

South West Yorkshire Area Prescribing Committee

Date: 18th April 2018

Time: 13:00-16:00

Location: NHS Bradford City CCG & NHS Bradford Districts CCG, Douglas Mill, Learning Areas 2&3.

ATTENDEES

Nigel Taylor (NT) – Chair – NHS Calderdale CCG

Becky Martin (RM) - Project Coordinator - Medicines Commissioning

Tracey Gaston (TG) – Head of Medicines Optimisation – NHS Bradford City & District CCGs

Kate Woodrow (KW) – Associate Director of Pharmacy – Mid Yorkshire Hospitals NHS Trust

Joanne Fitzpatrick (JF) -Head of Medicines Optimisation - NHS Wakefield CCG

Nicola Booth (NB) – Pharmacist – NHS Calderdale CCG

Kate Dewhirst (KD) – Deputy Chief Pharmacist and Medication Safety Officer – South West Yorkshire Partnership Foundation Trust

Makrand Goré (MG) - Head of Medicines Management - NHS Greater Huddersfield CCG / NHS North Kirklees CCG

Neil McDonald (NM) – Deputy Director of Pharmacy (Medicines Governance lead) – Bradford Teaching Hospital Trust

Rachel Urban (RU) – Head of Medicines Management – Locala

Fiona Smith (FS) - Deputy Clinical Director of Pharmacy - Calderdale & Huddersfield Foundation Trust

<u>APOLOGIES</u>

Sue Gough (SG) – Senior Medicines Commissioning Pharmacist

Phil Deady (PD) - Director of Pharmacy - Mid Yorkshire Hospital Trust

Fozia Lohan (FL) - Medicines Management and Medicines Safety Pharmacist - Spectrum Community Health CIC

Helen Foster (HF) - Medicines Management Lead- NHS Calderdale CCG

Sameera (Roohi) Azam (SRA) - GP Prescribing Lead - NHS Bradford City CCG

Ruth Buchan (RB) - Chief Executive Officer - Community Pharmacy West Yorkshire

Lisa Meeks (LM) - Service Implementation & Evaluation Lead - Community Pharmacy West Yorkshire

Joanna Alldred (JA) - Medicines Effectiveness Lead - Leeds CCG Partnership

Jaspreet Sohal (JS) - Bradford Teaching Hospital Trust

ITEM		ACTIONS	LEAD & TIMESCALES
1	Welcome, introductions and apologies		
	•Introductions were completed for all members in attendance as recorded above. •Apologies received and recorded above.		
2	Declarations of interest		
	•No declarations of interest disclosed for agenda items.		
3	Minutes from the last meeting (21.02.2018)		
	•Minutes reviewed by all members and approved as an accurate record of the last meeting on: 21 st February 2018.		
4	Action Log		
	•Action log updated		
	Please note update on the action log with regards to darbopoetin classification	ACTION	•Members to review action log and complete actions
	 Darbopoetin is classified as RED for dialysis induced anaemia and AMBER for all other non-dialysis indications. Issues were raised at the December APC meeting around renal teams asking nurses to administer darbopoetin. 		•
	•It was noted that CHFT were an outlier in terms of prescribing and did not use homecare delivery as per other areas within the SWYAPC.		
	•Prior to the APC making a decision around whether to re-classify as RED for all indications or whether a shared care guideline was required – Fiona Smith requested that she look at the number of patients and discuss with the renal team at CHFT.		
	•Following discussion with renal teams FS updated members that they are happy to change to RED for <u>all indications</u> . •Members agreed for RM to action this change on the SWYAPC website – but to note	ACTION	RM to update darbopoetin classification to RED for all indications.

that no RAG submission had been submitted. 5 To note updates / queries from the APC sub-groups: **Medicines Safety** Update received and acknowledged by members ·Humulin R: All stakeholders happy that all patients have been transitioned over to the Humulin R pens safely across the district and all of the patient's affected have been provided with support and advice. •Echo APP: Further discussions about the safety concerns and third party ordering stance. Lyndsey is liaising with NHS England (Gill Sealy) about the concerns raised at the group. •NUMSAS (NHS Urgent Medicine Supply Advanced Service): Concerns have been raised at the medicines safety group previously. LC attended the NUMSAS Controlled Drug meeting to discuss the concerns e.g. patients accessing multiple supplies via NUMSAS and is currently awaiting direction/quidance from CDAO. TG further explained to members that West Yorkshire is a high user of NUMSAS and that there is data available that can be broken down by Practices and Pharmacies. TG has requested for this information to be sent to each CCG's Heads of Medicines Management. RU to contact Usha Kaushal (Lead RU informed members that this was further discussed at Locala Drugs and Operational Pharmacist, NHS 111) re: **ACTION** Therapeutics Committee and there were conversations around how records can be how records are flagged to indicate flagged to indicate potentially high users of the system? This information would be potentially high users of the system. useful for Practices to know how to annotate the system to flag this. •Thickeners: All areas (except Mid Yorkshire NHS Trust) have now got a gum based (clear) thickener on formulary as first line choice.

Paula Briggs to initiate a further discussion with the SALT at the Trust as to why this is posing a problem in Wakefield.

•Discussion about the range of medicines that is contra-indicated in women of child bearing age/pregnancy— possibly a topic for a Medicines Safety Bulletin once information has been explored.

•Clozapine:

KD informed members of discussions that took place around clozapine and the risks, particularly when patients are admitted into the acute trusts. More work is ongoing around this.

Wound Management

•Update received and acknowledged by members

•Highlight from each area:

NHS Calderdale CCG: plan to go down the same route as NHS North Kirklees CCG in terms of centralising stock

CHFT (Community) - new leg ulcer guidelines are now published

NHS Wakefield CCG / MYHT: Due to go live on 21st May in terms of de-centralising stock

NHS North Kirklees CCG / Locala: updates on NK project re: supply of dressings all really positive. District Nurses really love the new way of working and it has significantly improved patient experience from a quality perspective - no longer needing to wait for prescriptions for particular dressings. Planning to roll this out into Intermediate Care, Practice Nurses and Care Homes. Challenge at the moment is around patients in the North and South - if a patient is in the North can give them a dressing if in the South (Greater Huddersfield) can't give them a dressing.

•Super absorbents:

Following discussion there was agreement amongst the members to add Zetuvit, Zetuvit plus and Vliwasorb to the formulary. If any member(s) of the group have any reservations around this - to send comments to Becky ahead of the next meeting on the 21.05.2018. If no comments are received Becky to add to the formulary.

These products have been tried and tested in other areas such as Leeds and Bradford and therefore do not need further trialling or testing (as per recommendation from APC)

The group made this decision based on the volume that was being currently prescribed looking at the prescribing data presented at the meeting. The top 2 were the Zetuvit range and the Flivasorb (Vliwasorb).

•Silver Dressings:

All APC CCGs are in the top quartile nationally for silver dressing prescribing. Action for CCGs is to include messages on Optimise RX and ScriptSwitch - to help reduce inappropriate prescribing or accidental prescribing of silver dressings.

•Formulary Compliance:

The tag has been updated but not validated

- •Greater Huddersfield over 70%
- •Wakefield over 70%
- North Kirklees around 67%
- •Calderdale around 61%
- •Bradford cannot be counted as they are using a different formulary

Moving forward members felt that this information would not be needed as prescribing will not be via FP10 once other areas have gone live with new supply of dressing routes. Members felt looking at the top 5 off formulary would be more useful to look at moving forward.

Antimicrobial

Update received and acknowledged by members

Primary Care Antimicrobial Guidelines:

•On 28/3 a task and finish group worked on the issues raised through comments on the first draft.

The meeting was successful and the guidelines have generally been approved with the adjustments. The adjustments are in process and awaiting just a few confirmations from Anu Rajgopal (Consultant Microbiologist at CHFT).

It was noted that there was representation from each of the areas within the SWYAPC – however apologies were received from Alison Haigh (Bradford's Lead Pharmacist, Antimicrobial Therapy). TG asked that NB shares the updated version with Alison to take into account any comments from a Bradford perspective.

ACTION

NB to share the updated guidelines with Alison Haigh (Bradford's Lead Pharmacist, Antimicrobial Therapy) for comments prior to sending to NT for approval / chairs action.

Members	were all in agreement that once the guidelines have been shared with Alison		
in Bradfor	d and comments received, NT can then take chairs action to approve the		
guidelines	prior to the next APC meeting scheduled in June.		
Antimicro	bbial meetings:		
	ting on the 12th April was cancelled due to high number of apologies. APC		
	were asked for their view on whether this sub-group needs to continue?		
	were advised that this sub-group was initially a task and finish group to plan ibiotic campaign.		
	of the group felt that it would be useful for the sub-group to continue to		
_	icularly if we want the antibiotic campaign to have a significant impact.		
	of the group also felt that it would be useful to monitor the implementation nary Care Antimicrobial Guidelines and to share best practice where		
	ents are seen in prescribing trend for antimicrobials.	ACTION	NB/RM work on TOR for the antimicrobial
	ns of Reference for the sub-group have been worked on and developed, but	ACTION	sub-group and bring to the next APC
	vet been approved. Agreement amongst members that the TOR need to be		meeting in June for approval.
approved	by the SWYAPC.		
6 Benzodia	zepines and suicide		
	agreement at the last APC meeting in February – KD has produced a		
	including recommendations to highlight the potential risks of suicide		
	d with benzodiazepine prescribing and withdrawal. nents were noted from members.		
	nt amongst members to add the statement to the SWYAPC Mental Health	ACTION	RM to upload the Benzodiazepines and suicide statement to the SWYAPC
	cines Safety Issues and Alerts sections of the website for information.		website.
7 Commiss	ioning Statements		
•No Comr	nissioning Statements to bring for approval at this meeting.		
Ear infor	mation:		
For inform	iialioii.		
	wing Commissioning Statements have been updated and have been sent to		
APC mem	bers for comments – comments are due back on: 25.04.2018		

•Probiotics		
•JF noted that the new NHSE guidance for conditions for which over the counter items should not routinely be prescribed in primary care should be referenced in the updated version of the probiotics commissioning statement.	ACTION	RM to ensure the NHSE guidance is referenced in the updated commissioning statement for probiotics.
•Brimondine		
Flash Glucose Monitoring Systems		
To check the progress across the SWYAPC footprint		
•Following discussion at the last APC meeting in February the interim commissioning position has been updated on the SWYAPC website; this has been adopted from Leeds West CCG and includes a list of FAQ's.		
https://www.swyapc.org/		
•FS informed members that CHFT have now had an initial meeting. The meeting included Helen Foster and Dr Robert Moisey (Consultant in Diabetes and Endocrinology)		
•At the meeting the RMOC statement was discussed and it was felt that <u>with some</u> <u>amendments</u> the RMOC statement would suffice.		
•There were 20 eligible adult patients identified under the criteria for CHFT – however it was noted that this would need to be an MDT approach to starting patients on the device.		
•It was noted that there is quite a significant variation in the number of patients eligible across the SWYAPC footprint.		
•RU informed members that following a discussion with the Diabetes Specialist Nurses for Greater Huddersfield she had been made aware that Children under 16 with diabetes receive a disability living allowance and wondered whether this could be used to self-fund the device in paediatrics?		
•There was discussion amongst members around the need for an STP wide approach to Flash Glucose Monitoring Systems in order to avoid post-code lottery for patients.		
•JF noted that Chris Ranson from Harrogate & Rural District had been contacting the CCGs within SWYAPC to find out their commissioning positions for flash glucose monitoring. Members discussed whether this could mean that work is starting on this at STP level or whether this is just a bench marking exercise. JF agreed to contact Chris to find out the purpose of his contact with CCGs.	ACTION	JF to feedback once she has spoken to Chris Ranson (Harrogate & Rural District) to find out whether work on Flash Glucose Monitoring Systems is starting at STP level.

•Agreement amongst members that the next step should be similar to the approach
taken by the East of England and for a meeting to take place with all 11 of the STP
CCGs Medicines Optimisation Teams, all Secondary Care Trusts and Diabetologists
within the STP area.

•The HoMM for the SWYAPC agreed to discuss this approach with Matt Walsh (Chief Officer NHS Calderdale CCG and lead for the STP Elective Care and Standardisation of Policies Programme).

ACTION

- 1. HF to set up a meeting with Matt Walsh (Chief Officer NHS Calderdale CCG and lead for the STP Elective Care and Standardisation of Policies Programme).
- 2. HoMM to discuss with MW Flash Glucose Monitoring Systems and the STP plans / approach.

Shared Care Guidelines

In development (for information):

a) Mercaptopurine

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- Agreement amongst the members that this Shared Care Guideline needs further work; there were a number of comments that had not been responded to particularly around white cell count and clarity is required around the length of time before responsibility is handed over.
- •KW to send comments log back to RR for further a response to the comments made by clinicians and to produce an updated version of the guideline. KW to request that this is sent back to RM who can then circulate to APC members to ensure whether comments have been accepted or declined prior to bringing back to the APC meeting for approval.
- •Members felt that it would be useful in SG's absence and in light of new members of the APC that the Shared Care Guideline Process / flow-chart is circulated for information.

b) Lithium

•A final version of the Lithium Shared Care Guideline for the treatment and prophylaxis of mania, bipolar disorder and recurrent depression has been produced

ACTION

- 1. KW to send comments log back to RR for further a response to the comments made by clinicians and to produce an updated version of the guideline. KW to request that this is sent back to RM who can then circulate to APC members to ensure whether comments have been accepted or declined prior to bringing back to the APC meeting for approval.
- 2. RM to send SCG process / flow-chart to APC members.

and comments received around discharge have been responded to. •KD confirmed that it is a shared care agreement but that GPs will be able to refer back to psychiatry for any concerns, without it being a new referral. •KD informed members of a piece of work currently ongoing between SWYPFT and NHS Calderdale CCG (with a view to extending to different localities) - to ensure timely access and advice from Secondary Care via a dedicated email and a response to be provided from a consultant within 48 hours. •Members felt that this was a good system to set up - TG requested that KD shared this information. •Members felt that more clarity was required around when the GP takes over prescribing and the below wording suggested: *Prescribers may be asked to take over prescribing whilst the specialist is still monitoring -So it is clear this is appropriate whilst still under the specialist. •Further clarity is also required around who is responsible for blood test monitoring. •NT made a further comment around ECG and wanted to ensure that this is done by the specialists and is not a requirement that is passed to the GP. •Agreement that once the changes have been made that this can be approved outside	ACTON	KD to share information on pilot with TG / APC members. KD to make minor changes around when the GP is required to take over prescribing. Once updated KD to send to RM / NT to ensure approval outside of the meeting by chairs action.
of the APC meeting as chairs action. c) Midodrine		
To discuss next steps: *Midodring has proviously been discussed at APC where issues were raised around		
 •Midodrine has previously been discussed at APC where issues were raised around blood pressure monitoring and whether there was a requirement for GPs to monitor a patient's blood pressure every three months lying and standing. •It was also noted that clarity is required around how frequently bloods needed to be taken. •Members also noticed on page one there is reference to the specialist community alcohol service – this was due to a previous template being used and needs removing. •Agreement amongst members for acute trusts to send the guideline to cardiology consultants for comments and clarity around the queries stated above. •Comments to be sent back to RM by 18th May. RM will then send all comments to NM and a further version produced for circulation and brought for approval to the meeting 	ACTION	CHFT / MYHT to send Midodrine SCG to cardiologists for comments and clarity around blood pressure monitoring and frequency of blood tests.

in June. RM to add SCGs due to expire to the agenda to look at what is due to go out of date in the next few months. •RM has recently sent a list of the Shared Care Guidelines that are due to expire on **ACTION** RM to extend the date on the SWYAPC the website and require an update from clinicians in secondary care. website for the SCGs that are already out •Members felt that it would be useful to have this as an agenda item so this can be of date. monitored and earlier notification provided. •Agreement amongst members to extend the date by 4 months for the Shared Care Guidelines that are already out of date. 9 Red drug administration by providers Update following meeting between Locala, CHFT & MYHT •Members felt that this specifically relates to providers and did not need further discussion at APC. •There is an open action on the action log for MG to write a statement on behalf of the APC stating that: Administration guidance is a requirement of Secondary Care Providers. Providers are commissioned to prescribe and supply red drugs to patients and it is their responsibility how this is administered. 10 **RAG Submissions** a) Sucroferric oxyhydroxide • RAG submission received from Fiona Smith (CHFT) currently classified as RED for the control of serum phosphorous levels in dialysis patients. •This was submitted to APC in February with the proposal to re-classify as AMBER and adopt Leeds Shared Care Guidelines so that this can be prescribed by GPs. •Following a discussion amongst the members in February it was felt that this should remain RED as it is a specialist drug and to remain consistent with other areas who also have this classified as RED. •FS has received a further request from CHFT renal consultants as a satellite unit of Leeds. This drug is AMBER in Leeds and RED in SWYAPC footprint. •It was noted that this is an NHSE commissioned drug and there would need to be a

shift of cost out into Primary Care from NHSE which they won't do.		
•Members also reiterated that Leeds are an outlier to the rest of the country – most		HoMM to raise differences in
other areas also have sucroferric oxyhydroxide classified as RED.	ACTION	classifications with Leeds at the meeting
•Members felt that there perhaps needs to be a conversation with Leeds around the		with Matt Walsh.
differences in classifications as it is not just isolated to this example. SWYAPC HoMM		
agreed that this is another point that they need to raise when they meet with Matt		
Walsh (Chief Officer NHS Calderdale CCG and lead for the STP Elective Care and Standardisation of Policies Programme).		
•Agreement amongst members for sucroferric oxyhydroxide to remain RED.		
•There was further discussion around repatriation for renal and cystic fibrosis.		
•LTHT are one of the specialist centres that have not repatriated; Primary Care are		
still picking up the costs.		
•JF informed members that Malcom Qualie (Specialist Pharmacy Services) stated that	ACTION	JF to clarify with Paul McManus re:
all new renal transplant patients should be RED and Primary Care should not be		repatriation for renal and CF.
prescribing.		
•Members noted that this has not been communicated to providers.		
•JF to have a conversation with Paul McManus to clarify whether the above statement		
from Malcom Qualie is correct and to provide an update at the next meeting.		DM: III I
		RM to add benzbromarone to the SWYAPC website as RED for treatment
b) Benzbromarone	ACTION	of gout.
		3
•RAG submission received from Kate Woodrow (MYHT) with proposal to classify as		
RED for the treatment of gout.		
•This is an unlicensed medicine unsuitable for use in primary care or is being used 'off-label' for an indication.		
•Agreement amongst members to classify benzbromarone for the treatment of gout as		
RED.		
•RM to update on the website.		
c) Nitazoxanide		
	ACTION	RM to add nitazoxanide to the SWYAPC
•RAG submission received from Kate Woodrow (MYHT) with proposal to classify as RED for the treatment of Cryptosporidiosis and Giardiasis.	ACTION	website for the treatment of Cryptosporidiosis and Giardiasis as RED.
•This is an unlicensed medicine unsuitable for use in primary care or is being used		
'off-label' for an indication with no established evidence base.		
•Agreement amongst members to classify nitazoxanide for the treatment of		
Cryptosporidiosis and Giardiasis as RED.		

•RM to update on the website.		
 d) Ferrinject (Ferric Carboxymaltose) RAG submission received from Kate Woodrow (MYHT) with proposal to classify as RED for heart failure patients with or without decreased haemoglobin levels. This requires long-term on-going specialist monitoring of efficacy or requires long-term on-going specialist monitoring of toxicity (either because of difficulty in recognising side effects or high cost/availability of investigations to identify toxicity) and is specifically designated as hospital only by nature of the product. Agreement amongst members to classify ferrinject (Ferric Carboxymaltose) as RED for heart failure patients with or without decreased haemoglobin levels. RM to update on the website. 	ACTION	RM to add Ferrinject (Ferric Carboxymaltose) to the SWYAPC website – RED for heart failure patien with or without decreased haemoglobilevels.
 e) Tofacitinib RAG submission received from Kate Woodrow (MYHT) with proposal to classify as RED. XELJANZ® in combination with methotrexate (MTX) is indicated for the treatment of moderate to severe active rheumatoid arthritis (RA) in adult patients who have inadequately responded to, or who are intolerant to, one or more disease-modifying antirheumatic drugs (DMARDs). XELJANZ® can be given as monotherapy in case of intolerance to MTX or when treatment with MTX is inappropriate. Agreement amongst members to classify as RED as this drug requires long-term on going specialist monitoring of efficacy or requires long-term on-going specialist monitoring of toxicity (either because of difficulty in recognising side effects or high cost/availability of investigations to identify toxicity) and is part of a defined commissioning arrangement. RM to update on the website. 	:	RM to add tofacitinib to the SWYAPC website – RED for the treatment of moderate to severe active rheumatoid arthritis (RA) in adult patients who have inadequately responded to, or who are intolerant to, one or more diseasemodifying antirheumatic drugs (DMARDs). XELJANZ® can be given monotherapy in case of intolerance to MTX or when treatment with MTX is inappropriate.
f) Ixazonib •RAG submission received from Kate Woodrow (MYHT) with proposal to classify as RED - Ixazomib in combination with lenalidomide and dexamethasone is indicated fo the treatment of adult patients with multiple myeloma who have received at least one		RM to add ixazonib to the SWYAPC website – as RED for the treatment of adult patients with multiple myeloma we have received at least one prior therap

prior therapy.

- •Agreement amongst members to classify as RED as this drug requires long-term ongoing specialist monitoring of efficacy or requires long-term on-going specialist monitoring of toxicity (either because of difficulty in recognising side effects or high cost/availability of investigations to identify toxicity) and is part of a defined commissioning arrangement.
- •RM to update on the website.

g) Daratumunab

- •RAG submission received from Kate Woodrow (MYHT) with proposal to classify as RED as monotherapy for the treatment of adult patients with relapsed and refractory multiple myeloma, whose prior therapy included a proteasome inhibitor and an immunomodulatory agent and who have demonstrated disease progression on the last therapy and also in combination with lenalidomide and dexamethasone, or bortezomib and dexamethasone, for the treatment of adult patients with multiple myeloma who have received at least one prior therapy.
- Agreement amongst members to classify as RED as this drug requires long-term ongoing specialist monitoring of efficacy or requires long-term on-going specialist monitoring of toxicity (either because of difficulty in recognising side effects or high cost/availability of investigations to identify toxicity) and is part of a defined commissioning arrangement.
- •RM to update on the website.

h) Safinamide

- •RAG submission received from Helen Foster (NHS Calderdale CCG) with the proposal to classify as GSI for the treatment of Parkinson's disease, as an adjunct to levodopa alone or in combination with other antiparkinsonian drugs, for mid- to latestage fluctuations.
- •NB noted that concern from HF was that there needs to be a clear pathway. FS confirmed that there is a pathway in place.
- •Agreement amongst members to classify as GSI as this requires a primary or secondary care clinician with specialist knowledge to enable patient selection.

ACTION

RM to add daratumunab to the SWYAPC website as RED for the treatment of adult patients with relapsed and refractory multiple myeloma, whose prior therapy included a proteasome inhibitor and an immunomodulatory agent and who have demonstrated disease progression on the last therapy and also in combination with lenalidomide and dexamethasone, or bortezomib and dexamethasone, for the treatment of adult patients with multiple myeloma who have received at least one prior therapy.

ACTION

RM to add safinamide to the SWYAPC website as GSI for the treatment of Parkinson's disease, as an adjunct to levodopa alone or in combination with other antiparkinsonian drugs, for mid- to late-stage fluctuations.

11	 •Further discussion amongst members around red drugs and the process of approval at APC and whether they need to be added to the SWYAPC website. •Members agreed that the prompts for classification come from the trust formulary groups and if red drugs are not brought to APC for approval and added to the website –GPs could inadvertently prescribe in Primary Care. •Agreement for the three trusts to look at the RAG form and amend for red drugs to reduce some of the information that is currently required. Suggestion was that the first four sections could be used. •RU queried whether dulaglutide had been to APC for classification as this does not appear on the website and is unsure whether it should be prescribed. •This has been approved at CHFT; FS to check whether she has completed a RAG submission form. 	ACTION	FS, KW, and NM to look at the RAG form and amend for red drugs to reduce some of the information that is currently required. Suggestion was that the first four sections could be used. FS to check whether a RAG submission form has been completed for dulaglutide.
	Proporibing guidelines		
	Prescribing guidelines For information		
	•The baby milk guidelines have now been approved by chairs action and the updated version is now uploaded onto the website for information.		
	•The Adult Vitamin D guidelines have been updated by CHFT. The updated version is with HoMM initially for comments (comments are due back on the 27 th April) After this date RM will send around to APC members and other interested colleagues for x4 weeks for further comments.		
	•The Paediatric Vitamin D guidelines are in the process of being updated. CHFT are		
	leading this update. Once updated RM will send around for further comments.		
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	Responsibility Prescribing between Primary and Secondary Care		
	•Added to the APC agenda to note the principles of shared care and to note whether there are any differences in current practice.		
	•Members felt that the points raised are already in place and operating across the SWYAPC footprint.		
	•KW queried local arrangements for providers of secondary and tertiary care in		

relation to the supply of medicines to patients.

- •The NHS standard Contract states that the provider is to supply medicines, where clinically appropriate:
- -on discharge from inpatient or day case care;
- -following clinic attendance (where a patient has an immediate need for medication, for example, where treatment is expected within 7 days);
- -in accordance with local policy agreed with its commissioners, but subject to covering a minimum period
- •Members advised that this is customised within each contract; MYHT will have contract arrangements with NHS Wakefield CCG and NHS North Kirklees CCG but stated that this tends to be around 14 days.
- •NT noted that the only time this tends to be an issue is with SWYPFT sending urgent faxes for GPs to prescribe medication.
- •KD stated that the reason for this is due to the fact that there is no prescribing specification in SWYPFT; this has been flagged with the Medical Director. KD advised to send evidence of this when an urgent request is sent through.
- •Members acknowledged the guidance and noted that SWYAPC are happy with their current arrangements for prescribing between Primary and Secondary / Tertiary Care.

NHS England guidance on over the counter medicines that should not be routinely prescribed.

To note what actions are being taken across the APC footprint https://www.england.nhs.uk/2018/03/nhs-england-frees-up-millions-of-pounds-which-could-be-used-for-frontline-services/

- •Members discussed the new guidance and agreed that a joint approach would be required with acute providers as issues were raised around patients attending A&E to obtain these types of medicines.
- •Agreement amongst the acute providers to write a policy statement for A&E.
- •The proposal / policy statement will be brought back to the next APC meeting in June for further discussion.
- •Members also felt that it was important that this message is consistent in walk in centres and out of hour's services. RU noted that this has already started to be implemented.
- •CCGs to share local implementation plans and provide information on how they plan

ACTION

Acute providers to produce a policy statement for A&E following the publication of the NHSE OTC medicines that should not routinely be prescribed.

CCGs to share local implementation plans and provide information on how they plan to implement the guidance locally

RM to add to agenda for discussion at the next meeting

ACTION

TG to contact Reema Caddies and find out how Local Care Direct have implemented the NHSE guidance on OTC medicines that should not routinely be supplied.

14	to implement the guidance locally at the next APC meeting in June.		
	Hepatitis A & B Travel Vaccine	ACTION	RM to add to the agenda for discussion at the next meeting.
15	•MG requested that this is deferred to the next meeting in June.		
	Date of next meeting – 20.06.2018 at Douglas Mill, NHS Bradford CCGs		
	•Agreement amongst members to continue to hold the APC meeting on Wednesday afternoons.		
	•Due to issues with visitor parking and the number of spaces available at Broad Lea House members agreed to hold the next two meetings at Douglas Mill in Bradford. •Dates for 2018 were decided:		
	-Wednesday 20th June – Douglas Mill		
	-Wednesday 15th August – Douglas Mill		
16	-Wednesday 7th November – Location – To be decided		
	For information only:		
	D&T updates		
	-MYHT – nothing to note		
	-CHFT – nothing to note		
	-SWYPFT – nothing to note		
	-Locala - minutes requested but not received.		

-AWC / BTHT – minutes requested but not received. -LAPC – minutes requested but not received.		
AOB To note GP attendance from member CCGs.	ACTION	CCGs to speak with GP leads and encourage attendance at APC.
•CCGs were encouraged to invite GP representation across the SWYAPC footprint; currently only Nigel Taylor that attends – but also chairs the meeting. •Agreement that more Primary Care representation would be beneficial. •RU also informed members that from October 2018 CGL (Change, Grow, Live) will be taking over the delivery of substance misuse services and asked members whether they needed to be invited to the APC meetings. •Members felt that CGL should only be invited when there is something relevant for discussion on the agenda.		