Brighton and Hove CCG
High Weald Lewes Havens CCG

Brighton Area Prescribing Committee

Minutes

Date: Tuesday 22nd November 2016 **Time:** 2-5pm

Location: Room G32, Hove Town Hall, Norton Road, Hove

Members:	
Paul McKenna (PMcK)	Senior Strategic Pharmacist, High Weald Lewes Havens (HWLH) and Brighton and Hove (BH) CCGs (Chair)
Paul Wilson (PW)	Head of Medicines Management, HWLH CCG (Deputy Chair)
Stephanie Butler (SB)	Principle Pharmacist, MSK, Sussex Community Foundation Trust (SCFT)
Lloyd Ungoed (LU)	Lay Member, BH CCG
Dr Michael Okorie (MO)	Associate Medical Director, Brighton and Sussex University Hospitals NHS Trust (BSUH) (part)
Katy Jackson (KJ)	Head of Prescribing and Medicines Commissioning, BH CCG
Penny Woodgate (PW)	Business Manager, East Sussex Local Pharmaceutical Committee
Dr Tim McMinn (TM)	Clinical Lead Prescribing, BH CCG
Rita Shah (RS)	Prescribing Advisor, BH CCG
Tim Sayers (TS)	Lay Member HWLH CCG
Clare Andrews (CA)	Prescribing Advisor, Crawley, Horsham and Mid Sussex CCGs (C, HMS CCGs)
Jed Hewitt (JH)	Chief Pharmacist (Governance) Sussex Partnership Foundation NHS Trust (SPFT)
Dr Riz Miakowski (RM)	Clinical Lead Prescribing, HMS CCG
Niall Ferguson (NF)	Chief Pharmacist, BSUH (part)
In Attendance:	
Jade Tomes (JT)	Specialist Pharmacy Technician, BH CCG (Secretary)
Scott Sweeney (SDS)	Lead Medicines Optimisation Technician, BH CCG
Julia Aram (JA)	Neurologist, BSUH (part)
Apologies:	
Judy Busby (JB)	Chief Pharmacist, Queen Victoria Hospital NHS Foundation Trust (QVH)
Dr Stewart Glaspole (SG)	Specialist Interface Pharmacist BH CCG
Iben Altman (IA)	Chief Pharmacist, SCFT
Ray Lyon (RL)	Chief Pharmacist (Strategy), SPFT
Sephora Shaw (SS)	Pharmaceutical Advisor, BHCCG

Item No	Item	Action
1	**Welcome and Apologies**	
	Chair welcomed the committee and introductions were made. Apologies received from JB, SG, SS and IA. SB deputising for IA.	
2	**Declarations of Interest**	
	As per register. RM noted that he had been provided lunch by numerous pharmaceutical companies including Merck and Flynn Pharma Ltd. No verbal declarations were made.	
3	**Urgent Any Other Business**	
	None	
4	**Previous Meeting and Actions**	
	• Supportive medicines in radiotherapy - on agenda • Costed model for the procurement of medicines via BSUH – SG not present. NF advised that he is awaiting information from SG which will outline potential medicines to be included in the model. • MSK SCG MMF – IA not present. SB advised the committee that the MMF SCG from BSUH is currently being used until the MSK SCG is approved. The SCGs will need to be updated with new BSR monitoring guidance when formally published and recirculated. The MMF SCG for MSK will be presented to the committee in January. • Gain advice from Charring Cross Gender Identity Clinic regarding switching ethinylestradiol to a cost effective alternative – RS advised that this action is ongoing. PMcK also advised that he had emailed a pediatrician at Western Sussex Hospitals NHS Trust with a specialist interest in gender identity but is yet to receive a reply. • Retiring of policy statements – JT advised that this action is still ongoing. • Respiratory guidance – Sephora Shaw (SS) was not present however it was noted that the COPD guidance is due to be presented at the January meeting. • Dressing packs – ongoing • Insulin degludec – it was noted that the results of the questionnaire are due to be presented at the January APC.	SG 20.12.16 SB 06.01.17 RS / PMcK 06.01.17 JT 02.12.16 SS 06.01.17 AS 13.01.17 NF 06.01.17

New drug / indication formulary applications

5.1	**Brivaracetam for use as adjunctive therapy in the treatment of partial-onset seizures with or without secondary generalization in adult and adolescent patients from 16 years of age with epilepsy – Presented by Dr Julia Aram**	
	JA gave a summary of the paper. JA advised that brivaracetam is the most recently licensed anti-seizure medicine and the reason why a request was being made to add to the formulary centered around the issue of unmet need. JA informed the committee that Sussex wide there have been 7 epilepsy related deaths so far this year. All 7 patients were aged between 20-40. Brivaracetam has a similar mechanism of action to levetiracetam. (*MO joined the committee at 2.15pm.*) Brivaracetam is hepatically metabolised and therefore would be a suitable option for patients with renal impairment. JA explained that cost wise brivaracetam is similar to the other 3rd line choice drugs (perampernal, zonisomide and lacosamide) and has a flat pricing structure. JA advised the committee of some instances where she has encountered	

	double dosing in patients on anti-epileptics with a flat pricing structure (i.e. perampernal). It was highlighted that if dosing was optimised then it would be more cost effective to the health economy. JA also discussed the use of generics but it was agreed that this is a separate discussion. JA informed the committee that there are currently 3 known patients who have exhausted all other formulary treatments and she believes that these patients would be suitable for brivaracetam treatment. Brivaracetem would be used as a last resort when other combinations of formulary adjunctive anti-epileptics have failed. The committee questioned where brivaracetam would sit in the pathway. JA advised that it would always be used adjunctively (never as monotherapy) and would be a third line treatment option. (*NF joined the committee at 2.25pm.*) Tolerability was discussed and JA advised that it is too early to know as there has only been a small study run by the company. There have been no head to head trials that compare brivaracetam with other anti-epileptic drugs. Patients with a good response to levetiracetam but experience side effects may respond well to brivacetam. JA explained that if approved, brivaracetam is recommended to be coded as Blue (specialist initiated). Prescribing would remain with the specialist for at least 3 months before handing over prescribing responsibility to primary care. (*JA left the committee at 2.35pm.*) The committee discussed the submission. PW commented that the AWMSG had approved brivaracetam. The committee concluded that brivaracetam should only be considered as an adjunctive treatment when other combinations of formulary adjunctive anti-epileptic drugs (first and second line) have failed. The committee were concerned that there could be slippage and it was felt that reassurance was needed as to what steps would be taken before initiation. **DECISION: Approved – BLUE – specialist recommendation only** (subject to gaining clarity on the treatment pathway before brivaracetam is initiated.) Brivaracetam to be added to the JF once clarity is gained. ***Post Meeting Note:*** *Brivaracetam may be considered for refractory patients in whom first line and adjunctive AED options as outlined in NICE CG 137: appendix E: Pharmalogical treatments have failed. Therefore the committee members agreed that it can be used as an option in the third column titled 'Other AEDs that may be considered on referral to tertiary care' and for initiation by specialist epileptologists only.*	PMcK 29.11.16 JT 09.11.16
5.2	**Caphosol for the prevention and treatment of oral mucositis following radiotherapy in head and neck cancer patients – Presented by Niall Ferguson**	
	NF gave a summary of the paper. It was stressed that saliva substitute products are not adequate to treat the symptoms of oral mucositis.	

	The committee noted that Portsmouth have listed Caphosol on their formulary. The addition of Caphosol on the Joint Formulary could result in a reduction of associated analgesia prescribing and hospital admissions. NF explained that this would be used short term (4-8 weeks) in a defined cohort of patients (approximately 10 per annum). The committee questioned the recommended colour status of green and discussed whether coding as blue (specialist recommended) would be more appropriate. It was agreed that coding as blue would reduce the risk of Caphosol being inappropriately prescribed for mild mouth conditions. The committee stressed that Caphosol should not be added to patients' repeats and should only be prescribed acutely. The committee agreed to approve as blue (specialist recommended) and felt that an information sheet would be of benefit. NF agreed and will provide the committee with an information sheet for approval at the January meeting.	NF 06.01.17
5.3	**Metformin for the management of weight gain in antipsychotic drug treatment – Presented by Jed Hewitt**	
	JH gave a summary of the paper. The committee questioned the need for the (metformin) submission with its current recommendation of metformin as a weight loss drug in patients gaining weight whilst on antipsychotics. It was suggested that a better approach might be to appropriately signpost primary care clinicians to the NICE Public Health Guidance 38 - Type 2 diabetes: prevention in people at high risk June 2012, referenced in the submission. This guidance allows for recommending metformin in those patients progressing towards type 2 diabetes despite best efforts of intensive life-style change programme …or if unable to participate in such programmes. It was also agreed that more work had to be done outside of the committee to link with community diabetes services and with the pharmacy team at SPfT and CCGs to ensure that: • the pre-diabetic benefits of metformin can be incorporated in a pathway that will benefit a wider cohort of patients in addition to those experiencing weight gain while taking antipsychotic medication • Share information and best practice around lifestyle change programmes tailored for this cohort of patients It was agreed that PMcK will link in the community diabetes team and other stakeholders and bring back outcomes to the February APC.	PMcK 17.02.17
5.4	**Diazoxide – Presented by Bhumik Patel (BP)**	
	PMcK advised that BP had given his apologies earlier in the day. PMcK summarised the submission and explained that currently there are no alternatives listed on the Joint Formulary. It had been suggested to add diazoxide as blue and an information sheet had been submitted. The committee discussed the information sheet and highlighted that under the consultant responsibility it notes changes to dosing. Whilst under the primary care prescriber responsibilities it notes for only the prescription to be issued. The committee questioned what the current practice at the Evelina was and if CCGs were the responsible commissioner. It was agreed to postpone the submission as it was felt that BP should be present to answer the committee's questions.	

Changes to traffic light status

6	Chlorothiazide RED to BLUE – Presented by Bhumik Patel	
	As the diazoxide submission was deferred, the committee agreed that this submission should also be deferred.	

Policies and Guidelines

7	Circadin Patient Information Leaflet – Presented by Paul McKenna	
	PMcK advised the committee that this patient information leaflet (PIL) has been produced by Surrey Heath CCG and approved by the Surrey CCGs. BH CCG wish to adopt this PIL and have forwarded the leaflet to BSUH, SCFT and SPFT for their comments. SB advised the committee of IA comments. It was suggested that there should be a statement included along the lines of: "*Please ask any member of the team caring for you if you need this information in large print, braille, easy read, audio tape, email. Or if you need help with understanding this information or require this in a language that is not English."* It was questioned whether parents / carers had been consulted prior to the leaflet being shared more widely. It was also raised that some patients were told to crush Melatonin 2mg m/r tablets to avoid the modified release effect. It was noted that this practice should also be highlighted in the leaflet. JH noted that there were inconsistencies throughout the document with regards to the description of the product's formulation. It was also noted that there was no acknowledgement in the leaflet of the resources produced by the SPFT aimed at teaching patients with swallowing difficulties techniques to swallow tablets. The committee advised that they were aware of the leaflets produced by SPFT. PMcK advised the committee of comments from RL sent prior to the meeting. RL thought that the leaflet gave contradictory advice and could be clearer. RM noted that there was no mention of off-label use of a licensed medicine. CA advised that a leaflet with this message would be welcomed as the prescribing of melatonin specials is a known problem. It was agreed that JT and PMcK would adapt the leaflet, considering the committee's comments and bring back to the January meeting.	JT / PMcK 06.01.17

Formulary Extensions

8	None	

Shared Care

9	None	

NICE TA Briefing

10	None	

Formulary Review

11	Continence Formulary and Associated Proformas – Presented by Jade Tomes	
	JT advised that post the previous unsuccessful submission, a meeting with the Lead Bladder and Bowel Nurse for Brighton had taken place. The traffic light status of most products listed had changed from green to blue (specialist recommendation/initiation only). 3 proformas were also presented and JT advised that these had been trialed by the B&B team and amended following feedback. The committee approved the formulary and the associated proformas. The continence formulary will be uploaded to the website and promoted in the next newsletter. **DECISION:** Approved for local use.	JT 09.12.16

NICE guidance and TAs

12	Published October 2016 – Presented by Paul McKenna	
	CG155: Psychosis and schizophrenia in children and young people: recognition and management – noted by the committee. CG98: Jaundice in newborn babies under 28 days – noted by the committee. TA413: Elbasvir–grazoprevir for treating chronic hepatitis C - commissioned by NHSE. Add to the joint formulary as **RED** TA414: Cobimetinib in combination with vemurafenib for treating unresectable or metastatic BRAF V600 mutation-positive melanoma (not recommended) – commissioned by NHSE. Add to the joint formulary as **BLACK** TA415: Certolizumab pegol for treating rheumatoid arthritis after inadequate response to a TNF-alpha inhibitor – commissioned by CCGs. Add to the joint formulary as **RED** TA416: Osimertinib for treating locally advanced or metastatic EGFR T790M mutation-positive non-small-cell lung cancer – commissioned by NHSE. Add to the joint formulary as **RED** QS134: Coeliac disease – noted by the committee. QS135: Preterm labour and birth – noted by the committee. QS133: Children's attachment – noted by the committee. ESNM78: Pre-exposure prophylaxis of HIV in adults at high risk: Truvada (emtricitabine/tenofovir disoproxil) – noted by the committee.	JT 09.12.16 JT 09.12.16 JT 09.12.16 JT 09.12.16

APC Admin

13	Decision Making Criteria – Presented by Paul McKenna	
	PMcK advised the committee that the Decision Making Criteria had been added to the APC submission pack. Authors will now be made aware of the Decision Making Criteria and will have this in mind when authoring any submission. The new submission pack is available online via the APC webpage on the BHCCG website.	

Any other business

14.1	**Trevicta Outcomes Payment Scheme – Presented by Jed Hewitt**	
	The APC was presented with the Trevicta Outcomes Payments Scheme. PMcK advised that it was being presented in the interest of transparency. The formulary submission for Trevicta was presented to the APC in September 2016. It was approved for use as Red (specialist only) in HWLH CCG and Blue (specialist initiation) in BH CCG due to the SMI LES. The committee discussed the scheme and agreed that the coding should be changed to Red for BH CCG until further information is presented to the committee.	
14.2	**NICE TAs and Blueteq – Presented by Paul McKenna**	
	PMcK advised that the governance surrounding Blueteq forms would be strengthened in the new year. KJ informed the committee that a sub-group would be set up.	

Close

15	**Date of next meeting**	
	Tuesday 24th January 2017. Room G90, Hove Town Hall, Norton Road, Hove, BN3 4AH (No meeting in December 2016.)	