NHS
Somerset
Clinical Commissioning Group

Minutes of the **Somerset Prescribing Forum** held in **Meeting Room 1, Wynford House, Lufton Way, Yeovil, Somerset** on **Wednesday 14 January 2015**

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| **Present:** | Dr Clare Barlow | Chair, Drug & Therapeutics Committee, Taunton & Somerset NHS Foundation Trust | CB |
| | Jon Beard | Chief Pharmacist, Taunton & Somerset NHS Foundation Trust | JB |
| | Steve Du Bois | Acting Head of Medicines Management, 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 |
| | Helen Kennedy | Prescribing Support Technician, NHS Somerset CCG | HK |
| | Dr Sally Knights | Chair, Drug & Therapeutics Committee, Yeovil District Hospital | SK |
| | Jean Perry | Commissioning Manager, NHS Somerset CCG | JP |
| | Dr Geoff Sharp | GP Delegate (Central Mendip Federation), Chair | GS |
| | Jon Standing | Chief Pharmacist, Yeovil District Hospital | JS |
| | Pip Tucker | Public Health Specialist | PT |
| **In Attendance:** | Dr Ian Lewin | Specialist Doctor, Somerset CCG Governing Body | IL |
| **Apologies:** | Rosemary Brook | Consultant Psychiatrist Somerset Partnership | RB |
| | Lynda Coles | Vice Chair, Local Pharmaceutical Committee | LC |
| | 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 |
| | Gordon Jackson | Patient Representative | GJ |
| | Stephanie Wadham | Medicines Information / Formulary Senior Pharmacist, Yeovil NHS Foundation Trust | SW |

## 1 WELCOME

**1.1** Geoff Sharp welcomed everyone to the meeting and introduced Pip Tucker who attended for Public Health in place of Orla Dunn and Dr Ian Lewin, specialist doctor from the CCG Governing Body who attended as an observer.

## 2 APOLOGIES

2.1 Apologies were provided as detailed above.

## 3 DECLARATIONS of INTEREST

**3.1** GS asked for declarations of interest no new interests were declared by anyone at the meeting.

## 4 MINUTES OF THE MEETING HELD ON 14th January 2015

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

**4.2** GS ran through the action points from the last meeting and most were complete. The following items were specifically noted:

**1) Review of SPF membership in accordance with the Terms of Reference (ToRs)**

CH said that the distribution list for SPF is long because some organisations have people who deputise for each other to attend SPF.

- SomPar has AD and RB on the list who could attend as senior clinicians
- LC and MH are both nominated to attend from LPC because they are able to cover for each other
- JS and SW are both nominated to attend from YDH because SW will sometimes attend in place of JS.

It was agreed that representatives from St Margaret's Hospice are not members of the SPF under the ToRs but should be kept on the distribution list.

GS requested that CH circulate the ToRs to SPF members for review at the next meeting. **Action: CH**

**2) The Drug Monitoring in Primary Care Enhanced Service.**

GS stated that he sits on the group reviewing this enhanced service spec and that further progress has not been made as there had not been a meeting since SPF last met. CH reported that she had spoken with Michael Bainbridge who is leading on this and that the revised spec has not yet been agreed. GS to update the group at the next meeting. **Action: GS**

**3) Ulipristal acetate 5mg tablets (Esmya®) for uterine fibroids-**

There had been no response on whether the gynaecologists at TST would like to use 2 courses of ulipristal instead of one for uterine fibroids. The license has been extended to allow for up to two courses instead of one. CB agreed

to follow this up with the consultants at TST. **Action: CB**

**4) SIGN 141 British Guidelines on the management of Asthma**

CH reported that the Respiratory Network have not yet had chance to review this guidance in detail. They will be meeting again on Friday where it will be discussed. Steve Moore to report back. **Action: Steve Moore**

**5) Tiotropium (Spiriva®) Respimat- asthma indication**

Steve Moore had reported that the clinicians at the Respiratory Network were not particularly keen on using tiotropium for asthma patients but that it may be useful in a small cohort. PAMM had agreed to add it to the TLS as amber (specialist initiated drug) for asthma. **Action: Steve Moore**

**6) NICE Appraisal Consultation Rivaroxaban for prevention of atherothrombotic events after Acute Coronary Syndrome with elevated cardiac biomarkers**

At the SPF meeting in September, Trusts had been asked to discuss the potential place of rivaroxaban after ACS with their cardiologists. Trusts reported that here was no real appetite amongst cardiologists to use rivaroxaban for this indication. It was agreed that this will be reviewed when the NICE TA is published (expected March 15)

**7) Medication Safety Network**

At the last meeting, it was agreed that Karen Taylor was going to set up a forum for Medicines Safety Officer and SG to discuss with her how learning can be shared.

It was reported that Karen is in the process of arranging the first meeting and relevant issues will be passed to SPF via the PAMM as appropriate. SG said that over time we need to establish who will be looking at which parts of the safety agenda.

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

**5.1 YDH Teriparatide Audit Correction and consensus statement**

At the November meeting SK had presented a formal correction of the recent audit on teriparatide use at YDH and a proposed 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. It was agreed that the group should go away and consider this before giving a final decision in January.

GS stated that after consideration and, given the current financial position, the CCG will not deviate from NICE guidance in the use of Teriparatide. An individual funding request (IFR) will be needed for patients who don't meet the NICE criteria. SK agreed to pass this on. **Action: Sally Knights**

**5.2 Aflibercept (Eylea®) 40 mg/ml solution for injection license extension for Diabetic Macular Oedema (DMO)**

The license for Aflibercept (Eylea®) has been extended to DMO. NICE guidance not due until June 15. At the last SPF meeting, it had been agreed that this indication could be added to the non-PbR drugs list pending confirmation from the Chief Pharmacists that DMO will be included in the Patient Access Scheme (PAS) for this drug if the PAS is extended.

JS had confirmed that the Eylea® PAS has been extended to cover DMO. SG confirmed that this product is now commissioned for patients fulfilling NICE criteria set for Lucentis®. Aflibercept (Eylea®) will appear in the TLS as a red (hospital only) drug for this indication. Formulary to be updated. **Action Steve Moore**

**5.3 Dexamethasone (Ozurdex®) 700 micrograms intravitreal implant- license extension or Diabetic Macular Oedema (DMO)**

The license for Ozurdex® intravitreal implant has been extended to cover DMO. NICE guidance not due until April 15. At the last SPF meeting, it had been agreed that this indication could be added to the non-PbR drugs list pending confirmation from the Chief Pharmacists that DMO will be included in the Patient Access Scheme (PAS) for this drug and will consider a formulary application for this indication if the PAS is extended.

JS and JB had confirmed that the manufacturer does not plan to extend the PAS for Ozurdex® intravitreal implant PAS has been extended to cover DMO. SG confirmed that this product will not be added to the TLS for this indication at present. This product will appear in the TLS as Black (not recommended for DMO). Formulary to be updated. **Action: Steve Moore**

**5.4 Updated Management of Infection Guidance for Primary Care**

A summary of the changes produced by Ana Alves (Medicines Manager was viewed and approved by the group. The updated guidance will be uploaded to the CCG website. **Action: Ana Alves**

**5.5 YDH perioperative analgesic guidelines**

GS and SG commented on the wide variation in practice both locally and across the country around the use gabapentin/ pregabalin post hip and knee surgery.

SG stated that Trusts are free to set their own protocols but as commissioners, the CCG would ask that they audit unexpected outcomes and undertake root cause analysis when things go wrong

SK and JS agreed to feed this back to YDH.

**5.6 Methotrexate (MTX) Shared Care Guideline (SCG)**

The MTX SCG has been revised by HK to account for the change from prefilled syringes to a prefilled pen device and put into the CCG template. The

rheumatologists at TST were asked to comment. The revised SCG was approved by the group.

**5.7 Update on commissioning of fomepizole for treatment of ethylene gycol/ methanol overdose**

At the last meeting, SG had agreed that a supply of fomepizole could be commissioned for use by YDH. JS confirmed that a 'risk share' arrangement had been reached with JB at TST where YDH keep fomepizole but TST is able access to it if needed. This will reduce wastage.

CB expressed concern that fomepizole needs to be given within one hour but JS reassured her that it is possible to arrange rapid transport. It was pointed out that ethanol can also be used as a treatment for ethylene glycol poisoning if fomepizole can't be accessed in time.

**5.8 Proposed Asacol® to Octasa® (mesalazine) switch**

GS had written to the gastroenterologists at TST and YDH to seek consensus. The group viewed a letter from the gastroenterologists from YDH stating that they accepted that selected stable patients have been taking Asacol, could be switched to Octasa. GS confirmed that TST had also indicated that they are OK with switching patients as laid out under the terms of the letter.

**6 D&TC DECISIONS**

**6.1 Somerset Partnership D&T meeting**

There were no minutes available yet from the last meeting held 8/1/15 so SD updated the group. It was specifically noted that:

- Sompar are reviewing the evidence for using melatonin in ADHD due to its high cost.
- Xenidate® is a branded generic modified release methylphenidate preparation marketed as an alternative to Concerta® now approved for use at Sompar..
- Luventa XL® is a branded generic modified release galantamine.
- SG asked that formulary applications for Xenidate® and Luventa XL® are brought to the next SPF. **Action CH**
- Sompar would still like to use Acetylcholinesterase inhibitors and Memantine in a small number selected dementia patients. PAMM and SPF have asked SomPar to retain prescribing of this combination because it is not specifically recommended by NICE. SD said that this prescribing would be kept within SomPar. SG stated that evidence would need to be presented by SomPar to SPF if they wanted the CCG to consider GP prescribing.
- Nalmefene NICE guidance has been reviewed and Sompar will continue it if patients are admitted taking it but they won't initiate patients on it.

**6.2 TST**

CB outlined the minutes of the last meeting held on Friday 14/11/14. The following were noted:

- Lucy Pollock is reviewing the TST policy on thromboprophylaxis in the elderly patients as there are significant risks in prescribing thromboprophylaxis in many frail elderly patients.
- Due to the recent increase in cost of dexamethasone, haematology and

oncology have been working use prednisolone to treat reduced appetite and fatigue. However discretion is being used in the treatment and prophylaxis for chemotherapy induced nausea and vomiting (CINV) with highly emetogenic chemotherapy. There is a high tablet burden when prednisolone is used for CINV. It could also be very costly if patients needed to be admitted with CINV in the event of treatment failure or more expensive drugs, such as aprepitant were needed.

- The Trust is also raising awareness of the high cost of intravenous cyclizine but TST don't tend to use this as a first line treatment for nausea and vomiting

**6.3 Taunton & Somerset Antimicrobial Prescribing Group (TSAPG)**

The minutes were viewed from the last meeting due held on Friday 12/11/14. The following were noted:

- TST are using pivmecillinam as first line antibiotic instead of trimethoprim due to the lower resistance rates. However the cost of doing this is in primary care is likely to be approx. £375k/ year for the CCG. SG stated that the patients seen in primary care are usually less complicated in secondary care and that the symptoms of cystitis are often self–limiting. The CCG is therefore continuing to use trimethoprim first line, reserving nitrofurantoin as a second line treatment for patients are at higher risk or where trimethoprim is contra-indicated/ not tolerated.
- The neutropenic sepsis card has been implemented and since launch all patients presenting with a card had the first dose of antibiotics administered within 1 hour.
- DEFINE data shows that TST and YDH are the lowest prescribers of antimicrobials in the region and among the lowest for antibiotics and carbapenems.

SG said that he would like to ensure that the antimicrobial group is a county-wide group as it was originally set up to be. GS asked for this to be formally proposed. Ana Alves to raise with Trusts. **Action: Ana Alves**

**6.4 YDH**

No further meetings have taken place since before the last SPF

**6.5 BNSSG Joint Formulary Group**

The last meeting was held 25/11/14 but there were no minutes available yet.

**6.6 RUH Bath D&TC**

The meeting minutes from Nov 14 were viewed and noted.

**7 NICE**

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

**7.2 TA323: Erythropoiesis‑stimulating agents (epoetin and darbepoetin) for treating anaemia in people with cancer having chemotherapy (including review of TA142)**

Noted- positive appraisal. Funded by specialist commissioning.

**7.3 TA 324: Dual-chamber pacemakers for symptomatic bradycardia due to sick sinus syndrome without atrioventricular block (part review of technology appraisal guidance 88)**

Noted- positive appraisal. SG to highlight this guidance to the cardiac network.

**7.4 TA 325: Nalmefene for reducing alcohol consumption in people with alcohol dependence**

Positive appraisal for people with alcohol dependence who:

- are still drinking more than 7.5 units per day (for men) and more than 5 units per day (for women) 2 weeks after an initial assessment and
- do not have physical withdrawal symptoms and
- do not need to either stop drinking straight away or stop drinking completely.

The marketing authorisation states that Nalmefene should only be taken if the person is also having continuous psychosocial support to change their behaviour and to continue to take their treatment, to help them reduce their alcohol intake.

**Discussion**

SG stated that GPs are not currently commissioned as part of their core contract to provide this level of support to patients with alcohol dependence. It is therefore unlikely that practices are in a position prescribe this drug because they are not commissioned to provide the psychosocial support required by the NICE guidance.

SG recommended that the need to provide a service that can provide the support required should be looked at as part of public health strategy.

SG recommended that Nalmefene should be given 'red drug status' and that public health may want to look at commissioning a service to prescribe it and provide the necessary psychosocial support. PT agreed to investigate further.

**Action: Pip Tucker**

Steve Moore to update the formulary **Action: Steve Moore**

**7.5 TA 326: Imatinib for the adjuvant treatment of gastrointestinal stromal tumours (review of NICE technology appraisal guidance 196)**

Noted- positive appraisal. Funded by specialist commissioning. Red Traffic Light status with a note- 'funded by NHS England'. **Action: Steve Moore**

**7.6 TA 327: Dabigatran etexilate for the treatment and secondary prevention of deep vein thrombosis and/or pulmonary embolism**

Noted. Dabigatran had previously been added to the formulary for this indication when its license was extended to cover treatment and secondary prevention of DVT and PE. Formulary and TLS to be updated with details of NICE TA.

**Action: Steve Moore**

**7.7 NICE TA328: Idelalisib for treating follicular lymphoma that is refractory to 2 prior treatments**

Noted. Terminated appraisal due to no evidence submission by the manufacturer. Black Traffic Light status with a note- 'terminated NICE appraisal'.

**Action: Steve Moore**

**7.8 CG189 Obesity: identification, assessment and management of overweight and obesity in children, young people and adults**

SG said that there is evidence that obesity surgery resolves type 2 diabetes mellitus in a significant number of cases which is why this guidance recommends surgery to patients who are at risk of complications of diabetes at lower levels of BMI. Early intervention may save money through prevention of diabetes complications

SG stated that there is currently a debate around whether obesity surgery should remain funded by specialist commissioning or come back to CCGs. A decision is expected shortly. A rapid appraisal will be needed if the responsibility comes back to CCGs to consider how this should be prioritised in Somerset.

GS commented that TST and RDE had recently asked the CCG to circulate some guidance to GPs on the use of supplements and monitoring for bariatric patients. GS said that this had not been circulated yet because it was unclear as to the process that had been followed to authorise the guidance. JB agreed to take these comments back to the bariatric surgeons to discuss due process and consider the evidence at the TST DTC.
**Action: JB**

**7.9 CG190 Intrapartum care: care of healthy women and their babies during childbirth**

SG stated that there are 3 childbirth related pieces of guidance on the agenda which have been issued by NICE. He has flagged these to Debbie Rigby who sits on the Child and midwifery groups and asked her to highlight any issues through the Policy Forum Group.

**7.10 CG191 Pneumonia**

SG noted the discrepancy in the recommended duration of antibiotic treatment between the public health and NICE guidance. He has flagged this up at national level.

The recommendation to provide near patient testing of CRP in primary care was also noted and that, at the moment, this is not available.

**7.11 CG192: Antenatal and postnatal mental health: clinical management and service guidance**

Noted. As per item 7.9.

**7.12 CG37: Postnatal Care (Update Dec-14)**

Noted. As per item 7.9.

**Public Health Guidance-**

**7.13 PH55 Vitamin D: increasing supplement use among at-risk groups**

Aimed at preventing Vitamin D deficiency in:

- infants and children aged under 5
- pregnant and breastfeeding women, particularly teenagers and young women
- people over 65
- people who have low or no exposure to the sun, for example, those who cover their skin for cultural reasons, who are housebound or confined indoors for long periods
- people with darker skin, for example, people of African, African-Caribbean or South Asian family origin.

SG stated that the evidence for giving vitamin D alone in patients over 65 is very poor. Patients who are symptomatic of Osteomalacia may benefit from calcium and vitamin D or a course of plain vitamin D. However, patients who are not frail/ do not have low bone mineral density and have no symptoms of osteomalacia are unlikely to have a clinical need for prescribing of calcium and vitamin D or plain vitamin D.

Where there is no clinical need for calcium and vitamin D, patients should be encouraged to self–care through sufficient exposure to sunlight and calcium and ensuring they have enough calcium and vitamin D in their diet. Patients can always purchase calcium and vitamin supplements if they wish.

SG stated that there are some changes in child health services coming which may make it easier to provide supplementation to breast feeding women and children for whom the evidence in support of vitamin D supplementation is stronger.

PT stated that Public Health is looking at how the guidance can be implemented.

**NICE Diagnostic Guidance- Nil 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 Nov and Dec 14**

**8.2**
- **UKMI Prescribing Outlook**
- **UKMi New Drugs Online Newsletter Sept 14**

**8.3**
- **A list of forthcoming NICE ESNM**

SG asked that Trusts highlight any changes that they would like to look at to SPF

**Action: All**

**8.4 NICE FAD: Ulcerative colitis (moderate, severe) - infliximab (review TA140), adalimumab (review TA262) & golimumab (2nd line) [ID695]**

The above NICE Final Appraisal Determination has been published for consultation and full NICE guidance is expected shortly. Previously, NICE TA 140 stated that Infliximab is not recommended for people with subacute, moderately to severely active ulcerative colitis. NICE TA 262 was terminated because the manufacturer of adalimumab failed to submit any evidence.

SG stated that NICE are looking a extending the cohort of patients who can be treated with biologic drugs and extending the choice to children too. We will review again once the full guidance is issued.

SG said that the potential increased usage had been taken into account in the budget setting process for secondary care in 15/16.

**9 FORMULARY APPLICATIONS**

**9.1 Somerset Traffic Light Scheme (TLS) review**

The TLS status of the following drugs was reviewed:

- **Methenamine Hippurate for UTI prophylaxis (application to change from amber to green)**

  The microbiologists would like this drug to be made Amber because they believe that it is safe enough for GPs to prescribe and they would not expect GPs to routinely contact them on decisions to start treatment. All agreed. Steve Moore to update the traffic light scheme. **Action: Steve Moore**

- **Invita D3 (application to change from amber to green)**
  This was discussed at PAMM in the morning and agreed that giving a green status would give GPs an option to give a once weekly dose of vitamin D rather than a daily dose which some patients may prefer. All agreed. Steve Moore to update the traffic light scheme. **Action: Steve Moore**

- **Ciclosporin in non-transplant indications (application to change from red to amber)**

  JB requested ciclosporin to be made an amber 'shared care' drug for all 'non-transplant' indications. The main uses at TST are in severe atopic eczema and psoriasis (around £60k/ year) and a small amount of use (£4-5k/ year) in ophthalmology.'

  JB explained that the precautions needed around use in non-transplant indications are significantly less than with transplants. Dosage adjustment is made based on side effect profile and disease response.

  GS stated that the PAMM was concerned about the safety of ciclosporin use in primary care for less common indications and the risks involved in retaining some prescribing in secondary care and passing on some prescribing to primary care. It was therefore decided that the traffic light status for ciclosporin should remain Red.

**9.2 Xultophy® 100units/ml insulin degludec +3.6mg/ml liraglutide solution for injection in a prefilled pen**

This is a newly launched product licensed for treatment of type 2 diabetes mellitus not controlled by oral antidiabetics alone *or* by oral antidiabetics in combination with basal insulin. Price = £159 for 5 x prefilled syringes.

Insulin degludec is not recommended in the Somerset but liraglutide (Victoza®) prefilled pen is funded in Somerset in accordance with the relevant NICE guidance. It was therefore agreed that Xultophy®**,** as a combined product, should have a black (not recommended) status in the TLS. **Action: Steve Moore**

**9.3 Levodpa/ carbidopa/ entacapone (Sastravi®, Activas) film coated tablets ranging from 50/12.5/200mg to 200/50/200mg £36.44 per 100 tabs**

This is a branded generic equivalent licensed product to Stalevo® and is available in the full range of strengths. It is about half the price of Stalevo®. The CCG spent approx. £52k on Stalevo in the 2nd quarter of 14/15.

CH reported that she had tried to obtain bioequivalence data comparing Sastravi® to Stalevo® but this had not been forthcoming from the manufacturer. It was agreed that CH would try to obtain bioequivalence data prior to the next meeting and that JB would ask the opinion of the neurologists as they may be able to make a cost saving against the originator brand. **Action: CH/JB**

**9.4 Duaklir Genuair® (Almirall), formoterol/ aclidinium inhaler**

This is a newly launched LAMA/ LABA inhaler. The **Eklira Genuair® (**aclidinium only) inhaler in this range (same device) is already on the formulary.

Dose is 1 puff BD and the inhaler costs £32.50) 60 doses. The price is the same as Anoro Ellipta which is the other LAMA/LABA combination inhaler on the formulary

Duaklir is licensed for COPD in adults. It currently has a blue livery but this will change in September to orange due to concerns that it may be mistaken for a reliever inhaler.

PAMM approved it to be added to formulary but with no specific switching is planned. SPF agreed to add. **Action: Steve Moore**

**9.5 Generic aripiprazole –differences between Abilify® and generic aripiprazole**

SG explained that a generic aripiprazole product is now available and this could potentially have significant cost savings but the generic product is not licensed to treat bipolar disease. Somerset Partnership has agreed to approve generic aripiprazole as per license and we are supportive of that approach.

SPF agreed to approve generic aripiprazole as per license. Steve Moore to update TLS. **Action: Steve Moore**

**9.6 Quetiapine XL branded Generics**

There are two branded generic XL olanzapine products that are available in the full range of strengths and are significantly less expensive than the originator brand. These are Biquelle® XL and Zaluron® XL. It was agreed that that these replace Ebesque® as preferred brands of olanzapine XL because they are

available in the full range of strengths. Steve Moore to update TLS.

**Action: Steve Moore**

### 9.7 Lyrica® (pregabalin) pain patent and generic prescribing

SG stated that the patent on Lyrica® (pregabalin) for the epilepsy and generalised anxiety disorder (GAD) indications has expired. However, the patent for neuropathic pain will remain until 2017. We may see generic products coming onto the market over the coming months but Pfizer have pointed out the risk of patent infringement if generic products are prescribed for neuropathic pain.

SG stated that the PAMM view was that when the new product is launched, it will only be licensed for epilepsy and GAD. The CCG will then ask for the new brand name to be prescribed to all patients taking pregabalin for epilepsy or GAD.

### 9.8 Epimax® cream

This is a newly launched emollient manufactured by the same company who manufacture Aquamax. It is marketed as a light emollient similar to aqueous cream, Diprobase, Cetraben etc. It does not contain sodium lauryl sulphate which is a sensitizer and is found in aqueous cream. It is not as greasy as Aquamax. PAMM had agreed for this to be added to the formulary. SPF agreed.

**Action: Steve Moore**

### 9.9 YDH request for Digoxin Specific Antibody Fragment

JS outlined that this is an antidote for digoxin toxicity recognised by the College of Emergency Medicine and National Poisons Service. This product appears on the PBR excluded list but YDH have never had a budget for it and they would like to keep a properly commissioned supply. SG agreed the CCG is happy to approve this and put it onto the non-PBR list. SG to agree budget with YDH and TST.

**Action: SG**

JB and JS have agreed that a supply will be kept at MPH but they will share access with YDH. They will share the 'write off costs' if it expires.

## 10 NHS ENGLAND SPECIALIST COMMISSIONING

### 10.1 New Cancer Drugs Fund list (CDF)

CB stated that there have been some changes to the CDF list because the fund has run out of money and while the overall budget has been increased, the fund is now looking at the cost effectiveness as well as the clinical benefits of the drugs on the list. The drugs that are now allowed on the list are not necessarily there based on the best evidence.

One or two drugs of minimal benefit have been removed. However, a significant number of drugs have been removed from the list which will have a big impact on the ability to treat breast and colorectal cancer in particular. Some of the decisions will change current practice significantly. Existing patients are able remain on treatment they are being given but no new patients will be able to receive the medicines that have been removed from March.

CB expressed concern that patients may start asking about co-payment for products that are no longer available through the CDF. Such a system would be

very complex and problematic for Trusts to administer

## 11 PBR EXCLUDED DRUG MONITORING

### 11.1 CCG PBR Excluded Drugs.

SG gave an overview of the figures. YDH are roughly meeting their budget. TST are projecting a bigger overspend, largely due to the budget setting process last year.

### 11.2 YDH PbR Excluded proposed 15/16 budget

SG explained that budget setting/ horizon scanning meetings had been held with both Trusts and that the draft budgets will need to be signed off by finance. JP confirmed that they are working to finalise the budgets.

SG agreed to update the group at the next SPF meeting on whether budgets have been approved. **Action SG**

### 11.3 TST PbR Excluded proposed 15/16 budget

As per 11.2

### 11.4 NICE Biosimilars statement

NICE has said that they will review biosimilar products as though they are the same as the originator brand if the license is the same

SK expressed concern that there may be unexpected consequences to using biosimilars. There can sometimes be issues with increased immunogenicity and clinicians will need to be alert to products losing their efficacy over time. More time may need to be invested in monitoring and recording outcomes and adverse events.

SG was clear that we don't want to commission new products which have poorer outcomes.

## 12 Medicines Optimisation Prototype Dashboard

Noted. SG said that this is a standing agenda item which we can use to benchmark Somerset against other areas. The prototype may change over time.

## 13 DRUG SAFETY

### 13.1 MHRA Drug Safety Update Sept and Oct 2014

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

Specifically, SG highlighted:

- SomPar should ensure that they monitor liver function before and regularly during treatment with agomelatine due to the risk of liver toxicity
- The MHRA guidance to only start ivabradine if the resting heart rate is at least 70 beats per minute and not prescribe ivabradine with other medicines that

cause bradycardia
- The risk of psychiatric disorders with isotretinoin which is a hospital only drug in Somerset.

**13.2 NHSE patient Safety Alert- risk of distress and death from inappropriate doses of naloxone in patients on long-term opioid or opiate treatment.**

Trusts were asked to review the alert and take appropriate action.

JB noted that at TST naloxone use is very low and only kept in A&E and ITU and that they monitor where it is being used.

**13.3 NHSE Patient safety alert – risk of death and serious harm from delays in recognising and treating ingestion of button batteries**

It was highlighted to the group that ingestion of button batteries should be treated as a medical emergency and that this alert should be raised with A&Es and MIUs. SD said that their MIUs are aware.

**13.4 NHSE Patient safety alert – Risk of death or serious harm from accidental ingestion of potassium permanganate preparations**

This alert was highlighted to the group and Trusts were asked to put appropriate procedures and counselling in place when dispensing/ prescribing potassium permanganate preparations.

**13.5 Trust Sepsis plans**

SG said that since the NHS England alert on recognition and treatment of sepsis he had asked Trusts to send in their Sepsis plans for oversight and potentially for the infection control groups to review. This is an important area of work because sepsis carries high mortality rates and poor outcomes. We are expecting a national CQUIN around sepsis.

Plans have been received from TST and YDH and SD confirmed that SomPar have a Sepsis Group working on this

**13.6 Public Health England advice to prescribers on the misuse of pregabalin and gabapentin**

This advice was noted. SG said that since tramadol became a controlled drug, pregabalin and gabapentin are increasingly being misused and asked that A&Es and out of hours services are made aware of these risks. Pain management will be a focus of medicines management work going forwards.

**14 ANY OTHER BUSINESS**

**14.1 Developing benchmarking or indicators for antibiotic prescribing in secondary care**

SG said Lucy Watson has become aware of some safety incidents involving antibiotics and that the CCG would like to focus on benchmarking that could be used in secondary care around antibiotic prescribing. He asked JB to bring some DEFINE antibiotic data to the next meeting. **Action: JB**

**14.2 Ophthalmology requests for branded rather that generic eye drops**
Jean Perry has had some reports from GPs that the opthalmologists are frequently requesting branded eye drops rather than by generic name. SG

agreed to revisit this with the opthalmologists.
**Action SG**

**15 DATE OF NEXT MEETING**

- 11th March 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 14 JAN 2015**

| NO. | SUBJECT | OUTSTANDING RESPONSIBILITY | ACTION LEAD |
|---|---|---|---|
| 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 Terms of Reference** | Circulate ToRs for review at next meeting | **CH 11th Mar 15** |
| 3 | **Enhanced Service for DMARDs** | GS to update the group on progress of the enhanced service at the next meeting | **GS 11th Mar 15** |
| 4 | **Ulipristal acetate 5mg tablets (Esmya®) for uterine fibroids-** | CB to ask specialists at TST and report back on whether their consultants would want to use 2 courses of ulipristal rather than one. | **CB 11th Mar 15** |
| 5 | **Xenidate[e] XL** | CH to bring formulary applications to the next PAMM and SPF | **CH 11th Feb 15** |
| 6 | **TA 324: Dual-chamber pacemakers for symptomatic bradycardia due to sick sinus syndrome without AV block** | SG to highlight to cardiac network. | **SG 11th Mar 15** |
| 7 | **TA 325: Nalmefene for reducing alcohol consumption in people with alcohol dependence** | Pip Tucker to investigate whether Public Health can commission a service that is able to prescribe nalmefene and provide the necessary psychosocial support | **PT 11th Mar 15** |
| 8 | **Guidance on the use of supplements and monitoring for bariatric patients.** | JB discuss due process for guidance with the bariatric surgeons and consider the evidence at the TST DTC. | **JB 11th Mar 15** |
| 9 | **Levodpa/ carbidopa/ entacapone (Sastravi®, Activas)** | Obtain bioequivalence data from Activas compared with Stalevo® | **CH 11th Mar 15** |
| 10 | **Levodpa/ carbidopa/ entacapone (Sastravi®, Activas)** | Seek neurologists views on using this product vs Stalevo® | **JB 11th Mar 15** |
| 11 | **YDH request for Digoxin Specific Antibody Fragment** | SG to agree a budget with YDH and TST | **SG 11th Mar 15** |
| 12 | **SIGN 141 British Guidelines on the management of Asthma** | Obtain feedback on this guidance from the respiratory network. | **Steve Moore 11th Feb 15** |
| 13 | **PbR Excluded 15/16 budget setting process** | SG to update the group on progress | **SG 11th Mar 15** |

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| 14 | **Formulary/ Traffic Light Changes** | • **Aflibercept (Eylea®)** for DMO indication – add to Traffic lights as RED<br>• **Dexamethasone (Ozurdex®) intravitreal implant** for DMO indication. – add to Traffic lights as BLACK<br>• **Nalmefene (Selincro®)** – add to Traffic lights as RED<br>• **Tiotropium (Spiriva®) Respimat-** – add asthma indication to formulary and TLS as AMBER<br>• **Dabigatran etexilate** for the treatment and secondary prevention of deep vein thrombosis and/or pulmonary embolism- update formulary and TLS with details of NICE TA 327<br>• **TA 326: Imatinib for the adjuvant treatment of gastrointestinal stromal tumours -** RED Traffic Light status with a note- 'funded by NHS England'<br>• **NICE TA328: Idelalisib for treating follicular lymphoma that is refractory to 2 prior treatments-** BLACK Traffic Light status with a note- 'terminated NICE appraisal'.<br>• **TA323: Erythropoiesis‑stimulating agents (epoetin and darbepoetin) for treating anaemia in people with cancer having chemotherapy (including review of TA142) –** RED Traffic Light status with a note- 'funded by NHS England'<br>• **Methenamine Hippurate for UTI prophylaxis-** change status from amber to GREEN<br>• **Invita D3 -** change status from amber to GREEN<br>• **Duaklir Genuair® (Almirall), formoterol/ aclidinium inhaler –** add to TLS as a GREEN drug<br>• **Generic aripiprazole–** amend TLS to state that generic is not licensed to treat bipolar.<br>• **Biquelle and Xaluron XL®** add to formulary as preferred brand of quetiapine XL and remove Ebesque®<br>• **Epimax cream –** add to formulary as GREEN | **Steve Moore 11th Feb 15** |

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| **15** | **DEFINE antibiotic benchmarking data** | JB to bring to next meeting | **JB**<br>**11th Mar 15** |
| **16** | **T&SAPG** | Ana to raise with the group re. the need for it to be 'county-wide' | **Ana Alves**<br>**11th Mar 15** |
| **16** | **Ophthalmology requests for branded eye drops** | SG to ask the ophthalmology to make generic eye drop requests to GPs rather than by brand. | **SG**<br>**11th Mar 15** |
| **17** | **Drug Safety Update and NHSE Patient Safety Alerts** | Trusts to identify relevant safety issues identified and discuss with relevant clinicians. | **All**<br>**10th Sept 14** |