Brighton and Hove
High Weald Lewes Havens
Clinical Commissioning Groups

Brighton Area Prescribing Committee

Minutes

Date: Tuesday 23rd July 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) (part)
Lloyd Ungoed (LU)	Lay Member, BH CCG
Iben Altman (IA)	Chief Pharmacist, Sussex Community Foundation Trust (SCFT) (part)
Samantha Lippett (SL)	Assistant Director of Pharmacy - Medicines Governance, Information, Education & Research Brighton and Sussex University Hospitals Trust (BSUH)
James Atkinson (JA)	Deputy Chief Pharmacist, Sussex Partnership Foundation Trust (SPFT) (part)
Rita Shah (RS)	Senior Medicines Optimisation Pharmacist, BH CCG
Kathryn Steele (KS)	Senior Medicines Optimisation Pharmacist, BH CCG
Ramiz Bahnam (RB)	East Sussex Local Pharmaceutical Committee Member (LPC)
Dr Josh Cullimore (JC)	GP representative, BH CCG
Dr Sarah Richards (SR)	GP representative, HWLH CCG
Ashleigh Bradley (AB)	Lead Clinical Commissioning Pharmacist, Crawley (C) CCG and Horsham and Mid Sussex (HMS) CCG (part)
In Attendance:	
Jade Tomes (JT)	Senior Medicines Optimisation Pharmacy Technician, BH CCG
Louise Ridley (LR)	Medicines Optimisation Pharmacist, HWLH CCG
Sallie Bergin (SB)	Senior Medicines Optimisation Pharmacist, HWLH CCG
Billy Doyle (BD)	Senior Medicines Optimisation Pharmacist, BH CCG
Trish Freeman (TF)	Senior Clinical Pharmacist, Children and Young People, SCFT (part)
Dr Ann White (AW)	Consultant Community Paediatrician, SCFT (part)
Sephora Shaw (SS)	Senior Medicines Optimisation Pharmacist, BH CCG (part)
Michelle Barnard (MB)	Specialist Commissioning Technician, C CCG and HMS CCG

Apologies:	
Dr Irma Murjikneli (IM)	Clinical Lead Prescribing, HWLH CCG
Dr Zoe Schaedel (ZS)	GP representative, BH CCG
Michael Cross (MC)	Chief Pharmacist, BSUH
Judy Busby (JB)	Chief Pharmacist, Queen Victoria Hospital NHS Foundation Trust (QVH)

Item No	Item	Action
1	**Welcome**	
	CO welcomed the Committee. Introductions were made. Apologies received from IM (SR deputising), ZS (JC deputising), JB, MC.	
2	**Declarations of Interest**	
	None.	
3	**Urgent AOB**	
	None.	

Previous meeting and actions

4	**June minutes and actions 2019**	
	CO advised that the minutes from the previous meeting had been approved virtually however, comments had been received post approval that needed addressing. It was recognised that an action from the respiratory chapter review item was incorrect and a post-meeting note needed to be added regarding AirFluSal. The Committee agreed with this. Comments had also been received post approval from the presenters of the SCFT drug charts item. It was felt that there were some inaccuracies in the minutes. It was agreed that this section of the minutes would be sent to the presenters to amend in track changes and returned back to the chair for ratification.	**CO 6.08.19**
	It was questioned if a submission was being brought to the Committee to review the evidence for carbocisteine following discussions at the previous APC. MB advised that the Surrey APC had recently tabled an evidence review and she would enquire of the outcome and if the submission could be shared with the Brighton APC.	**CO 9.08.19**
	• ADHD Information Sheet update – JA advised that this would be presented at the September meeting. • FreeStyle Libre (confirm frequency with providers) – CO still awaiting a response from paediatric diabetes team and ESHT and will chase. • RMOC feedback – CO has fed back to Gill Ells (RMOC South CCG representative) regarding the 'Maintaining patency of central venous catheters in adults: RMOC position statement' as it was not very clear and is inconsistent with other published guidance. The Committee will await a reply from the RMOC. • Vitamins and minerals, life after surgery leaflet – APC accepts the latest version. This is now uploaded on the WSHFT website. Links to be added to CCG website and Joint Formulary. • Rivaroxaban – addition still needs to be a made to the Joint Formulary. CO to discuss amending that formulary section with AW. • SCFT Medicine Charts – SL had shared documents with CO who had forward to the presenters from SCFT. • Wound care formulary review - ongoing • Ketone guidelines – further comments had been received and will therefore be discussed at the September SCFT MMG meeting. This would then be tabled at the October APC. • Cinacalcet – ongoing. • Sukkarto MR – JT will be notifed of when the wholesalers have stock. Local account managed information JT that this would be August / September.	**JA 30.08.19** **CO 6.08.19** **CO 24.09.19** **JT 9.08.19** **CO 6.08.19** **CLOSED** **CO 2.09.19** **IA 4.10.19** **SG 06.10.19** **JT 24.09.19**

New drug / indication formulary applications

5	**Slenyto (prolonged released melatonin). Presented by Trish Freeman and Dr Ann White**	
	2.20pm – Trish Freeman and Dr Ann White joined the meeting. TF advised that the application was asking the APC to consider adding Slenyto 1mg and 5mg tablets to the Joint Formulary for its licensed indication of insomnia in children and adolescents aged 2-18 years with Autism spectrum disorder, Smith-Magenis syndrome or severe neurodevelopmental disorders, where sleep hygiene measures have been insufficient. TF stressed that Slenyto would only be considered as an option after sleep hygiene and behavioural measures have been trialled and have been unsuccessful. Slenyto would be recommended by a specialist therefore, blue on the formulary. The Committee was advised that currently specialist health visitors and the child's paediatrician manage the sleep pathway. Current treatment is with Circadin which is used off-label. TF explained that Circadin was considered as the preferred melatonin at the time as other products were unlicensed. It is common practice for families to crush the Circadin tablets as children find it difficult to swallow this size of tablet. It was highlighted that crushing the tablet negates the slow release properties. The Committee were informed that the aim of melatonin treatment is to adjust sleep to a normal pattern and discontinue melatonin or reduce to the lowest effective dose. The current pathway has been modified to include Slenyto at the lowest effective dose therefore patients would be started on 1mg and increase only when necessary. It was explained that it would only be on the advice of a paediatrician that a patient would go up to a dose of 10mg. It was noted that doses between 5mg and 10mg would not be used. Doses where multiple tablets would be required (6mg, 7mg, 8mg, 9mg) would incur an extra cost. TF highlighted the benefits of Slenyto. The tablets are only 3mm in diameter which is significantly smaller than Circadin. They are favourless and odourless which makes them more acceptable to patients and they have a paediatric license. The Committee questioned if Slenyto would only be used within the licensed indications. AW advised that their service only see children with neurodevelopmental disorders. It was questioned if the service would use the liquid melatonin in young children unable to swallow tablets. AW advised that it is rare to use melatonin in such young children and recognise the cost and safety concerns with prescribing an unlicensed medication. It is thought that approving Slenyto would reduce the need for the liquid as the tablets were small. (The Committee were shown marketing material which included placebo tablets, demonstrating the size.) The Committee discussed the administration of Slenyto through a feeding tube as is known that a crushed Circadin tablet can cause issues with the tube blocking. It was raised that SPFT have reviewed the evidence for use in CAMHS and children with ADHD where they currently use Bio-Melatonin. SPFT did not approve its use due to the cost of switching over to Slenyto and because the evidence base in ADHD is around the use of an IR preparation. AW advised that she would be concerned with this position as Bio-Melatonin does not have a license to be used in children. JA advised that as there is not currently a licensed IR preparation and crushing an MR preparation creates an unlicensed preparation therefore SPFTs position is to use Bio-Melatonin. The Committee questioned the evidence for using the 10mg dose. AW advised that even though Slenyto has a license for the 10mg dose, she believes it would be very unusual for a patient to be on that dose. The Committee discussed the letters. Letter 1 – it was confirmed that the family not the GP would contact the sleep team for advice. It was agreed that this would be made clearer on the letter. Letter 3 – It was questioned who would instigate a 5 day medication free period once a year. It was confirmed that the family would instigate this, usually during the school holidays. This would be explained to the	**CO 09.08.19**

family as part of the education provided by the sleep team. It was agreed that the tick box regarding drug holiday be amended to include "at this stage" so this question would be asked again at a future date.
The Committee questioned what would happen once the patient reached 18 years old. AW explained that the patient would then be under the GP and as part of an annual medication review it would be expected that ongoing benefit would be discussed and if the patient should stop.
The Committee asked if the initial prescription would be provided by the service or be requested for the GP to supply and the pathway was discussed.
It was confirmed that a switch over to Senyto from Circadin would not be carried out on existing stable patients. The committee discussed the potential cost impact to the health economy and it was noted that 9/26 patients in their service were discharged on melatonin in a year. AW also explained that one of the advantages of Slenyto over Circadin is that the tablets start at 1mg, not 2mg, giving the option of a lower starting dose.

TF and AW were asked to step outside whilst the Committee discussed the application further.

The decision that SPFT had made was discussed and it was noted that the evidence they considered was in a different cohort of patients (ADHD in >18s). It was highlighted that the MENDS study recommended 3-5mg doses and showed little evidence for 10mg dose (which is more costly). The credibility of the study was discussed and it was noted that the prime investigator had a conflict of interest with the manufacturer. It was also highlighted that Slenyto is manufactured by the sister company of the Circadin manufacturer.
The Committee made reference to the MHRA licensing hierarchy and it was agreed that the Committee should support the use of licensed products where available and not endorse the use of unlicensed specials when a licensed alternative is available.
The decision making framework was discussed.

- Evidence – it was recognised that the evidence for doses ≥5mg is flawed and limited.
- Safety – no concerns.
- Cost effectiveness – cost effectiveness analysis is not available however, it is expensive compared to current medication treatment option (3 times the cost of Circadin).
- Place in treatment pathway – after sleep hygiene and behavioural support.
- Patient outcomes – benefits are outlined in evidence.

The Committee discussed the pathway once sleep hygiene and behavioural support had failed and questioned who would prescribe the initial supply when the dose could potentially be escalating to achieve adequate response.
The Committee discussed the prescribing responsibility and it was confirmed that currently the GP would be asked to provide the initial supply with the sleep team advising the family of dose changes throughout the titration period. It was confirmed that the APC have the principle that the prescribing, monitoring and any titration should not be separated in the interest of safety. It was noted that CAMHS keep the prescribing responsibility of melatonin until the patient is on a stable dose.

The Committee asked TF and AW to re-join the meeting.

The Committee explained the safety concerns and risk with the current ask that GPs prescribe the initial supply and the sleep team monitor and up-titrate. AW and TF were asked if there were any barriers to the team providing the initial supply. IA advised that this would have to be discussed with the Trust and commissioners.
The Committee questioned the place for the 10mg dose. AW advised that some children (including an end of life patient) were currently on a 10mg dose and this

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	has been used as a last resort when there is nothing else to try before potentially referring the patient to a London specialist. *TF and AW left the Committee.* The Committee discussed the application further. It was noted that as the evidence for the 10mg dose was lacking and the increased cost, the APC would request that an audit is undertaken of all Slenyto initiation and data (including patient numbers started, stopped, stable dose distribution and outcomes) be submitted to the Committee in 12 months' time for review and consideration. The Committee confirmed that they would approve Slenyto to be added to the Joint Formulary as Blue if the initial prescribing (until the dose was stable) was carried out by the service and if the service agreed to collect audit data to be submitted to the Committee to review in 12 month's time. The notes section of the formulary would state community paediatric use for licensed indications only - namely ASD, Smith-Magenis syndrome and neurodevelopmental disorders. SL asked if the Committee would consider an addition to the formulary of a liquid preparation for use in feeding tubes. It was agreed that a separate submission would be required. **Decision: pending** **ACTION: feedback to the authors and IA.**	**CO 9.08.19**

Shared Care

6	**Anti-dementia Information Sheet – updated. Presented by Sephora Shaw.**	
	3.15pm – Sephora Shaw joined the meeting. SS advised that some changes had been made following the comments received at the April APC meeting. SS explained that this information sheet now reflects the current practice and service. One change was that the prescribing information had been moved to a separate section, which summarised NICE TA and Clinical Guidelines. SS advised that this would be an interim information sheet as it is likely to be updated next year with regards to the new memory assessment service and locally commissioned service in Brighton and Hove. SR commented that in the HLWH area with the golden ticket pathway, the memory assessment service carries out the prescribing until the patient is stable and therefore the specialist responsibilities needed to be updated. The Committee agreed to these changes. **Decision:** Approved pending changes to the information sheet which reflect the practice in the HWLH area. **ACTION:** Make changes to the information sheet and forward to JT for uploading to the CCG website.	**CO 9.08.19**

New drug / indication formulary applications

7	**Pitolisant. Presented by Michelle Barnard.**	
	MB advised that she was presenting the submission on behalf of QVH who were a specialist sleep centre. MB gave a brief overview of the submission and explained that pitolisant was the first of a new class of drugs (histamine H3-receptor antagonist) which had been licensed to treat narcolepsy with or without cataplexy in adults. It had been shown to be inferior to modafinil which is before pitolisant in the proposed pathway. MB highlighted that strong evidence is for its use as monotherapy however, clinical experience from Guys and St Thomas' NHS Foundation Trust (GSTT) suggested that combination therapy is more effective in clinical practice. MB also advised that pitolisant had been removed from the Payment By Results tariff (PBRe) therefore the cost lies with the commissioners. As pitolisant is expensive, it is last line in the treatment	

	pathway. It was noted that sodium oxybate (a controlled drug) was also in the pathway and could be used in addition to pitolisant. It was noted that QVH follow same pathway as GSTT which includes pitolisant and the requirement to improve by 3 points or more compared to baseline on the Epworth Sleepiness Scale for treatment to be continued after 3 months. It was explained that currently patients were being referred to GSTT to access the drug which has led to lengthy waiting times. MB noted that GSTT carried out an internal audit which showed 50% of patients were non-responders within the first 3 months of starting pitolisant. MB advised that negotiations with Trusts and the manufacturers are ongoing regarding free access to 3 months treatment. MB informed the Committee that there were discussions being had between RMOC and NHS England to consider changing sleep services, including the drugs to become a specialised commissioned service (NHSE commissioned). The Committee discussed the governance process for a new PBRe drug. MB advised that the submission had been through QVH governance who had approved its use however as the CCG will be funding the drug, it needed to be raised at APCs. It was noted that Blueteq would be used to govern appropriate use and data would continue to be collected for audit purposes. Patient numbers were likely to be small (8-9 per annum) at QVH. The Committee concluded that they were satisfied that the evidence had been appraised at GSTT and QVH who had approved its use and it was noted that approving locally would negate the need for patients to be referred to GSTT to access treatment. The Committee discussed the SCG for the management of Narcolepsy (+/- cataplexy) and idiopathic hypersomnia in adults from the South East Area London Prescribing Committee. It was agreed that as this was not a local shared cared prescribing guideline (from a provider member) the APC would not endorse its use and would advise that primary care prescribers consider each out of area shared care guideline on a case by case basis and only take on prescribing responsibility if they felt clinically competent. It was noted that the CCG Medicines Management Teams could provide support or advice to prescribers if needed. **Decision:** Approved – RED – specialist prescribing only **ACTION:** Add to the Joint Formulary as RED. Create Blueteq forms.	**JT 09.08.19** **CO 16.08.19**

Shared Care

8	**Testosterone enantate 250mg/mL oily injection Information Sheet - updated. Presented by Stewart Glaspole**	
	SG advised the Committee that some minor errors and typos were discovered on the information sheet, which has led to two changes being made. Changes had been highlighted on the document and the Committee agreed to these changes. **Decision:** Approved. **ACTION:** Upload amended version to the CCG website. The Committee discussed the testosterone products on the Joint Formulary. It was highlighted that the 1st line product (testosterone decanoate) was formulated in arachis oil and was therefore not suitable for those with a nut allergy. It was agreed to add that testosterone enantate was 2nd line as suitable for patients with peanut allergy to the Joint Formulary. **ACTION:** Add note to the Joint Formulary entry on testosterone enantate – 2nd line as suitable for those with a nut allergy.	**JT 9.08.19** **JT 9.08.19**

Formulary Extension

9	Teromeg. Presented by Jade Tomes	
	SG, IA, AB and JA left the Committee. JT advised the Committee that Teromeg is a branded generic of omega 3 acid ethyl esters. (Originator brand Omacor.) Previously the Joint Formulary listed Nebbaro brand however, this had been discontinued and subsequently the brand removed from the Joint Formulary. JT explained that currently Teromeg is more cost effective than if omega 3 acid ethyl ester was to be prescribed generically and if all prescribing of generically written omega 3 and Omacor was changed to Teromeg in BH and HWLH, this would save over £13k per annum. It was noted that BSUH were currently buying in Teromeg as this was on contract therefore and if Teromeg was approved this would ensure brand consistency throughout the local health economy, assisting with transfer of care. JT explained that implementation would be via OptimiseRx and the Pharmacy Technician work programme as they were currently reviewing the appropriateness of Omega 3 prescribing in line with the NHS England guidance: Items not to be routinely prescribed in primary care and the Joint Formulary. It was noted that community pharmacies would be available to access Teromeg via Alliance wholesalers. The Committee questioned if there were any omega 3 preparations suitable for vegans. It was noted there were no licensed products that were suitable for vegans. **Decision:** Approved – **BLUE** – specialist recommended only (lipid clinic and HIV) **ACTION:** Add to the Joint Formulary as **BLUE**	**JT 9.08.19**

Policies and guidelines

10.1	Liothyronine. Presented by Ciara O'Kane.	
	CO advised that RMOC had updated their guidance to include the recommendation that existing patients should be referred back to a specialist endocrinologist. The APC had previously requested an economic assessment and financial data from the RMOC in order to consider the local impact if the commissioning position was to change however, they had not provided this. It was highlighted that BSUH's position had not changed and the endocrinologists feel that this position should remain and only be reviewed once NICE guidance had been published. (Expected November 2019.) The Committee agreed to wait until NICE had published their guidance before reviewing the local commissioning position. It was recognised that the CCGs statement on the prescribing of liothyronine would need to be updated to reflect the Committee's current stance. It was noted that liothyronine was red (specialist only) in the North CCGs however a status of amber (specialist initiated with a SCG) would be considered in the coming months to align with the Surrey CCGs. **Decision:** Deferred until NICE guidance is published. **ACTION:** Update liothyronine position statement and add to Kahootz for virtual approval and send to JC and SR.	**JT / CO 9.08.19**

10.2	**Overseas Travel Prescribing. Presented by Kathryn Steele.**	
	KS advised the Committee that this item concerns two current documents; the Overseas Travel Prescribing guidance (for Healthcare professionals) and Overseas Travel guidance for patients. It was proposed that; diazepam for the fear of flying, medicines to postpone menstruation and melatonin for jet-lag should not be provided on an NHS prescription and should therefore be coded as black on the Joint Formulary. The Committee agreed with this. It was noted that it would be difficult to police. KS recognised this however explained that this message would be communicated to prescribers as part of the self-care campaign messaging and about the appropriate use of NHS resources. It was highlighted that a local GP had asked the medicines management team for guidance around these items being prescribed on the NHS for such indications. The Committee noted that without guidance from the CCG, there is variation between practices and prescribers. It was agreed that the addition of the clinical considerations for the prescribing of diazepam for fear of flying would be of benefit, as it would provide useful information for prescribers. It was also agreed to add the clinical risk factors to prescribing norethisterone e.g. DVT risk. It was noted that travel clinics and online pharmacies are offering medicine for the postponement of menstruation. It was agreed that this information would be added to the guidance. **Decision:** Approved pending agreed amendments as detailed above **ACTION:** To update the guidance with the agreed amendments and forward to SR. Once agreed forward to JT for uploading to the CCG website.	**KS / JT / 9.08.19**

Traffic Light Status Change

11.1	**Diazepam – BLACK for fear of flying.**	
	See item 10.2. **Decision: Approved – BLACK – not routinely prescribed for the fear of flying.** **ACTION:** add as black to the joint formulary	**JT 9.08.19**
11.2	**Norethisterone – BLACK for postponement of menstruation for e.g. a holiday or event.**	
	See item 10.2. **Decision: Approved – BLACK – not routinely prescribed for the postponement of menstruation.** **ACTION:** add as black to the joint formulary	**JT 9.08.19**
11.3	**Medroxyprogesterone – BLACK for postponement of menstruation for e.g. a holiday or event.**	
	See item 10.2. **Decision: Approved – BLACK – not routinely prescribed for the postponement of menstruation.** **ACTION:** add as black to the joint formulary	**JT 9.08.19**

Formulary review

12	**None**	

NICE TA Briefing

13	**None**	

NICE Guidance

14	**NICE Guidance published June 2019. Presented by Ciara O'Kane**	
	NG123 Urinary incontinence and pelvic organ prolapse in women: management. Update noted by the Committee. NG133 Hypertension in pregnancy: diagnosis and management. Noted by the Committee. AW to confirm if the Joint Formulary is compliant. ***Post meeting note:*** *AW confirmed it was however, it was recommended that a note be added to the enalapril entry "Drug of choice for post-natal BP and breastfeeding" and a hyperlink to NG133 added.* NG134 Depression in children and young people: identification and management. Noted by the Committee. QS183 Physical activity: encouraging activity in the community. Noted by the Committee. QS184 Dementia. Noted by the Committee. TA171 Lenalidomide for the treatment of multiple myeloma in people who have received at least 2 prior therapies. Update noted by the Committee. TA322 Lenalidomide for treating myelodysplastic syndromes associated with an isolated deletion 5q cytogenetic abnormality. Update noted by the Committee.	**JT 09.08.19**
	TA583 Ertugliflozin with metformin and a dipeptidyl peptidase-4 inhibitor for treating type 2 diabetes. Commissioned by Clinical Commissioning Groups. Already listed on the Joint Formulary as **GREEN**. Add link to NICE TA.	**JT 09.08.19**
	TA584 Atezolizumab in combination for treating metastatic non-squamous non-small-cell lung cancer. Commissioned by NHS England. Add as **RED** to the Joint Formulary.	**JT 09.08.19**
	TA585 Ocrelizumab for treating primary progressive multiple sclerosis. Commissioned by NHS England. Add as **RED** to the Joint Formulary.	**JT 09.08.19**
	TA586 Lenalidomide plus dexamethasone for multiple myeloma after 1 treatment with bortezomib. Commissioned by NHS England. Add as **RED** to the Joint Formulary.	**JT 09.08.19**
	TA587 Lenalidomide plus dexamethasone for previously untreated multiple myeloma. Commissioned by NHS England. Add as **RED** to the Joint Formulary.	**JT 09.08.19**

APC admin

15.1	**Regional Medicines Optimisation Committee (RMOC) updates. Presented by Ciara O'Kane.**	
	RMOC newsletter noted by the Committee. RMOC Briefing on adalimumab noted by the Committee. Rarely Used and Urgent Medicines List noted by the Committee.	
15.2	**Provider update.**	
	BSUH. SL gave an update from the June 2019 MGG. Points to note included: • A statement regarding the prescribing of cannabis was currently in draft form and comments were being received. It was questioned if an entry for cannabis should be added to the Joint Formulary so there is a recognised commissioning position with the approved statement linked to this entry. SL to discuss at MGG. • Feraccru's license had now been widened to include iron deficiency anaemia. It was noted that a submission could be brought to a future APC as it was hoped that use of Feraccru would reduce the need for patients to attend the hospital for iron infusions.	**SL 24.09.19**

	• New Adult inpatient drug chart has been signed off and gone to the printers. These will be ready for the new doctors cohort in September.	

AOB

16		
	• MB advised that she was looking at a newly licensed DOAC reversal agent with the view to bring an evidence review to a future APC. This would be red (specialist only) however CCGs could potentially be responsible commissioners. SL to send details of BSUH specialists for MB to consult with. • JT advised that there would not be a meeting next month therefore the Committee would next sit in September.	**SL 09.08.19**

Close

17	Date of next meeting	
	Tuesday 24th September 2019. Room G79, Hove Town Hall, Norton Road, Hove, BN3 4AH.	