Brighton and Hove
High Weald Lewes Havens
Clinical Commissioning Groups

Brighton Area Prescribing Committee

Minutes

Date: Tuesday 23rd May 2017 **Time:** 2-5pm
Location: Room 181, Hove Town Hall, Norton Road, Hove

Members:	
Paul Wilson (PW)	Head of Medicines Management, HWLH CCG (Chair)
Katy Jackson (KJ)	Chief Pharmacist, Brighton and Hove CCG (Deputy Chair)
Dr Stewart Glaspole (SG)	Specialist Interface Pharmacist, BH CCG
Penny Woodgate (PWo)	Business Support Manager, East Sussex Local Pharmaceutical Committee
Clare Mace (CM)	Pharmaceutical Advisor, Crawley, Horsham and Mid Sussex (C,HMS) CCGs left at 3.20
Judy Busby (JB)	Chief Pharmacist, Queen Victoria Hospital NHS Foundation Trust (QVH) *joined at 2.20*
Tim Sayers (TS)	Lay Member, HWLH CCG
Dr Irma Murjikneli (IM)	Clinical Lead Prescribing, HWLH CCG
Dr Tim McMinn (TM)	Clinical Lead in Urgent Care and Medicines Management, BH CCG *joined at 2.30*
Ray Lyon (RL)	Chief Pharmacist - Strategy, Sussex Partnership NHS Foundation Trust (SPFT) *joined at 2.20*
Iben Altman (IA)	Chief Pharmacist, SCFT *joined at 2.20*
Niall Ferguson (NF)	Chief Pharmacist, Brighton and Sussex University Hospitals NHS Trust (BSUH) *joined at 2.20*
Dr Michael Okorie (MO)	Consultant Physician and Associate Medical Director for Medicines Safety & Prescribing, BSUH
In Attendance:	
Jade Tomes (JT)	Specialist Pharmacy Technician and APC Secretary, BH CCG
Dr Susannah George (SGe)	Consultant Dermatologist, BSUH
Susan Finall (SF)	Prescribing Support Technician, BH CCG
Natalia Guerrero (NG)	Prescribing Support Technician, BH CCG
Asha Mistry	Pre-registration Pharmacist, BSUH
Kerry Stenning	Pre-registration Pharmacist, BSUH
Apologies:	
Paul McKenna (PMcK)	Senior Strategic Pharmacist, High Weald Lewes Havens (HWLH) CCG
Lloyd Ungoed (LU)	Lay Member, BH CCG
Rita Shah (RS)	Prescribing Advisor, BH CCG
Dr Riz Miakowski (RM)	Clinical Lead Prescribing, HMS CCG
Jay Voralia (JV)	Head of Medicines Management, CHMS CCG

Better health for our city

Item No	Item	Action
1	**Welcome**	
	PW welcomed the committee. Introductions were made. Apologies received from LU, PMcK, RS, RM and JV	
2	**Declarations of Interest**	
	As per the register. No verbal declarations were made.	
3	**Urgent AOB**	
	None.	

Previous meeting and actions

4	**April 2016**	
	• Gender identity – PMcK to share information received from the gender identity clinic with specialised commissioning for them to disseminate wider – outstanding • Insulin degludec results of questionnaires back to the committee – NF advised that the diabetologists that work for BSUH don't see patients any more as the service has changed to SCFT. It was agreed that PMcK will follow up with Paul Grant, clinical lead for diabetes at DCFY and IA. • Caphosol – awaiting information from the clinical lead regarding the treatment pathway. • Anti-dementia info sheet – IM had commented on Kahootz. *"I have looked into dementia memory tests, as we were not sure at the last meeting which test to recommend, so:* *These are memory tests recommended by NICE:* • *Mini Mental State Examination (MMSE)* • *6-Item Cognitive Impairment Test (6-CIT)* • *General Practitioner Assessment of Cognition (GPCOG)* • *7-Minute Screen.* **DECISION:** Information sheet approved (as no change required) **Action:** Upload to website • LABA/LAMA pathway and inhaler crib sheet action – ongoing • Prontosan audit – awaiting info from Valerie Dowley - ongoing • Community pharmacy/wholesaler issues – PWo outlined the national guidance which is best practice. It was agreed that the LPC would be contacted as and when issues arise.	**PMcK 27.6.17** **PMcK 7.6.17** **NF 7.6.17** **JT 9.6.17** **CLOSED**

Formulary Extensions

5.1	**Betacap Scalp Application – presented by Paul Wilson**	
	PW gave a brief summary of the application. He advised that Betacap scalp application is an alternative to Betnovate scalp application. The cost of 100ml of Betnovate Scalp is £4.99 and Betacap scalp application is £3.19 for 100ml. This may result in an annual saving of £21.60 per patient. **DECISION:** Approved for non-specialist initiation. To be added to the Brighton Joint Formulary as **GREEN** (reference to Betnovate removed)	**JT 9.6.17**

5.2 Soltel CFC Free MDI – presented by Paul Wilson

PW gave a brief summary of the application. He advised that historically salmeterol has only been available as Serevent brand but now this is available generically as Soltel.
GSK have been contacted and they advise that the price of Serevent price will not be reduced in near future.
Switching to Soltel would result in a cost savings of £9.31 per inhaler. (Annual saving of £111.21 per patient.)

DECISION: Approved for non-specialist initiation.

To be added to the Brighton Joint Formulary as **GREEN** (reference to Serevent MDI removed) — **JT 9.6.17**

5.3 Bupeaze Transdermal Patches – presented by Paul Wilson

PW gave a brief overview of the application. He advised that Bupeaze is a generic 96 hour patch buprenorphine patch (alternative to Transtec).
It was noted that this would be for primary care only as the hospital have Transtec on contract.
On average switching to Bupeaze would save £78 per patient per annum.
Bupeaze patches are bioequivalent to Transtec.
The committee discussed that some patients may be sensitive to the adhesive. It was agreed that having a choice of products would be beneficial as this would give the patient options.
It was noted that patients need to be informed to remove the existing patch before using a new patch.

The committee questioned who is notified of formulary changes. PW confirmed that the Joint Formulary will be amended, the primary care prescribing decision support tool (OptimiseRx) will be amended to reflect the change and an update will be published in prescribing newsletters which are sent to primary care and other local pharmacy colleagues. It was noted that many of these changes will be implemented pro-actively through the prescribing support technician medicines optimisation programme.
It was noted that there are improvements to be made with how Joint Formulary changes are communicated to staff at BSUH. Especially those who deal with the transfer of care and discharge summaries as the JF is not integrated into the prescribing systems.
The LPC confirmed that the communication to Community Pharmacy from the Medicines Management Team is very good. The MMT had previously presented at an LPC evening and informed about the JF and the medicines optimisation work they carry out.

DECISION: Approved for non-specialist initiation.

To be added to the Brighton Joint Formulary as **GREEN** (reference to Transtec removed) — **JT 9.6.17**

5.4 Shortec liquid, concentrate oral solution, solution for injection or infusion – presented by Jade Tomes

JT gave a brief summary of the paper. Shortec is the only branded generic available with the full OxyNorm range of formulation and doses with identical benefits, formulation, dosing, appearance, manufacturing and supply chain.
Shortec capsules are already on the formulary. Adding Shortec liquid, concentrate and solution for injection or infusion would mean the whole range is available.

	Cost savings per pack range from £1.43 - £6.99 for the liquid and £1.20 - £10.51 for the solution for injection or infusion. **DECISION:** Approved for specialist initiation or recommendation. To be added to the Brighton Joint Formulary as **BLUE**	**JT 9.6.17**
5.5	**Tamoxifen, Raloxifen and Anastrazole; compliance with NICE CG164 – presented by Dr Stewart Glaspole**	
	SG gave a summary of the background to the submission. He advised that the NICE CG164 (Familial breast cancer: classification, care and managing breast cancer and related risks in people with a family history of breast cancer) had been updated in March 2017 to include chemoprevention for women with no personal history of breast cancer. The drugs included in the CG are already listed in the Joint Formulary. Approval of this submission would mean that the drugs would be available to use as per CG164 for chemoprevention. The CG advises: 1.7.20 Healthcare professional within secondary care or specialist genetic clinics should discuss the absolute benefits and risks of options for chemoprevention with woman at high or moderate risk of breast cancer. Therefore, it is recommended that these drugs are coded blue for this use. **DECISION:** Approved. To be added to the Brighton Joint Formulary as **BLUE**	**JT 9.6.17**

Formulary review

6.1	**Chapter 14 – Immunological Products and Vaccines – presented by Paul Wilson**	
	No changes to be made. **DECISION:** Approved. Reviewed date to be added to the front page and upload to website.	**JT 9.6.17**
6.2	**Appendix 1 – Borderline Substances – presented by Paul Wilson**	
	It was discussed that some borderline substances are also listed in Chapter 9 and 13. It was agreed to add a link to these chapters for completeness. **DECISION:** Approved Links to be added to Chapter 9 and 13. Reviewed date to be added to front page and upload to website.	**JT 9.6.17**

Policies and Guidelines

7	**NONE**	

Change to traffic light status

8	**NONE**	

NICE TA briefing

9	**NONE**	

NICE Guidance and TA

10	April 2017 – presented by Paul Wilson	
	CG61: Irritable bowel syndrome in adults: diagnosis and management – update noted by the APC.	
	CG100: Alcohol-use disorders: diagnosis and management of physical complications – update noted by the APC.	
	CG158: Antisocial behaviour and conduct disorders in children and young people: recognition and management – update noted by the APC.	
	NG68: Sexually transmitted infections: condom distribution schemes – noted by the APC.	
	QS149: Osteoporosis – noted by the APC.	
	TA440: Pegylated liposomal irinotecan for treating pancreatic cancer after gemcitabine – not recommended – add to **Blacklist**	**JT 9.6.17**
	TA441: Daclizumab for treating relapsing–remitting multiple sclerosis – NHS England Commissioned – add to Joint Formulary as **RED**	**JT 9.6.17**
	TA442: Ixekizumab for treating moderate to severe plaque psoriasis – CCG Commissioned – add to Joint Formulary as **RED**	**JT 9.6.17**
	TA443: Obeticholic acid for treating primary biliary cholangitis - NHS England Commissioned – add to Joint Formulary as **RED**	**JT 9.6.17**
	The committee discussed the processes around managing new and updated NICE Clinical Guidelines. The committee questioned if this would be something the RMOCs could take on but acknowledged that this would not be immediately. In the interim it was agreed that the work would be added to the APC work plan and shared out between members.	
	The committee noted that NICE are implementing a fast track system for TAs which must be implemented within 30 days. The mechanism for how this will be dealt with will be discussed outside of the meeting.	**JT / PMcK 27.6.17**

APC Admin

11	Members 6 monthly declarations on interest due – presented by Jade Tomes	
	JT advised members that their 6 monthly declarations of interests are now due. Notifications will be sent via Kahootz. The actions for members are to either inform JT that there has been no change since the last DOI or complete a new form with updated information.	**ALL**

Shared Care

12.1	Diazoxide 250mg in 5ml suspension information sheet – Presented by Paul Wilson	
	The committee discussed the information sheet. Traffic light coding had already been agreed as blue but the Joint Formulary had not been updated as the committee were awaiting the submission of an information sheet.	
	DECISION: Approved	
	Information sheet to be added to website and Diazoxide to be added as **BLUE** to in JF (with link to info sheet included).	**JT 9.6.17**

12.2	**Chlorothiazide 250mg in 5 ml suspension information sheet – Presented by Paul Wilson**	
	The committee discussed the information sheet. Traffic light coding had already been agreed as blue but the Joint Formulary had not been updated as the committee were awaiting the submission of an information sheet. **DECISION:** Approved Information sheet to be added to website and Chlorothiazide to be added as **BLUE** to in JF (with link to info sheet included).	**JT 9.6.17**
12.3	**Testosterone Enantate 250mg/ml oily injection information sheet – presented by Stewart Glaspole**	
	SG advised of the background to the submission of the information sheet. Testosterone enantate injection is currently red on the Joint Formulary however GPs can administer this under the Locally Commissioned Service (LCS). As testosterone enantate is not licensed for use in children, it was felt some assurance was needed for primary care prescribers before they took on the responsibility of prescribing. Additionally, this is a request to dual code Testosterone Enantate as Blue (in line with the information sheet) and Red for any other indication. Monitoring was discussed and it was confirmed that no drug monitoring is required only evaluating the response to the treatment which the specialist will do. The primary care prescriber responsibility was discussed and it was highlighted that administration wasn't noted. It was agreed that administration should be noted and made clear whose responsibility this is (prescribers or parent/carer). **DECISION:** Approved on the basis that the primary care prescriber responsibility is amended as above. Feedback to Bhumik Patel the committee's outcome.	**JT 9.6.17**
12.4	**Sustanon 250mg/ml solution for injection information sheet – presented by Stewart Glaspole**	
	The committee came to the same conclusion as the previous item. **DECISION:** Approved on the basis that the primary care prescriber responsibility is amended as above. Feedback to Bhumik Patel the committee's outcome.	**JT 9.6.17**

New drug / indication formulary applications

13	**Soolantra / Ivermectin 1% Cream – Presented by Dr Susannah George**	
	Dr Susannah George gave an overview of the submission. She advised that Soolantra is a topical form of invermectin which is used to treat inflammatory lesions of rosacea (papulopustular) in adult patients. It is a once daily application which can be used for up to 4 months. Alternative treatments are topical metronidazole and azelaic acid. Patients have usually trialed these treatments before being referred to secondary care. Secondary care then usually prescribes a course of oral antibiotics (tetracycline or erythromycin). There is a general concern that antibiotics are used too frequently in dermatology which increases resistance therefore, non-antibiotic options should a used first. Evidence from trials suggests that it is more efficacious than topical metronidazole which Dr George backs up from her experience in clinic. The committee discussed the application and confirmed that it would be used first	

	line over topical metronidazole and oral antibiotics. It was suggested that if coded as Green on the Joint Formulary then this would allow primary care prescribers to initiate and may lead to a reduction in referrals to dermatology. The committee discussed the treatment length and it was agreed that improvement should be seen within 3 months. If patients have not experienced any improvement then not to prescribe any further supplies. Relapse rate was discussed and it was recognised that papulopustular rosacea it is a chronic condition and a further course of treatment may be required in the future. The committee agreed that the primary care prescriber should prescribe two tubes as a course for 12 weeks and to advise the patient to return if not effective. All three treatment options should be trialed before referral to secondary care. Prescribers can also refer to secondary care if there is diagnostic doubt. **DECISION:** Approved for non-specialist initiation. To be added to the Brighton Joint Formulary as **GREEN** for papulopustular rosacea. 1st line choice (equal to azelaic acid) ahead of antibiotic options. Additional prescribing information regarding quantity and treatment length to be added.	**JT 9.6.17**

AOB

14	NONE

Close

15	Date of next meeting
	Tuesday 27th June 2017. **Room 181, Hove Town Hall, Norton Road, Hove, BN3 4AH**