EPSOM AND ST HELIER UNIVERSITY HOSPITALS NHS TRUST

NEW DRUG AND INTERFACE GROUP

MINUTES OF THE MEETING HELD ON WEDNESDAY 14th June 2017
IN FLORENCE ROOM, WELLS WING, EPSOM HOSPITAL

Present:
Dr S Patel (Chair) **SP**
Dr V De Silva (Consultant Nephrologist) **VDS**
Dr S Moodie (Consultant Gastroenterologist) **SMo**
Sharon Kitkatt (Consultant Nurse, Acute Pain Service) **SK**
Sarah Taylor (Chief Pharmacist, Sutton CCG) **ST**
Dr R Scott (Joint Medicines Management Lead, GP Sutton CCG) **RSc**
Liz Clark (Lead Commissioning Pharmacist, Surrey Downs CCG) **LC**
Anne Davies (Chief Pharmacist) **AD**
Anne Lowson (Secretary) **AL**

In attendance:
Jill Stevens (Deputy Chief Pharmacist, Clinical Services) **JKMS**
Sumbo Adeyemo (Medicines Management Pharmacist) **SA**
Ria John (Medicines Management Administration Coordinator) **RJ**
Kuljit Gata-Aura (Medicines Management Technician) **KGA**
Lynne Thornton (Pharmacist) **LT**

No	Item	Responsible for Action
1.	**Apologies for Absence** Dr M Gardner (Consultant Anaesthetist) **MG** Dr J Bendig (Consultant Microbiology) **JB** Susie Mallinder (Head of Nursing, Renal Division) **SM** Dr P O'Mahony (Consultant Stroke Physician) **PO** Dr A Pitsiaeli (GP, Surrey Downs CCG) **AP** Dr A Mahmood (Consultant Gastroenterologist) **AM**	
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 the 5 April 2017** The minutes of the meeting held on 5 April 2017 were agreed.	
4.	**Matters Arising**	
	a) SWL - Pathway for Melatonin Meeting held with representatives from Sutton CCG and SWL and St Georges Mental Health Trust. Work is ongoing to estimate patient numbers requiring long-term melatonin liquid. **b) Updated - Donepezil, galantamine, rivastigmine and memantine for the treatment of Alzheimer's disease – TA217** Surrey Downs CCG have already advised that the clinicians would need to provide information to their PCN that they could meet the criteria laid out in the current shared care protocol. Sutton and Merton also support this approach. They are also reviewing the patient pathway. Update at future meeting if necessary. **c) Calcipotriol/Betamethasone cutaneous (Enstilar ®)** Trust paper to be discussed at the next available Surrey PCN meeting. Sutton CCG will	**AL/KGA/NK**

	discuss possible changes to the patient pathway with GPs. If required, this will be discussed in future.	
5.	**New Drug Requests**	
	a) Topical tacrolimus for eczema (atopic dermatitis) in children Dr Williams (Dermatology Consultant) presented the case for prescribing tacrolimus ointment for severe eczema in children; the 0.03% strength in children under 2 years old and 0.1% in children under 16 as a 2nd line treatment after topical steroids. Topical calcineurin inhibitors are already an established alternative to topical corticosteroids for the treatment of eczema in children and recommended by NICE. Tacrolimus ointment is licensed for eczema but 0.03% in children over 2 years and the 0.1% in adults and children over 16. Hence this application is for off-label use of this preparation. NICE did not review off-label use. Dr Williams asked the group to consider that this has been routine practice both worldwide and in the trust for years (evidenced by prescribing records of previous dermatology consultants and explained the 0.03% strength will only be used in children under 2 years for a small number of patients. <u>Evidence for 0.03 % ointment in children under the age of 2 years</u> There is limited evidence available in this patient cohort. One 2 year study provides some evidence base for using tacrolimus ointment 0.03% in children aged from 3 months to 2 years. Thirty nine children completed the 2 year study which as expected showed an improvement in all disease and patient orientated outcomes. With respect to safety which is probably the most important aspect in this cohort this small study showed that the incidence of adverse events is consistent with previous studies using 0.03% in children. This study also confirmed that in this age group with large BSA to body size ratio that there was an undetectable amount of systemic absorption of tacrolimus and no evidence of accumulation with treatment duration. <u>Evidence for 0.1 % ointment in children from age 2 to 15 years</u> There is a much larger evidence base for off-label use in this age group; 4 studies (2 RCTs and 2 long term open label) with an approx. total population exposed to 0.1% of 165 for 3 weeks; 118 for 12 weeks; 182 for 12 months; and 300 for 3 years. These studies showed that use of the high strength, 0.1% ointment is effective and safe in this patient cohort. Comparative efficacy between 0.03% and 0.1% remains unconfirmed as there are conflicting results from 2 relevant studies. Adverse events did not differ between the 2 patient cohorts. No new safety concerns were identified; common adverse events observed were the same as those seen when the preparation is used within its license and these were transient skin burning, application-site infections and itching. There is more supporting evidence available for use of the 0.1% in children under 16. More evidence is required to determine the safety of 0.03% in infants under 2 years old. However, children under 2 years are treated with the 0.03% instead of potent topical steroids which may result in severe side effects such as skin atrophy and growth retardation. Larger long term comparative studies are necessary to determine the efficacy of 0.03% compared to 0.1% in children from age 2 to 15 years. Dr Williams informed the group that generally GPs have been in agreement to continue topical tacrolimus treatment for paediatric eczema including when used off-label. Primary care representatives at the meeting agreed that transfer of care was acceptable after follow up by the specialist. Off-label prescribing must be stated on the transfer letter and the number of tubes required per month. Also that an information sheet outlining adverse events to monitor, eg cutaneous infections including herpes, and the contact details for the dermatologists including out of hours	

should be developed to support GP prescribing.

Decision
Use of topical ***tacrolimus ointment*** 0.03% and 0.1% to treat eczema to be extended to include off-label use in children;
0.03% in infants and children under 2 years;
0.1% in children age 2 to 15:
Initiation by Dermatologists only and transfer of care to GPs after follow up.
Dermatologists to develop an information sheet to support transfer of care to GPs.

b) Topical tacrolimus for vitiligo in children
Dr Williams (Dermatology Consultant) also presented the case for prescribing tacrolimus ointment for **vitiligo in children**. Topical tacrolimus is not licensed for this indication however its use is recommended by the British Association of Dermatologists as a follow on or an alternative to the use of high potency topical steroids. Dr Williams explained that the main reason topical tacrolimus is used in children is as a steroid sparing agent especially for facial areas which would be more prone to skin atrophy. Only potent topical steroids are effective in the treatment of vitiligo and limited to 8 weeks. In practice dermatologists do not find the 0.03% particularly effective. Babies and infants are not usually treated until older and children with lighter skins do not require treatment. Duration of treatment is long term , usually
The evidence for efficacy in children comes from 10 (controlled, open, prospective and retrospective) studies in children from age 2 to 16; treatment duration varied from 1 to 6 months. Treatment was mostly applied twice daily. In summary, a more complete response (at least 50%) was observed on face, head and neck areas than trunk and extremities. The best response was obtained with segmental facial vitiligo. Topical tacrolimus was more effective than clobetasol on facial areas and at least as effective on other areas. Children showed significantly better response rates than adults. Response rates did not differ based on strength of ointment (0.03% or 0.1%). Response rates were unaffected by previous treatment or ethnic origin and higher with twice daily than once daily application. Depigmentation occurs after cessation of treatment.
The evidence shows that tacrolimus is well tolerated causing either no treatment related adverse events or only minimal burning, stinging, itching, erythema at initiation of treatment. Symptoms either resolved spontaneously or after a few days pause in treatment. No atrophy or telangiectasia of the skin in was observed. A single case of hyperpigmentation with application of 0.03% was reported in a 10 year old. There is also no risk of hypothalamic-pituitary-adrenal axis suppression as seen with the widespread use of potent topical steroids.
Monitoring for children being treated for vitiligo will not be transferred to GPs and remains with the specialist, however there are usually long intervals between clinic appointment and dermatologists are requesting GPs to continue prescribing during these intervals.
Liz Clarke, representing Surrey Downs CCG felt that GPs would be in agreement to supply in this way as its use is recommended by a National body. Sutton CCG representatives were in agreement.
As with off-label treatment of eczema the group requested that the GP be informed that prescribing is off-label on the transfer letter and that the number of tubes required per month should be indicated. Also that an information sheet outlining adverse events to monitor and the contact details for the dermatologists including out of hours should be developed to support GP prescribing.
Decision
Use of topical ***tacrolimus ointment*** 0.03% and 0.1% on the Trust formulary to be extended to include use for **vitiligo in children** from 2 years old.

	Initiation by Dermatologists only and transfer of prescribing to GPs after/between clinic appointments. Dermatologists to develop an information sheet to support transfer of care to GPs.	
	c) Biosimilar rituximab There is now a biosimilar version of rituximab, Truxima®, in the UK. Clinical similarity has been shown between Truxima® and MabThera® brands in moderate to severe rheumatoid arthritis and in patients with follicular lymphoma. Within the specialised commissioning CQUINs for 2017/18 and 2018/19, NHS England aim to support the faster adoption of best value medicines with a focus which includes best value biological medicines. The Trust rheumatologists, renal physicians and haematologists have supported this change for all new patients. Vasculitis patients on ongoing treatment may need to be discussed individually. Haematology patients can be switched mid-cycle, as agreed by the clinical lead. Another biosimilar version of rituximab is expected to be marketed later in the year, but any negotiations on this will be managed by LPP. Prescribing will be by brand name, ie Truxima® and the Pharmacy dispensing system will record the brand used for a particular patient. A patient leaflet on biosimilar medications is published by the Cancer Vanguard. **Decision** Biosimilar rituximab (Truxima®) to be added to the Trust formulary for use within its licensed indications.	**AL/KGA**
6.	**Six Month New Drug Reviews** Nothing for this meeting	
7.	**Feedback from CCGs and Trust Committees**	
	a) Respiratory Working Group SA has met with Sutton CCG colleagues and Trust clinicians to discuss the asthma guidelines flowchart and devices poster. There is a request to add Relvar® to the Trust formulary for use in asthma, and this will be discussed at the next meeting in August.	**SA**
	b) DOACs: DVT/PE The forms for initiation and transfer of care to the GP for DOACs have been completed electronically and these are currently being reviewed by cardiology, haematology and stroke clinicians. After finalisation, SP will link with AMU/respiratory clinicians to ensure pathways are agreed and propose an implementation plan.	**SP**
	c) <u>SWL Sutton & Merton CCGs</u> **I. Minutes** For information **II. Managing Diabetes in Primary Care** **a. Blood Glucose Management Pathway for Adults with Type 2 Diabetes Mellitus** This document is intended to be an easy reference guide for managing type 2 diabetes in primary care and will form part of a larger document containing local pathways, etc. The Trust diabetologists have been involved in its development and support its guidance. **b. Patient information leaflet for blood glucose testing** This document is an updated patient information leaflet on blood glucose testing for people with type 2 diabetes (not on insulin). Trust diabetologists have contributed to and support this document. **III. Shared care guidelines – a. Riluzole®** This is an updated shared care guideline for use of Riluzole® for motor neurone disease in adults. The hospital will still provide the patient with a minimum initial supply of one month treatment. Document agreed. **b. Ibrandronic acid – for information** This is an updated shared care guideline for ibrandronic acid for the prevention of	**AL/KGA**

	fractures in adult patients with metastatic breast cancer and is for information as the Trust will not initiate in this patient cohort.	
	d) SWL Medicines Optimisation Group **I. Medicines Optimisation Committee** Minutes not available for this meeting. **II. Self-monitoring of INR** This document outlines the process for delivering self-monitoring of international normalisation ratio (INR) in clinical practice. The Trust currently have a small number of patients who monitor their own INR and clinical procedures are in place for managing these patients, but because of the contractual arrangements, patients are asked to purchase their own test strips. This document advises that the monitoring service provider provides the strips. Referred to the Trust contract management team. Update at future meeting if necessary. **III. Heart failure** This guidance on the pharmacological management of heart failure has been shared with the Trust cardiologists. The Trust does not currently have nebivolol on the formulary, but the guidance suggests it as a third line option beta blocker for LVSD if the patient is over 70 years old. It was felt that this small cohort of patients could be managed internally if necessary. **IV. De-prescribing** ST gave a summary of the current reasons for the de-prescribing strategy and the ongoing workstreams, eg reducing waste, stopping medicines of limited value, etc. There is also a list of medicines call the 'drop list' which is prepared nationally for local implementation if the CCG support it. Secondary care have a lead pharmacist on the SWL medicines optimisation group to whom comments should be fed back. However, the process needs consideration with respect to timelines and ratification by different organisations. AD suggested a list of all documents with version numbers included and final documents to be circulated to the Trust. **V. SWL Position Statements** **a. Position Statement on the Prescribing of Probiotics** SWL CCGs do not routinely support the prescribing of probiotics for any indication except VSL #3 for ileoanal pouchitis. Patients not eligible for treatment, who wish to continue therapy, can purchase probiotics over the counter. The Trust support this position statement. **b. Position Statement on the prescribing of Tadalafil** SWL CCGs do not support routine prescribing of daily tadalafil (Cialis® once a day) for treatment of erectile dysfunction. Alternative, more cost-effective PDE-5 inhibitors, such as sildenafil on-demand, should be used before daily tadalafil. The hospital may consider tadalafil for penile rehabilitation post-prostatectomy, but prescribing must remain hospital-only. The Trust supports this position statement. **c. Position statement on the prescribing of Cannabis sativa extract (Sativex®)** SWL CCGs do not support the routine prescribing of cannabis sativa extract (Sativex®). The Trust does not have this preparation on the formulary.	**AD** **AD/ST**

	d. Position statement on the prescribing of Lidocaine 5% medicated plasters (Versatis®) SWL CCGs do not support the routine prescribing of lidocaine 5% medicated plasters (Versatis®). It would be restricted to recommendation by a pain specialist for postherpatic neuralgia where other treatment options have failed or cannot be used due to comorbidity or for patients who are unable to take oral medication. The Trust have advised that they do use these for neuropathic pain under the guidance of the pain team, and it has been agreed at NDAIG that, in these circumstances, GPs would maintain prescribing if trial treatment had been successful. SK advised she would discuss with the pain team. It was also discussed that Trust prescribing may be inappropriate in cases of fractured ribs, where a block can't be used; clinicians to be made aware of this. **e. Position statement on the prescribing of eflornithine 11.5% cream (Vaniqa®)** SWL CCGs do not support the routine prescribing of eflornithine 11.5% cream (Vaniqa®) for any indication. The Trust do not have this preparation on the formulary. **f. Position statement on the prescribing of thyroid extracts, compound thyroid hormones, iodine containing preparations and dietary supplementation** SWL CCGs do not support the routine prescribing of thyroid extracts, compound thyroid hormones, iodine containing preparations and dietary supplementation in the management of hypothyroidism. The Trust supports this position statement. **g. Position statement on the prescribing of oral liothyronine (L-Tri-iodothyronine, T3) containing products for the treatment of primary hypothyroidism** SWL CCGs do not support the routine prescribing of liothyronine monotherapy or combination therapy for the treatment of primary hypothyroidism. Liothyronine is for specialist hospital prescribing only. Surrey CCG have position statements on the use of liothyronine and these have been agreed by the Trust endocrinologists and shared with Sutton CCG. Private patients have been referred into the Trust for review, but numbers need to be managed. **h. Position statement on the prescribing of oral liothyronine (L-Tri-iodothyronine, T3) containing products for patients with documented intolerance to levothyroxine** SWL CCGs support the prescribing of liothyronine monotherapy in secondary/tertiary care for use in patients with documented intolerance to levothyroxine. In patients with a documented intolerance to levothyroxine, liothyronine may be an alternative, but this should be confirmed by a specialist endocrinologist and it should only be prescribed by a hospital specialist. The Trust endocrinologists will be contacted with regards to all three documents regarding thyroid preparations. **i. Position Statement on the prescribing of Aliskiren.** SWL CCGs do not support the routine prescribing of aliskiren. The Trust cardiologists agree this position statement and it is not on the Trust formulary. **j. Position Statement on the prescribing of Amiodarone** SWL CCGs do not support routine prescribing of amiodarone for rate-control in chronic atrial fibrillation. It may be an option:	**SK** **AL/KGA** **AL/KGA**

	- For rhythm control in patients with left ventricular impairment or heart failure - When pharmacological cardioversion has been agreed in new onset atrial fibrillation (AF) - In patients undergoing cardiothoracic surgery to reduce risk of post-op AF - 4 weeks before and up to 12 months post electrical cardioversion The comments of the cardiologists include that if cardioversion is successful, treatment with amiodarone may need to be used for up to 24 months.	
	e) <u>SWL Cardiovascular Group for Discussion</u> **Summary of anti-platelet options** This document has been shared with all SL CCGs and Trusts for comment. The cardiologists have comments regarding the noting of drug eluting balloons and the duration of dual anti-platelet therapy following transcatheter aortic valve insertion (TAVI). Comments will be considered and a revised version brought back to the committee.	
	I. <u>Surrey Prescribing Clinical Network</u> **II. Minutes April 2017** Minutes for information. **III. Minutes May 2017** Minutes for information. **IV. Surrey Policy Statements** **a. Insulin Degludec (Tresiba®) in Type II diabetes** The PCN have revised their statement on insulin degludec to recommend its use in type II diabetes in poorly controlled patients who: - Do not reach their target HbAIc because of significant hypoglycaemia, or - Who experience significant hypoglycaemia on NPH or insulin detemir or glargine irrespective of the level of HbAIC, or - Cannot use the devices for NPH or insulin glargine/detemir, but could administer their own insulin if a switch to one of the long acting insulin analogues was made, or who need a carer or healthcare professional to administer insulin as it has a wider window for daily administration The Trust endocrinologists have been informed of this change for Surrey patients, but it remains hospital-only for SWL patients. **b. Glycopyrronium in children and adolescents aged 3 years and older with chronic neurological disorders** Glycopyrronium solution has been supported for short intermittent use where treatment alternatives cannot be used for treatment of severe sialorrhoea in children with chronic neurological conditions. This is not currently on the Trust formulary, but the statement will be considered when an application is received. **c. Biosimilar rituximab (Truxima®) for use in all licensed indications where CCGs are the responsible commissioners** The PCN supports the branded prescribing of biosimilar rituximab (Truxima®) for licensed indications (see 5c). **d. Fulvestrant (Faslodex) for the treatment of locally advanced metastatic breast cancer** The PCN supports fulvestrant for the treatment of locally advanced metastatic breast cancer in line with NICE TA239. The Trust has also agreed this NICE TA.	**AL/KGA** **AL/KGA** **AL/KGA** **AL/KGA**

	e. Testosterone Gel for low libido in post-menopausal women (unlicensed indication) The PCN supports the use of testosterone gel for low libido in post-menopausal women (unlicensed indication). The Trust has also supported this use in line with NICE guidance NG23.	**AL/KGA**
	f. Omnipod Insulin Pump for Type I Diabetes (all age groups) The PCN supports omnipod as a treatment option in type I diabetes for all age groups if NICE guidance is met. The Trust clinicians will submit applications via Blueteq.	**AL/KGA**
	g. Tiotropium (as bromide) dry powder device (Braltus Zonda®) for management of COPD The PCN supports tiotropium dry powder device (Braltus®) as a cost-effective alternative to the Spiriva handihaler. The Trust have yet to consider this device.	**AL/KGA**
	h. Apremilast (Otezla) for the treatment of active Psoriatic Arthritis The PCN supports apremilast for treating active psoriatic arthritis in line with NICE TA433. The Trust have also agreed this NICE TA.	**AL/KGA**
	f) Shared Care Prescribing Guidelines **I. Brivaracetam (Briviact®)** **II. Azathioprine (oral)** **III. Leflunomide (oral)** **IV. Methotrexate** **V. Hydroxycarbamide** **VI. Tacrolimus prescribed by brand (Prograf®, Envarsus®, Advagraf®, Adoport®, Modigraf®)** **VII. Sirolimus prescribed as the brand Rapamune®** **VIII. Midodrine** The Trust support the revised version of the shared care guidelines for azathioprine, leflunomide and methotrexate. The Trust support the information sheets for brivaracetam, tacrolimus, sirolimus and midodrine. The Trust renal clinicians have been involved in the development of the tacrolimus and sirolimus documents. The Trust will request a review of the hospital-only status of midodrine in SWL. The Trust will request a review of the hospital-only status of midodrine in SWL. The Trust support the revised information sheet on hydroxycarbamide.	**AD**
8.	**NICE/MHRA Guidance**	
	Updates	
	Nothing for this meeting	
	Technology Appraisals for Discussion	
	a) Cetuximab and panitumumab for previously untreated metastatic colorectal cancer – TA439 Certuximab and panitumumab will be added to the Trust formulary in line with this NICE TA for patients with previously untreated metastatic colorectal cancer if admitted on therapy.	**AL/KGA**
	b) Pegylated liposomal irinotecan for treating pancreatic cancer after gemcitabine – TA440 Pegylated liposomal irinotecan will be added to the Trust formulary in line with this NICE TA for treating pancreatic cancer after gemcitabine if admitted on therapy	**AL/KGA**
	c) Daclizumab for treating relapsing-remitting multiple sclerosis- TA441	

	Daclizumab will be added to the Trust formulary in line with this NICE TA for treating relapsing-remitted multiple sclerosis. Patients will be referred to St George's Hospital for initiation	**AL/KGA**
	d) Ixekizumab for treating moderate to severe plaque psoriasis – TA442 Ixekizumab will be added to the Trust formulary for treating moderate to severe plaque psoriasis. Applications for use from Trust rheumatologists will be via Blueteq.	**AL/KGA**
	e) Obeticholic acid for treating primary biliary cholangitis – TA443 Obeticholic acid will be added to the Trust formulary for treating primary biliary cholangitis in line with this NICE TA. Consultant gastroenterologists have a small number of eligible patients.	**AL/KGA**
	f) Certolizumab pegol and secukinumab for treating active psoriatic arthritis after inadequate response to DMARDs – TA445 Certolizumab pegol and secukinumab will be added to the formulary for this indication. The Trust rheumatologists would like to use them in line with this NICE TA.	**AL/KGA**
	Technology Appraisals Terminated	
	The Trust note the terminated appraisals: **g)** Elotuzumab for previously treated multiple myeloma (terminated appraisal) – TA434 **h)** Tenofovir alafenamide for treating chronic hepatitis B (terminated appraisal – TA435 **i)** Bevacizumab for treating EGFR mutation-positive non-small cell lung cancer (terminated appraisal) – TA436 **j)** Ibrutinib with bendamustine and rituximab for treating relapsed or refractory chronic lymphocytic leukaemia after systemic therapy (terminated appraisal) – TA437 **k)** Alectinib for previously treated anaplastic lymphoma kinase-positive advanced non-small cell lung cancer (terminated appraisal)- TA438 **l)** Afatinib for treating advanced squamous non-small-cell lung cancer after platinum-based chemotherapy (terminated appraisal) – TA444	
	Technology Appraisals For Information	
	Nothing for this meeting	
	Technology Appraisals Not Recommended	
	Nothing for this meeting	
	Clinical Guidelines Updated For Information	
	m) Early and locally advanced breast cancer: diagnosis and treatment (updated) – CG80 This guideline is for information only.	
	Clinical Guidelines for Discussion	
	n) Familial breast cancer: classification, care and managing breast cancer and related risks in people with a family history of breast cancer (updated) – CG164 CG164 has been updated in Section 1.7 on chemoprevention for women with no personal history of breast cancer. The drugs referred to are already available on the Trust formulary. **o) Alcohol-use disorders: diagnosis and management of physical complications- CG100** CG100 has been updated in Section 1.3 on corticosteroid treatment for people with severe alcoholic hepatitis. Olanzapine injection has been removed as it is no longer available. **p) Irritable bowel syndrome in adults: diagnosis and management (updated) – CG61** CG61 has updated recommendations on recognition and referral for suspected cancer in patients with irritable bowel syndrome. **q) Intravenous fluid therapy in adults in hospital (updated)- CG174** CG174 has been updated. No additional fluids have been added, and the Trust	

	intensivists have been made aware of the changes. **r) Type 2 diabetes in adults: management- NG28** NG28 has been updated with the addition of SGLT-2 inhibitors. Trust diabetologists are aware of these amendments. **s) Managing medicines for adults receiving social care in the community- NG67** NG67 is around the governance for managing medicines safely and effectively in adults receiving social care in the community. Health professionals working in primary and secondary care have an important role in advising and supporting care workers, eg simplifying medicines regimen, stopping medicines, changing formulations and supporting problems with medicines adherence. Prescribers should communicate changes to a persons' medication and provide clear directions on how a medicine should be taken. There are a number of workstreams within the Trust which will support compliance with this guideline, eg monitored dosage project with CCGs, care homes and social services. Funding for pharmacists to work with Epsom Health and Care Alliance on admission avoidance and supporting earlier discharge.	
	Clinical Guidelines for Information	
	t) Mental health of adults in contact with the criminal justice system – NG66 This guideline is for information only.	
	Quality Standard Updated	
	u) End of life care for adults (updated) – QS13 QS13 has been updated and now refers to QS144 for care of dying adults in the last days of life.	
	Quality Standard for Information (medicine related issues only)	
	v) Osteoporosis – QS149 QS149 covers managing osteoporosis in adults, including assessing risk and preventing fragility fractures. Trust rheumatologists are aware of this QS.	
	Quality Standard for Information	
	w) Haematological cancers – QS150 QS150 covers diagnostic reporting and the organisation of haematological cancer services. Trust haematologists are aware of this QS.	
	Highly Specialised Technologies for Discussion	
	x) Impact of the exclusion of trientine and chenodeoxycholic acid from tariff in 2017/18. NHSE have advised that trientine and chenodeoxycholic acid have been removed from tariff in 2017/18. Trientine is used for Wilson Disease and chenodeoxycholic acid for cerebrotendinous xanthomatosis. Patients currently being treated with either drug should continue to receive treatment funded by NHSE specialised services until a commissioning policy position is agreed. Trientine will only be funded in patients who have not responded to or are intolerant of penicillamine and zinc acetate. A re-challenge may be necessary if adverse effects were not severe. New patients will need to use the individual funding request (IFR) until the commissioning policy is in place.	
	Health Technology Assessment	
	Nothing for this meeting.	
	For Discussion	
	Nothing for this meeting.	
	MHRA Guidance	
	y) April 2017 This details a new alert asking for patient review and further consideration of risk minimisation measures to support the safe prescribing and dispensing of valproate medicines in women and girls. There is also a new PSA to support this work. Pharmacy is working with the paediatricians with regards to these documents.	

	The haematologists have been updated on the risk of vascular occlusive events and the neurologists the multiple sclerosis therapy fingolimod and the signals of rebound syndrome after stopping or switching therapy with ponatonib, with the recommendation to consider dose reduction in patients with chronic phase CML. **z) May 2017** The urologists have been advised of rare reports of depression and suicidal thoughts in men taking finasteride, although the reports are in men taking 1mg of the drug for male pattern hair loss. Depression is also associated with finasteride 5mg.	
9.	**Patient Safety Alerts**	
	a) Resources to support the safety of girls and women who are being treated with valproate See 8y. **b) Risk of death and severe harm from error with injectable phenytoin** **I. Medicines Matters Bulletin** Following the PSA on the risk of death and severe harm from error with injectable phenytoin, the Trust has revised the medical emergency guideline for managing status epilepticus and circulated this bulletin on prescribing, administration and monitoring of injectable phenytoin to all staff.	
10.	**Operational Issues**	
	a) 3M Tegaderm IV securement dressing for central venous and arterial catheter insertion sites Awaiting response from the infection control committee.	**AD/Donna Francis**
	b) Review of Trust Vitamin D Guidance CCG and Trust colleagues have revised the Trust Vitamin D deficiency guidance in adult patients. It now includes a section on Vitamin D in patients with renal impairment, guidance on Vitamin D in fractured neck of femur, and the treatment levels reflect those reported by the laboratory. The committee supported the principle that it generally preferred to use daily rather than weekly dosing. Guidelines agreed, subject to these amendments. Comments included: - Use generic drug name rather than brands, eg Adcal D3 - Update the Trust logo and amend the footer to reflect update With regards to the Vitamin D preparations on the Trust formulary, these will be amended to reflect the doses proposed in the guidance. These will be a 1000 unit preparation and a 50,000 unit preparation. The brand used will be dependent on cost and suitability for vegetarians and nut allergy sufferers. Primary care may use alternative products. SP to link with Dr Singh to discuss the recommendations around Vitamin D in fractured neck of femur, and revisions to the pathway. The guidelines will be circulated via eupdate in future.	**AD/KGA** **SP**
	c) Regional Medicines Optimisation Area Committees No update for this meeting.	
	d) Patient information leaflet – Supplies of medication The aim of this leaflet is to inform patients and support clinicians in clinic and pharmacists in managing the supply of medicines at outpatient appointments. Comments included: - GPs should not be asked to supply until they have received the clinic letter - Consider a statement around what to do if the patient cannot get the prescription dispensed at the hospital, eg because of waiting times or personal situation Revised version will be brought to the next meeting.	**AD/Susan Wright**
	e) CQUIN – IV Systemic Anti-Cancer Therapy The CQUIN for implementation of dose banding of intravenous systemic anti-cancer	

	therapy (IV SACT) 2017/18 and 2018/19 involves dose banding of drug doses. Some of the listed drugs have been done previously, but the dose banding has been revised and made tighter, eg in terms of patient factors like weight and renal and hepatic impairment. Other drugs are new to the CQUIN. Haematology support the CQUIN and will work with Pharmacy to move it forward.	**AD**
11.	**Any Other Business**	
	SP asked the CCGs to consider working with the Trust clinicians to improve the process for IFRs for biologics. It might be useful to review a few cases and identify the issues that have arisen and reflect. Rheumatologists would be happy to engage in this review. CCG representatives to feedback to SP.	**ST/LC**
12.	**Date of Next Meeting**	
	Wednesday 9th August 2017, 12.30-2.00pm, Boardroom, 5th Floor, Ferguson House, St Helier Hospital.	