Brighton and Hove
High Weald Lewes Havens
Clinical Commissioning Groups

Brighton Area Prescribing Committee

Minutes

Date: Tuesday 23rd January 2018 **Time:** 2-5pm

Location: Room G70, Hove Town Hall, Norton Road, Hove

Members:	
Paul McKenna (PMcK)	Senior Strategic Pharmacist, High Weald Lewes Havens (HWLH) CCG (Chair)
Dr Stewart Glaspole (SG)	Specialist Interface Pharmacist, Brighton and Hove (BH) CCG
Fionnuala Plumart (FP)	Prescribing Advisor, BH CCG
Samantha Lippett (SL)	Lead Antimicrobial Pharmacist, Brighton and Sussex University Hospitals NHS Trust (BSUH)
Julia Powell (JP)	East Sussex Local Pharmaceutical Committee Member
Dr Riz Mirakowski (RM)	Clinical Lead Prescribing, Horsham Mid Sussex (HMS) CCG
Brian Chatfield (BC)	Lay Member, HWLH CCG
Iben Altman (IA)	Chief Pharmacist, SCFT
Rita Shah (RS)	Prescribing Advisor, BH CCG
Clare Mace (CM)	Pharmaceutical Advisor, Crawley, Horsham and Mid Sussex (C,HMS) CCGs
Dr Zoe Schaedel (ZS)	GP representative, BH CCG
Lloyd Ungoed (LU)	Lay Member, BH CCG
Dr Irma Murjikneli (IM)	Clinical Lead Prescribing, HWLH CCG
In Attendance:	
Jade Tomes (JT)	Specialist Pharmacy Technician and APC Secretary, BH CCG
David Heller (DH)	Chief Pharmacist, Surrey and Sussex Healthcare NHS Hospitals Trust and Chair of the Surrey Prescribing Clinical Network
Patrick Daines	Prescribing Support Technician, HWLH CCG
Dr Ali Chakera	Consultant in diabetes and endocrine, RSCH
Emma King (EK)	Public Health Registrar
Apologies:	
Ray Lyon (RL)	Chief Pharmacist, Sussex Partnership NHS Foundation Trust (SPFT)
Paul Wilson (PW)	Head of Medicines Management / Chief Pharmacist, HWLH CCG and BH CCG (Deputy Chair)
Judy Busby (JB)	Chief Pharmacist, Queen Victoria Hospital NHS Foundation Trust (QVH)
Dr Michael Okorie (MO)	Chair of the DTC, BSUH
Jay Voralia (JV)	Head of Medicines Management, C HMS CCG

Item No	Item	Action
1	**Welcome**	
	PMcK welcomed the Committee. Introductions were made. Apologies received from RL, PW, JB, JV and MO.	
2	**Declarations of Interest**	
	As per the register.	

Formulary Extension

3	**Zeroveen emollient. Presented by Dr Susannah George (via telecom)**	
	Dr Susannah George joined via telecom. Dr George gave a brief overview of the submission via telecom. She advised that there is little evidence to show which emollient is the best. It is known that emollients containing colloidal oat milk are well liked by users and helpful in the treatment of some skin conditions. Currently Aveeno is on the Brighton and Hove Formulary and Zeroveen is an equivalent product which is more cost effective. Aproderm was considered, however this contains apricots which is not favourable. Zeroveen is more cost effective than Aproderm. Dr George advised that she has never prescribed Aveeno products as there is some evidence to suggest that applying food protein on damaged skin could increase the risk of oral allergies, particularly in children. For this reason, many allergy clinics do not use emollients containing food proteins. It was noted that removing Aveeno from the formulary without providing a suitable alternative would cause a lot of upset with patients as this is a popular emollient. Dr George informed the APC that she had given her colleagues samples of both Aveeno and Zeroveen to see if they could tell the difference. Some patients were also given samples to see if Zeroveen would be a suitable alternative. No concerns were raised with Zeroveen and it was seen to be on par with Aveeno. *Dr George telecom ended.* The Committee discussed the current joint formulary status of Aveeno and the place in the treatment pathway, considering the decision making criteria. The Committee agreed that Zeroveen should replace Aveeno. It was confirmed that Zeroveen should not be first or second line and added to the joint formulary with the same restricted use (ACBS criteria) to match Aveeno. Therefore, it is only recommended to be prescribed for those with endogenous or exogenous eczema, xeroderma, ichthyosis or senile pruritus associated with dry skin where first and second line emollients have been tried. **DECISION:** Approved – **GREEN** (3rd line) – non-specialist initiation only To be added to the Joint Formulary as Green.	**JT 9.2.18**
4	**Urgent AOB**	
	None.	

Previous meeting and actions

5	November 2017	
	• DOIs – Noted that some members' DOIs were still outstanding. • Metformin for the management of weight gain – PMcK explained the background to this action. Advised that a meeting had taken place with Public Health and pathways / services for patients accessing lifestyle advice were discussed. The National Diabetes Prevention Programme (NDPP) will be contacted to see if there was something more bespoke can be provided for this patient cohort to access. RL has been invited to submit a paper to a future Committee if he wishes with results from audit and national uptake. • Dressing packs – ongoing. Audit is taking place in the North. • Paracetamol and ibuprofen dispensing at BSUH – principle approved at BSUH DTC. Communications need to be launched internally. The Chair requested that the communications pack be presented to the APC for information. The Committee discussed that discretion needs to be used for exceptions and discussions with individual patients need to take place. It was noted that when patients are discharged to a community setting it is requested that 2 weeks' worth of all medication is supplied. IA advised that if patients are discharged to an intermediate care bed then this location does not have any medicines kept as stock and therefore it is necessary that the patient is discharged with all their medication. SL advised that this example will be included in the communications pack. • Outpatient prescribing – MO to bring information on this to next meeting. • BSUH SCGs – still need to be updated. • Review of golden ticket leaflet (HWLH) – document will come to the February meeting. • Sodium clodronate – SL advised that the consultants had recommended a 3 monthly monitoring regime. The Committee discussed this in depth and it was agreed that SL and SG would author an information sheet to support sodium clodronate prescribing in primary care. Once the information sheet is approved, sodium clodronate would be added to the Joint Formulary.	**CLOSED** **SL / SG 9.2.18**

Policies and Guidelines

6	Items which should not be routinely prescribed in primary care. Presented by Paul McKenna	
	PMcK advised that guidance for commissioners had been written post the NHSE consultation. The Committee discussed each medicine in detail and considered the guidance recommendations, the current Joint Formulary position and any potential changes or actions. **1. Co-proxamol** The APC agreed with the NHSE guidance. The Joint Formulary already lists co–proxamol as black. The APC supports de-prescribing therefore at existing patients next medication review, de-prescribing needs to be actively considered and alternatives discussed. **ACTION:** No action required. **2. Dosulepin** The APC agreed with the NHSE guidance. The Joint Formulary currently lists dosulepin as blue. The APC agreed to code dosulepin as black for new patients. The APC supports de-prescribing therefore at existing patients next medication review, de-prescribing needs to be actively considered and alternatives discussed. **ACTION:** Change dosulepin from blue to black.	**JT 9.2.17**

3. Doxazosin MR

The APC agreed with the NHSE guidance. The Joint Formulary currently doesn't list doxazosin MR in any chapter or on the blacklist therefore it is non-formulary. The APC agreed to code doxazosin MR as black for new patients. The APC supports de-prescribing therefore at existing patients next medication review, de-prescribing needs to be actively considered and alternatives discussed.
ACTION: Add doxazosin MR as black. **JT 9.2.17**

4. Immediate release fentanyl

The APC agreed with the NHSE guidance. The Joint Formulary currently lists immediate release fentanyl as blue for patients under palliative care. The APC agreed to code immediate release fentanyl as black for new patients except for those who fall under NICE CG140. (Palliative care for adults: strong opioids for pain relief). The APC supports de-prescribing in those who are not under palliative care therefore at existing patients next medication review, de-prescribing needs to be actively considered and alternatives discussed.
ACTION: Add immediate release fentanyl as black for non-palliative care indications. **JT 9.2.17**

5. Glucosamine and chondroitin

The APC agreed with the NHSE guidance. The Joint Formulary already lists glucosamine as black. Chondroitin is currently non-formulary. The APC agreed to code chondroitin as black. The APC supports de-prescribing therefore at existing patients next medication review, de-prescribing needs to be actively considered and alternatives discussed.
ACTION: Add chondroitin as black. **JT 9.2.17**

6. Herbal products

The APC agreed with the NHSE guidance. The Joint Formulary already lists herbal products as black. The APC supports de-prescribing therefore at existing patients next medication review, de-prescribing needs to be actively considered and alternatives discussed.
ACTION: No action required.

7. Homeopathy

The APC agreed with the NHSE guidance. The Joint Formulary already lists homeopathy as black. The APC supports de-prescribing therefore at existing patients next medication review, de-prescribing needs to be actively considered and alternatives discussed.
ACTION: No action required.

8. Lidocaine plasters

The APC agreed with the NHSE guidance. The Joint Formulary currently doesn't list lidocaine plasters in any chapter or on the blacklist therefore it is non-formulary. The APC agreed to code lidocaine plasters as green as per NICE CG173 (Neuropathic pain in adults: pharmacological management in non-specialist settings) and black for conditions not listed in NICE CG173. The APC supports de-prescribing in those who are prescribed lidocaine plasters for conditions not listed in NICE CG173 therefore at existing patients next medication review, de-prescribing needs to be actively considered and alternatives discussed.
SL advised that BSUH use lidocaine plasters for indications not listed in NICE CG173. It was agreed that the suggested coding would be added to the formulary however the Committee would welcome any formulary applications to be presented at a future meeting. SL will discuss with MO regarding inpatient use only and feedback to the Committee. **JT 9.2.17**
ACTION: Add lidocaine plasters as green as per NICE CG173 and black for all other indications.

9. Liothyronine (including Armour Thyroid and liothyronine combination products)

PMcK advised that the RMOC South would be discussing liothyronine at their meeting next week. It was agreed that the Committee would await the outcome to ensure that all necessary information is available at the time of the decision therefore no change will be made to the formulary.

ACTION: None.

10. Lutein and antioxidants (e.g. vitamin A, C, E and zinc) for AMD

The APC agreed with the NHSE guidance. The Joint Formulary already lists eye supplements for ocular health as black. The APC supports de-prescribing therefore at existing patients next medication review, de-prescribing needs to be actively considered and alternatives discussed.

ACTION: No action required.

11. Omega-3 fatty acid compounds

The APC questioned the NHSE guidance as it is unclear whether the use of omega-3 fatty acid compounds in patients with HIV or high triglycerides (>8) had been considered. The chair will question this with NHSE and bring back any information to the Committee. No change will be made to the formulary until this information is sought.

ACTION: None.

12. Oxycodone and naloxone combination product

The APC agreed with the NHSE guidance. The Joint Formulary currently doesn't list oxycodone and naloxone combination product in any chapter or on the blacklist therefore it is non-formulary. The APC agreed to code oxycodone and naloxone combination product as black for new patients. The APC supports de-prescribing therefore at existing patients next medication review, de-prescribing needs to be actively considered and alternatives discussed.

ACTION: Add oxycodone and naloxone combination product as black. **JT 9.2.17**

13. Paracetamol and tramadol combination product

The APC agreed with the NHSE guidance. The Joint Formulary currently doesn't list paracetamol and tramadol combination product in any chapter or on the blacklist therefore it is non-formulary. The APC agreed to code paracetamol and tramadol combination product as black for new patients. The APC supports de-prescribing therefore at existing patients next medication review, de-prescribing needs to be actively considered and alternatives discussed.

ACTION: Add paracetamol and tramadol combination product as black. **JT 9.2.17**

14. Perindopril Arginine

The APC agreed with the NHSE guidance. The Joint Formulary currently doesn't list perindopril arginine in any chapter or on the blacklist therefore it is non-formulary. The APC agreed to code perindopril arginine as black for new patients. The APC supports de-prescribing therefore at existing patients next medication review, de-prescribing needs to be actively considered and alternatives discussed.

ACTION: Add perindopril arginine as black. **JT 9.2.17**

15. Rubefacients

The APC agreed with the NHSE guidance. The Joint Formulary currently lists Capsacin (both strengths) as blue and Algesal as green. Other rubefacients are non-formulary. The APC discussed the coding of Algesal and agreed to leave as green but code rubefacients (including the low strength Capsacin) as black for new patients. (High strength Capsacin to be left as blue as included in NICE CG173). The APC supports de-prescribing therefore at existing patients next medication review, de-prescribing needs to be actively considered and alternatives discussed.

ACTION: Add rubefacients as black. Change Capsacin 0.025% cream from blue to black. **JT 9.2.17**

	16. Once Daily Tadalafil The APC agreed with the NHSE guidance. The Joint Formulary currently lists once daily tadalafil as green. The APC agreed to code once daily tadalafil as black for new patients. The APC supports de-prescribing therefore at existing patients next medication review, de-prescribing needs to be actively considered and alternatives discussed. **ACTION:** Change once daily tadalafil from green to black.	**JT 9.2.17**
	17. Travel Vaccines The APC agreed with the NHSE guidance. The Joint Formulary already lists certain travel vaccines as black. It was noted that the combined hep A and B vaccine should not be used for travel. **ACTION:** Update the blacklist to include Hep B and combined Hep A and B vaccine.	**JT 9.2.17**
	18. Trimipramine The APC agreed with the NHSE guidance. The Joint Formulary currently doesn't list trimipramine in any chapter or on the blacklist therefore it is non-formulary. The APC agreed to code trimipramine as black for new patients. The APC supports de-prescribing therefore at existing patients next medication review, de-prescribing needs to be actively considered and alternatives discussed. **ACTION:** Add trimipramine as black.	**JT 9.2.17**
	All recoding actions will be made by the secretary once the minutes are finalised. Liothyronine and Omega 3 fatty acid compound recommendations will be discussed at the future meeting once further information is made available.	**PMcK 9.2.17**

Traffic light status change

7	**Anti-dementia drug prescribing (HWLH CCG only.) Presented by Ashleigh Bradley (via telecom)**	
	BC declared a personal interest. PMcK advised that he should refrain from taking part in the discussion. *Ashleigh Bradley (AB) joined via telcom.* AB gave an overview of the traffic light colour change request applications. It was explained that the drugs requested to be re-coded are being used in mixed dementia in current practice. *AB telecom ended.* The Committee discussed both applications and agreed to change the status of anti-dementia medications (including cholinesterase inhibitors (donepezil, galantamine and rivastigmine) and memantine from red to blue for Lewy body dementias, vascular dementias and where memantine treatment is added to a cholinesterase inhibitor for the treatment Alzheimer's or mixed Alzheimer's dementia. It was noted that this is for HWLH patients only who are part of the golden ticket pathway. **DECISION:** Approved – **BLUE** – specialist recommendation / initiation only. (For HWLH golden ticket pathway only.) To be added to the Joint Formulary as Blue.	**JT 9.2.17**

New Drug / Indication Formulary Applications

8.1	**Insulin Fiasp. Presented by Dr Ali Chakera.**	
	Dr Ali Chakera was welcomed to the Committee and gave an overview of the submission. He explained that insulin Fiasp is a faster acting insulin aspart. It is a new formulation of NovoRapid analogue insulin. It has a faster onset of action than current analogue insulins and its optimal time of administration is 2-5 minutes before eating, rather than the 15 minutes before meals that current rapid analogue insulins require.	

	Dr Chakera advised that patients already using Fiasp have commented on greater responsiveness to hyperglycaemia and the ease of use in relation to meal timing. It was noted that the safety profile of Fiasp is similar to that of NovoRapid. The Committee discussed costings and it was highlighted that Fiasp is cost equivalent to NovoRapid with the FlexTouch pre filled pen being slightly cheaper. Dr Chakera advised the Committee that Dr Andy Smith at PRH is contemplating switching all insulin pump patients to Fiasp. The Committee asked Dr Chakera if he was planning on switching patients. He confirmed that there are no plans for blanket switching however, a number of patients have already asked for Fiasp. Dr Chakera thought it would be used as an alternative for those whose HbA1c was not meeting target. The place on treatment pathway was discussed and Dr Chakera confirmed that this would be on the treatment pathway for people living with type 1 or type 2 diabetes as an option to other analogue insulins. *Dr Chakera left the Committee.* The Committee discussed the submission and considered the decision making criteria. It was agreed to approve as blue. The committee noted that this section of the formulary could be reviewed to rationalise the choice of fast action insulins as rationalisation would promote safe prescribing. **DECISION:** Approved – **BLUE** – specialist initiation only To be added to the Joint Formulary as Blue.	**JT 9.2.17**
8.2	**Colesevelam (cholestagel). Presented by Emma King.**	
	Emma King (EK) gave a brief overview of the submission. She advised that colesevelam is licensed to reduce cholesterol however the submission to the APC was for its use to treat bile acid malabsorption (which is off-label). NICE had produced an evidence summary which showed that there is limited evidence for this use as a second line treatment option failing treatment with cholestyramine. EK highlighted that it is known that colesevelam is well tolerated compared to cholestyramine and that it is effective in improving symptoms (persistent diarrhoea). EK explained the existing treatment and it is estimated that 25% of patients only take half the recommended dose because it is unpalatable. Colesevelam comes as a tablet and has a good safety profile. (Not as many interactions with other medications). The cost of colesevelam was discussed. If approved this would result in an extra cost of approximately £800 per patient per year. EK explained that it had been difficult to estimate how many patients this would affect but guessed approximately 100 patients at BSUH. EK asked that colesevelam is added to the formulary as second line to cholestyramine and only to be prescribed after an adherence check and trial of first line with taking with food or juice. *EK left the Committee.* The Committee considered the decision making criteria. It was agreed that an OpimiseRx message be authored to ensure that cholestyramine had be trialled 1st line (and information added to advise mixing with food or drink). **DECISION:** Approved – **BLUE** – specialist initiation only 2nd line to cholestyramine (after adherence check and trialling with food/drink) To be added to the Joint Formulary as Blue.	**JT 9.2.17**

APC Admin

9	**APC Membership Survey. Presented by Paul McKenna and Jade Tomes.**	
	PMcK thanked members for taking part in the APC survey. Himself and JT had reviewed the responses and identified some areas for improvement or discussion with members which was outlined in the supporting information. Themes and actions included:	

- Venue – alternatives will be explored once it is known how the development of the Alliance will impact the APC.
- Wi-Fi – the supporting information explained how members can log into the Wi-Fi
- Refreshments – members are asked to bring their own however, where possible water will be provided
- Comfort break – 1 break will always be scheduled on the agenda
- Telecom with presenters – if a presenter cannot attend the meeting in person then a telecom will be offered
- NICE Guidance – only CCG commissioned TAs will be verbally discussed at the meeting. All other published guidance will be on the agenda but not discussed.
- Agenda timings – it was noted that it is necessary to provide timings to ensure the meeting runs efficiently
- Feedback from providers – will now be a standing agenda item. Provider DTCs (or equivalent) will be welcome to submit their minutes for information.
- The use of acronyms and NHS jargon – members agreed for these not to be used. Where they are used, they must be explained.
- AOB items – will be clear if the item is for action or information only
- APC templates – will be reviewed by the Chair and Secretary
- Actions – will be added to Kahootz prior to the minutes being made final
- Kahootz – training will be provided in the near future.

RM left the meeting 4.30

Formulary Review

10 Chapter 4 – CNS – Mental Health Review only. Presented by Paul McKenna

It was noted that without the presence of a representative from Mental Health (SPFT) this item should not be discussed as per the terms of reference. PMcK advised that this item would be rolled over to the next meeting where a member from SPFT is present. However, it was agreed that the following actions should be commenced:

APC and Surrey PCN Chairs to write to NICE with regards to discontinued drugs included in NICE TAs and formulary TA compliance. **PMcK / DH 16.2.17**

PMcK to speak to RL regarding the drugs that are being requested to be added to the Joint Formulary and the possibility of grand parenting the Maudsley guidelines. **PMcK 16.2.17**

Formulary Extension

11 Testogel for women. Testim gel being discontinued. Presented by Paul McKenna

PMcK advised the Committee of the background to this submission. Ferring Pharmaceuticals had notified CCGs that Testim gel would be discontinued in February therefore, an alternative needs to be added to the Joint Formulary. The dosage of the Testogel and Tostran gel was discussed in depth. The Committee acknowledged Dr Rockwell's comments and the original submission for Testogel.

The Committee felt reassured that the patient would be advised that 1 sachet of gel would need to last at least 7 days and that experts from London are using Testogel.
It was noted that the PIL needs to be amended so that the word tube is replaced with the word sachet.

DECISION: Approved – **GREEN** – suitable for non-specialist prescribing.

	Add to the Joint Formulary as green. (Replacing Testim gel.)	**JT 9.2.18**
	PMcK to find out the stability of the product once the sachet has been opened. PMcK will then discuss with Dr Rockwell how this information should be communicated to patients.	**PMcK 9.2.18**

Shared Care

12	**NONE**

NICE TA Briefing

13	**NONE**

NICE Guidance and Technology Appraisals

14.1	**Published November 2017**	
	CG71: Familial hypercholesterolaemia: identification and management. Update noted by the APC.	
	ES16: Antimicrobial prescribing: Ceftazidime/avibactam. Noted by the APC.	
	NG37: Fractures (complex): assessment and management. Update noted by the APC.	
	NG80: Asthma: diagnosis, monitoring and chronic asthma management. Noted by the APC.	
	NG81: Glaucoma: diagnosis and management. Noted by the APC.	
	QS7: Glaucoma in adults. Update noted by the APC.	
	QS25: Asthma. Update noted by the APC.	
	TA417: Nivolumab for previously treated advanced renal cell carcinoma. Update noted by the APC.	
	TA458: Trastuzumab emtansine for treating HER2-positive advanced breast cancer after trastuzumab and a taxane. Update noted by the APC.	
	TA462: Nivolumab for treating relapsed or refractory classical Hodgkin lymphoma. Update noted by the APC.	
	TA483: Nivolumab for previously treated squamous non-small-cell lung cancer. Commissioned by NHS England. Add to Joint Formulary as **RED**.	**JT 9.2.18**
	TA484: Nivolumab for previously treated non-squamous non-small-cell lung cancer. Commissioned by NHS England. Add to Joint Formulary as **RED**.	**JT 9.2.18**
	TA485: Sarilumab for moderate to severe rheumatoid arthritis. Commissioned by Clinical Commissioning Groups. Add to Joint Formulary as **RED**. Bluteq form required.	**JT 9.2.18**
	TA486: Aflibercept for treating choroidal neovascularisation. FAST TRACK TA. Commissioned by Clinical Commissioning Groups. Add to Joint Formulary as **RED**.	**JT 9.2.18**
	TA487: Venetoclax for treating chronic lymphocytic leukaemia. Commissioned by NHS England. Add to Joint Formulary as **RED**.	**JT 9.2.18**
	TA488: Regorafenib for previously treated unresectable or metastatic gastrointestinal stromal tumours. Commissioned by NHS England. Add to Joint Formulary as **RED**.	**JT 9.2.18**
	TA489: Vismodegib for treating basal cell carcinoma. Not recommended. **BLACK** on the Joint Formulary.	
	TA490: Nivolumab for treating squamous cell carcinoma of the head and neck after platinum-based chemotherapy. Commissioned by NHS England. Add to Joint Formulary as **RED**.	**JT 9.2.18**
	TA491: Ibrutinib for treating Waldenstrom's macroglobulinaemia. Commissioned by NHS England. Add to Joint Formulary as **RED**.	**JT 9.2.18**
	CA left the meeting 4.50	

14.2	Published December 2017	
	CG128: Autism spectrum disorder in under 19s: recognition, referral and diagnosis. Update noted by the APC.	
	TA495: Palbociclib with an aromatase inhibitor for previously untreated, hormone receptor-positive, HER2-negative, locally advanced or metastatic breast cancer. Commissioned by NHS England. Add to Joint Formulary as **RED**.	**JT 9.2.18**
	TA496: Ribociclib with an aromatase inhibitor for previously untreated, hormone receptor-positive, HER2-negative, locally advanced or metastatic breast cancer. Commissioned by NHS England. Add to Joint Formulary as **RED**.	**JT 9.2.18**
	DG14: Atrial fibrillation and heart valve disease: self-monitoring coagulation status using point of care coagulometers (the CoaguChek XS system). Update noted by the APC.	
	TA494: Naltrexone–bupropion for managing overweight and obesity. Not recommended. **BLACK** on the Joint Formulary.	**JT 9.2.18**
	TA492: Atezolizumab for untreated locally advanced or metastatic urothelial cancer when cisplatin is unsuitable. Commissioned by NHS England. Add to Joint Formulary as **RED**.	**JT 9.2.18**
	TA493: Cladribine tablets for treating relapsing–remitting multiple sclerosis. Commissioned by NHS England. Add to Joint Formulary as **RED**.	**JT 9.2.18**
	QS124: Suspected cancer. Noted by the APC.	
	MIB132: Point-of-care and home faecal calprotectin tests for monitoring treatment response in inflammatory bowel disease. For information only.	
	TA497: Golimumab for treating non-radiographic axial spondyloarthritis. FAST TRACK TA. Commissioned by Clinical Commissioning Groups. Add to Joint Formulary as **RED**.	**JT 9.2.18**

APC admin

15.1	RMOC update
	JP advised that the RMOC South is meeting Tuesday 30th January. An update with come to the Committee in February.
15.2	**Provider update**
	None. DTC minutes to be embedded on the February APC agenda.

AOB

16	
	• IA asked the Committee if the MSK service could extend the expiry dates of the MSK SCGs to March 2018. (They previously expired October 2017.) This would allow the updated SCGs to be presented at the February meeting. The Committee agreed to this.

Close

17	Date of next meeting
	Tuesday 27th February 2018. Room G70, Hove Town Hall, Norton Road, Hove, BN3 4AH