Brighton and Hove
High Weald Lewes Havens
Clinical Commissioning Groups

Brighton Area Prescribing Committee

Minutes

Date: Tuesday 24th September 2019 **Time:** 2-5pm

Location: Room G79, 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)
Dr Irma Murjikneli (IM)	Clinical Lead Prescribing, HWLH CCG
Dr Zoe Schaedel (ZS)	GP representative, BH CCG
Michael Okorie (MO)	Associate Medical Director, Brighton and Sussex University Hospitals Trust (BSUH)
Judy Busby (JB)	Chief Pharmacist, Queen Victoria Hospital NHS Foundation Trust (QVH) (part)
Billy Doyle (BD)	Senior Medicines Optimisation Pharmacist, BH CCG
Iben Altman (IA)	Chief Pharmacist, SCFT
Christine Holkham (CH)	Senior Clinical Pharmacist, Sussex Community Foundation Trust (SCFT)
James Atkinson (JA)	Deputy Chief Pharmacist, Sussex Partnership Foundation Trust (SPFT) (via phone)
Rita Shah (RS)	Senior Medicines Optimisation Pharmacist, BH CCG
Ramiz Bahnam (RB)	East Sussex Local Pharmaceutical Committee Member (LPC)
Ashleigh Bradley (AB)	Lead Clinical Commissioning Pharmacist, Crawley (C) CCG and Horsham and Mid Sussex (HMS) CCG
David Russell (DR)	Senior Medicines Optimisation Pharmacist, BH CCG
Samantha Lippett (SL)	Assistant Director of Pharmacy - Medicines Governance, Information, Education & Research, BSUH
In Attendance:	
Jade Tomes (JT)	Senior Medicines Optimisation Pharmacy Technician, BH CCG
Dan Jenkinson (DJ)	GP Lead, Diabetes Care For You (DCFY) (part)
Christian Chadwick (CC)	Highly Specialist Pharmacist, Children's and Women's Services, Royal Alexandra Children's Hospital (part)
Ali Chakera (AC)	Consultant in Diabetes & Endocrinology, Clinical Lead for Diabetes, BSUH (part)
Robert Matson (RM)	Medicines Optimisation Pharmacy Technician, BH CCG
Claire Marsh (CM)	Medicines Optimisation Pharmacy Technician, HWLH CCG

Apologies:	
Lloyd Ungoed (LU)	Lay Member, BH CCG

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

Previous meeting and actions

4	**July 2019 minutes and actions**	
	July 2019 minutes were approved virtually post meeting. IA requested an amendment to the minutes regarding the indication for Slenyto. IA to email JT with the requested amendment.	**IA 11.10.19**
	• SCFT medicines charts – on the agenda.	**CLOSED**
	• Dementia information sheet – had been updated post the July meeting and is now on the CCG website. JA to check if the previous version had been removed from the SPFT website.	**JA 11.10.19**
	• Carbocisteine – Information from Surrey passed to BSUH.	**CLOSED**
	• Slenyto – discussions ongoing.	**IA 18.10.19**
	• Pitolisant – Added to the Joint Formulary. Blueteq forms yet to be created.	**CO 18.10.19**
	• ADHD Information Sheet update – on the agenda.	**CLOSED**
	• Rivaroxaban – addition still needs to be a made to the Joint Formulary. CO to discuss amending that formulary section with Alison Warren.	**CO 22.10.19**
	• Ketone guidelines – further comments had been received and the guidelines would be discussed at the September SCFT MMG meeting. These would then be tabled at the October APC.	**IA 4.10.19**
	• Cinacalcet (NG132) – ongoing. Blue information sheet had been drafted and shared with clinicians at BSUH. This would be presented at a future Committee.	**SG 4.10.19**
	• FreeStyle Libre (confirm frequency with providers) – CO still awaiting a response from paediatric diabetes team and ESHT. Committee agreed to close the action as no reply.	**CLOSED**
	• 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.	**CO 22.10.19**
	• Cannabis prescribing statement - No formal application had been made to include cannabis on the Joint Formulary and as such, cannabis should not be added to the JF. A position statement has been finalised by the BSUH MGG. SL to share with APC.	**SL 4.10.19**

Policies and Guidelines

5.1	**Items which should not be routinely prescribed in primary care: Guidance for CCG's. Version 2. Presented by Ciara O'Kane**	
	CO explained the background to this item and referred to the supporting information included in the agenda, which compared the current Joint Formulary	

position with the recommendations in the guidance.

5.1 Aliskiren [NEW]
Included in the guidance due to the drug being clinically effective but more cost-effective products are available. Currently non-formulary. It was suggested that aliskiren was coded as black. The Committee agreed with this.
Decision/ACTION: Change to **BLACK**. **CO 11.10.19**

5.2 Amiodarone [NEW]
Included in the guidance due to having significant safety concerns. Currently blue (specialist initiated) on the formulary. The Committee discussed guidance recommendations and the possibility of changing to amber with a shared care arrangement. The Committee considered Alison Warren's comments and concluded that specialist initiated (blue) was appropriate for the local health economy. It was noted that patients should be under the specialist for a review of ongoing need and if used, the PINCER tool would help with safe prescribing in primary care.
Decision/ACTION: Keep as **BLUE**.

5.3 Bath and Shower preparations for dry and pruritic skin conditions [NEW]
Included in the guidance due to the lack of robust evidence of clinical effectiveness. Currently green on the formulary. It was suggested that bath and shower preparations were coded black. The Committee discussed the guidance and its implementation. It was noted that Care Homes would need to be engaged and educated to aid implementation and the change would need to be effectively managed in primary care to prevent an increase in workload for GPs. SL advised the Committee that local dermatologists had been informed of the guidance and had received no response.
Decision/ACTION: Change to **BLACK**. **CO 11.10.19**

5.4 Co-Proxamol
Included in the guidance due to having significant safety concerns. Currently black on the formulary. It was suggested to keep co-proxamol as black.
Decision/ACTION: Keep as **BLACK**.

5.5 Dosulepin
Included in the guidance due to having significant safety concerns. Currently blue for existing patients and black for new initiations on the formulary. It was suggested that the blue status for existing patients was removed. The Committee agreed with this and discussed how existing patients should be managed. It was confirmed that OptimiseRx would only present for new initiations. JA advised the Committee that SPFT are putting together a statement on the mental health drugs included in this guidance as there was a concern that existing patients would be referred to SPFT for a review. CO to forward the dosulepin PrescQIPP bulletin to JA (which was previously endorsed by SPFT DTC).
Decision/ACTION: Keep as **BLACK** for new initiations and remove the **BLUE** status for existing patients. **CO 11.10.19**

5.6 Doxazosin MR (updated)
Included in the guidance due to the drug being clinically effective but more cost-effective products are available. Currently black on the formulary for new initiations. It was agreed that doxazosin should be black for all prescribing.
Decision/ACTION: Remove '**new initiations**' from the **BLACK** status. **CO 11.10.19**

5.7 Dronedarone [NEW]
Included in the guidance due to having significant safety concerns. Currently blue on the formulary. Alison Warren's comments were considered. As the monitoring is more onerous than that of amiodarone, it was suggested that dronedarone was kept as blue but with an information sheet. The Committee agreed with this.
Decision/ACTION: Keep as **BLUE** and add an **information sheet**. **CO 11.10.19**

It was noted that C CCG and HMS CCG had decided to make amiodarone and dronedarone red (specialist only). The Committee questioned which acute provider they had engaged or consulted with to reach that decision. They also asked how such decisions were communicated to the local health system. It was noted that C and HMS CCG had not had a GP representative attend the Committee for nearly a year. SL to email AB with her concerns. **SL 11.10.19**

Post meeting note: The committee was made aware of the fact that only dronedarone is now red (specialist only) on C CCG and HMS CCG formulary.

5.8 IR Fentanyl (updated)
Included in the guidance due to the drug being clinically effective but more cost-effective products are available. Currently blue on the formulary for palliative care and black for non-palliative care indications. It was suggested to keep as blue for palliative care and black for non-palliative care indications.
Decision/ACTION: Keep as **BLUE** / **BLACK**.

5.9 Glucosamine and Chondroitin
Included in the guidance due to the lack of robust evidence of clinical effectiveness. Currently black on the formulary. It was suggested to keep as black.
Decision/ACTION: Keep as **BLACK**.

5.10 Herbal Treatments
Included in the guidance due to the lack of robust evidence of clinical effectiveness. Currently black on the formulary. It was suggested to keep as black.
Decision/ACTION: Keep as **BLACK**.

5.11 Homeopathy
Included in the guidance due to the lack of robust evidence of clinical effectiveness. Currently black on the formulary. It was suggested to keep as black.
Decision/ACTION: Keep as **BLACK**.

5.12 Lidocaine Plasters (updated)
Included in the guidance due to the lack of robust evidence of clinical effectiveness. Currently black on the formulary for new indications and red for post rib fracture in BSUH. It was suggested to keep the formulary statuses unchanged until consideration of the evidence and financial impact to CCGs was presented at a future APC. The Committee discussed the implementation of the NICE guidance CG173 and where in the pathway lidocaine plasters for post herpetic neuralgia would be. It was agreed that this would be worked on and information submitted to a future APC.
Decision/ACTION: Keep as **RED** / **BLACK** CO to speak to Kathryn Steele. **CO 11.10.19**

5.13 Liothyronine (including Armour Thyroid and combination products) (updated)
Included in the guidance due to the drug being clinically effective but more cost-effective products are available. Currently black on the formulary for thyroid replacement and red for myxedematous coma and thyroid cancer. It was suggested that the Committee wait until NICE publish their guidance in November before reviewing the formulary position (also considering RMOC guidance). It was noted that the local endocrinologists were supportive of that decision. It was fed back to the Committee that Surrey CCGs have coded liothyronine for hypothyroidism as blue (specialist initiated). It was also reported that SASH had received referrals for Brighton CCG patients. The Committee agreed to wait until NICE guidance had been published (expected November 2019).
Decision/ACTION: Keep as **RED** / **BLACK**.

5.14 Lutein and Antioxidants
Included in the guidance due to the lack of robust evidence of clinical effectiveness. Currently black on the formulary. It was suggested to keep as black.
Decision/ACTION: Keep as **BLACK**.

5.15 Minocycline [NEW]
Included in the guidance due to having significant safety concerns. Currently non-formulary. It was suggested to change to black.
Decision/ACTION: Change to **BLACK**.

CO 11.10.19

5.16 Needles for Pre-Filled and Reusable Insulin Pens (>£5 / 100) [NEW]
Included in the guidance due to the item being clinically effective but more cost-effective products are available. A range of suggestions were presented to the Committee. It was discussed if the formulary should include <£5 / 100 needles, <£4 / 100 needles or <£3 / 100 needles. The Committee considered the benefits and resource required for each option and concluded that <£3 / 100 needles should be added to the formulary. Implementation was discussed and it was agreed that the switch would need to be effectively managed by the MMT for existing patients (not via an OptimiseRx message for the first 12 months). It was also noted that the manufacturers should be contacted prior to implementation to ensure that they have adequate supplies to cope with the excess in demand. It was agreed that if any brands were to become <£3 / 100 needles post the meeting, then these would be added to the Joint Formulary.
Decision/ACTION: Remove current formulary preferred needles. Add <£3 / 100 needles to the formulary as **GREEN**. Add >£3 / 100 needles as **BLACK**.
SL will follow up with maternity.

CO 11.10.19
SL 11.10.19

5.17 Omega-3 Fatty Acid Compounds
Included in the guidance due to the lack of robust evidence of clinical effectiveness. Currently black for ADHD (children), behavioural problems, learning difficulties and blue for lipid clinic recommendation only or use in HIV only. The Committee discussed that guidance and agreed to keep the current formulary statuses.
Decision/ACTION: Keep as **BLUE** / **BLACK**.

5.18 Oxycodone and Naloxone combination product
Included in the guidance due to the drug being clinically effective but more cost-effective products are available. Currently black on the formulary for new initiations. The Committee discussed the guidance and implementation. It was noted that the combination product is licensed for restless leg syndrome. The

	Committee agreed to keep as black as new initiations however, it was agreed that the pharmacy technician SOP would include a step to check the indication for its use. **Decision/ACTION**: Keep as **BLACK** for new initiations.	
	5.19 Paracetamol and Tramadol combination product Included in the guidance due to the drug being clinically effective but more cost-effective products are available. Currently black on the formulary for new initiations. It was suggested that new initiations be removed from the status. The Committee agreed with this. **Decision/ACTION**: Remove '**new initiations**' from the **BLACK** status.	**CO 11.10.19**
	5.20 Perindopril Arginine Included in the guidance due to the drug being clinically effective but more cost-effective products are available. Currently black on the formulary for new initiations. It was suggested that new initiations be removed from the status. The Committee agreed with this. **Decision/ACTION**: Remove '**new initiations**' from the **BLACK** status.	**CO 11.10.19**
	5.21 Rubefacients (excluding topical NSAIDs) (update regarding capsaicin cream only) Included in the guidance due to the lack of robust evidence of clinical effectiveness. Currently rubefacients (excluding Algesal which is green) are black. Capsaicin 0.025% is black and the 0.075% is green / blue. It was suggested that the 0.025% be added to the formulary for osteoarthritis. The Committee agreed that current formulary statuses should be kept as they were however, capsaicin 0.025% should added to the formulary as green. The Committee questioned where in the treatment pathway capsaicin would be. **Decision/ACTION**: Keep rubefacients (excluding Algesal) as **BLACK**. Add capsaicin 0.025% as **GREEN** to the formulary. Establish where in the treatment pathway it would be.	**CO 11.10.19**
	5.22 Silk Garments [NEW] Included in the guidance due to the lack of robust evidence of clinical effectiveness. Currently black on the formulary. It was suggested to keep as black. It was noted that providers would need to be engaged with the implementation. Dermatology had been asked to comment however, no response was provided by BSUH. **Decision/ACTION**: Keep as **BLACK**.	
	5.23 Once Daily Tadalafil Included in the guidance due to the drug being clinically effective but more cost-effective products are available. Currently black on the formulary for new initiations. It was suggested that new initiations be removed. It was noted that local BSUH urology specialists were recommending once daily tadalafil as it appears as a treatment option on template letters. It was agreed to remove new initiations. **Decision/ACTION**: Remove '**new initiations**' from the **BLACK** status.	**CO 11.10.19**
	5.24 Travel Vaccines (vaccines administered exclusively for the purposes of travel) (wording updated) Included in the guidance due to the travel vaccines being considered of low priority. It was suggested to align the formulary with the wording in the guidance. The Committee agreed with this.	**CO 11.10.19**

Decision/ACTION: Keep as **BLACK** and align wording.

5.25 Trimipramine (updated)
Included in the guidance due to the drug being clinically effective but more cost-effective products are available. Currently black on the formulary for new initiations. It was suggested that new initiations be removed. The Committee discussed implementation. It was agreed that CO would forward the trimipramine PrescQIPP bulletin to JA (previously endorsed by SPFT DTC) and remove new initiations from the formulary status.
Decision/ACTION: Remove '**new initiations**' from the **BLACK** status.

CO 11.10.19

5.2 Type 2 diabetes guideline (update) – Presented by Dr Dan Jenkinson

DJ advised the Committee that these guidelines were initially developed in 2017 having been adapted from the Derbyshire guidelines.
DJ explained the main changes;

- removal of the reference to DESMOND as Diabetes Care For You (DCFY) now runs an in-house educational programme.
- with emerging evidence for the use of SGLT2i and GLP1 agonists in people with diabetes and CVD, it was requested to remove Key Point "…There is little evidence, for some adults, to guide management strategies on treatment combinations that do not include metformin (NICE NG28)…. ". This was agreed on the basis that the preceding key point "Metformin therapy is suitable for most adults with type 2 diabetes; its use is contraindicated or not tolerated in approximately 15% of individuals (NICE NG28). Metformin is the most cost effective of the initial therapy treatments" remained.
- flow chart had been amended to include the newly recommended threshold for BP (140/90) however, it was recognised that the QOF threshold is 140/80. The Committee asked that a footnote be added to highlight NICE vs QOF targets.
- Spironolactone promoted to be first choice as 4th line agent for BP when poorly controlled.

The Committee discussed the guideline and agreed that;

- BP targets table would be amended regarding retinopathy which no longer requires tight targets, whilst tighter BP targets remain for patients with microalbuminuria as per NICE Hypertension Guidelines August 2019 NG136
- Place of ramipril in treatment pathway would be reviewed in African-Caribbean following updated NICE guidance NG136 which recommends angiotensin II receptor blocker (ARB), in preference to an angiotensin-converting enzyme (ACE) inhibitor.
- Paragraph regarding Freestyle Libre would be updated to signpost to the NHSE funding criteria.

CO 11.10.19

It was noted that it would be useful to link the guidance to the clinical guidelines page on the CCG website.

Decision: Approved on the basis that the above amendments are actioned.
ACTION: Amend guidelines as above and forward to CO and RS.
Upload to website (with link in the clinical guidelines page)

5.3 SCFT Medicine Charts. Presented by Christine Holkham and Iben Altman

CH advised the Committee that these charts had been in use since 2011 and had been recently reviewed and updated to ensure consistency in format. New version had minor changes. SL had emailed SCFT requesting changes which were yet to be incorporated. CH advised that the original charts would be in circulation until the reviewed charts had been approved.
It was raised that there was a potential risk due to having separate prescriptions

	and administration record. This could potentially lead to transcribing errors. CH confirmed that no audit work around this had taken place however, there had been no reported problems over the past 8 years. CH advised the Committee that there was a move to make the prescriptions electronic and therefore the administration record could be printed off. SL questioned if in the meantime the risk could be mitigated by having a combined prescription and administration record. IA advised that this would be difficult as many different healthcare professionals use the administration record and GPs workload would increase with having to sign the prescription more frequently. Also, the community nurses have asked for this set up. The risk of transcribing onto the administration records was discussed by the Committee. IA advised that in 2011 the Brighton and Hove Medicines Optimisation Group (superseded by the APC) agreed the SCFT palliative care chart. The Martlets Hospice used different chart based on the Sussex Cancer Network chart. The Committee discussed the process once a patient had been discharged from hospital with an end of life prescription and how then those medicines were recorded onto an SCFT administration record. It was highlighted that the process was not clear. It was raised that there could be an opportunity to develop a palliative care chart that is used STP wide however it was recognised that this piece of work was larger than the APC. IA requested that the Committee agree that SCFT charts as otherwise the outdated 2011 charts were still in circulation, which delays them being implemented electronically. IA also noted that Coastal West Sussex APC had agreed the charts. MO summarised that there was a short-term need to implement the changes suggested in order for the 2011 charts to be updated and made electronic however there was a longer-term request to rationalise the charts in use by multiple providers across the STP. It was noted that the Committee did not have any comments on the SOPs. IA advised that CWS CCG were developing guidance for GP on anticipatory medicines. **Decision:** pending suggested updates **ACTION:** send updated documents to CO for uploading onto Kahootz. Members to approve updated documents. CO to pass on contact details for the CCG palliative care lead to SL and IA. Set up task and finish group for the collaborative palliative care chart including SCFT and the Martlets. CO to link in the CWS re anticipatory medicine guidance.	**IA/CH** **11.10.19** **CO** **11.10.19** **CO** **11.10.19**

Formulary Extension

6.1	**Hydventia – hydrocortisone tablets. Presented by Jade Tomes**	
	To be approved virtually on Kahootz. **ACTION:** members to confirm if they approve.	**ALL** **11.10.19**
6.2	**Wound care formulary – Prontosan and Kerlix AMD. Presented by Jade Tomes**	
	To be approved virtually on Kahootz. **ACTION:** members to confirm if they approve.	**ALL** **11.10.19**

Shared Care

7	**ADHD information sheet – resubmission. Presented by James Atkinson.**	
	JA advised that this information sheet had been presented to the Committee before and it now includes both children and adults, which was based on the Coastal West Sussex information sheet. JA also informed the Committee that the branded generic methylphenidate XL had been added, contact details had	

	been updated and the responsibilities of the specialist and primary care prescriber clarified. The Committee asked if point 9 in the specialist responsibility could be amended so that it is clearer what applies to adults and what applies to children. The Committee questioned if liver function tests were required with atomoxetine as previous information sheets had advised it was required. It was also noted that when lisdexamfetamine is used in adults, the licensed product should be prescribed and dispensed, therefore it was agreed that the brand Elvanse Adult would be referenced in the information sheet. JA also advised the Committee that NICE recently released guidance on baseline ECGs for those prescribed ADHD medications and the information sheet reinforces NICE. **Decision:** Approved on the basis that the above changes were made. **ACTION:** update the info sheet and upload to SPFT website	**JA 11.10.19**

Traffic Light Status Change

8	**Duloxetine BLUE to GREEN. Presented by David Russell.**	
	DR advised that duloxetine is currently blue on the Joint Formulary for depression however, it was requested that duloxetine was changed to green allowing GPs to initiate in primary care. DR noted that duloxetine is currently more cost effective than venlafaxine which is green on the formulary. Changing to green would align with the CHMS CCGs. SPFT have reviewed the application. The Committee were supportive of the application. **Decision:** Approved – GREEN – suitable for non-specialist initiation. **ACTION:** Change duloxetine from blue to green for depression	**CO 11.10.19**

New drug / indication formulary applications

9.1	**Paravit-CF. Presented by Christian Chadwick.**	
	CC advised the Committee that this item was a resubmission. The original paper was presented in May 2019. All the changes and additions had been highlighted on the resubmission. The comparisons with the current supplement regimes had been included along with more in-depth cost analysis. It was also noted that nearly half of all specialist centres were using the Paravit-CF as their vitamin regime of choice. It was confirmed that the recommendation was for Paravit-CF to be added to the Joint Formulary as blue (recommended by the paediatric CF team). The Committee questioned if the regime would be life-long and CC confirmed yes however, when the patient was of adult age, they would be under an adult service who may review their regime. The current local adult centre was Kings where they use DEKAs. This was currently more expensive and less tolerable (in RACH's experience). The Committee considered the APC decision-making criteria. All points were satisfactory however, it was noted that whilst this would be cost burden, it would improve patient outcomes, as they would have a simplified vitamin regime. **Decision:** Approved – BLUE – paediatric CF team recommendation only. **ACTION:** Add to the Joint Formulary as blue (paediatric CF team recommendation only).	**CO 11.10.19**
9.2	**Quinagolide. Presented by Dr Ali Chakera.**	
	AC summarised his item. He advised that quinagolide was used as part of routine practice. Cabergoline is used a first line. It was discovered recently due to a GP declining to prescribe that quinagolide was non-formulary, hence the submission. AC informed the Committee that quinagolide was not an expensive or novel drug / use and he felt that its omission was just an oversight when the Joint Formulary was developed. It was noted that the patient	

	numbers would be very small. AC has only prescribed quinagolide for approximately 2 patients in the past 3-4 years. The Committee questioned why bromocriptine was not used. AC advised that it used to be a treatment choice before cabergoline. It was acknowledged that it is cheaper than quinagolide however, the side effect profile was greater. The lower cost of quinagolide against cabergoline was noted. AC advised that they have more experience with using cabergoline however, the efficacy and side effect profile of both drugs are similar. AC informed the Committee that he would take that back to the endocrinology team for their thoughts. The Committee considered the decision-making criteria and was satisfied. The Committee questioned who would initiate and provide the first prescription. AC confirmed that a specialist would recommend that a starter pack be prescribed in primary care. The patient would be followed up by the specialist, response assessed and advice given to the prescriber. **Decision:** Approved – BLUE – specialist recommended **ACTION:** Add to the Joint Formulary as blue.	**CO 11.10.19**

Formulary review

10	**None**	

NICE TA Briefing

11	**None**	

NICE Guidance

12.1	**NICE Guidance published July 2019. Presented by Ciara O'Kane**	
	CG30: Long-acting reversible contraception. Update noted by the APC. CG113: Generalised anxiety disorder and panic disorder in adults: management. Update noted by the APC. CG173: Neuropathic pain in adults: pharmacological management in non-specialist settings. Update noted by the APC. CG186: Multiple sclerosis in adults: management. Update noted by the APC. DG36: Therapeutic monitoring of TNF-alpha inhibitors in rheumatoid arthritis. Noted by the APC. NG42: Motor neurone disease: assessment and management. Update noted by the APC. NG61: End of life care for infants, children and young people with life-limiting conditions: planning and management. Update noted by the APC. NG115: Chronic obstructive pulmonary disease in over 16s: diagnosis and management. Update noted by the APC. Application for inhaled triple therapy would be presented at a future APC. NG127: Suspected neurological conditions: recognition and referral. Update noted by the APC. QS14: Service user experience in adult mental health services. Update noted by the APC. QS15: Patient experience in adult NHS services. Update noted by the APC. QS35: Hypertension in pregnancy. Update noted by the APC. QS101: Learning disability: behaviour that challenges. Update noted by the APC. QS185: Hearing loss in adults. Noted by the APC. QS186: Lyme disease. Noted by the APC. Local anti-microbial guidelines had been updated by the CCG to include Lyme disease treatment. Guidelines are currently awaiting local antimicrobial expert comment (BSUH ASG) before being ratified at a future APC. MO confirmed that in the absence of an ASG at BSUH, the guidelines would be tabled at MGG. CO advised that she would	**CO**

	speak with the lead antimicrobial pharmacists at BH CCG to arrange attending the November MGG. QS187: Learning disability: care and support of people growing older. Noted by the APC.	**11.10.19**
	TA464: Bisphosphonates for treating osteoporosis. Update noted by the APC.	**CO 11.10.19**
	TA588: Nusinersen for treating spinal muscular atrophy. Commissioned by NHS England. Add as RED to the Joint Formulary.	**CO 11.10.19**
	TA589: Blinatumomab for treating acute lymphoblastic leukaemia in remission with minimal residual disease activity. Commissioned by NHS England. Add as RED to the Joint Formulary.	**CO 11.10.19**
	TA590: Fluocinolone acetonide intravitreal implant for treating recurrent non-infectious uveitis. Commissioned by NHS England. Add as RED to the Joint Formulary.	**CO 11.10.19**
	TA591: Letermovir for preventing cytomegalovirus disease after a stem cell transplant. Commissioned by NHS England. Add as RED to the Joint Formulary.	**CO 11.10.19**
12.2	**NICE Guidance published August 2019. Presented by Ciara O'Kane**	
	MTG43: PICO negative pressure wound dressings for closed surgical incisions. Update noted by the APC. Local Lead Tissue Viability Nurses had been made aware and they had highlighted to staff. NG25: Preterm labour and birth. Update noted by the APC. NG28: Type 2 diabetes in adults: management. Update noted by the APC. NG89: Venous thromboembolism in over 16s: reducing the risk of hospital-acquired deep vein thrombosis or pulmonary embolism. Update noted by the APC. NG135: Alcohol interventions in secondary and further education. Noted by the APC. NG136: Hypertension in adults: diagnosis and management. Noted by the APC. Alison Warren was contacted to confirm if the formulary and local guidelines were compliant. She has highlighted some actions in order for this to happen. The local hypertension guide and secondary care referral pathway are to be updated. Training would also be delivered to primary care and primary care networks. QS135: Preterm labour and birth. Noted by the APC. QS188: Coexisting severe mental illness and substance misuse. Noted by the APC.	
	TA592: Cemiplimab for treating metastatic or locally advanced cutaneous squamous cell carcinoma. Commissioned by NHS England. Add as RED to the Joint Formulary.	**CO 11.10.19**
	TA593: Ribociclib with fulvestrant for treating hormone receptor-positive, HER2-negative, advanced breast cancer. Commissioned by NHS England. Add as RED to the Joint Formulary.	**CO 11.10.19**
	TA594: Brentuximab vedotin for untreated advanced Hodgkin lymphoma (terminated appraisal). Not approved.	
	TA595: Dacomitinib for untreated EGFR mutation-positive non-small-cell lung cancer. Commissioned by NHS England. Add as RED to the Joint Formulary.	**CO 11.10.19**
	TA596: Risankizumab for treating moderate to severe plaque psoriasis. Commissioned by Clinical Commissioning Groups. Already added as RED to the Joint Formulary due to being a FastTrack TA. Blueteq forms were live.	
	TA597: Dapagliflozin with insulin for treating type 1 diabetes. Commissioned by Clinical Commissioning Groups. Already GREEN on the Joint Formulary, add link to NICE TA.	**CO 11.10.19**
	TA598: Olaparib for maintenance treatment of BRCA mutation-positive advanced ovarian, fallopian tube or peritoneal cancer after response to first-line platinum-based chemotherapy. Commissioned by NHS England. Add as RED to the Joint Formulary.	**CO 11.10.19**

APC admin

13.1	**Regional Medicines Optimisation Committee (RMOC) updates. Presented by Ciara O'Kane.**	

	RMOC newsletter issue 6 noted by the Committee.
	MO provided the Committee with an update from the RMOCs:
	• hydroxychloroquine retinopathy was raised. CO advised that the local information sheet was updated a few months ago to include details of ophthalmology reviews. SG was leading this work. CO to discuss linking in with MO regarding this.
	• RMOCs will reform into seven Committees to mirror regional footprints.
	• RMOCs do not have the capacity to manage Blueteq centrally, therefore, principles of good management and use had been developed.
	• EU exit – key messages are:
	  ○ business as usual, continue to report shortages
	  ○ advise the public and healthcare staff not to stock pile medicines locally
	  ○ be aware of the information on supply disruption
	SL advised that flu vaccinations had been delayed again that week.
		CO 11.10.19

15.2	**Provider update.**	
	BSUH. • MGG August 2019 minutes noted by the Committee.	

AOB

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	• CO advised the Committee that Modecate (fluphenazine depot injection) had been discontinued. All formularies across Sussex (apart from BH CCG) code Modecate as RED (specialist only) and SPFT provide and administer the depot. BH CCG have coded Modecate as BLUE (specialist initiated) due to the Serious Mental Illness Locally Commissioned Service (SMILES), which provides access to anti-psychotic depots in primary care.
	SPFT have publicised in a previous newsletter that a specialist import company in Germany (where it is licensed) can source supplies of Modecate. They advised that the price would be roughly the same as they currently pay for the Sanofi product. CO informed the Committee of two points.
	  ○ Product is unlicensed in the UK and therefore the prescriber and healthcare professional administering the depot have an increased level of clinical and legal risk and responsibility. The Committee discussed this point and questioned liability and indemnity.
	  ○ Not all community pharmacies would be able to order the product via the specialist import company as their ordering systems would default to their preferred wholesaler. CO had be informed that one wholesaler could obtain the imported product in a pack of five for £148.50 (Modecate was £22.55 for 10) however, this price was not fixed and could change from one month to the next.
	The Committee discussed the situation and there was a general consensus that the prescribing and administering of an imported, depot in primary care did not sit comfortably (regardless of the cost). It was clarified that practice nurses would be administering the injection, which raised questions over indemnity. JA informed the Committee of the potential options:
	  1. Patients to receive the imported depot in primary care under SMILES
	  2. Patients to receive the imported depot from SPFT
	  3. Patients to be reviewed by SPFT with the view to switch to an alternative licensed depot which can be provided under SMILES in primary care	

		It was highlighted that if patients were seen under SMILES, they were stable and being managed in the community. If they were to be reviewed and switched to an alternative, this could destabilise them. If patients were to be called back to SPFT for their depots, could this be seen as a backwards step for them. The Committee questioned the reliability of the supply chain. JA confirmed that SPFT have had assurance about the stability of the supply chain and have no concerns about the long-term availability of the product. JA advised that the cost quoted by the wholesaler to obtain the imported product was less than the cost of an atypical anti-psychotic depot. Therefore, if switched to a licensed depot, it could cost more and destabilise the patient. JA was asked if SPFT could post the injection to the patient (as they currently do with bio-melatonin). JA advised that he would explore this option. The Committee agreed that the potential cost impact alone should not be a reason for change and it would be prudent to engage with nurses who are delivering the SMILES and commissioning from a contractual point. It was agreed that CO would forward the list of practices where Modecate (and fluphenazine) depot is currently being prescribed to JA and arrange a task and finish group to look at the issue and report back to APC.	**CO 11.10.19**

Close

17	Date of next meeting	
	Tuesday 22nd October 2019. Room G79, Hove Town Hall, Norton Road, Hove, BN3 4AH.	