GM to send Domperidone SCP to March 2016 GMMMG for final approval

8) Clarification of RAG entry for inhaled/nebulised Tobramycin and Colomycin

Following a request from UHSM the group agreed to clarify the RAG status of inhaled/nebulised tobramycin and colomycin on the RAG list as follows to avoid some of the confusion that has arisen.

Drug (proprietary examples)	BNF Chapter	Indications and Rationale	Status	Comment	Responsible commissioner
Tobramycin - inhaled	5	For Cystic Fibrosis patients (Tobi Podhaler®)	Red		NHSE
Tobramycin - nebulised	5	For Cystic Fibrosis patients (Tobi®, Bramitob®)	Red (for new patients only)		NHSE
Tobramycin - nebulised	5	For Cystic Fibrosis patients (Tobi®, Bramitob®)	Amber (for existing patients only awaiting repatriation)		NHSE
Colistimethate - inhaled	5	For Cystic Fibrosis patients (Colobreathe®)	Red		NHSE
Colistimethate - nebulised	5	For Cystic Fibrosis patients	Red (for new patients only)		NHSE
Colistimethate - nebulised	5	For Cystic Fibrosis patients	Amber (for existing patients only awaiting repatriation)		NHSE
Colistimethate - nebulised	5	For non- Cystic Fibrosis patients	Amber		CCG

ACTION: GM to update RAG list and publish on website.

9) Future inclusion of medical devices on RAG list

10) Updates from Other Groups

New Therapies Subgroup

Next meeting is in January 2016 – looking at Guanfacine for ADHD, Sacubitril + Valsartan, and Esyma® (new intermittent indication.

Formulary Subgroup

The FSG is currently developing COPD/Asthma pathway, and a Pain pathway.

GMMMG

The January 2016 meeting was cancelled.

11) AOB

RAG status of unlicensed drugs.

The text agreed at the January 2016 IPS meeting is to be amended to include paediatrics and will come to the March 2016 IPS meeting for approval.

Date of Next Meeting: 10th March 2016, 1pm-3pm, Room 410, Number One Riverside, 3rd Floor, Smith Street, Rochdale, OL16 1XU

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