Milton Keynes Clinical Commissioning Group

Milton Keynes Community Health Services

Milton Keynes Hospital NHS Foundation Trust

JOINT NHS TRUSTS'
MILTON KEYNES PRESCRIBING ADVISORY GROUP (MKPAG)

Notes of the meeting held on Wednesday 29th May 2013
At 12:45pm in the Eaglestone Function Room, MKHFT

Present: (Chairman) Sue Ashwell (SA1), Chief Pharmacist Milton Keynes Hospital NHS Foundation Trust (MKHFT)

MKPAG secretariat and MKHFT

Folake Kufeji (FK)	Pharmacist, Medicines Information and Formulary Services Manager
Dupe Fagbenro (DF)	Pharmacist, MKPAG lead

MKCCG

Janet Corbett (JC)	Director of Clinical Development and Chief Pharmacist
Dr Nigel Fagan (NF1)	GP and MK GP Prescribing group representative
Natalie McLennan-Murray (NMM)	Pharmacist, Neighborhood

MKHFT

Carol Jellicoe (CJ)	Advanced Nurse Practitioner, Acute Pain and Division of Surgery
Debbie Morrison (DM2)	Pharmacist, Oncology
Dr Lakshmi Ragunathan (LR)	Consultant Microbiologist
Katie Rockliffe (KR)	Practice Development Nurse / Rapid Response

MKCHS

Helen Chadwick (HC)	Chief Pharmacist MKCHS / Central & NW London NHS FT
Naomi Fleming	Antibiotics Pharmacist, MKCHS (C&NWL NHSFT)

Presenting applications

Maria Alonso-Jura (MA-J)	Pharmacist, Homecare
Dr Sarah Aturia (SA2)	Consultant, Anaesthesia and Pain Medicine
Dr Maria Fernando (MF)	Specialist Registrar, A&E
Ms Yasmeen Hasnain (YH)	Consultant, A&E
Dr Yaser Mehrez (YM)	Consultant, Anaesthesia and Pain Medicine
Dr Dushyant Mital (D M1)	GUM Consultant
Ruth Thomas (RT)	Senior. Community Respiratory Nurse / Practice Nurse, attending in place of Mark Baverstock MKHFT Respiratory ANP

Note taker: Olie Spring, Pharmacy

List of Abbreviations
Respiratory LIT – Respiratory Local Implementation Team
CF – Cystic Fibrosis
NICE – National Institute of Health and Care Excellence
RCPCH – Royal College of Paediatrics and Child Health
CEM - College of Emergency Medicine
PHN – Post Herpetic Neuralgia
HPA – Health Protection Agency (now part of Public Health England)
ASG – Antimicrobial Stewardship Group
MFF – Market Forces Factor (Payment by Results for England)
APC&OPPROC – Admitted Patient Care & Out Patient Procedures

		ACTION
1.	**Welcome and introductions** The Chairman opened the meeting and welcomed members. Members of the group introduced themselves to the applicants who were attending the meeting. 1.1 Apologies were received from Mark Baverstock (Advanced Nurse Practitioner, Respiratory Medicine), Sheila Begley (Associate Director of Adult and Older people's Services and Deputy Director of Nursing, MKCHS. 1.2 Applicants not able to attend: re Buprenorphine Patches and Lidocaine plasters, Dr Jane Wale (Consultant, Palliative Care)	SA1 / FK
2.	**Declaration of potential conflict of interests** The Chairman asked members to declare any interests pertinent to the agenda and complete a written declaration using the standard MKPAG form. • NOTE: a written declaration of potentially competing interests must be completed in the MKPAG format at each meeting attended by all persons attending MKPAG, in whatever capacity and by all persons submitting an application and all persons submitting written or verbal comments on MKPAG business. • It is for the meeting chairman to decide whether a potential conflict of interest may be relevant. For the chairman's declaration the most senior pharmacist present will be asked to make that judgment. • All completed declaration forms will be held on record by the Medicines Information team in the pharmacy at MKHFT. No potential conflicts were noted in relation to any of the items on the agenda for this meeting of MKPAG.	
3.	**Any other business, not on the agenda, for consideration at this meeting** None requested	
4.	**Notes of previous meeting** The notes of the previous meeting were checked for accuracy. There were no amendments and the Chair approved and signed off the notes as a true record of the previous meeting.	SA1
5.	**Matters Arising from previous meeting**	
5.1	The chairman updated actions from the notes of the previous meeting in April 2013 • 4.6 Wednesday **17th July 2013** has been set for training on **"Developing Skills in Local Decision-Making".** ○ We have invited a facilitator (Harriet Lewis) who was part of the team who wrote the national guidance on 'Local Decision-Making'. ○ Members were asked to register their interest with the Chair. ○ Papers to be circulated week beginning 8th July for those who express an interest in attending. • 5.1 Levetiracetam Shared Care Guidelines: primary care views have been sought and the final version has been agreed and will go up on the website. • 6.1 Ulipristal: DF to meet with Mr Nakade (Consultant, Obs & Gyn). ○ The application will be brought back to the next meeting. • 6.2 Talc pressurized spray: Useful information has been received from Dr Kavidasan's	SA1 FK DF DF

		ACTION
	team. We are awaiting information on the business case from the MKHFT finance team. *Post meeting notes:* 1. *The income associated with this particular product and procedure has been included in the business case and is from the PbR tariff income for elective APC&OPPROC 2013-14; HRG code DZ06Z Minor Thoracic Procedure £544 plus MFF* 2. *Dr Bhattacharya has set out his expectation that when talc spray is used for pleurodesis as part of the thoracoscopy procedure the HRG code is either DZ04B Intermediate Thoracic Procedure, patient without complications £2,153 plus MFF, or DZ04A Intermediate Thoracic Procedure, patient with complications £2,933 plus MFF*	SA1/DF SA1
	• 7.1 Rivaroxaban: SA1 / DF are in discussion with Dr White and Dr Mehdi. We are waiting for the medical team to resolve the anticipated number of patients so that we understand what we will be asking the GPs to consider prescribing and get a clearer picture of how the system will be managed including at what stage prescribing responsibility may be transferred or shared. In the interim, if use of this drug is needed for treatment of VTE it should be prescribed by the hospital for the full period of required treatment (usually, 3, 6 or 12 months). *Post meeting Note: there are a number of NICE Technology Appraisals for Rivaroxaban. The current activity through MKPAG relates only to use to treat VTE and long-term treatment as required to prevent secondary progression.* *All TAs are listed here for convenience, and to make clearer the context of current discussions on how Rivaroxaban as an "option" for treatment may be used within the Milton Keynes health system. In each case Rivaroxaban (one of three currently available newer oral anti-coagulants ("NOACs") is considered as an alternative to Low Molecular Weight Heparin (LMWH) followed, in some patient groups where appropriate, by warfarin (a Vitamin K antagonist).* ○ *TA170 (April 2009) As an option in the prevention of VTEs in patients undergoing elective hip or knee replacement; if used this is funded within the procedure tariff for the whole course. Dabigatran is used at MKHFT for the same indication (also covered by NICE guidance for this use).* ○ *TA 256 (May 2012) As an option for the prevention of stroke and systemic embolism in some patients with AF. Also covered by a commissioner's statement on where that option is most appropriate for individual patients and the health system.* ○ *TA261 (July 2012) As an option for treating DVT and preventing recurrent DVT and PE after a diagnosis of DVT in adults. NICE states that further research on clinical effectiveness of Rivaroxaban compared with LMWH in patients with active cancer should be conducted.* ○ *TA287 (June 2013 for consideration at July MKPAG) As an option for treating PE and preventing recurrent DVT and PE in adults. Comments in relation to use in patients with cancer are as in TA261.*	SA1
	• 8.1 NICE TA266 Mannitol Dry Powder in Cystic Fibrosis: The Chair has a meeting	

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	booked with the CF Nurse Specialist and Consultant. We are also talking to Oxford University Hospitals (OUH) pharmacists about arrangements for implementation and supply of this drug initiated through this tertiary centre for CF. • 8.2 NICE TA267 Ivabradine in Chronic Heart Failure: FK confirmed that cardiologists have advised that current practice is in accordance to NICE guidance. • 8.3 NICE TA268 Ipilimumab for Melanoma (Stage III or IV): DM confirmed this drug for skin cancer is not currently used in the Trust • 8.4 NICE TA269 Vemurafenib for Melanoma (BRAF V60 Mutation positive, unresectable metastatic): DM confirmed this drug for skin cancer is not currently used in the Trust • 8.5 NICE TA270 Leukaemia (AML) Decitabine : Terminated appraisal, and not used in the Trust, therefore no action required • 8.6 NICE TA271 Fluocinolone intravitreal implant for Macular Oedema: not recommended. No use currently at MKHFT therefore no action required in response to this negative recommendation. • 8.7 NICE TA272 Vinflunine Urothelial tract carcinoma (transitional cell, advanced metastatic): DM confirmed the drug is not currently used in the Trust • 8.8 NICE TA273 Hyperplasia (Benign prostatic) Tadalafil: Terminated appraisal (no submission from the manufacturer). • 8.9 NICE TA274 Ranibizumab for Diabetic Macular Oedema: process to identify patient numbers and patient flows (to MKHFT or Stoke Mandeville Hospital Buckinghamshire Ophthalmic Service) need to be established within 3 months from the publication of the NICE TA. This is being followed up by pharmacy • 8.10 NICE TA275 Apixaban (a NOAC) for the same indication as Rivaroxaban in TA256: FK confirmed that Apixaban is on the formulary. The cardiologists have agreed to use it in line with current guidelines on use of Dabigatran and Rivaroxaban for non-valvular AF. • 8.11 NICE TA276 Colistimethate sodium and Tobramycin dry powder devices in CF to treat and prevent Pseudomonas lung infection, as an alternative to delivery of these drugs using a nebuliser. The Chair has a meeting booked with the CF Nurse Specialist and Consultant and will feedback at the next meeting. • 8.12 NICE TA277 Methylnaltrexone in palliative care: Terminated appraisal, and not used in the Trust, therefore no action required • 11.2 Fosfomycin for selective treatment of UTIs, to reduce the need for patients to be admitted to hospital or treated at home with IV antibiotics: The Chair invited NF2 to comment on Fosfomycin. NF2 set out details of the information to go to the GPs	SA1

		ACTION
	(copies available from MKHFT Pharmacy or MKCCG medicines management team on request). SA1 added that the hospital will supply all MKCCG community pharmacies by end June 2013 with stock that will then be paid for by MKCCG. *Post-meeting note: Supplies are now available in local pharmacies (two packs per pharmacy) and replacement supplies may be ordered from MKHFT pharmacy (to speed availability and reduce the costs in primary care.*	
6.	**Applications to add medicines to formulary**	
6.1	**Capsaicin patch (Qutenza®)** 6.1.1. The Chair invited Dr Sarah Aturia (SA2) to present the application for Qutenza® (a hospital only product). SA2 explained that chronic pain is difficult to treat and it has psychological, social and physical effects on patients. Patients with chronic pain are reported as being five times more likely to visit their GP. Members were informed of the potential benefits of this patch in neuropathic pain. Qutenza® is a 1-site application patch that may keep patients pain free for up to 3 months or longer. Its use should result in fewer visits to hospital, and may reduce drug use e.g. a variety of analgesics and ultimately avoid the need for invasive techniques. The clinical efficacy, safety and benefits as stated in the drug evaluation report were reiterated. YM was invited to speak to the item and he supported the application. 6.1.2. Noted that Qutenza® has been accepted for use in both Scotland and Wales in specific, limited circumstances. It was reported that in England, 53 Trusts currently use the patch and 39 more Trusts have secured funding. SA2 confirmed that MK have a group of patients who may benefit from Qutenza®. SA2 presented two patient scenarios to illustrate the potential place in therapy. 6.1.3. Noted that SA2 was aware of a cohort of 10 patients trialed on Qutenza® for twelve months at Northampton General Hospital. This limited use was evaluated by monitoring this small group of patients pre- and post- therapy; their business case for use in a wider group of their patients was dependent on the results of the evaluation. 6.1.4 The Chair invited the primary care colleagues NF and JC to comment because, if the business case put forward by the CSU were to be successful, they will be picking up the bill through the activity costs. There were discussions regarding the treatment this patch will be replacing, the dissemination, implementation and audit of the proposed 30 patients and members suggested mechanisms for this to ensure the process is transparent. 6.1.5. NMM commented that the patch is not guaranteed to work as the number needed to treat (NNT) from trials is around 8 to 12 for one patient to benefit; YM replied that in the research, success was measured if pain relief is 50% or more. YM confirmed that 30% pain relief is a success in chronic pain and therefore we may expect a larger proportion of chronic pain patients to be deemed to have benefitted. **SA2 confirmed the most recent Cochrane review gives an NNT of 8. This would mean the spend for MKCCG for one patient to benefit from the intervention could be £67,000. Noted this is for an intervention where there may be other alternatives.** The Chair invited JC to comment on any clinical issues outstanding that need to be	

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	resolved. JC asked how will GPs monitor and titrate analgesia in patients on Qutenza®? JC raised concerns that it may end up being used widely and measures should be in place to ensure it is not used outside its licensed indication. YM confirmed that there will be a follow-up plan with all patients. SA1 confirmed that the consideration of this for the business case and for the formulary was dependent upon there being an evaluation plan in place, agreed with JC and MKCCG GP prescribing group, before prescribing of Qutenza could be initiated. 6.1.6 It was agreed that clear indications for use, and arrangements for action by GPs, need to be agreed between primary and secondary care. Pharmacy will facilitate this process. GPs of patients who received this treatment will know in advance of all issues agreed in the evaluation. 6.1.7 DF asked if there is will be any approved training programme for nurses. SA2 advised that this was in hand. The plan is to ensure that the patch will be applied in a nurse-led clinic and only by nurses who have received approved training. 6.1.8 The Chair closed the discussion and confirmed that the business case and funding will be finalised outside of the meeting with the pain team and pharmacy. Details of the evaluation process will be prepared between pharmacy and the pain team on the use of Qutenza® for approval by MKCCG before the business case can be signed off. Intended HRG code for the business case: AB04Z Major pain procedure Recommendation Qutenza was supported to be added to the formulary <u>after</u> consideration of the business case, evaluation criteria & process, and contingent on funding being agreed by MKCCG for the associated activity.	SA1/ SA2 SA1/ SA2
6.2	**Lidocaine 5% plasters (Versatis®)** 6.2.1 The Chair presented the application put forward by Dr. Wale. Lidocaine is currently on the formulary for PHN. It was noted that primary care had received a number of requests to prescribe Lidocaine outside the formulary indication. It was therefore important, when considering this application to note the intended use and that this was being brought to MKPAG by the palliative care team rather than for use for other types of pain. This proposal is for the treatment of neuropathic pain (an unlicensed indication) in a very small patient group: selected palliative patients with mesothelioma or chest wall disease. 6.2.2 The Chair invited comments from NF and JC. It was agreed that a conversation needs to take place outside this meeting about other unlicensed uses of Lidocaine patches by talking to the pain team. Recommendation The use of Lidocaine patches was supported in this small patient group in this limited indication. The indication must be made explicit on the formulary entry.	SA1/ FK
6.3	**Buprenorphine patch** 6.3.1 The Chair presented the application put forward by Dr. Wale. This application is for the use of Buprenorphine as an alternative in palliative care patients. We currently have the sublingual tablets but not the patches on the formulary.	

		ACTION
	Primary care accepted that it is suitable for a well-defined group of patients, but wished to understand why this might be used if the patient was "opioid intolerant". 6.3.2 JC – asked for clarification why Butans® was chosen over Transtec®. There were discussions on morphine equivalence of various products. Noted that Transtec is a higher strength product. 6.3.3 SA1 asked FK to attach a morphine equivalence table to the products when added to the formulary. 6.3.4 A six-month audit was agreed to be brought back to the group. Recommendation The principle was accepted for both Butrans and Transtec to be added to the formulary. The Chair will feedback to Dr Wale. *Post meeting note: Dr Wale advised that at higher doses in palliative care she would normally recommend Fentanyl patches, rather than Transtec.*	FK /SA1
6.4	**Intranasal Diamorphine** 6.4.1 The Chair invited Miss Yasmeen Hasnain to present the application for Intranasal Diamorphine (a hospital only product) for use only for restricted indications (defined in the application) for children presenting to the MKHFT Emergency Department. Members were informed of the difficulty of achieving adequate pain relief in children that have traumatic injuries e.g. complex fractures and trauma resulting in tissue loss. Reported that Intranasal diamorphine is currently being used in 60% of A&Es in the country including Stoke Mandeville hospital. 6.4.2 This route and method of pain relief in children is recommended by the RCPCH and CEM and the paediatric ED team are proposing to use the licensed intranasal diamorphine for moderate to severe pain. It has a quicker administration time, therefore faster pain relief and is anticipated to save 15 to 20 minutes of nursing time per patient. 6.4.3 YH confirmed the anticipated number of patients to be 50 to 55 over 2 to 3 months (experience suggesting this would be higher in the summer). 6.4.4 The Chair invited comments on the proposal. There were discussions on the licensed preparations becoming available in two strengths shortly. • HC asked if they expected the licence to be for a dose based on weight. SA1: Yes; • HC asked how the 2 bottles of different strengths would be managed to avoid the potential risk of overdose. SA1 advised that this had been considered and a solution developed through discussion with ED staff who dealt with these patients, including NMPs in the ED. 6.4.5 The Chair closed the discussion and confirmed that Pharmacy will work closely with the emergency department and the paediatric nurses to put measures in place to reduce these risks. A new CD cupboard in the A&E paediatric area will be secured. The drug is delivered through a neat multidose device that requires no dilution or calculation by nurses at the time of use, unlike previous systems for delivering this intervention; this helps to reduce the risk of overdose. SA1 advised that has been secured at half the full list price for MKHFT by acting promptly.	DF

		ACTION
	This will be its only use. Recommendation Intranasal Diamorphine is recommended as an option for use within the paediatric area in the Emergency Department (A&E) at MKHFT.	
6.5	**Valaciclovir** 6.5.1 The Chair invited Naomi Flemming (NF2) to present the application for Valaciclovir as an alternative to Aciclovir in a limited group of patients. Members were informed that it is used for the treatment of shingles. Currently we only have Aciclovir on the formulary which needs to be taken 5 times per day. Valaciclovir is taken 3 times a day which may be easier and may aid compliance. 6.5.2 The HPA recommend the use of Valaciclovir or Famciclovir as second line options, however Famciclovir is more expensive. 6.5.3 LR expressed concerns that GPs will be initiating the drug for ophthalmic shingles. A statement to be added to the formulary that GPs must refer all cases of ophthalmic shingles to emergency care. 6.5.4 The Chair took us back to Dr Mital's earlier request for Valaciclovir in HIV patients. Confirmed this needs a separate application because it's for a different group of patients. Recommendation: Recommended Valaciclovir for use in primary care where 5 times a day Aciclovir is not acceptable. Formulary to show this limitation on use.	FK MA-J FK
6.6	**Piperacillin and Tazobactam IV injection (Tazocin generic equivalent) for use by Bolus IV injection (Unlicensed route of administration)** 6.6.1 The Chair invited LR and KR to comment on the proposed change in administration guidelines: The Trust will be administering Tazocin as an IV bolus over 3 -5 minutes instead of its licensed use as an IV infusion. The paper submitted to MKPAG set out the risks and benefits of this change back to the pre-November 2012 arrangements. Noted that due to EMEA-initiated licensing changes in August 2012 all branded and generic versions of this product had their licence changed to IV infusion, to harmonise across all manufacturers. Noted this was not on grounds of efficacy or safety. Noted that prior to November 2012 switch to IV infusion at MKHFT the generic product had been used off-licence by the IV bolus route. Information was shown to MKPAG demonstrating that the IV bolus route would deliver levels that would be satisfactory for antimicrobial efficacy. The Consultant Microbiologist member of MKPAG supported the application. The rationale for reverting to bolus administration is to reduce delays in patients receiving treatment as may occur if IV lines are disconnected or flow stopped by patient movement. 6.6.2 This has been agreed for ED Sepsis-Six bundle and the OPAT service; now being requested for the whole Trust. It about changing route of administration, not the drug. KR – representing Jon White, (Practice Development Lead) informed members that the IV	FK / WM

		ACTION
	bolus administration route is in line with the sepsis-six bundle. Currently IV administration of Tazocin takes 30 minutes to an hour to administer as an IV infusion. The practice development team supports the initiative of administering Tazocin as a bolus. Recommendation: The administration of Tazocin as an IV bolus is recommended for implementation throughout the Trust; Pharmacy to implement the change.	
7.	**Late applications received**	
7.1 & 7.2	**Pyrimethamine & Sulphadiazine** 7.1.1 The Chair invited Dr Mital (DM1) to set the frame work and present the application for both Sulphasalazine and Pyrimethamine in the management of toxoplasmic encephalitis secondary to HIV/AIDS. The two drugs are currently in use. The aim of the application is to regularise its use and understand where it fits in therapy. 7.1.2. DM1 presented the case for both drugs: Milton Keynes has a relatively high prevalence of HIV and AIDS. Anticipated use is as follows: 1. Acute toxoplasmosis 2. Cerebral toxoplasmosis 3. Empirical treatment in HIV patients with an MRI showing space occupying lesions; Treatment is commenced until toxoplasmosis has been ruled out 7.1.3 The Chair asked DM1 to clarify anticipated numbers and if these are new patients or transfers from other providers; she also asked him to elucidate for MKPAG whether the patients on the prophylactic regime would be on the drugs long-term. DM1 responded that the team sees 5 to 8 new HIV patients per month; they anticipate 3 to 5 cases to require both the drugs each year. Some of those will be new, some will be transfers but numbers are small. 7.1.4 DM1 asked if the primary care colleagues would be happy to continue prescribing the prophylactic regimes after appropriate training. JC suggested that it could go through homecare; DM1 agreed homecare could be an option. Noted some patients do not have a GP. Agreed not for shared care. 7.1.5 LR – We should look into the use in pregnancy and in the paediatric population. Pharmacy will liaise with with our paediatric team managing HIV patients before any action is taken for this patient group. The Chair concluded the discussions and confirmed that these drugs will be for specialist use only in Adults. Recommendation: Sulphadiazine and Pyrimethamine are recommended to be added to the formulary for hospital use only by the HIV specialist team. Other uses are non-formulary unless and until further applications are made.	MA-J FK / SA1
8.	**Published NICE Technology Appraisals (TA)**	

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8.1	**TA278 – Asthma (severe, persistent, patients aged 6+, adults) - omalizumab (rev TA133, TA201)** This guidance updates and replaces NICE TA201 Asthma (in children) - omalizumab and NICE TA133 Asthma (uncontrolled) - omalizumab. Recommended as an option with restrictive conditions on where use is recommended. Hospital only. NHS England to fund. NICE anticipates this guidance is unlikely to result in a significant change in resource use in the NHS. To be discussed with paediatrics	FK
8.2	**TA279 – Vertebral fractures - vertebroplasty and kyphoplasty** This is a non-drug Technology Appraisal. No action required from MKPAG.	
8.3	**TA280 – Rheumatoid arthritis - abatacept (2nd line) (rapid review of TA234)** Rheumatoid arthritis - abatacept (2nd line) (rapid review of TA234) Recommended as an option with restrictive conditions on where use is recommended; to be used in line with other biological with and after DMARDs The manufacturer provides it with the discount agreed in the Patient Access Scheme. Hospital only. CCGs to fund. The cost impact of abatacept with the discount is anticipated to be similar to other biological drugs for RA. DM and JC are working on this to ensure that the place in the patient pathway is clear and is shared with hospital prescribers.	DM/JC
8.4	**TA281 – Gout - canakinumab (terminated appraisal)** Not recommended for NHS funding – Terminated	
8.5	**TA282 – Idiopathic pulmonary fibrosis – pirfenidone** Recommended as an option with restrictive conditions on where use is recommended in line with other biological DMARDs and the manufacturer provides it with the discount agreed in the Patient Access Scheme. Hospital only – Initiation in tertiary care, subsequently shared care with secondary care and homecare. (NHS England Specialised Commissioning). NICE anticipates an additional cost of £518,000 pa of implementing this guidance locally.	SA1 / DF
9.	**Audit & follow up of previous formulary recommendations**	
	None outstanding at the May 2013 meeting. Follow-up from previous recommendations to be brought to the July meeting: 1. Ferrinject injection 2. Zolendronic acid 4mg injection	
10.	**Chair's action for information & oversight**	
	No action had been dealt with through Chairman's action since the April 2013 MKPAG meeting	
11.	**Feedback from other groups**	

		ACTION
11.1	**Antimicrobial Stewardship Group (ASG)** 11.1.1 LR noted the previous ASG minutes were not marked as draft. Secretarial team to add a watermark to the electronic version. 11.1.2 There were discussions around CQUIN for antimicrobial stewardship. 11.1.3 Primary care requested information on recent antibiotics used for patients in Hospital on their discharge letters. 11.1.4 JC invited comments from LR on the issue of teicoplanin & the current increased incidence of anaphylaxis. JC asked: a) have these been reported to the MHRA via the yellow card system? b) Have there been other cases nationally? LR advised that the cases have been reported via yellow cards. To look into the national incidence and bring back as 'matter arising' to the next meeting.	DF
11.2	**MK Respiratory LIT – COPD leaflets / Flare up packs** 11.2.1 The Chair invited Ruth Thomas to provide an overview of the proposed support for patients experiencing an exacerbation (Flare UP) of their COPD by using a standardised COPD leaflet and Flare Up pack of drugs. Noted this is a joint venture, led by the MK Respiratory LIT in primary care, between the Respiratory Physicians in Hospital, specialist nurses and pharmacists in primary and secondary care and GPs. 11.2.2 This will help us to implement NICE quality standards for managing COPD for MK patients. The quality standard for COPD is made up of 13 statements that describe high-quality care for patients. These statements are about the best care our patients can receive and statement 7 reads: '*People who have had a flare-up of COPD are given written advice, tailored to the individual, to help them recognise future flare-ups early; a plan for managing flare-ups at home (including having antibiotics and corticosteroids to use at home if appropriate); and the name and details of a healthcare professional to contact'*. 11.2.3 There are COPD exacerbation management leaflets available in other NHS organisations; these formed the basis of local work. The MK Respiratory LIT tasked a subgroup, that Ruth Thomas chairs, to produce a package of information and a supply process to support patients in the self-management of a Flare Up. The subgroup represents primary, secondary and community health service professionals working with patients with COPD. Together they agreed a draft leaflet and agreed, with antimicrobial pharmacist advice, on the drugs to be recommended for use in a Flare Up for self-management by patients. Comments have been sought from patients who attend the pulmonary rehabilitation programme, practice nurses, GPs and community matrons. Colour has been used to make it simple and easy to read and understand. A number of patients did not want "Exacerbation" to be written on the leaflet hence it does not appear on it. 11.2.4 The leaflet contains what to do when a patient has a COPD flare-up, when to take the steroids and when to take the antibiotics and what to do in an emergency. The plan is for the leaflet to go in a clear plastic bag with 1) Prednisolone 5mg tablets (2x28 tablets)	RT/DF

		ACTION
	2) Doxycycline 100mg capsules (8 capsules) FK suggested that the duration instructions for prednisolone be similar to Doxycycline and read: …..for 6 *more* days. This was supported. 11.2.5 The Chair invited comments from JC and LR. The aim of the flare-up packs is that any patient who comes into Hospital with COPD will be given this pack in addition to their regular medicines and will receive counseling. The GP practice will be asked to provide prescriptions as necessary to replace the drugs when used and to follow up the patient after an exacerbation/request for replacement supplies. The leaflets and guidance on prescribing should mean the message on self-management of Flare Ups (exacerbations) will be more consistent across the whole of MK. 11.2.6 The Chair noted that there may be issues with patients with bronchiectasis who require longer periods of antibiotic treatment for their exacerbations, and this issue is being discussed with the physicians. 11.2.7 Noted that we have about 3,500 patients across MK with COPD. NF1 commended the initiative and reported that this had been supported when presented at the MK GP prescribing group. 11.2.8 JC noted that there may be a risk in the leaflet not being completed with the dosage of salbutamol puffs. RT made a note and will address this issue when rolling out the training programme. 11.2.9 Doxycycline was chosen as the antibiotic of choice as it is a first line option for management of COPD in both primary and secondary care and as its use avoids issues with penicillin allergy. The Trust will get the leaflets printed, for consistency.	
12.	**Any other business**	
	None	
13.	**Date of next meeting** **Wednesday 24th July 2013. 12.45pm to 2pm.** **Venue: Eaglestone Restaurant Function Room** Agenda items to be submitted no later than two weeks before meeting date. Applications for new drugs to be submitted ASAP in all cases. • **Members who notify their attendance at MKPAG by Tuesday 16th of July will be sent a hard copy of papers** • **All other members and corresponding members will receive papers by email.**	