NHS
Somerset
Clinical Commissioning Group

Minutes of the **Somerset Prescribing Forum** held in **Meeting Room 1, Wynford House, Lufton Way, Yeovil, Somerset** on **Wednesday 9th September 2015**

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

1 WELCOME

GS welcomed everyone. Dr Orla Dunn (Public Health Consultant) was introduced to the group.

2 APOLOGIES

Apologies were provided as detailed above.

3 DECLARATIONS of INTEREST

SG asked for declarations of interest.

JS said that he had sent revised declaration of interests (DOI) to the CCG. JS to forward DOI with CH to update SPF list. **Action: JS**

A recent letter from NHS England was shared with the group regarding a small number of individuals within the NHS who have allegedly acted inappropriately in their dealings with pharmaceutical companies.

CCGs have been asked to provide a number of assurances to NHSE around ensuring that appropriate systems and processes are in place to ensure that potential conflicts of interests are declared and mitigated.

The CCG has requested formal declarations of interest from all its' staff involved in decisions about medicines, including Medicines Management sessional staff. GS said that while the CCG had been found to have broadly robust policies and procedures relating to medicines decisions and dealing with the pharmaceutical industry, we are expecting a report from the auditors recommending that the CCG further tightens its procedures.

SG asked Trusts to consider looking at their own processes. CB assured the group that TST has good processes for dealing with conflicts of interest and that she believes that TST is already compliant with the requirements set out in the letter.

JS said that YDH is currently in the process of reviewing its procedures.

4 MINUTES OF THE MEETING HELD ON 15th July 2015

4.1 The Minutes of the meeting were agreed as an accurate record except:
CB pointed out that item 5.6 needs to be deleted (page 4) **Action CH**

4.2 GS ran through the action points from the last meeting. Most actions were complete or raised on the agenda. The following items were specifically noted:

- **Melatonin for Hemicrania Continua and PD related sleep disorder**- the agreed preparation is licensed Circadin but SG and Mark Fish need to arrange a meeting to discuss treatment length. **Action SG**

- **Acute Kidney Injury (AKI)** - At the July meeting YDH had been asked to identify some patients who had been admitted from primary care with AKI and provide anonymised data to the CCG for review at SPF. JS asked for clarification over what was being asked for. **Action SG/JB**

- **NICE NG12 Suspected cancer: recognition and referral-** Trusts had been asked to bring any concerns from their specialists back to SPF on areas where this might cause pressure.

CB responded that this guidance looks at recognition, referral and diagnosis for all aspects of all cancers meaning that it is difficult for her to make specific comment. SG stated that there is a group looking at cancer recognition and referral within the CCG who should be able to look at specific areas of pressure.

- **Rituximab use in Rheumatoid Arthritis**- JB commented that he had been assured by the rheumatologists that all use in RA is within guidance and that benchmarking data suggest RA use of all biologicals is still lower that most trusts.

- **Ivermectin Cream for inflammatory lesions of rosacea-** YDH have commented that there might be some interest from the dermatologists but there has been no application for this yet. It was agreed that an application should be brought to the next PAMM and SPF meetings. **Action CH**

- **YDH Infliximab use**- JS stated that YDH are now switching existing patients to biosimilar infliximab and that letters are going out to all affected patients.

  JB said that TST is in the process of writing a biosimilars policy. SG asked JB to bring the new policy for review at the next SPF. Action JB

5 MATTERS ARISING (not otherwise on the agenda)

5.1 Low Molecular Weight Heparin (LMWH) bridging therapy guidance

The specialists had reviewed the guidance in the light of the queries raised at the last SPF and provided the following comments:

- **The policy should be reviewed in the context of the BRIDGE study:** The specialists commented that BRIDGE covered AF patients only and that they have referenced it am included an option to continue some surgery on anticoagulation or stop anticoagulation completely without bridging in low risk patients.
- **CHA_2DS_2-VASC rather than CHADs2 score should be used to assess stroke risk in patients with Atrial Fibrillation (AF).** This has been addressed within the policy
- **YDH need to be consulted regarding the policy.** Ideally, there would be a consensus between YDH and TST. TST are clear that consulting with YDH and obtaining consensus should not hold up their processes.
- **There needs to be clear guidance within the policy on what should happen when surgery is cancelled.** This has been addressed within the policy.
- **LMC have asked that the policy should provide clarity over who will be undertaking monitoring and prescribing. At the moment, this is not explicit.** TST feel that the policy is clear that POAC will prescribe and, where appropriate, arrange administration but there will sometimes be occasions where primary care will need to be involved.

SG and GS explained that PAMM had agreed that this guidance is now much improved. CH said that LMC had requested that the following sentence on the first page of the policy is amended as highlighted below:

Arrangements are made for prescription and administration of LMWH ***by POAC****. This will involve individual liaison with the patient's general practice, and may involve*

community or hospital administration of LMWH. Patient has INR checked prior to surgery to ensure adequate control.

It had also been requested that contact numbers for POAC are included on the discontinuation timelines. Once these amendments are made, PAMM and SPF will be happy with this protocol.

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

The dieticians at TST had been asked to review the discrepancies between the recent British Obesity and Metabolic Surgery Society (BOMSS) Guidance and their own guidance. They had responded that the BOMSS guidelines provide safe minimal recommendations as a starting point because, unlike TST, many centres had no guidelines and lacked nutritional expertise. The BOMSS guidelines note that treatment for individuals may vary depending upon centre/treatment.

They have reviewed their local guidance, with consultant support, and feel that it is appropriate to have this in addition to the BOMMS guidance.

SG thanked TST for reviewing their guidance. He explained that PAMM had agreed that from a prescribing point of view, evidence is lacking but we accept the explanations put forward for the discrepancies.

SG highlighted that within the NHS England (NHSE) national specification for bariatric surgery it states that the secondary care provider needs to monitor the patient for 2 years after surgery. He warned that the bariatric service may experience some GP resistance to accepting patients early because they feel that they are not commissioned to do this. LMC are discouraging the early acceptance of bariatric patients.

SG pointed out that the planned mailshot to go to GPs regarding this guidance should make reference to PAMM and SPF having reviewed the guidance.

GS raised an issue regarding a particular consultant who was been requesting liquid medicines for patients with long term conditions. JB agreed to pick this up with the consultant stating that TST have an agreement that crushed tablets are acceptable where there is evidence for doing this. **Action JB**

5.3 IV Iron Therapy

SG explained that:

- The ambulatory care working group in the CCG is looking at services that could be moved closer to patient's homes.
- One area under review is the provision of IV iron infusions by community hospitals.
- The group are investigating how this can be done safely and appropriately.
- The infusion of choice has not been firmly decided but Ferinject® is on the formulary in view of its reduced infusion time and fewer side effects compared with alternative IV iron products.
- The plan is for both secondary care consultants and GPs to be able to refer patients into the service
- It is anticipated that the majority of patients who would be eligible for this treatment in a community hospital setting will be under the care of a secondary care consultant. It is rare that GPs would initiate IV iron.
- A lot of IV iron sits with specialist commissioning at the moment such as renal

patients. However, it would be positive to, where possible, move some appropriate patients away from acute Trusts.

- There are some medico legal issues to be addressed if GPs are being asked to prescribe the iron at the point of referral to the service
- The current view is that SomPar should be commissioned to supply the drug with the CCG being recharged to prevent issues with patients not remembering to collect their prescription or storing the iron inappropriately etc.
- The CCG is aware that this may be viewed as a commissioning issue by acute Trusts.

It was agreed that the GP should not need to obtain signed consent from the patient to receive treatment at the point of referral because this will only need to be requested again in clinic.

GS said that this would be a positive change for patients who live in remote areas such as Mendip.

5.4 National acute trust PHE antibiotics data validation audit

This data has been submitted from both YDH and TST.

Both Trusts commented that there were quite a number of discrepancies, some quite large, between their data and that provided by IMS particularly when looking at inpatients supplies. This was due to the differences in the IMS interpretation/mapping of what constitutes an outpatient vs inpatient supply in our Trust is not accurate. There were also issues with pack size discrepancy between the data.

JB commented that the system needs to differentiate between pack sizes and local transfers as this is incorrectly inflating the hospital usage figured.

SG commented that this is the first attempt to get national hospital antibiotic usage data and that it would be easier if Trusts use electronic prescribing. This is national work and we will need to wait to see what the feedback is.

5.5 NG5: Medicines optimisation baseline assessment

The CCG has carried out a baseline assessment. This has highlighted a number of gaps. There is still some work to be done on the assessment.

TST have completed their baseline assessment, YDH are still working on theirs and will provide it once complete. SDB was asked to provide a baseline assessment for SomPar. **Action JS and SDB**

It was agreed that CH will collate the completed baseline assessments once they are returned so that priority areas of work can be looked at by SPF once all gaps are identified. **Action CH**

There was a general discussion about the aims of the baseline assessment The main points were:

- There are things that we know aren't happening and it is difficult to guarantee full compliance in all areas. Not all of the guidance is practical to implement.
- Not all processes around medicines reconciliation are robust and there are difficulties in achieving this at weekends
- Self-management plans are being implemented especially via the Symphony project.

- There is some good work around involving patients in decisions and some helpful patient decision aids included in the formulary. There were comments from specialists that it is very difficult to discuss all safety information in an ordinary consultation and that this might be undesirable. Patients needing complex treatments such as chemotherapy and rheumatology, often want to be guided on the best options and they are often overwhelmed by the amount of information given to them.
- Consultants do try to provide safety information during their discussions with patients and this will often be reiterated and expanded on when patients are seen by the clinical specialist nurses when the first dose of a drug is given in hospital.
- Screening with STOPP/START tools are not universally in place
- All Trusts are participating in the Medicines Safety Network which will improve the learning from incidents both locally and nationally.

5.6 Acute Kidney Injury (AKI) Trust actions to identify and minimise AKI

Dr Duncan Whitehead had responded on the actions being taken by TST to identify and minimise AKI.

JS shared the YDH medication safety bulletin covering AKI which they recently circulated internally.

SomPar were asked to provide details on actions taken to identify and minimise AKI before the next meeting. **Action SDB**

CH was asked to collate all Trust actions once returned. **Action CH**

6 OTHER ISSUES - no other issues were raised

7 Formulary Applications

7.1 Abasaglar (biosimilar insulin Glargine) 100 units/mL solution for injection in cartridge & pre-filled pen (£35.28 for 5 x 3ml cartridges/ pens)

This biosimilar insulin is approximate £6 per 5 cartridges cheaper than non biosimilar insulin glargine. It has the same amino acid sequence as Lantus.

Agreed to add to the formulary as first choice insulin glargine with GREEN traffic light status. Formulary to be updated. **Action Steve Moore**

7.2 Spiolto Respimat 2.5 microgram/2.5 microgram, inhalation solution

This is tiotropium bromide monohydrate and olodaterol hydrochloride (LAMA/LABA) inhaler for adults with COPD. The individual respimat devices are already on the formulary.

It was agreed to add this inhaler to the formulary for those patients with COPD already using either tiotropium or olodaterol in a respimat device that need a second agent. Giving the combined inhaler would cost effective and may improve compliance. GREEN traffic light status. Formulary to be updated.

Action Steve Moore

7.3 Alzain® (pregabalin) capsules

Rewisca® (Consilient brand) is currently the formulary choice of pregabalin for patients with epilepsy and generalised anxiety disorder but the requirement for pharmacies to provide redacted copies of prescriptions has caused some problems.

Dr Reddy's are now offering Alzain a price at least 30% below the category C drug tariff price and at least 5% below any category M guaranteed for 2 years. This makes the product the most cost effective of the choices currently on offer. There is no requirement to fax scripts to the manufacturer.

Teva have also launched a product which is 30% cheaper than the category C Drug Tariff price.

Agreed to add both Alzain and Teva pregabalin to the formulary for GAD and Epilepsy indications ONLY alongside Rewisca brand. Formulary to be updated.
Action Steve Moore

7.4 Repatha® SureClick and Repatha® Prefilled Syringes (evolocumab)

This is the first in a new class of lipid lowering drug (an IG2 monoclonal antibody) licensed for:

Adult patients with hypercholesterolaemia and mixed dyslipidaemia as an adjunct to diet:

• in combination with a statin or statin with other lipid lowering therapies in patients unable to reach LDL-C goals with the maximum tolerated dose of a statin or,

• alone or in combination with other lipid-lowering therapies in patients who are statin-intolerant, or for whom a statin is contraindicated.

It is also licensed in patients aged over 12 years who have familial hypercholesterolaemia.

The SPC states that the effect of Repatha® on cardiovascular morbidity and mortality has not yet been determined.

Dose is usually 140mg every 2 weeks or 420mg by injection once a month. Price =£320 for 2 x 140mg pens or prefilled syringes

Due to the cost and lack of clinical outcome data, It was agreed that the CCG will wait until NICE publish their guidance (due April 16) or until SPF receive a specialist application. This product will have a BLACK 'Not recommended' TLS status. Steve Moore to update formulary. **Action: Steve Moore**

7.5 Ikervis® 1 mg/mL eye drops, emulsion (ciclosporin)

Licensed for the severe keratitis in adult patients with dry eye, which has not improved despite treatment with tear substitutes. Price = £72.0 for 30 unit doses

The recent NICE Final Appraisal Determination was negative. Agreed this product will have a BLACK 'Not recommended' TLS status. Steve Moore to update formulary. **Action: Steve Moore**

7.6 Glucoject® lancets PLUS 33G (200) £5.50

These lancets are more cost effective than other lancets on the market. They are ultrafine compatible with most type A lancing devices. It had been agreed earlier at PAMM that this product would be added to the formulary as the preferred option. Formulary to be updated. **Action: Steve Moore**

7.7 Apomorphine commissioning decision

It was explained that YDH have a doctor who would like to use apomorphine in a small cohort of patients. This is a red hospital only drug and has the potential for a building cost pressure for YDH when some savings on other drugs for parkinson's disease might be released in primary care due to this therapy.

SG said that this is within YDH baseline funding and that there is no facility to negotiate anything outside already agreed budget mid-year. He suggested that Jon Standing contact Steve Brown at NHSE to raise nationally as to why this is not PbR excluded.

8 D&TC DECISIONS

8.1 **Somerset Partnership D&T meeting**

Minutes from last meeting were noted. Verbal update had been given at the last meeting. Their next meeting is due to take place tomorrow- 10/9/15

8.2 TST

The minutes of the last meeting held on 31/7/15 were noted. CB said that:

- Rosemary Brook and SDB had attended the meeting to discuss melatonin use in children with TST specialists. It had been agreed that the paediatricians will try to ensure that patients try other things first before resorting to melatonin.

- The opthalmologists had made an application for Brinzolamide/brimonidine drops (Simbrinza®) for lowering intraocular pressure. Simbrinza® is a combination eye drop containing carbonic anhydrase inhibitor, brinzolamide and alpha-2 adrenergic agonist, brominidine to lower intraocular pressure. The drops are non-inferior to the component eye drops as similar cost. TST had agreed to this product as an AMBER (specialist initiated) product where the request for use is when compliance with multiple drops is judged likely to be poor or when a greater total of drops per eye is likely to lead to promote ocular surface disease. It was agreed to add this as an Amber Drug as already added to TST formulary at their last DTC.

  SPF also agreed to add Simbrinza® to the formulary with AMBER TLS status.

  Action: Steve Moore

- Bone morphogenic protein was discussed. JB stated that he had received an email from one of their managers saying that they could continue ordering BMP as normal until the end of the financial year. SG asked for Shane Lord to contact him so that he could clarify the position that the CCG does not commission BMP.

  Action JB

8.3 Taunton & Somerset Antimicrobial Prescribing Group (TSAPG)

Minutes from last meeting not yet received.

8.4 YDH DTC

No meetings since last SPF

8.5 BNSSG Joint Formulary Group

No new minutes received. Most recent update to the formulary website April 15.

8.6 RUH Bath D&TC

Minutes noted

9 NICE Guidance

9.1 NICE

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.

9.2 NHS Sheffield CCG framework of NICE guidance

It was agreed that this document is a useful summary for use at PAMM and SPF. CH to obtain copies going forwards. **Action CH**

9.3 **TA345: Naloxegol for treating opioid-induced constipation**

Positive appraisal noted. Naloxegol is recommended as an option for treating opioid induced constipation in adults whose constipation has not adequately responded to laxatives. Cost = £55/ month

The guidance is quite specific on what constitutes an inadequate response to laxatives:

An inadequate response is defined as opioid-induced constipation symptoms of at least moderate severity in at least 1 of the 4 stool symptom domains (that is, incomplete bowel movement, hard stools, straining or false alarms) while taking at least 1 laxative class for at least 4 days during the prior 2 weeks.

Agreed to add to formulary as per NICE with GREEN TLS status. Formulary to be updated. **Action Steve Moore**

9.4 TA346: Aflibercept for treating diabetic macular oedema

Previously approved pre-NICE guidance in response to positive Final Appraisal Determination (FAD) from NICE. Positive appraisal from NICE. Formulary to be with details of NICE TA. **Action: Steve Moore**

9.5 TA348: Everolimus for preventing organ rejection in liver transplantation (for noting)

Positive appraisal noted. Funded by Specialist Commissioning. Formulary to be updated re.funding by NHSE. **Action: Steve Moore**

9.6 TA349: Dexamethasone intravitreal implant for treating diabetic macular oedema

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**

9.7 TA350: Secukinumab for treating moderate to severe plaque psoriasis (for noting)

Positive appraisal noted- Funding already agreed at July SPF in response to positive NICE FAD secukinumab is potentially more effective than alternatives. Formulary to be updated with details of NICE guidance–RED (hospital only status).

Action: Steve Moore

9.8 **TA 351: Cangrelor for reducing atherothrombotic events in people undergoing percutaneous coronary intervention or awaiting surgery requiring interruption of anti‑platelet therapy (terminated appraisal) (for noting)**

Terminated appraisal noted.

9.9 **TA352 Vedolizumab for treating moderately to severely active Crohn's disease after prior therapy**

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**

9.10 **TA353 Bevacizumab for treating relapsed, platinum‑resistant epithelial ovarian, fallopian tube or primary peritoneal cancer (terminated appraisal) (for noting)**

Negative appraisal noted.

9.11 **TA354: Edoxaban for treating and for preventing deep vein thrombosis and pulmonary embolism**

Positive appraisal. Agreed that the CCG will commission for patients covered by the TAG. Formulary to be updated –GREEN traffic light status. NOAC chart to be updated.

Action: Steve Moore

10 **NICE Clinical Guidance**

10.1 **NG14: Melanoma: assessment and management**

CB confirmed that there are no major recommendations around drugs in this guidance and said that the field is rapidly changing. She confirmed that TST is already following this guidance.

10.2 **NG15: Antimicrobial stewardship: systems and processes for effective antimicrobial medicine use**

The recent NHSE patient safety alert on antimicrobial stewardship was also viewed. SG said that the CCG has robust stewardship in place and that he will highlight this guidance and the patient safety alert to relevant groups.

10.3 **NG17: Type 1 diabetes in adults: diagnosis and management**

SG stated that:

- all the new diabetes guidance has been flagged to the diabetes group.
- we will be adopting the insulin guidance into the formulary. **Action: Steve Moore**
- continuous blood glucose monitoring will be looked at by other groups.

10.4 **NG18: Diabetes (type 1 and type 2) in children and young people: diagnosis and management**

See notes for item 10.3

10.5 **NG19: Diabetic foot problems: prevention and management**

See notes for item 10.3

11 **NHS ENGLAND SPECIALIST COMMISSIONING**

No new information.

12 PBR excluded drug monitoring

12.1 Trust Data

CH reported issues with the TST data this month in that some of the drugs were missing from the list and there were discrepancies in the budgets listed from last month to this month. CH to continue to chase up to date budget information for TST.

JS reported that the YDH overspend position should start to recover with the switch to biosimilar infliximab.

SG pointed out that biosimilar etanercept will be available soon.

12.2 DEFINE data demonstration on PbR excluded drugs

JB provided some DEFINE benchmarking data looking at the use of different biologics at TST compared with other Trusts.

DEFINE looks at prescribing data for 126 Trusts who feed data into the system. The Carter Index was used as a denominator which adjusts for various factors the relative business of individual Trusts, size of Trust, maternity unit etc.

TST was shown to have relatively lower spend on biologics than other Trusts. There was debate around the need to consider whether there was a need for additional capacity in some services such as ophthalmology,

13 Medicines Optimisation Prototype Dashboard

Trusts expressed some doubt over the usefulness of various indicators within the dashboard. JB pointed out that the NHS benchmarking audit data is more helpful.

14 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:

- **RDTC Monthly Horizon Scanning document July and Aug 15**
- **UKMI Prescribing Outlook and New Drugs Online**
- **A list of forthcoming NICE ESNM**
- **NICE forward planner**

SG noted that the 2015 Prescribing Outlook document has just been published. Trust will need to look at this in time for next year's contract negotiations.

15 DRUG SAFETY

15.1 Medication Safety Network Terms of Reference

It was noted that these are not quite finalised and that Trusts need to take them through their own governance processes. PAMM had reviewed these earlier in the day.

15.2 **Prednisolone 25mg tablets safety issue**

An example of harm caused in primary care was provided where a patient had taken a big overdose of prednisolone because they didn't understand the different strength of tablets. It was agreed that the 25mg strength would be made non formulary.

Action: Steve Moore

15.3 **MHRA Drug Safety Update July and Aug 2015**

Trusts were asked to review these documents address relevant issues.

15.4 NHSE Patient Safety Alert on ambulance dispatch and satellite navigation systems

Alert noted.

16 BNF Changes

Noted.

17 ANY OTHER BUSINESS

None noted.

DATE OF NEXT MEETING

- 11 November 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 9 SEPT 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)**	JS to forward his revised DoI to CH for list to be updated	**JS/ CH 11th Nov 15**	**Complete**
3	**July SPF minutes amendment**	CH to amend July minutes as per comments under item 4.1	**CH 11th Nov 15**	**Complete**
4	**Melatonin for Hemicrania Continua and PD related sleep disorder**	SG awaiting information on agreed duration of treatment from Mark Fish	**SG/ Mark Fish 11th Nov 15**	**Pending**
5	**Acute Kidney Injury (1)**	YDH and TST to bring back some anonymised case studies of patients admitted with AKI from primary care at next SPF.	**JS/JB 11th Nov 15**	**Response from TST only but none from YDH yet**
6	**Acute Kidney Injury (2)**	SomPar to provide a detailed list of actions taken	**SDB 11th Nov 15**	**Complete**
7	**Acute Kidney Injury (3)**	Collate Trust actions for review at next SPF	**CH 11th Nov 15**	**On agenda**
8	**Ivermectin Cream (Soolantra®)**	CH to bring an application to the next PAMM and SPF	**CH 11th Nov 15**	**On agenda**
9	**TST Biosimilars Policy**	JB to share policy at next SPF	**JB 11th Nov 15**	**Not approved by TST yet**
10	**Liquid medications for patients having bariatric surgery**	JB to follow up requests for liquid medicines with consultants	**JB 11th Nov 15**	**Complete**
11	**NG5: Medicines optimisation (1)**	CCG, YDH and SomPar to bring a baseline assessment back to SPF.	**CH, JS & SDB 31st Oct 15**	**Awaiting YDH assessment**
12	**NG5: Medicines optimisation (2)**	CH to collate completed assessments so priority areas of work can be identified	**CH 11th Nov 15**	**Awaiting all Trust responses first**
13	**Prednisolone Safety**	Prednisolone 25mg tabs to be made non-formulary. Safety spreadsheet to be updated	**Steve Moore 11th Nov 15**	**Complete**
14	**TST PBR excluded drug data**	CH to chase up accurate 15/16 budget data from TST	**CH 11th Nov 15**	**Some data but not in correct format**

NO.	SUBJECT	OUTSTANDING RESPONSIBILITY	ACTION LEAD	Status
15	**Formulary/ Traffic Light Changes**	• **Abasaglar (biosimilar insulin Glargine) 100 units/mL cartridges & pre-filled pens –** same amino acid sequence as Lantus. Saving of approx. £6 per 5 cartridges. Add as preferred glargine insulin. GREEN in TLS • **Spiolto Respimat 2.5 microgram/2.5 micrograms, inhalation solution (tiotropium bromide monohydrate and olodaterol hydrochloride)** for adults with COPD- Add as an option for those already using either tiotropium or olodaterol in a respimat device who need a second agent. • **Alzain® (pregabalin) capsules and Teva Pregabalin -** add to the formulary for GAD and Epilepsy indications- alongside Rewisca® • **Repatha® SureClick and PFS (evolocumab)- TLS BLACK-** not recommended • **Ikervis 1 mg/mL eye drops, emulsion (ciclosporin).** Licensed for the severe keratitis in adult patients with dry eye, which has not improved despite treatment with tear substitutes. Recent NICE FAD was negative- therefore 'BLACK'- not recommended- Traffic light status. • **Glucoject lancets PLUS 33G (200) £5.50-** more cost effective than other lancets on the market. They are ultrafine and compatible with most type A lancing devices. Add as first choice lancet.	**Steve Moore 11th Nov 15**	**Complete**

	Formulary/ Traffic Light Changes	• **Brinzolamide/brimonidine drops (Simbrinza®)** Add with AMBER TLS Status. • **NICE TA345: Naloxegol for treating opioid induced constipation-** Add to formulary with GREEN TLS status as per TA as an option for treating opioid induced constipation in adults whose constipation has not adequately responded to laxatives. • **NICE TA346: Aflibercept for treating diabetic macular oedema -** Previously approved in view of positive FAD. Update TLS with NICE tag. • **NICE TA348: Everolimus for preventing organ rejection in liver transplantation** Positive appraisal. Formulary to be updated as funded by NHSE Specialist Commissioning. • **NICE TA349: Dexamethasone intravitreal implant for treating diabetic macular oedema-** Formulary to be updated –RED TLS (hospital only status) and reference TAG • **NICE TA350:** Secukinumab for treating moderate to severe plaque psoriasis- Funding already agreed at July SPF in response to positive NICE FAD. Update to reference TAG • **NICE TA352: Vedolizumab for treating moderately to severely active Crohn's disease after prior therapy. Add as per NICE TAG. RED (hospital only status).** • **NICETA354: Edoxaban for treating and for preventing deep vein thrombosis and pulmonary embolism**. Add with Green TLS status and update NOACs table	**Steve Moore 11th Nov 15**	**Complete**