Lincolnshire Integrated Medicines & Prescribing Service

NHS Lincolnshire Integrated Care Board

Meeting Minutes

Lincolnshire Prescribing and Clinical Effectiveness Forum (PACEF)
in association with Lincolnshire Integrated Care Board, Lincolnshire Community Health Services, United Lincolnshire Hospitals Trust, and Lincolnshire Partnership Foundation Trust

Date: Wednesday 20th September 2023
Time: 1.30pm to 3.00pm
Venue: This meeting was held using Microsoft Teams

Attendees:
[REDACTED]

Apologies:
[RECACTED]

Item	Description
1. 2.	**<u>Welcome & Apologies</u>** Welcome from **[REDACTED],** chair for the meeting. Members introduced themselves to the group. Apologies were received. **<u>Declarations of conflict of interest</u>** There were no declarations of conflict of interest.
	Items for discussion
3. 3.1 3.2 3.3 3.4 3.5 3.6 3.7	**<u>Minutes of the previous meeting held on th January 2023</u>** The minutes were approved with no amendments. **<u>Action log</u>** <u>Covid Medicines Delivery Unit (CMDU) primary care pathway</u> PACEF members requested flow diagram to be added to the pathway. <u>Lincolnshire Smoking Cessation Guidance approved subject to suitable wording being added to the formulary guiding the use of e-cigarettes.</u> Since submission to PACEF the authors have requested some further changes. <u>Shared care covering the use of ADHD medication.</u> Comments from PACEF discussion to be feedback to ULHT lead community paediatricians. Request made to include references to Children B.P charts. A.O.B <u>Request from Nottingham university hospitals to prescribe Moducren IBD (Specialist feed) for a young child with Crohn's. GP wanted view of PACEF members on request.</u> **[REDACTED]** to request relevant papers and circulate to PACEF members. Subsequent discussion with Nottingham lead dietician resulted in hospital dietetic team providing patient with supplies. <u>Request to review new range of Epistatus brand of midazolam liquid.</u> **[REDACTED]** to coordinate rapid review.
4. 4.1	**<u>Guidance</u>** <u>Blood Glucose Testing Strips (BGTS)</u> **[REDACTED]** presented an overview of new guidance focusing on prescribing of BGTS for diabetic patients, based on NHSE recommendations. There are exceptions when non NHSE approved meters and test strips can be sued for certain patient cohorts. The new guideline recommends 1st line options (Green) and 2nd line options (Amber) and it applies to new and existing diabetic patients who have been assessed as suitable to self-monitor their blood glucose and ketone levels by a healthcare professional. The guidance recommends switching all patients who are using non-formulary BGTS to the formulary approved products with the exception of patients who use their meters in conjunction with insulin pumps. If a clinician identifies a patient who wishes to be switched, they need to refer this patient to the specialist diabetes team that is in charge of their management and able to advise accordingly. Freestyle Opt glucose and ketone strips are not on the NHS list and therefore are exempt from the BGTS guideline. **[REDACTED]** also reminded all PACEF attendees that patients with a Type 2 diabetes mellitus should not be routinely offered self-monitoring. This advice was in line with the NICE guideline NG28.

4.2	**[REDACTED]** advised that paediatric team at ULHT wanted to submit formulary request for test strips and asked if **[REDACTED]** or **[REDACTED]** were aware. **[REDACTED]** advised that this information was not available to **[REDACTED]** prior to the PACEF meeting and **[REDACTED]** would be happy to have a separate conversation with **[REDACTED]** after the meeting. **[REDACTED]** proposed to include **[REDACTED]** in the email correspondence so that she can more information to hand. **[REDACTED]** queried the number of recommended brands and expressed concerns related to the aligned BGTS prescribing and its possible implication on cost effectiveness of the switch process. **[REDACTED]** advised that wide range of BGTS was introduced to accommodate specialist recommendations and initiations of BGTS outside of area so that patients from Lincolnshire can receive continuous care. The new guideline includes all of the products that are listed on the NHS formula, but recommendations specific to the Lincolnshire area were made, and these took into account local preferences in in terms of where we are at the moment when we've looked at. ACTION: **[REDACTED]** agreed to copy **[REDACTED]** into correspondence between **[REDACTED]** and the ULHT paediatric team. **[REDACTED]** and **[REDACTED]** were to review the proposed guidance and ensure that it aligns with the initiative of the Prescribing Incentive Scheme for 2023/24. <u>DOAC Guidance</u> **[REDACTED]**presented an update on the guideline on use of DOACs in non-valvular AF. The guideline was written by **[REDACTED]** and has been widely shared with colleagues from the ICB Lipid and Cardiovascular Steering Group and also with cardiologists, colleagues from ULHT. At the moment we are waiting for clarification in relation to drug choices, but Edoxaban remained our first line choice of DOAC. The guideline is based on advice given by the Primary Care Cardiology Society and the UK Clinical Pharmacy Association. Information content includes: DOAC initiation, DOAC switch, switch from warfarin to DOAC, tools for assessment and risk stratification. The calculation of creatinine clearance (CrCl) at the extremes of body weight is awaiting clarification, hence the guideline remains as a draft. **[REDACTED]** asked if the guideline allows patients to make a choice in relation to their preferred DOAC option as the ULHT guideline has this recommendation in place. **[REDACTED]** also mentioned that only apixaban is licensed for crushing or use in compliance aids and other DOACs aren't. Therefore, this information should be clearly outlined in the guideline.
11.	<u>NICE TA - Rimegepant for preventing migraine (TA 906)</u> **[REDACTED]** advised that ideally Rimegepant is an item that currently is initiated in secondary care. It should be reviewed and if after 3 months of therapy, the specialist should contact patient's GP and advise on prescribing Rimegepant in primary care. **[REDACTED]** advised that some issues in regards how do we monitor a high-cost drug in primary care can arise and that this is something she needs to clarify. The product is recommended in the NICE Technology appraisal guidance [TA906] to be prescribed as 75mg once daily every other day, but the product SPC allows clinician to increase the dose to 75mg once daily every day. This would have an adverse impact on the cost of therapy. **[REDACTED]** advised that the usual dose of 75mg every other day equals to 15 tablets a month. The patient should be advised to keep a headache diary and be assessed by the specialist during the 3 months trial with Rimegepant, which would be issued via Blueteq. Ideally the headache diary should be uploaded to the clinical system for the specialist to review. Once consultant is satisfied that Rimegepant is efficacious they would contact primary care to take over

	prescribing of Rimegepant. If at some point the patient would report changes to their migraine onset they would be eligible to re-referral to the consultant for a review. **[REDACTED]** emphasized that this is first time a medication is issued to prevent episodic migraine (4-8 attacks of migraine a month). Secondary care consultants should be able to identify the suitable cohort of patients but before the Rimegepant is recommended other preventative treatments should be tried (amitriptyline, propranolol or topiramate). In some cases, 3 months of initial trial with Rimegepant might not be sufficient so in some cases this could be extended up to 9 months. Rimegepant safety profile is good, and it can be used in patients over 65 years old. **[REDACTED]**asked what the GP should do if the newly established on Rimegepant patient reports lack of efficacy. Should the GP consider dose change? **[REDACTED]** advised that there should be no dose changes as the protocol for prescribing Rimegepant is fixed on 75mg every other day. **[REDACTED]** added clarification that although NICE TA is clear on dosage regimen for the Rimegepant, the SPC allows for the dose to be increased, and she just wanted to make everyone aware of that fact. **[REDACTED]** reiterated that prescribing Rimegepant would be quite straight forward, and the risk of adverse effects is low. **[REDACTED]** asked about the any issues that may arise from patient's adherence when taking Rimegepant every other day. **[REDACTED]** advised that skipping the dose and taking medication every other day should not be an issue, especially that Rimegepant half-life is about 11 hours. **[REDACTED]** asked if there will be a clear guidance for the management of headaches that will be submitted via PACEF in the near future. **[REDACTED]** answered that **[REDACTED]** would welcome expressions of interest to work with **[REDACTED]** and **[REDACTED]** on the headache's pathway. **[REDACTED]** advised that she would be interested in helping and **[REDACTED]** supported this as **[REDACTED]** worked on headaches pathway for the Nottinghamshire Area Committee. **[REDACTED]** advised that Lincolnshire headache pathway is based on Nottinghamshire guideline so the support from **[REDACTED]** would be welcomed. **[REDACTED]** clarified that Rimegepant will be classed as AMBER 2. Action: **[REDACTED]** to liaise with **[REDACTED]** and agree action plan in relation to the development of guidelines for the management of headaches. Rimegepant to be classed as AMBER 2 on the Lincolnshire Formulary with an annotation: after referral to neurology.
4.3	Specials Guideline **[REDACTED]** advised about new guidance on specials, which originally was requested in a form of a bulletin. The document consists of a table with listed special products and their current price. A section on GPs responsibilities in relation to asking patient for a consent when prescribing an unlicensed product was also added. **[REDACTED]** thanked **[REDACTED]** for **[REDACTED]** effort in putting the guidance together and advised it is a clear and useful document. ACTION: The guidance was approved and should be uploaded to the PACE website.
5. 5.1	Policies for noting. Rebate Policy **[REDACTED]** advised that last PACEF meeting we went through the updated policy and process in terms of managing rebates. The update included the process agreed last time and the decision form that must be completed every time a rebate is considered. The document must go through the ICB Clinical Policy Subgroup, so once PACEF agrees it is appropriate, then it will go through formal approval by the ICB.

	[REDACTED] asked if everyone was happy with the policy and after gaining approval advised **[REDACTED]** that it can be submitted for a review and approval process by the ICB Clinical Policy Subgroup. ACTION: Rebate policy to be send over to the ICB Clinical Policy Subgroup.
6 6.1 6.2 6.3 6.4a& b	**<u>Formulary</u>** <u>RDA Cortiment</u> **[REDACTED]** advised that Cortiment is already on the formulary and classed as a red hospital only drug. There is a range of nine budesonide products on our local formulary and each product can be prescribed for various indications such as oesophagitis, autoimmune hepatitis, colitis and others. Therefore, it is important to prescribe them by brand to gastroenterologists. **[REDACTED]** also advised that **[REDACTED]** and the nurse **[REDACTED]** contacted **[REDACTED]** and asked if we could review the formulary classification for Cortiment because it was classed as Red and all of the other budesonide oral products are classed as AMBER. **[REDACTED]** advised that treatment with Cortiment should be initiated by a specialist but because the product is used within its licence an AMBER traffic light status should be assigned to it rather than RED. **[REDACTED]** agreed with **[REDACTED]** suggestion to reclassify Cortiment to AMBER2. <u>RDA Udrate</u> **[REDACTED]** shared information from the July's meeting of the ULHT DTC. Udrate contains 10% urea and 5% lactic acid. The dermatology team updated the emollient guide but they felt that there's an unmet need for certain group of patients who are suffering some ichthyosis - a group of chronic skin disorders that are characterised by very dry, itchy skin. The dermatology team felt that the skin condition is best managed by a combination of high strength urea and lactic acid. Currently there is no such product on the Lincolnshire formulary and Udrate would be the appropriate product for the cohort of patients suffering from ichthyosis. The product will be mainly prescribed by a dermatologist but they have not suggested any particular RAG classification for the Udrate so it is up to the PACEF to make this decision. **[REDACTED]** advised that Udrate would be a replacement for the Calmurid cream so it would make sense to replace it with the same traffic light classification. **[REDACTED]** checked the formulary and advised that Udrate should be temporary classification as Green until clarification from the dermatology team is obtained. ACTION: **[REDACTED]** to contact dermatology and obtain clarification on RAG classification for Udrate. <u>Letter from ULHT highlighting issues on prescribing of rasagiline</u> **[REDACTED]** advised that PACEF received a letter from **[REDACTED]** about the Rasigiline as Amber 2. **[REDACTED]** informed that Rasagiline after consultation with **[REDACTED]** that it should be recommended by specialist and the first prescription should be prescribed by the GP. **[REDACTED]** asked GPs participating in the PACEF meeting if this is reasonable. **[REDACTED]** said that **[REDACTED]** was happy with this arrangement and highlighted thar Parkinson's should be diagnosed and assessed by a specialist but once this is done and specialist feels that Rasagiline is appropriate for the patient it could be initiated in primary care. Therefore, classification as Amber 2 should remain in place. ACTION: **[REDACTED]** to write back to **[REDACTED]** and inform about outcome of PACEF decision made today. <u>Progesterone for the treatment of early miscarriage</u>

	[REDACTED] advised that previously PACEF considered use of progesterone off licence for the treatment of early pregnancy if threatened by a miscarriage. This approach is covered by a NICE guidance 129. **[REDACTED]** advised that similar guidance issued by Peterborough was not followed as there was some resistance from GP to take on the prescribing progesterone. This occurred because at the time the Peterborough pathway did require GPs to do a cervical examination on patients. The ULHT pathway does not require such action from the GPs. **[REDACTED]** advised that patient will be seen and picked up by the Valley Pregnancy Service. There is a bit of a confusion about recommendation to prescribe the progesterone pessary, especially that treatment should start as soon as possible after pregnancy is confirmed. The first prescription will be issued by the hospital, and this is happening now. However, progesterone pessary is a Red drug. Once the patient is initiated then they should usually receive one month supply; then there is some negotiation in terms of whether the rest of the supply up to 16 weeks of pregnancy is supplied by a GP or the hospital. Some GP practises are quite happy to take the requests and to prescribe. Others are more reluctant because of the Red traffic light listing, and because it's an unlicensed use of the product. Therefore, they would prefer to refer patient back to secondary care services. **[REDACTED]** suggested to reclassify progesterone pessary from Red to Amber 2 but advised that **[REDACTED]** suggested to hospital colleagues to consider provision of the whole supply to the patient without involving GPs. **[REDACTED]** agreed that the whole supply should be provided by the hospital colleagues as they are best placed to assess and advise patient accordingly. However, as there is NICE guidance in place an Amber 2 classification could also be considered. **[REDACTED]** asked if the unlicensed use of Progesterone would be questioned by some GPs resulting in inconsistent service across Lincolnshire. **[REDACTED]** agreed to write back to the hospital service provider to obtain more clarification. ACTION: **[REDACTED]** to write back to the hospital service provider to obtain more clarification.
7. 7.1 7.2 7.3 7.4 7.5 7.6	**<u>Shared care</u>** **[REDACTED]** advised that shared care documents were written with support from **[REDACTED]** and extensively reviewed in line with national standards. The new documents were circulated, approved and will be replacing existing shared care agreements. **<u>Atomoxetine</u>** **<u>Dexamfetamine</u>** **<u>Guanafacine</u>** **<u>Lisdexamfetamine</u>** **<u>Methylphenidate</u>** **<u>Melatonin request to extend protocol to March 2024</u>** **[REDACTED]** informed that a couple of weeks ago **[REDACTED]** was informed of a new licenced melatonin oral solution that is going to be launched at the beginning of October called Ceyesto. This is significantly more cost-effective than the current licenced melatonin liquid discussed at PACEF meeting in July. After contacting specialist, it was a general agreement that the current shared care protocol should be extended to allow evaluation of this new licenced product with the intention of adding it to the shared care, and potentially replacing the higher cost brand with Ceyesto brand. **[REDACTED]** advised that where possible a licensed product should be used and asked if in view of current situation, the shared care protocol can be extended for another 6 months. **[REDACTED]** confirmed on behalf of PACEF that the extension period for the shared care agreement on melatonin liquid has been granted, covering period of next 6 months.
6.5	**<u>Rapid Cost comparison Atomoxetine.</u>** **[REDACTED]** advised that **[REDACTED]** submitted the rapid cost comparison for the Atomoxetine and found out on Wednesday that Strattera-the preferred brand, is being discontinued. A generic is available and also a branded generic Atomoxetine. A price cost comparison was

	undertaken based on these two items. However, there are ongoing supply issues with all Atomoxetine products. **[REDACTED]** advised that in view of this rapidly changing situation we would have to go with the available generic which might not be the most-cost effective option. **[REDACTED]** advised **[REDACTED]** was in touch with the local specialists did not have any particular preferences and were inclining for more cost-effective product to be added to the local formulary. **[REDACTED]** said that an update to the shared care protocol will be required, with the generic Atomoxetine on it. However, we need to obtain a confirmation that Strattera is no longer available. Then we'll send it out to PACEF members for final approval.
8. 8.1	**Terms of reference for consideration** **Draft TOR for APC** **[REDACTED]** informed that PACEF is going to be transformed into an Area Prescribing Committee (APC) with an emphasis on working across the healthcare system which is integrated care system. The updated terms of reference takes into account the different committees in place across the health care system, the current TORS are no longer valid as the organisation committee (CCG) no longer exist. **[REDACTED]** asked for comments from existing PACEF members. The APC will be hosted by the ICB because the ICB is the commissioner and funds the drugs and therapies used for the Lincolnshire population. **[REDACTED]** advised that majority of drugs are prescribed in primary care settings. At the moment drug submissions are reviewed at first by the organisational DTC commissions, then PACEF confirms the traffic light classification. This can mean a delay of two to four months to finalise decision depending on the frequency of the meeting. Introduction of one APC, would allow streamlining of the decision-making process as all submissions and reviews would go through one committee. The hospitals and the provider organisations will still retain DTC's because there will be some drugs and treatments and guidelines that will be specific just to their organisation. **[REDACTED]** invited comments on appointing/ electing the Chair and Vice Chair. Decision making by consensus. If not achieved require process for voting on decision, who should be a voting Member and who shouldn't be a voting Member. **[REDACTED]** reported the intention to increase the frequency of the meetings from bi-monthly to monthly. **[REDACTED]** also advised that Medication Safety Network is being developed and their representatives will be present at the APC meetings. Also, inclusion of wider representation of GPs and PCN colleagues would be invaluable. **[REDACTED]** asked members of PACEF for comments reminding that we need to have a formal procedure in place in terms of any appeals for decisions made, especially in view of evidence based and cost-effective choices. **[REDACTED]** asked if feedback from members will be sufficient to decide if a separate meeting of PACEF will be held to agree the outcome. **[REDACTED]** advised that the draft APC TOR will be reviewed by the IPMO and DTCs. The draft with the feedback will be then sent to PACEF for a review. **[REDACTED]** asked members to provide feedback to **[REDACTED]**.
9. 9.1	**ICB Position statements** **ICB Position statement CGM** **[REDACTED]** advised that NICE clinical guidelines referring to diabetes are NG17 that relates to adults with type one diabetes, NG18 relates to adults and children with all types of diabetes and then NG28 which relates to adults with type 2 diabetes were released. They all recommended the use of continuous glucose monitoring (CGM), which caused some concerns about the potential costs. To address that, we issued an interim statement which effectively didn't approve any CGM for any patient unless they were using an insulin pump. Now as we've approved the use of the Freestyle Libre and Dexcom One in line with NICE NG17, also allowing the use of CGM for those patients that are pregnant. We've updated the interim CGM statement to include those and that's why it came to PACEF today. The statement was agreed by the **[REDACTED]** and **[REDACTED]** and today it came to PACEF for noting. Once it will be finally signed off by the ICB, the statement will be put on our PACE and ICB websites. **[REDACTED]** thanked **[REDACTED]** for the information shared.

9.2	**<u>ICB Position statement Co-Proxamol</u>** **[REDACTED]** informed that the co-proxamol position statement was approved by the CRG for opioids as we have seen a high number of co-proxamol prescribing in Lincolnshire. The CRG is currently working on a deprescribing guide and a position statement saying that co-proxamol prescribing is no longer approved across Lincolnshire. **[REDACTED]** agreed that the statement is useful and approved it on behalf of PACEF as no objections were submitted.
10.	**<u>Medicine shortages (Standing agenda item)</u>** **[REDACTED]** advised about shortage of Atomoxetine as discussed earlier. Nationally there are many medicines shortages affecting prescribing at the moment. Optmise Rx has now more updated messages to help with addressing shortages, which will alert clinicians at the point of prescribing that some medications might be out of stock.
11. 11.3 11.4 11.5 11.6 11.7 11.8 11.9	**<u>NICE Guidance</u>** **<u>To note</u>** **<u>ULHT report NICE TA's</u>** **<u>BlueTeq forms (GPA requests) for noting.</u>** **[REDACTED]** advised requests have to be completed for any of the high-cost drugs in relation to how they're being used and to and these forms have to be completed to ensure that the patient is eligible for treatment under the stated nice NICE TA. These forms were all clinically signed off by the DTCs clinical specialists, but because the ICB is a commissioner of these treatments, they have to come to PACEF for noting. **[REDACTED]** agreed with information provided by **[REDACTED]** **<u>GPA TA878 Nirmatrelvit plus ritonavir for treating COVID 19</u>** **<u>GPA TA878 Sotrovimab for treating COVID 19</u>** **<u>GPA TA 878 Tocilizumab for treating COVID 19</u>** **<u>GPA TA 888 Risankizumab – moderate to severe Crohn's disease</u>** **<u>GPA TA 905 Upadacitinib – moderate to severe Crohn's disease</u>** **<u>GPA TA 907 Deucravacitinib -moderate to severe psoriasis</u>**
13. 13.1 13.2 13.3	For information MHRA Drug Safety Update July 2023 MHRA Drug Safety Update August 2023 National Patient Safety Alert 18th July 2023 **[REDACTED]** and **[REDACTED]** asked how we are going to tackle management of drug shortages that affect the whole system. **[REDACTED]** advised that there is a plan that drug shortages will become a part of the medicine safety network workstreams, but nothing is place at the moment. For this NatPSA shortage alert ULHT has produced a guidance which could be shared across other organisations. **[REDACTED]** asked if **[REDACTED]** can confirm that the NatPSA relates to the shortage of the GLP-1 drugs, and after receiving confirmation, **[REDACTED]** advise that the Medicine Optimisation collated bulletins with an advice on how to approach the GLP-1 shortage. **[REDACTED]** said that in **[REDACTED]** and **[REDACTED]** opinion, we should ensure that in future we should have a system approach to tackle this sort of issues. **[REDACTED]** agreed and asked **[REDACTED]** to ensure this is minuted and taken forward as we should have a central place where we can discuss this, until medicine safety network is fully established. ACTION: **[REDACTED]** and **[REDACTED]** to feed back shared agreement from PACEF that significant shortages such as GLP-1 should be co-produced with other service providers to ensure consistency in advice and guidance for clinicians and patients.
12. 12.1	AOBs **[REDACTED]** fed back on **[REDACTED]** behalf, that **[REDACTED]** asked about ADHD service provision across the Lincolnshire. **[REDACTED]** felt it was more of a pathway query and asked if this something we can progress via PACEF.

12.2	**[REDACTED]** responded that the Commissioners have been doing a review of the providers of the ADHD services, and they are still collating their information and once that's been completed, they will be sending out some advice to practises. **[REDACTED]** asked if **[REDACTED]** could clarify if PACEF could be involved in pathways reviews. **[REDACTED]** informed PACEF that **[REDACTED]** is retiring, **[REDACTED]**. **[REDACTED]** thanked **[REDACTED]** for all **[REDACTED]** hard work and commitment through many years. **[REDACTED]** agreed and also thanked **[REDACTED]** for all the support **[REDACTED]** provided to PACEF.
Date of the next meeting Wednesday 16h November 2023 1.30pm to 3.30pm via Teams	