EPSOM AND ST HELIER UNIVERSITY HOSPITALS NHS TRUST

NEW DRUG AND INTERFACE GROUP

MINUTES OF THE MEETING HELD ON WEDNESDAY 9th August 2017
IN THE BOARDROOM, FERGUSON HOUSE, ST HELIER HOSPITAL

Present:
Dr S Patel (Chair) **SP**
Dr J Bendig (Consultant Microbiologist) **JB**
Dr M Gardner (Consultant Anaesthetist) **MG**
Dr R Shephard (Consultant Neonatologist) **RS**
Dr L Mulleague (Consultant Anaesthetist) **LM**
Anne Davies (Chief Pharmacist) **AD**
Anne Lowson (Secretary) **AL**
Sharon Kitkatt (Consultant Nurse, Acute Pain Service) **SK**
Dr R Scott (Joint Medicines Management Lead, GP Sutton CCG) **RSc**
Dr A Pitsiaeli (GP, Surrey Downs CCG) **AP**
Liz Clark (Lead Commissioning Pharmacist, Surrey Downs CCG) **LC**
Sophie Bye (Senior Pharmacist Sutton CCG) **SB**

In attendance:
Kuljit Gata-Aura (Medicines Management Technician) **KGA**
Laura Govender (Neonatal Nurse Practitioner, Guy's and St Thomas' NHS Foundation Trust)
Haleemah Faruki (Sutton CCG Pharmacy work experience student)
Miss A McElvanney (Consultant Ophthalmologist)
Mr P Ursell (Consultant Ophthalmologist)
Mr E Lee (Consultant Ophthalmologist)
Dr V Varney (Respiratory Consultant)

No	Item	Responsible for Action
1.	**Apologies for Absence** Dr A Mahmood (Consultant Gastroenterologist) **AM** Dr R Bogle (Consultant Cardiologist) **RB** Sarah Taylor (Chief Pharmacist, Sutton CCG) **ST** Dr S Moodie (Consultant Gastroenterologist) **SMo** Sumbo Adeyemo (Medicines Management Pharmacist) **SA** Susie Mallinder (Head of Nursing, Renal Division) **SM** Dr P O'Mahony (Consultant Stroke Physician) **PO** Ria John (Medicines Management Administration Coordinator) **RJ**	
2.	**Declarations of Interest** No additional declarations of interest for this meeting from members or from the new drug presenters.	
3.	**Minutes of the Meeting held on 14 June 2017** The minutes of the meeting held on 14 June 2017 were agreed.	
4.	**Matters Arising**	
	a) SWL – pathway for Melatonin Work is ongoing with Pharmacy and Trust clinicians.	
5.	**New Drug Requests**	
	a) Cacicol® – to prevent progression of corneal damage and to promote epithelial healing. Resubmission following rejection at NDAIG December 2016 Cacicol is a new technology in the field of regenerative medicine. It is a therapeutic matrix agent applied to chronic and persistent corneal defects where patients are refractory to conventional therapies and would otherwise require surgery.	

	The request was originally discussed in December 2016 and rejected due to the quality and limited amount of evidence available. This meeting had not been quorate and Miss McElvanney re-presented the case. Evidence is only available from small studies or case series due to the prevalence of the disease. Persistent/recurrent corneal epithelial defects and neurotrophic keratitis/ulcers have a poor prognosis. Other measures to manage them include the use of autologous serum, conjunctival flaps and amniotic membrane grafting. Surgical techniques entail other risks including corneal scarring. The decision of Moorfields Eye Hospital NHS Foundation Trust recently has been to add to their formulary to treat non-healing corneal ulcer/persistent epithelial defects. Clinicians may be advised to start with once a week and can increase frequency up to three times a week if there is delayed or absent healing response. If continued use of Cacicol® has failed to show a beneficial effect after two months, alternative strategies should be explored. The Pharmacy were unable to obtain Moorfields' evidence-based review. Miss McElvanney also advised that the Queen Victoria Hospital in East Grinstead are using Cacicol®. A recent audit of patients prescribed treatment at Epsom and St Helier (using the one-off drug request process) has shown only one patient out of four has failed treatment and this is due to compliance issues. The limited data available suggests approximately a 70% response rate. If agreed, the proposal would be to use the eye drops first line as there would be a delay in accessing the alternative options detailed above. Miss McElvanney advised that the hospital was a competent centre to carry out the treatment. Patients are reviewed 48 hours after initiation of treatment and approximately every 48 hours for one week. Treatment would usually be for one month, healing monitored, and then the patient followed up. It may be necessary to re-treat the patient with Cacicol® and co-prescribe corticosteroid or herpetic eye treatment. **Decision** To add Cacicol® eye drops (medical device) to the Trust formulary for use by Miss McElvanney or her team for treatment of non-healing corneal ulcers/persistent epithelial defects. Treatment to start with once a week and to increase to three times a week if delayed or absent healing. Stop if no response after two months. Miss McElvanney to be encouraged to keep a registry of patients given this preparation to collect outcome data.	
	b) Mydrane® (tropicamide, phenylephrine and lidocaine solution for injection) – for cataract surgery to obtain mydriasis and intraocular anaesthesia during the surgical procedures Mydrane® is a solution for intracameral injection which combines two mydriatic agents and a local anaesthetic and is used for cataract surgery to obtain mydriasis and intraocular anaesthesia. It is administered at the start of the surgical procedure. Patients must have demonstrated, at a previous visit, satisfactory pupil dilation with topical mydriatic therapy. The current standard topical regimen would involve three eye drops being given over 30 minutes, which involves nursing time and this resource could be better used. There is also a risk of medication error and ocular surface toxicity. Patients could be better staggered with the intracameral injection which dilates in 30 seconds. Mr Ursell advised that the drops don't work in approximately 5% of patients, and then a spring device is needed.	

	Evidence is from a randomised controlled trial compared with a standard regimen of topical drops, and it showed the injection to be as effective as the topical regimen. Pre-operative time was lower. Mr Ursell would like to use the injection in a small number of patients and, if this was felt to be a useful product with the perceived benefits, prepare a business case for the division. The injection is more expensive than the use of drops. The company have offered a small supply, free of charge, and this will be considered outside of the meeting and post the clinical decision being made. **Decision** To add Mydrane® to the Trust formulary for use in cataract surgery to obtain mydriasis and intraocular anaesthesia in adults. Discussion required with division regarding financial implications and patient flow.	
	c) Alteplase – for submacular haemorrhage associated with exudative age related macular degeneration Mr Lee advised that the patients present with sudden loss of central vision which is later diagnosed as submacular haemorrhage (SMH), often associated with exudative age-related macular degeneration. There is no standard treatment, but several surgical techniques have been used to physically remove submacular haemorrhage. Vitreoretinal surgery has been used to evacuate the haemorrhage, but results have been disappointing. The proposal would be to use alteplase administered by sub-retinal injection during a vitrectomy procedure and followed by gas displacement. Supporting evidence is from small case series. The Sandhu study in 16 patients carried out in Sunderland showed 11 out of 16 patients had complete displacement of submacular haemorrhage and 10 of the 16 patients (63%) had improved vision by two or more lines. To date, the Trust has treated five patients in two years using the one-off drug request process, using 12.5-25mcg per patient. 60% of patients have had a one line improvement. Studies are difficult to compare due to different inclusion criteria and outcome data reported. The exact procedure and route of administration also varies slightly. It is recognised that a large randomised prospective trial is needed to compare this technique against others; however, this is difficult to do due to the complexity and urgency of need. Mr Lee advised that the off-label use of alteplase by subretinal injection is well-established in the UK, including at Moorfields Eye Hospital NHS Foundation Trust, Birmingham and Midland Eye Centre, and Bristol Eye Hospital. With regards to the safety of the procedure, Mr Lee advised that there are potential problems, as with any technique of haemorrhage displacement, eg increase of vitreous haemorrhage; these are managed during surgery or with repeat surgery, if needed. Side effects include risk of infection and retinal detachment. The committee recognised that the risk related to the procedure rather than the drug. There is limited evidence, but the committee recognised that, if nothing was done, the patient would be registered blind. With regards to the preparation, there needs to be dilution of a 10mg injection to give a dose of 10-50mcg in 0.1ml. Mr Lee has a protocol for dilution and this will be circulated. A nurse and a consultant are involved in the procedure. SMH is a relatively common and severe complication of choroidal neovascularisation in wet AMD and the technique is effective at increasing the chances of the patient	

	becoming eligible for NHS-funded treatment of the underlying pathology (wet AMD). **Decision** To agree the use of alteplase for subretinal treatment of submacular haemorrhage associated with exudative age-related macular degeneration. For use as part of vitrectomy and gas operation. It will be used on a named patient/named consultant basis. The consultant must be named and competent to carry out the procedure. Protocol to be reviewed.	
	d) Relvar® – for asthma Dr Varney presented the case for the addition of the preparation for use in asthma which contains inhaled corticosteroid and long-acting beta$_2$ agonist. It is also licensed for COPD and is on the formulary for this indication. Dr Varney advised that it is a once-daily preparation which does not require high inspiratory flow to use, and the Ellipta® device offers good inhaled delivery and is easy to use. The once-daily dosing regimen is expected to increase concordance in patients who are currently finding it difficult to manage a twice-daily regimen, eg younger people. The price is also competitive. The SIGN/BTS guidelines have been reviewed in 2016. Relevant steps are now: Step 1: Regular low dose ICS Step 2: Add LABA to low dose ICS (normally as combination) Step 3: If LABA beneficial but still inadequate control, increase to medium dose ICS/LABA inhaler Step 4: Increase to high dose ICS/LABA Step 5: Oral steroids at lowest effective dose and maintain high dose ICS/LABA Short acting β_2 agonists on a prn basis as recommended at all steps. The guidelines categorise Relvar® 92/22 as a low to medium ICS and Relvar® 184/22 as a high dose ICS. The license covers patients not adequately controlled with inhaled corticosteroid and 'as needed' inhaled short-acting β_2 agonists. Therefore, Relvar® 92/22 would be appropriate for patients at Step 2-3 and Relvar® 184/22 would be appropriate for patients at Step 4. Review of inhaled corticosteroids should be considered every three months. There are two issues with Relvar®; firstly, if a patient currently on Relvar® 92/22 needs to step down to a Step 2 treatment (regular ICS monotherapy), the fluticasone furoate is not available as monotherapy, so an alternative preparation would be needed. The second issue is that the inhaler has a shelf life of six weeks once opened, which may increase the risk of the patient using an expired inhaler, particularly if the patient has inhalers in different locations. Currently only interim primary endpoint results are available from the Salford Lung Study, but it shows positive results. **Decision** To add Relvar Ellipta® to the formulary for use in the treatment of asthma in line with the licensed indications and BTS guidelines, where once daily dosing is most appropriate. Surrey representatives to discuss reconsideration of the current Black Status on the Surrey PAD and feedback at the next meeting.	
6.	**Six Month New Drug Reviews** Nothing for this meeting.	
7.	**NICE/MHRA Guidance**	
	MHRA Guidance **I. June 2017** This MHRA bulletin includes reports on osteonecrosis of the external auditory canal caused by denosumab and the risk of systemic cardiovascular effects of brimonide gel.	

	II. **July 2017** This MHRA bulletin includes the risk of severe liver injury with daclizumab, initiation in multiple sclerosis now restricted and review patients already on treatment. Bendamustine increased mortality observed in recent clinical studies in off label use and nivolumab, pembrolizumab reports of organ transplant rejection.	
	Updates	
	Nothing for this meeting	
	Technology Appraisals for Discussion	
	a) Brentuximab vedotin for treating CD30-positive Hodgkin lymphoma – TA446 Brentuximab vedotin will be added to the Trust formulary for treating CD30-positive Hodgkin lymphoma in adults if they have relapsed disease after autologous stem cell transplant or relapsed/refractory disease after at least two previous therapies and they cannot have a stem cell transplant. Funding will be via the Cancer Drugs Fund/NHS England.	AL/KGA
	b) Pembrolizumab for untreated PD-L1-positive metastatic non-small-cell lung cancer – TA447 Pembrolizumab for untreated PD-L1-positive metastatic non-small-cell lung cancer will be added to the Trust formulary for patients admitted on therapy. Funding will be via the Cancer Drugs Fund/NHS England.	AL/KGA
	c) Etelcalcetide for treating secondary hyperparathyroidism – TA448 Etelcalcetide for treating secondary hyperparathyroidism will be added to the Trust formulary for patients on haemodialysis if cinacalcet is not suitable for patients admitted on therapy. Funding will be via NHS England.	AL/KGA
	d) Everolimus and sunitinib for treating unresectable or metastatic neuroendocrine tumours in people with progressive disease – TA449 Everolimus and sunitinib will be added to the Trust formulary for treating well or moderately differentiated unresectable or metastatic neuroendocrine tumours (NETs) of pancreatic origin and everolimus for NETs of gastrointestinal or lung origin in adults with progressive disease. Patients are likely to be managed by the oncology teams of the Trust/The Royal Marsden NHS Foundation Trust. Funding will be via NHS England.	AL/KGA
	e) Blinatumomab for previously treated Philadelphia-chromosome-negative acute lymphoblastic leukaemia – TA450 Blinatumomab will be added to the Trust formulary for treating Philadelphia-chromosome-negative relapsed or refractory B-cell acute lymphoblastic leukaemia in adults. Funding will be via NHS England.	AL/KGA
	f) Ponatinib for treating chronic myeloid leukaemia and acute lymphoblastic leukaemia – TA451 Ponatinib will be added to the Trust formulary for treating chronic accelerated or blast phase chronic myeloid leukaemia when the disease is resistant to dasatinib or nilotinib or when the patient cannot tolerate these agents and imatinib is not appropriate or the T3151 gene mutation is not present. It is also an option in Philadelphia-chromosome-positive acute lymphoblastic leukaemia when the disease is resistant to dasatinib or the patient cannot tolerate this agent and imatinib is not appropriate or the T3151 gene mutation is present. Funding will be via NHS England.	AL/KGA
	g) Adalimumab, etanercept and ustekinumab for treating plaque psoriasis in children and young people – TA455 Adalimumab, etanercept and ustekinumab will be added to the Trust formulary for	AL/KGA

	treating plaque psoriasis in children and young people in line with this guidance. Funding will be via NHS England.	
	h) Ustekinumab for moderately to severely active Crohn's disease after previous treatment – TA456 Ustekinumab for moderately to severely active Crohn's disease after previous treatment will be added to the Trust formulary for patients who have had an inadequate response with, lost response to, or were intolerant to conventional therapy or a TNF-alpha inhibitor or have medical contraindications to such therapies. Funding will be via the CCGs.	AL/KGA
	i) Carfilzomib for previously treated multiple myeloma – TA457 Carfilzomib for previously treated multiple myeloma will be added to the Trust formulary for patients who have had only one previous therapy which did not include bortezomib. Funding will be via the Cancer Drugs Fund. Patients will be treated by the haematology team. See 7y also.	AL/KGA
	j) Trastuzumab emtansine for treating HER2-positive advanced breast cancer after trastuzumab and a taxane – TA458 Trastuzumab emtansine will be added to the Trust formulary for treatment of HER2-positive advanced breast cancer after trastuzumab and a taxane for patients admitted on therapy. Funding will be via NHS England.	AL/KGA
	k) Collagenase clostridium histolyticum for treating Dupuytren's contracture – TA459 Collagenase clostridium histolyticum for treating Dupuytren's contracture will be added to the Trust formulary for use in line with this guidance for patients admitted on therapy. Funding will be via the CCGs.	AL/KGA
	l) Adalimumab and dexamethasone for treating non-infectious uveitis – TA460 Adalimumab and dexamethasone intravitreal will be added to the Trust formulary for treating non-infectious uveitis in the posterior segment of the eye. Adalimumab is recommended after inadequate response to corticosteroids and dexamethasone intravitreal implant if there is active disease and worsening vision with a risk of blindness. Funding is via NHS England for adalimumab and the CCGs for dexamethasone.	AL/KGA
	m) Roflumilast for treating chronic obstructive pulmonary disease – TA461 Roflumilast will be added to the Trust formulary for treatment of chronic obstructive pulmonary disease within the disease criteria specified. It should be started by a specialist in respiratory medicine and is funded via the CCGs.	AL/KGA
	n) Nivolumab for treating relapsed or refractory classical Hodgkin lymphoma – TA462 Nivolumab will be added to the Trust formulary for treating relapsed or refractory classical Hodgkin lymphoma after autologous stem cell transplant and treatment with brentuximab vedotin. Funding is via the Cancer Drugs Fund. The Trust is likely to refer patients to The Royal Marsden NHS Foundation Trust for treatment. See 7x also.	AL/KGA
	Technology Appraisals Terminated	
	o) Ibrutinib for untreated chronic lymphocytic leukaemia without a 17p deletion or TP53 mutation – TA452 NICE has been unable to make a recommendation on the use of ibrutinib for untreated chronic lymphocytic leukaemia without a 17p deletion or TP53 mutation as no evidence submission was received from the manufacturers.	

	p) Bortezomib for treating multiple myeloma after second or subsequent relapse – TA453 NICE has been unable to make a recommendation on the use of bortezomib for treating multiple myeloma after second or subsequent relapse as no evidence submission was received from the manufacturers. **q) Daratumumab with lenalidomide and dexamethasone for treating relapsed or refractory multiple myeloma – TA454** NICE has been unable to make a recommendation on the use of daratumumab with lenalidomide and dexamethasone for treating relapsed or refractory multiple myeloma as no evidence submission was received from the manufacturers.	
	Technology Appraisals for Information	
	Nothing for this meeting.	
	Technology Appraisals Not Recommended	
	Nothing for this meeting.	
	Clinical Guidelines Updated for Information	
	r) Idiopathic pulmonary fibrosis in adults: diagnosis and management – CG163 These guidelines have been updated to reflect the NICE TA on nintedanib. **s) Suspected cancer: recognition and referral – NG12** These guidelines have been updated and reflect the new guidance on quantitative faecal immunochemical tests to guide referral for colorectal cancer in primary care.	
	Clinical Guidelines for Discussion	
	t) Constipation in children and young people: diagnosis and management – CG99 These guidelines have been updated and include the latest guidance on coeliac disease. Manufacturers' information has also been revised but the formulary includes treatment options for the different therapeutic classes. **u) Parkinson's disease in adults – NG71** These guidelines have been updated including pharmacological management. Discussion will be required with the neurologists and elderly care clinicians regarding several drug related issues including use of modafinil, melatonin, rotigotine in nocturnal akinesia, and quetiapine and clozapine for treating hallucinations or delusions. Update at next meeting.	AL/KGA
	Clinical Guidelines for Information	
	Nothing for this meeting.	
	Quality Standard Updated	
	Nothing for this meeting.	
	Quality Standard for Discussion (medicine related issues only)	
	v) Liver disease – QS152 This quality standard includes the recommendations to use prophylactic IV antibiotics in cirrhosis and upper GI bleeding patients at presentation. Dr Bendig will document the guidance and this will be fed back at the next meeting.	JB/Donna Francis
	Quality Standard for Information	
	Nothing for this meeting.	
	Highly Specialised Technologies Guidance	
	w) Eliglustat for treating type 1 Gaucher disease – HST5 Eliglustat is recommended within its marketing authorisation for treating type 1 Gaucher disease; that is, for long-term treatment in adults who are cytochrome P450 2D6 poor, intermediate or extensive metabolisers. Funding is via NHS England.	
	Highly Specialised Technologies for Discussion	
	x) Nivolumab for treating relapsed or refractory classical Hodgkin lymphoma Nivolumab in line with NICE TA462 is funded via the Cancer Drugs Fund from 2 June	

	2017 and an application made via Blueteq site. **y) Carfilzomib for previously treated multiple myeloma** Carfilzomib in line with NICE TA457 is funded via the Cancer Drugs Fund from 9 June 2017 and an application made via Blueteq site. **z) Olaratumab in combination with doxorubicin for treating advanced soft tissue sarcoma** Olaratumab in combination with doxorubicin for treating advanced soft tissue sarcoma has been supported in the NICE TA final appraisal determination. Funding is available from 9 June 2017 via the Cancer Drugs Fund and an application made via Blueteq site. **aa) Cenegermin (Oxervate®) in the treatment of moderate (persistent epithelial defect) or severe (corneal ulcer) neurotrophic keratitis in adults** An Early Access scheme has been put in place for cenegermin (Oxervate®) for the treatment of moderate (persistent epithelial defect) or severe (corneal ulcer) neurotrophic keratitis in adults. Patients need to be referred to a specialised ophthalmology service detailed, which includes Moorfields Eye Hospital NHS Foundation Trust. **bb) Daclizumab for treating relapsing–remitting multiple sclerosis** NICE TA441 for the use of daclizumab in treating relapsed-remitting multiple sclerosis has been revised to update the access criteria. The London centres that are commissioned for daclizumab include St George's University Hospitals NHS Foundation Trust. **cc) Obeticholic acid for treating primary biliary cholangitis** NICE TA443 for the use of obeticholic acid for treating primary biliary cholangitis has been funded from 25 July 2017 within specialised hepatobiliary centres which include King's College Hospital and St George's University Hospital NHS Foundation Trust.	
	Health Technology Assessment	
	Nothing for this meeting.	
	For Discussion	
	Nothing for this meeting.	
8.	**Patient Safety Alerts**	
	a) Resources to support the safety of girls and women who are being treated with valproate Work is ongoing to implement this alert.	Nashreen Maudarbacus /AL/AD/KGA
9.	**Operational Issues**	
	a) 3M Tegaderm IV securement dressing for central venous and arterial catheter insertion sites ITU/HDU are in the process of developing a trial usage of 3M Tegaderm IV securement dressing. Update at next infection control committee.	Donna Francis
	b) Review of Trust Vitamin D Guidance SP to link with Dr Singh to discuss the recommendations around Vitamin D in fractured neck of femur and revisions to the pathway.	SP
	c) Regional Medicines Optimisation Area Committees No update for this meeting.	
	d) Patient information leaflet – Supplies of medication Revised version will be brought to the next meeting.	
	e) Feedback from CCGs – IFRs for biologics ST and LC to consider an appropriate forum for discussion/feedback of the IFR process.	LC/ST

10.	**Feedback from CCGs and Trust Committees**	
	a) Respiratory Working Group No update for this meeting.	
	b) DOACs: DVT/PE Draft versions of the Guidelines for Common Medical Emergencies for management of PE have been prepared. These include the use of DOACs. Awaiting feedback from the respiratory consultants. Dr Appiah-Cubi has reviewed the Trust anticoagulation protocol and this was discussed at the July MMCBG. This also details the use of DOACs in DVT/PE. Update at next meeting.	AL/AD/SP
	c) SWL Sutton & Merton CCGs **I. Minutes** For information.	
	d) SWL Medicines Optimisation Group **I. Pharmacological management of heart failure** This document has been shared with the cardiologists and agreed. Patients who require nebivolol in line with this guideline will be managed via the one-off drug request process. The committee supported this guideline. **II. SWL Position Statements** **a. Position statement on the prescribing of topical antifungal nail treatment on prescription** **b. Amorolfine patient review letter** The Trust supports this statement that SWL CCGs do not support routine prescribing of topical antifungal nail treatment, except for a child on specialist advice. Amorolfine is on the Trust formulary and has been used by the dermatologists who have been made aware of the position statement. Patients are being advised of the change in prescribing practice. **c. Position statement on the prescribing of complementary and alternative medicines** The Trust supports this statement that SWL CCGs do not support the routine prescribing of complementary and alternative medicines. This includes herbal supplements, homeopathic preparations, aromatherapy flower essence, etc. The Trust does not have these agents on the formulary. **d. Position statement on the prescribing of doxazosin modified release tablets** The Trust supports this statement that SWL CCGs do not support the routine prescribing of doxazosin modified release tablets. Both preparations are administered once daily, therefore there is no advantage in terms of compliance. The Trust does not have the modified release tablets on formulary. Doxazosin modified release should only be prescribed for patients who cannot tolerate the immediate release preparation. **e. Position statement on the prescribing of topical preparations for the treatment of haemorrhoids on prescription** The Trust supports this statement that SWL CCGs do not support the routine prescribing of topical preparations for the treatment of haemorrhoids except in patients with persistent and severe symptoms or symptoms that have failed to resolve despite use of over the counter preparations. Patients for whom over the counter preparations are not suitable can also receive treatment on prescription.	AL/KGA

	The Trust does have Anusol® and Anusol HC® on the formulary for acute treatment and, where appropriate, a tube will be supplied at discharge, but the GP is unlikely to need to re-supply. **f. Position statement on minocycline for the management of acne vulgaris** The Trust supports this statement that SWL CCGs do not support the routine prescribing of minocycline for the management of acne vulgaris. Minocycline is currently on the formulary for resistant acne and rosacea, although it is not used routinely. **g. Position statement on the prescribing of omega 3 fatty acids in primary care** The Trust supports that SWL CCGs only support the use of omega 3 fatty acids for the management of hypertriglyceridemia with or without a statin depending on cardiovascular risk. This is in line with the SWL guidance for hypertriglyceridemia. **h. Position statement on the prescribing of perindopril arginine** The Trust supports that SWL CCGs do not support the routine prescribing of perindopril arginine, as it has no clinical benefit over generic perindopril erbumine. The Trust does not have perindopril on the formulary. **i. Position statement on prescribing of topical rubefacients on prescription** The Trust supports that SWL CCGs do not support the routine prescribing of topical rubefacients on prescription. The Trust does not have topical rubefacients on the formulary. **j. Position statement on the prescribing of Tramacet® tablets** The Trust supports that SWL CCGs do not support the routine prescribing of Tramacet®. The Trust does not have this combination product on the formulary. **k. Position Statement on the prescribing of aliskiren in primary care** The Trust supports that SWL CCGs do not support the routine prescribing of aliskiren for hypertension. Aliskiren is not currently on the Trust formulary. **l. Position Statement on the prescribing of Amiodarone for rate control in chronic Atrial Fibrillation** The Trust supports that SWL CCGs do not support routine prescribing of amiodarone for rate control in chronic atrial fibrillation. Amiodarone is currently on the Trust formulary for other indications. It may be needed for up to 24 months after cardioversion, if the treatment has been successful.	
	e) SWL Cardiovascular Group for Discussion **I. Summary of anti-platelet options** The Trust cardiologists support this summary of antiplatelet options in cardiovascular disease. The Trust has the antiplatelets listed on the formulary. Document to be added to the Medicines Resource site. **II. Cardiovascular Disease Pharmacists for South London End of year report 2016/17** This report is for information and details the work carried out in 2016/17 and workplan for 2017/18.	RJ/KGA
	f) Surrey Prescribing Clinical Network **I. Minutes July 2017**	

	Minutes for information. Surrey PCN noted that the cost of anticoagulation to the local health economy has been growing and some of that is due to the need to diagnose AF and the increase use of Direct Oral Anticoagulants (DOACs). Warfarin remains an option. They have devised and supported a pathway highlighting edoxaban as the locally preferred DOAC as it has the lowest cost due to a proposed rebate scheme. Trust clinicians have been asked for comments and they support the principle. However, they require further clarity on the process to be followed if alternative DOACs are deemed the most suitable for a specific patient. Meeting may be required to discuss. **II. Surrey Policy Statements** **a. Prescribing of branded medicines** Surrey CCG have a list of branded drugs that are available generically and request that the brands are not included in information for GPs regarding medication. Generic versions of these drugs are used in the Trust. **b. Certolizumab pegol and secukinumab for treatment active psoriatic arthritis after inadequate response to DMARDs (NICE TA445)** The Trust supports the policy statement on certolizumab pegol and secukinumab for treating active psoriatic arthritis after inadequate response to DMARDs in line with this NICE guidance. **c. Ixekizumab for treating moderate to severe plaque psoriasis (NICE TA442).** The Trust supports the policy statement on ixekizumab for treating moderate to severe plaque psoriasis in line with this NICE guidance.	AL/LC/AP/ Dr Bogle
	g) Shared Care Prescribing Guidelines **I. Riluzole for Motor Neurone Disease in Adults** The shared care guidelines for riluzole for motor neurone disease in adults have been updated. The Trust neurologists have supported this document.	
11.	**Any Other Business**	
	None.	
12.	**Date of Next Meeting:**	
	Wednesday 11th October 2017, 12:30-2:00pm, Carew Room, PGMC, 1st Floor, B Block, St Helier Hospital.	