Somerset
Clinical Commissioning Group

Minutes of the **Prescribing and Medicines Management Group** held via Microsoft Teams, on **Wednesday, 13th October 2021.**

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| Present: | Shaun Green (SG) | Deputy Director of Clinical Effectiveness and Medicines Management, CCG |
| | Dr Juliet Balfour (JB) | GP at Glastonbury Surgery and Menopause Specialist |
| | Hels Bennett (HB) | Medicines Manager, CCG |
| | Daniela Broughton (DB) | Prescribing Technician, CCG |
| | Dr David Davies (DD) | West Somerset Representative |
| | Steve Du Bois (SDB) | Somerset NHS Foundation Trust Chief Pharmacist |
| | Dr Adrian Fulford (AF) | Taunton Representative |
| | Dr Guy Miles (GM) | LMC Representative |
| | Sam Morris (SM) | Medicines Manager, CCG |
| | Dr Carla Robinson | Public Health Representative |
| | Emma Waller (EW) | Yeovil Representative |
| Apologies: | Dr Andrew Tresidder (AT) | Chair, CCG GP Patient Safety Lead |
| | Kyle Hepburn (KH) | North Sedgemoor Representative & LPC Representative |
| | Dr Piers Jennings (PJ) | East Mendip & Frome Representative |
| | Dr James Nicholls (JN) | West Mendip Representative |

## 1 APOLOGIES AND INTRODUCTIONS

Apologies were provided as detailed above.

SG chaired the meeting in AT's absence.

Dr Guy Miles was introduced to the group as the new LMC Representative.

Dr Juliet Balfour was introduced to the group at 10:00am to present item 9.1. Juliet left the meeting after this item.

## 2 REGISTER OF MEMBERS' INTERESTS

2.1 The Prescribing and Medicines Management Group received the Register of Members' Interests relevant to its membership.

There were no further amendments to the Register.
The Prescribing and Medicines Management Group noted the Register of Members' Interests.

## 3 DECLARATIONS OF INTEREST RELATING TO ITEMS ON THE AGENDA

3.1 Under the CCG's arrangements for managing conflicts of interest, any member making a declaration of interest is able to participate in the discussion of the particular agenda item concerned, where appropriate, but is excluded from the decision-making and voting process if a vote is required. In these circumstances, there must be confirmation that the meeting remains quorate in order for voting to proceed. If a conflict of interest is declared by the Chairman, the agenda item in question would be chaired by a nominated member of the Prescribing and Medicines Management Group.

There were no declarations of interest relating to items on the agenda.

## 4 MINUTES OF THE MEETING HELD ON 8th September 2021

4.1 The Minutes of the meeting held on 8th September were agreed as a correct record.

### 4.2 Review of action points

Most items were either complete or, on the agenda. The following points were specifically noted:

**Action 2: QRISK –** QRISK®3 includes more factors than QRISK®2 to help enable doctors to identify those at most risk of heart disease and stroke. These are

- Chronic kidney disease, which now includes stage 3 CKD
- Migraine
- Corticosteroids
- Systemic lupus erythematosus (SLE)
- atypical antipsychotics
- severe mental illness
- erectile dysfunction
- a measure of systolic blood pressure variability

Add to MM newsletter. **Action: MM Team**

**Action 4: Adults and ADHD medication private & shared care requests –** SDB provided an update on the adult ADHD service. They have now recruited to all posts and the service is up and running, with a soft start. This is a great step forward for a gap which Somerset has had for a long time and hopefully helps to avoid issues we have had in the past with patients going to private services. The main non-medical prescriber has now been signed off and has use of a service level prescription pad so is able to write an initial prescription if appropriate as part of the review.

**Action 8: [NG202] Obstructive sleep apnoea/hypopnoea syndrome and obesity hypoventilation syndrome in over 16s –** This guidance potentially brings changes to CCG surgical policies and is on the agenda for that team to review. From a prescribing point of view we are in line with this guidance.

**Action 12: [NG198] Acne vulgaris: management –** Add to next MM newsletter. **Action: MM Team**

## 5 Matters Arising

### 5.1 COVID-19 vaccinations

SG provided an update on COVID-19 vaccinations. The booster vaccination programme is going well so far. We are due to receive Moderna into the Somerset system shortly. The Moderna booster dose is half the dose of the initial Moderna vaccinations.

One area where Somerset and the rest of the country are struggling is the school vaccination programme. Delivering both the COVID-19 and nasal flu vaccinations to school aged children, ideally before the half term break, is proving challenging due to workforce issues.

The new vaccination centre at Firepool in Taunton has opened and replaces the existing site at Taunton Racecourse. The large vaccination centre will be open seven days a week, enabling up to 800 people a day to have their COVID-19 vaccinations.

There has been some anti-vaccination activity in the area, including at schools and other sites. Vaccination sites have been asked nationally to revisit security measures.

### 5.2 Antipsychotic shared care guidance

SM attended the SFT Mental Health D&TC meeting where this guidance was discussed. They shared some concerns and HB has further strengthened the guidance.

The guidance includes information on deprivation of liberty and Liberty Protection Safeguards (LPS). It details that a clear rationale for prescribing antipsychotic medicines should be recorded in the patient's clinical notes (which should be explained to the patient and everyone involved in their care) and that a plan is clearly documented for monitoring side effects, how long the medicine should be taken for and when and how the treatment should be reviewed and stopped.

There was a discussion around monitoring of patients. CR requested that the line '**After** 12 months take over annual physical monitoring' is amended to '**At** 12 months take over annual physical monitoring', in line with the table above, to avoid any ambiguity.

PAMM approve of the guidance once this amendment has been made.

Amend wording as discussed. **Action: Hels Bennett**

**5.3 [NG199] Clostridioides difficile infection: antimicrobial prescribing**

Helen Spry has updated the CCG antimicrobial guidance following publication of this NICE guideline. NICE are recommending vancomycin as the first line antibiotic.

There are concerns around the availability of oral vancomycin in community pharmacies, as it is not something that they would routinely keep in stock which could potentially lead to a delay in treatment. SG flagged that (accepting they are under significant workload and workforce pressures), community pharmacies do have the ability to get things ordered urgently and delivered by wholesaler express same day delivery/courier if there is an urgent need to do so and they can claim out of pocket expenses for this. The prescribing clinician should contact the nominated pharmacy and ask them to arrange this. The group noted that the vast majority of requests for oral vancomycin would come from the microbiologist.

AF asked whether the pharmacies participating in the Specialist Medicines Enhanced Service could stock oral vancomycin. This is something that has been suggested to NHSE who commission community pharmacies and the CCG will follow up on this.

It was highlighted that the line 'If there are still difficulties obtaining oral vancomycin, it can be acquired via acute hospital pharmacy departments in Somerset' should be removed from the guidance since Musgrove Park don't have a wholesalers license.

CR highlighted a couple of typographical errors to be corrected.

Amend antimicrobial prescribing guidance as discussed. **Action: Helen Spry**

For MM newsletter. **Action: MM Team**

**6 Other Issues for Discussion**

**6.1 National Overprescribing Review**

The group viewed the National Overprescribing Review and had a discussion around the recommendations.

We have done a lot of work on overprescribing, including the care home work which got published nationally and internationally and has been adopted by some PCNs. Despite all the work done so far around overprescribing, there is still a lot of work to do. It is hoped that the recommendations in this publication are picked up at a national and local level. The MM team will try to pull out any factors which haven't been looked at locally and incorporate them into our workstreams going forwards and we welcome feedback on this.

There was a discussion around the potential links between overprescribing, deprivation, ethnicity and inequalities and the impact this has on the health of

the population. CR may liaise with SG about this outside of the meeting.

EW highlighted some of the collaborative work that Yeovil PCN are doing at the Gateway, including homeless walk-in clinics, the use of Health Coaches, liaising with the Lord's Larder and linking in with the council. They have recently employed a Mental Health Nurse who is liaising with Talking Therapies to highlight alternate routes for people to take where appropriate. SG advised that some PCNs are employing Dietician's who help with diabetes prevention and food first, etc.

**6.2 Childhood Antibiotics data**

National data is now being produced around childhood antibiotic prescribing. Somerset benchmark very well so thanks to primary care for all their work around antimicrobial prescribing. The MM team have shared data and advice with prescribers around childhood antibiotic prescribing. A number of resources have been linked on the MM website to support prescribers and parents/carers, including leaflets on 'when should I worry' and 'caring for children with coughs'.

**6.3 Patient Group Direction: For the supply of Aspirin 75mg dispersible tablets by Community Pharmacists in Somerset to pregnant patients considered to be at high risk of pre-eclampsia**

The use of aspirin is off-label for this indication so currently patients are only able to obtain it via a prescription. Pregnant patients may be advised by their midwife or the antenatal clinic to take low dose aspirin but may not be given a prescription at their secondary care appointment or may not follow up with their GP to obtain a prescription following their antenatal appointment and may try to obtain aspirin from a community pharmacy. This PGD will enable pregnant patients considered to be at high risk of pre-eclampsia who are advised to take low dose aspirin as per NICE guidelines (NG133) to obtain it from a community pharmacy.

The PGD sets out criteria for those patients who are considered to be at higher risk of pre-eclampsia, as per NICE guidance (NG133). The guidance has gone out to Somerset NHS Foundation Trust, the LPC and LMC for comments.

The committee reviewed the guidance. CR requested that the criteria for inclusion section is re-worded to make it clear that the patient must be aged 17 years or over, have given valid informed consent **and** either any of the high risk factors or two or more of the moderate risk factors listed.

EW requested that the line 'advise patient that drinking alcohol with aspirin may increase the risk of gastrointestinal bleeding and prolong bleeding time' is expanded upon to also advise that it is recommended not to drink alcohol at all in pregnancy.

The quantity to be supplied under the PGD has not yet been agreed, however the committee approved of the suggested quantity which is as follows:

- An initial supply of 112 tablets
- It is intended that the GP will continue to supply the medication thereafter
- However, further supplies of 28 days duration may be supplied against this PGD if required

Amend PGD as discussed and have it signed off by the relevant persons.
**Action: Hels Bennett**

Issue communications once signed off. **Action: Shaun Green**

**7 Other Issues for Noting**

None this month

**8 Additional Communications for Noting**

**8.1 SGLT2 workstream**

Information on the SGLT2 workstream, approved by PAMM and SPF, has been shared with practices.
Dose of SGLT2 may need adjusting depending on renal function changes post initiation. SGLT2s will join metformin as the mainstay of therapy going forwards and we have a long-term strategy to increase use ahead of other agents such as gliptins to ensure we achieve best outcomes for these patients. We will continue to ask for support from practices to free up resources in other areas to ensure the affordability of this program.
The most cost effective intervention the whole system can make remains helping prevent patients slipping into type 2 diabetes or making dietary changes to reverse their diabetes.

-Noted.

**8.2 Congratulations on massive improvement - statin potency**

Somerset has moved from the 79$^{th}$ centile of CCCs to now the 14$^{th}$ best centile in under a year, with associated better outcomes expected for our patients. Practices are thanked for their hard work on this quality measure.

Practices are reminded that for those patients unable to tolerate a higher dose statin, or where it is contraindicated, then generic ezetimibe is available on formulary at £2.04 per 28 tablets. We would recommend that ezetimibe is offered to patients with LDL persistently 2.6 mmol/l or more, despite maximum tolerated lipid-lowering therapy (where possible confirmed patient concordance with taking therapy).

-Noted.

**8.3 Community Pharmacy services: Briefing for practices**

A briefing has been shared with practices around the changes to the community pharmacy contract services which commence in September and October. Some of these will link to PCN and national priority areas and may lead to patient referrals back to practices particularly for respiratory, hypertension and anticoagulation.

-Noted.

**8.4 Liberty Protection Safeguards - CQC - Chemical restraint**

It has been flagged to primary care that CQC have announced they will be adding chemical restraint as something they will be asking for returns on and inspecting in care providers going forwards – which will hopefully help rearding STOMP/STAMP and LPS. Once enacted LPS will apply to patients in their own homes.

-Noted.

**8.5 Dipstick & link to UTI antibiotics in over 65s - week 88 update**

At week 88 the overall Somerset CCG rate of prescribing linked to UTI dipsticks was 72.5% lower than the week 1 baseline.

-Noted.

**8.6 Untreated Familial Hypercholesterolemia**

The MM team have set up a new search on Eclipse looking for patients coded with familial hypercholesterolaemia (FH) or a family history of FH who are currently untreated with a statin. The initial search identifies 185 Somerset patients at high risk who we would recommend as high priority for clinical review and discussion/initiation of treatment. Those who have not tolerated simvastatin or atorvastatin previously can be trialled with rosuvastatin 10mg and ezetimibe if required.

-Noted.

**8.7 PCN responsibilities from October**

A reminder of the changes which start from today and to highlight those coming from 2022.

Specifically highlighting the inhaler work which we have been facilitating for the last two years now moves to PCNs although we will continue to support inhaler alignment for the rest of the year.

In addition, two further indicators aimed at reducing inhaler carbon emissions will commence in October 2021:
• Dry Powder Inhalers (DPIs) and Soft Mist Inhalers (SMIs) offer a low-carbon alternative to Metered Dose Inhalers (MDIs). From October 2021, the IIF will reward increased prescribing of DPIs and SMIs where clinically appropriate. The aim is that, in line with best practice in other European countries, by 2023/24 only 25% of non-salbutamol inhalers prescribed will be MDIs.
• Salbutamol MDIs are the single biggest source of carbon emissions from NHS medicines prescribing. From October 2021, the IIF will also reward increased prescribing of less carbon intensive salbutamol MDIs. The ambition

is to reduce the mean life-cycle carbon intensity of salbutamol inhalers prescribed in England to 13.4 kg by 2023/24.

Feedback, to be published later in the year, suggests that the majority of asthma patients using MDIs would change device for environmental reasons so long as the new inhaler was efficacious, easy to use and fitted their current routine, and that they could change back if needed. Additional guidance and advice will therefore be provided alongside rollout of these indicators to support shared decision making and patient choice of inhaler. Pharmacies will be actively encouraging return of unwanted or used inhalers for more sustainable disposal and can provide a New Medicines Service consultation and inhaler technique check for patients prescribed an inhaler for the first time or are changing or have changed to a new inhaler device during the pandemic.

A number of these dovetail with new services being commissioned from community pharmacies so we recommend discussions with local pharmacies to get the best out of workstreams.

-Noted.

**8.8 Supply issue with Asacol® (Mesalazine) 800mg MR**

A Medicine Supply Notification has been issued for Asacol® (Mesalazine) 800mg MR gastro-resistant tablets. CCG preferred brands remain in stock.

-Noted.

**8.9 Improving CVD outcomes and SLGT2 options**

A thank you to primary care for all the ongoing work to improve cardiovascular outcomes via uptake of more potent statins, ezetimibe and SGLT2 inhibitors instead of gliptins in our Type-2 Diabetic population with CVD, HF and renal co-morbidity.

Clarification that although NICE have approved Ertugliflozin and we have added it to the formulary, currently the evidence NICE was expecting on improved CVD outcomes in patients prescribed ertugliflozin has not yet appeared and so class effect is not yet proven. The best we have currently is non inferiority to placebo.

-Noted.

**8.10 Supply issues update October 2021**

-Noted.

**9 Formulary Applications**

**9.1 Testosterone prescribing for menopause**

Dr Juliet Balfour, GP at Glastonbury Surgery and menopause specialist, attended the meeting to present this item. Juliet is presently trying to obtain funding for a Somerset NHS specialist menopause clinic.

Juliet explained the background information for this formulary application. It is an off-license indication, however NICE guidance [NG23] Menopause: diagnosis and management recommends considering testosterone supplementation for menopausal women with low sexual desire if HRT alone is not effective.

Juliet explained that there are a couple of issues with using testosterone in menopause, one being GP education and the other that there is currently no licensed preparation in the UK specifically for this indication. Juliet explained that Testim gel (tubes) and Testogel (sachets) can be used. Whereas a man would use a whole tube or sachet per day, for women the starting dose is a tenth of a tube or sachet. Therefore, the cost is low as one box of 30 will last a woman 300 days. Juliet has received concerning reports of patients being prescribed other preparations, for example she was made aware of a recent case where the patient was prescribed Testogel pump preparation with the directions on the prescription 'use as directed', which is dangerous as there is no way for them to work out a safe dose from the pump. There is also Tostran gel, which is given every other day rather than every day and may potentially lead to inadvertent overdosing. GPs are increasingly being asked to prescribe testosterone but are potentially prescribing the wrong preparation due to a lack of education on the subject. Having the appropriate products and guidance on the formulary would hopefully help with this.

It was noted that testosterone is a schedule 4 controlled drug therefore it does have certain requirements for information on prescriptions.

Juliet explained that patients need to have bloods done after being on testosterone for two months and again at six months and then annually, to ensure that free androgen index is below 5%.

The committee were asked for their thoughts on whether this should be a green or amber indication. GP members agreed that they lack confidence and education in this area and would be reluctant to prescribe an unlicensed formulation unless they had been advised in writing by a specialist therefore it was suggested that amber would be a pragmatic start and that the traffic light status could be reviewed in future. However, we don't currently have an NHS service for this in Somerset so making it amber would potentially be a block. Also, some GPs in Somerset have a special interest and/or additional training in menopause and they would not necessarily want or need to refer to a specialist. It was agreed that rather than having to refer to a specialist, a new category could be introduced – e.g. 'on the advice of a GP with special interest/additional training'.

Committee members advised that they would really like some written guidance on the products/dose and monitoring requirements. The MM team have recently reviewed and updated the HRT formulary and have created a new section of the website for menopause. Guidance around testosterone could be added to the formulary and website so it is unambiguous for prescribers where they do require guidance.

It was agreed that secondary care should also be consulted for their views on this.

SM will liaise with Juliet outside of the meeting and they will discuss with the trust and come back.

Liaise with Juliet to clarify products, dose and guidance. **Action: Sam Morris**

Consult with secondary care. **Action: Sam Morris**

Add to TLS **GREEN** 'on advice of a specialist or GP with additional training in menopause/ hormone replacement therapy'. **Action: Zoe Talbot-White**

Add to MM website **Action: Daniela Broughton**

EW asked whether there is any specifically designed lower dose product on the horizon. Juliet explained that it is hoped a company will start making a product designed for this indication and she has a meeting around this coming up, however this will take a long time to come to the market.

GM reported that in his experience, a lot of patients will see a private specialist and come back to the GP requesting oestrogen and Utrogestan. Juliet explained this is because Utrogestan is the only body similar progesterone.

**9.2 Trimbow NEXThaler® DPI (beclometasone 88micrograms / formoterol 5micrograms / glycopyrronium 9micrograms), Chiesi Limited.**
£44.50 (120 inhalations)

Maintenance treatment in adult patients with moderate to severe chronic obstructive pulmonary disease (COPD) who are not adequately treated by a combination of an inhaled corticosteroid and a long-acting beta2-agonist or a combination of a long-acting beta2-agonist and a long-acting muscarinic antagonist.

Approved.

Add to formulary. **Action: Daniela Broughton**

Add to TLS **GREEN**. **Action: Zoe Talbot-White**

**9.3 Eyeaze® Sodium Hyaluronate 0.1%, 0.2% & 0.4% preservative free eye drops, Ridge Pharma.**
£4.15 (10ml)

Treatment of dry eyes.

The eye formulary chapter is currently under review.

Approved.

Add to formulary. **Action: Daniela Broughton**

**9.4 Staladex® 10.72 mg Implant (as leuprorelin acetate 11.25 mg), Typharm Limited.**
£208.79 (1)

Staladex is used in men for the following indications:

For the treatment of hormone-dependent, advanced prostate cancer.

For the treatment of high risk, localized and locally advanced, hormone-dependent prostate cancer in combination with radiotherapy.

Approved.

Add to formulary. **Action: Daniela Broughton**

Add to TLS **AMBER**. **Action: Zoe Talbot-White**

**9.5 Bijuve® estradiol 1mg/progesterone 100mg soft capsules, Theramex UK Limited.**
£8.14 (28)

Indicated for continuous combined hormone replacement therapy (HRT) for estrogen deficiency symptoms in postmenopausal women with intact uterus and with at least 12 months since last menses.

Approved.

Add to formulary. **Action: Daniela Broughton**

Add to website guidance. **Action: Daniela Broughton**

Add to TLS **GREEN**. **Action: Zoe Talbot-White**

**10 Reports From Other Meetings**
**Feedback**

**10.1 Primary Care Network Feedback**
EW reported that Yeovil PCN has recruited a new pharmacist, who has an interest in respiratory disease. Yeovil are busy trying to get flu vaccinations done and finish delivering COVID-19 booster vaccinations. SG thanked EW and the PCN for all their work on the vaccination programme.

DD noted that the focus in West Somerset seems to be shifting slightly from vaccinations to everything else, e.g. early cancer diagnosis, care home ward rounds, etc. Their newly recruited pharmacy technician is doing rounds successfully.

Nothing to report from the other PCNs.

**Summary**

**10.2 Clinical Executive Committee Feedback – Last meeting 08/10/21**

Discussions are ongoing around ICS development.

**10.3 YDH Medicines Committee meeting – Last meeting 24/09/21**

SM attended this meeting and reported the following:

- Sativex was discussed and will be brought back to a future meeting.
- There was a discussion around steroid emergency cards to support early recognition and treatment of adrenal crisis in adults.
- There was a discussion around COVID-19 vaccines. They have started their staff booster vaccinations.
- SM gave feedback on their acute pain policy. They will take her suggestions and bring this back to the next meeting.
- There was a discussion around an alert: potent synthetic opioids implicated in increase in drug overdoses. This alert was due to some high potency adulterated gear on the UK market.

-Noted.

**10.4 Somerset NHS Foundation Trust D&TC – Next meeting – 19/11/21**

**10.5 Somerset NHS Foundation Trust Mental Health D&TC – Last meeting 21/09/21**

SM attended this meeting and reported the following:

- There was a discussion around methylphenidate. There is a concern that some SFT prescribers may be recommending that GPs prescribe Concerta which is actively discouraged in the Trust. There is ongoing work to reduce Concerta prescribing across Somerset. It was suggested it would be helpful for prescribers to have more information about the different preparations of methylphenidate with release profile characteristics for each. They discussed a useful document on the Choice and Medication website which provides this information and contains graphs of the release profiles.
- They presented the results of the 2nd cycle of an audit of benzodiazepines prescribed on discharge from mental health inpatient wards. It was acknowledged that there are some issues with benzodiazepine discharges and they are looking at how these can be addressed, including around tapering regimes/timescales and the process being communicated clearly to GPs.
- Phenelzine is no longer available in the UK. The stocks that are available are imported and therefore more expensive and vulnerable. GPs are concerned about stopping the prescribing of this drug abruptly in the event of supply disruption as some patients have had side effects trying to stop or switch in the past. It was agreed that SFT need to flag up to prescribers in the Trust about the supply chain problem and that they should review and switch patients to an alternative medication where possible. No new patients should be initiated on this medication.

-Noted.

**10.6 Somerset Antimicrobial Stewardship Committee – Last meeting 11/08/21 – Minutes not received**

**10.7 South West Medication Safety Officer Network Meeting – Next meeting TBC**

**10.8 LPC Report**

No LPC representative at this meeting.

**10.9 Exceptional items from out of area formulary meetings**

The MM team will review and bring back anything relevant.

**10.10 RMOC Update**

Consultation 5 in the RMOC shared care guidance workstream has been published and is open for comments.

HB will review and anything relevant will be brought back to PAMM and/or fed back to RMOC.

**11 Current Performance**

**11.1 Prescribing Update**

- SG gave an update around the financial position
- Increases in NCSO monthly price concessions continue to drive inflation in prescribing costs and there continue to be additional COVID related shifts in prescribing e.g. from warfarin to DOACs, etc.
- Nationally and locally there is an increased focus on medicines shortages and supply chain resilience. Prescribers are reminded to maintain normal prescribing intervals and pharmacies have been informed not to stockpile.
- New NICE technology appraisal will drive prescribing costs with growth expected for example from approval of incilisiran (for lipid management) and SGLT2 inhibitors for HF and CKD.
- Latest national benchmarking shows Somerset continues to perform very well on a basket of financial and quality measures.
- Somerset has the lowest spend in the country on pharmaceutical licensed and unlicensed specials which has been achieved through many years work advising GP prescribers on safer and more cost effective alternatives via the CCG specials guidance.
- Somerset has the lowest GP prescribing spend in the SW region and the eighth lowest spending ICS in the country, spending £11.58M less than national average per year on GP prescribing.
- The CCG continues to maintain its excellent anti-microbial stewardship position and there has been an improvement in each of the four national measures.
- Between April and May there was no improvement in the 2021-21 scorecard quality indicators with the May position being 491 green

indicators, however July saw a significant increase to 528 greens. This is very pleasing given all the workload and workforce issues in primary care.

- Practices reviewing eclipse live safety alerts remains a key recommendation which will stand CCG practices in a good position as nationally greater focus is turned to the safe prescribing agenda. It will also support practices given the CQC focus on safe monitoring of harmful medication.
- Somerset benchmarks well on most national safety metrics, but still has some where improvements are required. Polypharmacy and over prescribing of hypnotics, anti-psychotics and opioid and other analgesics remains an area of focus. New resources have been produced to support the opioid reduction programme.
- Prescribing of teratogenic medication to women of child bearing age continues to grow in national importance following the valproate safety program. We continue to increase the number of searches on eclipse live flagging such patients. A specific Somerset CCG QI program around teratogenic medication safety has been initiated by the CCG medicines optimization team led by Sam Morris.
- Changes have been announced to the Community Pharmacy contract which again should support improved clinical outcomes and medicines optimisation, these should be welcomed by the Somerset system and again mirror much of our focus.

**11.2 July Scorecard Primary Care Network Trend**
-Noted.

**12 Rebate Schemes**
**12.1** None this month

**13 NICE Guidance October**
-Noted

**14 NICE Technology Appraisals**
**14.1 [TA733] Inclisiran for treating primary hypercholesterolaemia or mixed dyslipidaemia**
NICE has recommended inclisiran as an option for treating primary hypercholesterolaemia (heterozygous familial and non-familial) or mixed dyslipidaemia as an adjunct to diet in adults. It is recommended only if:

• there is a history of any of the following cardiovascular events:
– acute coronary syndrome (such as myocardial infarction or unstable angina needing hospitalisation)
– coronary or other arterial revascularisation procedures
– coronary heart disease
– ischaemic stroke or
– peripheral arterial disease, and

• low-density lipoprotein cholesterol (LDL-C) concentrations are persistently 2.6 mmol/l or more, despite maximum tolerated lipid-lowering therapy, that is:

– maximum tolerated statins with or without other lipid-lowering therapies or,
– other lipid-lowering therapies when statins are not tolerated or are contraindicated,

The committee discussed the NICE TA and recommended that before initiation of inclisiran all patients with a history of cardiovascular disease and LDL-C persistently 2.6 mmol/l or more are identified and reviewed to ensure:

1) They have had a shared decision making discussion and understand the benefits of and agree to taking their prescribed statin
2) Their prescribed statin dose has been maximum titrated or switched to a potent dose – rosuvasatin having less interactions than other statins.
3) If prescribed maximum potent statin dose and concordant with taking they are also trialled with additional ezetimibe

The recommended dose is 284 mg inclisiran administered as a single subcutaneous injection: initially, again at 3 months, followed by every 6 months.

Treatment transition from monoclonal antibody PCSK9 inhibitors:
Inclisiran can be administered immediately after the last dose of a monoclonal antibody PCSK9 inhibitor. To maintain LDL-C lowering it is recommended that inclisiran is administered within 2 weeks after the last dose of a monoclonal antibody PCSK9 inhibitor.
Some patients fitting NICE criteria may prefer switching to 6 monthly inclisiran instead of using regular PCSK9 injections – it is recommended that prescribers discuss this with their specialist before switching.

Members reported receiving a number of queries from patients since inclisiran was recently in the media. SG will re-emphasise the pathway when issuing communications.

Add to formulary as per NICE guidance. **Action: Daniela Broughton**

Add to TLS **GREEN**. **Action: Zoe Talbot-White**

Issue communications, re-emphasising lipid pathway. **Action: Shaun Green**

**15 NICE Clinical Guidance**

**15.1 [NG191] COVID-19 rapid guideline: managing COVID-19**

-Update.

Added new recommendations on casirivimab and imdevimab. Also updated the supporting evidence on the use of heparins with the peer reviewed REMAP-CAP trial results. This update does not change the current recommendations.

-Noted.

**15.2 [CG181] Cardiovascular disease: risk assessment and reduction, including lipid modification**
-Update.

Added recommendation 1.3.52 in response to the publication of NICE's technology appraisal guidance on inclisiran for treating primary hypercholesterolaemia or mixed dyslipidaemia.

-Noted.

**16 Risk Review and Management**
Nothing to report.

**17 Safety Items, NPSA Alerts and Signals**

**17.1 MHRA Drug Safety Update September and October**
-Noted

**17.2 NIHR Signal: Even low doses of steroids increase the risk of cardiovascular disease in people with inflammatory diseases**
-Noted.

**18 BNF Changes**

**18.1 BNF Update September**
-Noted.

**18 Any Other Business**
None this month.

**DATE OF NEXT MEETINGS**
10th November 2021 (SPF following)
19th January 2022 (SPF following)
16th February 2022 (SIMO following)
16th March 2022 (SPF following)
6th April 2022 (SIMO following)
11th May 2022 (SPF following)
15th June 2022 (SIMO following)
13th July 2022 (SPF following)
14th September 2022 (SPF following)
12th October 2022 (SIMO following)
16th November 2022 (SPF following)