GMMMG Interface Prescribing Subgroup

Minutes

12th May 2016, 1pm-3pm
Number One Riverside, HMR CCG
Smith Street, Rochdale

Present:

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

Anna Swift (AS) Medicines Management Pharmacist, Wigan CCG

Dr Heather Procter (JP) General Practitioner, Stockport CCG

Jeanette Tilstone (JT) Medicines Management Lead, Bury CCG

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

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

Jason Farrow (JF) Medicines Management Pharmacist, Salford CCG

Hong Thoong (HT) Lead Pharmacist - Paediatric Medicine, CMFT

Roisin McCanney (RM) Senior Pharmacist, Manchester Mental Health & Social Care Trust

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

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:

Jane Wilson – Chief Pharmacist – Greater Manchester West Mental Health NHS Foundation Trust

Sandy Bering - GM Strategic Lead Commissioner for Mental Health

Lorna Hand - Medicines Management Pharmacist, CMFT

Apologies received: Lesley Smith, Gary Masterman, Barry Robertson

Declarations of Interest

No declarations of interest relating to the agenda were raised.

1) Minutes of the meeting on 14th April 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 January 2016 meeting – awaiting GMMMG approval

The RAG recommendations made at the January 2016 Interface Subgroup were approved at the April 2016 GMMMG meeting. The RAG list on the website has now been updated.

2b) RAG List Recommendations from February 2016 meeting

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

2c) RAG List Recommendations from March 2016 meeting

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

After discussion 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			
Capsaicin patch (Qutenza®) for peripheral neuropathic pain non-diabetic adults	RED		
Anal irrigation systems		✓	If used correctly does not fit RED criteria but needs a pathway before RAG status finalised.
Ramucirumab	RED		
Olaparib	RED		
Panobinostat	RED		
Nintedanib for idiopathic pulmonary fibrosis	RED		
Dulaglutide	Green		As per all other GLP-1's.
3) RAG List Review – products on formulary currently with no RAG status			
None			
4) Changes to current RAG status			
None			
5) No Change to Current RAG status			
None			
6) Miscellaneous Decisions			
Diltiazem Ointment for Anal Fissure	Green (following specialist advice)		
Diazoxide	Green (following specialist initiation)		
Fumaderm® / Fumarate Esters for Psoriasis	RED		

With regard to Diltiazem ointment it was suggested that the FSG be asked to re-consider its current inclusion in the GMMMG formulary given the limited evidence base.

ACTION:	**GM to send final recommendation on RAG status of these drugs to the June 2016 meeting of GMMMG for approval.** **GM to update RAG list and publish on website once approval received from GMMMG**

2d) RAG List Recommendations from April 2016 meeting

These were circulated to Trusts and CCGs for comment with a deadline for comments of the 31st May 2016. Any comments received will be reviewed by the group at the June 2016 meeting.

2e) Azathioprine in ILD Shared Care Protocol

The Azathioprine in ILD Shared Care Protocol was approved at the April 2016 GMMMG meeting and is now available on the website.

2f) Oral Atypical Antipsychotics Shared Care Protocol

The Oral Atypical Antipsychotics Shared Care Protocol was approved at the April 2016 GMMMG meeting and is now available on the website.

2g) Azathioprine for IBD in Paediatrics Shared Care Protocol

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

2h) Typical antipsychotics depot injections Shared Care Protocol

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

3) Drugs Requiring a Review of RAG status

- Sucroferric Oxyhydroxide – recommended be classified as RED as PBR excluded and NHSE commissioned.
- Olanzapine for eating disorders in children & young people – recommended be classified as RED because this indication is unlicensed and there is lack of national guidance to support this indication.

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

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

- Sacubitril/Valsartan - recommended be classified as Green (following specialist initiation) with a GP information sheet to support this RAG rating. A suggested GP information sheet was presented to and approved by the group.
- Guanfacine – recommended be classified as AMBER as per all the other ADHD drugs.
- Idarucizumab – recommended be classified as RED.

ACTION:
AM to contact Trusts and CCGs with proposed RAG status.
GM to send Sacubitril/Valsartan GP information leaflet to June 2016 GMMMG for approval.

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

- Goserelin in breast cancer

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

6) Shared Care Protocols – comments received

Apomorphine

The group noted that this was the final draft for approval. The group discussed the comments received from CCGs/Trusts. The group agreed to recommend approval to GMMMG subject to the following changes:

- Make clear max dose to be prescribed
- Add in specialist to assess risks of using domperidone as per recent MHRA Drug Safety Update.
- Add in that any homecare service needs to be Hackett compliant. The group noted that the manufacturer provides a homecare service free of charge.
- Add in that specialist/PD nurse responsible for ensuring community pharmacy knows how to order product and that GP knows what plus how to prescribe lines & waste bins if applicable.

ACTION: GM to make changes as above and then send to June 2016 GMMMG for approval.

Amiodarone in paediatrics

The group noted that this was the final draft for approval. The group discussed the comments received from CCGs which all reflected GPs reluctance to prescribe amiodarone to children and concerns about separating responsibility for monitoring from that of prescribing. After discussion the group felt that a RED RAG status not AMBER was more appropriate as GPs are not responsible for monitoring. The group noted that this may have implications for those children on amiodarone from Alder Hey, and that GPs concerns re prescribing this drug for this group of patients should be feedback to Alder Hey. It was suggested all prescribing should be done by secondary care using FP10HP scripts for these patients.

ACTION: GM/AM/HT to feedback concerns of Manchester GPs to Alder Hey.

7) Shared Care Protocols – 1st draft

- Growth hormone in Paediatrics
- Hydroxychloroquine in dermatology
- Ciclosporin in dermatology
- Mycophenolate in dermatology
- Azathioprine in dermatology

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

With regard to the DMARDs the group agreed that ideally there should be one SCP for each drug covering all the indications to ensure the monitoring for a particular drug is the same no matter what the indication.

The group also question the need for regular blood monitoring for hydroxychloroquine in the draft dermatology SCP as this is outside the recommendations of UKMi and the British Association of Dermatologists.

ACTION: AM to send draft SCPs out to CCGs/Trusts for comment.

8) Methylphenidate SCP – use of methylphenidate XL in combination with methylphenidate IR

The group discussed a request to modify the current methylphenidate SCP to include the following statement:

"For 8 hourly release preparations, in certain circumstances, it may be necessary to give an additional afternoon/top up dose of an immediate release preparation"

This statement was included in the previous CMFT SCP but not the Pennine Care version. After discussion the group agreed to make no change to the current SCP at this stage because not all local CAHMS teams follow this practice, and the evidence/SPCs for the 8 hourly preparations suggest that if a top-dose is required to may be more appropriate to switch the patient to BD dosing product or a 12-hourly OD product rather than an 8-hourly OD dosing product.

9) Update to GMMMG CAMHS SSRI Shared Care Protocols Approved in Oct 2015

CAMHS SSRI Shared Care Protocols.
SSRIs for the treatment of Anxiety Disorders in children and adolescents
SSRIs for the treatment of Depression in children and adolescents
SSRIs for the treatment of OCD and Body Dysmorphic Disorder (BDD) in children and adolescents

There are 3 SCPs for CAMHS that have recently been uploaded onto the GMMMG website following approval in Oct. However Section 9 and 10 is vastly different to what PCFT thought had been approved and there have been several complaints from GPs and consultants.
In the current GMMMG version the following are listed as baseline and ongoing monitoring requirements;
Full Blood Count
Urea and Electrolytes
Liver function tests
Fasting plasma glucose
ECG, blood pressure, pulse.
Weight, height, BMI

HOWEVER it is not clear where this has come from as it is not standard clinical practice, not this seems to have been a mistake.

The following suggested changes were proposed and agreed by the group:

Section 9: Baseline investigations
The use of antidepressants has been linked with suicidal thoughts and behaviour; children, young adults, and patients with a history of suicidal behaviour are particularly at risk.
Parents/ carers should be specifically warned about this risk, and this should be recorded in the notes. Where necessary patients should be monitored for suicidal behaviour, self-harm, or hostility, particularly at the beginning of treatment or if the dose is changed. Specific arrangements must be made for careful monitoring of adverse drug reactions, as well as for reviewing mental state and general progress; for example, weekly contact with the child or young person and their parent(s) or carer(s) for the first 4 weeks of treatment. The precise frequency will need to be decided on an individual basis by secondary care, and recorded in the notes.

Section 10: Ongoing monitoring requirements to be undertaken by GP.
No specific monitoring is required as specialist CAMHS services will continue to monitor for adverse drug reactions, mental state and general progress at appropriate intervals.

14. Responsibilities of initiating specialist

- Initiate treatment and prescribe until dose is stable or provide instructions/directions to the GP to continue prescribing of medication where agreed.
- Documentation of full medical and psychiatric history.
- To arrange for concurrent psychological therapy.
- ~~Undertake baseline monitoring.~~
- Dose adjustments or advise GP on dose adjustments.
- Monitor patient's initial reaction to and progress on the drug.
- Ensure that the patient has an adequate supply of medication until GP supply can be arranged.
- Continue to monitor and supervise the patient according to this protocol, while the patient remains on this drug, and agree to review the patient promptly if contacted by the GP

- Provide GP with diagnosis, relevant clinical information ~~and baseline results~~, treatment to date, treatment plan and duration of treatment before consultant review.
- Provide GP with details of outpatient consultations, ideally within 14 days of seeing the patient *or* inform GP if the patient does not attend appointment
- Provide GP with advice on when and how to stop this drug. Where antidepressant medication is to be discontinued, the drug should be phased out over a period of 6 to 12 weeks with the exact dose being titrated against the level of discontinuation/withdrawal symptoms.
- Provide patient with relevant drug information to enable Informed consent to therapy.
- Provide patient with relevant drug information to enable understanding of potential side effects and appropriate action.
- Specifically warn parents/ carers about the risk of suicidal thoughts and behaviour with antidepressant use.
- ~~Provide patient with relevant drug information to enable understanding of the role of monitoring.~~
- Review patient at least monthly during initiation and then 6-12 monthly depending on the individual patient.

15. Responsibilities of the GP

- Continue or initiate treatment as directed by the specialist.
- Ensure no drug interactions with concomitant medicines
- To monitor and prescribe in collaboration with the specialist according to this protocol.
- Symptoms ~~or results~~ are appropriately actioned, recorded and communicated to secondary care when necessary.
- Inform the consultant immediately if a patient has become pregnant or is planning to become pregnant for treatment options to be considered
- Notify the consultant of any circumstances that may preclude the use of SSRIs for example, the use of illicit drugs or contraindications to treatment.
- Seek urgent advice from secondary care if:
  - Ø Toxicity is suspected ~~– seizures cardiac problems as above~~
  - Ø Non-compliance is suspected
  - Ø The GP feels a dose change is required
  - Ø There is marked deterioration in the patient's condition
  - Ø The GP feels the patient is not benefiting from the treatment
- The shared care agreement will cease to exist, and prescribing responsibility will return to secondary care, where:
  - Ø The clinical situation deteriorates such that the shared care criterion of stability is not achieved.
  - Ø The clinical situation requires a major change in therapy.
  - Ø The patient is a risk to self or others
  - Ø GP feels it to be in the best stated clinical interest of the patient for prescribing responsibility to transfer back to the Consultant. The Consultant will accept such a transfer within a timeframe appropriate to the clinical circumstances.

ACTION: GM to update the relevant SCPs and update the website.

10) Updates from Other Groups

New Therapies Subgroup

The May 2016 meeting is to review ticagrelor (new MI indication), Lesinuard, Brivacetam, and an pathway for allergic rhinitis.

Formulary Subgroup

The COPD pathway, Wound Care Formulary and Chapter 5 of the formulary are all currently out for comment on the GMMMG website.

GMMMG

The April 2016 meeting approved the botulinium toxin policy, gluten free policy, and a sub-group has been formed to finalise the new GMMMG terms of reference.

11) AOB

Lisdexamfetamine

The group agreed to add the new 20mg, 40mg and 60mg strengths to current GMMMG Lisdexamfetamine SCP for paediatric ADHD.

PCSK-9 Inhibitors

It was agreed to add this to the agenda of the June 2016 IPS to assign a RAG recommendation.

Date of Next Meeting: 9th June 2016, 1pm-3pm, Room 410, Number One Riverside, 4th Floor, Smith Street, Rochdale, OL16 1XU

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