NHS
Somerset
Clinical Commissioning Group

Minutes of the **Somerset Prescribing Forum** held in **Meeting Room 1, Wynford House, Lufton Way, Yeovil, Somerset** on **Wednesday 10 September 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
	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
	Dr Geoff Sharp	GP Delegate (Central Mendip Federation)	GS
	Stephanie Wadham	Medicines Information / Formulary Senior Pharmacist, Yeovil NHS Foundation Trust	SW
In Attendance:	Dr Nicola Hare	Consultant Gastroenterologist Taunton & Somerset NHS Foundation Trust	NH
Apologies:	Andrew Brown	Head of Medicines Management, Somerset Partnership NHS Foundation Trust	AB
	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 Andrew Dayani	Medicines Director, Somerset Partnership NHS Foundation Trust	AD
	Steve Du Bois	Senior Pharmacist Somerset Partnership NHS Foundation Trust	SD
	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
	Jon Standing	Chief Pharmacist, Yeovil District Hospital	JS

1 WELCOME

1.1 Geoff Sharp welcomed everyone to the meeting.

2 APOLOGIES

2.1 Apologies were provided as detailed above

3 DECLARATIONS of INTEREST

3.1
- Dr Barlow declared that she had some educational sponsorships to declare.
- It was noted that there was no declaration for Jon Standing or Matt Harvey.

CH agreed to find out and update the list accordingly.

Action CH

4 MINUTES OF THE MEETING HELD ON 9th July 2014

4.1 The Minutes of the meeting were agreed as an accurate record subject to the following amendments:

- SG stated that we recommended that domperidone to increase lactation at a dose of 10mg TDS for 1 week should be considered 'red' (hospital only) and that trusts should look at mechanisms through which to make a supply. CH to update the minutes.

Action CH

4.2 GS ran through the schedule of actions from the 9th July 2014 meeting. The following actions were discussed. All other actions were complete.

1. **Review of traffic light status of aripiprazole long acting injection–** SG had reviewed the evidence and agreed that the Traffic Light status of this product could be changed from BLACK to RED as requested by SomPar at the last meeting.

   Action: Steve Moore

2. **Neutropenic Sepsis Card-**

   At the last meeting Mark Ashley Reported that the first patients had recently been issued with cards last week with the intention of auditing and publishing the results. JB updated the group that these cards have now been quite widely disseminated and the figures are audited every month including those who don't have cards. There were no failures in August.

   YDH offer a different system where they use a PGD to treat suspected neutropenic sepsis instead of a card (which is essentially a prescription)

   Action closed

3. **Sharing SPF minutes with other Trusts-** CH reported that she had contacted RUH again regarding whether their DPG would like to see copies of SPF minutes in future. There has been no response. GS to follow up.

   Action: GS

4. **Humulin R U-500 insulin** - At the last meeting SG asked SW to check whether this product falls under 'Tariff'. SD had previously reported that he had spoken Su Down about this and SW also said the YDH had spoken to the diabetic nurses.

Action closed

5. **NICE DG12- Measuring fractional exhaled nitric oxide concentration in asthma.**

   Steve Moore had reported back the Respiratory Network Meeting that Dr Stone from TST had reported that they are using nitric oxide at TST the moment (Rob Stone says they are a useful diagnostic tool when new cases are referred). He also reported that although they are not using eosinophil saliva tests yet, it is probable feeling that NICE will approve these as best practice, so they are prepared for a switch.

   Dr Claire Parker (Respiratory Consultant) at YDH had previously said that they may want to use this and that there probably is some role for it.

   Noted and action closed

6. **Needle and Syringe Programmes Public Health Guidance –** Public Health have informed CH that they do not plan to review service provision against this guidance until at least October.

   It was noted that Orla Dunn will hopefully be returning to SPF from November so we should remove public health actions from the list as she should be able to update on progress in future.

   Noted and action closed

7. **DMARD Enhanced Service –**SG reported that no further progress had been made on the review of the Enhanced Service as the meeting has not taken place yet. SG to update at next meeting.

   Action SG

8. **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 she had contacted RUH again with no response. GS agreed to follow up.

   Action GS

9. **Universal Drug Chart –** SK reported that YDH had considered using the universal chart at their D&T meeting but had agreed not to implement it because the main value is in it being universal and no one else is using it.

   Noted and action closed

10. **Medicines Optimisation Prototype Dashboard-** SG Reported that the MMT had reviewed the dashboard and found a few actions for primary care which were noted at PAMM

    It was agreed that the dashboard would be brought back to a future SPF meeting because it will be developed and secondary care may also find it useful. **Action CH**

11. **PH 53: Overweight and obese adults - lifestyle weight management**

It was noted that Orla Dunn will hopefully be returning to SPF from November so we should remove public health actions from the list as she should be able to update on progress in future.

Noted and action closed

12. Subcutaneous (s/c) Tocilizumab- SK reported that YDH D&T had agreed that this would be an option in very stable patients only on a case by case basis.

SK noted that s/c tocilizumab is significantly more expensive than intravenous and that while the remission rates are very good there are issues around monitoring bloods. Tocilizumab often causes neutropenia. Homecare services are not flexible enough to deliver in a timely manner which makes it difficult to react to changes in blood results.

SK noted that YDH is treating complex patients with tocilizumab who have failed to respond to other therapy.

Noted and action closed

13. Ulipristal acetate 5mg tablets (Esmya®) for uterine fibroids-

YDH Response: SW reported that Mr Shah had said that 2 courses would not be regular practice but he may use it in a small number of patients

TST response: No response yet. TST to report back.

Action CB/JB

14. YDH Teriparatide Audit

SK reported that she is still working on the audit correction.

Action SK

SK reported that she has drafted a consensus statement for use of teriparatide when bone density scans of the lumbar spine are likely to be meaningless e.g. in the presence of progressive vertebral fractures. Statement to be presented at the next meeting.

Action SK

15. Subcutaneous methotrexate- SG reported that Jon Standing (JS) had written a letter to local GPs to highlight YDH passing the prescribing of s/c methotrexate back to GPs.

SK reported that some GP practices have been more helpful than others in taking on this prescribing. She asked for data on which practices in Somerset are and aren't prescribing methotrexate injections. SG agreed that we can provide the data to SK and JS.

Action CH

5 **MATTERS ARISING** (not otherwise on the agenda)

5.1 **Proposed Asacol® to Octasa® (mesalazine) switch -** Dr Nicola Hare (Inflammatory Bowel Disease lead for TST) attended the meeting to discuss proposed switch. The main points of the discussion were:

- GS apologised that the Medicines Management Team (MMT) had started promoting a switch from Asacol® to Octasa® before discussions with TST had been concluded.
- GS and SG said that given the current financial pressures in primary care, if possible, they would like to switch appropriate patients from Asacol® to Octasa®. If all patients were switched, this would result in a £74k/ year saving in primary care across Somerset
- Dr Hare (NH) explained that they appreciate the need to prescribe cost effectively but believe that it is important to be very careful about switching between 5-ASA products.
- NH expressed concern that there are no patient studies, only in vitro studies that demonstrate bioequivalence therefore we don't really know what the effect on patients will be from switching between products. There are no long term outcome data from switches to Octasa®. Some patients are very sensitive to particular product and may get a flare up of disease.
- NH said that the approach at TST is that they want to make sure that adherence is good because there is strong evidence that this is critical to preventing relapse and that giving a smaller number of tablets less frequently helps. There is also evidence that once daily dosing is non-inferior to multiple daily dosing.
- NH said that there is also good evidence that patients achieve better maintenance of remission at mesalazine doses of 2.4g Asacol® or 2g Pentasa® (these are considered equivalent doses). TST believe that Pentasa® 2g OD is no more expensive than Octasa® 2.4g/day.
- Going forward NH said TST will be favouring Pentasa® as their first line mesalazine product because it is a once daily product when used in maintenance therapy. They are looking to cease to initiating patients on Asacol® .This is consistent with the approach of most Trusts in the south west.
- NH said that they would prefer to advocate that patients taking Asacol® are not switched. If the CCG does go ahead with switching patients they would like to ensure that these patients are monitored very closely.
- SW said that YDH gastroenterologists are comfortable initiating patients on Octasa® but while Dr Gotto is relatively relaxed about switching patients from Asacol® to Octasa®, not all their consultants take this view.
- SK commented that if patients become unstable, this is likely to be expensive to the NHS. However, patients who have been stable for a long time may be in a different category when it comes to switching between products whereas she would be much more concerned about patients with more serious/ unstable disease.
- SG and JB said that there is good in vitro data showing that that Asacol® to Octasa® are the same i.e. they dissolve at the same PH and will therefore release into the same part of the bowel and the dissolution rates are almost identical.SG stated that the MMT believes that on the basis of the in vitro studies, Asacol® to Octasa® are equivalent and that there is no evidence of harm from switching to Octasa®.
- GS said that in the light of the in vitro data, he felt less concerned about switching between these two products although he acknowledged that he would probably only want to switch patients with a history of long term stability.

- SG said that switching patients from BD to OD dosing may also affect bioavailability but TST are doing this. He said that there will always be a natural occurrence of relapse. The MMT would rather see Octasa® used first line.
- SG said that 25% of patients taking mesalazine in primary care are prescribed it generically which leaves them at risk of receiving a different brand every time they collect their prescription. It therefore makes sense to prescribe these products by brand. NH agreed with this point.

It was agreed that:

- the MMT will review the relative cost Pentasa® 2g OD v Octasa® 2.4g/day.
- the MMT will not encourage a 'blanket' switch of all patients taking Asacol® to Octasa®. GPs will be asked to consider switching patients on a case by case basis, in discussion with the patient.
- switches would only be made in patients with no history of poor control/ difficulties and patients known to be especially sensitive to changes in brand of mesalazine will not be changed. These expectations will be made clear to GPs and the MMT
- of the 25% of patients currently prescribed mesalazine generically, it would be reasonable to start prescribing a consistent brand for these patients.
- patients who are switched will be told to inform their GP of any change in symptoms.
- any changes would be limited to switching Asacol® to Octasa® and will not involve any other mesalazine products because the evidence of bioequivalence does not exist for other brands.
- GS would like to send a letter to secondary care setting out clearly, what we are intending to do

Action GS and SG

5.2 **Draft Antipsychotic Shared Care Guideline**- CH explained that the SCG proposed at the last meeting had been revised in the light of comments from PAMM and SPF on 9/7/14. CH ran through the main changes to the document and explained that she would be asking SomPar to make a couple of extra amendments requested by PAMM that morning. Once everyone is happy, the SCG will be published on the website. Forum members were in agreement.

Actions: CH to take comments back to SomPar D&T 11/9/14. CH to ask the psychiatrists to make reference to the SCG on the website in their letters to GPs.

Action CH

5.3 **Updated Infection Management Guidance.** The group viewed and noted a summary of recent changes to the infection management guidance.

5.4 **Golimumab – Simponi Patient Outcome commitment-** SG explained that MSD are offering reimbursement for patients who fail treatment on golimumab (all licensed indications) and that this may change the cost effectiveness of the rheumatoid arthritis pathway. SG asked whether it would be worth make it 'joint first choice' with certolizumab as both products are approved by NICE in this indication.

SG would like to ensure that the CCG gets a share of any reimbursement if made joint first line.
SK said that:

- rheumatologists don't perceive that one drug is better than another however, a

good accounting process would be required because the reimbursement formula is on this scheme is very complicated.

- The scheme is not currently delivering many savings because, in order to qualify, golimumab has to be used first line. YDH currently use it 2nd or 3rd line in RA and they really only use it in ankylosing spondylitis. It also requires home care to trigger the rebate.
- Certolizumab is currently being provided free by the company for the first 3 months but the perception is that patients are responding to the initial loading dose but then not responding at re-assessment. TST have reported a high failure rate with certolizumab.
- There will be no real loss to the Trust if a choice of first line agents is agreed and some patients may prefer once a month dosing that comes with golimumab.

SG and rheumatologists to review the position of golimumab in the RA pathway outside the meeting.

Action SG

5.5 **Draft cellulitis guideline-** the group viewed the draft guideline written by Dr Baker (Consultant Microbiologist)

The draft guidance was viewed- this had already been approved at PAMM subject to changing the word 'admit' to refer because primary care can't force an admission to hospital.

Action Ana Alves

6 D&TC DECISIONS

6.1 Somerset Partnership MICP

Last meeting 10/7/14. Minutes noted.

- It was noted that SomPar had approved the use of lurasidone (a new oral antipsychotic) via a managed entry system. A formulary application has been made to PAMM and SPF
- It was noted that Sompar are trying to address their high usage of modified release venlafaxine.

6.2 TST

Last meeting is due to take place 25/7/14. Minutes noted. CB updated the group that:

- Insulin degludec use is being audited in the Trust. Two recent patients have now been treated for 6 months as per predetermined indicators. It has been agreed that GPs can prescribe on a named patient basis. Trusts should state in their letter transferring treatment back to GPs that SG has agreed named patient prescribing by GPs after 6 months of treatment. Traffic light status to remain the same but note to be added.

Action Steve Moore

- Aprepitant-a new antiemetic licensed for prevention of nausea and vomiting associated with highly emetogenic chemotherapy. TST are thinking of extending its use for some further chemotherapy regimen. We should not expect to see requests for this in primary care.

6.3 BNSSG

The BNNSG formulary decisions webpage was viewed. It has been decided that because Weston belong to the BNSSG formulary group, it would be more helpful to view the BNSSG minutes in future. CH will make efforts to obtain the minutes to the BNSSG formulary meetings before the next PAMM.

6.4 YDH

Last meeting 22/7/14. SW updated the group on the minutes of their last meeting. Minutes noted.

6.5 Taunton & Somerset Antimicrobial Prescribing Group (TSAPG)

The notes from the last meeting attended by Ana Alves were viewed and noted

6.6 RUH Bath D&TC

The minutes of the June 14 were noted but no more up to date minutes available. GS to follow up.

Action GS

7 NICE

7.1

A summary of the NICE guidance published since the last SPF was presented to the Forum for information.

7.2 NICE TA316 Prostate cancer (hormone relapsed, metastatic) - enzalutamide (after docetaxel) (for noting)

Noted- positive appraisal- funded by specialist commissioning

7.3 NICE TA317: Acute coronary syndrome - prasugrel with PCI (review TA182)

Positive appraisal. Approved. Need to ensure that TLS and formulary are updated.

Action: Steve Moore

7.4 NICE TA318: Constipation (chronic idiopathic) - lubiprostone

Positive appraisal. Approved for formulary as per NICE guidance. Ensure that TLS and formulary are updated.

Action: Steve Moore

7.5 NICE TA319: Melanoma (previously untreated unresectable stage III or IV) - ipilimumab

Noted- positive appraisal- funded by specialist commissioning

7.6 NICE CG320: Multiple sclerosis (relapsing remitting) - dimethyl fumarate (for noting)

Noted- positive appraisal- funded by specialist commissioning

7.7 NICE CG 181: Lipid modification (update)

SG highlighted the updated guidance. The formulary will be updated with NICE recommendations.

Action: Steve Moore

7.8 **NICE CG 182: Chronic kidney disease (update)**
SG highlighted the updated guidance.

7.9 **NICE IPG 496: Endoscopic radiofrequency ablation for Barrett's oesophagus with low-grade dysplasia or no dysplasia-** Guidance noted

7.10 **NICE IPG 497: Endoscopic radiofrequency ablation for squamous dysplasia of the oesophagus-** Guidance noted

7.11 **NICE IPG 499: Minimally invasive video-assisted thyroidectomy -** Guidance noted

7.12 **NICE IPG 499: Total prosthetic replacement of the temporomandibular joint -** Guidance noted

8 **HORIZON SCANNING**

The following horizon scanning documents were made available to SPF members in advance of the meeting. Relevant items had from these had already been added to the agenda:

8.1

- **RDTC Monthly Horizon Scanning document May and Jun 14**

8.2

- **UKMI Prescribing Outlook –** SG noted that there will be external meetings using this document to plan for next year. He will start to arrange these.

Action SG

8.3

- **UKMi New Drugs Online Newsletter**

8.4

- **A list of forthcoming NICE ESNM and ESUOM**

9 **FORMULARY APPLICATIONS**

9.1 **Lurasidone (Latuda®)**

This is a new oral antipsychotic which has been approved for use in SomPar via a 'managed entry' system. The group agreed to approve as a RED drug. Steve Moore to update TLS.

Action: Steve Moore

9.2 **Budesonide/ Formoterol fumerate dihydrate inhaler (Duoresp Spiromax®) Teva**
A new inhaler being marketed by Teva. It is equivalent to Smbicort but has a different delivery system and is approximately 20% cheaper than Symbicort. Agreed to add the formulary and traffic lights as a GREEN drug. **Action: Steve Moore**

9.3 **Empagliflozin 10 mg & 25 mg film-coated tablets** (Jardiance®), Boehringer Ingelheim)
A newly launched SGLT-2 inhibitor. Dapagliflozin and canagliflozin are alternative drugs in this category and are already on the formulary for use in accordance with

NICE guidance on dapagliflozin. Empagliflozin is roughly the same price as the other SGLT-2 inhibitors.

Agreed to add to the formulary as a GREEN drug. Formulary and TLS to be updated.

Action: Steve Moore

9.4 **Apixaban 2.5 mg & 5 mg film-coated tablets** (Eliquis®) BMS/Pfizer

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

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

Action: Steve Moore

9.5 **Liothyronine prescribing**

The group viewed data showing the high cost of liothyronine prescribing to the CCG. SG explained that the Royal College of Physicians does not recommend treating hypothyroidism with T3. It should normally only be used in the severe, acute hypothyroid states where a rapid effect is needed or as an adjunct to carbimazole to prevent sub-clinical hypothyroidism during treatment for thyrotoxicosis.

SG said the CCG is clear that it does not want to commission a treatment that is not recommended for long term use. He proposed that consultant requests for liothyronine, should be treated as red drug in the traffic light scheme and that we should adopt a strong position that this is not recommended in primary care. SPF agreed. Steve Moore to update the TLS.

Action: Steve Moore

10 **NHS ENGLAND SPECIALIST COMMISSIONING**

10.1 **Changes to the PbR excluded drugs list-** SG explained that the list has been updated and noted that:

- The CCG should no longer be billed for sodium oxybate because this is now funded by NHSE. Jean Perry will need to work on this.

Action: JP

- Octreotide and lanreotide are now funded by NHSE for specified conditions. Trusts will need to have clear procedures to identify that these drugs are being charged and used appropriately.

- Trusts will need to go through the list. After this meeting, the CCG will no longer fund ongoing costs for drugs in the revised list.

Action JB and SW

11 **PBR EXCLUDED DRUG MONITORING**

11.1 **CCG PBR Excluded Drugs.**

HK had produced a spreadsheet allowing the group to compare YDH non-PBR budget data with TST data. SG explained that this is not ideal as TST are unable to provide data in the standard format that we requested. The main points identified were:

- TST has≈ £75k overspend on the drugs that we are able to compare with YDH. This largely comes from aflibercept and lots of the biologicals. There is a big underspend on ranabizumab.
- YDH has≈ £63k undererspend on the drugs that we are able to compare with YDH. SK commented that this may be partly due their capacity to see patients at YDH and longer wait times. SG agreed to discuss capacity issues outside the meeting.
- Much of the data that TST provide is on devices rather than drugs which is not within the remit of SPF to review but there is an overspend
- SG commented that one of the reasons for the TST overspend is because their budget uplift was calculated based on the budget for last year rather than the outturn (which wasn't overspent). However, we will need to seek assurances that drugs we are overspent on are being used in accordance with NICE guidance.

12 DRUG SAFETY

12.1 **MHRA Drug Safety Update July and Aug 2014**

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

Action: All

12.2 NICE Safe staffing guidance for nursing in adult inpatient

Agreed that all trusts should discuss and address

Action: YDH, SomPar and TST

12.3 NHSE Patient safety alert: Patient safety alert on risks arising from breakdown and failure to act on communication during handover at the time of discharge from secondary care

Agreed that all trusts should discuss and address. NHSE requested that organisations provide feedback on activity in these areas.

Action: All

12.4 NHSE Patient safety alert: Risk of inadvertently cutting in-line (closed) suction catheters

Agreed that all trusts should discuss and address if appropriate to their services.

Action: YDH, SomPar and TST

12.5 NHSE Patient safety alert: resources to support the prompt recognition of sepsis and the rapid initiation of treatment

Agreed that all trusts should discuss and address.

Action: All

13 ANY OTHER BUSINESS

No other business was raised

14 DATE OF NEXT MEETING

- 12 November 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 10 SEPT 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	**Declarations of interest**	Update the list for Dr Barlow, Matt Harvey and Jon Standing	**CH 12th Nov 14**
4	**Sharing SPF minutes with other Trusts**	Follow up RUH regarding whether they would regularly like to see copies of SPF minutes	**GS 12th Nov 14**
5	**Enhanced Service for DMARDs**	SG to update the group on progress of the review of Enhanced service	**SG 12th Nov 14**
6	**RUH thromboprophylaxis for patients post fracture**	CH to follow up again in September to see whether there has been any further progress.	**CH 12th Nov 14**
7	**Medicines Optimisation Prototype Dashboard**	Consider at a future meeting	**CH 12th Nov 14**
8	**Ulipristal acetate 5mg tablets (Esmya®) for uterine fibroids-**	TST to report back on whether their consultants would want to use 2 courses of ulipristal rather than one.	**CB/JB 12th Nov 14**
9	**Teriparatide audit and bone density scanning**	SK to present audit correction and consensus statement on bone density scanning at next meeting	**SK 12th Nov 14**
10	**Subcutaneous Methotrexate injection**	CH to provide SK and JS with ePACT data on which Somerset practices are prescribing MTX s/c injections	**CH 12th Nov 14**
11	**Review costs of Pentasa® vs Octasa®**	Review cost Pentasa® vs Octasa® at equivalent maintenance doses.	**CH 12th Nov 14**
12	**Proposed Asacol® to Octasa® (mesalazine) switch**	Write to YDH and TST gastroenterologists setting out what we are intending to do.	**GS & SG 12th Nov 14**
13	**Antipsychotic SCG**	CH to finalise with SomPar	**CH 12th Nov 14**
14	**Golimumab**	SG and rheumatologists to review the position of golimumab in the RA pathway outside the meeting.	**SG 12th Nov 14**
15	**Draft Cellulitis Guidance**	Ana Alves to ensure that the necessary amendments are made to wording as agreed at PAMM.	**Ana Alves 8th Oct 14**

NO.	SUBJECT	OUTSTANDING RESPONSIBILITY	ACTION LEAD
16	**RUH DPG Minutes**	GS to ask whether they can continue to send minutes of DPG meetings,	**GS** **8th Oct 14**
17	**Jaydess® coil**	SomPar to bring an application to PAMM and SD to look into whether extra training is needed- as per July SPF minutes.	**SD** **8th Oct 14**
18	**Prescribing horizon scanning/ planning meetings**	SG to arrange	**SG** **12th Nov 14**
19	**Formulary/ Traffic Light Changes**	• **Aripiprazole Long Acting Injection** – update Traffic light status to RED • **NICE CG 181: Lipid modification -** update formulary to reflect new guidance • **NICE TA317: ACS - prasugrel with PCI-** update formulary and TLS • **Lubiprostone-** Add to formulary and TLS as per NICE guidance • **Liothyronine-** Update Traffic Light status to 'not recommended' but RED for consultant requests • **Lurasidone** (Latuda®) Add to TLS as a RED drug • **Duoresp Spiromax®-**Add to formulary and TLS as a GREEN drug • **Empagliflozin-** Add to formulary and TLS as a GREEN drug • **Apixaban-** extended licensed indications of DVT and PE to be added to the formulary	**Steve Moore** **12th Nov 14**
20	**Sodium Oxybate**	Ensure that the CCG is no longer being charged for this drug	**JP** **12th Nov 14**
21	**Changes to the PBR excluded list**	Trusts to go through the revised list and ensure that they are no longer charging for drugs that have been added to the list	**JB &SW/ JS** **12th Nov 14**
22	**Drug Safety Update and NHSE Patient Safety Alerts**	Trusts to identify relevant safety issues identified and discuss with relevant clinicians.	**All** **10th Sept 14**