NHS
Somerset
Clinical Commissioning Group

Minutes of the **Somerset Prescribing Forum** held in **Meeting Room 1, Wynford House, Lufton Way, Yeovil, Somerset** on **Wednesday 15th July 2015**

Present:	Jon Beard	Chief Pharmacist, Taunton & Somerset NHS FT	JB
	Shaun Green	Associate Director, Head of Medicines Management, NHS Somerset CCG	SG
	Liz Harewood	Acting Deputy Head of Medicines Management, SD Somerset Partnership NHS Foundation Trust	LH
	Catherine Henley	Medicines Manager, NHS Somerset CCG	CH
	Gordon Jackson	Patient Representative	GJ
	Albe Ng	Pharmacoeconomic Pharmacist, Yeovil District Hospital	
	Jean Perry	Commissioning Manager, NHS Somerset CCG	JP
	Donna Yell	Prescribing Support Technician, NHS Somerset CCG	DL
Apologies:	Dr Clare Barlow	Chair, Drug & Therapeutics Committee, Taunton & Somerset NHS FT	CB
	Rosemary Brook	Consultant Psychiatrist Somerset Partnership	RB
	Lynda Coles	Vice Chair, Local Pharmaceutical Committee	LC
	Steve Du Bois	Acting Head of Medicines Management, Somerset Partnership NHS Foundation Trust	SD
	Dr Orla Dunn	Consultant in Public Health, Somerset County Council	OD
	Dr Steve Edgar	GP, Somerset Local Medical Committee representative	SE
	Matt Harvey	Development and Liaison Officer, Somerset LPC	MH
	Dr Sally Knights	Chair, Drug & Therapeutics Committee, Yeovil District Hospital	SK
	Dr Geoff Sharp	GP Delegate (Central Mendip Federation), Chair	GS
	Jon Standing	Chief Pharmacist, Yeovil District Hospital	JS
	Stephanie Wadham	Medicines Information / Formulary Senior Pharmacist, Yeovil NHS Foundation Trust	SW

1 WELCOME

Shaun Green welcomed everyone and explained that he would be acting as chair because GS was at another meeting. Albe Ng (Pharmacoeconomic Pharmacist from YDH) was introduced to the group as she was at the meeting to represent YDH following apologies from, JS, SW and SK.

2 APOLOGIES

Apologies were provided as detailed above.

3 DECLARATIONS of INTEREST

SG asked for declarations of interest- no new interests were declared. Albe Ng stated that she had no interests to declare. CH to update declarations accordingly.

Action CH

4 MINUTES OF THE MEETING HELD ON 20th May 2015

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

4.2 SG ran through the action points from the last meeting. The following items were specifically noted:

1. **Bisphosphonate drug holidays** SG stated that Scotland are looking at publishing guidelines on this topic and requested that this should be kept on the agenda for SPF. **Action CH**

2. **Teriparatide-** JB stated that 2 IFRs had been raised by TST for men receiving teriparatide. There are no men who are having teriparatide via YDH.

3. **CG61 Irritable bowel syndrome in adults**

   The issue of 'off label' use of TCAs and SSRIs in IBS had been considered and accepted by YDY Drug and Therapeutics Committees (DTCs) and this item is on the July agenda for TST.

4. **Statement to go to GPs on Nalmefene for reducing alcohol consumption in people with alcohol dependence.** CH had drafted a statement and was waiting for comment from Christina Gray (Public Health Consultant) before sharing.

5. **NG5: Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes.** It was decided that this item would be postponed until September to allow everyone time to finalise their assessments.

5 MATTERS ARISING (not otherwise on the agenda)

5.1 Melatonin for Hemicrania Continua (HC) and Parkinson's Disease (PD) – choice of product and duration of treatment

SG stated that lots parts of the country use melatonin with sparse evidence and at high cost. New applications need to have a supportive evidence base.

Nigel Ankcorn had been asked to enquire with the specialists regarding the intended choice of product and intended duration of treatment for patients with.

SG acknowledged that there is potentially large population of patients with Parkinson's Disease who will fit into the licensed indications for Circadin® i.e. over 55s with insomnia for max treatment duration of 13 weeks.

However, with Hemicrania Continua we have asked Nigel Ankcorn to confirm with the specialists the doses they would wish to give and what drugs they would trial in the pathway before using melatonin. The CCG would expect would expect to see a therapeutic trial showing benefit before the GP should be asked to prescribe. CH to follow up with Nigel Ankcorn. **Action CH**

LH stated that SomPar may bring an application for use. SG said that the CCG would be happy to consider new evidence.

5.2 Acute Kidney Injury- Trust actions to identify and minimise AKI

It was noted that YDH had put in place a package of measures to help identify, and minimise the risk of AKI including yellow stickers to prompt a risk assessment and review of AKI risk. Junior doctors at YDH have been issued with lanyards providing details of actions to prevent/ screen for AKI

SG asked AN to help identify patients who had been admitted to YDH with AKI from primary care and provide anonymised data to the CCG. **Action AN**

SomPar confirmed that they are compliant with NICE Quality Standard 76

JB had contacted the renal specialists to request a response on action taken to minimise and identify AKI. Unfortunately, they had not yet responded. JB confirmed that the order comms system has an alert report which is created after each U&E request – this identifies patients at risk of AKI and has been in use since March 15. Await response for renal specialists. **Action: JB/CH**

It was agreed that DY would collate the YDH, TST and SomPar responses and circulate to Rachael Rowe, SG and Steve Moore. **Action: DY**

It was agreed that the CCG AKI resources would be shared with YDH, TST and SomPar. **Action: CH**

5.3 Bone morphogenic protein (BMP)

SG explained that spinal surgery is under the remit of NHS England (NHSE) specialist commissioning. BMP is no longer 'routinely commissioned' by NHSE and therefore it was agreed that Individual Funding Requests (IFRs) would be required going forward.

There is some use at TST but none in YDH. JB agreed to inform the spinal surgeons of decision.

5.4 Low Molecular Weight Heparin bridging therapy guidance

SG explained that the CCG is not yet in a position to agree the guidance from Taunton which has been reviewed and improved. There are a number of areas that need further review/ clarification:

- The policy should be reviewed in the context of the BRIDGE study.
- CHA_2DS_2-VASC rather than CHADs2 score should be used to assess stroke risk in patients with Atrial Fibrillation (AF), in line with current NICE guidance.
- YDH need to be consulted regarding the policy. Ideally, there would be a consensus between YDH and TST.
- LMC have asked that the policy should provide clarity over who will be

undertaking monitoring and prescribing. At the moment, this is not explicit.
- There needs to be clear guidance within the policy on what should happen when surgery is cancelled.

JB agreed to take these comments back to the specialists and ask them to review again. **Action JB**

SG asked that Trusts ensure that committees looking at policies that may affect primary care, have some dialogue with primary care

5.5 Guidance on use of supplements and monitoring for bariatric surgery Progress of Drug Monitoring in Primary Care Enhanced Service

This document written by the dieticians at TST was approved at the last TST DTC meeting. SG has since passed on recent (British Obesity and Metabolic Surgery Society (BOMs) Guidance. JB agreed to ask TST to look at the discrepancies between their document and the BOMs guidance. **Action JB**

The Royal College of General Practitioners (RCGP) has also produced some guidance on monitoring and prescribing after bariatric surgery and LMC have been asked to consider whether GPs could prescribe and monitor in line with the RCGP guidance. SG to follow up with LMC. **Action SG**

SG emphasised that the national specification for bariatric surgery states that the secondary care provider needs to monitor the patient for the first 2 years after surgery. He also stated that the LMC needs to find some agreement with the CCG, perhaps to improve shared care.

5.6 Antipsychotic Shared Care Guideline (SCG)

CH reported that SomPar had agreed to add patients with bipolar disorder who are being treated with antipsychotics. This in line with the NICE guideline for bipolar disorder which also recommends that the secondary care team should maintain responsibility for monitoring the efficacy and tolerability of antipsychotic medication for at least the first 12 months and that the monitoring requirements are the same as those laid out in CG178.

Since then, the NICE guidance (NG11) 'Challenging behaviour and learning disabilities' had been published which also states that patients taking antipsychotics should be monitored by the secondary care team for at least the first 12 months as per NICE CG178. At the recent SomPar meeting, CH had requested that this group is also added to the SCG. However, Sompar had raised concerns that this may result in GPs returning patients who are stable to the care of the secondary care specialists, which could reduce the responsiveness of their services. LH mentioned that lots of patients with learning disabilities get placed in Somerset because it is cheaper for their own Trusts and that this would also have implications for SomPar if they started seeing these patients referred back to them.

It was agreed that:
- dementia patients taking antipsychotics will not be included in the SCG but this does not remove the responsibility of clinicians to review these regularly.
- the SCG is primarily intended to cover new patients rather than to push back stable patients into secondary care.
- the SCG will be amended to cover patients included in NICE NG11 taking an antipsychotic.

- a line will be added stating that the SCG covers patients with learning disabilities who have been initiated on an antipsychotic under the care of a **Somerset specialist** in psychiatry.
- the amended version of the SCG will be published on the CCG website.

Action SG

SG stated that LMC and Sompar should raise via the commissioning route if they believe the SCG places an additional burden on their services.
SG highlighted the recently published national call to action on 'over medication' in learning disabilities following a number of reports detailing significant evidence of over-use of antidepressant and antipsychotic drugs in this group of patients. There will be increased scrutiny in this area of prescribing going forwards.

5.7 National acute trust PHE antibiotics data validation audit

This audit is a requirement under the CCG Quality Premium for this year. YDH confirmed that they are participating and TST confirmed that they are working on the data. Trusts were asked to confirm when the data has been submitted.

Action JB/AN

5.8 Traffic Light status of Rifaximin for preventing episodes of overt hepatic encephalopathy

It was noted that both acute Trusts that the traffic light status of rifaximin for this indication should be RED (hospital only) for Somerset patients. Formulary to be updated.
Action Steve Moore

6 OTHER ISSUES - no other issues were raised

7 D&TC DECISIONS

7.1 Somerset Partnership D&T meeting

There were no minutes available from the last meeting held 8/7/15.

LH gave a verbal update:

- they discussed medicines guidance in NICE NG10 on short term management and the violence and aggression in mental health settings and SomPar are reviewing their rapid tranquilisation guidance in response to this.
- Translabel was highlighted. It is a free website http://www.translabel.co.uk/ that translates pharmacy labels into a large number of different foreign languages and can also provide large print labels. The translations are all validated. SG agreed that the Medicines Management Team (MMT) should review the website as it may be useful in primary care. **Action: MMT**

7.2 TST

There had been no new meetings of TST DTC since the last SPF. Their next meeting is due 31/7/15.

7.3 Taunton & Somerset Antimicrobial Prescribing Group (TSAPG)

SG stated that a county wide group has not been agreed because each of the Trusts wanted to keep their own groups. LH stated SomPar do not currently have a specific antimicrobial lead and that antibiotic stewardship is an issue for them..

SG said that there is a county wide strategic infection control group and he has asked to have some oversight of the antimicrobial work so that we are seen to have a county wide group.

LH highlighted that they sometimes have problems with the differences in advice with RuH facing community hospitals. SG responded that we recommend that patients are treated in line with the Somerset Formulary but acknowledged that Trusts are free to make their own decisions.

7.4 YDH DTC

- The manufacturer of apremilast is currently providing supplies free of charge in appropriate patients with plaque psoriasis until the NICE guidance is published. SG has agreed the use of apremilast on behalf of the CCG for TST and YDH on the understanding that the drug company pick up the cost of the complete course for any patients who have been commenced on apremilast.

- YDH have approved apomorphine for selected patients with Parkinson's disease. The formulary status remains red (hospital only) because it is not a PbR excluded drug. Steve Moore to update the formulary. **Action Steve Moore**

  AN stated that while YDH has clinically approved this use of apomorphine, they haven't yet given financial approval. SG and AN agreed that there needs to be further consideration around what to do regarding patients who don't respond to apomorphine. SG said that if a home care route becomes available for apomorphine, then that may make it a PbR excluded drug. He will investigate further.

- Micafungin® approved for invasive candidiasis in line with decision already made by TST
- Magnaspartate® has been approved as a licensed magnesium supplement.

  Yeovil are looking at using Ferinject® but JB commented that TST are looking at reducing its use. JB said it was introduced in 2012 at TST by the haematologists who believed that the costs would be offset by reduced transfusion costs and staff time. However, TST have found that their transfusion and staff costs have not reduced as a result. JB warned that YDH should be very cautious in the use of Ferinject® as it may just increase cost pressures. AN agreed to take this information back for YDH to review. **Action: AN**

SG said that Ferinject® is amber in primary care but there is no funding for use. There is a group within the CCG looking at IV iron use. There is the potential that there may be some use in Frome Community Hospital as part of a pilot of an ambulatory care project. This will need to be evaluated in detail.

7.5 BNSSG Joint Formulary Group

No new minutes received.

7.6 RUH Bath D&TC

It was noted that RuH have approve Dulaglitide- a once weekly GLP1 agonist. The basis for the decision was that it is licensed for patients on insulin (where other drugs is the class aren't) and it has a better needle guard so some patients find it more comfortable to inject compared with once weekly exenatide. However the group

noted that it is significantly more expensive than once weekly exanetide.
PAMM and SPF decided against adding this product to the formulary in March 2015 and it was decided that the CCG would maintain this position.

8 NICE

8.1 A summary of the NICE guidance published since the last SPF was provided to the Forum for information. Relevant items had been placed on the agenda.

8.2 TA339: Omalizumab for previously treated chronic spontaneous urticaria

Positive appraisal noted- funded by NHS Specialist Commissioning. Formulary to be updated –RED (hospital only status). **Action: Steve Moore**

8.3 TA340 Ustekinumab for treating active psoriatic arthritis (rapid review of technology appraisal guidance 313)

Positive appraisal with patient Access Scheme (PAS)- agreed that the CCG will commission for patients covered by the TAG. Formulary to be updated –RED (hospital only status). **Action: Steve Moore**

8.4 TA 341 Apixaban for the treatment and secondary prevention of deep vein thrombosis and/or pulmonary embolism

Positive appraisal- agreed at PAMM in June. Formulary to be updated –GREEN Traffic Light Status **Action: Steve Moore**

8.5 TA 342: Vedolizumab for treating moderately to severely active ulcerative colitis

Positive appraisal agreed that the CCG will commission for patients covered by the TAG. Formulary to be updated –RED (hospital only status). **Action: Steve Moore**

8.6 TA343 Obinutuzumab in combination with chlorambucil for untreated chronic lymphocytic leukaemia

Positive appraisal noted- funded by NHS Specialist Commissioning. Formulary to be updated –RED (hospital only status). **Action: Steve Moore**

8.7 TA344: Ofatumumab in combination with chlorambucil or bendamustine for untreated chronic lymphocytic leukaemia

Positive appraisal noted- funded by NHS Specialist Commissioning. Formulary to be updated –RED (hospital only status). **Action: Steve Moore**

8.8 FAD ID718: Secukinumab for treating moderate to severe plaque psoriasis

SG commented the final appraisal determination (FAD) is positive so NICE are likely to recommend secuckinumab in moderate to severe plaque psoriasis unless there is an appeal.

The FAD clearly states that secuckinumab is superior to ustekinumab in this indication and the CLEAR study also backs this up. SG recommended that Trusts highlight this internally as we may get better results for the money. The group agreed to commission secukinumab in advance of the NICE guidance in line with the recommendations in the FAD. Formulary to be updated –RED (hospital only status). Action: Steve Moore

8.9 **NG 8: Anaemia management in people with chronic kidney disease**

SG explained that this guidance talks about the place of oral iron, IV iron, erythropoetins and blood transfusions. He asked Trusts to review their practice and ensure that everything is being used in the correct place. He asked Trusts to highlight any gaps in provision to meet this guidance.

Guidance also talks about patients who are on dialysis and we may need to raise with the provider.

8.10 **NG 9: Bronchiolitis in children**

SG stated that he had rasied this guidance with Trusts via paediatrics and microbiology.

8.11 **NG10: Violence and aggression: short-term management in mental health, health and community settings**

SomPar had already confirmed that they are reviewing their practice in the light of this guidance.

SG stated that it may also be relevant in non-mental health settings such as A&E and community hospitals and suggested that acute trusts may also want to consider this guidance

8.12 **NG11: Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges**

SG highlighted that this guidance encourages clinicians to avoid over medicating patients with learning disabilities. Antipsychotics should not be used unless they are absolutely necessary and that the NICE monitoring guidelines for antipsychotics should be followed. SG encouraged all areas to work together to improve prescribing for this group of patients.

LH stated that this is an area that SomPar will be looking at in more detail.

8.13 **NG12 Suspected cancer: recognition and referral**

SG explained that this guidance has implications for the number of referrals and diagnostic tests needed. He acknowledged that this was potentially positive provided the right patients are being referred.

The idea of having a validated 'rules based decision making' referral system to ensure that appropriate patients are referred, that may help to minimise referrals. There is a risk of the system getting clogged with inappropriate referrals. SG asked that Trusts work with the CCG on this to evaluate the possible solutions to improve the referral process and access to direct referral for GPs.

JB agreed to ask Dr Clare Barlow to bring back any concerns from the specialists back to SPF where there are areas that will create pressure. AN to ask YDH to consider.

Action: JB/CB/AN

8.14 **NG13: Workplace policy and management practices to improve the health and**

wellbeing of employees
SG has highlighted this guidance to the CCG HR department and suggested that Trusts, as employers to consider this too.

8.15 SG noted that NICE have been asked not to proceed with further 'safe staffing guidance'

Public Health Guidance- None in May or June 15

NICE Diagnostic Guidance- Nil Noted

9 HORIZON SCANNING

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

9.1 • **RDTC Monthly Horizon Scanning document May and June 15**

9.2 • **UKMI Prescribing Outlook and New Drugs Online**

9.3 • **A list of forthcoming NICE ESNM**

9.4 • **NICE forward planner**

SG encouraged Trusts to raise items with SPF.

SG noted that that biosimilar insulin glargine and etanercept will be launched soon and asked Trusts to raise this internally. Somerset will be looking at early adoption of these products (provided they are more cost effective than the originator product) in order to release cost savings.

JB stated that TST have looked in detail at the ethical considerations around asking patients to receive biosimilar products that have data showing that their safety and efficacy is comparable to the originator brand. They have concluded that there should be no problem with asking patients to receive a biosimilar product SG asked Trusts to work with their clinicians to get them to look at adopting biosimilar products where they become available. Our understanding of NICE guidance is that biosimilars can be considered equivalent to the originator brand. SG pointed out that given current cost pressures, the CCG, as commissioner, may have to insist that biosimilars are used if budgets start to overspend.

10 FORMULARY APPLICATIONS

10.1 Fosfomycin Trometamol 3g granules

A licensed fosfomysin product is now available. The current pathway requires a proforma to be sent to acute Trusts that hold imported stock.
SG would like to raise awareness that this product is GREEN Traffic Light status but only on the recommendation of microbiology.

10.2 Consilient brand emergency contraception: Levonorgestrel 1500mcg tablet (Upostelle®)

This is equivalent to Levonelle® but more cost effective and has been accepted onto the Somerset formulary. Trusts were asked to look into adopting. Formulary to be updated, Formulary to be updated. **Action Steve Moore**

10.3 Nutilis clear

Noted as a more cost effective thickener. This has been added to the formulary on the advice of the dieticians . Formulary to be updated. **Action Steve Moore**

10.4 Sirdupla Metered Dose Inhalers (MDI)

This product is a like-for –like Seretide MDI equivalent but it is 25% cheaper than Seretide. It was highlighted that only the 125 and 250 strengths are currently being manufactures, it is not licensed in patients under 18 years and it is not licensed and COPD.

Trusts were informed that they may start to see patients on this product. SG also highlighted that primary care are looking to step-down patients from inappropriately high doses of inhaled corticosteroid where they have been stable for some time.

JB reported that the TST respiratory team is not all that keen on switching to branded generic respiratory products. However, he will continue to try.

AN reported that their respiratory specialists were OK with switching to Sirdupla within licensed indications.

Formulary to be updated. **Action Steve Moore**

10.5 Prednisolone Dompe 1mg/ml oral solution single dose (5ml) vials

This product has been added to the formulary because it is 35% cheaper than the soluble tablets. Trusts to consider.

Formulary to be updated. **Action Steve Moore**

10.5 Nutriplen Compact

This product is nutritionally equivalent to Fortisip Compact but 25% cheaper in primary care. The CCG currently spends £120k/ yr on Fortisip Compact. Trusts were asked to tell their dieticians not to specify a brand in their letters.
The group agreed that this should be added to the formulary. **Action Steve Moore**

10.5 Ivermectin Cream (Soolantra®) 10mg/g for the treatment of the inflammatory lesions of rosacea £18.29/ 30g)

This product has been licensed for the treatment of the inflammatory lesions of rosacea. NICE guidance is not due until December.

SG stated that it is more costly than topical metronidazole but it may stop a cohort of patients progressing to oral antibiotics.

Trusts were asked to contact their dermatology and microbiology departments to ask whether they would like to bring an application. **Action JB/AN**

10.6 Fultium®-D3 2740IU/ml Drops

SG explained that there is a small cohort of patients who may benefit from additional vitamin D. It was agreed to add this to the formulary but not to actively recommend. Children who need a liquid preparation may qualify for Healthy Start vitamins.

Formulary to be updated. **Action Steve Moore**

10.7 Invita® D3 2,400 IU/ml oral drops

Added to formulary in the same way as Fultium® drops (see above)
Formulary to be updated. **Action Steve Moore**

10.8 Laxido® Paediatric Plain

This product is equivalent to Movicol® Paediatric but is 35% cheaper and was added to the formulary. SG pointed out that this may be something that Trusts wish to look at. Formulary to be updated. **Action Steve Moore**

11 NHS ENGLAND SPECIALIST COMMISSIONING

11.1 Updated national Cancer Drugs Fund (CDF) List

SG highlighted that Trusts should be aware of the updated list.

11.2 Annual investment decisions on certain specialist services

SG said that he wanted to make Trusts aware via the Forum that this document has been published highlighting what NHSE commissions. A number of their routine commissioning policies have also been updated. Trusts should look at these.

12 PBR EXCLUDED DRUG MONITORING

12.1 Trust Data

YDH and TST still have no agreed budgets for PbR excluded drugs for 15/16.

SG pointed out the escalating costs of rituximab at TST. JB agreed to look into why the growth has occurred and whether they are using it within the agreed pathways. SG also asked TST to ensure that the CCG is not being inappropriately charged for cancer patients who should be funded via the Cancer Drugs Fund. JB said that he is sure that all supplied are appropriately mapped. SG pointed out that rheumatology patients should have vailed on an anti TNF first before moving on to rituximab. JB and SG agreed that the overall spend by the end of the year may balance but this needs to be looked into. **Action JB**

SG also highlighted that YDH is on a trajectory towards an overspend on infliximab and pointed out that they should be reviewing patients who are on non biosimilar infliximab. At the moment YDH are only starting new patients on the biosimilar product. SG discussed this with Jon standing last week and he is aware of this.

JB pointed out that against national DEFINE data, both Trusts perform very well nationally (well below average) for PbR excluded spend. SG asked JB to bring the DEFINE data to the next meeting. **Action JB**

SG emphasised that patients have an NHS constitutional right to receive NICE approved treatment. It should be made possible for all patients who meet the NICE criteria to receive the treatment regardless of the budget that has been set.

13 Medicines Optimisation Prototype Dashboard

SG stated this has been updated. He asked Trusts to review and bring back action pints next time. **Action JB/ AN/LH**

14 DRUG SAFETY

14.1 MHRA Drug Safety Update May and June 2015

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

Specifically, the following items were highlighted and Trusts were asked to take appropriate action:

- **SGLT2 inhibitors- risk of diabetic ketoacidosis –** This has been raised in primary care particularly around type 1 diabetics for whom, SGLT2 inhibitors are not licensed. SG asked Trusts to make the diabetes team aware
- **High dose Ibuprofen- cardiovascular risks –** SG stated that very few patients on more than 1200mg/d had been highlighted by Eclipse Live. Trusts should be aware of this issue.
- **IUD-** risk of uterine perforation during lactation and in the 36 weeks after birth- LH confirmed that the CASH service is aware. JB agreed to ensure that BPAS are also aware.

JB to check whether GPs are referring into secondary care to carry out coil insertion. The pathway needs to be reviewed if this is happening.

14.2 Patient safety alert – risk of death or severe harm due to inadvertent injection of skin preparation solution.

It was agreed that Trust should highlight this internally.

15 ANY OTHER BUSINESS

None noted

16 DATE OF NEXT MEETING

- 9th September 2015 **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 ARISING FROM THE MEETING HELD ON 15 JULY 2015

NO.	SUBJECT	OUTSTANDING RESPONSIBILITY	ACTION LEAD	Status
1	**Declarations of interest (1)**	Members were asked to notify the Prescribing Forum secretary of any standing declarations of interest, which could be held on record.	**All (on going)**	**Ongoing**
2	**Declarations of interest (2)**	Update list with declaration for Albe Ng	**CH 9th Sept 15**	**Complete**
3	**NG5: Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes**	Trusts to bring a baseline assessment back to SPF to look at any gaps in provision alongside the CCG.	**SG, JB, JS & SDB 9th Sept 15**	**On Sept agenda**
4	**Melatonin for Hemicrania Continua and PD related sleep disorder**	CH to follow up the intended choice of melatonin product and duration of treatment for these conditions with Nigel Ankcorn.	**CH 9th Sept 15**	**Discussions with SG ongoing**
5	**Acute Kidney Injury (1)**	YDH to help identify patients who have been admitted to YDH with AKI from primary care and provide anonymised data to the CCG for review at next SPF.	**AN 9th Sept 15**	**Ongoing**
6	**Acute Kidney Injury (2)**	Follow up actions on AKI with TST renal specialists	**JB/CH 9th Sept 15**	**On Sept agenda**
7	**Acute Kidney Injury (3)**	CCG to share AKI resources with YDH, TST and SomPar	**CH 9th Sept 15**	**Complete**
8	**Acute Kidney Injury (4)**	Collate Trust actions and share with Rachael Rowe, Steve Moore and SG	**DY 9th Sept 15**	**Complete**
9	**LMWH perioperative bridging policy**	Ask the specialists to look at the policy again in the context of the BRIDGE study, SPF and LMC comments	**JB 9th Sept 15**	**On Sept agenda**
10	**Guidance on the use of supplements and monitoring for bariatric patients. (1)**	JB to ask TST to look at discrepancies between its guidance and the BOMMs guidance	**JB 9th Sept 15**	**On Sept agenda**
11	**Guidance on the use of supplements and monitoring for bariatric patients. (2)**	SG to follow up comments around RCGP guidance and TST policy with LMC	**SG 9th Sept 15**	**On Sept agenda**

NO.	SUBJECT	OUTSTANDING RESPONSIBILITY	ACTION LEAD	Status
12	**Antipsychotic Shared Care Guideline (1)**	Amend SCG to cover NICE guidance on learning disabilities and challenging behaviour.	**SG 9th Sept 15**	**Complete**
13	**National acute trust PHE antibiotics data validation audit**	Trusts to confirm when data has been submitted	**JB/AN 9th Sept 15**	**Complete**
14	**Translabel- label translation website**	Await comments on guidance from the LMC	**Meds Management Team 9th Sept 15**	**Complete**
15	**NG12 Suspected cancer: recognition and referral**	JB agreed CB to bring back any concerns from the specialists back to SPF where there are areas that will create pressure. AN also to ask YDH to consider.	**JB/CB &AN 9th Sept 15**	**Awaiting Response**
16	**Ivermectin Cream (Soolantra®)**	Trusts to ask their specialists whether they would like to bring an application to SPF for this product.	**JB & AN 9th Sept 15**	**Complete- No application form dermatologists at present**
17	**TST Rituximab use**	JB to review Trust use of Rituximab and ensure that it is within Pathway	**JB 9th Sept 15**	**Complete**
18	**YDH Infliximab use**	YDH to review position on Biosimilar infliximab	**AN/JS 9th Sept 15**	**Awaiting Response**
19	**DEFINE Data on PbR excluded drugs**	JB to bring benchmarking data to the next meeting	**JB 9th Sept 15**	**On Sept agenda**
20	**Medicines Optimisation Prototype Dashboard**	Trusts to review and bring back action points to next meeting	**JB, AN & LH 9th Sept 15**	**On Sept agenda**
21	**IUD- risk of uterine perforation-** during lactation and in the 36 weeks after birth	JB to highlight recent MHRA alert to BPAS	**JB 9th Sept 15**	**Complete**
22	**Secondary Care IUD referrals**	JB to check whether GPs are referring into secondary care to carry out coil insertion. Pathway will need to be reviewed if this is happening.	**JB 9th Sept 15**	**Complete- no concerns reported**

23	**Formulary/ Traffic Light Changes**	• **NICE TA337: Rifaximin for preventing episodes of overt hepatic encephalopathy – RED** Traffic Light status • **Apomorphine for Parkinson's Disease–** ensure **RED** Traffic Light status • **NICE TA339: Omalizumab for previously treated chronic spontaneous– RED** Traffic Light status – with a note' Funded by NHSE Specialist Commissioning • **TA340 Ustekinumab for treating active psoriatic arthritis (rapid review of technology appraisal guidance 313) RED** Traffic Light status. CCG commissioned, • **TA 341 Apixaban for the treatment and secondary prevention of deep vein thrombosis and/or pulmonary embolism -** ensure added to TLS as GREEN as per NICE • **TA 342: Vedolizumab for treating moderately to severely active ulcerative colitis-** RED Traffic Light status. CCG commissioned. • **A343 Obinutuzumab in combination with chlorambucil for untreated chronic lymphocytic leukaemia RED** Traffic Light status – with a note' Funded by NHSE Specialist Commissioning • **TA344: Ofatumumab in combination with chlorambucil or bendamustine for untreated chronic lymphocytic leukaemia-** Traffic Light status – with a note' Funded by NHSE Specialist Commissioning • **FAD ID718: Secukinumab for treating moderate to severe plaque psoriasis-** RED Traffic Light status. CCG commissioned. • **Fosfomycin Trometamol 3g granules** TLS as GREEN –on recommendation of microbiology ONLY.	**Steve Moore 9th Sept 15**	**In progress**

NO.	SUBJECT	OUTSTANDING RESPONSIBILITY	ACTION LEAD	Status
24	**Formulary/ Traffic Light Changes continued**	• **Fosfomycin Trometamol 3g granules** TLS as GREEN –on recommendation of microbiology ONLY. • **Levonorgestrel 1500mcg tablet (Upostelle®)** TLS as GREEN • **Nutilis Clear-** TLS as GREEN • **Sirdupla Metered Dose Inhalers** TLS as GREEN • **Prednisolone Dompe 1mg/ml oral solution single dose (5ml) vials** TLS as GREEN • **Nutriplen Compact T**LS as GREEN • **Fultium-D3 2740 IU/ml Drops** TLS as GREEN • **Invita-D3 2400 IU/ml Drops** TLS as GREEN • **Laxido Paediatric** TLS as GREEN	**Steve Moore 9th Sept 15**	**In progress**