Oxfordshire Area Prescribing Committee (APCO)
Bullet Points
12th March 2019

Prescribing Points and the Traffic light system are available on the OCCG website. The OCCG Formulary is available online. -links below.
This document summarises the discussions and decisions taken at APCO in March 2019.

Local Guidance: OCCG Formulary

The classifications are:

- Red – Specialist Prescribing Only
- Amber Continuation - Medicines which should be initiated or recommended by a specialist for continuation in primary care. The specialist must notify the GP that the prescribing responsibility has been transferred.
- Amber Shared Care Protocol - Medicines which are appropriate to be initiated and stabilised by a specialist, once stabilised the medicine may be appropriate for responsibility to be transferred from secondary to primary care with the agreement of a GP and a formal 'shared care' agreement. The shared care protocol must be approved by the Area Prescribing Committee Oxfordshire (APCO).
- Green - Medicines which are suitable for initiation and ongoing prescribing within primary care.
- Brown – Prescribe only in restricted circumstances
- Black – Not recommended for use in primary or secondary care
- Holding List – Pending APCO / Priorities Forum decision

Drug	Traffic Light Classification	Rationale
Abemaciclib with an aromatase inhibitor for previously untreated, hormone receptor-positive, HER2-negative, locally advanced or metastatic breast cancer	Red	In line with NICE TA563
Lenvatinib for untreated advanced hepatocellular carcinoma	Red	In line with NICE TA551 (NHS England commissioned)
Liposomal cytarabine–daunorubicin for untreated acute myeloid leukaemia	Red	In line with NICE TA552 (NHS England commissioned)
Pembrolizumab for adjuvant treatment of resected melanoma with high risk of recurrence	Red	In line with NICE TA553 (NHS England commissioned)
Tisagenlecleucel for treating relapsed or refractory B-cell acute lymphoblastic leukaemia in people aged up to 25 years	Red	In line with NICE TA554 (NHS England commissioned)
Regorafenib for previously treated advanced hepatocellular carcinoma	Red	In line with NICE TA555 (NHS England commissioned)
Pembrolizumab with pemetrexed and platinum chemotherapy for untreated, metastatic, non-squamous non-small-cell lung	Red	In line with NICE TA557 (NHS England commissioned)

Drug	Traffic Light Classification	Rationale
cancer		
Nivolumab for adjuvant treatment of completely resected melanoma with lymph node involvement or metastatic disease	Red	In line with NICE TA558 (NHS England commissioned)
Axicabtagene ciloleucel for treating diffuse large B-cell lymphoma and primary mediastinal large B-cell lymphoma after 2 or more systemic therapies	Red	In line with NICE TA559 (NHS England commissioned)
Venetoclax with rituximab for previously treated chronic lymphocytic leukaemia	Red	In line with NICE TA561 (NHS England commissioned)
Encorafenib with binimetinib for unresectable or metastatic BRAF V600 mutation-positive melanoma	Red	In line with NICE TA562 (NHS England commissioned)
Darvadstrocel for treating complex perianal fistulas in Crohn's disease	Black	In line with NICE TA556
Dabrafenib with trametinib for treating advanced metastatic BRAF V600E mutation-positive non-small-cell lung cancer (terminated appraisal)	Black	In line with NICE TA564
Bunov Buprenorphine Patches	Brown	To replace butec patches on formulary and to be used in line with current opioid prescribing guidance. The OUH have now added this to their formulary as this brand is more cost effective, this will align choice across Oxfordshire
Opicapone	Non-formulary	For Parkinson's disease. Not on OUH formulary
Strontium Ranelate	Non-formulary	Previously brown, but now discontinued so have moved to non-formulary

Miscellaneous

Freestyle Libre

NHS England central funding details published recently.
'From 1 April 2019, for patients who satisfy these criteria, NHS England will reimburse CCGs for the ongoing costs of flash glucose sensors. These criteria are estimated to represent up to 20% of England's type 1 diabetes population. The national funding arrangements are time limited to include 2019/20 and 2020/21, which will allow time for CCGs and prescribers to implement NICE guidelines and recoup the financial benefits of Flash Glucose Monitoring usage'
In 2019/20 CCGs will be reimbursed £26.03 for each sensor prescribed. This takes into account a proportion of the cost savings to CCGs from a reduced requirement to fund testing strips for finger-prick blood glucose monitoring. Will fund up to £396k.
NHS E criteria similar to our current policy but includes pregnant women with type 1.
Some changes suggested for commissioning policy statement – to be discussed at next priorities committee meeting and updated statement will be brought back to APCO.

Bearing this in mind, APCO also asked to decide how OCDEM should deal with any exceptions outside of criteria but not IFR (i.e. there is a patient cohort).
Note that this was requested by APCO in January and discussed at MOPB (prior to NHS England guidance publication)
Noted that self-funded patients who have not met criteria but have gained benefit should not be considered an acceptable exception on its own as goes against NHS constitution.
MOPB felt it would be appropriate to allow the Libre Allocation Committee to approve 20 exceptional cases per year without seeking CCG approval, any further cases will need to be run past OCCG. The 3 approved exceptions can be used as approved examples, but the committee will not be restricted to these requirements. Approved. APCO will review again if 20 patient limit is reached in year.

Shared Care Protocols (SCP)

Oral antibiotics for the management of Bone and Joint Infections – adult patients SCP

SCP brought back again following last APCO plus email consultation. More amendments suggested by LMC. Note that funding is available for any blood tests required in primary care under NPT LES
The areas amended are:

- clarifying under specialist responsibilities that the specialist review usually takes place at 6 weeks post discharge
- removing the requirement for the patient to be asked about side effects from rifampicin at al interactions with a HCP and instead state that patient should be asked this during medication reviews
- Addition of community pharmacist responsibility section. Request to check side effects if patient taking rifampicin when dispensing prescription
- Clarity about requirement for an ECG after starting ciprofloxacin in patients taking medication that prolong the QT interval

Discussed inclusion of pharmacist section and that comments have been sought from LPC. LPC commented by email and it was agreed that it is good practice to ask patients about side effects, however as community pharmacists may not be aware of SCP and do not sign up to the shared care agreement then their action would not be enforceable and may not be complied with. Agreed that a patient action would be included to inform pharmacist of any side effects (who would then discuss with GP). The SCP will be noted in the next LPC newsletter and the need to check for side effects of rifampicin will also be included to raise awareness.

Shared Care Protocol (SCP) Best Practice Guidelines.

A task and finish group met in Jan with reps from CCG, OH and OUH to discuss local shared care issues and the various shared care protocols currently available and how best to update them. The protocols were shared out among the representatives of the group to discuss with the specialists involved.
The group also agreed that a 'best practice guideline' should be produced to help with some of the local issues identified and this has been brought to APCO for comments and approval. It encompasses some local information as well as info in the NHSE

guidance on Responsibility for prescribing between Primary & Secondary/Tertiary Care. Note that RMOC are also doing some work on shared care and this will be adopted locally when it is complete. However, it was felt that some issues needed clarifying sooner and therefore this guidance (if approved) will be circulated among all providers. LMC have raised some issues - suggested that GP could reject SCP if 'not sufficient resources are in place'. APCO agreed that practice would need to have the relevant equipment in place to ensure can carry out monitoring but capacity should not be seen as a reason for rejection. If a safety issue then this would be ok. May be more of an issue with smaller practices. GMC statement 'decisions about who should take responsibility for continuing care or treatment after initial diagnosis or assessment should be based on the patient's best interests, rather than on your convenience or the cost of the medicine and associated monitoring or follow-up' included but not accepted by LMC to be used to enforce shared care. APCO felt patient best interest is important sentiment but that the full statement is not necessary. Agreed to adapt wording to remove second part of sentence about convenience and cost. It was felt that the APCO process should ensure that approved SCPs are clinically robust and have appropriate funding in place for monitoring requirements. Cross boundary issues guidance welcomed – to share guidance with local CCGs
Approved subject to amendments above

Guidelines

Primary Care Prescribing Protocol to Support the Diagnosis and Management of People with Dementia - update

Resubmission of guideline discussed in November APCO following comments from DTG and specialist team. Guideline has been updated to reflect the changes, which include:

- Prescribing of other subtypes e.g. Dementia in Parkinson's Disease (PDD).
- Boundaries on referral to secondary care – routine referral for reassessment in dementia progression is not required
- Management of patients with delirium
- Re-emphasis on treatment continuation despite some initial decline which would be expected, as long as medications are tolerated.
- Update on rivastigmine patch use.

Noted that it has been clarified that following initiation of treatment patients would be reviewed and reassessed after 3 months by the memory clinic.
The section regarding patients not appropriate for initiating prescribing in primary care was queried and whether the list including patients with a history of hallucinations, Lewy body dementia etc. were linked or exclusive of each other. It was clarified that they were exclusive and that this will be made clearer on the document
Assessment criteria used queried, full NICE guidance suggests shouldn't use GPCOG. Should it be used? Only comment from specialists was that it was quite a blunt tool. NICE gives a number of other options, should the guidance list the several of tools and suggest one of these is used? Noted that copyright could be a problem with some of them, will have to check which ones could be used. Agreed to let local specialists decide whether to use GPCOG or not.

Approved, subject to confirmation of inclusion of GPCOG

Denosumab – clarity of responsibilities if patient housebound and using Denosumab for Osteoporosis in Primary Care

Updated following discussions at January APCO. Documents have been updated and include a flowchart of process. They were discussed and noted that, following some further discussions with a practice pharmacist, it would be better for denosumab to be on patient's repeat but with a single issue to avoid it being issued without checking bloods rather than an acute script. Reduces risk of it falling off patient record and therefore it not being clear that patient is on this drug. It was agreed that would be useful to add a screen shot to show the 'one issue' to make this clear. Otherwise approved.

Denosumab prescribing guideline has also been updated to show DN risk assessment. Raised that numbers of housebound patients on denosumab may be increasing and this links to the discussion about length of treatment and who should be treated – suggested to request audit group of patients on DN caseload? To discuss with service
Noted, that methotrexate SCP may need to be updated as well to make it clear who can give it e.g. DNs and to make housebound process clear.
Related to this it was commented that in the longer term we need to be aware that shared care protocols will also be used by clinicians other than GPs e.g. Nurse Prescribers, Prescribing pharmacists etc. Suggest that OCCG MO team to think about how we communicate to all relevant colleagues.

Physical health monitoring for patients taking oral and depot antipsychotic medication

Version of guidelines have been used within the trust for 8-10 years. Aimed at trying to reduce the number of tests being requested from GPs. Secondary care responsible for monitoring in the first 12 months. Monitoring comes under the annual review so not asking for GPs to do anything more than would be the case normally – exception is prolactin. Based on Bucks guideline. Should result in patients not being missed when it comes to monitoring.
Note was raised at recent LMC meeting that specialists recommending unusual monitoring of risperidone by GPs (too frequent blood tests, ECGs) however GPs do need to ensure that they are responsible for a yearly health check (BP, weight etc.) this guideline should help clarify responsibilities.
Noted that there is an 'Improving Physical Health in Patients with a Severe Mental Illness' LES available to GPs in Oxfordshire which does offer funding for much of the monitoring referred to in the document. It was agreed that a link to this should be added into the guidance. Requested that we should also include a link to the CCG shared care protocol section of the website. Asked that David Chapmen is aware of final version.
Approved subject to adding in the links to the LES/guidance.

Coeliac Disease and Gluten Free Prescribing -Patient Information Leaflet

Put together by our dietician to explain gluten free prescribing policy to patients (request from a practice pharmacist)
Could make prescribing policy section more prominent as this was the main premise of the request.
Also agreed to remove information about cakes/biscuits etc.

Noted that restricting prescriptions to bread and bread mixes only is in line with national guidance from NHS England and should also be reference

Approved subject to amendments above

Blandford Fly-Insect Bites PIL

Noted that these fly bites can be particularly nasty but can still, in most cases, be treated by patient and do not require antibiotics. This poster has been used in some practices in the north of the county and was put together by a practice nurse (with some pharmacy input). It has been requested to have this available on the CCG website to share with other practices and endorse the advice.
Advice all in line with NHS choices and NICE CKS
Approved and agreed posters to be shared with pharmacies and hospitals as well as practices.

Chair's Actions

1. The brand Espranor (buprenorphine oral lyophilisate) is currently Black on the Oxfordshire CCG formulary and it states that the drug and alcohol service 'Turning Point' are not using it. However, Turning Point are now prescribing it for some patients, therefore the line 'Note: Espranor® is not being used by Turning Point' will be removed from the formulary entry noting that they may be prescribing it in some circumstances. This does not change the status for GPs and remains non-formulary.