EPSOM AND ST Helier UNIVERSITY HOSPITALS NHS TRUST

NEW DRUG AND INTERFACE GROUP

MINUTES OF THE MEETING HELD ON WEDNESDAY 12th June 2019, 12.30 – 2.00pm
Boardroom, St Helier Hospital

Present:
Dr V De Silva (Chair) **VDS**
Liz Clark (Lead Commissioning Pharmacist, Surrey Downs CCG) **LC**
Sarah Taylor (Chief Pharmacist, Sutton CCG) **ST**
Anne Davies (Chief Pharmacist) **AD**
Dr M Gardner (Consultant Anaesthetist) **MG**
Anne Lowson (Secretary) **AL**

In attendance:
Jill Stevens (Deputy Chief Pharmacist) **JKMS**
Kuljit Gata-Aura (Medicines Management Technician) **KGA**
Angela Miers (Respiratory Nurse Specialist) **AM**
Dr S Walter (Consultant Audio vestibular Physician) **SW**
Dr Vijayanerand (Consultant Audio vestibular Physician) **VJ**
Dr R Nithiyananthan (Consultant Endocrinologist) **RN**

No	Item	Responsible for Action
1.	**Apologies for Absence** Dr R Shephard (Consultant Neonatologist)**R Shepherd** Dr J Bendig (Consultant Microbiologist) **JB** Dr R Scott (Joint Medicines Management Lead, GP Sutton CCG) **RSc**	
2.	**Declarations of Interest** Nil for this meeting. Revised DoI forms to be circulated for completion for 2018. These are currently with AD for sign-off.	**AD/RJ**
3.	**Minutes of the Meeting held on 10th April 2019** The minutes from 10th April 2019 were agreed.	
4.	**Matters Arising** The Trust diabetes teams have been contacted regarding the completion of initiation and transfer of care forms for Freestyle Libre® and the issue resolved. The importance of completion of the data set required has also been emphasised. **I. Venous Thromboembolism Prophylaxis Guidelines – Trust VTE Guidelines** The final version of this policy is for ratification. The SWLEOC VTE prophylaxis guideline has been added as an appendix and the guidance reflects the recommendations made in NICE CG89 and a clinical consensus on the use of LMWH in renal impairment. This now needs to be approved by CQAC and then the Policies Review Group. It can then be added to the Trust intranet.	**RJ/KGA**
5.	**New Drug Requests**	
a)	**Riboflavin for migraine prophylaxis** The case for the addition of riboflavin to the formulary for prophylaxis in the management of migraine was presented by Dr Walter. NICE CG150 for managing headache including migraine advises that riboflavin 400mg once a day is recommended for preventative treatment of migraine as there is evidence it reduces migraine frequency and intensity in some people. Riboflavin is available as a	

	food supplement and may be purchased over the counter. It also recognises that riboflavin does not have a UK authorisation for this indication. Dr Walter advised that clinicians do follow the NICE guidance with regards to therapeutic options which include topiramate, propranolol and amitriptyline and they also link with the neurologists for their recommendations and consider acupuncture if appropriate. However, some patients wish to try therapies with fewer side effects than these conventional medicines and some have concomitant medication which may interact, e.g. warfarin or are pregnant. The exact mechanism of action of riboflavin in migraine is unclear. A deficit of mitochondrial energy metabolism may play a role in migraine pathogenesis. Small studies have shown some clinical benefit but they recognise the need for larger RCTs. The NICE guidelines are for children aged 12 years and older and studies in children younger than this are very limited with poor response rates. The management plan would be to use 400mg daily for 3 months and if it helps then to continue for 6 months, then stop and review. It is currently being used by clinicians at St George's, Chichester and Royal Surrey Hospitals, but it may not be being prescribed. Patients can buy riboflavin online or in health food shops as a food supplement and Dr Walter is happy for this in the majority of cases. However, for certain patients, money is an issue and supplies unaffordable. In this cohort, GPs could be asked to prescribe. Patient numbers who cannot afford were thought to be low out of approximately 50 patients per year who would take up this treatment. It was recognised that the quality of food supplements is variable as unlicensed products are not subject to control by the licensing authority, and that unlicensed specials may be expensive when prescribed by GPs. **Decision** It was recognised that migraine has a big impact on lifestyle and can be difficult to manage effectively. NICE does support signposting patients to riboflavin preparations as an option for the prophylaxis of migraine but evidence is limited. There is currently no licensed product available and while the committee did express a desire to help it was felt that there was no practical solution available to allow the prescription of riboflavin within current NHS resources. Patients can continue to be given the option to purchase as food supplements as suggested by NICE.	
b)	**Semaglutide for type 2 diabetes** Semaglutide is a once-weekly GLP-1 receptor agonist for the treatment of adults with insufficiently controlled type 2 diabetes mellitus as an adjunct to diet and exercise. The case for its inclusion on the formulary was presented by Dr Nithiyananthan. The evidence is based on 7 trials including over 8000 patients with type 2 diabetes. Semaglutide was superior at reducing HbA1c from baseline when compared with dulaglutide, exenatide (once weekly), sitagliptin and insulin glargine. It also provided superior and sustained weight loss compared with dulaglutide, exenatide (once weekly) and insulin glargine. It was recognised that there was an increase in the risk of diabetic retinopathy when glycaemic control improved and that GLP-1 therapy should only be offered in combination with insulin with specialist advice and ongoing support from a consultant-led MDT. NICE have clear criteria for using GLP-1 therapy as the final step of second intensification of drug treatment before starting insulin. They should be considered as an add-on if triple therapy with metformin and two other oral drugs is not effective, not tolerated or contraindicated and if the adult also has: • a BMI of 35kg/m^2 or higher or • a BMI of lower than 35kg/$m^2$and:	

	○ for whom insulin therapy would have significant occupational implications, or ○ weight loss would benefit other significant obesity-related co-morbidities They also advise to continue if there is a reduction of at least 11mmol/mol (1%) in HbA1c and weight loss of at least 3% of initial body weight in 6 months. The formulary currently includes several GLP-1 receptor agonists and it was felt that exenatide once weekly could be removed. Whilst lixisenatide is the cheapest, currently there is limited evidence and it is not used widely. With regards to initiation and transfer of prescribing to GPs, it was proposed that the Trust would start treatment at 0.25mg once weekly. The dose titrations could be managed by the GP and diabetic nurses will then review at 6 months with the consultant. However, there was concern that the dose increment to 1mg once weekly should be consultant-led, and that all dose titration should remain under secondary care. It was felt that diabetic nurse prescribers, including those in the community, could initiate under the guidance of a diabetes consultant. Once the patient is on the maximum appropriate dose, the GP can be asked to consider taking over the prescribing. It was also felt that feedback, including the number of patients, percentage HbA1c reduction and percentage weight decrease with the dosage specified should be discussed at a future meeting in approximately 9 months' time. **Decision** Semaglutide can be added to the formulary for the licensed indications in line with NICE guidelines for initiating and review of GLP-1 therapy. However this product does have a more complicated dose titration process than existing products and there was concern that this might not work well unless carefully supervised by secondary care. It was recommended that an implementation plan should be developed by the diabetes team describing how this additional complexity will be managed and then submitted to the committee for consideration before the product is made available. GPs should not be asked to dose titrate or prescribe until the patient is on the most appropriate/effective dose. The committee also felt that feedback on efficacy and usage, e.g. number of patients, percentage HbA1c reduction, percentage weight decrease with the dosage specified should be presented to a future meeting in approximately 12 months' time once prescribing starts after the approval of the implementation plan. Update at next meeting. It was noted that this evidence review was prepared and presented in the new draft form for an addition of a medicine to the formulary proposed by the SWL formulary merger group. Comments on the new form included: • Ensure it is clear who has requested and completed the form • Declaration of interest should be included • Consider if side effects/contraindications of the medicine should be included • Processes for funding are currently different in different organisations • Primary care considerations and which section needs to be completed may require further clarity • Where should costs of alternative medicines be added These will be fed back to Shireen Rahhal.	**AL**
c)	**Procaine penicillin + benzathine penicillin for neurosyphilis** The Trust's sexual health services team have requested that benzathine and	

	procaine penicillin be added to the formulary in line with the national guidelines on the management of syphilis (2015). The place in therapy is clearly documented and supported by the microbiologists. It will be proposed for addition to chapter 5 of the merged formulary. These penicillins will only be supplied on a patient-specific basis and will not be made available as stock in wards/units.	**AL**
6.	**Six Month New Drug Reviews**	
	No reviews for this meeting.	
7.	**NICE/MHRA Guidance**	
	a) April 2019 The Trust does not administer yellow fever vaccine but clinicians have been advised of the extra caution needed in people who may be immunosuppressed and those 60 years and older. The Trust has already advised relevant clinicians of the new annual risk acknowledgement form and clinical guidance to support compliance with the pregnancy prevention programme. ePMA now includes a link to the form and cautions when prescribing girls and women of childbearing potential. The Trust does not have belimumab on formulary for treatment of systemic lupus erythematosus but clinicians will be made aware of the increased risk of depression and suicidal ideation of behaviour/self-injury. The Trust has treated pregabalin and gabapentin as schedule 3 controlled drugs since 1st April 2019. All staff have been informed of the changes in prescribing and recording required. The HIV team have been advised to avoid the use of elvitegravir boosted with cobicistat in pregnancy due to the risk of treatment failure and maternal to child transmission of HIV-1. **b) May 2019** Multiple sclerosis patients who may have been treated with alemtuzumab will have received treatment via a specialist centre at St George's. There are now new restrictions to use and strengthened monitoring requirements due to serious cardiovascular and immune-mediated adverse reactions. Neurologists will be informed. There are new restrictions for the 10mg twice daily dose of tofacitinib following study observations of an increased risk of pulmonary embolism and overall mortality with this dose in rheumatoid arthritis. While a review of these risks is ongoing, the 10mg twice daily dose authorised for ulcerative colitis must not be prescribed in patients at high risk of pulmonary embolism. Rheumatologists and gastroenterologists will be informed. Maternal administration of magnesium sulphate for longer than 5-7 days in pregnancy has been associated with skeletal adverse effects and hypocalcaemia and hypomagnesemia in neonates. If use of magnesium in pregnancy is prolonged or repeated, consider monitoring neonates for abnormal calcium and magnesium levels and skeletal adverse effects. This will be raised with Dr R Shephard for dissemination within the division.	**KGA** **KGA** **KGA** **KGA**
	Technology Appraisals for Discussion	
	a) Daratumumab with bortezomib and dexamethasone for previously treated multiple myeloma – TA573	

	Daratumumab plus bortezomib and dexamethasone will be added to the Trust formulary for treating relapsed multiple myeloma in people who have had previous treatment. Funding will be via the Cancer Drugs Fund.	**KGA**
	b) Certolizumab pegol for treating moderate to severe plaque psoriasis – TA574 Certolizumab pegol will be added to the Trust formulary for treating moderate to severe plaque psoriasis within the criteria specified in the TA. Funding will be via BlueTeq application.	**KGA**
	c) Tildrakizumab for treating moderate to severe plaque psoriasis – TA575 Tildrakizumab will be added to the Trust formulary for treating moderate to severe plaque psoriasis within the criteria specified in the TA. Funding will be via BlueTeq application.	**KGA**
	d) Brentuximab vedotin for treating CD30-positive cutaneous T-cell lymphoma – TA577 Brentuximab vedotin will be added to the Trust formulary for treating CD30-positive cutaneous T-cell lymphoma but patients will not be initiated on treatment by the Trust.	**KGA**
	e) Durvalumab for treating locally advanced unresectable non-small-cell lung cancer after platinum-based chemoradiation – TA578 Durvalumab will be added to the Trust formulary for treatment of locally advanced unresectable non-small-cell lung cancer after platinum-based chemoradiation but patients will not be initiated on treatment by the Trust.	**KGA**
	f) Abemaciclib with fulvestrant for treating hormone receptor-positive, HER-2 negative advanced breast cancer after endocrine therapy – TA579 Abemaciclib with fulvestrant will be added to the Trust formulary for treating hormone receptor-positive, HER-2 negative advanced breast cancer after endocrine therapy but patients will not be initiated on treatment by the Trust.	**KGA**
	g) Nivolumab with ipilimumab for untreated advanced renal cell carcinoma – TA581 Nivolumab with ipilimumab will be added to the formulary for treating untreated advanced renal cell carcinoma, but patients will not be initiated on treatment by the Trust. Funding will be via the Cancer Drugs Fund.	**KGA**
	h) Atezolizumab in combination for treating metastatic non-squamous non-small-cell lung cancer – TA584 Atezolizumab plus bevacizumab carboplatin and paclitaxel will be added to the Trust formulary for metastatic non-squamous non-small-cell lung cancer within the criteria specified in the TA but patients will not be initiated on treatment by the Trust.	**KGA**
	Technology Appraisals Terminated	
	i) Bosutinib for untreated chronic myeloid leukaemia – TA576 This appraisal has been terminated as no evidence submission was received from the manufacturer.	
	j) Cabozantinib for previously treated advanced hepatocellular carcinoma – TA582 This appraisal has been terminated as no evidence submission was received from the manufacturer.	

	Technology Appraisals for Information	
	None for this meeting	
	Technology Appraisals Not Recommended	
	k) Enzalutamide for hormone-relapsed non-metastatic prostate cancer – TA580 Enzalutamide is not recommended for treating high-risk hormone-relapsed non-metastatic prostate cancer in adults.	
	Clinical Guidelines for Discussion	
	l) Surgical site infections: prevention and treatment – NG125 This guideline has made new recommendations on nasal decolonisation, preoperative skin preparation antiseptics and antimicrobials before wound closure and methods of wound closure. These will be discussed at the next antimicrobial steering group meeting. Update at next meeting. **m) Crohn's disease: management – NG129** This guideline replaces CG152 and provides new guidance on maintaining remission in Crohn's disease after surgery. Ustekinumab and vedolizumab have a place in therapy and are already on the formulary. To maintain remission, people with ileocolonic Crohn's disease with a resection should be considered for treatment with azathioprine with up to 3 months postoperative metronidazole. This will be circulated to the gastroenterologists and the microbiologists but the Trust formulary already includes the listed medicines. **n) Ulcerative colitis: management – NG130** This guideline replaces CG166 and provides new guidance on maintaining remission in mild to moderate ulcerative colitis (UC). The place in therapy of oral and topical aminosalicylates is defined and tofacitinib added as a biologic option in treatment of moderate to severe active UC. The Trust formulary already includes the listed medicines. **o) Prostate cancer: diagnosis and management – NG131** This guideline has been updated and now includes bone targeted therapies e.g. oral or IV bisphosphonates. The Trust formulary already includes the listed medicines. **p) Hyperparathyroidism (primary): diagnosis, assessment and initial management – NG 132** This guideline includes guidance on non-surgical management e.g. calcimimetics. Clarity is required on whether the Trust can now initiate this in patients as NHSE have previously issued guidance on which centres can initiate treatment. The management of primary hyperparathyroidism in pregnant women should be discussed at an MDT in a specialist centre. Cinacalcet should not be offered as treatment. Update at next meeting.	**Donna Francis/JB** **KGA/AL**
	Clinical Guidelines Updated	
	q) Ectopic pregnancy and miscarriage: diagnosis and initial management – NG126 This guideline has been updated and new recommendations on the diagnosis of tubal ectopic pregnancy using ultrasound and expectant management of ectopic pregnancy made.	
	Clinical Guidelines for Information	
	r) Suspected neurological conditions: recognition and referral – NG127 This guideline is for information. **s) Stroke and transient ischaemic attack in over 16s: diagnosis and initial management – NG128** This guideline is for information. The pharmacological treatments are available on the Trust formulary.	

	Quality Standard Updated	
	None for this meeting	
	Quality Standard for Discussion (medicine related issues only)	
	None for this meeting	
	Quality Standard for Information	
	t) Prostate cancer- QS91 QS for information. **u) Physical activity: encouraging activity in the community-QS183** QS for information.	
	Highly Specialised Technologies Guidance	
	v) Inotersen for treating hereditary transthyretin amyloidosis – HST9 Inotersen is recommended as an option for treating stage 1 and 2 polyneuropathy in adults with hereditary transthyretin amyloidosis. The national amyloidosis centre in London is the only specialised service in the UK and treatment would be started there.	
	Highly Specialised Technologies for Discussion	
	w) Technology Appraisal 312: Alemtuzumab for treatment relapsing-remitting multiple sclerosis – update to access criteria The Trust does not currently initiate alemtuzumab for this condition; patients would be referred to St George's.	
	Health Technology Assessment	
	Nothing for this meeting.	
	For Discussion	
	Nothing for this meeting.	
8.	**Patient Safety Alerts**	
	None for this meeting.	
9.	**Operational Issues**	
a)	**a) Regional Medicines Optimisation Committees** **I. RMOC Newsletter 2019 – Issue 4** A framework to help the CCGs make commissioning decisions would be helpful for the use of sodium oxybate in narcolepsy and cataplexy. Update at a future meeting. A summary of the evidence of the effect on cardiovascular outcomes of GLP-1 mimetics for diabetes will be helpful to APCs and the Specialist Pharmacy Service will look to publish a summary of clinical trials in this field. This may impact the formulary options in future. Ongoing work programmes include: • antimicrobial resistance mapping tool and networks • neonatal overprescribing review **II. Principles guiding the decision making about the route of supply of medicines to outpatients** This document aims to support best practice in the supply of medicines and will be used when discussing the various supply routes for high cost medicines with the SWL MOG. The actions required by acute providers are: • Consider current and future outsourced arrangements within the trust and ensure HPTP plan is in place for improving productivity and efficiency, including consideration of alternative supply routes, such as homecare providers or community pharmacies • Review current supply routes for medicines in line with above guiding principles to ensure that arrangements are fit for purpose and provide value for money	**AD**

	• Ensure that systems are in place to promote patient engagement such that the right route is used to supply the right medicine at the right time • Discuss outsourced arrangements with relevant commissioners • Contact regional leads where available for advice and support; improve collaborative working • Access resources as required to support development of future outsourced arrangement • Embed effective performance management systems from the outset Update at a future meeting. **III. Standardising strengths of high risk, unlicensed oral liquids formulations for anti-TB medicines** Rifampicin is available as a licensed oral liquid. Ethambutol pyrazinamide and isoniazid oral liquids are available only as unlicensed productions. There is a variation in strengths and formulations within primary and acute care and between the two. The lack of product standardisation also means that the supply chain is not efficient or robust and supply problems are very common. Therefore, there is a consensus in support of a standardised strength of the three main products: • Ethambutol 400mg in 5ml • Pyrazinamide 500mg in 5ml • Isoniazid 50mg in 5ml The Trust has complied with this and only stock these strengths. No other strengths are available to order on the pharmacy ordering system. **IV. NHSE Catalogue of material to support CCGs, GP practices and others to undertake initiatives to support STOMP** This document aims to support stopping of over-medication of people with a learning disability, autism or both. **V. STOMP (Stopping Over-medication of People with a Learning Disability (LD), Autism or Both) – The Bury Way** This document aims to support stopping of over-medication of people with a learning disability, autism or both. **VI. Minutes of RMOC Midlands and East meeting – April 2019** Minutes for information. The section on antimicrobial resistance will be shared with the antimicrobial team for their information. **VII. Minutes of RMOC London – March 2019** Minutes for information. Items discussed include: • Hydrocortisone granules in capsules for opening • Polypharmacy update • Multicompartment compliance aids • Deprescribing • Antimicrobial resistance/stewardship • Best value biological medicines subgroup update	**KGA/JB/ Donna Francis**
b)	**NHSE guidance on OTC and self-care prescribing (Communication materials)** AD advised that A&E now have information screens which could include messages about medication that can be bought over the counter/pharmacist advice for certain self-limiting conditions, etc. the posters provided by NHSE advise patients to seek advice from their GP rather than an appropriate member of the secondary care team, and have not been revised. ST to share messages that have been used in GP practices.	**AD** **ST**
c)	**Avastin® – Wet AMD** There is no update on the legal situation of using Avastin® off-label in wet AMD and	

	the Trust will review the usage once this is available. Remove from the agenda. The ophthalmologists have recently requested the use of Avastin® for other off-label indications for which there is no licensed treatment, e.g. neovascular glaucoma. Patients are currently being transferred to Moorfields for treatment. It has been established that a product can be obtained containing 2.5mg in 0.1ml and 5mg in 0.2ml, available in 24-48 hours. The ophthalmologists will be requested to provide a list of indications, doses, evidence base, etc., and an idea of how the governance around the administration etc. could be managed. Moorfields have been contacted regarding the evidence base but no document has been received. Royal Surrey Hospital may also use Avastin® in similar situations so they will be contacted.	**VDS/AL/AD**
d)	**Minocycline for Acne** Minocycline for use in acne was discussed at the last meeting and the agreement was that it will not be used for treatment of acne. Trust formulary to be updated. The use of minocycline in rarer dermatological conditions was discussed at the Surrey dermatology clinical network meeting in May. Dr Pinder was representing the Trust. It was noted that there is limited evidence for managing the following conditions with minocycline: • folliculitis decalvans • rosacea • peri oral dermatitis • indolent pyoderma gangrenosum • bullous pemphigoid • CARP However, the specialists agreed that its use was justified. This prescribing, however, should remain with the specialist and therefore minocycline will be classified as red on the traffic light status, i.e. hospital only. The dermatologists are aware of this approach, and the Trust formulary will be updated.	**KGA**
e)	**South West London Joint Formulary** **I. SWL Formulary Harmonisation Project update** **a) General update** The progress of and governance around the project will be discussed at a meeting at the end of June. **b) Chapter 3** Chapter 3 will be discussed at a meeting to be held at St Helier on 20th June. **c) Chapter 5** Chapter 5 has been reviewed and discussed, issues raised and addressed. It is thought it will be for ratification at the meeting at the end of June. **d) Chapter 12** A meeting to discuss Chapter 12 was held at Croydon Hospital at the end of May. Formulary differences were discussed and proposals for change identified. These will be discussed by the ENT clinicians at the beginning of July to ensure agreement across the different specialities within ENT and Trusts.	
f)	**Rapid Tranquilisation – Management of Acute Disturbance in Adults, Children and Older Adults** This guidance has been updated by Dr Bolton and now includes guidance on post-incident review by an MDT. It also includes the management of acute disturbance in children 6-12 and young people 13-17 years old.	

	Dr Sharma has requested that a CAMHS consultant should be contacted via switchboard (available 24/7), except in emergencies, for children and young people. He will also share this document with the CAMHS liaison steering committee. Comments awaited from SABP and St George's mental health team will be contacted for comment. Update at next meeting.	**AL/KGA**
g)	**Guidelines for GPs** **I. Gout** **II. Polymyalgia Rheumatica (PMR)** These guidelines have been written by Dr Fazal Sheikh, Consultant Rheumatologist, and they were felt to provide useful clinical information and were clearly written. However, it was thought to be helpful to have background to the reason for development, and how they will be cascaded to primary care. These may then be able to be ratified outside of the meeting.	**AL/ST/VDS**
h)	**Smoking Cessation Protocol** These guidelines for nicotine replacement therapy (NRT) have been supported by the respiratory consultants and the aim is to allow patients easier access to combination NRT. It includes local NHS stop smoking contacts and advice for discharge of patients who smoke. The use of a mouth spray containing nicotine was felt to be useful as a quick-acting NRT add-on. This will be added to the Trust formulary. Supplies of patches will be added to the stock lists on A&E, AMU, ASU and respiratory wards on both sites. Appropriate quick-acting NRT will be supplied on an individual patient basis. Guidelines agreed. It was raised that maternity are currently doing a piece of work around smoking in pregnant women and this document will be shared with them.	**KGA** **KGA/AL**
i)	**Pathway for Romiplostim/Eltrombopag in ITP NICE TA221/293** Following the consultation for Eltrombopag/Romiplostim (and Rituximab) in ITP, the updated application forms are now available on Blueteq. The following changes were made: • Requirement for splenectomy has been removed as per SPC • Splenectomy remains part of the pathway/algorithm as an option for patients with persistent symptoms • Splenectomy should be still considered but it is acceptable if surgery is not appropriate following shared decision making with patient The pathway and algorithm have been updated in this context and will be added to the reference link following SWL MOG in July 2019.	
j)	**Zolendronic Acid injection - Primary care follow up** Primary care have requested information on how patients managed by the orthogeriatricians given zolendronic acid injections in the Trust are followed up. No pathways are documented but patients are followed up and given injections yearly for three doses. Some patients, mainly very elderly, are given just one dose and no follow up. This should be communicated to the GP and it be made clear that patients on yearly injections should not receive oral bisphosphonates.	**AD**
10.	**Feedback from CCGs and Trust Committees**	
a)	**Trust/CCG Antimicrobial Review Meeting** A joint meeting was held in November 2018 but no minutes are available. Date for next meeting to be arranged.	**AD**

b)	**Methenamine tablets- UTI** Awaiting the final version of Chapter 5. This will hopefully include a statement around the use of methanamine.	
c)	**SWL Sutton & Merton CCGs** **I. Minutes – March 2019** Minutes for information.	
d)	**SWL Medicines Optimisation Group** **I. Quick Reference PNS Supplement Guidance for Dietitian Reference** No update for this meeting.	
e)	**SWL Cardiovascular Group for Discussion** Nothing for this meeting	
f)	**SWL Medicines Optimisation Clinical Network** Nothing for this meeting.	
g)	**Respiratory Working Group** Nothing for this meeting.	
h)	**Shared Care Prescribing Guidelines** Nothing for this meeting	
i)	**Surrey Area Prescribing Committee** **I. Minutes – April 2019** Minutes for information. **II. Surrey Policy Statements** **a) Cannabis-based products for medicinal use (medicinal cannabis)** The Trust supports this statement. Currently no Trust clinicians are on the Special Register of the General Medical Council and so we are currently not prescribing this. **b) Desmopressin (Noqdirna) for the treatment of idiopathic nocturnal polyuria** The Trust supports this statement but does not have desmopressin for this indication on the formulary. However, a couple of one-off drug requests have been received, so a review will be needed. **c) Ustekinumab dose optimisation (dose escalation) in patients with moderately to severely active Crohn's Disease** The Trust supports this statement which is in line with NICE TA456. Application is via BlueTeq form to the CCG. **d) Vitamin B compound tablets** The Trust supports this statement but do not have Vitamin B compound tablets on the formulary. **e) Vitamin B compound strong tablets for re-feeding syndrome** The Trust supports this statement and use Vitamin B compound strong tablets for re-feeding syndrome. To be circulated to the dieticians to ensure the duration is clearly identified when recommending and consider an addition to ePMA to clarify indication for use. **f) Vitamin B compound strong tablets for malabsorption due to chronic alcohol consumption** The Trust supports this statement. **g) Flash Glucose Monitoring System (FGS) for patients (over 4 years of age)** The Trust supports this statement, which reflects NHSE arrangements. **III. Surrey & North West Sussex CCGs Interface Prescribing Policy 2019-20** **a) Flash Glucose Monitoring System Interim Patient Agreement for Adults**	**KGA/AL**

	The Trust supports this interim April 2019 patient agreement document. **b) Flash Glucose Monitoring System Interim Patient Agreement for Paediatrics** The Trust supports this interim April 2019 patient agreement document. **c) Flash Glucose Monitoring System Interim Patient Agreement for Pregnant Adults** The Trust supports this interim April 2019 patient agreement document. **d) Flash Glucose Monitoring System Interim Continuation Patient Agreement – After 6 months review** The Trust supports this interim April 2019 patient agreement document. **e) Flash Glucose Monitoring System Continuation Patient/Carer Agreement – After 6 months review** The Trust supports this interim April 2019 patient agreement document. **f) Nocturia in adults** This has been circulated to the urologists for information. See (10i (IIb)) above for information on desmopressin. **g) Crohn's Disease (Pathway 4) – Biologic Treatment Pathway** The Trust supports this biologic treatment pathway and the gastroenterologists have been involved in its development. **h) High strength buprenorphine patches – consideration for one approved branded generic** Patients should be initiated on a locally preferred brand to be decided by MCG of the high strength buprenorphine patches (35mcg/hour, 52.5mcg/hour, and 70mcg/hour). The Trust, where possible, will maintain the brand prescribed on discharge. It was noted that some brands are changed every 72 hours and some every 96 hours. The Trust has done work to ensure that this is clear on prescribing systems. **i) Hepatitis B vaccine recommendations during supply constraints** For information. **j) Plan for phased re-introduction of hepatitis B vaccine for lower priority groups in 2018** For information.	
j)	**Shared Care Prescribing Guidelines** Nothing for this meeting.	
11.	**Any Other Business**	
	None.	
12.	**Date of Next Meeting:**	
	Wednesday 14th August 2019, 12:30-14:00. Boardroom, Ground Floor, Headley Wing, Epsom Hospital	