BEDFORDSHIRE AND LUTON JOINT PRESCRIBING COMMITTEE

Notes of the meeting on Wednesday 27th February 2019, Endeavour House (Building 50), Wrest Park, Silsoe, Bedfordshire, MK45 4HS.

Attendees:-

Dr J Fsadni (JF)	GP (Retired) Committee Chairman
Jacqueline Clayton (JC)	Secretary/Pharmaceutical Adviser, Bedfordshire CCG (BCCG), working on behalf of BCCG & Luton CCG (LCCG)
Dona Wingfield (DW)	Pharmacist Representative, BCCG
Fiona Garnett (FG)	Assistant Director and Head of Medicines Optimisation, BCCG
Tess Dawoud (TD)	Assistant Head of Medicines Optimisation, LCCG
Sandra McGroarty (SMcG)	Pharmaceutical Advisor, BCCG (working JPC work streams)
Dr Kate Randall (KR)	GP Representative, BCCG
Dr Jenny Wilson (JW)	GP Representative, BCCG
Dr Lindsay Mackenzie (LMacK)	GP Representative, BCCG (1pm-3pm)
Dr S Mehmood (SM)	GP Representative, LCCG
Dr Joy Muttika (JM)	Medical Representative, Keech Hospice (KH)
Anne Graeff	Pharmacist Representative, LCCG
Gemma McGuigan (GMcG)	Pharmacist Representative, Bedford Hospital NHS Trust (BHT)
Melanie Whittick (MW)	Pharmacist Representative, the Luton and Dunstable University Hospital NHS Foundation Trust (LDUH)
Dr Marian Chan (MC)	Medical Representative, The Luton & Dunstable University Hospital NHS Foundation Trust (LDUH)
Russell Foulsham (RF)	Pharmacist Representative, Cambridgeshire Community Services (CCS)
Kike Pinheiro (KP)	Pharmacist Representative, East London Foundation Trust (ELFT)

In attendance (full meeting as Observer) – Dr Sarah Whiteman, Medical Director, Bedfordshire, Luton & Milton Keynes Clinical Commissioning Groups; Courtney Pearson, Care Homes Pharmacist, BCCG; Adelaide Addai (AA), Diabetes Specialist Nurse, the Luton & Dunstable Hospital and Ophelia Roberts, Rapid Response Sister, Cambridgeshire Community Services NHS Trust.

For agenda item 5.5 - Matt Davies, Pharmaceutical Adviser, BCCG.
For agenda item 5.6 - Dr Danute Kucinskiene (DK), Consultant Neurologist, Bedford Hospital Trust; Sian Pither (SP), Planned Care Commissioning Manager, BCCG.

	Agenda item	Action
1	**Welcome and Apologies –** The chair welcomed everyone to the meeting. **Apologies for absence were received from -** Adrian Spurrell, Dr Hafeez, Dr M Nisar, Dr Oseiwa Kwapong, Rushnara Begum Janice Jones, and Gerald Zeidman. The Secretary had received notification of two resignations from the Committee Dr Hafeez (BCCG GP representative) and Dr Mehmood (LCCG GP representative). The Chair (on behalf of the Committee) thanked the GPs for their valued service to the Committee. Replacement representatives were being sought by the CCG Heads' of Medicines Optimisation.	**FG/TD/RJ**
2	**Conflicts of interest declaration –** No conflicts of interest were declared relating to the current meeting agenda by Committee members. The following Committee members were reminded that their biannual written conflict of interest declarations were overdue and asked to complete them (those members not in attendance at the meeting would be contacted by email):- Dr Kwapong, Dr Nisar, Dr Peter Graves, Dr Protiva Dhatta, Rushnara Begum, Natasha Patel, and Adrian Spurrell. The biannual Conflict of Interest Declarations were also overdue for the following people who receive the JPC papers for information:- Maire Stapleton, Kay Hoare, Janet Corbett. They have been contacted by email and asked to update their declarations.	**JC (Action completed)**
3	**Minutes of the last meeting (28th November 2018)** The minutes of the meeting were approved for accuracy. The Secretary thanked DW for producing the minutes and all of the other JPC work that she had undertaken since the last meeting in the absence of JC.	
4	**Feedback on miscellaneous actions not included on the agenda.**	
4.1.1	**Camouflage Creams Statement** Due to other workload priorities, production and consideration of an updated statement has been deferred to the April 2019 JPC meeting. This is therefore an ongoing action.	**JC**
4.1.2	**Oral bisphosphonates for post menopausal women in Early Breast Cancer** At the November 2018 JPC meeting it was confirmed that BCCG and LCCG currently support ibandronic acid rather than sodium clodronate as the oral bisphosphonate of choice. It was agreed that a caveat would be entered into the current bulletin to state:' sodium clodronate is the oral bisphosphonate of choice recommended by NICE. Patient individual factors such as adherence, patient preference and side-effect profile should be taken into consideration'. It was further agreed that specialists	**DW**

	would be approached to confirm or otherwise whether their practice had changed re oral bisphosphonate of choice following the issue of the NICE Guidance. The Specialist had been contacted and a response was awaited. This was therefore an ongoing action.	
4.1.3	**Third line biologic in Psoriasis Funding Route** Scheduled for discussion at the April 2019 JPC meeting and is therefore an ongoing action.	**DW/AG**
4.1.4	**Pain Guideline – LCCG Review** LCCG had opted out of the Pain Guideline which was endorsed by the JPC for BCCG use in September 2018. LCCG had agreed to review the guideline and present a locally amended guideline for JPC review. This is scheduled for discussion at the April 2019 JPC meeting and is therefore and ongoing action.	**TD/RJ**
4.1.5	**Avastin Update - post judicial review** There was nothing to report on this item. It was therefore agreed that this item is closed until further guidance/information is available.	**Close Action**
4.1.6	**Antimicrobial Guidance Update – November 2019** The Committee had been asked to approve the final version of the amended antimicrobial guidance agreed at the November meeting after DW had consulted with Dr Mulla. The amended document was circulated for final approval with the meeting papers but as quoracy was not attained, this will be considered under agenda item 5.2.	**Close Action**
4.1. 7	**SystmOne Template to support guanfacine monitoring in line with the shared care guideline** The CCG work on SystmOne is under review. This action will be taken forward when the review is complete and is therefore ongoing.	**LMacK/ SMcG**
4.1.8	**GP Representative BCCG – Deputy** Dr Amjad Khan had agreed to deputise for JW. This action could therefore be closed.	**Close Action**
4.1.9	**Clarification of Insulin Degludec (Tresiba®) and Insulin Glargine 300 units / ml (Toujeo®) recommendations** At the November 2018 JPC meeting the Committee agreed to support the updated recommendations of East of England Priorities Advisory Committee recommendations with respect to the definition of hypoglycaemia in each of these bulletins. The Committee had previously approved slightly modified recommendations relating to the EoEPAC bulletins e.g. replacing recommendation relating the 'Consultant Diabetologist' with 'Specialist Diabetes Service'. The Committee was therefore asked to confirm that JPC modified recommendations relating to Tresiba® and Toujeo stand®, with the only change being the recommendation relating to the definition of hypoglycaemia as agreed at the November 2018. The Committee supported these clarifications of the recommendations.	
4.2	**Update on Action Plan from 3rd October 2018 Training Meeting.**	

	The Committee reviewed the paper which provided an update on the actions and incorporating the agreements made at the November 2018 JPC meeting. The paper came mainly for information but the Committee was asked to ratify or otherwise:- • The revised JPC Terms of Reference. (Approved with the additional inclusion of a reference to the RMOC in the 'Purpose' Section bullet point 10) The Committee members were asked to confirm that they had read and understood the proposed Committee Member Job Description and to agree or otherwise to ratify it. This was confirmed and ratified. The Committee noted the following additional actions:- • Public Health Representation to the Committee. The Secretary had met with the BCCG and LCCG Heads of Medicines Optimisation re this representation and they had agreed to escalate this issue. An update will be reported back to the next meeting. • LMC Representation to the Committee. The Secretary had contacted the LMC who had agreed to try and obtain a representative to attend the Committee. • Fast track Formulary Sub Committee. The Secretary had met with the BCCG and LCCG Heads of Medicines Optimisation and it was agreed that a 'Fast-track Formulary Sub Committee' was not required at present due to the low number of Formulary requests but that this situation should be monitored over the next 6-12 months and the decision reviewed if necessary. It was further agreed that the JPC would make use of the GPs who were already funded by the CCG for specific disease areas, where possible, when setting up sub-groups. • HMMC. The Secretary had approached HMMC to confirm or otherwise whether this Committee would still be happy to consider our 'Appeals Process'. A response was awaited and would be followed up prior to the next meeting. **Post meeting note:** HMMC had confirmed that they were happy to continue with the current reciprocal arrangement re Process Appeals.	**JC (Action Completed)** **RJ/FG** **JC**
5	**Items for consideration**	
5.1	**Humalog 200 units/ml KwikPen** Bedford Hospital Specialised Diabetes Team had asked the Committee to consider whether Humalog ® 200 units/ml KwikPen could be added to the Bedfordshire and Luton Joint Primary and Secondary Care Formulary. The request was for initiation by the Specialist Diabetes Team in certain patient groups followed by	

	GP continuation of prescribing. The intention was to use the product in patients who require large doses of insulins to be administered per dose to increase patient compliance. The paper was reviewed and the following key points raised:- • No comments had been received from the Luton Dunstable Hospital Specialist Diabetes Team. AA agreed to follow-up with Dr Soo. • The major issue raised was relating to safety. GMcG had assessed the product against the RMOC Safety checklist. The company confirmed that the kwikpen is the only device to be produced (no cartridge planned). The kwikpen (200 units/ml) is also dark blue with bright yellow warning labels. The Humalog 100® units/ ml is light blue so the company has taken measures to differentiate between the two products. GMcG also agreed to ensure that the Specialist Diabetes Teams counselled the patients appropriately as concerns were raised that mistakes could be made, particularly at the primary/secondary care interface. JC agreed to highlight in the JPC Newsletter. FG to highlight to LPC. • Humalog 100® units/ml is already on the Formulary. • Since Humalog® 200 units/ml has been shown to be bioequivalent to the Humalog® 100 units/ml formulation, the demonstration of efficacy previously conducted for the Humalog® 100 units/ ml formulation applies and the safety profile of the Humalog® 200 units/ml formulation is as equally well defined. The efficacy and safety profile of Humalog® 100 units/ml has been gained in over 18 years of commercial availability since its initial European marketing authorisation and US approval in 1996. Humalog® 100 units/ml is a well- understood and extensively researched product with an established efficacy and safety profile in patients with diabetes requiring insulin therapy for glycaemic control. • High strength insulin products have been developed to reduce the number & volume of injections. One of the proposed benefits is a reduction in injection site problems, because of the smaller injection volumes which may be less painful. There are no trial/real world data to confirm lower injection site reactions or pain with Humalog® 200 vs Humalog® 100. ○ As an example patients injecting 20 units would be injecting 0.2ml of Humalog® 100 or 0.1ml of Humalog® 200. • Patients requiring >60 unit doses of Humalog® 100 or 200 would require more than 1 injection. • Humalog® 200 units/ml has the potential to reduce insulin wastage. In an online survey of type 1 and type 2 patients across Europe (n=400) injecting >20 units of rapid-acting	**AA** **GMcG** **JC** **FG**

	insulin per day using a prefilled pen or cartridge for durable pen, on average 8.6 units per pen are wasted with each pen transition. As Humalog® 200 units/ml KwikPen contains twice as many units as Humalog® 100 units/ml (600 vs 300) transferring these patients to Humalog® 200 units/ml KwikPen could potentially save 397 units per patient per year by halving the number of required pen transitions.Within this patient group 63.5% also reported on occasion splitting the dose across pens/cartridges (i.e. administering two injections) and 15% of patients reported on occasion taking just what remained in their current pen/cartridge (i.e. a smaller-than- recommended dose). 36.3% of patients discarded prefilled pens/cartridges still containing insulin (i.e. took full dose with a new pen).Participants who wasted insulin considered it frustrating, time-consuming and painful to inject twice. Patients taking >20 units/day meal time insulin can find transitions between insulin pens challenging. The study highlights the need to identify ways of improving transitions between pens to make transitions easier for insulin users, which could potentially improve adherence to prescribed doses and reduce waste. • Humalog® 200 is priced at double of Humalog® 100 so per unit cost is the same. (These prices have been confirmed in the Drug Tariff). • Patient numbers (Bedford Hospital) – around 50 patients/annum. • The product is licensed for use when a patient requires at least 20 units of insulin per dose. • Neighbouring area prescribing committees have approved the product for use. E&NHT – threshold – patients needing at least 30 units of insulin per dose. CJPG – threshold – patients needing at least 40 units of insulin per dose. • Dr Melvin (Consultant Diabetologist) Bedford Hospital and Julie Pledger (Specialist Diabetes Nurse, Bedford Hospital) had advised that a threshold of patients requiring 40 units of insulin/dose would be appropriate. • Dr Morrish (Consultant Diabetologist), Bedford Hospital had commented that use in patient requiring 20 units/dose insulin was a very low threshold. • The Committee was advised that the BCCG and LCCG Equality and Diversity Leads had differing opinions on whether a full Equality and Diversity Assessment was required for this agenda item. The BCCG Equality and Diversity Lead felt that this was not required and that the current statement was a proportionate response to the request. The LCCG Equality and Diversity Lead advised that any change in a policy which had either a positive or negative impact needed to be fully assessed. As the	

	Committee is decision-making for BCCG and Advisory for LCCG, it was agreed the advice of the BCCG Equality and Diversity Lead would be followed. **See appendix 1** for the Equality and Diversity Impact Statement (agreed with the BCCG Equality and Diversity Lead). The Committee agreed to the addition of Humalog 200 units/ ml KwikPen to the Bedfordshire and Luton Joint Primary and Secondary Care Formulary with the following criteria for use:- Specialist Diabetes Team initiation in adult patients requiring a minimum of 40 units of insulin per dose with the GP to continue. This Formulary addition is therefore Amber. JC to ensure that the product is added to the Formulary with GMcG to check the entry.	**JC (Action completed)/GMcG**
5.2	**Antimicrobial Guidelines Update** The Committee was asked to ratify the changes made to the Antimicrobial Guidelines following the November 2018 meeting as a quorate response had not be obtained by virtual consideration:- • Acute UTI • Pyelonephritis • Recurrent UTI • Prostatitis The specific actions which had been confirmed following the November 2018 meeting were:- • Confirmation that cephalexin is the drug of choice for pregnant women with a UTI. (This had been confirmed by Mrs Reynolds, Consultant in Obstetrics and Gynaecology, Bedford Hospital). • Confirmation that Dr Mulla would report antibiotic choices in line with the guidelines. • Addition of further information on how to manage mixed growth cultures. The Committee ratified the November 2018 updates to the guidelines. The February 2019 update to the Antimicrobial Guideline had been discussed prior to the meeting via a teleconference with relevant stakeholders and additional comments had also been received. The February 2019 update consisted of the following:- • Revised section on Chronic Obstructive Pulmonary Disease (acute exacerbation): antimicrobial prescribing following	

	review of NICE guideline NG114 nice.org.uk/guidance/ng114 Published: 5 December 2018. • New section on Bronchiectasis (non-cystic fibrosis), acute exacerbation: antimicrobial prescribing following review of NICE guideline NG117 nice.org.uk/guidance/ng117 Published: 18 December 2018 and NICE CKS Bronchiectasis, last updated December 2018 https://cks.nice.org.uk/bronchiectasis • New section on Urinary tract infection (catheter- associated): antimicrobial prescribing following review of NICE guideline NG113 nice.org.uk/guidance/ng113 Published: 23 November 2018. (The Committee was asked to note that the BASHH updates {chlamydia and gonorrhoea} will be reviewed at the April 2019 meeting) The following key points were raised:- **COPD Update** The local antibiotic choices following discussion at the COPD teleconference and antimicrobial teleconference: 1st line: amoxicillin for 5-7 days 2nd line: doxycycline for 5-7 days or clarithromycin for 5-7 days 3rd line: alternate 2nd line If 2nd line not susceptible: co-amoxiclav for 5-7 days. The NICE guideline supported amoxicillin, doxycycline and clarithromycin as joint first line choices for a 5 day course. The 5-7 day duration has been retained in the local guideline for practical reasons e.g. oral steroid courses, pack sizes etc. The local choices in part reflect the World Health Organisation (WHO) ACCESS, WATCH and RESERVE lists (See below for further information), and the fact that we have always had a systematic approach in our guidelines offering 1st, 2nd and 3rd line choices. Amoxicillin, doxycycline, and co-amoxiclav are on the ACCESS list while clarithromycin is on the ACCESS list for some indications and the WATCH list for others **WHO ACCESS, WATCH AND RESERVE LISTS** In summary, to assist in the development of tools for antibiotic stewardship at local, national and global levels and to reduce	**DW**

	antimicrobial resistance, WHO has developed three different categories – ACCESS, WATCH and RESERVE groups. To improve both access and clinical outcomes, antibiotics that were first or second choice antibiotics in at least one of the reviewed syndromes are designated as key ACCESS antibiotics, emphasising their role as the antibiotics that should be widely available, affordable and quality-assured. WATCH group -This group includes antibiotic classes that have higher resistance potential and so are recommended as first or second choice treatments only for a specific, limited number of indications. These medicines should be prioritised as key targets of stewardship programs and monitoring. RESERVE group - This group includes antibiotics that should be treated as "last resort" options that should be accessible, but whose use should be tailored to highly specific patients and settings, when all alternatives have failed (e.g., serious, life-threatening infections due to multi-drug resistant bacteria). For full information – see - https://apps.who.int/iris/bitstream/handle/10665/273826/EML-20-eng.pdf?ua=1 A section on WHO ACCESS WATCH and RESERVE list has been added to the introduction pages of the guidelines and going forward, as part of the JPC antimicrobial update workstream it was agreed that the JPC works with the microbiology teams at both Bedford and Luton & Dunstable Hospitals to create a localised list and include this as an appendix to the guidelines. **Bronchiectasis for adults** This was a new section which, in addition to the NICE Guideline, was referenced to the NICE Clinical Knowledge Summaries (CKS). There was a proposed change from the NICE recommendation of joint first line (amoxicillin, doxycycline, clarithromycin) to :- 1st line: amoxicillin or clarithromycin – 'check allergy status' added in the first choice section. 2nd line: doxycycline. The doxycycline was moved to second line choice as a result of safety concerns. These decisions also support the use of empirical therapy in early diagnostic stages and narrow spectrum where clinically indicated. The choice of fluoroquinolones for pseudomonas infection was discussed. NICE recommend the use of levofloxacin over ciprofloxacin as it has a broader spectrum of activity, which is important when the antibiotics are used for empirical use. NICE	**DW**

	also wanted the option to use the higher dose of levofloxacin (particularly for people who are more severely ill). Therefore 500mg, once or twice a day, which is a licensed dose for some indications such as community-acquired pneumonia was recommended. It was noted that currently, ciprofloxacin was used more often locally than levofloxacin for the treatment of bronchiectasis. Levofloxacin was considerably more expensive than ciprofloxacin. Dr Thomas, Consultant in Respiratory medicine supported the use of levofloxacin. The Committee noted that using a less expensive drug, may be a false economy if an additional GP appointment/hospital admission was required as a result of a failed treatment. The Committee also raised the question on whether treatment at 3rd line would be empirical and it would be useful to have resistance data. DW to confirm with Dr Mulla. Advice from tertiary care was also discussed e.g. Lung Defence Clinic at Addenbrookes. The Committee noted that the use of antimicrobial guidelines to provide choice would not be required in these scenarios as the tertiary centre would provide the necessary advice to GPs. The Committee agreed to support the use of levofloxacin for the treatment of pseudomonas infection as a third line treatment option. Post meeting note: The antibiotic choice, ciprofloxacin versus levofloxacin was discussed at the Respiratory Implementation group on Thursday 28th Ferbuary and Dr Timothy Chapman and Farida Parker were supportive and stated that prior to new local guidance, BTS guidance was used. **Bronchiectasis (Children)** NICE recommend joint first line (amoxicillin, clarithromycin, doxycycline). Teleconference recommendation:- 1st line: amoxicillin or clarithromycin (if penicillin allergic) – 'check allergy status' added in at the first choice section. 2nd line: doxycycline (not licensed and contraindicated in children under the age of 12). Following the teleconference, feedback had been received asking for an expansion on the contraindications of tetracycline in the footnote. It was proposed (and agreed by the Committee) that this would be done and the footnote added as appropriate elsewhere within the document to ensure consistency. It was also noted that the BNFC age cut off is up to 17 years in the antimicrobial section of the BNF. It was therefore proposed (and agreed by the Committee) to remove the reference 'for older	**DW** **DW** **DW**

	children refer to the BNF' in all sections recently updated by NICE as all reference children 17 years and under. The Committee discussed whether it was necessary to include a section on Bronchiectasis for children as this was a rare occurrence in clinical practice with guidance to GPs coming from secondary and tertiary care. It was agreed to leave the section in the guidelines. **Catheter related UTI** The updated section in the guidelines has built on existing information in the previous guideline which discussed the lack of rationale for taking urine samples via catheters if the patient is asymptomatic. NICE endorses the approach of treating the patient (symptoms), not the urine sample in isolation. No antibiotics had previously been included in this section as if antibiotics had been considered clinically appropriate, antibiotic choice would have been as per the UTI section of the guidelines. The teleconference participants agreed to support the NICE approach:- <u>Antibiotics for non-pregnant women and men aged 16 years and over to treat catheter related UTI</u> First-choice oral antibiotic if no upper UTI symptoms Nitrofurantoin – if eGFR≥45 ml/minute Trimethoprim – if low risk of resistance Amoxicillin (only if culture results available and susceptible) Second-choice oral antibiotic if no upper UTI symptoms (when first-choice not suitable) Pivmecillinam (a penicillin) First-choice oral antibiotic if upper UTI symptoms Cefalexin Co-amoxiclav (only if culture results available and susceptible) Trimethoprim (only if culture results available and susceptible) Ciprofloxacin (consider safety issues) <u>Antibiotics for pregnant women aged 12 years and over to treat catheter related UTI</u> First-choice oral antibiotic – Cefalexin <u>Antibiotics for children and young people under 16 years to treat catheter related UTI</u> Children under 3 months	

	Refer to paediatric specialist and treat with intravenous antibiotics in line with the NICE guideline on fever in under 5s. Children aged 3 months and over First-choice oral antibiotics Trimethoprim – if low risk of resistance Amoxicillin (only if culture results available and susceptible) Cefalexin Second-choice oral antibiotics Co-amoxiclav (only if culture results available and susceptible) Continence nurse colleagues had been contacted with reference to the HOUDINI method which is used to assist staff on making the decision on whether a catheter is required and the Royal Marsden guidance on catheter insertion. The nurses confirmed that both guidance are still actively used. In addition, the Continence Nurses stated that they have adapted the PHE 2018 UTI quick reference tool for primary care which DW will include as a reference within the local guidelines. With the above amendments agreed at the meeting the proposed update to the antimicrobial guidelines were approved and DW and all participants in the teleconference thanked for their hard work. **Equality and Diversity Statement –** see appendix 1. **Post meeting note:** The LPC Secretary had advised that:- 1. Antimicrobial Prescribing Guidelines – UTIs. There are ongoing supply issues with Pivmecillinam (selexid) 2. Antimicrobial Prescribing Guidelines – Scabies 0.5% Malathion aqueous lotion is only available as Derbac M, which has a long term supply issue. The product is possibly discontinued.	**DW**
5.3	**Gender Identity Services –shared care and Eflornithine.** The Committee previously discussed the April 2016 NHSE Guidance on Primary Care Responsibilities for Hormonal Treatments and Shared Care Guidelines produced by Charing Cross Hospital. As a Consultation had just started on how these services would be provided in the future, the Committee agreed to make the Shared Care Guidelines available on GPref as a resource for GPs to use.	

	NHSE has recently issued updated circulars/specifications relating to this topic and the JPC was asked to consider if any changes to the current JPC recommendations/information was required as a result of the publication of the new NHSE documents. The paper was discussed and the following key points noted:- • Although a change in commissioning model was proposed which would potentially change GP responsibilities with respect to prescribing, at the current time, the 'status quo' had not changed i.e. GPs were asked to initiate prescribing of hormonal treatments under the direction of the Specialist Centre. • The local and national picture was very similar. Most APCs had endorsed the NHSE position but GP prescribing was variable. Some practices/GPs were happy to prescribe under shared care while some were not. • Some GPs were not even happy to prescribe HRT to those born women when it would be appropriate. • TD advised the LCCG Prescribing Committee had a cautious view on prescribing by GPs. It was noted, however, that as with all shared care guidelines, GPs could choose to opt out. • GPs were sometimes asked to prescribe non UK medicines by patients started on treatment overseas. Use of the shared care guidelines which include recognised UK medicines would provide some support to GP colleagues. The Committee was asked to:- To decide whether to retain the current Shared Care Guidelines for information, formally endorse them, or to remove the guidelines in favour of Patient Specific Guidelines. The Committee agreed to formally endorse the Charing Cross shared care guidelines. (The GPref information would be amended to note this change). The views of the JPC (and Consultees) were sought on the NHSE advice included in this Specialised Services Circular relating to patients seen privately. The following key points were raised:- • GPs are asked to take on prescribing if the GP is assured that the recommendation is made by an expert gender specialist working for a provider that offers a safe and effective service. This may be difficult for the GP to do. Anecdotal evidence suggests that GPs are being asked to start prescribing by non expert gender specialists.	**SMcG**

	• GP prescribing on the recommendation of a private specialist is in line with national and local policy relating to NHS to Private Care. • GPs can contact the CCG Medicines Optimisation Teams for advice if they are unsure about the status of the private prescriber/provider. • There is a risk if GPs do take on this prescribing, a situation will be created similar to that of liothyronine. The following recommendation/actions were agreed by the Committee:- • To support the recommendations in the NHSE Circular 'Primary Care Responsibilities in Regard to Requests by Private On-Line Medical Service Providers to Prescribe Hormone Treatments for Transgender People (Specialised Services Circular 1826, issued January 2018)' i.e. GPs are asked to take on prescribing if the GP is assured that the recommendation is made by an expert gender specialist working for a provider that offers a safe and effective service. • The CCG Medicines Optimisation Teams will (on request by the GP) assist in validating the status of the Private Prescriber/Provider. • The CCG Medicines Optimisation Teams to share information with each other on validated and non-validated providers so that a database can be produced. The JPC was asked to agree or otherwise whether to change the current JPC recommendation with respect to Eflornithine. To retire the JPC bulletin, update with the additional clinical information obtained or provide a guidance statement only stating the recommendations? The following was noted:- • There had been very little additional evidence of safety/efficacy relating to Eflornithine since this was last considered by the Committee. • The NHSE Specialised Service Specification 1719 states that Ornithine decarboxylase inhibitors (Eflornithine {Vaniqa®}) may be recommended as an adjunct to facial hair reduction interventions. The JPC previously agreed that patients who have undergone transgender reassignment surgery should be treated in the same way as all other patients as outlined in JPC Bulletin 188. Comments received during the consultation supported no change to the current position. • The Committee agreed to retain the current recommendations relating to Eflornithine:- • The treatment of hirsutism is a cosmetic procedure which is a low priority for funding by CCGs.	**FG/TD**

	• If hirsutism is mild and does not significantly interfere with the woman's quality of life, consider no additional treatment. Hirsutism is not usually associated with any significant medical abnormality. • Eflornithine 11.5% cream offers very little benefit for the management of facial hirsutism in women. There is limited evidence for efficacy and patient satisfaction with eflornithine. • Self-funded cosmetic treatments for reduction in hair growth or hair removal (e.g. shaving, plucking, laser treatment, electrolysis) should be the primary options for the majority of women with hirsutism. • It is important that the patient is properly assessed and underlying causes addressed (such as weight reduction if obese) before pharmacological therapy is considered as hirsutism can result from serious medical conditions or from medication (e.g. ciclosporin, glucocorticoids, minoxidil, phenobarbitone, phenytoin, combined oestrogen-androgen hormone replacement therapy). It was further agreed that the bulletin could be retired and the above recommendations retained as a position statement which includes the other agreed recommendations within this agenda item. The Committee supported the information contained in the NHSE manual of Prescribed Specialised Services (https://www.england.nhs.uk/wp-content/uploads/2017/10/prescribed-specialised-services-manual.pdf) and recommended that there should be no primary care prescribing of hormonal treatments for children and adolescents undergoing gender reassignment. **Equality and Diversity Statement –** As with agenda item 5.1, the BCCG and LCCG Equality and Diversity Leads had different views relating to the need to complete a full Equality and Diversity Impact Assessment. The Committee agreed that the statement produced and agreed with the BCCG Equality and Diversity Lead was proportionate and acceptable - **see appendix 1.**	**SMcG**
5.4	**COPD Guideline Review** The guideline has been updated following the review of • Chronic obstructive pulmonary disease (acute exacerbation): antimicrobial prescribing https://www.nice.org.uk/guidance/ng114 • Chronic obstructive pulmonary disease in over 16s: diagnosis and management https://www.nice.org.uk/guidance/ng115	

	A teleconference involving local clinicians reviewed the guideline and the following changes were made:- Pharmacologically, the main change in relation to inhaled therapies is the recommendation from NICE is to move to dual therapy from SABA rather than SABA to LAMA. The teleconference agreed to endorse a modified GOLD 2019. It was recognised that locally and as per GOLD 2019 there is a cohort of patients with MRC less than 2 and CAT of less than 10 would benefit from LAMA alone. The NICE rationale for the recommendation was based mainly on a Cochrane review which had a large sample size and a range of severity of disease. In the high risk population there were reduced exacerbation rates which made dual therapy a cost-effective approach. NICE also indicated that GOLD was too complex and therefore a simpler message – to assess patients for any signs of asthma and asthma overlap syndrome and if there weren't any, to use a LABA/LAMA combination. Our local guideline is a simplified version of GOLD 2019 approach and NICE state that the reduced exacerbation rates were linked to the high risk population whereas the use of the LAMA as monotherapy included in the local guidelines was for a cohort with less severe COPD (MRC 2 or below, CAT 9 or below). Additional changes to the guideline included an emphasis on non-pharmacological interventions prior to pharmacological treatments and patient information. CAT score had been included to be more consistent with GOLD and this appears on the Jardines SystmOne template. Additional criteria on the use of ICS/LABA versus LAMA/LABA based on NICE (ACO symptoms) and GOLD (eosinophil count) have been included. NB GOLD 2019, had removed the warning that eosinophil count is not recommended for use in routine clinical practice as stated in GOLD 2018. Symbicort® MDI (as an alternate to Symbicort® turbohaler) had been added as an ICS/LABA option as it is licensed for use in COPD and this will be added to the Joint Bedfordshire and Luton Formulary. NICE NG 115 also recommends prophylactic antimicrobial therapy with azithromycin for a certain cohort, this is specialist initiation only and has been included in the appendix. Appendix 2b has been added and is a locally modified GOLD Pharmacological management template for clinicians who prefer the grid presentation.	**JC**

	Additional information from GOLD 2019 (step 4c, pharmacological management) on supporting clinicians to 'step down' treatment options has been included as a new section. This is an area of focus for local Prescribing Incentive Schemes and it has been agreed that as part of promotion of the new guidelines, training sessions for prescribers will be held with further detail on stepping treatment up and down will be covered. Our local Respiratory Consultants have offered to be involved in this training and to provide criteria to support stepping therapy up and down. Local antibiotic choices – see agenda item 5.2. NICE NG 115 states that the prednisolone course can have a duration of 7-14 days and the flow chart in the local guidelines has been amended to reflect this guidance. Additional information on patient education (including British Lung Foundation {BLF} leaflets) and self-management has been included as has brief guidance on care home residents and deprescribing on review of COPD patients. There is also as update to the nutritional section to include 'Managing Malnutrition in COPD' guideline and links to the leaflets. The oxygen section has also been updated to include emphasis on structural risk assessment, BOC register and the 20 minute rule. There is addition information on oxygen therapy, patient education and self-management, incidental findings on CT, prognosis and the addition of Symbicort MDI. NICE NG 115 also makes recommendations on managing pulmonary hypertension and cor pulmonale and lung volume reduction procedure. While this has had a brief mention in the guidelines, it was agreed that assessment would be outside the scope of this guideline which is primary care. A number of minor formatting/rewording amendments had been noted during the consultation period and the guidelines would be updated to include the proposed changes where appropriate. The Committee supported the proposed changes to the Guideline outlined above and thanked DW and the clinicians who were involved in the teleconference for all of their hard work. Post meeting note: The COPD guideline update was presented at the Respiratory Implementation Group on 28th February 2019 and agreed that psychological services would be added to the guideline **Equality and Diversity Impact Statement -** see appendix 1.	

	GMcG had advised the Secretary that one of the Respiratory Clinicians had requested the addition of the Relvar® range of inhalers to the Formulary. It was noted that these had already been reviewed and declined by the JPC as the product choices do not fit with the current ICS/LABA/LAMA choices within the COPD and Asthma guidelines. This included the triple therapy Trelegy® inhaler. It was agreed that the inclusion of the Trelegy® inhaler would be reviewed when NICE had issued its guideline on triple therapy as it may offer an advantage in that it is a different device to the current formulary choice Trimbo®.	**DW**
5.5	**Anticoagulation Resources for Atrial Fibrillation (AF)** The JPC had previously ratified anticoagulant resources for atrial fibrillation produced by both the East of England Priorities Advisory Committee (EoEPAC) and PrescQIPP. EoEPAC has just produced an Atrial Fibrillation Anticoagulant Clinical Decision Aid which has resulted in the need to review the current resources previously ratified by the JPC. The Committee was asked to review the paper and agree or otherwise the following:- 1) **Ratify** the EoEPAC Atrial Fibrillation Anticoagulant Clinical Decision Aid. This document was developed by local experts and circulated to local specialist as part of the EoEPAC consultation and consideration. The JPC was advised that the document presented to the Committee was the final draft document currently in the final stages of Q and A. A few amendments had been suggested but these were minor formatting/ slight re-wording issues. The Committee agreed to ratify the final draft EoEPAC document and to publish (on GPref) the final PAC document when it became available. 2) Anticoagulants in Atrial Fibrillation – Atrial Fibrillation anticoagulation patient information and decision aid - http://www.gpref.bedfordshire.nhs.uk/media/204783/Atrial%20fibrilation%20anticoagulation%20PRESQIPP.pdf To be **retained but renamed** 'Anticoagulants in Atrial Fibrillation – Patient information and decision aid booklet'. The Committee agreed to support this minor change. 3) Anticoagulants in Atrial Fibrillation – Drug Interactions with NOACs. http://www.gpref.bedfordshire.nhs.uk/media/204786/Drug%20interactions%20with%20NOACs%20(PREQIPP).pdf To be **replaced** by updated EoEPAC document. The Secretary reported that during the Q and A process, there had been some queries raised and these were in the process of being reviewed by the authors. The Committee agreed that the final EoEPAC document could be circulated for virtual approval when it became	**SMcG** **SMcG** **JC/SMcG**

	available and then published as a replacement document, as outlined above, on GPref. 4) Anticoagulants in Atrial Fibrillation – NOAC Patient Information http://www.gpref.bedfordshire.nhs.uk/media/204789/NOAC%20patient%20information%20(PRESQIPP).pdf To be **retained.** This was supported by the Committee. 5) Anticoagulants in Atrial Fibrillation – Table of NOAC Comparisons http://www.gpref.bedfordshire.nhs.uk/media/204792/Table%20of%20NOAC%20comparisons%20(PRESQIPP).pdf To be **retained**. This was supported by the Committee. 6) JPC Bulletin 216 – Anticoagulants in Atrial Fibrillation. Propose **retire bulletin** as the information contained within in has been updated and replaced by the new resources. This was supported by the Committee. 7) JPC Bulletin 224 – Choice of Non-Vitamin K Antagonist Anticoagulant (NOAC) http://www.gpref.bedfordshire.nhs.uk/media/200160/Choice%20of%20NOACs%20-%20Bulletin.pdf To shorten the bulletin (as much of the original clinical information has now been updated and contained in the other resources) and turn it into a position statement as per the paper presented to the Committee. This was agreed by the Committee with the slight rewording proposed by AG i.e. on P2 'The JPC **was (rather than 'is')** asked to consider whether it is appropriate to recommend the use of a particular NOAC to the Health Economy….' It was noted that the link to the Clinical Decision Aid (contained within the document) would need to be updated when it was published The Committee thanked Matt and Saskia for their work on producing the Clinical Decision Aid and the updated Drug Interactions document. **Equality and Diversity Impact Statement -** see appendix 1	**SMcG** **SMcG**
5.6	**Management of Primary Headache (Adult)** On the request of the BCCG Clinical Reference Group, the BCCG Planned care commissioning team was asked to design a headache and migraine pathway for use in primary care with the aim of empowering GPs to manage patients in Primary Care and reduce First outpatient appointments, resulting in a shorter referral to Treatment rates (RTT). The remit was to provide information in line with the NICE Clinical Knowledge Summaries (CKS) guidance. It was noted that the information provided was as per the NICE CKS Guidance.	

	It had been confirmed that the information was to be used by both BCCG and LCCG. While all clinicians in the BCCG and LCCG areas had been given the opportunity to comment, the LCCG planned care team had not. It was agreed that the agenda item would be discussed and after finalised, the BCCG planned care lead from the programme SP would take comments from the LCCG Planned Care Team prior to final publication. The Committee reviewed the draft guidance which had been produced by the BCCG Planned Care Commissioning team and the following key points were raised :- • The title had been amended to read – 'Management of Primary Headache'. It was suggested that this should be changed to 'Diagnosis and Management of Primary Headache' and this was agreed. • Information to check OTC medication history had been added to the 'detailed history' section on page 1. It was agreed at the meeting to also add 'herbal medicines' to this list. • Clarification of how to contact Specialists to be included i.e. via ERS. • The BCCG Equality and Diversity Lead had suggested the inclusion of a footnote reminding the GPs using the tool to remember to think about any equality considerations that may be relevant, for example where a patient with a learning disability may have communication difficulties that could lead to an underestimation of the impact of the headache, migraine, etc. The Committee considered this but felt that this was something that GPs automatically did and therefore it did not need to be included. • Headache diaries – include under review and assessment • Under 'Detailed history' – 'consider lifestyle' to be added. • Pregnancy and Breastfeeding – reference to the full CKS information via a web link was considered sufficient information. • Detailed History – Some comments had been received re the definition of 'aura'. The Committee discussed this and agreed to support the NICE Clinical Knowledge Summary (CKS) wording and agreed to all of the other NICE CKS information in this section. • Agreed to add ' refer to BNF/SmPC' in the document as there had been a number of comments stating that certain drugs should not be used under certain circumtances. • Use of Triptans in the over 65's – usually patients would have started on treatment before this age and a diagnosis of migraine at this stage would be very unlikely. Therefore, there was no need to add any additional information.	**SP**

	• Under 65's – what was the maximum recommended monthly dose of Triptans? (DK stated about 8 tablets per month would suggest referral required). • Agreed that only Formulary Triptans would be included and that the inclusion of a table giving details of the three Formulary choices, onset and duration of action should be included. There should also be a link to the Formulary. • Discussion about whether amitriptyline and pizotifen should be used for migraine prophylaxis (as not in CKS). The CKS recommends propranolol and topiramate - agreed that they should be tried prior to referral even though they are not in the CKS. SMcG to work with neurologists to agree change in wording. • Menstrual Migraine – leave as written (CKS). • Tension Headache – wording is fine, including the information on acupuncture. • Verapamil – for Cluster Headaches – specialist only initiation. • Medication overuse – GP needs to discuss and agree a management plan with the patient – wording needed to be changed as it is not necessary to refer to neurology. SMcG/JW to agree amended wording. • The effectiveness of using magnesium was raised. DK stated that it had been used overseas. • Botulinum toxin for migraine – refer to NICE TA criteria. • SMcG to produce second draft, based on the changes agreed above, discuss with JW and neurologists and then circulate to the Committee for virtual approval. **Equality and Diversity Impact Statement -** see appendix 1	**SMcG** **SMcG/JW**
5.7	**FreeStyle Libre Update** Following on from the information provided at the November 2018 JPC meeting, it was agreed that the Committee would be kept updated on any developments relating to FreeStyle Libre Criteria for funding and funding sources:- 'NHS England issued a press statement on 14th November 2018, https://www.england.nhs.uk/2018/11/nhs-to-provide-life-changing-glucose-monitors-for-type-1-diabetes-patients/ of intent to fund a cohort of patients. There has been no further information relating to the patient criteria for funding and funding sources for FreeStyle Libre. However, the DVLA has updated the guidance on glucose testing prior to driving which now permits the use of interstitial glucose readings e.g. using Flash Glucose Scanning (FreeStyle Libre) and CGM systems **for group 1 drivers only. CLICK HERE FOR FULL INFORMATION** as finger prick tests are still required (even for group 1 drivers) under certain circumstances.	

	This makes the use of Flash Glucose Scanning (FreeStyle Libre) more cost effective for use in patients who drive. The Committee noted the update for information.	
6	**NICE Guidance**	
6.1	**NICE Guidance Summary – Published Guidance – from 15th November 2018 – 13th February 2019** **The following NICE Technology Appraisal Guidance (CCG Commissioned) have been published:-** **Tofacitinib for moderately to severely active ulcerative colitis Technology appraisal guidance [TA547] Published date: 28 November 2018. https://www.nice.org.uk/guidance/ta547** Using the NICE Assumptions and the Patient Access Scheme Prices, it is anticipated the total cost of the guidance to **BCCG and LCCG will be approximately £45,000 and £21,000 respectively. This is over a 5 year period.** **Darvadstrocel for treating complex perianal fistulas in Crohn's disease** **Technology appraisal guidance [TA556] Published date: 09 January 2019** **https://www.nice.org.uk/guidance/ta556** No financial impact anticipated as this is a negative NICE TA **The following NICE Guidelines (Medicine related and CCG Commissioned) have been published/updated and were noted for information and action as appropriate:-** **Urinary tract infection (catheter-associated): antimicrobial prescribing**, NICE guideline [NG113] Published date: November 2018 https://www.nice.org.uk/guidance/ng113 **JPC Action -** Update Community Antimicrobial Guidelines - **See agenda item 5.2** **Chronic obstructive pulmonary disease (acute exacerbation): antimicrobial prescribing**. NICE guideline [NG114] Published date: December 2018, https://www.nice.org.uk/guidance/ng114 **JPC Action -** Update Community Antimicrobial Guidelines - **See agenda item 5.2** **Chronic obstructive pulmonary disease in over 16s: diagnosis and management,** NICE guideline [NG115] Published date: December 2018, https://www.nice.org.uk/guidance/ng115 **JPC Action -** Update COPD Guidelines – **See agenda item 5.4** **Post-traumatic stress disorder,** NICE guideline [NG116] Published date: December 2018 https://www.nice.org.uk/guidance/ng116	

	This guideline covers recognising, assessing and treating post-traumatic stress disorder (PTSD) in children, young people and adults. It aims to improve quality of life by reducing symptoms of PTSD such as anxiety, sleep problems and difficulties with concentration. Recommendations also aim to raise awareness of the condition and improve coordination of care. **Recommendations** This guideline includes new and updated recommendations on:access to care and supporting transitions between servicesprinciples of care, including providing support and informationmanagement of PTSD in children, young people and adultscare for people with PTSD and complex needs **Bronchiectasis (non-cystic fibrosis), acute exacerbation: antimicrobial prescribing** NICE guideline [NG117] Published date: December 2018 https://www.nice.org.uk/guidance/ng117 **JPC Action -** Update Community Antimicrobial Guidelines - **See agenda item 5.2** **Cerebral palsy in adults**, NICE guideline [NG119] Published date: January 2019 https://www.nice.org.uk/guidance/ng119 This guideline covers care and support for adults with cerebral palsy. It aims to improve health and wellbeing, promote access to services and support participation and independent living. **JPC Action – Current Policy covers use of Botulinum Toxin in Paediatric Cerebral Palsy. Added to the EoEPAC review of Botulinum Toxin which will come to the JPC for discussion when published.** **Cough (acute): antimicrobial prescribing** NICE guideline [NG120] Published date: February 2019https://www.nice.org.uk/guidance/ng120 **JPC Action - Update Community Antimicrobial Guidelines – For April 2019 JPC agenda** **The following Technology Appraisal Guidance are the commissioning responsibility of NHSE and were noted by the Committee for information:-** Gemtuzumab ozogamicin for untreated acute myeloid leukaemia, Technology appraisal guidance [TA545] Published date: 14 November 2018 https://www.nice.org.uk/guidance/ta545 Padeliporfin for untreated localised prostate cancer, Technology appraisal guidance [TA546] Published date: 21 November 2018 https://www.nice.org.uk/guidance/ta546	

	Decitabine for untreated acute myeloid leukaemia (terminated appraisal)Technology appraisal [TA548] Published date: 05 December 2018 https://www.nice.org.uk/guidance/ta548 Denosumab for preventing skeletal-related events in multiple myeloma (terminated appraisal)Technology appraisal [TA549] Published date: 05 December 2018 https://www.nice.org.uk/guidance/ta549 Vandetanib for treating medullary thyroid cancerTechnology appraisal guidance [TA550] Published date: 12 December 2018 https://www.nice.org.uk/guidance/ta550 Lenvatinib for untreated advanced hepatocellular carcinoma,Technology appraisal guidance [TA551] Published date: 19 December 2018 https://www.nice.org.uk/guidance/ta551 Liposomal cytarabine–daunorubicin for untreated acute myeloid leukaemia,Technology appraisal guidance [TA552] Published date: 19 December 2018 https://www.nice.org.uk/guidance/ta552 Pembrolizumab for adjuvant treatment of resected melanoma with high risk of recurrence,Technology appraisal guidance [TA553] Published date: 19 December 2018https://www.nice.org.uk/guidance/ta553 Tisagenlecleucel for treating relapsed or refractory B-cell acute lymphoblastic leukaemia in people aged up to 25 years Technology appraisal guidance [TA554] Published date: 21 December 2018 https://www.nice.org.uk/guidance/ta554 Regorafenib for previously treated advanced hepatocellular carcinoma,Technology appraisal guidance [TA555] Published date: 09 January 2019. https://www.nice.org.uk/guidance/ta555 Pembrolizumab with pemetrexed and platinum chemotherapy for untreated, metastatic, non-squamous non-small-cell lung cancer,Technology appraisal guidance [TA557] Published date: 10 January 2019. https://www.nice.org.uk/guidance/ta557 Nivolumab for adjuvant treatment of completely resected melanoma with lymph node involvement or metastatic diseaseTechnology appraisal guidance [TA558] Published date: 23 January 2019. https://www.nice.org.uk/guidance/ta558 Axicabtagene ciloleucel for treating diffuse large B-cell lymphoma and primary mediastinal large B-cell lymphoma after 2 or more systemic therapies. Technology appraisal guidance [TA559] Published date: 23 January 2019 https://www.nice.org.uk/guidance/ta559	
6.2	**NICE Guidance Summary – Anticipated Guidance – February 2018 – April 2019** This paper was noted by the Committee for information only	
7 **7.1**	**Virtual Recommendations/Documents – for discussion/ratification:-** **Update to Chronic Pain Guidelines for Non Cancer pain in Adults (Bedfordshire only)** The JPC ratified the addition of the availability of IAPT services to the chronic pain guidelines**.**	

8	**Drug Safety Updates** The MHRA Drug Safety Update for December 2018, January 2019 and February 2019 were noted by the Committee for information:- **December 2018 DSU** **https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/765896/PDF-Dec-2018.pdf** Oral lidocaine-containing products for infant teething: only to be available under the supervision of a pharmacist. Valproate medicines: are you in acting in compliance with the pregnancy prevention measures? Emollients: new information about risk of severe and fatal burns with paraffin-containing and paraffin-free emollients. Direct-acting antivirals for chronic hepatitis C: risk of hypoglycaemia in patients with diabetes. Hydrocortisone muco-adhesive buccal tablets: should not be used off-label for adrenal insufficiency in children due to serious risks. **January 2019 DSU** **https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/770006/PDF-Jan-2019-publication.pdf** Tapentadol (Palexia): risk of seizures and reports of serotonin syndrome when co-administered with other medicines. Ipilimumab (Yervoy): reports of cytomegalovirus (CMV) gastrointestinal infection or reactivation. Yellow Card App: download the updated App to receive the latest MHRA safety news and report suspected side effects, including in pregnancy. **February 2019 DSU** **https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/779462/DSU-PDF-Feb-2019.pdf** Carbimazole: increased risk of congenital malformations; strengthened advice on contraception. Carbimazole: risk of acute pancreatitis. SGLT2 inhibitors: reports of Fournier's gangrene (necrotising fasciitis of the genitalia or perineum).	

	BCCG Medicines Optimisation Responses to the DSUs for information:- **Lidocaine for infant teething** – no action as a self-care item and pharmacies will deal with this. **Valproate in pregnancy** – Local provider services and trusts emailed as this needs to be dealt with as it is an audit in the new GP contract. **Emollients with high paraffin content** – this was already on Scriptswitch – GMcG to shared modified patient information leaflet for distribution with local pharmacies to be given to patients upon dispensing and receipt of medication. **Hepatitis C –** no action **Hydrocortisone muco-adhesive buccal tablets** – Added this to the SystmOne formulary with a prepopulated dose making it clear it is for buccal use only, plus a message on scriptswitch. Also flagged to the LPC and asked them to send a reminder out to all pharmacists about the important of communication with the patient at the point of supply. **Tapentadol** – added a message to Scriptswitch **Ipilimumab** – no action If provided before the meeting notes were finalised, it was agreed that information relating to LCCG actions relating to the alerts would be added. GMcG advised that she had done an update to the NPSA patient information leaflet to include all emollients – paraffin containing and paraffin free and agreed to share the information and also upload it on to the Formulary.	**TD/JC** **GMcG (Action completed)**
9	**Wound Care Formulary Update -** none	
10	**East of England Priorities Advisory Committee (PAC) – items for discussion and noting.**	
10.1	**Draft PAC Minutes - November 2018.** The minutes were noted for information.	
10.2	**Medical Devices Update** In February 2017, PrescQIPP published a bulletin which reviewed the evidence and made recommendations on a range of medical devices. The JPC reviewed this bulletin and either supported or locally modified the recommendations. The approved JPC bulletin (249) may be accessed using the following hyperlink:- http://www.gpref.bedfordshire.nhs.uk/media/158127/advguid_medicaldevices_bulletin249.pdf The document for review summarises the evidence from PAC recommendations (originally published in April 2015), on the use of other selected devices which have not been reviewed and included in the in the PrescQIPP DROP-List, and makes commissioning recommendations for CGGs to consider for local	

	adoption. Patient pathways and prescribing responsibility are to be agreed locally. The information contained in this document therefore complements JPC Bulletin 249. The JPC reviewed the document and agreed to support the EoEPAC recommendations for each device as follows:- **Adjunctive treatment of hypertension e.g. Resperate®** - Not recommended **Vaginal dilators or trainers e.g. Femmax®, Ameillee Care®, and Ameille Comfort®** - Recommended for women following vaginal reconstruction surgery or following pelvic radiotherapy when recommended by an appropriate Secondary Care Specialist. (Local supply recommendation – GP to prescribe on recommendation of the Specialist). **Jaw rehabilitation device, e.g. Therabite** - Recommended for patients following head and neck radiotherapy or head and neck surgery when recommended by an appropriate Secondary Care Specialist. (Local supply recommendation – GP to prescribe on recommendation of the Specialist). **Vacuum pumps for erectile dysfunction (ED)** - Recommended. Arrangements for supply and appropriate training should be agreed locally. For Bedfordshire and Luton the supply and training would be in Secondary Care. For information – the Committee was asked to note that NHSE had issued 'Items which should not routinely be prescribed in primary care: an update and a consultation on further guidance for CCGs.' Recommendations on Silk Garments are included in this document but the draft recommendations are in line with current JPC recommendations'. **Equality and Diversity Statement –** As with agenda item 5.1, the BCCG and LCCG Equality and Diversity Leads had different views relating to the need to complete a full Equality and Diversity Impact Assessment. The Committee agreed that the statement produced and agreed with the BCCG Equality and Diversity Lead was proportionate and acceptable - **see appendix 1.**	
11	**Bedfordshire Local Prescribing Committee Minutes for information**	
11.1	Minutes from the Luton and Dunstable Hospital DTC meeting – November 2018	
11.2	Minutes of the Bedford Hospital DTC meeting – December 2018 and January 2019	
11.3	ELFT Medicines Management Committee Minutes (Mental Health) - September and November 2018	
11.4	Minutes of Circle/MSK MMC Meeting – November and December 2018	

11.5	Minutes of the Bedfordshire and Luton Wound Management Formulary Steering Group – November 2018 and January 2019	
11.6	Minutes of the Cambridgeshire Community Services Medication Safety and Governance Group – October and December 2018	
12	**Additional Documents for information**	
12.1	Horizon Scanning and work programme – **paper deferred.**	
12.2	**Regional Medicines Optimisation Committee (RMOC) Update** The latest RMOC meeting update is available at https://www.sps.nhs.uk/articles/regional-medicines-optimisation-committee-update-2019-issue-1/ The JPC noted this paper for information.	
13	**Any other Business -** None	3.50 pm
14	**Dates of future 2019 meetings - all at Endeavour House (Building 50), Wrest Park, Silsoe, Bedfordshire, MK45 4HS.** • **Wednesday 24th April 2019** • **Wednesday 19th June 2019** • **Wednesday 18th September 2019** • **Wednesday 4th December 2019**	
Please inform Jacqueline Clayton of any apologies on 01525 624382 or email Jacqueline.clayton@nhs.net Circulation: JPC Members, BCCG Medicines Optimisation Team (not JPC members)		

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Appendix 1

Bedfordshire and Luton Joint Prescribing Committee – 27th February 2019 Meeting

Updated Equality Impact Assessment

Agenda item	Equality Impact Assessment
5.1 Humalog 200 units/ml KwikPen	This is a proposal to introduce insulin this would mean that appropriate patients would not need to inject such a large volume of insulin. This will be positive for those patients who would be affected and those within that group that would be considered disabled under the equality act.
5.2 Antimicrobial Guideline Update	The guideline is being reviewed in the light of new national (NICE) guidance. The national guidance serves the population and to understand the impact of the NICE recommendations on antibiotic choice locally, local microbiology and clinical speciality teams have been engaged during the consultation process. There is no anticipated impact on the protected characteristics under the Equality Act.
5.3 Gender Identity Services – Primary Care Prescribing Responsibilities for Hormonal Treatments (Including Eflornithine for the treatment of Hirsutism)	The recommendations relate to Gender reassignment which is a protected characteristic under the Equality Act. There a number of decisions be reviewed around GP prescribing responsibilities. There is no proposed change to the current recommendations on availability and prescribing of the hormonal preparations for this patient group which are in line with local and NHSE Guidance. If the recommendations change, a more detailed review of the Equality Impact Assessment will be required.
5.4 COPD/ACO Guideline Update	The guideline is being reviewed in the light of new national (NICE) guidelines. The national guidelines serve a population and to understand the impact of the NICE recommendations on management locally, we have engaged with local respiratory and microbiology teams as part of the consultation process. There is no anticipated impact on the protected characteristics under the Equality Act.
5.5 Anticoagulant Resources for Atrial Fibrillation	Agreed that no assessment under the Equality Act is required. The treatment does not discriminate on age etc. Patients are scored based on age and gender (and a number of risk factors) but this is a clinical scoring for the risk of stroke and therefore identifies patients who need anticoagulation. There is therefore no

	anticipated impact on the protected characteristics under the Equality Act.
5.6 Management of Primary Headache Guidance (Adults)	The guidance will apply universally to the whole adult population therefore no specific equity or equality issues are predicted.
10.2 Medical Devices Update – East of England Priorities Advisory Committee	It is proposed that the recommendations on following are agreed:- Vaginal dilators or trainers – This will have a positive impact under the Equality Act on the group of women for whom they are recommended. Vacuum pumps for erectile dysfunction – This will have a positive impact under the Equality Act for men who choose to use these devices. Jaw rehabilitation device – this is recommended for a specific group of patients as assessed clinically. No impact on the protected characteristics of the Equality Act is anticipated. The Adjunctive treatment of hypertension is not recommended due to lack of evidence. No impact on the protected characteristics of the Equality Act is anticipated.

Jacqueline Clayton

Professional Secretary

Bedfordshire and Luton Joint Prescribing Committee

20th February 2019