Brighton and Hove
High Weald Lewes Havens
Clinical Commissioning Groups

Brighton Area Prescribing Committee

Minutes

Date: Tuesday 26th September 2017 **Time:** 2-5pm

Location: Room 181, Hove Town Hall, Norton Road, Hove

Members:	
Paul McKenna (PMcK)	Senior Strategic Pharmacist, High Weald Lewes Havens (HWLH) CCG (Chair)
Paul Wilson (PW)	Head of Medicines Management, HWLH CCG (Deputy Chair)
Dr Stewart Glaspole (SG)	Specialist Interface Pharmacist, Brighton and Hove (BH) CCG
Iben Altman (IA)	Chief Pharmacist, Sussex Community Foundation Trust (SCFT)
Lloyd Ungoed (LU)	Lay Member, BH CCG
Susan Mills (SM)	Deputy Chief Pharmacist, Brighton and Sussex University Hospitals NHS Trust (BSUH)
Clare Mace (CM)	Pharmaceutical Advisor, Crawley, Horsham and Mid Sussex (C,HMS) CCGs
Dr Irma Murjikneli (IM)	Clinical Lead Prescribing, HWLH CCG
Rita Shah (RS)	Prescribing Advisor, BH CCG
Julia Powell (JP)	East Sussex Local Pharmaceutical Committee member
Michael Okorie (MO)	Chair of the DTC, BSUH
In Attendance:	
Jade Tomes (JT)	Specialist Pharmacy Technician and APC Secretary, BH CCG
Kim Holt (KH)	Prescribing Support Technician, HWLH CCG
Ana Llamas (AL)	Public Health Registrar, Brighton and Hove City Council (part)
Ellen Bloomer (EB)	Public Health Registrar, Brighton and Hove City Council (part)

Apologies:	
Katy Jackson (KJ)	Chief Pharmacist, BH CCG
Judy Busby (JB)	Chief Pharmacist, Queen Victoria Hospital NHS Foundation Trust (QVH)
Ray Lyon (RL)	Chief Pharmacist - Strategy, Sussex Partnership NHS Foundation Trust (SPFT)
Fionnuala Plumart (FP)	Prescribing Advisor, BH CCG
Stephanie Butler (SB)	Principle Pharmacist MSK, SCFT
Neil Fergusson (NF)	Chief Pharmacist, BSUH

Item No	Item	Action
1	**Welcome**	
	PMcK welcomed the committee. Introductions were made to Julia Powell who has joined as a member. Penny Woodgate would no longer sit on the committee representing East Sussex LPC.	
2	**Declarations of Interest**	
	As per the register. SM – Abbvie, consultancy RS – attended diabetes specialist interest group, funded by various device and pharmaceutical companies (no hospitality was taken)	
3	**Urgent AOB**	
	None.	

Previous meeting and actions

4	**July 2017**	
	• Caphosol – action now removed as no information was forthcoming. The APC welcomed BSUH to bring this item back when they are ready.	**CLOSED**
	• Metformin for the management of weight gain – PMcK to facilitate meeting with interested parties. PMcK to report back to the APC in November and share good practice.	**PMcK**
	• Insulin degludec – primary care prescribing data for both BH and HWLH CCGs was presented to the committee. The committee considered this and agreed that an OptimiseRx message be authored to ensure that this is not prescribed for patients who do not fulfil the criteria.	
	• Prontosan audit – PMcK advised that the committee requested data / information from other CCGs regarding its use and its possible effects on the reduction of antimicrobial prescribing. It was confirmed that no local CCGs are collecting this data. In light of this the APC agreed to add Prontosan irrigation solution and gel X as blue (specialist recommendation only). It was agreed to review the prescribing of this in March 2018.	**JT / PMcK** **JT / PMcK**
	DECISION: approved – BLUE – specialist (tissue viability nurse) recommendation only To be added to the Brighton Joint Formulary as BLUE.	
	• Type 2 diabetes guideline – Now uploaded onto the website however, if the alogliptin and linagliptin applications are successful (on the main APC Sept agenda) then this guidance will need to be amended.	**JT**
	• Pivmecillinam – awaiting information from Maggie Dolan. FP to feedback in October.	**PMcK**
	• Paracetamol and ibuprofen dispensing at BSUH - information to be included on the TTO sheet and a patient information leaflet to be developed. SM will present a final leaflet for noting.	**FP**
	• Dressing packs – in progress. SG had discussed with IA. The committee will be updated in due course.	**SM**
	• Golden ticket link – outstanding	
	• Outpatient prescribing policies at BSUH – it was confirmed that these need updating and all staff at BSUH be reminded of them. PMcK to forward to SM. MO advised that the hypertension clinic have a proforma that they use. Health care professionals hand write what is required and give this to the patient to give to the GP. This has proved successful and would mitigate the problems. The APC recommended that this practice is standardised and used across all outpatient departments.	**SG** **PW** **PMcK** **SM**

Evidence Review

5.1 Sodium clodronate to prevent and manage bone disease in patients with multiple myeloma. Presented by Ana Llamas, Public Health Registrar, Brighton and Hove City Council

SG introduced AL who gave a brief summary of the submission. It was highlighted that zoledronic acid is the first drug of choice; disodium pamidronate is recommended if zoledronic acid is contraindicated or not tolerated. Clodronic acid is recommended when zoledronic acid and disodium pamidronate are contraindicated, not tolerated, declined or not suitable.

The committee were advised that it is estimated that 20 patients per year would require clodronic acid and thus it is not anticipated to have a significant impact on primary or secondary care. The use of clodronic acid in primary care will provide another treatment alternative to IV therapy.

The APC questioned the monitoring requirements (what monitoring and how frequently). AL advised that the SPC and NICE guidelines do not specify the monitoring frequency; this should be guided by local clinicians. The APC noted that if the required monitoring is over and above normal GP practice, then this needs to be considered and added to the LCS, which would require uplift.

AL left the committee.

The committee considered the decision making criteria and concluded that there is robust evidence to support its use and there is a clear place in the treatment pathway. Cost is not significant as small patient numbers, however the outcomes are not as good as zolendronic acid.

The committee discussed the lack of monitoring information and agreed that the local specialist must be asked for their advice. This would then be noted on the Joint Formulary. **SM / SG 13.10.17**

The committee agreed to approve, subject to information on monitoring being supplied. If the monitoring requirements are more than normal in GP practice then discussions regarding an LCS will be required.

DECISION: approved (subject to monitoring info) – BLUE – specialist initiated.

To be added to the Brighton Joint Formulary as BLUE when monitoring information has been supplied. (This should also be noted on the JF) **JT 23.10.17**

5.2 Alogliptin benzoate for the treatment of Type 2 diabetes mellitus. Presented by Ellen Bloomer, Public Health Registrar, Brighton and Hove City Council

EB gave a brief overview of the submission, highlighting the clinical effectiveness. It was noted that adding alogliptin to the formulary would increase patient choice for available therapies from one single agent. The cost impact of adding alogliptin to the formulary for new patients is a cost-saving, as it is cheaper than the existing preferred first line DPP-4, sitagliptin (£26.60 vs £33.26 per 28 tablets). It was recommended to replace sitagliptin with alogliptin as the preferred first line DPP-4 inhibitor when used in combination with the following glucose lowering medicinal products when these, together with diet and exercise, do not prove adequate glycaemic control, in adults aged 18 or older with type 2 diabetes:

- As dual therapy with metformin
- As dual therapy with sulphonylurea
- As dual therapy with a pioglitazone
- As triple therapy with metformin and pioglitazone

Alogliptin is not licensed for monotherapy use; therefore, sitagliptin should remain as the preferred first-line DPP-4 inhibitor for monotherapy use.

It was highlighted that the FDA have issued a drug safety warning suggesting that healthcare professionals should consider discontinuing alogliptin in patients who develop heart failure.

The APC questioned if this would be included in a CCG level switching programme and it was noted that this would require a lot of resource for little

return.
EB left the committee.
The decision making criteria was considered and the committee confirmed that there was robust evidence to support its use however, acknowledged the safety concerns around heart failure. It was agreed that there would be an OptimiseRx message enabled alerting prescribers and directing them to via a link to the FDA safety warning.

DECISION: approved – GREEN – non-specialist initiated for the treatment of Type 2 diabetes mellitus. (Can be used for new and existing patients.)
To be added to the Brighton Joint Formulary as GREEN with a link to the FDA warning. OptimiseRx message to be enabled.

JT 20.10.17

5.3 Linagliptin for the treatment of Type 2 diabetes mellitus. Presented by Ellen Bloomer, Public Health Registrar, Brighton and Hove City Council

EB gave a brief overview of the submission, highlighting its clinical effectiveness. It was stressed that the reason for this submission was that linagliptin is the only DPP-4 inhibitor which is licensed for use at all levels of renal function without the need for dose adjustment. It is recommended that it be added to the formulary for those with type 2 diabetes and renal impairment as an adjunct to diet and exercise to improve glycaemic control as:

- Monotherapy, when metformin is inappropriate due to intolerance, or contraindicated due to renal impairment
- Combination therapy, in combination with insulin with or without metformin, or in combination with metformin and a sulphonylurea

EB left the committee.
The committee discussed the application and considered the decision making criteria. It was confirmed that there was robust evidence and no safety concerns. The cost effectiveness of linagliptin is neutral as it is the same cost as sitagliptin. The committee agreed that this should be available for patients with reduced renal function.

DECISION: approved – GREEN – non-specialist initiated for the treatment of type 2 diabetes mellitus in those patients with renal impairment.
To be added to the Brighton Joint Formulary as GREEN.

JT 20.10.17

It was recognised that the type 2 diabetes guidelines would now require updating.

PMcK 27.10.17

Formulary extension

6.1 Asacol foam - presented by Stewart Glaspole

SG gave an overview of the application. He explained that only the retention enema is currently on the formulary. Anecdotally, patients experience poor satisfaction with the retention enema compared to the foam enema. The foam enema has previously been more expensive.

The committee discussed the application and concluded that approval would improve patient outcomes and be cost effective for the health economy as now cheaper than the enema.

DECISION: Approved - **GREEN – non-specialist initiated**
To be added to the Brighton Joint Formulary as GREEN.

JT 20.10.17

6.2 Alzest rivastigmine patches – presented by Jade Tomes

JT explained that this had previously been presented to the committee however there were some concerns raised from the specialists that the Alzest patch did not adhere well compared to the originator brand.

JT presented information published from the company which stated that the adhesion of the patches was generally good and comparable between Alzest and

	Exelon patches, with almost all subjects having the patch completely attached or with only the edges lifting at 24 hours after application. Current prescribing data and potential savings were discussed and the Committee agreed that Alzest should be added to the Joint Formulary. **DECISION: approved – BLUE – specialist initiated.** To be added to the Brighton Joint Formulary as BLUE.	**JT 20.10.17**

Shared care

7.1	**Anti-dementia information sheet (for noting only as approved under Chair's action) presented by Paul McKenna**	
	PMcK advised that this agenda item had come to the committee for noting only as had previously been approved under Chair's action.	
7.2	**Azathioprine and Mycophenolate Shared Care Guidelines (with neurology indications added) – presented by Paul McKenna**	
	PMcK advised that these SCGs had been put forward to the committee as the specialist neurology pharmacist at BSUH had added neurological indications to the guidelines. The committee discussed these at length and SG reminded the committee that where a GP does not feel comfortable to continue the prescribing then they can "opt out" or contact the specialist department to discuss. It was noted that the updated BSR and BAD guidelines had not been considered in the SCGs. SM advised that BSUH would update these when they have capacity. SG advised that the SCGs as they are, are not unsafe. It was agreed that the "rheumatology (non-MSK partnership)" wording be removed as all patients should now been seen under the MSK service. **DECISION: approved (with rheumatology (non-MSK partnership) removed)** To be added to the website. *IA left the committee.*	**SM Jan 18** **JT 20.10.17**

Polices and guidelines

8.1	**Items which should not be routinely prescribed in primary care – A consultation on guidance for CCGs – presented by Paul Wilson**	
	PW advised that NHS England and Clinical Commissioners currently have a consultation open on "Items which should not be routinely prescribed in primary care – A consultation on guidance for CCGs". The committee discussed the consultation and it was explained that the joint formulary is compliant will all of their recommendations apart from 3. PW advised that he will draft a response on behalf of the APC. A final list of recommendations will be published in December once all the responses have been considered.	**PW 24.10.17**
8.2	**HWLH CCG – Golden Ticket service HWLH CCG GP medication document – presented by Paul Wilson**	
	PW advised that SPFT have produced a generic guidance document which will be sent to GPs and added to care plans. It was noted that some amendments were required and these will be fed back to the author. **DECISION: Approved subject to amendments.** To be reviewed after 6 months.	**PW 20.10.17**
8.3	**Bariatric surgery – update from CWS (as lead commissioner for the Specialised Complex Obesity service at WSHFT) – presented by Paul McKenna**	

	PMcK advised of the background and updated the committee on the position taken by CWS CCG (the lead commissioner). The decision has been made by CWS CCG to commission the provider to supply 6 weeks of supplementation to patients post-surgery and then for the patient to provide their own. (They have asked that the patient sign a self-care contract prior to surgery.) It was clarified that the only intervention for the patients' GP is to administer B12 injections. The committee noted that the issues regarding the need and prescribing of liquid medicines had not been addressed. It was agreed that the interim policy is no longer required and that it can be removed from the website and replaced by the letter from CWS CCG.	**JT 20.10.17**

Formulary Review

9.1	**Chapter 1 – Gastro-intestinal – presented by Jade Tomes**	
	The proposed minor changes were noted and approved by the committee. It was acknowledged that no comments were received from BSUH. **DECISION:** Approved. Make changes to formulary.	**JT 20.10.17**
9.2	**Chapter 8 – Malignant Disease and Immunosuppression – presented by Paul McKenna**	
	PMcK advised that comments from oncology are still outstanding. BSUH representatives will follow this up.	

NICE TA briefing

10	**NONE**	

NICE guidance and TAs

11.1	**Published July 2017**	
	CG99 - Constipation in children and young people: diagnosis and management. Noted by the APC.	
	MIB110 - FreeStyle Libre for glucose monitoring. Noted by the APC. The committee were advised that specialists in Diabetes plan to apply to the APC to consider its use in patients who fulfil defined criteria. It was confirmed that until this is approved and added to the Joint Formulary, it should not be prescribed on the NHS locally.	
	TA452 - Ibrutinib for untreated chronic lymphocytic leukaemia without a 17p deletion or TP53 mutation (terminated appraisal). Not recommended. **BLACK** on Joint formulary	
	TA453 - Bortezomib for treating multiple myeloma after second or subsequent relapse (terminated appraisal). Not recommended. **BLACK** on Joint formulary	
	TA454 - Daratumumab with lenalidomide and dexamethasone for treating relapsed or refractory multiple myeloma (terminated appraisal). Not recommended. **BLACK** on Joint formulary	
	TA455 - Adalimumab, etanercept and ustekinumab for treating plaque psoriasis in children and young people. Commissioned by NHS England – add to joint formulary as **RED.**	**JT 20.10.17**
	TA456 - Ustekinumab for moderately to severely active Crohn's disease after previous treatment. Commissioned by CCGs – added to joint formulary as **RED** (as per chairs action from July APC).	**JT 20.10.17**

	TA457 - Carfilzomib for previously treated multiple myeloma. Commissioned by NHS England – add to joint formulary as **RED.**	**JT 20.10.17**
	TA458 - Trastuzumab emtansine for treating HER2-positive advanced breast cancer after trastuzumab and a taxane. Commissioned by NHS England – add to joint formulary as **RED**	**JT 20.10.17**
	TA459 - Collagenase clostridium histolyticum for treating Dupuytren's contracture. Commissioned by CCGs – already on the joint formulary as **RED**	**JT 20.10.17**
	TA460 - Adalimumab and dexamethasone for treating non-infectious uveitis. Adalimumab commissioned by NHS England and dexamethasone commissioned by CCGs. Add to joint formulary as **RED**	**JT 20.10.17**
	TA461 - Roflumilast for treating chronic obstructive pulmonary disease. Commissioned by CCGs – add to joint formulary as **RED**	**JT 20.10.17**
	TA462 - Nivolumab for treating relapsed or refractory classical Hodgkin lymphoma. Commissioned by NHS England – add to joint formulary as **RED**	**JT 20.10.17**
11.2	**Published August 2017**	
	CG32 - Nutrition support for adults: oral nutrition support, enteral tube feeding and parenteral nutrition. Noted by the APC.	
	CG81 - Advanced breast cancer: diagnosis and treatment. Noted by the APC.	
	CG160 - Fever in under 5s: assessment and initial management. Noted by the APC.	
	CG192 - Antenatal and postnatal mental health: clinical management and service guidance. Noted by the APC. MHRA links have recently been added to the valproate entry of the JF.	
	NG72 - Developmental follow-up of children and young people born preterm. Noted by the APC.	
	PH56 - Vitamin D: supplement use in specific population groups. Noted by the APC.	
	TA160 - Alendronate, etidronate, risedronate, raloxifene and strontium ranelate for the primary prevention of osteoporotic fragility fractures in postmenopausal women. Noted by the APC.	
	TA161 - Alendronate, etidronate, risedronate, raloxifene, strontium ranelate and teriparatide for the secondary prevention of osteoporotic fragility fractures in postmenopausal women. Noted by the APC.	
	TA190 - Pemetrexed for the maintenance treatment of non-small-cell lung cancer. Noted by the APC.	
	TA463 - Cabozantinib for previously treated advanced renal cell carcinoma. NHSE commissioned. Add to the Joint Formulary as **RED**.	**JT 20.10.17**
	TA464 - Bisphosphonates for treating osteoporosis. CCG commissioned**. Oral alendronic acid, ibandronic acid, risedronate sodium** and **IV zoledronic acid** are already listed on the Joint Formulary. **IV ibandronic** acid to be added as **RED** to the Joint Formulary.	**JT 20.10.17**
	TA465 - Olaratumab in combination with doxorubicin for treating advanced soft tissue sarcoma. NHSE commissioned. Add to the Joint Formulary as **RED**.	**JT 20.10.17**
	TA466 - Baricitinib for moderate to severe rheumatoid arthritis. CCG commissioned. Add to the Joint Formulary as **RED**.	**JT 20.10.17**
	TA467 - Holoclar for treating limbal stem cell deficiency after eye burns. NHSE commissioned. Add to the Joint Formulary as **RED**.	**JT 20.10.17**
	TA468 - Methylnaltrexone bromide for treating opioid-induced constipation (terminated appraisal). Noted by the APC. **BLACK** on Joint formulary.	
	TA469 - Idelalisib with ofatumumab for treating chronic lymphocytic leukaemia	

(terminated appraisal). Noted by the APC. **BLACK** on Joint formulary.

TA470 - Ofatumumab with chemotherapy for treating chronic lymphocytic leukaemia (terminated appraisal). Noted by the APC. **BLACK** on Joint formulary.

TA471 - Eluxadoline for treating irritable bowel syndrome with diarrhoea. CCG commissioned. Add to the Joint Formulary as **BLUE** specialist initiated (secondary care). **JT 20.10.17**

TA472 - Obinutuzumab with bendamustine for treating follicular lymphoma refractory to rituximab. NHSE commissioned. Add to the Joint Formulary as **RED**. **JT 20.10.17**

TA473 - Cetuximab for treating recurrent or metastatic squamous cell cancer of the head and neck. NHSE commissioned. Add to the Joint Formulary as **RED**. **JT 20.10.17**

APC Admin

12.1 RMOC – update from inaugural meeting of the South Committee – presented by Michael Okorie

MO had attended the inaugural meeting of the South RMOC. He explained that there are 4 committees and the aim is to promote joined up working. There were 3 Medicines Optimisation areas of priority which each RMOC discussed (Antimicrobial Resistance, Polypharmacy and Biosimilars.) Going forward, RMOCs will be asked to produce recommendations which will then be considered at APCs and DTCs.

It was agreed that MO / JP will feed back to the committee on RMOCs at every meeting.

12.2 Declarations of Interest – presented by Paul McKenna

PMcK advised that there are still a number of DOIs outstanding. Another email reminder will be sent. Failure to provide an up to date DOI will result in removal from the APC membership until the DOI has been received.

AOB

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- SM advised that BSUH are experiencing a few issues with Blueteq (biosimilar drop down box and preset consultant details). SG advised that these can be worked on.

Close

22 Date of next meeting

Tuesday 24th October 2017.

Room 181, Hove Town Hall, Norton Road, Hove, BN3 4AH