SUMMARY OF THE COMMISSION ON HUMAN MEDICINES MEETING HELD ON THURSDAY 15 OCTOBER and FRIDAY 16 OCTOBER 2015

Information is being withheld, under Section 43 of the Freedom of Information Act 2000, on the grounds that information regarding the issue under consideration and advice from the CHM remains confidential at the date of this summary and will remain so until a final decision has been taken. There is no overriding public interest to release such information in advance of the regulatory process being completed. Any request for future information should be made direct to the MHRA (via info@mhra.gsi.gov.uk) and will be considered in accordance with the FOI Act.

LICENSING

NEW DRUGS *(not previously licensed in the United Kingdom)*

The Commission considered and advised on:

- a medicine indicated for use as emergency pain relief in adult patients following trauma
- a medicine indicated for the treatment of Duchenne muscular dystrophy, a condition resulting from a genetic defect that affects normal muscle function.

ABRIDGED (*Applications for new licences for known drug substances which rely in part on previously submitted data or on data submitted by other licence holders).*

The Commission considered and advised on:

- a medicine used to treat blood clots (venous thromboembolism) and to prevent their recurrence
- a medicine for the treatment of nocturia (frequent need to get up to urinate at night) due to nocturnal polyuria (overproduction of urine during the night) in adults
- a medicine to reduce inflammation and suppress the immune system, for example in patients with severe allergic reactions
- a medicine used in the treatment of Type 2 diabetes mellitus.

VARIATIONS *(Any change to the information registered in a marketing authorisation (MA) is referred to as a variation to the MA. MA holders must apply to the Licensing authority for approval of such changes. Variations may range from the addition of a significant new indication to changes in the manufacturing process or straightforward changes in company names)*

The Commission considered and advised on a medicine for use in the treatment of lung cancer.

PRE–HEARING *(The Commission considers the company's written data a month before the potential oral hearing and decides whether or not the data have resolved the questions put to the company)*

The Commission considered and advised on a medicine for the treatment of constipation.

PHARMACOVIGILANCE *(The process of identifying and responding to drug safety concerns arising with marketed medicines)*

The Commission noted that there was a 24% increase in the total number of spontaneous reports received between January 2015 and August 2015 compared to the same time period

last year. The Commission was made aware that in the year to date, 43% of reports were from industry, 44% from healthcare professionals and 13% from the public.

PAPERS/ OTHER ITEMS

The Commission discussed a new chemical entity for treating non-small cell lung cancer patients who have progressed on previous treatment(s). The product was discussed in the context of the UK Early Access to Medicine Scheme (EAMS).

The Commission was provided with an update on the Expert Working Group on Hormone Pregnancy Tests and endorsed the revised terms of reference for the Group.

Human Papillomavirus (HPV) vaccine

The Commission considered an update on the safety of human papillomavirus (HPV) vaccine, and advised that the available evidence does not support a causal association between vaccination and development of postural orthostatic tachycardia syndrome (POTS) or complex regional pain syndrome (CRPS).

Risk of pneumonia with inhaled corticosteroids

Inhaled corticosteroids are a class of medicines used to reduce inflammation of the airways of the lung to make breathing easier. They are usually taken via inhalers which contain a corticosteroid alone or in combination with another medicine to improve breathing. These inhalers are sometimes used to treat patients with chronic obstructive pulmonary disorder (COPD), a disease of the lung where there is persistent obstruction of the airways of the lung (mainly due to narrowing of the airway) that can interfere with breathing and is not fully reversible by medicines which are normally used to treat airway obstruction.

These medicines have been recognised to be associated with a risk of pneumonia (infection of the lung), however this review evaluated whether the risk is higher with some types of this class of medicines. The Commission advised that the risk of pneumonia is considered to be similar across the class of inhaled corticosteroids and that a warning should apply to the product information for all medicines containing inhaled corticosteroids for the treatment of COPD.

Proposal to introduce independent prescribing by radiographers and paramedics

1. The Chair welcomed Ms Suzanne Rastrick, the Chief Allied Health Professions (AHP) Officer, NHS England and the following additional attendees:

   Ms Shelagh Morris OBE, Deputy Chief Allied Health Professions Officer, NHS England
   Mr Will Flower, Stakeholder Strategy Lead, NHS England
   Ms Rebecca Blessing, Section Head - Non-Medical Prescribing and General Prescribing Issues, Department of Health
   Ms Nicole Casey, Policy Manager, Health and Care Professions Council
   Mrs Jan Beattie, Allied Health Professions Officer, Primary Care in Scottish Government
   Ms Dianne Hogg, Non-Medical Prescribing Lead, East Lancashire Hospitals NHS Trust

Mrs Sharon Harrison, National Programmes Manager, Directorate of Education and Quality, Health Education England
Ms Helen Marriott, Allied Health Professions Medicines Project Lead, NHS England
Mrs Christina Freeman, Professional Officer, The Society and College of Radiographers
Ms Sarah Griffiths, Consultant Therapeutic Radiographer, University Hospitals Bristol NHS Trust
Ms Fiona Henderson, Diagnostic Strategy & Development Manager, University College London Hospitals
Mr Andy Sharman, Project Officer, College of Paramedics
Mr Dylan Griffin, Advanced Clinical Practitioner, Royal Derby Hospital

2. Ms Rastrick introduced the proposals which were UK-wide. She outlined the strategic context behind the proposals and why they were important for the NHS in terms of challenges such as gaps in healthcare and development of new models of working.

Radiographers

3. Ms Marriott gave a presentation on the proposal for independent prescribing by radiographers working at an advanced level of practice. This included prescribing from a full formulary (subject to the prescriber's scope of practice and competency), access to a restricted list of controlled drugs and enabling independent radiographer prescribers to mix medicines or direct others to mix.

4. Ms Marriott explained that the proposals would apply to diagnostic and therapeutic radiographers who were advanced practitioners. Diagnostic radiographers take lead responsibility for the management and care of patients undergoing a spectrum of clinical imaging examinations. Therapeutic radiographers take lead responsibility for the management and care of patients with cancer undergoing radiotherapy during the pre-treatment, treatment delivery and immediate post-treatment phases.

5. The presentation included radiographers' scope of practice and the fact that this would be determined by local formularies and the development of an individual personal formulary. It also covered the training programme for prescribing and the organisation support which would be available for new prescribers including local prescribing leads.

6. Ms Marriott summarised the outcome of the public consultation which was supported by the vast majority of respondents. However, she did highlight that one response from the Royal College of Radiologists did not support independent prescribing for diagnostic radiographers believing that existing mechanisms for access to medicines such as patient group directions worked sufficiently well. They also noted that these practitioners work in a diagnostic environment and many, if not most, radiologists did not prescribe anything other than diagnostic contrast media.

7. Commissioners had many questions about the proposals relating, for example, to the definition of an advanced practitioner, potential numbers of people training to be prescribers and the training itself. Also, in relation, to mixing, Commissioners expressed some concerns about the "others" who might mix and whether they were qualified health professionals. (A note on mixing of medicines (see **Annex A**) has since been provided by MHRA.) Commissioners asked if the expected benefits of prescribing were theoretical or based on data. Attendees advised that this could not be quantified until the evidence was available although this would be addressed in the work being undertaken to evaluate podiatrist and physiotherapist prescribing. Information provided by Ms Griffiths suggested that she would only use a very limited number of medicines

in her area of practice. Commissioners questioned the need for independent prescribing in these circumstances. Ms Griffiths said that the current mechanisms for accessing medicines for example supplementary prescribing and PGDs had definite drawbacks. She also pointed out that therapeutic radiographers working in other areas would use a different range of medicines.

8. Commissioners were concerned about the rationale for allowing diagnostic radiographers to independently prescribe if radiologists did not routinely currently do so. Attendees explained that the issue was about consistency in advanced practice and future developments in advanced practice for example, in supporting interventional radiologists. There was also an issue about separating the two strands of the profession (therapeutic and diagnostic) as they were not identified separately on the HCPC register.

Paramedics

9. Ms Marriott gave a further presentation on the proposals for independent prescribing by paramedics which included also access to a full formulary (subject to scope of practice and competency) a limited list of controlled drugs and enabling mixing of medicines. The presentation was on similar lines to the radiographers, covering the scope of practice, the positive outcome of the public consultation and the potential benefits to patients. She emphasised that currently, two thirds of paramedics' workload involved patients with urgent care needs whilst only one third of patients presented with acute life-threatening emergencies. Also, she mentioned that paramedics were starting to work in different settings such as GP surgeries, accident and emergency departments, walk-in facilities and urgent care centres.

10. Ms Marriott summarised training and education for paramedics. The entry level was a certificate of higher education but the majority of approved courses were at degree level. In addition, the proposals were aimed at advanced paramedics and the vast majority of these had Masters level qualifications or higher. In response to a question, the Commission were advised that there was no consistent definition of an advanced paramedic but the Health Education England were planning to look at this in November.

11. Similarly to the radiographers' proposals, Commissioners had many questions in relation to paramedics. Attendees were asked how the profession would be trained to deal with a vast range of conditions that they might encounter. Ms Marriott explained that it was not intended that paramedics would prescribe outside their scope of practice or competency and would be limited by local formularies and their personal formulary.

12. Attendees confirmed that paramedics would have a prescription pad. One Commissioner had concerns that this would mean people were not referred to hospital especially in the case of the elderly who might have more complex medical needs. Also, a concern was raised about how quickly and easily an FP10 prescription could be filled "out of hours". Ms Morris advised that in their new care model "vanguard" sites, NHSE were looking at links with social care and the third sector how they might provide support to certain groups of patients.

13. Attendees also advised that paramedic prescribers will be highly experienced and would develop their skills and knowledge post-qualification. There was discussion about repeat visits to patients and the possibility that a different paramedic on a second visit might not have access to the same medicines and skills as the first. Ms Rastrick said there was a need for clarity about population needs and employees in

order to strategically target resources.

14. Attendees confirmed that the current mechanisms available to paramedics for example, the use of PGDs and exemptions work well in emergency care and that independent prescribing would mainly be utilised for patients with urgent care needs where the current mechanisms have drawbacks. Commissioners questioned how well the risks and problems that paramedics encountered would be reported and fed back into training. Ms Marriott mentioned the ongoing evaluation of podiatrist and physiotherapist independent prescribers which would inform this issue. Attendees also advised that paramedics would use reporting mechanisms including verbal reports, declarations by colleagues and monitoring fitness to practice. Mr Griffin said that his organisation produces a newsletter which highlights practice issues. There is also evidence of emergence of reflective practice within peer groups of non-medical prescribers.

15. In response to a question from a Commissioner about whether there were any groups of health professional who should not be prescribers. Ms Rastrick said that NHSE evaluate individual cases in relation to patient needs very seriously rather than simply considering if prescribing was appropriate or not for the profession. The 2009 Scoping exercise identified that art, music and drama therapists were examples of a group where there was no current need for independent prescribing or supply and administration mechanisms.

16. Commissioners raised a number of other issues. In particular, whether paramedic prescribing of antibiotics would exacerbate the problem of antimicrobial resistance? Ms Marriott said in prescribing training programmes, the use of antibiotics were foremost in mind and the focus was heavily on avoiding antimicrobial resistance, using local formularies and consulting with a microbiologist where necessary. Paramedics currently use PGDS for supply of antibiotics but this is done cautiously. Commissioners raised further concerns about whether paramedics would have sufficient training in differential diagnosis of the wide range of conditions they may encounter. Ms Morris explained the prescribing courses focussed on prescribing but people joining had appropriate levels of diagnostic skills. These skills were demonstrated as part of the assessment by the Designated Medical Practitioner. Ms Marriott added that paramedics would not be prescribing in isolation.

CHM Discussion

17. Commissioners supported the proposal for independent prescribing by therapeutic radiographers. They did not support independent prescribing for diagnostic radiographers. Attendees in the first part of the meeting had only talked about diagnostic radiographers in terms of future proofing and Commissioners did not consider this was sufficient. Any benefits had not been made apparent and they were not convinced that prescribing by this group of radiographers was appropriate or clinically necessary.

18. Commissioners noted that medically qualified radiologists did not routinely prescribe and were surprised by the decision to take forward the proposals for diagnostic radiographers without the support of the Royal College of Radiologists. Apart from that they saw no great demand for independent prescribing by this group. Commissioners commented that it would also have been helpful to have seen a risk assessment setting out what types of condition diagnostic radiographers might prescribe for and what training they would receive in the assessment and diagnosis of these conditions. Commissioners accepted there was a need to ensure the two areas of practice within

the profession could be distinguished for the purpose of HCPC registration and legislation.

19. With regard to paramedics Commissioners were concerned about the very wide range of conditions that they might encounter and were concerned that there was no definition of what an advanced practitioner was. Some of the examples cited to demonstrate a need for independent prescribing did not seem logical. Commissioners were uncertain how prescribing could help in the case of someone at high risk of falls where the emphasis was likely to be on reviewing which drugs might be discontinued. Because of this Commissioners felt that independent prescribing might represent a risk to patient safety for example if the wrong diagnosis was made and an inappropriate treatment was prescribed.

20. In summary, Commissioners agreed that there were key questions which had not been addressed adequately:

    i. There was lack of clarity as to what constituted an advanced paramedic practitioner and how such a practitioner would be trained in the assessment and diagnosis of the conditions that they may encounter.

    ii. There was a lack of clarity as to the clinical need for independent prescribing by diagnostic radiographers; what range of conditions would they be expected to prescribe for and how would they be trained in the assessment and diagnosis of these conditions?

21. In conclusion, the Commission:

    - Was unable to recommend independent prescribing for diagnostic radiographers on the grounds that there was insufficient information as to the range of conditions they might be expected to prescribe for; and how they would be trained in the assessment and diagnosis of these conditions so that an appropriate treatment could be prescribed. Until clarification of these points could be provided it was felt that prescribing by diagnostic radiographers might represent a threat to patient safety.

    - Was unable to recommend independent prescribing by paramedics since it was clear that paramedics could potentially encounter a very wide range of conditions and it was not clear if they would have adequate training to assess and diagnose these conditions and prescribe the appropriate treatment. It was therefore felt that at present independent prescribing may represent a risk to patient safety.

    - Concluded that the case for independent prescribing by therapeutic radiographers was reasonable and they were content for this proposal to go forward.

Annex A

NOTE ON MIXING OF MEDICINES PRIOR TO ADMINISTRATION IN CLINICAL PRACTICE

Background

1. Under current legislation, except in very restricted circumstances, mixing medicines together, where one is not a vehicle for the administration of the other, creates an unlicensed medicine. The person undertaking this preparation, unless an exemption applies, must hold a manufacturer's licence. In this context, "mixing" is the combination of two or more licensed medicinal products together for the purposes of administering them to meet the needs of a particular patient.

2. In 2008, the MHRA realised that the legal position could potentially obstruct the provision of effective pain relief and symptom control to patients receiving palliative care. As a holding measure, the Agency issued a statement that enforcement action would not be taken for breaches of medicines legislation by independent prescribers and nurses in palliative care who were engaged in mixing medicines, unless it would be in the public interest to do so.

3. To regularise the position permanently, MHRA published a consultation (MLX 356) on mixing of medicines in palliative care in December 2008. A CHM Working Group was also established around the same time to consider the issue of mixing of medicines in clinical practice and the results of the consultation. External experts were invited to offer views and advice. It became clear to the Working Group that "mixing" was not restricted to palliative care and that any legislative amendment which only addressed this area would not meet current clinical needs.

4. The CHM Working Group recommendations, which were fully endorsed by the CHM and Ministers, formed the basis of changes to medicines legislation in 2009.

Legal position: Who can mix medicines?

5. Currently, doctors, dentists, supplementary prescribers and nurse, pharmacist, podiatrist and physiotherapist independent prescribers can mix medicines or direct others to mix. A prescriber's directions for another person to mix medicines must be in writing.

6. There are no restrictions on who can mix medicines in accordance with directions. At the time, the CHM WG recognised that patients or carers of patients may also "mix" medicines for administration at the discretion of a doctor. Some patients would wish to retain this aspect of their treatment to themselves for as long as possible. Another example could be where a child patient was more reassured by the medication being prepared and administered primarily by a parent or carer. It was also essential in rural areas or in unusual circumstances to provide a back-up when a nurse was unable to get to the patient. The WG did recommend that a person mixing medicines must be competent and no-one should be obliged to mix and administer medicines if they did not feel able or content to do so.

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Appointment/Re-appointments to Expert Advisory Groups

The Commission approved the re-appointment of the following member to its Neurology, Pain & Psychiatry Expert Advisory Group (NPPEAG) for a period of four years:

Professor John T O'Brien BA MA BMBCh DM FRCPsych
Professor of Old Age Psychiatry, University of Cambridge

Procedural Items

In addition, the Commission completed its usual procedural business including the need to observe the confidentiality of the meeting, to declare interests, apologies, announcements, approval of minutes and European updates. Professors Park, Taylor, Sir Munir Pirmohamed, Drs Forfar, Gilson and Mrs Barrett declared interests in one or more agenda items and the appropriate action was taken.

i. A list of Commissioners and invited experts who attended the meeting is at **Annex B**.

ii. Medicines Healthcare products Regulatory Agency staff may be present for all or part of the meetings or for specific items.

iii. On Thursday 15th October, the meeting started at 10.04am and finished at 6.30pm. On Friday 16th October, the meeting started at 9.45am and finished at 11.43am.

The next meeting will take place on Thursday 12th & Friday 13th November 2015.

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Useful website links

Drug Safety Update:
https://www.gov.uk/drug-safety-update

Members' declaration of interests:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/446872/Human_Medicines_Regulations_2012_Advisory_Bodies_Annual_Report_2014.pdf

European Medicines Agency updates:
http://www.ema.europa.eu/ema/index.jsp?curl=pages/news_and_events/landing/news_and_events.jsp&murl=menus/news_and_events/news_and_events.jsp&mid=WC0b01ac0580022519

MHRA Website:
https://www.gov.uk/government/organisations/medicines-and-healthcare-products-regulatory-agency

Yellow Card Website:
http://yellowcard.mhra.gov.uk/

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ANNEX B

MEMBERS ATTENDING:

Chair

Professor Stuart Ralston MB ChB MD FRCP FMedSci FRSE
Arthritis Research UK Professor of Rheumatology, University of Edinburgh, Western General Hospital, Edinburgh

Members

Mrs Eileen J Barrett BSc PGCE CPE LPC
Lay Member. HR and Legal Director, Source BioScience, Nottingham

Dr J Colin Forfar BSc (Hons) MBChB PhD MD MA FRCP FRCP (Edin)
Consultant Physician and Cardiologist, John Radcliffe Hospital, Oxford

Dr Jamie Fraser BSc MB ChB MRCGP
GP Partner, Southside Surgery, Inverness

Professor Jonathan S Friedland MA PhD FRCP FRCPE FRCPI FMedSci
Hammersmith Campus Director & Head of Section of Infectious Diseases & Immunity, Imperial College London; Hon Consultant in Infectious Diseases ICHT

Dr Richard Gilson MD FRCP
Director, Centre for Sexual Health & HIV Research and Head, Research Department of Infection and Population Health, University College London

Professor Martin Gore MBBS PhD FRCP
Medical Director and Consultant Medical Oncologist, The Royal Marsden NHS Foundation Trust and Professor of Cancer Medicine, Institute of Cancer Research

Professor Malcolm R Macleod BSc MBChB MRCP PhD FRCP (Edin)
Professor of Neurology and Translational Neurosciences, University of Edinburgh and Honorary Consultant Neurologist, NHS Forth Valley

Dr Rebecca Mann BMBS FRCPCH *(Thursday Only)*
Consultant Paediatrician, Taunton and Somerset NHS Foundation Trust

Dr Siraj Misbah MBBS (Hons) MSc FRCP FRCPath
Consultant Clinical Immunologist, Lead for Clinical Immunology, Oxford University Hospitals

Professor David G C Owens MD (Hons) FRCP FRCPsych
Professor of Clinical Psychiatry, Edinburgh University

Professor B Kevin Park BSc PhD FMedSci FRCP (Hon) FBTS
Director of MRC Centre for Drug Safety Science, Professor of Pharmacology & Head of Institute of Translational Medicine, University of Liverpool

Professor Sir Munir Pirmohamed MB ChB (Hons) PhD FRCP FRCP (Edin) FMedSci
Professor of Clinical Pharmacology, University of Liverpool, NHS Chair of Pharmacogenetics and Director of the Wolfson Centre for Personalised Medicine

Professor Shirley Price MSc PhD FBTS ERT FHEA FSB
Head of Academic Appeals and Academic Quality and Professor of Toxicology, University of Surrey *(Thursday Only)*

Carolyn, Lady Roberts HV Cert. MSc D Univ
Member of The Ethox Foundation - Oxford Centre for Ethics and Communication in Healthcare Practice

Professor Kevin M G Taylor BPharm PhD FRPharmS
Chair of the British Pharmacopoeia Commission and Professor of Clinical Pharmaceutics, UCL School of Pharmacy, London

Professor Angela E Thomas MB BS PhD FRCPE FRCPath FRCPCH **(Vice-Chair)**
Consultant Paediatric Haematologist, Royal Hospital for Sick Children, Edinburgh

Professor Simon H L Thomas BSc MBBS MD FRCP FRCP (Edin)
Professor of Clinical Pharmacology and Therapeutics, Newcastle University and Consultant Physician, Newcastle Hospitals NHS Foundation Trust

Dr Christopher Weir BSc (Hons) PhD MSc FRSS C.Stat C. Sci
Reader in Medical Statistics, Centre for Population Health Sciences, University of Edinburgh

Invited Experts

Professor Janet H Darbyshire CBE MB ChB FMedSci FRCP FFPH FRSS (Hon)
Emeritus Professor of Epidemiology, University College London

Dr Andrew Grace MB PhD FRCP FACC FESC
Consultant Cardiologist, Papworth and Addenbrooke's Hospitals Cambridge & Research Group Head, Department of Biochemistry, University of Cambridge & member of the Cardiovascular, Diabetes, Renal, Respiratory and Allergy EAG *(via teleconference)*

Dr Clifford Mann MB BS FRCP FCEM
President of the Royal College of Emergency Medicine and Consultant in Emergency Medicine, Taunton and Somerset NHS Foundation Trust *(Thursday only)*

Dr Catherine F Stannard MB ChB FRCA FFPMRCA, Pain Clinic Macmillan Centre, Frenchay Hospital, Bristol *(via teleconference)*