Brighton and Hove
High Weald Lewes Havens
Clinical Commissioning Groups

Brighton Area Prescribing Committee

Minutes

Date: Tuesday 25th June 2019 **Time:** 2-5pm

Location: Room G91, Hove Town Hall, Norton Road, Hove

Members:	
Ciara O'Kane (CO)	Principal Pharmacist, High Weald Lewes Havens (HWLH) CCG (Chair)
Dr Stewart Glaspole (SG)	Principal Pharmacist, Brighton and Hove (BH) CCG (Deputy Chair)
Lloyd Ungoed (LU)	Lay Member, BH CCG
Dr Irma Murjikneli (IM)	Clinical Lead Prescribing, HWLH CCG
Dr Zoe Schaedel (ZS)	GP representative, BH CCG
Samantha Lippett (SL)	Assistant Director of Pharmacy - Medicines Governance, Information, Education & Research Brighton and Sussex University Hospitals Trust (BSUH)
Michael Cross (MC)	Chief Pharmacist, Brighton and Sussex University Hospitals NHS Trust (BSUH)
James Atkinson (JA)	Deputy Chief Pharmacist, Sussex Partnership Foundation Trust (SPFT)
Rita Shah (RS)	Prescribing Advisor, BH CCG
Stacey Nelson (SN)	Senior Medicines Optimisation Pharmacist, BH CCG
Ramiz Bahnam (RB)	East Sussex Local Pharmaceutical Committee Member (LPC)
In Attendance:	
Scott Sweeney (SS)	Operations Manager, Medicines Management Team, BH CCG
Angharad Parsons (AP)	Thrombosis and Anticoagulation Nurse Specialist, BSUH
Dr Steve Coombs	Consultant Cardiologist, BSUH
Janet May	Senior Clinical Pharmacist, SCFT
Christine Holkham	Senior Clinical Pharmacist, SCFT
Susan Martin	Lead Tissue Viability Nurse, SCFT (HWLHCCG)
Emily Dean	Lead Tissue Viability Nurse, SCFT (HWLHCCG)

Apologies:	
Jade Tomes (JT)	Senior Medicines Optimisation Pharmacy Technician BH CCG
Iben Altman (IA)	Chief Pharmacist, Sussex Community Foundation Trust (SCFT)

Item No	Item	Action
1	**Welcome**	
	CO welcomed the Committee. Introductions were made. Apologies received from JT, IA	
2	**Declarations of Interest**	
	None	
3	**Urgent AOB**	
	None.	

Previous meeting and actions

4	**May 2019**	
	• Free of charge (FOC) medicine schemes – on the agenda.	**CLOSED**
	• Vitamins and minerals, life after surgery leaflet	**ONGOING**
	• RMOC feedback – CO has fed back to Gill Ells (RMOC South CCG representative). The Committee will await a reply from the RMOC.	**ONGOING**
	• FreeStyle Libre – confirm frequency of reviews – CO advised that she had received responses from 3 providers, Diabetes Care For You, BSUH and MTW: ○ Follow up frequency is unchanged from previously. The minimum the patients get is – ▪ Group Libre start - as previously with patient signing contract, letter sent to GP etc. - this is as it was previously. ▪ Then one month telephone follow up with DSN (BSUH sometimes with diabetes dietician) ▪ 3 month DSN follow up (BSUH sometimes with diabetes dietician) ▪ 6 month Consultant follow up. At the 6 month appointment there is a decision made to continue or not the Freestyle Libre and this is communicated by letter to GP. ○ If patient does not attend, the documentation makes it clear that they may have funding for their Libre withdrawn. ○ If a patient meets the relevant criteria at 6 months, then the GP would be notified to continue to issue the prescriptions provided patients continue to demonstrate a benefit at follow up appointments. The Committee questioned if this information included the paediatric cohort. CO advised that she is still awaiting a response from paediatric diabetes team and ESHT and will chase.	**ONGOING**

Polices and Guidelines

5	**INR Self-Testing Audit. Presented by Angharad Parsons.**	
	Angharad Parsons presented the outcome of an audit of self-testing patients at the anticoagulation clinic at BSUH. The committee discussed the audit. AP noted that patient satisfaction is high and although a couple of patients skewed time in range results, these were generally as expected. No adverse events were noted.	

	Noted that patients who frequently Did Not Attend would be discharged back to their GP, but could be referred back to the service. When patients are re-referred the patient is fully counselled and the patient agreement is refreshed. RS asked that the discharge letter be specific in asking the GP to stop prescribing test strips. Noted that moving patients to CPAMS could be difficult as CPAMS required certainty of INR range required, and the original source may not always be available. RS requested that when patients are discharged to CPAMS, the service should write to the GP to advise that strips should no longer be prescribed since CPAMS provide the INR strips directly to the patient as part of the service. The committee thanked AP for her attendance and approved the continuation of the policy. **Decision: Continuation of policy approved**	

Formulary review

6	**Appendix 4 Wound management products and elasticated garments. Presented by Emily Dean and Susan Martin**	
	2.30pm - Emily Dean (ED) & Susan Martin (SM) joined the meeting SM presented a revision of appendix 4 of the Joint Formulary – Wound Management Products and Elasticated Dressings. Noted that there are no major changes and are mainly cost-saving. Noted that Aproderm was included as the tissue viability nurses felt that a paraffin free oat product was required. CO asked that hospital only dressings be left in the formulary to provide clarity for prescribers. The TV team at BSUH had not yet been consulted about the changes. At MC's suggestion, SM agreed to meet with the BSUH TV nurses to agree the changes. CO noted that CliniPod is out of stock long term and Sal-E-Pod would be substituted. Noted that Zerolon is already on the formulary. Noted that Devon Foam products should be used after first line measures such as turning. These would be green in the JF. They will be available through ONPOS, or the HWLH proforma. CO noted that supporting information was provided by industry reps, which is not considered best evidence. CO asked that the TVNs meet with her and JT, and BSUH TVNs to finalise the appendix. Noted that costs have gone down since ONPOS was introduced in BHCCG. ONPOS not offered in HWLHCCG as costs there are generally lower. **Decision:** Deferred until document finalised. **ACTION:** JT and CO to meet with TVNs to finalise appendix	**JT, CO 31.8.19**

Policies and Guidelines

7	**Holiday Prescriptions. Presented by Neveen Sorial**	
	Carried over **Decision:** deferred until author available to present	

Formulary Review

8	**Chapter 3 – Respiratory. Presented by Stacey Nelson**	
	SN presented a revision of chapter 3 of the Joint Formulary. The review was done by CCG Senior Medicines Optimisation Pharmacists in conjunction with secondary care respiratory consultants and the respiratory pharmacist. SN noted that triple therapies for COPD have not been included in anticipation of expected NICE guidance, Attention has been paid to the environmental impact of MDI devices, DPI devices are listed first, and a link to the NICE patient decision aid has been included. As requested via feedback it will be added that	

this decision aid details the environmental impact, ZS? Requested that it is detailed that the decision aid is for use in adults

Remove salbutamol autohaler as salamol easybreathe available as a breath actuated MDI .

Remove salbutamol inj 250mg/5ml and terbutaline syrup as no longer available.

Remove Serevent MDI as Soltel is more cost-effective.

Remove Spiriva Handihaler as Braltus is first choice and a switch programme has been run.

Remove N-Acetylcystine tabs and caps as unlicensed and acetylcystine soluble tabs are available.

Add Atimos as MDI version of formeterol

Add fexofenadine 120mg and 180mg, likely to be prescribed in secondary care, and are already in use.

Add Kelhale in preference to QVAR as more cost effective. Otherwise equivalent – neither have a counter and both can be used with a spacer. SL asked whether the chapter reviews apply also to paediatrics and highlighted Kelhale is not licensed in this cohort, SN noted that Christian is reviewing several chapters. Committee agreed to retaining QVAR for children, with Kelhale for adults.

The committee discussed the inconsistency of paediatric use across the formulary. Noted that the current format of the formulary makes including paediatric uses difficult. Noted that there are more similarities than differences, and these can be dealt with on a case by case basis, Agreed that both adult and paeds should be considered for future applications but current items will not be reviewed until Christian has provided his input.

Remove Duoresp Spiromax to streamline chapter as Symbicort is more widely used across South Place. Feedback received from Debbie Eaton,Lead COPD nurse BSUH, does not like Duoresp device and has experienced oral thrush in patients

SL requested Seretide Accuhaler should be removed in preference to Airflusal Forspiro for cost effectiveness - agreed.

SL noted that Airflusal MDI 25/250 is cheaper for BSUH than Sereflo/Sirdupla,. Agreed to keep Airflusal 25/250 for secondary care, with OptimiseRx messages to remind primary care to switch to Sereflo/Sirdupla. To be added as RED for use in secondary care only

SL asked whether we should list carbocisteine sachets as more cost effective than liquid. SN noted that the liquid is licensed in paeds and retained for this cohort alone. SN noted that acetylcystine is available for adults with swallowing difficulties. Jo Congleton's view is that a second line is not required due to lack of evidence of mucolytics. This would be supported by an OptimiseRx message.

Noted that mucolytics should be used for a four week trial and stopped if no benefit. Add comment to chapter The committee discussed removing carbocisteine completely. SG noted that it is in NICE guidance, SN noted also in GOLD. SL & MC requested that BSUH and CCG would identify spend and if significant, would ask for an evidence review.

Post Meeting Note: E-mail received following APC from Jemma Sanger, Lead

	Respiratory Medicine, requesting that AirFluSal MDI is not added as Sereflo/Sirdupla are also most cost effective in secondary care. **Decision:** Remove salbutamol auto-haler; salbutamol inj 250mg/5ml; terbutaline syrup; Serevent MDI; Spiriva Handihaler; N-Acetylcystine tabs and caps; Duoresp Spiromat. Add Atimos MDI as green; fexofenadine tabs 120mg and 180mg as green; Kelhale as green **ACTION: Make changes to joint formulary as agreed above**	**CO 19.7.19**

Shared Care

9	**Hydroxychloroquine information sheet. Presented by Stewart Glaspole**	
	SG presented an updated blue information sheet for hydroxychloroquine, to reflect updated guidance from the Royal College of Ophthalmologists, on patient monitoring. A service for such patient is now available at BSUH. Noted that: • care is shared between ophthalmology, and the initiating specialist. • there is the potential to move the monitoring to optometrists in the future. • not all of the tests required are yet available from every optometrist. • the title should refer to inflammatory conditions and not connective tissue. • visual screening should be specifically mentioned at point 11. • work is being done to identify patients who should be in review. No monitoring blood tests are needed, but SL noted that the SPC mentions periodic monitoring. The committee discussed what this means. SG noted that blood monitoring is not required by BSR guidance. IM noted that such patients would receive routine blood monitoring. IM suggested SG ask the specialists. MC suggested that monitoring for symptoms would be a better approach than blood tests. SL noted that the PIL warned the patient to see their GP if they have symptoms or concerns. Noted that the sheet mentions that the consultant's responsibility to counsel the patient on the possibility of side effects. SG noted that blood monitoring has not previously been part of care, the risk is unclear and the evidence missing. JA noted that the information leaflet from the British Association of Dermatologists says regular blood test are not required. MC suggested that the need for blood monitoring seems more likely to protect the prescriber than the patient. **Decision:** With the suggested changes the document was approved. **ACTION: SG to make suggested amendments**	**SG 19.7.19**

New drug / indication formulary applications

10	**Rivaroxaban 2.5mg. Presented by Dr Steven Coombs**	
	4.00pm – Dr Steven Coombs, Janet May & Christine Holkham joined the meeting Dr Coombs presented an application for Rivaroxaban 2.5mg, co-administered with aspirin for the prevention of atherothrombotic events in adult patients with CAD or PAD at high risk of ischaemic events, to be added to the formulary. CO noted that the RMOC have said that they will issue a holding statement re rivaroxaban in CAD and PAD. For specialist initiation for selected very high risk PAD/CAD patients. The COMPASS trial showed good results in these patients; NICE guidance is expected but would like to start in advance of this. RS noted that the indications listed in the application seem to be looser than this specific group. Dr Coombs noted that the selection criteria in the trial were stringent. Expected numbers are 20 per 100,000. The cardiology team would use early experience to develop protocols that other could use as the drug	

	becomes more widely available. CO asked if Alison Warren could reformat the section of the formulary to make the medicine fit. Dr Coombs confirmed that treatment is lifelong. Initial follow up would be with cardiology, but could be passed to the GP. Where patients have a bleed, they could be stopped and left on aspirin alone. The committee noted the evidence is very good in carefully selected patients. IM asked what would happen if NICE are not favourable? IM asked for an information sheet to support GPs in stopping the medicine as the patient ages. MC noted that the trial was short and long term data is not available. Dr Coombs noted that the data was available for up to four years, and the efficacy was not expected to drop off. He noted that DOACs carry high risk over time but was not higher in these patients. He agreed that the medicine would be stopped if renal function declined. These patients could be referred back to cardiology. **Decision:** Added to formulary as blue initiation, with clearly specified patient groups (to match criteria in COMPASS trial). To be reviewed post-NICE and/or RMOC guidance. **ACTION:** AW to reformat relevant section of joint formulary. To be added to JF	**AW, JT 26.7.19**

Formulary extension

11	**None**	

Traffic light status change

12	**None**	

NICE TA Briefing

13	**None**	

NICE Guidance

14	**NICE Guidance published May 2019. Presented by Ciara O'Kane**	
	HST9: Inotersen for treating hereditary transthyretin amyloidosis. Commissioned by NHS England. Add to the Joint Formulary as RED MTG43: PICO negative pressure wound dressings for closed surgical incisions. Already listed on the Joint Formulary NG127: Suspected neurological conditions: recognition and referral. Noted by APC NG128: Stroke and transient ischaemic attack in over 16s: diagnosis and initial management. Noted by APC NG129: Crohn's disease: management. Noted by APC NG130: Ulcerative Colitis management. Noted by APC NG131: Prostate cancer: diagnosis and management. Noted by APC NG132: Hyperparathyroidism (primary): diagnosis, assessment and initial management. Noted by the APC. **The committee was asked for consideration to be made for dual coding for cinacalcet – blue for primary hyperparathyroidism as per NICE NG132, with desirability of either shared care and/or blue information sheet for cinacalcet for primary**	**JT 19.7.19** **SG 6.9.19**

	hyperparathyroidism. (Action SG) QS131: Prostate Cancer. Noted by APC TA578: Durvalumab for treating locally advanced unresectable non-small-cell lung cancer after platinum-based chemoradiation. Commissioned by NHS England. Add to the Joint Formulary as **RED** TA579: Abemaciclib with fulvestrant for treating hormone receptor-positive, HER2-negative advanced breast cancer after endocrine therapy. . Commissioned by NHS England. Add to the Joint Formulary as **RED** TA580: Enzalutamide for hormone-relapsed non-metastatic prostate cancer. Not recommended TA581: Nivolumab with ipilimumab for untreated advanced renal cell carcinoma. . Commissioned by NHS England. Add to the Joint Formulary as **RED** TA582: Cabozantinib for previously treated advanced hepatocellular carcinoma (terminated appraisal). Not recommended	**JT 19.7.19** **JT 19.7.19** **JT 19.7.19**

APC admin

15.1	**Regional Medicines Optimisation Committee (RMOC) update. Presented by Ciara O'Kane.**	
	Not discussed	
15.2	**Provider update.**	
	BSUH MGG May 2019. Minutes embedded in APC agenda, July 2019	

Policies and Guidelines

16	**SCFT Medicine Charts. Presented by Janet May & Christine Holkham**	
	CH presented a number of SCFT community nursing medicine charts. The existing charts have been in use since 2011 and that the revised charts taken to the APC only had minor amendments made to reflect requests from in particular GPs and also to look at anticipatory prescribing following Gosport from SCFT perspective. A review date of three months for the charts was generally felt appropriate although this could be longer or shorter if indicated by the prescriber. The charts will be used where SCFT community nurses are to administer medicines when a prescriber's signature is required. SL noted that the templates used by the palliative care network are different, having regular and PRN medicines on the same side of the page. OPAT use specific SCFT IV therapy charts. A copy of the palliative care chart would be sent to CH. SL to forward other charts to CO for onward sharing. CH stated that the SCFT community nurses preferred the PRN medicines to have a separate page to the regular medicines. SL considered that separate prescription and administration sheets could lead to transcription errors. CH explained a small pilot for the charts was expected to run for one month in a small number of HWLH practices. SS suggested this trial should be at least three months as this will be the time that the community nurse charts would require a review if no other expiry was specified on the chart. MC asked whether the charts had ever been audited for transcription errors. Suggested that an audit would be done as part of the pilot.	

	RS noted that Specialist Pharmacy Services are gathering samples of charts to identify best practice, and will send some good examples to IA. The committee asked that further work will be done with the palliative care network to harmonise the various charts and to consider wider consultation. CH / JM also presented two documents: *Use of Medicine Instruction Charts for Administration of Medicines in Community Nursing Procedure* and *Anticipatory Medicines Guidance for use by Registrants working in the Community*. They are seeking interim approval of the documents. Noted possibility of confusion for prescribers about which community nurse chart to complete. The use of Medicine Instruction Charts for Administration of Medicines SOP identifies that IV meds, insulin, intravenous medicines, medicines via syringe driver, injectable medicines with variable doses or medicines where the directions on the pharmacy label are unclear or ambiguous need a prescriber's signature. JM noted that other medicines that have been dispensed and labelled, a prescriber's signature is not required and SCFT had their own internal medicines administration charts for SCFT nurses to use. JM asked if the Anticipatory Medicines Guidance could be approved as the period of a three month expiry of the palliative care charts was the only issue relating to the charts. MC asked what would happen if the clinical picture changed. Suggested clarification in the Anticipatory Medicines Guidance about clinical change. JM to revise the SOP. The APC had no other comments on the *Use of Medicine Instruction Charts for Administration of Medicines in Community Nursing Procedure* and *Anticipatory Medicines Guidance for use by Registrants working in the Community*. **Decision:** deferred until palliative chart revised **Action:** SL to share sample charts with CO; CO to pass charts to CH. CH to work with palliative care services to refine the palliative care chart. CH to pilot charts in two HWLH CCG practices, to include an audit of transcription errors. CH to bring revised palliative care chart and SOPs back to APC for further consideration. **Post-meeting note:** As the actions from these discussions were unclear the chair has agreed with SCFT that the community nursing medicines charts and SOPs will be tabled on the APC agenda in September 2019.	**CO 6.9.19**

AOB

17		
	• None	

Close

18	**Date of next meeting**	
	Tuesday 23rd July 2019. Room G91, Hove Town Hall, Norton Road, Hove, BN3 4AH.	