NHS
Somerset
Clinical Commissioning Group

Minutes of the **Somerset Prescribing Forum** held in **Meeting Room 1, Wynford House, Lufton Way, Yeovil, Somerset** on **Wednesday 9 July 2014**

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

1 WELCOME

1.1 Shaun Green welcomed everyone to the meeting.

2 APOLOGIES

2.1 Apologies were provided as detailed above

3 DECLARATIONS of INTEREST

3.1 No new interests were declared

4 MINUTES OF THE MEETING HELD ON 14 May 2014

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

SD asked for the decision on the traffic light status of aripiprazole long acting injection to be revisited as currently BLACK (not recommended). SomPar would like it to be a RED because they are currently undertaking a controlled entry of this product within the Trust. SG agreed that the decision would be revisited outside the meeting.

Action: CH & SG

4.2 SG ran through the schedule of actions from the 14th May 2014 meeting. All actions were complete. The following issues were specifically noted

1. **TST Thromboprophylaxis in elderly patients NICE guidance on secondary prevention of MI-** Trusts had been asked to ensure that risks and benefits of anticoagulation be discussed and documented prior to discharge into primary care. At the last meeting JB reported 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.

   Mark Ashley (MA) informed the group that he has not been able to meet with Dr Solanki yet but the decision is based on clinical assessment of the patient and the decision should be recorded on the VTE assessment form.

   SW reported that YDH document the decision on a VTE risk assessment and SD reported that SomPar are doing something similar.

2. **Neutropenic Sepsis Card-** At the last meeting JB said that TST would be organising an audit of the trial of this card and agreed to report back on progress.

   MA reported that the first patients were issued with cards last week with the intention of auditing and publishing the results. SG asked that results are reported when they are available.

   Action: JB

   SW reported that YDH are happy with their own internal procedures around neutropenic sepsis.

3. **Sharing SPF minutes with other Trusts-** CH reported that Geoff Sharp had e-mailed his contact at RUH who is going to ask their DPG whether they would like to see copies of SPF minutes in future. We are awaiting a response. GS to follow up.

Action: GS

4. **Humulin R U-500 insulin** at the last meeting SW and JB were asked to provide feedback to SPF on how the safety issues would be addressed.

   SW presented the following on behalf of YDH:

   - Standard letter to go to GP explaining the issues with Humulin 500 around dose, syringes to be used and that the patient should get all Humulin **R U-500** supplies direct from the hospital.
   - Humulin **R U-500** guide to go in patient notes explaining dose and that should the patient become unable to self-administer, what alternative insulin and dose should be use.
   - Standard letter to go to patients using Humulin **R U-500** re. dose, syringes to be used, storage ONLY in the purple box which is supplied to the patient and that the patient should get all Humulin **R U-500** supplies direct from the hospital.

   YDH have just 2 patients using this product at present. SW agreed to speak to Sue Down to ensure that the DNs are informed that they may occasionally see Humulin **R U-500** and that they shouldn't administer it to patients. They should seek an alternative insulin prescription if DNs are required to administer.

   SG asked SW to check whether this product falls under 'Tariff'.

   Action SW

   MA explained that TST are not using Humulin 500 at the moment.

5. **NICE DG12- Measuring fractional exhaled nitric oxide concentration in asthma.** Trusts had been asked to raise within their organisations and feedback on whether this is something they want to use.

   TST response: No feedback from TST

   YDH response: SK reported that Claire Parker (Respiratory Consultant) thinks they may want to use this and there probably is some role for it.

   We need to ask Steve Moore for feedback from yesterday's Respiratory Network Meeting on whether they believe there is a place for measurement fractional exhaled nitric oxide concentration in asthma.

   Action CH

6. **Needle and Syringe Programmes Public Health Guidance –** Public Health had informed CH that they plan to review service provision against this guidance in the autumn. CH to chase up in September, before next SPF.

Action CH

7. **Avanafil–** a new PDE-5 inhibitor for erectile dysfunction added to formulary at last PAMM and SPF. However, we need to check whether this has been included under Drug Tariff 'SLS' criteria yet.

Action CH

8. **CCG PBR Excluded Drugs monitoring –** At the last SPF**,** 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 explained that unfortunately we have still not reached any agreement with TST regarding providing the data in a standardised format to make it easier to compare. We will have to work with the format we have been given. For further discussion, see item 11.1.

9. **DMARD Enhanced Service –**SG reported that no further progress had been made on the review of the Enhanced Service. SG to update at next meeting.

Action SG

10. **RUH thromboprophylaxis for patients post fracture –** RUH have proposed a model where some of the costs of thromboprophylaxis in high risk patients post fracture were passed on to GPs.

    CH reported that RUH had been asked whether they are implementing this model and they have said that it had progressed no further. CH to follow up again in September. SG has raised with local A&Es to ensure that they also have local procedures in place to identify high risk patients and supply appropriate thromboprophylaxis.

Action SG

11. **Universal Drug Chart –** SK reported that YDH are considering implementing a universal drug chart. This will be considered at their D&T meeting. There is a benefit to rotational junior doctors. Since they implemented a good diabetic management chart, they believe they are getting fewer errors involving insulin. YDH to report back on progress.

Action SK/SW

MA explained that TST do not feel that a universal drug chart would be a step forward as they believe that their charts compare favourably with the universal drug chart

Sompar are running a MAR chart audit.

SG asked Trusts to take a joint decision if possible.

5 MATTERS ARISING (no otherwise on the agenda)

5.1 Medicines Optimisation Prototype Dashboard- The group viewed the dashboard. SG presented the new dashboard and accompanying national guidance from the Department of Health.

It can be used to review CCG level data looking at primary care prescribing and QoF data. The medicines management team will look at this in more detail and discuss areas where we are outliers

SG asked that Trusts go back and look at the data which is relevant to them for benchmarking purposes and to present any issues that they identify back to SPF.

Action: Trusts and Medicines Management Team

5.2 Draft Antipsychotic Shared Care Guideline- CH presented the revised SCG to the group noting that it is to go to SomPar D&T group on 10/7/14 so not yet approved. The guideline has been updated to reflect the monitoring requirements laid out in the new NICE guidance on antipsychotics and schizophrenia.

SG explained that the guideline was discussed at PAMM meeting which took place earlier the same day. The main points were:

- There was a consensus that GPs should be responsible for dealing with physical problems that develop in patients taking antipsychotics and are picked up during routine monitoring e.g. treating diabetes or hyperlipidaemia. This is something that the psychiatrists don't always feel able to address.
- If metabolic problems occur, GPs would like the psychiatrists to ensure that there is a review of the antipsychotic medication to ensure that that a dose/ drug change is considered where appropriate.
- There should be more emphasis within the guidance on taking action in response to abnormal results. It would be good to link the guideline to the Lester flow chart. If the patient displays a feature in the 'red zone' then the GP should be asked to treat in accordance with the relevant NICE guideline e.g. hypertension, lipid management
- The PAMM would like clarity on what 'referral back' means- does it mean inform and discuss with the psychiatrist or complete referral back into psychiatric services
- Requested the wording for the frequency of blood tests is changed to 'at baseline', 3 months after starting antipsychotic and at 12 months, then annually thereafter.

Main points of the discussion at SPF were:

- We are moving away from 'named patient' shared care guidelines where there is a formal request to accept care.
- The consultant needs to highlight the existence of the SCG in their letter when they write to the GP asking them to share the care of the patient.
- The SCGs will sit on the CCG website and GPs will be able to access them from there.

- Formatting of the ticks in boxes would be better in **bold**.

CH to feed back to SomPar D&T and work with Rosemary Brook and Jill Leppard to review.

Action: CH

6 D&TC DECISIONS

6.1 Somerset Partnership MICP

There had been no meeting since the last SPF. Next meeting is due to take place 10/7/14. Minutes noted.

6.2 TST

There had been no meeting since the last SPF. Next meeting is due to take place 25/7/14. Minutes noted.

6.3 Weston

There had been no meeting since the last SPF. Next meeting is due to take place 8/5/14. Minutes noted.

6.4 YDH

There had been no meeting since the last SPF. Next meeting is due to take place 22/7/14. Minutes noted.

6.5 Taunton & Somerset Antimicrobial Prescribing Group (TSAPG)

Last meeting 9/5/14. No formal minutes available yet.

The group viewed the notes made by Ana Alves specifically regarding:

Cellulitis Guidelines

- TSAPG recommends that Doxycycline doses are aligned with current secondary care guidance: 2x100mg stat then 1x100mg OD due to:
  (i). unusual situation of having higher doses recommended in primary care than in hospitals
  (ii) The logic for increasing the flucloxacillin dose was a microbiological one; more likely to exceed the Minimum Inhibitory Concentrations s of most staphs and streps with higher dose flucloxacillin. That means no need to use benzylpenicillin in addition, thus avoiding IVs and admission for most patients. That logic does not apply to doxycycline.
  (iii) also concern is to do with cytochrome activity and drug interactions, especially warfarin, in the higher doses.

  PAMM in June had agreed that that primary care adopt the MPH recommendation of 200mg stat followed by 100mg od so that primary care is aligned with secondary care

- The group does not recommend widespread community use of IV ceftriaxone because of its C Diff risk where safer alternatives exist therefore suggests that IV antibiotics are only given through Microbiology advice.

Balance Activ BV™ (Lactic acid 4.9%) for bacterial vaginosis

- Approved by the group with (the intention to use instead of Clindamycin). This follows no consensus at TST D&T 9th May.

  SG explained that this has been approved by PAMM for treatment ONLY.

Finally:

- The summary of changes to antimicrobial guidance was highlighted**.**
- SG flagged the increased costs of using nitrofurantoin.
- The group noted that work has been done in primary care and A&E to educate staff to recognise the signs and symptoms of scarlet fever, which is a notifiable disease.

6.6 RUH Bath D&TC

The group reviewed the Minutes of the May 14 meeting and noted that RUH have told us that the business case for thromboprophylaxis for ambulatory patients with lower limb fractures has not moved forwards. The RUH will update SPF when there is news on this.

Action: CH

7 NICE

7.1 A summary of the NICE guidance, including Quality Standards, published in Since the last SPF was presented to the Forum for information.

7.2 NICE TA312 Multiple sclerosis (relapsing-remitting) – Alemtuzumab

Noted- funded by specialist commissioning

7.3 NICE TA313: Psoriatic arthritis (active) ustekinumab.

Noted - negative appraisal

SK said that this was disappointing in some respects as usketinumab can be useful for some patients who don't respond to anti- TNFs. SG said that it is possible to apply for exceptional funding via the IFR panel.

Agreed 'BLACK' formulary status as not recommended by NICE. Traffic lights to be updated.

Action: Steve Moore

7.4 NICE TA314: Implantable cardioverter defibrillators and cardiac resynchronisation therapy for arrhythmias and heart failure (review of TA95 and TA120)

SG noted that this is a significant cost pressure for the CCG because the number of patient groups eligible for ICDs has been significantly extended.

7.5 NICE TA315: Canagliflozin in combination therapy for treating type 2 diabetes

It was noted that Canagliflozin had been approved by NICE as an option for the treatment of diabetes. Canagliflozin can be used in triple therapy with metformin and a sulphonylurea but dapagliflozin can't.

SG explained that the Medicines Management Team (MMT) needs to review the formulary chapter on diabetes and ensure that all NICE guidance is incorporated into the pathway. The team will share with specialists for their views.

MMT to update the group at next meeting.

Action: MMT

7.6 NICE CG180: Atrial Fibrillation (June 14)

SG explained that the new NICE guidance:

- is very clear that aspirin alone should NOT be used for patients with AF. This will probably lead to a group of patients being transferred onto NOACs
- that the risks and benefits of anticoagulation need to be discussed with patients
- guidance now recommends use of CHADSvasc and HAS-BLED scores when assessing potential treatment risks and benefits.
- defines the amount of time a patient on warfarin needs to be within range, otherwise a NOAC should be considered .
- sotalol no longer recommended for rate control in permanent AF, another beta blocker should be offered.

SG explained that Somerset CCG is larger user of sotalol than the rest of the country and we will be raising this with GPs. TST have told SG that they don't use quite as much sotalol now.

Action: MMT

SG also explained that for the last 2.5 years, NOACs had been managed outside GP prescribing budgets but the money for this has now been moved back within the prescribing budget. This may deter prescribers from prescribing NOACs but our advice hasn't changed and GPs should continue to prescribe in accordance with current NICE guidance.

7.7 NICE CG81: Advanced Breast Cancer (Update): Diagnosis and treatment July-14. Addendum to Managing Complications (Chapter 6)

SG highlighted that this guidance has been published. The main point is that exercise is considered to be neither beneficial or harmful in lymphoedema.

SG has a meeting planned with the lymphoedema service and he will point this out.

7.8 PH 53: Overweight and obese adults - lifestyle weight management

CH to e-mail to public health to ask them what action they are taking on this.

Action CH

7.9 Evidence Summaries: new medicines for discussion/noting

The following was noted:

- SD stated that the CASSH service would like to start using the Jaydess coil® SomPar to bring an application to PAMM and SD to look into whether extra training is needed.

Action SD

7.21 NICE Consultations

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

The following was noted:

- SG highlighted the consultation on excess winter deaths. It contains guidance on discharging patients to a warm house that is fit to receive them. SG has pointed this out to the hospital transport services.

8 HORIZON SCANNING

8.1 The following horizon scanning documents were presented to the Forum for information:

8.2

8.3

8.4

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

9 FORMULARY APPLICATIONS

9.1 Fluoxetine dispersible tablets (Olena®)

SG explained that these were added to the formulary at the last PAMM because the dispersible tablets are significantly cheaper than liquid. Tablets can be halved to provide a 10mg dose. GREEN traffic light status. Need to ensure formulary and TLS are updated.

Action: CH

9.2 Balance Activ BV® - Lactic Acid Gel

SG explained that these were added to the formulary at the last PAMM for Bacterial Vaginosis treatment ONLY. Patients will need to purchase for prophylaxis.

9.3 Cosmocol® Macrogol laxative

SG explained that this is a 'me too' macrogol laxative that is equivalent to Movicol® but around 40% cheaper than Movicol®**.** Agreed to add to the formulary.

Action: Steve Moore

Laxido® have now dropped their price by 20% in primary care. SG explained that, in accordance with guidance, we are trying to reduce lactulose usage in primary care.

9.4 Golimumab for Ulcerative Colitis

SW explained that Golimumamb is licensed for treatment of moderate to severely active UC. Alternatives licensed for this indication are infliximab and adalimumab. YDH are proposing to offer golimumab with moderate to severe UC because it can be 'self- administered' and the dosing interval is longer than for adalimumab. Patients will be able to obtain supplies via a homecare company.

NICE is currently reviewing the guidance for infliximab, adalimumab and golimumab but publication not expected until Jan 15. There are no direct comparisons of the 3 agents.

SG noted that there is no information on the NICE to guide us yet. SW stated that because of the current problems with homecare services, YDH are looking at using one particular company and starting just a few patients at a time. This would give them more control if any problems did arise.

SG stated that there should be no use outside current NICE criteria. As with other preparations, a maximum of 3 doses should be used to induce remission with no ongoing treatment. Outside this, a business case would be needed. SG asked SW to update the next SPF on what price is being paid for golimumab, what the benefits are to the healthcare system. Also, to contact the drug company to discuss price.

Action: SW

9.5 Subcutaneous Tocilizumab (RoActemra®, Roche)

SG explained that he had asked TST DTC to consider using Tocilizumab (Roactemra®) pre-filled syringes as a potential option for patient self-administration in the community. Tocilizumab is a cytokine modulator.

Tocilizumab (RoActemra®) pre-filled syringes, in combination with methotrexate (MTX) are licensed for the treatment of moderate to severe active rheumatoid arthritis (RA) in adult patients who have either responded inadequately to, or who were intolerant to, previous therapy with one or more disease-modifying anti-rheumatic drugs (DMARDs) or tumour necrosis factor (TNF) antagonists. In these patients, RoActemra® can be given as monotherapy in case of intolerance to MTX or where continued treatment with MTX is inappropriate.

NICE TA247 recommended the IV infusion for the treatment within the current guidance was published prior to the launch of the pre-filled syringes.

Although the prefilled syringes are more expensive for most patients, this should save NHS time and money, reducing the number of outpatient appointments to attend for infusions. It will be cheaper to obtain the syringes on FP10HP every month via community pharmacy rather than via hospital pharmacy.

This had been approved at TST provided the cost is met by funding in line with the NICE guidance. Rheumatology specialist prescribing only. Dispensing by an agreed community pharmacy, possibly for homecare delivery in the future.

SG asked whether YDH would be happy to do something similar. SK stated that, with tocilizumab, you need to monitor white cell count very closely. Most patients

would need to be assessed by a nurse on a monthly basis due to the frequent complication of neutropaenia, which requires dose adjustment. Given the current concerns about homecare services, it may not be possible to get bloods taken with the frequency that will be required. There is a risk of drug wastage if already delivered before review and treatment, delay if not. It may be possible to use for very stable patients. SK/SW to feedback from YDH DTC.

Action: SK/SW

9.6 Octasa® Mesalazine Tablets (Tillots)

The group looked at an evidence summary by UKMI:

The BNF now states that 'following a review of the literature, changes have been made to the recommendations on interchangeability of oral mesalazine preparations. There is no evidence to show that any one oral preparation of mesalazine is more effective than another; however, the delivery characteristics of oral mesalazine preparations may vary. If it's necessary to switch a patient to a different brand of mesalazine, the patient should be advised to report any changes in symptoms'.

The British Society of Gastroenterology 2011 guidelines for management of inflammatory bowel disease do not differentiate between different brands of mesalazine. The guidelines state that efficacy with aminosalicylates may depend more on adherence with the prescribed dose than the delivery system.

- Asacol MR, Ipocol MR, Mezavant XL, Octasa MR, Pentasa Slow Release and Salofalk are all licensed for treatment of mild to moderate ulcerative colitis and maintenance of remission in ulcerative colitis. Asacol MR and Octasa MR are also licensed for maintenance of remission in Crohn's ileo-colitis.
- Asacol MR, Ipocol MR and Octasa MR are all similar in terms of formulation, optimal pH for drug release and site of drug release. Mezavant XL, Pentasa Slow Release and Salofalk have slightly different formulations and optimal pH for drug release. Pentasa has a slightly different site of drug release too.
- There is some in vitro evidence of inequivalence between Ipocol MR and Asacol 400mg MR particularly with regard to the timing of dissolution at neutral pH. Octasa MR 400mg has a virtually identical in vitro dissolution profile to Asacol 400mg MR.
- In a small clinical trial, Ipocol MR has been shown to be as safe and effective as Asacol 400mg MR. Octasa MR 400mg has not been compared to Asacol 400mg MR in a clinical trial.

Discussion

Given the evidence of interchangeability between some brands of mesalazine, SG asked trusts to discuss with the gastroenterologists with a view to potentially switching from Asacol® to Octasa®. There are significant cost savings to be made in primary care through doing this.

Action: SW and MA

9.7 **Molita® Dipyridamole 200mg/ Aspirin 25mg** modified release hard capsules (Dr Reddy's)

This is a new branded generic which is equivalent to Asasantin Retard® but is 43% cheaper. The only pack size currently available is 100 (2 x 50 tablet bottles) and because SPC says the pack should be discarded 30 days after opening which could lead to wastage. PAMM had earlier agreed that the application should be withdrawn until the smaller packs are available.

9.8 **InVita® 25,000 IU Vitamin D** suspension (Consilient)

The launch of this high strength vitamin D preparation was noted and it was agreed that specialists should be approached to clarify place in therapy.

SG stated that there is no local or national consensus over the benefits of vitamin D therapy. We therefore, don't support 'mass screening' for deficiency (except in at risk pregnant women and where a drug SPC recommends screening) until there is evidence of patient outcomes.

Trusts were asked to review their use of unlicensed vitamin D preparations in favour of licensed preparations.

Action: SW, MA and SD

9.9 **Vitaros® topical Alprostadil Cream** (Takeda)

The launch of this alprostadil topical cream licensed for the treatment of erectile dysfunction was noted. This may be helpful for men who prefer not to inject alprostadil as with Caverject®

There have been some supply issues with other alprostodil products on the market. As the price compares favourably to other products, the group agreed to add it to the formulary once it has been added to the Drug Tariff 'SLS' list

Action: CH

9.10 **Ulipristal acetate 5mg tablets (Esmya®, Meda)for uterine fibroids license variation**

The license for Esmya® now allows for the 3 month course of treatment to be repeated once. Treatments should not exceed 2 courses.

It was agreed that Trusts will take back to their specialists to consider whether this is something that they want to use.

Action: SW and MA

9.11 **Denosumab (Prolia®) 60 mg solution for injection in pre-filled syringe.**

Now licensed for men at increased risk of fracture (already recommended by NICE). The group agreed that the formulary should be updated.

Action: Steve Moore

9.12 **Dabigatran (Pradaxa®)110 mg & 150 mg hard capsules**

Now licensed for treatment of deep vein thrombosis and pulmonary embolism, and prevention of recurrent DVT & PE in adults. NICE Guidance expected Oct 14

SG stated that there had been no formal requests for this from specialists. He

proposed that dabigatran could be used within license fir DVT and PE treatment as per rivaroxaban NICE guidance. The group agreed that this dabigatran could be added to the formulary as an option for the treatment of this indication.

Action: Steve Moore

Trusts were asked to highlight this to their clinicians.

Action: SW, MA and CH

9.13 **Budesonide 9 mg gastro-resistant granules (Budenofalk®, Dr Falk Pharma).** Now licensed for induction of remission in patients with mild to moderate active Crohn's disease affecting the ileum and/or the ascending colon.

The dose is 9mg once daily – the granules are equivalent to and no more expensive than the 3mg capsules used three times a day. The group agreed to add to formulary.

Action: Steve Moore

9.14 **Leuprorelin** 3.75 mg & 11.25 mg injection (Prostap® SR DCS, Prostap® 3 DCS, Takeda).
Now licensed for neo-adjuvant treatment prior to radiotherapy in patients with high-risk localised or locally advanced prostate cancer. The group agreed NOT to take this forward as an application but Trusts should raise with specialist teams to ask where this fits with NICE pathways.

Action: SW and MA

10 NHS ENGLAND SPECIALIST COMMISSIONING

No new information was presented

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.

SG explained that unfortunately we have still not reached agreement with TST regarding providing the data in a standardised format to make it easier to compare.

The following points were discussed:

- Going forward we need to put the spend for YDH and TST onto the same spreadsheet to make the data easier to compare.

Action: CH

- The Individual Funding Review (IFR) route should be used if NICE criteria are not met.
- SG highlighted that we may need to implement a system of ‘application’ for non-PBR drugs.
- SG pointed out that there are some drugs in the TST list that shouldn’t be there.
- TST has a growing overspend around biologic drugs.

- The budget that was given was based on the half-year position last year.
- SG identified that there are growing numbers of patients who need these drugs and the budget hasn't been set to account for this.
- SG said that it is likely that the CCG will need to work with TST to review usage of non-PBR drugs
- SG to speak to John Beard where overspends are occurring and discuss where we need to do some work.

Action: SG

11.2 YDH Teriparatide Audit

SK pointed out that:

- YDH teriparatide usage is very low- only 3 patients started in the last 12 months
- YDH appeared to be non-compliant with NICE teriparatide
- The bone mineral density (BMD) of one patient who'd had multiple vertebral fractures appeared normal because BMD increases in places where such fractures have occurred. This makes DEXA scanning unhelpful. They therefore appeared to be non-NICE compliant when, in fact, they were.

SG asked that:

- YDH provides a formal correction of the audit
- SK drafts a proposal the need eliminate the need for DEXA scanning of patients with progressive vertebral fractures.

It was agreed that assurances around NICE compliance should be sought through audit as well as debate with clinicians, rather than audit alone.

Action: SK

11.3 Oncotype Dx

SG said that both Specialist Commissioning and NHS England have both said that they won't be commissioning this technology. He asked that Trusts feed this information back to the relevant clinicians.

Action: SK and MA

12 DRUG SAFETY

12.1 **MHRA Drug Safety Update May and June 2014**

SG asked that trusts review the Drug Safety updates and take appropriate action. The following points were specifically noted:

- SG has spoken to the ambulance trust about the May DSU item on adrenaline auto-injectors for anaphylaxis. They think they are compliant.
- New drug driving legislation is becoming a prominent issue. This is due to come into force in March 15.
- The Medicines Management Team (MMT) are trying to work with primary care to review patients taking multiple Renin Angiotensin System drugs.
- Trusts were asked to discuss the risk of ivabradine causing bradycardia with their clinicians and that concomitant use of rate reducing calcium channel blockers should be avoided. SG has highlighted this to the cardiologists because GPs may need advice when they start reviewing these patients.

12.2 **NHSE Patient safety alert: On risk of harm relating to interpretation and action on PCR results in pregnant women**

Agreed that all trusts should discuss and address

12.3 **NHSE Patient safety alert: Standardising the early identification of acute kidney injury**

Agreed that all trusts should discuss and address.

12.4 **NHSE Patient safety alert: Risk of using vacuum and suction drains when not clinically indicated**

Agreed that all trusts should discuss and address

12.5 **MHRA – Managing Medical Devices Guidance and Checklist**

The MHRA has brought out new guidance on managing medical devices. Trusts should ensure that this is looked at within their own organisations. They will need to have an approval process for new devices and to ensure that procurement complies with guidance.

Action: SK, MA and SD

12.6 Domperidone GI restrictions UKMI Rapid review on alternatives and action plan

This information has been issued to primary care. SG said that where Domperidone is requested to increase lactation, we will state in the formulary that a maximum maternal dose of 30mg for one week should be used and this should be considered a 'red' (hospital only) drug for this indication. SG will raise this with the trusts – PAMM supports this position. Trusts should discuss and address internally.

13 ANY OTHER BUSINESS

JS mentioned that he would like to start pushing subcutaneous methotrexate into primary care.

SG said that this had already been done in Taunton, patients should be self-injecting but to be aware that practices can decline. Practices are paid for monitoring under the DMARD enhanced service.

MMT to highlight this change to GPs.

Action: CH/ SG

14 DATE OF NEXT MEETING

- 10 September 2014 **at Wynford House (Meeting Room 1), Yeovil**

Venue: Meeting Room 1, Wynford House, Lufton Way, Yeovil, Somerset BA22 8HR between 2.30pm and 5pm

SCHEDULE OF ACTIONS

NO.	SUBJECT	OUTSTANDING RESPONSIBILITY	ACTION LEAD
ACTIONS ARISING FROM THE MEETING HELD ON WEDNESDAY 9 JULY 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	**Review of traffic light status of Aripiprazole Long Acting Injection**	Consider changing status from BLACK to RED with reference to available evidence.	**CH & SG** **10th Sept 14**
3	**Neutropenic Sepsis Card**	TST to report back on results of audit of the pilot scheme when results are available.	**JB** **(when results are available)**
4	**Sharing SPF minutes with other Trusts**	GS to chase up RUH regarding whether they would regularly like to see copies of SPF minutes	**GS** **10th Sept 14**
5	**Humulin R-U500**	SW to speak to Sue Down to ensure that the DNs may see Humulin R-U500 and that they shouldn't administer. They should seek an alternative insulin prescription if DNs are required to administer. SW to check whether this product falls under 'Tariff'.	**SW** **10th Sept 14**
6	**NICE DG12- Measuring fractional exhaled nitric oxide concentration in asthma.**	Ask Steve Moore for feedback from yesterday's Respiratory Network Meeting on whether they believe there is a place for measurement fractional exhaled nitric oxide concentration in asthma.	**CH** **10th Sept 14**
7	**Needle and Syringe Programmes Public Health Guidance**	CH to chase up actions taken by Public Health in September, before next SPF.	**CH** **10th Sept 14**
8	**Avanafil**	Need to check whether Avanafil for erectile dysfunction is included in Drug Tariff SLS rules	**CH** **10th Sept 14**
9	**Enhanced Service for DMARDs**	SG to update the group on progress of the review of Enhanced service	**SG** **10th Sept 14**

NO.	SUBJECT	OUTSTANDING RESPONSIBILITY	ACTION LEAD
10	**RUH thromboprophylaxis for patients post fracture**	CH to follow up again in September to see whether there has been any further progress.	**CH** **10th Sept 14**
11	**Universal Drug Chart**	YDH to report back on progress	**SW/SK** **10th Sept 14**
12	**Medicines Optimisation Prototype Dashboard-**	Medicines Management Team to look at this in more detail and discuss areas where we are outliers.	**MMT** **10th Sept 14**
13	**Medicines Optimisation Prototype Dashboard-**	Trusts to consider data which is relevant to them for benchmarking purposes and to present any issues that they identify back to SPF.	**JB/MA** **JS/SW** **AB/SD** **10th Sept 14**
14	**Antipsychotic Shared Care Guideline**	CH to feed back to SomPar D&T and work with Rosemary Brook and Jill Leppard to review.	**CH** **10th Sept 14**
15	**NICE CG180: Atrial Fibrillation (June 14)**	Medicines management team to ask GPs to review sotalol prescribing with respect to patients with a diagnosis of AF	
15	**NICE TA313: Psoriatic arthritis (active) ustekinumab.**	Update 'BLACK' Traffic Light status	**Steve Moore** **10th Sept 14**
16	**Update of the formulary chapter and treatment pathway on diabetes**	Ensure that all current relevant NICE guidance is incorporated into the pathway. MMT to share with specialists for their views and update the group on progress at next meeting.	**MMT** **10th Sept 14**
17	**PH 53: Overweight and obese adults - lifestyle weight management**	CH to e-mail Public Health	**CH** **10th Sept 14**
18	**Jaydess® coil**	SomPar to bring an application to PAMM and SD to look into whether extra training is needed.	**SD** **8th Oct 14**
19	**Fluoxetine dispersible tablets (Olena®)**	Ensure formulary and traffic lights have been updated	**CH** **12th Nov 14**

NO.	SUBJECT	OUTSTANDING RESPONSIBILITY	ACTION LEAD
20	**Cosmocol® Macrogol laxative**	Ensure formulary and traffic lights have been updated	**Steve Moore 10th Sept 14**
21	**Golimumab for Ulcerative Colitis**	SW to update the next SPF on what price is being paid for golimumab, what the benefits are to the healthcare system. Also, to contact the drug company to discuss price	**SW 10th Sept 14**
22	**Subcutaneous Tocilizumab**	YDH to consider and provide feedback from their DTC meeting	**SW/ SK 10th Sept 14**
23	**Octasa® Mesalazine Tablets**	YDH and TST to consider, with the gastroenterologists, whether it would be viable to switch patients from Asacol® to Octasa® in primary care.	**SW and MA 10th Sept 14**
24	**InVita® 25,000 IU Vitamin D suspension**	Trusts were asked to review their use of unlicensed vitamin D preparations in favour of licensed preparations.	**SW, MA and SD 10th Sept 14**
25	**Vitaros® topical Alprostadil Cream**	Check SLS status and add to formulary if now covered by the SLS list	**CH 10th Sept 14**
26	**Ulipristal acetate 5mg tablets (Esmya®) for uterine fibroids**	Trusts to take back to their specialists to consider whether they would want to use 2 courses.	**SW and MA 10th Sept 14**
27	**Denosumab (Prolia®) 60 mg solution for injection in pre-filled syringe.**	Update formulary to reflect license extension.	**Steve Moore 10th Sept 14**
28	**Dabigatran (Pradaxa®)110 mg & 150 mg hard capsules**	Indication for treatment and prevention of DVT and PE to be added to formulary	**Steve Moore 10th Sept 14**
29	**Dabigatran (Pradaxa®)110 mg & 150 mg hard capsules**	Trusts to highlight to their clinicians that the indication for treatment and prevention of DVT and PE has been added to formulary	**SW, MA and SD 10th Sept 14**
30	**Budesonide 9 mg gastro-resistant granules (Budenofalk®)**	Add to formulary for induction of remission in patients with mild to moderate active Crohn's disease affecting the ileum and/or the ascending colon.	**Steve Moore 10th Sept 14**
31	**Leuprorelin 3.75 mg & 11.25 mg injection (Prostap® SR DCS, Prostap® 3 DCS) for neoadjuvant therapy in prostate cancer.**	Trusts to discuss with their teams about where this fits with NICE pathways.	**SW and MA 10th Sept 14**
32	**CCG PBR Excluded Drugs.**	CH to design a spreadsheet to compare YDH and TST data	**CH 10th Sept 14**
33	**CCG PBR Excluded Drugs- TST data**	SG to speak to John Beard about areas of overspend	**SG 10th Sept 14**

NO.	SUBJECT	OUTSTANDING RESPONSIBILITY	ACTION LEAD
34	**YDH Teriparatide Audit**	YDH to provide a formal audit correction SK to draft a proposal to eliminate the need for DEXA scanning of patients with progressive vertebral fractures.	**SK** **10th Sept 14**
35	**Oncotype Dx**	Trusts to feedback to clinicians that Specialist commissioning and NHSE have NOT agreed to fund this technology	**SK and MA** **10th Sept 14**
36	**Drug Safety Update**	Trusts to identify relevant safety issues identified and discuss with relevant clinicians. Especially discuss bradycardia risk with ivabradine,	**SW, MA and SD** **10th Sept 14**
37	**NHSE Patient Safety Alerts**	Trusts to discuss and address	**SW, MA and SD** **10th Sept 14**
38	**MHRA – Managing Medical Devices Guidance and Checklist**	Trusts to discuss and address	**SW, MA and SD** **10th Sept 14**
39	**Domperidone Restrictions**	Trusts to discuss and address	**SW, MA and SD** **10th Sept 14**
40	**Subcutaneous methotrexate**	Highlight the YDH passing the prescribing of s/c methotrexate back into primary care	**JS** **10th Sept 14**