NHS
Somerset
Clinical Commissioning Group

Minutes of the **Somerset Prescribing Forum** held in **Meeting Room 1, Wynford House, Lufton Way, Yeovil, Somerset** on **Wednesday 14 May 2014**

Present:	Dr Clare Barlow	Chair, Drug & Therapeutics Committee, Taunton & Somerset NHS Foundation Trust	CB
	Jon Beard	Chief Pharmacist, Taunton & Somerset NHS Foundation Trust	JB
	Lynda Coles	Vice Chair, Local Pharmaceutical Committee	LC
	Steve Du Bois	Senior Pharmacist Somerset Partnership NHS Foundation Trust	SD
	Dr Steve Edgar	GP, Somerset Local Medical Committee representative	SE
	Shaun Green	Associate Director, Head of Medicines Management, NHS Somerset CCG	SG
	Catherine Henley	Medicines Manager, NHS Somerset CCG	CH
	Helen Kennedy	Prescribing Support Technician, NHS Somerset CCG	HK
	Dr Sally Knights	Chair, Drug & Therapeutics Committee, Yeovil District Hospital	SK
	Ann Lee	St Margaret's Hospice	AL
	Jean Perry	Commissioning Manager, NHS Somerset CCG	JP
	Stephanie Wadham	Medicines Information / Formulary Senior Pharmacist, Yeovil NHS Foundation Trust	SW
	Dr Geoff Sharp (Chair)	GP Delegate (Central Mendip Federation)	GS
Apologies:	Andrew Brown	Head of Medicines Management, Somerset Partnership NHS Foundation Trust	AB
	Dr Andrew Dayani	Medicines Director, Somerset Partnership NHS Foundation Trust	AD
	Dr Joanna Dunn	Consultant in Palliative Care Medicine, St. Margaret's Somerset Hospice	JD
	Gordon Jackson	Patient Representative	GJ

1. WELCOME

1.1 Geoff Sharp welcomed everyone to the meeting and apologies were noted as above. It was noted that:

- Dr Rosie Benneyworth, Dr Iain Phillips and John Martin have now resigned from the SPF.
- Ulrike Harrower no longer works for Somerset County Council
- Orla Dunn is away on maternity leave

2. APOLOGIES

2.1 Apologies were provided as detailed above

3. DECLARATIONS of INTEREST

3.1 No new interests were declared- it was noted that the DoIs have been amended slightly due to an error under the entry for Lynda Coles.

4. MINUTES OF THE MEETING HELD ON 12 March 2014

4.1 The Minutes of the meeting were agreed as an accurate record.

4.2 GS ran through the schedule of actions from the 12th March 14 meeting and the following items were noted

1. **NICE PH45** - **Tobacco Harm Reduction**
   SG stated that the importance of offering NRT to patients with severe mental illness should be highlighted in the formulary. Otherwise, this action can be closed off. This has not yet been done- CH to follow up with Steve Moore.

   Action CH

2. **TST Thromboprophylaxis in elderly patients NICE guidance on secondary prevention of MI-** TST has been asked to ensure that risks and benefits of anticoagulation be discussed and documented prior to discharge into primary care.

   JB updated the group that he had emailed Dr Solanki to invite him to discuss how this might be reliably achieved with Mark Ashley (MPH pharmacy anticoagulant expert) with no response yet. JB will update the group once Dr Solanki and Mark Ashley have met.

   Action JB

3. **TST outsourcing of services for home delivery**- **TST to update SG on progress**

   JB updated the group that due to the current national problems caused by one provider of homecare withdrawing from the market, all expansion of homecare is on hold. He reported that that he was not aware of any instances of 'no supply' but there have been late deliveries. The trust is now considering the set- up of a privately owned subsidiary homecare company to make local homecare arrangements more reliable. This is likely to be a medium term project if it is pursued.

4. **Linaclotide for IBS- TST to consider whether this is to go onto their formulary**

JB reported that linaclotide was approved at TST DTC ON 9TH May for prescribing (as a RED for TLS hospital only drug) by the gastroenterologists on a 'named patient' basis' whilst defining which patients will benefit.

It was agreed that the linaclotide should be changed to RED status in the Somerset CCG formulary Traffic Light Scheme (TLS) to match the status at YDH and TST.

Action: Steve Moore

5. **Certolizumab for Psoriatic Arthritis (PsA)**

CH reported that certolizumab is now in the TLS as a RED 'hospital only drug' but no indications have been specified. The group agreed that indications need to be added. CH to speak to Steve Moore.

Action CH

6. **YDH switch back to aspirin from dabigatran post hip and knee replacement. YDH to provide evidence to support this.**

SW updated the group that whilst the orthopaedic surgeons at YDH have mentioned that they may think about reverting to aspirin post THR and TKR, there has been no formal application yet. SW will update the group if this changes.

7. **Neutropenic Sepsis card**

Jon Beard reported that the neuropenic sepsis card is at the printers and that full scale testing and implementation will begin on their receipt starting with haematology. SG asked for the results from this trial to be audited and JB agreed to bring the audit results back SPF.

Action JB

8. **Non-PbR drugs data collection Spreadsheet** – Spreadsheet updated and redesigned but no data supplied by TST yet. It was agreed to discuss this under point 11.1 under the agenda

5. MATTERS ARISING (no otherwise on the agenda)

5.1 Azathioprine Shared Care Guideline (SCG) for the treatment of Ulcerative Colitis and Crohn's Disease

SK expressed some concern that this SCG doesn't match the rheumatology protocol. However, she accepted that until the professional bodies align what they are trying to monitor, it will be difficult to get SCGs that match**.**

It was reported that the gastroenterologists TST have reviewed the SCG. TST DTC approved on 9th May 14. SPF agreed to approve the revised SCG. CH to ensure that the new SCG is put onto the relevant section of the website.

Action CH

SG stated that he has requested a review of the DMARD enhanced service to ensure that the specification matches the monitoring parameters set out in the SCG. SG to update group on progress at next meeting. **Action SG**

5.2 Modafanil Shared Care Guideline (SCG) for the treatment of narcolepsy

SG reported that the existing SCG was out of date and has been reviewed in consultation with the neurologists at TST. TST DTC approved on 9th May 14. SPF agreed to approve the revised SCG.

Action CH

6. D&TC DECISIONS

GS commented that perhaps other Trusts would like to see the minutes of SPF in the same way that SPF requests them from RuH etc. GS/ JP to investigate.

Action GS/JP

6.1 PAMM DECISIONS

SG reported that PAMM had reviewed the following products:

Vesomni® (solifenacin and tamsulosin tablets) – positive SMC decision but agreed 'non-formulary' at PAMM on 9th April. SPF agreed should be non-formulary.

Xailin® preservative free eye preparations added to formulary at PAMM on 9th April. SPF noted.

6.2 Somerset Partnership MICP

CH gave a verbal report of the most recent March meeting:

- Sompar have reviewed the following NICE guidance in relation to their services.
  - CG179 Pressure Ulcer Management
  - MTG17 Debrisoft pad
  - PH51 Contraceptive services

- The group looked at the evidence around a new antipsychotic- Lurasidone which may have benefits in causing fewer metabolic side effects than other antipsychotics. This won't be launched in the UK until August so the group agreed to wait until then before deciding on formulary status.

- SomPar have agreed to disband their Medicines Management Group because its work is being duplicated in other places, including MICP. The MICP group will be renamed the Drugs and Therapeutics Committee to reflect the absorption of some of the roles of the Medicines Management Group.

- SomPar have devised a form to record the physical monitoring of patients taking antipsychotics. The details of how this information will be sent to GPs are still being worked out. Paper copies had been shared with PAMM. SG asked that the proposed monitoring form along with the SomPar NICE CG 178 compliance assessment be shared with SPF Members

Action CH

- CH had asked MICP when the planned review of the antipsychotic Shared Care Guideline (SCG) would take place. Rosemary Brook has responded that once the monitoring form is implemented, then the SCG will be reviewed. This is likely to be 3 -6 months from now.

- CH reported that Sally Irving (Acting Tissue Viability Manager) raised the issue that they are getting a rising number of requests from hospitals including TST and RD&E for 'Pico' negative pressure dressings for wounds that, in her opinion don't necessarily need these dressings. The tissue viability service does not hold funds to supply these dressings and, in some cases, the hospital is insisting that the dressings continue to be supplied. Sally has asked the Trusts to provide evidence that these dressings are useful but has had no luck so far.

SG responded that SPF doesn't have the capacity to review dressings. It is therefore best to take this through the wound formulary group for consideration. CH to let Sally Irving know.

Action CH

- SD questioned the 'Black' CCG traffic light status of aripiprazole long acting injection because this product was agreed at Mar-14 MiCP for SomPar prescribing only (i.e. to be treated as "red"). SG said CCG had reviewed evidence and had decided "black" and if SomPar would like evidence reviewed they should bring back to next SPF.

6.3 TST

Last meeting 9/5/14 so no formal minutes available yet. CB updated the group:

- **Lactic acid (Bioactiv BV™) for bacterial vaginosis (BV)-** No consensus.TST would like a PAMM/SPF opinion.

CB outlined that the TST consultants would like to use this gel to prevent recurrent presentations and that it would be intended for or persistent BV as part of a clear management plan.

Discussed:

- lactic acid 4.9% and glycogen 0.1%. vaginal gel
- class 1 medical device indicated for the treatment and prevention of bacterial vaginosis (BV). It is an acidifying gel which restores and preserves the healthy vaginal pH balance
- Proposed to use this for patients who have metronidazole intolerance/allergy for the treatment of bacterial BV), for supportive treatment for first-line treatment failures and for the preventative treatment of recurrent and persistent BV.
- Metronidazole and clindamycin administered orally or vaginally are effective in the treatment of BV. Oral metronidazole is the recommended first-line treatment for BV in the UK. Intravaginal metronidazole gel (Zidoval™) or intravaginal clindamycin cream (Dalacin™) are alternative choices if the woman prefers topical treatment or cannot tolerate oral metronidazole.
- Nigel Ankcorn had produced a report which had concluded that there is insufficient evidence to make a recommendation on the use of vaginal acidification for the treatment of BV - evidence on the efficacy of vaginal acidification with lactic acid or acetic acid is conflicting and

studies are generally small and of poor quality.

- **Drug Tariff, April, 2014 -** Balance activ BV™ Box of 7x 5mL tubes: £5.25 (+VAT) OTC price: £8.65
  Dose: Treatment of BV: Use one tube daily for 7 days. Prevention of BV: Use one or two tubes per week.
- SG was concerned that in using this product for the prevention of BV, the assumption is being made that any recurrence is due to the same pathogen.
- Discussed the idea of creating a clear management plan to empower patients to manage symptoms but making it clear that if used preventatively then the patient should 'self-care' i.e. purchase the product themselves.

Conclusion

- Await review by T&S Antimicrobial Prescribing Group to get a microbiological opinion. Bring back to PAMM and SPF for discussion after that.

Action: Ana Alves

- Noted that all antimicrobial requests from other directorates first get a microbiology opinion to ensure consistency with anti-microbial stewardship approach before coming to forum.

- It would be reasonable to trial Lactic Acid Gel treatment as a last resort but given the potential for spontaneous resolution and lack of benefit in randomised trials, patients may choose to self-treat. SPF would not recommend long term prescribing for prophylaxis.

- **Methenamine hippurate (Hiprex™) for prophylaxis of lower urinary tract infections.** Requested by the microbiologists for the prophylaxis and long term treatment of chronic or recurrent lower urinary-tract infections in patients without known renal tract abnormality.

  Discussed

  Approved by TST DTC 9/5/14

  Dr Baker (microbiologist) produced an application for the TST DTC. The report states that:

  - Methenamine hippurate (**Hiprex™**) is indicated in the prophylaxis and long-term treatment of chronic or recurrent lower urinary-tract infections. It releases formaldehyde, a non-specific bactericide, by hydrolysis at acid pH. Methenamine is rapidly and almost completely eliminated in the urine, and provided this is acidic (preferably below pH 5.5) bactericidal concentrations of formaldehyde occur. Most Gram-positive and Gram-negative organisms and fungi are susceptible. Because of the time taken for hydrolysis, however, these do not occur until the urine reaches the bladder and is, therefore, ineffective for upper urinary-tract infections; It may have a role in the prophylaxis and treatment of chronic or recurrent uncomplicated lower urinary-tract infections.

  - The aim is to reduce reliance on oral antibiotic prophylaxis for chronic and recurrent urinary tract infections, but not to replace any drug. It is proposed for patients with recurrent urinary tract infections without known renal tract abnormality, excluding children under 6 years and patients with

eGFR less than 10ml/min/1.73m^2 .

- The mechanism of action of methenamine cannot cause resistance to existing antimicrobial agents.

- Currently more than 35% of common urinary isolates are resistant to Trimethoprim, the current first-line for treatment of UTI.

- SIGN guidance 88 recommends to consider the use of methenamine hippurate to prevent symptomatic UTI in patients without known upper renal tract abnormalities.

Conclusion

- Agreed to add to TLS as an Amber Drug (i.e. after recommendation by a consultant)

Action: Steve Moore

- SPF asked for Ana Alves (Medicines Management Microbiology link) to investigate whether Dr Baker thinks it is worth switching patients already taking prophylactic antibiotics to methenamine hippurate instead.

Action: Ana Alves

- **Linaclotide (Constella™) for irritable bowel syndrome with constipation.** Approved on a gastroenterologist named basis cohort whilst defining exactly which patients will benefit; RED for TLS

- **Domperidone dosage and use in lactation**. In view of latest alert it was agreed that in-house MPH use should limit to 10mg TDS up to 7 days; Oncology will adopt the same policy. There has been no formal application from midwives for use to increase lactation**.**

6.4 Weston

Minutes noted

6.5 YDH

SW verbally updated the group on the most recent YDH DTC meeting:

- **Anidulafungin (Ecalta™) for invasive fungal disease in critical care.** Approved RED drug for Traffic Light Scheme. SW is aware that this is a PbR excluded drug and YDH is contacting Specialist commissioning to check that they are willing to fund.

- **YDH formulary has been updated to include Relvar Ellipta®**

- **Tapentadol:** approved for post-op colorectal surgery patients (≈5 patients/week) for whom constipation is likely to be a problem. Prescribing will be restricted to Pain Specialists. YDH will discharge with full course (on average up to 2 weeks supply) and add information on discharge summary for GPs to highlight need for follow-up review in community; it was noted that immediate release formulations are licensed for acute pain and modified release for chronic pain.

Discussion

- This indication should be **RED** (hospital only) on the formulary
- SPF are keen that information provided on the discharge summary is clear to reduce the risk of GPs inadvertently continuing the supply of

tapentadol .

- Update to be sent out in the next newsletter

Action:Steve Moore

- **Humulin 500 insulin Vials:** A highly concentrated, unlicensed insulin approved by YDH for a very limited group of patients against very strict criteria (approx. 2 patients/ year) as a RED hospital only drug which will be supplied by the hospital. It will be used in patient who are insulin resistant and need a large volume of insulin at normal concentrations because it can be problematic administering a large volume of insulin in one place.

  Discussion

  - SW outlined that patients will need to be highly motivated and able to administer the insulin themselves.
  - The insulin will be supplied in a special box containing all the paperwork.
  - In patients are only allowed to continue using the insulin if they are able to administer it themselves. Otherwise nurses will have to revert to a conventional insulin regime. This could also have implications for community nursing teams.
  - SG has requested formal feedback from YDH and TST on how the safety issues will be addressed.

Action SW/JB

- SG stated that concentrated insulin is part of NICE guidance and so should be part of the 'tariff'.

6.6 RUH

Minutes noted.

Thromboprophylaxis post fracture proposal discussed. RUH appeared to have agreed to a model where some of the costs of thromboprophylaxis in high risk patients post fracture were passed on to GPs. The business proposal from RUH stated:

"Options include Hybrid of ED paying for bloods, clinical time and initial LMWH pack and GP/orthopaedics paying for LMWH and sharps bin after fracture clinic for high risk patients. Total cost £26,078.93"

It was agreed that while it is important to implement in order to reduce avoidable patient harm, the SPF questioned whether this is actually happening or whether BANES CCG had agreed to absorb the costs of this model.

Action: GS

6.7 Taunton & Somerset Antimicrobial Prescribing Group (TSAPG)

No further meetings since last SPF. Next meeting 14/5/14

7. NICE

7.1 A summary of the NICE guidance published in Mar and Apr 2014 was presented to the Forum for information.

The following NICE guidance was noted:

7.2 NICE TA307 Colorectal cancer (metastatic) aflibercept- **(to note)**
Noted- Not recommended in combination with irinotecan and 5-FU for metastatic colorectal cancer that has progressed after oxaliplatin. - specialist commissioning.

7.3 NICE TA308: Vasculitis (anti-neutrophil cytoplasmic antibody Associated) rituximab (with glucocorticoids)

Noted as an option for treatment- specialist commissioning.

7.4 NICE TA309: Lung cancer (non small cell, non squamous) pemetrexed

Noted- Not recommended as maintenance treatment for people with locally advanced or metastatic non squamous non-small-cell lung cancer after therapy with pemetrexed and cisplatin. - specialist commissioning.

7.5 NICE TA310: Lung cancer (non small cell, EGFR mutation positive) – afatinib
Noted as an option for treatment. Funded by specialist commissioning

7.6 NICE TA311: Multiple myeloma - bortezomib (induction therapy)-

Noted as an option for treatment. Funded by specialist commissioning

7.7 NICE TA311: Multiple myeloma - bortezomib (induction therapy)- Funded by specialist commissioning

Clinical Guidelines- to note

7.8 NICE CG179: Pressure ulcers (noted)

SG has forwarded to Ana Alves to take up with the Wound Care Group

Action: Ana Alves

Diagnostic Guidelines- to note

7.9 NICE DG12: Measuring fractional exhaled nitric oxide concentration in asthma guidance

SG asked whether this is something that trusts currently use or want to use going forwards. Trust representatives to raise at YDH and TST and provide feedback.

Action: SK and CB

Public Health Guidelines- to note

7.10 NICE PH 51: Contraceptive services with a focus on young people up to the age of 25

Guidance noted:
SG has raised this with Public Health England (PHE), particularly around the requirement to increase preventative prescribing for the morning after pill. Discussed at last PAMM- no action to be taken until PHE provide us with proposals.

7.11 NICE PH 52: Needle and Syringe Programmes

Guidance noted: Needs to be raised with Public Health England

Action: CH

7.12 NICE Consultations

A list of the current NICE consultations was presented to the Forum for information.

SG specifically pointed out the current NICE Consultation on the use of point-of –care coagulometers which the group will need to look at once guidance has been published

8 HORIZON SCANNING

The following horizon scanning documents were presented.

- RDTC Monthly Horizon Scanning document Mar and Apr 14
- UKMi New Drugs Online Newsletter
- A list of forthcoming NICE ESNM and ESUOM

The group discussed that relevant items had been identified by CH and SG and put onto the SPF agenda.

9 FORMULARY APPLICATIONS

9.1 Dapagliflozin and metformin (Xigduo®) 5mg/850mg and 5mg/1g for Type II Diabetes

GS explained that this is a combination product which is taken twice a day. Nice have said that this product is covered by their existing guidance on dapagliflozin.

They recommend dapagliflozin in dual therapy with metformin or insulin (but not triple therapy) for the treatment of diabetes.

Dose 1 tab BD. Price = £36.59 /56 tabs (the same price as 28 days treatment with dapagliflozon alone)

GS explained that PAMM didn't think it was worth having on the formulary but could be added as GREEN in the TLS for patients who had been stabilised on both drugs. All agreed.

Action:Steve Moore

9.2 Avanafil (*Spedra*®) for treatment of erectile dysfunction

A new PDE 5 Inhibitor license for the treatment of erectile dysfunction.
Price: £10.94 for a 4-pack of 50mg tabs to £39.40 for an 8-pack 200mg (£4.90/ tab)

GS explained that this is another PDE5 inhibitor for the treatment of erectile dysfunction. It is less expensive per dose than Tadalafil and has a longer half life than Sildenafil. PAMM had agreed to add it to the formulary as a 2nd line option, all agreed.

Action:Steve Moore

9.3 Brimonidine (*Mirvaso*®) gel for the treatment of facial erythema of rosacea in adults

Price: £33.69 for a 30 day supply Applied to whole face daily

Cutaneous facial application of a highly selective alpha2-adrenergic receptor agonist reduces erythema through direct cutaneous vasoconstriction.

SG explained that no applications have been received for this product yet. Trusts should take back to the dermatologists to find out whether they want to make an application. Update the TLS as BLACK i.e. not recommended at present.

Action: Steve Moore

9.4 Fultium D3 3200iu capsules for the treatment of vitamin D deficiency

Fultium-D3 3,200IU Capsules- price £13.32 for 30 tabs

Until now, there has been no licensed 'higher dose' vitamin D product available Preparation but this product has just been launched for use in:

This product is licensed for Vitamin D deficiency in adults and the elderly (serum levels <25 nmol/l) 1 capsule (3,200 IU) daily for up to 12 weeks dependent on severity of disease and response to treatment. (the same as the 800iu Fultium). This product cannot be used for maintainence or prevention of vitamin D deficiency.

However, the 800iu tablets can also be used for maintainence in adults and the elderly and for prevention of vit D therapy

It is was noted that a recent Cochrane review of a large number of post menopausal women and older men patients concluded that:

- Vitamin D alone is unlikely to prevent fractures in the doses and formulations tested so far in older people.
- Supplements of vitamin D and calcium may prevent hip or any type of fracture.
- There was a small but significant increase in gastrointestinal symptoms and renal disease associated with vitamin D and calcium.
- This review found that there was no increased risk of death from taking calcium and vitamin D.

A previous paper also showed lack of benefit on falls. It is therefore unlikely that there would be a benefit from mass screening for vitamin D deficiency except where specifically stated in drug SPC or in pregnancy/ prevention of rickets.

Formulary and TLS need to be updated to reflect this. PAMM had earlier agreed that an article on around vitamin D prevention in the MM newsletter and treatment doses would be helpful.

Action: Steve Moore

10 NHS ENGLAND SPECIALIST COMMISSIONING

New list of specialist commissioning drugs now provided by NHS England.

SG noted that policies that been produced so that where patients are outside the parameters specified by NHSE, an individual funding request will need to be submitted.

11 PBR EXCLUDED DRUG MONITORING

11.1 CCG PBR Excluded Drugs.

A spreadsheet detailing the CCG-responsible PBR drug spend against budget for TST and YDH was presented and discussed.

A spreadsheet to gather data on PBR excluded drugs, in a helpful format has been compiled. YDH are using this to submit data to the SPF for review but unfortunately, TST have not agreed to use this form to submit data despite requests from JB. GS pointed out that this makes it very difficult to compare 'like with like' and therefore makes it impossible for SPF to undertake one of its stated functions i.e. monitoring non PBR spend.

It was agreed that SG would write to Paul Goodwin stating that currently SPF can't monitor the PBR excluded drugs spend because TST won't provide the figures in a standard format. SG to update the group on progress.

Action: SG

12 DRUG SAFETY

12.1 MHRA Drug Safety Update Mar and Apr 2014

SK noted that all patients getting anti-TNFs get TB screening prior to startingtreatment. YDH are trying to raise awareness of the need for screening and monitoring as these drugs move into other directorates.

SG asked that trusts review the Drug Safety updates and take appropriate action.

12.2 PRAC recommends against combined use of medicines affecting the renin-angiotensin system

The SPF noted this guidance and will await further information from the MHRA.

12.3 MHRA update on medicines containing domperidone- in line with the European Medicines Agency PRAC Committee recommendations. The MHRA main recommendations are that:

- Domperidone-containing medicines should restricted for the relief of nausea and vomiting only. They are no longer be authorised to treat other conditions such as bloating or heartburn.
- The recommended dose is reduced to 10mg up to three times daily by mouth for adults for a maximum of one week.

- Domperidone must not be given to patients with moderate or severe impairment of liver function, or in those who have existing abnormalities of electrical activity in the heart or heart rhythm, or who are at increased risk of such effects.
- It must not be used with other medicines that have similar effects on the heart or reduce the metabolism of domperidone.

CB noted that oncology at TST was probably one of the biggest prescribers, often at oral doses of 20mg TDS. They have now restricted usage to fall within the MHRA guidance.

SG pointed out that trusts should go through an approval process where "off label" indications are considered necessary.

Trust representatives to feedback to their organisations on the MHRA advice

Action All

12.4 Patient Safety Alert: Stage One. Warning Residual anaesthetic drugs in cannulae and intravenous lines NHS England

Trusts that use anaesthetics were asked to pass on this information within their organisations

Action All

12.5 Patient safety alert on minimising risks of omitted and delayed medicines for patients receiving homecare services

Trusts were asked to take action in accordance with the alert to ensure that the risk of omitted doses through the use of homecare services is minimised.

Action All

13 ANY OTHER BUSINESS

SG pointed out that NHS England and the MHRA have produced 2 safety alerts- one for medical devices and the other for medicines. The alerts have a requirement that large healthcare providers:

- Identify a board level director (medical or nursing supported by the chief pharmacist) or in community pharmacy and home health care, the superintendent pharmacist, to have the responsibility to oversee medication error incident reporting and learning;
- Identify a Medication Safety Officer (MSO) and email their contact details to the Central Alerting System (CAS) team. This person will be a member of a new National Medication Safety Network, support local medication error reporting and learning and act as the main contact for NHS England and MHRA; and,
- Identify an existing or new multi-professional group to regularly review medication error incident reports, improve reporting and learning and take local action to improve medication safety.

SG requested that trusts feedback to CH on who their nominated trust medicines and medical safety officers are.

Action SW, JB, SD

14 DATE OF NEXT MEETING

- 09 July 2014, 2.30pm and 5pm, **at Abbey Manor Business Park, Yeovil**

SCHEDULE OF ACTIONS

NO.	SUBJECT	OUTSTANDING RESPONSIBILITY	ACTION LEAD
ACTIONS ARISING FROM THE MEETING HELD ON WEDNESDAY 14 MAY 2014			
1	**Declarations of interest**	Members were asked to notify the Prescribing Forum secretary of any standing declarations of interest, which could be held on record.	**All (on going)**
2	**NICE PH45 Tobacco Harm Reduction**	Importance of offering NRT or support to stop smoking to patients with severe mental illness to be highlighted in the formulary.	**CH 09-July-14**
3	**TST Thromboprophylaxis in elderly patients**	TST has been asked to ensure that risks and benefits of anticoagulation be discussed and documented prior to discharge into primary care. JB to organise a discussion between Dr Solanki and Mark Ashley and update the group once they have met.	**JB 09-July-14**
4	**Linaclotide for IBS**	Traffic Light Scheme Status to be updated to Red	**Steve Moore 04-June-14**
5	**Certolizumab**	CH to Steve Moore to add ankylosing spondylitis and psoriatic arthritisto the TLS as approved indications for certolizumab.	**CH 09-July-14**
6	**Neutropenic Sepsis card**	JB organise an audit of trial of this card and to report back on results. JB to update on progress at July meeting	**JB 09-July-14**
7	**Azathioprine SCG for UC and Crohn's**	CH to ensure that revised SCG is placed onto the relevant part of the website	**CH 09-July-14**
8	**Enhanced Service for DMARDs**	SG to update the group on progress of the review of Enhanced service	**SG 09-July-14**
9	**Modafanil SCG for narcolepsy**	CH to ensure that revised SCG is placed onto the relevant part of the website	**CH 09-July-14**
10	**Sharing SPF minutes with other Trusts**	JP/GS to investigate whether other Trusts such as RUH would like to see the SPF minutes	**JP/GS 09-July-14**
11	**Physical monitoring of patients taking antipsychotics**	Proposed SomPar physical monitoring form along with the SomPar NICE CG 178 compliance assessment be shared with SPF Members	**CH 09-July-14**
12	**Bioactive BV, lactic acid gel**	Ana Alves to obtain feedback from the T&S antimicrobial prescribing group on the lace of this product in therapy	**Ana Alves 04-June-14**

NO.	SUBJECT	OUTSTANDING RESPONSIBILITY	ACTION LEAD
13	**Methenamine hippurate (Hiprex™) (1)**	Add to the formulary as 'AMBER' on consultant recommendation for prophylaxis of lower urinary tract infections.	**Steve Moore 04-June-14**
14	**Methenamine hippurate (Hiprex™) (2)**	SPF asked for Ana Alves to investigate whether Dr Baker thinks it is worth switching patients already taking prophylactic antibiotics to methenamine hippurate instead.	**Ana Alves 09-July-14**
15	**Tapentadol post Colorectal surgery at YDH**	Add to formulary as RED for patients post colorectal surgery for whom constipation is likely to be a problem. Will be Rxd by the pain specialists for short courses only. Discharge summaries to make this clear. Update needs to be put into the meds management newsletter.	**Steve Moore 04-June-14**
16	**Humulin 500 Insulin**	SG has requested formal feedback from YDH and TST on how the safety issues will be addressed.	**SW/JB 09-July-14**
17	**Thromboprophylaxis in high risk post fracture patients**	Need to find out whether RUH are actually implementing their proposal to ask GPs to prescribe thromboprophylaxis to high risk, post fracture patients after initial supply.	**GS 04-June-14**
18	**NICE CG179: Pressure Ulcers**	Ana Alves to raise with the Wound Care Group	**Ana Alves 09-July-14**
19	**NICE DG12: Measuring fractional exhaled nitric oxide concentration in asthma guidance**	Trust representatives to raise at YDH and TST and feedback on whether this is something that they currently use or want to use going forwards.	**CB/SK 09-July-14**
20	**NICE PH 52: Needle and Syringe Programmes**	CH to ask Public Health England what action has been taken	**CH 09-July-14**
21	**Dapagliflozin and metformin (Xigduo®) 5mg/850mg and 5mg/1g for Type II Diabetes**	Add to the TLS as green as an option to improve compliance in patients stabilised on both drugs at an appropriate dose	**Steve Moore 04-June-14**

NO.	SUBJECT	OUTSTANDING RESPONSIBILITY	ACTION LEAD
22	**Avanafil (Spedra®) for treatment of erectile dysfunction**	Add to formulary and TLS as a GREEN second line option PDE5 inhibitor for the treatment of erectile dysfunction	**Steve Moore** **04-June-14**
23	**Fultium D3 3200iu capsules for the treatment of vitamin D deficiency**	Update formulary and TLS to include this product. Include an article in the meds management newsletter.	**Steve Moore** **09-July-14**
24	**CCG PBR Excluded Drugs monitoring**	SG to write to Paul Goodwin stating that currently SPF can't monitor the PBR excluded drugs spend because TST won't provide the figures in a standard format. SG to update the group on progress.	**SG** **09-July-14**
25	**Nominated Medicines Safety Officers**	Trusts to e-mail CH with their named medicines and medical device safety officers	**SW/ JB/ SD** **09-July-14**