BEDFORDSHIRE AND LUTON JOINT PRESCRIBING COMMITTEE
Notes of the meeting on Wednesday 24th April 2019, Endeavour House (Building 50), Wrest Park, Silsoe, Bedfordshire, MK45 4HR.

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 M Sarkar (MS)	GP Representative, LCCG
Dr Joy Muttika (JM)	Medical Representative, Keech Hospice (KH)
Anne Graeff	Pharmacist Representative, LCCG
Dr Marian Chan (MC)	Medical Representative, the Luton and Dunstable University Hospital NHS Foundation Trust (LDUH)
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)
Russell Foulsham (RF)	Pharmacist Representative, Cambridgeshire Community Services (CCS)
Kike Pinheiro (KP)	Pharmacist Representative, East London Foundation Trust (ELFT)
Gerald Zeidman (GZ)	Chief Officer, Bedfordshire LPC
Adrian Spurrell (AS)	Lay Representative

In attendance (full meeting as observer) – Bukola Oye (Pharmacist, LCCG) and Janice Jones Pharmacist Representative, Northamptonshire Healthcare NHS Foundation Trust (NHFT).

For agenda item 5.1 – Sue Burridge, Senior Officer for Public Health – Sexual Health, Bedford Borough, Central Bedfordshire and Milton Keynes.

For agenda item 5.2 - Sian Pither, Planned Care Lead, BCCG.

For agenda item 5.3 – Dr Jayalath (BCCG Mental Health GP Lead) and Sue Marchant, Care Homes Pharmacist, BCCG.

For agenda item 5.4 - Joy Mooring, Pharmacy Technician, BCCG.

	Agenda item	Action
1	**Welcome and Apologies –** The chair welcomed everyone to the meeting. In particular, Dr Mitan Sarkar, the new LCCG GP Representative. **Apologies for absence were received from –** Dr Lindsay MacKenzie, Victoria White and Dr Dhatta.	
2	**Conflicts of interest declaration** No conflicts of interest were declared relating to the current meeting agenda by Committee members. The Committee members were reminded that the 6 monthly written Conflict of Interest Declarations were due (or overdue) for a number of members and that these should be completed and returned to the Secretary as soon as possible.	ALL
3	**Minutes of the last meeting (27th February 2019)** The minutes of the meeting were approved for accuracy.	
4	**Matters Arising**	
4.1	**Flash Glucose Monitoring System (FreeStyle Libre®) Update** At the February 2019 meeting, the Committee was advised that national guidance was awaited on the funding arrangements for Flash Glucose Monitoring (FreeStyle Libre®) System. This guidance had now been published https://www.england.nhs.uk/publication/flash-glucose-monitoring-national-arrangements-for-funding-of-relevant-diabetes-patients/. The JPC was asked to note that both BCCG and LCCG had agreed to support the national criteria for funding of Flash Glucose Monitoring (FreeStyle Libre®) System. (Approved by both CCG Prescribing Committees between meetings). As a result of this, the JPC endorsed bulletins have been retired and replaced by the national guidance. The JPC was asked to retrospectively approve these changes. The new information can be accessed at http://www.gpref.bedfordshire.nhs.uk/referrals/bedfordshire-and-luton-joint-prescribing-committee-(jpc)/flash-glucose-monitoring-system.aspx In particular, the Committee was asked to note that the initial supply of the Flash Glucose Monitoring (FreeStyle Libre®) System will be made by the Specialist Service with the GP being asked to continue prescribing on the advice of the Specialist, in line with national funding arrangements. Most patients will be reviewed by the Specialist Team at 6 months and annually thereafter. The GP will be advised by the Specialist Team on whether it is appropriate for a patient to continue to receive FreeStyle Libre®, after each review. In addition, that the CCGs had agreed funding for 2 years (from 1st April 2019) and that continuation of funding would be reviewed before April 2021.	

	The Committee agreed to support the changes outlined above. The Equality and Diversity Leads had asked about the effect of race on English Language skills in relation to the use of the device as did the LPC representative. The Secretary advised that she contacted both the Diabetes Specialist Teams at Bedford Hospital and the Luton & Dunstable Hospital but anticipated that both teams would have solutions in place to deal with this potential barrier. GMcG confirmed that the BHT Diabetes teams either communicated the information via an English Speaking Family member or used a telephone translating service. **Post meeting note:-** The Luton and Dunstable Hospital Diabetes Teams (Adult and children) had confirmed that they would provide an interpreter for patients who were not English Speaking. FG also advised that the manufacturer of the device had an online (1 hour) webinar training session which any Health Care Professional could access in order to answer any patient queries. All of the locally agreed information was available on GP ref and this included a 'FAQ' section. A link to the manufacturer's 'FAQ's would be included after the information had been updated to include the new DVLA information. FG particularly asked GZ to advise Community Pharmacists that if a patient had a faulty sensor, they needed to contact the manufacturer to obtain a replacement (not ask the GP to prescribe) and that there were limits on the number replacements that a patient could request from the manufacturer. **Post meeting note: -** JC checked with the manufacturer – there are currently no plans to make patient information leaflets available in any other language aside from English. The LPC Representative and RF advised that there were anecdotal reports of problems relating to the supply of FreeStyle Libre. FG informed the meeting that the manufacturer has prioritised supplies to the NHS and there is sufficient stock. GMcG informed the meeting that patients at Bedford Hospital were being advised to make early contact with their regular Community Pharmacist to ensure continuity of supplies. Secondary care are actively informing patients at point of initiation to flag to their local pharmacy that they have commenced the technology to prompt **Equality and Diversity Statement (BCCG, Equality and Diversity Lead):-** Equality Impact considered in the body of the report. Potential positive impact identified. Also identifies the potential need for mitigating actions for those without the proficiency in English language needed to benefit fully from the	

	proposals. Mitigating actions suggested. This should be considered alongside other factors as part of the decision making process. **Equality and Diversity – Additional comments:- (LCCG (Equality and Diversity Lead).** Further to the response from the BCCG Equality and Diversity Lead (to which I am in agreement), my only query is in relation to 4.1 whereby there will be an impact on race – in particular for those who do not speak English. Therefore an action needs to be put in place to demonstrate how the impact will be mitigated. **Author's response -** Will check with Specialist Teams but would expect that 'Duty of Care' of the Hospital (and indeed GP Surgeries) to ensure that a patient understands how to use the device by employing interpreters or ensuring that a member of the patient's family attends who does understand English. **Additional Comment – BCCG, Equality and Diversity Lead.** If I've understood things correctly, and please correct me if I haven't, the JPC can only advise on the use of the system and that it is for GPs to follow that guidance. It is the GPs responsibility to arrange interpreters as the face-to-face service provider. The JPC EqIA can, and does, point out that there may need to be consideration of how patients whose first language isn't English will manage the system and that's where the influence of the JPC on that stops. It can't make GPs arrange interpreters so can't, realistically, require it of GPs as a mitigating action.	
4.2	**Vitamin D Leaflet – for approval** The JPC had previously approved Vitamin D treatment pathways for both adults and children. A patient leaflet has been produced to support the implementation of the pathways, and if approved, would be linked to the pathways. The Committee discussed the leaflet and the following key points were raised:- • The leaflet needed to be simplified e.g. language around deficiency and insufficiency throughout the leaflet. • Supplements obtained from Health food shops were food supplements and not therefore licensed medicinal products. These are only used as part self-care and therefore in the majority of cases, prophylaxis only. • GPs were referring patients to Community Pharmacies and suggesting that they purchase POM vitamin D branded preparations. • AS asked about what people should be wearing when trying to attain the required sun exposure. It was noted that the information in the leaflet had been taken directly from national guidance but we would go back to the author to ask for further clarification. It was noted however that most people in this country would need to take a supplement as they would be unlikely to attain the required level of skin exposure. In addition, other factors e.g. skin tone were	

	involved which meant that the leaflet couldn't cover all subjective possibilities. With the following amendments with leaflet was approved, subject to virtual agreement by the Committee:- • Simplification of the language throughout the leaflet e.g. language around deficiency and insufficiency. • GPs to be advised (via the Newsletter) that patients should not be referred to their Community Pharmacy to purchase POM vitamin D preparations. GPs can advise patients to seek 'Vitamin D supplement' from their community pharmacy and the community pharmacists can signpost to appropriate • Clarification of skin exposure when trying to attain the required sun exposure. After approval, the leaflet will be linked to the Vitamin D Guidance. **Post meeting note:-** The amended leaflet was approved virtually by the Committee. **Equality and Diversity Statement:-** Are there any particular groups that will be impacted by the removal of this product from prescription? i.e. has it been identified that an ethnic group is found to have very low levels of Vitamin D? When looking at the Vitamin D Deficiency risk groups the following are identified - therefore will the removal have a negative impact on them? There will of course be an impact on affordability, however cheap the over the counter products may be. Pregnant women, Young/Older people, Ethnic Groups. If you have any data that supports the impact on the above mentioned groups, that will be useful. **Author response:** Vitamin D patient information leaflet – This is just to compliment the guideline that was already approved by JPC and you and Paul reviewed back in September 2018, I attach our correspondence. Therefore the impact has already been assessed – self-care is a national agenda mandated by NHSE for all patients irrespective of risk factors so we are not restricting access to any specific groups and prescriptions are made available to those who require it. In terms of ethnic groups, the darker your skin tone, the more difficult it is to absorb the UV light to produce vitamin D so it's a physiological mechanism rather than evidence. The national guidance is that everyone takes vitamin D during certain periods in the UK, you are at higher risk of vitamin D if you have the risk factors so those groups should be encouraged to take the supplement in light of this there are no restrictions as such only the identification that there are high risk	DW/RN DW DW/RN SMcG/ DW

	groups and within the guideline we talk about how to treat patients with vitamin deficiency. **Equality and Diversity response**: Thanks, that explanation is fine.	
4.3	**Feedback on miscellaneous actions not included on the agenda**	
4.3.1	**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 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 Specialists had been contacted and a response was awaited. This was therefore an ongoing action. AG has advised that LCCG are now supporting the use of Zoledronic Acid as a first line treatment option**.** **Post meeting:** The JPC Bulletin has been updated to reflect LCCG's change in first line treatment option. Comments received from the specialists, Bedford Hospital oncology team, Luton and Dunstable Hospital oncology team consulted, no comments received. Summary of comments: Dr Sarah Smith and Prof. Robert Thomas, consultant oncologists at Bedford Hospital agree with the updated statement and reflects current practice. Juliet Morris, from Bedford Hospital Trust agreed with the approach regarding the use of ibandronic acid as the oral bisphosphonate of choice considering individual patient factors. Richard Jones, Head of Medicines Management, LCCG - LCCG position is in line with NICE NG101 Oral = sodium clodronate and not ibandronic acid Updated bulletin to be sent to GP Ref for approval and included in the newsletter for reference, then action to be closed.	DW DW/AG SMcG

4.3.2	**Pain Guidelines – LCCG Review** LCCG had not signed up to the JPC agreed Pain Guidelines and had agreed to present to the Committee, for consideration, an amended version of the guidelines that they were happy to support. This action can be closed as following a lot of discussion and deliberation at the LCCG Prescribing Committee, the following was agreed :- • LCCG Prescribing Committee concluded that they will sign up to the current iteration of the Pain Guidelines. • LCCG still has reservations on how the guidelines might be interpreted by clinicians and perhaps patients with regard to opioid place in management of chronic pain. • LCCG emphasis will be on implementation linking the guidance to their local pain pathways. The electronic version of the Pain Guidelines would be updated to reflect the LCCG support, then action to be closed.	SMcG/ BS
4.3.3	**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
4.3.4	**GP Representative, BCCG – Replacement for Dr Hafeez** **Verbal Update at meeting** Ongoing action to replace Chiltern Vale BCCG representative, currently no representative has come forward due to work commitments. JF raised that Chiltern Vale as default will need to abide by the decisions made by the committee in the interim. FG reported that once the primary care networks are formed there will be more direction on this.	FG
4.3.5	**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. LCCG has approached Luton public health lead, currently no capacity for regular attendance however they can provide support ad hoc basis on pertinent agenda items requiring public health input. RJ to meet with Rachel Joyce to explore options further. AG/RJ to feedback outcome. **Verbal Update at meeting** An update will be reported back to the next meeting.	AG/RJ
3.3.6	**Humalog 200 units/ml KwickPen – Safety Concerns** **1.** GMcG had agreed to ensure that the Specialist Diabetes Teams were aware of the need to counsel patients appropriately – action completed and closed.	Close action

	2. FG had agreed to highlight safety concerns to the LPC- action completed and closed.	
4.3.7	**Antimicrobial Guidelines Update - multiple actions as follows:-** Action 1 – A section on WHO ACCESS WATCH and RESERVE list has been added to the introduction pages of the guidelines, close action. Action 2 - 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 work stream 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 – Naomi Currie will pick this up in October 2019 as full engagement with microbiology specialist teams is required and this is outside the scope of JPC – more an ongoing work stream – ongoing action. Action 3 - Bronchiectasis in Adults - Would 3rd line treatment be empirical? It would be useful to have resistance data. DW confirmed with Dr Mulla that sensitivity data for this clinical condition cannot be obtained – action closed.	Close Action JC
4.3.8	**Gender Identity Services - Shared Care and Eflornithine –** 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. As these are likely to be long term ongoing actions, it was agreed that these could be closed.	Close Action
4.3.9	**COPD Guideline Update –** Agreed at the February 2019 meeting that the Relvar preparations would be reviewed when the COPD Guidelines are next reviewed. This is on the work plan for the September 2019 meeting after NICE issues its advice on triple therapy. This is therefore an ongoing action.	GMcG/ JP/ DW
4.3.10	**Anticoagulants in Atrial Fibrillation Resources - Drug Interactions with NOACs.** To be replaced by updated EoEPAC document. The Secretary reported at the February 2019 meeting 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 available and then published as a	SMcG

	replacement document, as outlined above, on GPref. This was an ongoing action as the final PAC Document had not yet been published.	
5	**Items for consideration**	
5.1	**Antimicrobial Guideline Update** NICE has issued guidance on antimicrobial prescribing in the following areas: • Acute Cough • Sore Throat BASHH has issued guidance updates on antimicrobial prescribing in the following areas: • Chlamydia (uncomplicated) • Gonorrhoea (uncomplicated) • Pelvic Inflammatory Disease (PID) As a result, the JPC was asked to discuss the following updates to the Antimicrobial Guidelines:- • Revised section on Chlamydia following review of BASHH guidance update September 2018 https://www.bashhguidelines.org/media/1191/update-on-the-treatment-of-chlamydia-trachomatis-infection-final-16-9-18.pdf • Revised section on Gonorrhoea following review of BASHH guidance January 2019 https://www.bashhguidelines.org/media/1208/gc-2019.pdf • Revised section on Pelvic Inflammatory Disease following 2019 interim guidance issued https://www.bashhguidelines.org/media/1217/pid-update-2019.pdf • Revised section on Sore Throat following review of NICE guideline January 2019 NG84 https://www.nice.org.uk/guidance/ng84 • New section on Acute Cough following review of NICE guideline February 2019 NG120 https://www.nice.org.uk/guidance/ng120 The proposed changes to the guidelines were discussed and the following key points raised:- General changes to genital infections section: • Signposting to iCaSH for Bedfordshire and Luton Sexual Health including information on retesting kits and criteria for retesting • Change in terminology - GUM to Sexual Health • Risk factors for screening particularly in chlamydia and gonorrhoea	

	• Safety warnings for quinolones and tetracyclines • Vulvovaginal NAAT testing for chlamydia and gonorrhoea - iCaSH clinical service lead and BCCG Planned care service lead confirms that NAATs is requested by specialist team only (Page 50)- to include that this test is done by specialist team (NICE CKS also states NAATs should be done in accordance with local procedures) • Revised statement through sexual health section on partner notification - Partner notification and contact details are essential for reducing the risk of re-infection and onward transmission of infection. If the patient declines to give details please refer to the sexual health team who can perform provider referral (anonymous partner notification) • Removal of sexual team contact numbers and reference the website links only to enable future proofing (the Bedfordshire team contact number stated on document was no longer current) <u>Revised section on Chlamydia following review of BASHH guidance update September 2018</u> • BASHH 2019: As a consequence of its potential to select for macrolide resistance in MGen and its inadequacy as a treatment for rectal CT, BASHH no longer recommends **single dose azithromycin** for treatment of uncomplicated chlamydia infection at any site, regardless of the gender of the infected individual, dose now 1g stat dose followed 500mg daily for 2 days (2g in total). In addition, SDA has also been shown to be less effective than doxycycline for rectal chlamydia. • Added section on vulvovaginal swab, First Catch Urine and NAAT (dual nucleic acid amplification tests) to replace original information on urine samples in PID section – author to say that NAATs is specialist team only (page 51) • Chlamydia rescreening criteria confirmed (TOC in 8-12 weeks for those under under 25 years) (page 51) • NICE CKS: A test of cure is not usually necessary. However it is recommended in pregnant women at least 3 weeks after completion of treatment. Repeat testing should be **<u>offered</u>** to all people under the age of 25 years diagnosed with chlamydia 3–6 months after completion of treatment to check for re-infection. Repeat testing should also be **<u>considered</u>** for people over the age of 25 years who are at high risk of re-infection. The committee approved the updated section to the guideline.	

	Revised section on Gonorrhoea following review of BASHH guidance January 2019 • In 2019, BASHH reviewed the treatment recommendations; and now support the use of ceftriaxone monotherapy as first line empirical treatment (previously dual therapy with azithromycin was recommended). This recommendation is based on the lack of high quality evidence regarding the best strategy to delay the emergence of resistance. Since 2011, the prevalence of azithromycin resistance in the UK and globally has increased (9.2% in Gonococcal Resistance to Antimicrobials Surveillance Programme (GRASP) 2017). When treating Gonorrhoea, BASHH recommends that treatment for Chlamydia is included in the regimen if co-infection present. • Ciprofloxacin added into first line if susceptibility known (page 52) • Chlamydia co-infection updated to include doxycycline (as only included ceftriaxone and this is for pregnant women/ patients with intolerance/allergy to tetracycline) (treat co-infection as per current treatment recommendations for chlamydia) (page 52) • Amendment to oral cefixime treatment with regards to chlamydia co-infection- BASHH states for chlamydia co-infection, if an individual has already received azithromycin 2g for the treatment of gonorrhoea then this should be sufficient to treat chlamydia and no further doses of azithromycin are required (page 53) • Removal of information on cultures after treatment failure as ideally a discussion or referral to sexual health team would occur and the GP would refer/ act on advice from the sexual health team – confirmation that NAATs is specialist team only (page 53) • NICE CKS for gonnorhoea states: Confirm the diagnosis, preferably using nucleic acid amplification testing (NAAT), according to local protocols and procedures. If NAAT positive for gonorrhoea, take swabs for culture before prescribing antibiotics to enable sensitivity testing and identification of resistant strains – does not imply that GPs do the test, this is up to local procedures (in our case specialist team responsibility) • For epididymo-orchitis, ceftriaxone dose increase from 500mg to 1g due to recommendation in BASHH gonorrhoea update: Gonococcal epididymo-orchitis:	

	Ceftriaxone 1g intramuscularly as a single dose in addition to the regimen chosen to treat epididymo-orchitis The committee approved the updated sections to the guideline. <u>Revised section on Pelvic Inflammatory Disease following 2019 interim guidance issued</u> • Updated following interim BASHH 2019 guidance update • Main changes: quinolones (ofloxacin, levofloxacin and moxifloxacin) are now recommended as second line therapy except for the treatment of M genitalium associated PID where no alternative therapy is available. Dose of ceftriaxone increased from 500mg to 1g • Confirmation that M Gen PID should be referred to specialist team for management. (Page 50) • Gonococcal PID risk factors included (page 51) • Revision of testing methods for chlamydia and gonorrhoea, included in sections for respective condition • NICE CKS: recommends 500mg ceftriaxone – author has sent query to NICE to ask for further clarification as locally we are now endorsing 1g. **Post Meeting Note:-** BASHH from 2018 and the interim BASHH guidance states now that an increased dose of ceftriaxone, 1g is recommended. The NICE CKS still references the previous dose of 500mg. NICE have confirmed that they are going to update the dose to 1g. The committee approved the updated section to the guideline. <u>Revised section on Sore Throat following review of NICE guideline January 2019 NG84</u> • Revision of existing section in line with NICE NG84 • Self-care advice included (page 15) • To continue to use feverPAIN score (NICE recommends this measurement and also CENTOR), the teleconference members agreed to stick with FeverPAIN as clinicians are already familiar with this scoring system (page 15) • Table split into adults over 18 and children and young people (page 16) as per NICE recommendations • Local guidelines were the same as NICE recommendations	

	• In reference to NICE course length – 5 -10 days, 5-10 days, teleconference agreed that consider longer course lengths (10 days) for FeverPAIN 4-5 or recurrent infection. NICE report a range for duration of 5-10 days – in most studies reviewed clarithromycin and erythromycin courses are 5 days, penicillin v is 10 days – specifically recurrent infection 10 day course, and symptomatic cure 5 days. • For children's table, teleconference members agreed with removal of dose banding and adding links to BNFC • Addition to the comments section about how BD Pen V may support medicines adherence • DW to add patient information leaflet from NICE (link within comments) and RCGP target toolkit. • In relation to impact on courses that differ to course pack quantities, the committee acknowledged that this may be additional work generated in the community pharmacy however the committee consensus was that providing the specific quantity per course would support the local, national and global agenda to reduce antimicrobial resistance. • Phenoxymethylpenicillin supply quantity to be updated on SystmOne to 5 day supply (40 tablets) rather than 10 day supply (80 tablets) The committee approved the updated section to the guideline following suggested amendments. <u>New section on Acute Cough following review of NICE guideline February 2019 NG120</u> • New section added in line with NICE NG 120 • Definition included (NICE and Public Health England definition) (page 24) • Scope for prescribing addressed in introduction 'It is important to consider differential diagnosis and treat the suspected underlying cause of acute cough. Please refer to the relevant sections of the guideline to treat underlying infective cause e.g. COPD, non CF bronchiectasis.' And to consider the treatment options stated in the section if the infective cause of cough is not related to the conditions covered in this guideline. (page 24) • In relation to self-care options (not to be prescribed), it has been included as information - some people may wish to try or have tried the interventions stated which have limited evidence of some benefit for the symptomatic relief of cough symptoms (page 24)	DW/JM

	• Local amendment by teleconference members for practicality duration changed to 5-7 days from 5 days – NICE doesn't state a difference in relation to duration – just that the shortest course should be used • Patient Information Leaflet links to be added into this section (RCGP target toolkit) The committee approved the new section in the guideline. The committee approved the antimicrobial updated presented at the meeting and thanked DW and the team involved with the update. **Equality and Diversity Statement:** – With regards to the Antimicrobial Guideline update, the proposal is to consult with commissioners, etc. The initial impact will be neutral, however, if this changes as a result of the consultation, the impact assessment will need to be updated to reflect this. **Author response** - Antimicrobial guideline - There was no change as a result of the consultation so impact is neutral **Equality and Diversity response**: - Thanks, that explanation is fine.	
5.2	**Primary Headache Pathway – for ratification** 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 design a pathway in line with the NICE Clinical Knowledge Summaries guidance. The Committee was asked to review this updated draft guidance produced by the Planned Care Commissioning team / Medicine Management team with the aim of achieving ratification of the guidelines at the meeting (for intended use by both BCCG and LCCG.) A draft version was discussed in detail at the February 2019 JPC meeting. There were amendments from the February 2019 JPC meeting which SMcG agreed to implement: • 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 circumstances. • 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. • 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).	SMcG

	• Tension Headache – wording is fine, including the information on acupuncture. • 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. An updated draft had been produced incorporating some new information around triptans and the general amendments suggested at the February meeting following a meeting with planned care and JW with pragmatic review. Changes made by SMcG as a result of the meeting: • The migraine acute treatment a statement about OTC use has been included to signpost patients to self-care • Asterisk included in dose part as it is higher than expected to use • Prescribing notes in relation to triptans take earlier at point of migraine onset – added information on when triptans should not be used in certain rare migraine types • Table on triptan onset and duration of action included • Listed options for migraine, amitriptyline, pzotifen etc. rather than listed it as sequential option lines, variance in NICE CKS The pathway was discussed by the committee at the April 2019 meeting and the following key points were raised:- • Migraine – Preventative Treatment - Pizotifen – specialist initiation to be changed to 'seek advice from specialist' to reduce necessity for referral, joint formulary to be amended to reflect this. • Migraine – Preventative Treatment – topiramate, information on foetal abnormality to be put in bold. • Migraine – Preventative treatment move Pizotifen and topiramate lower down on the list below propranolol and amitriptyline. • Amitriptyline for prevention of Migraine (page 8) and Tension-Type headache (page 12) to include specific advice on dose titration to allow lowest effective dose use. • It was noted that the sections on Lifestyle Interventions for Migraine (page 10) and Tension Type Headaches (page 13) and Patient Advice for Cluster Headache (page 16) that are found at the end of their relevant treatment sections to be moved to the start to encourage lifestyle advice from point of diagnosis.	SMcG

	• Linked to NICE CKS to be reviewed and checked • Migraine aura it was decided to be consistent with NICE CKS • The committee agreed to exclude section on menstrual migraine until SMcG has reviewed menstrual migraine treatment including NICE CKS recommendation of frovatriptan currently non formulary. • Verapamil in cluster headache –it was agreed to be 'specialist initation only' at the JPC February meeting, subsequently the committee agreed to change this to 'discuss with specialist' at April 2019 meeting. • SystmOne template to be considered following implementation. Current LCCG position, TD reports that Dr Bakhai, lead clinician at LCCG prefers the NICE CKS and noted the use of candesartan for migraine prophylaxis. The CKS guidance says there is little evidence to support its use, the committee agreed that candesartan for this indication would likely to be initiated by the specialist/ GPs would prescribe under guidance of specialist. The committee approved the pathway for BCCG only, SMcG and Sian from planned care for their hard work. **Equality and Diversity –** Assessed at the February 2019 meeting - The guidance will apply universally to the whole adult population therefore no specific equity or equality issues are predicted.	
5.3	**Shared Care/Transfer of Care – Drugs for the treatment of Alzheimer's Dementia Update – BCCG only** **T**he publication of NICE NG97 June 2018 and update of NICE TA 217 resulted in potential change in practice of prescribing cognitive enhancing drugs (CEDs). The BCCG Mental Health lead GP, Dr Jayalath, has had discussions at locality level as to when prescribing of CEDs should move to primary care. The result of the consultation was that:- • GPs are not happy for the transfer of care to happen any earlier and wish the current time scales to be retained. • Some GPs had indicated that they are happy to initiate memantine as an adjunct to acetylcholinesterase (AChE) inhibitors in moderate and severe Alzheimer's if considered appropriate. The Shared Care/Transfer of Care Guideline had therefore been updated to reflect the NICE Guideline and the results of the consultation.	

	Summary of the changes during consultation period include: • Primary care clinicians may start treatment with memantine as an adjunct to acetylcholinesterase (AChE) inhibitors without taking advice from a specialist clinician. This only applies to those clinicians who have received training and are comfortable to manage this addition. • Transfer of care (commissioning arrangements) remains unchanged: 'When a requisite response has been achieved at a dose commensurate with patient tolerability (usually after 6-8 months), consideration can be given to the transferring of prescribing and on-going monitoring of the CED to the GP' - this is the commissioning arrangement initially agreed with ELFT during consultation (confirmed with Dr Jayalath). • In relation to once the patient is stable, the GP will accept transfer of care within 3 months of the patient being transferred (post meeting action, to confirm wording) • The Memory Assessment Clinic are responsible for diagnosis and initiation and titration of medication. The community mental health team (specialist team) will review the patient if further mental health input is warranted, e.g. behavioural disturbances/ deterioration in cognitive function, discontinuation of treatment. This will be reflected in the shared care guideline upon receipt of the contact details for community mental health team from the memory assessment service/ ELFT (post meeting action) • Update of the contact details for the specialist team (including community mental health team) and memory assessment service to be included (post meeting action) • Update of drug information within the appendices (post meeting action) The updated guidelines were reviewed by the Committee and the following key points raised:- The Committee were asked the current update to include memantine as an option for GPs to prescribe if they have received the appropriate training and are clinically comfortable with prescribing.	SM SMcG

	The committee noted that this change will help with patients in care homes that may have practical challenges attending psychiatric appointments. Dr Jayalath reported that a new template for dementia on SystmOne has been developed that will support shared care guideline implementation. In relation to shared care, the committee raised that we are moving to 'opting in' and to notify specialist team to 'opt out' and noted that the shared care still endorsed GPs notifying the specialist team. As this is in relation to the transfer of care the GP will need to notify the service/ communicate with the service to accept care. A letter template to refuse shared care is included in the appendix of the shared care guideline for reference and there is a SystmOne template. The committee were asked to consider if the shared care guideline should be expanded and updated to include two further indications of dementia, Lewy body and vascular dementia. GPs have been asked historically to manage non Alzheimer's dementia e.g. Lewy body and vascular dementia, the treatment options of which are 'off label' but recommended by NICE. The GPs agreed that this was common practice and guidance would be welcomed. The GPs would not be expected to initiate, it would be continuation of prescribing once the patient has been stabilised for a period of time by the specialist team and/or memory assessment service. The committee approved this proposal. Dr Jayalath agreed to support the team with the shared care guideline to include information on Lewy body and Vascular dementia and bring back to the committee. The Shared care guideline is currently BCCG specific as the commissioning positions are slightly different to LCCG, LCCG has a shared care guideline in place that is due for review. LCCG have been consulted during this update and are currently having discussions with their prescribing committee. AG to take back to RJ for update. LCCG to inform committee if they wish to opt into the shared care guideline. The committee approved the shared care guideline following the update in relation to Alzheimer's and will be published in due course. Work will commence on LCCG engagement and extending scope of the shared care guideline for consideration at a future meeting. The committee thanked SM and Dr Jayalath for their contribution to the shared care guideline update.	AG/RJ SM/JC

	Equality and Diversity - No equality impact assessment required as this is an administrative change which is not expected to change the outcome for patients**.**	
5.4	**Camouflage Creams** As part of the alignment of medicine formularies across Bedfordshire and Luton, the formulary working group had asked that the JPC to produce a position statement on the criteria for use of camouflage creams. This was previously discussed at the September 2018 JPC meeting, however a number of issues were raised at this meeting which required further investigation. The Committee was asked to review the updated paper which provided the additional information requested by the Committee and to agree a recommendation from the following options following consultation with the Equality and Diversity Lead: **Option 1:** The prescribing of camouflage creams by GPs is only supported if the patient has a disfiguring facial skin condition that is causing extreme distress, impacting in a restrictive way on the patient's life. In all cases the patient will need to have been seen by a Specialist Dermatology Team and referred to a trained skin camouflage practitioner for colour matching. **Option 2:** The prescribing of camouflage creams by GPs is only supported if the patient has a disfiguring skin condition that is causing emotional distress that impacts in a restrictive way on the patient's life. In all cases the patient will need to have been seen by a Specialist Dermatology Team and referred to a trained skin camouflage practitioner. **Option 3:** Self care The paper was discussed and the following key points raised:- • **Product costs and handling fees** - prices for C&D retail prices, not prices that pharmacy will charge for product as handling fee included. Author noted that the handling fee varies from pharmacy to pharmacy according to which supplier used. Independent pharmacies approached, to enable accurate figures to be obtained, extreme variation, length of time of delivery can also vary. Limit confusion to patient what they pay over the counter. It was noted that patients can buy from the manufacturer directly at prices quoted via C&D. Currently not priced in the Drug Tariff. The purpose of the paper was to address the cohort of	

	patients who would be eligible for supply via NHS. The cost impact is relatively low as the cohort numbers are lower. The 'cost to purchase' wording to be amended within the paper. • Option 2 enables patients to access treatment in other areas (not restricted to the face). AG and FG noted that in relation to other policies e.g. low priority items, they are restricted to the face. • The committee also considered whether Consultant Dermatologist referral is necessary. The aim of the paper was to empower GPs to prescribe if required. The Committee noted that nationally 'Changing faces' can be accessed via GP referral and self-referral. JM reported that Dr Burova, consultant dermatologist at Bedford Hospital supported dermatology input for diagnostic purposes to determine underlying cause. The Committee suggested that the reference to 'dermatologist' could be generalised to 'specialist' as it may be more appropriate for another specialist team (other than dermatology) to intervene e.g. plastics for disfigurement secondary to burns. Assessment of degree of distress for referral was discussed. It was agreed that GPs would make the assessment. The committee enquired about the Red Cross service, JM reported that GPSIs also raised this and that it was no longer an active service. • It was noted that a colour matching technician was in post at Bedford Hospital who was previously managing patients locally, currently the post is vacant. • It was noted that quality of make up and expertise in application has improved so there is a place for self-care and products available on amazon. If the committee were to endorse self-care a full equality and diversity assessment would be required. • It was noted that extreme distress was used in option 1 and not in option 2, the consensus was to remove the term 'extreme'. The committee considered if locally we go against status quo (other CCG positions and national low priority policies) of limiting to face and extending our guidance to disfiguration in other areas as GPs could make this decision on a case by case basis. It was acknowledged by the committee that GPs would refer if they felt that the patient needed referral to specialist team if the patient was in extreme distress due to non-facial disfiguring skin condition. GPs expressed the challenges to quantify impact on distress, this is subjective.	JM/SMcG

	• The committee agreed that the position statement would be changed to a guideline. • It was noted that if we commissioned non facial disfigurement, the greater cohort would increase trust activity and costs incurred to the CCG. • High impact areas could be considered as a term in place of 'facial' or 'disfiguring areas' as a compromise, high impact areas would be defined as areas that is exposed whereby the impact psychologically is high. • It was suggested that a caveat to include 'self care has been considered' could be included within the statement which the committee supported. • The committee noted that a majority of patients will buy their own products, once they have colour match they will manage their own, a small cohort will not be able to afford the products, these are the patients whereby the distress will be prominent and impacting on their lives. The mental distress may also impact other areas causing other problems. Following extensive discussion, the consensus was that the Committee decided on whether the commissioning position for camouflage creams via NHS should be restricted to the face or extended to other areas. Self-care alone was ruled out as an option. Disfigurement through burns or other injury does not require diagnosis but may require specialist advice on best management. The committee approved option 1 with the following amendments: - Removal of the term 'extreme' - Change wording from 'dermatologist' to 'specialist' - Inclusion of wording 'self-care should be considered as the first option, alongside self-referral, if the patient requires an NHS prescription for supply they will need referred to the specialist in the first instance - Change of title from statement to guideline The following JPC recommendations were agreed: Prior to prescribing, self-care options should be considered. If NHS Prescribing is required, the following recommendations apply:- • The prescribing of camouflage creams by clinicians is **only** supported if the patient has a disfiguring facial condition that is causing distress, impacting in a restrictive way on the patient's life. • Prior to prescribing:-	JM/ SMcG

	○ the patient should be referred to a Secondary Care Specialist for advice on optimal management and investigation of any underlying cause. ○ the patient should be referred to a trained skin camouflage practitioner for colour matching. The guideline was approved by the committee following the amendments agreed at the meeting. The committee thanked JM for her hard work. **Equality and Diversity -** Equality impact covered in the body of the report, including identifying where further assessment may be required depending on the path the committee wish to take. Where the path chosen by the committee requires a full equality impact assessment the final decision should be deferred until that assessment has been completed and the committee can consider its findings alongside the proposals. (A Full Impact Assessment was not required as this was only required if Option 3 – Self Care had been adopted).	
5.5	**Treatment of Severe Psoriasis Pathway - 3rd line Biologic Update** The current severe psoriasis pathway allows routine use of first and second line biologics, in line with NICE technology appraisal guidance and local policy, but requires submission of an individual funding request (IFR) for third line biologics. Bedfordshire and Luton CCGs have received a number of requests, via the IFR route, for third line biologics and therefore the pathway needs to be reviewed and there are a number of new biologics on the horizon that are due to be recommended by NICE for psoriasis. NICE CG1532 (Psoriasis: assessment and management), published October 2012, specifically reviewed the evidence for sequential use of biologics for the treatment of severe psoriasis. For adults in whom there is an inadequate response to a second biological drug, seek supra-specialist advice from a clinician with expertise in biological therapy. This was the rationale for the current policy, allowing second line use as routine commissioning A review of the available evidence was requested from UKMI, which identified that the evidence on the use of third (and subsequent line) biologics is relatively scarce. Evidence is generally limited to case reports and small open label studies. The British Association of Dermatologists (BAD) made the following recommendation in their 2017 guidelines for biologic therapy for psoriasis, although they state that these are weak recommendations and represent options with a weighting of	

	"consider", rather than "offer", as treatment options: 'When a person's psoriasis responds inadequately to a second or subsequent biologic agent seek advice from a clinician with expertise in biologic therapy' CCGs in adjacent regions commission a pathway allowing routine use of third line biologics without the requirement for tertiary level referral. Further afield, a number of CCGs allow routine use of third line biologics, and some CCGs allow up to 4 different biologics within their pathway. With our ICS, all three CCGs currently commission routine use of second line biologics, but require submission of an individual funding request for third line biologics. The Committee was asked to review the evidence available regarding the use of third line biologics in the treatment of psoriasis and to decide on whether a change should be made to the existing treatment pathway. The Committee was also asked to consider whether the requirement for "supra-specialist" involvement for third line biologics should be changed. The committee noted that the NICE guideline was issued at a time whereby there was minimal evidence for sequential biologic use (as not yet established). It was raised that the experience with biologics from when NICE issued the guidance to present day, has most likely increased and in reference to 'supra specialist advice', could this be seeking a second opinion from a consultant dermatologist within the Trust who specialises in biologics rather than tertiary referral. MC reported that in practice, sequential biologics is not as established in Dermatology as it is in Rheumatology. AG raised that seeking advice from a tertiary centre may not be the optimal system from a practical perspective. It was agreed by the committee that third line biologics would be routinely commissioned provided initiation has been on advice of a consultant dermatologist with expertise in biologics. It was recognised that in conditions like psoriatic arthritis, where there is a potential cross over/ partnership in clinical decision making amongst the specialist teams, the Rheumatology Consultant may provide this advice. AG received feedback to make the biosimilar usage more prominent in the pathway to support biosimilar use e.g. adalimumab biosimilar switch. The committee approved the pathway update with suggested amendments and agreed that AG would update the pathway to include the two new drugs: tildrakizumab and certolizumab endorsed by NICE for treatment of psoriasis in April 2019. The committee thanks AG for her hard work with the update. The pathway will be uploaded onto GP ref in due course.	AG SMcG

	Equality and Diversity - Possible positive impact identified. This should be considered alongside other factors as part of the decision making process.	
5.6	**Antibiotic Prophylaxis to prevent exacerbations for Non-Cystic Fibrosis Bronchiectasis – Focus on the use of Inhales/Nebulised Tobramycin and Inhaled/Nebulised Colistimethate sodium** LCCG has received a number of Individual Funding Requests relating to the use of inhaled/nebulised Tobramycin for the prevention of exacerbations of Non-Cystic Fibrosis Bronchiectasis. In most of these cases, inhaled/nebulised Colistimethate sodium has been tried prior to the inhaled/nebulised Tobramycin. The Committee was therefore asked to review the evidence of efficacy, safety and cost with a view to agreeing a policy for the use of these two medicines. The paper was reviewed by the Committee and the following key points raised:- • Bronchiectasis is a chronic respiratory condition characterised by abnormal, dilated, thick-walled bronchi. Non-cystic fibrosis Bronchiectasis is a bronchiectasis not related to underlying cystic fibrosis, but more commonly caused by a previous severe lower respiratory infection. • The NICE evidence review of continuous nebulised or inhaled antibiotics in adults with stable state bronchiectasis is based on 6 placebo controlled (4 double-blind, 2 open-label) RCTs from 1 systematic review (Hnin al 2015). Antibiotics included Tobramycin (2 studies), gentamicin (1 study), Tobramycin and ceftazidime combined (1 study), and ciprofloxacin 2 studies). The duration of antibiotic administration ranged from 4 weeks to 12 months. • Nebulised or inhaled antibiotics did not significantly reduce the number of participants with exacerbations or hospitalisations compared with placebo or standard care. The number of participants with exacerbations was reported by 4 RCTs of Tobramycin, gentamicin or ciprofloxacin (2 studies). Three of these reported a reduction in exacerbations in the treatment group and 1 reported a non significant increase in exacerbations in the treatment group. The trial that reported an increase in exacerbations was a small trial (n=74) of nebulised Tobramycin in people who cultured for Pseudomonas aeruginosa. • The same trial of nebulised Tobramycin compared with placebo reported a significant increase in the adverse	

	event of dyspnoea, and a non-significant increase in wheeze and chest pain in the treatment group. There was no significant difference in other adverse events, no significant difference in the number of withdrawals due to intolerable side-effects and no difference in the emergence of resistance. • The evidence review for nebulised colistimethate sodium is based on one placebo controlled double-blind RCT in adults with bronchiectasis who had chronic Pseudomonas aeruginosa infection and had been treated with an antipseudomonal anti antibiotic for an infection in the last 21 days. • There was no significant difference between nebulised colistimethate sodium and placebo in the time to first exacerbation in the intention to treat population. However, there was a significant difference between groups when participants who were at least 81% adherent were analysed. • There was no significant difference between colistimethate sodium and placebo in the number of participants experiencing adverse events, serious adverse events or withdrawals due to adverse events. • The majority of evidence for prophylactic antibiotics was for oral macrolide antibiotics in adults, where they reduced exacerbation rates and the number of people with an exacerbation. However, they also increased antibiotic resistance and adverse effects. • No systemic reviews or RCTs were identified that investigated nebulised antibiotics in children or young people with stable state bronchiectasis. There is therefore little clinical evidence available to guide treatment decisions in the paediatric population. Much of current practice is extrapolated from the clinical evidence in patients with Cystic Fibrosis. • NICE does not recommend routine antibiotic prophylaxis to prevent acute exacerbations of bronchiectasis but to seek specialist advice about options for preventing exacerbations in people with repeated acute exacerbations, which may include a trial of antibiotic prophylaxis. NICE does make specific recommendations on the choice of antibiotic for prophylaxis, because this will be an individualised decision based on the clinical needs of the person, their preferences and advice from a specialist. • BTS and European Guidance for the Treatment of Non Cystic Fibrosis Bronchiectasis (adult patients) recommend that long term antibiotics should be considered (on the advice of a Specialist) if a patients who experience 3 or more exacerbations per year. For *P. aeruginosa* colonised patients inhaled colistimethate sodium is suggested as a first line treatment option followed by inhaled gentamicin as	

	a second line alternative. Neither guideline recommend the use of inhaled/nebulised tobramycin except in the context of eradication of potentially pathogenic micro-organisms (BTS). • When consideration is given to starting patients on long term antibiotics, there should be shared decision-making between the patient/carer and clinician reviewing the benefits and risks of treatment. The committee raised the following points during discussion: • There is limited clinical evidence to support the long term use of antibiotics to prevent exacerbations in patients with non-Cystic Fibrosis Bronchiectasis. National guidance supports specialist use. Should the Committee make recommendations on specific antibiotics or endorse the NICE Guidance which leaves the choice of agent up to the specialist? The Committee agreed to discuss and agree recommendations on the drugs under discussion. Committee agreed that the indications should be split into paediatrics and adults as the treatment regimens differ (two prior approval proformas). • The Committee discussed the feasibility of developing a local pathway. NICE states patients should be treated on an individual case basis via sputum culture sensitivity. The adult pathway could be lined up with BTS guidance. The paediatric population would be more challenging as niche area. Further work to follow on from policy approval to include proforma generation and pathway development. • The JPC supported the use of inhaled/nebulised colistimethate sodium and/or tobramycin, working with the local clinicians to develop funding criteria E.g – 3 or more exacerbations per year (BTS guidelines), clinically significant/symptomatic pseudomonal lung infection (impacting on the patient's activities of daily life), would otherwise be admitted for IV antibiotics, previous history of repeated admissions with lengthy hospital stays, prescribed by a respiratory specialist (adult/children). • The Committee agreed that GPs would continue prescribing colistimethate following initiation by the consultant, it is common practice. Tobramycin prescribing in primary care is not established (according to ePACT) and therefore shared care (GPs to continue prescribing) is currently not supported. Further work is required to look into the logistics of shared care. The committee agreed to support use in line with criteria to be developed in conjunction with the Specialists and there would be no funding until the criteria were agreed and proformas set up. The committee thanked JC for her hard work and it was agreed	AG/TD

	that the proformas and pathways would be developed as a result of the commissioning policy approval. **Equality and Diversity -** Equality impact identified as either neutral or that further assessment may be required depending on the path the committee wish to take. Where the path chosen by the committee requires a full equality impact assessment the final decision should be deferred until that assessment has been completed and the committee can consider its findings alongside the proposals**.**	
6	**NICE Guidance**	
6.1	**NICE Guidance Summary – Published Guidance – from 14th February to 17th April 2019 (Inclusive)** **The following NICE Technology Appraisal Guidance (CCG Commissioned) have been published:-** **Abatacept for treating psoriatic arthritis after DMARDs (terminated appraisal)** Technology appraisal [TA568] Published date: 13 March 2019, https://www.nice.org.uk/guidance/ta568 As this is a terminated appraisal, no financial impact is anticipated. **Ertugliflozin as monotherapy or with metformin for treating type 2 diabetes,** Technology appraisal guidance [TA572] Published date: 27 March 2019, https://www.nice.org.uk/guidance/ta572 No significant resource impact is anticipated. To add onto the formulary following feedback from trust clinicians. The committee are awaiting feedback from the Trusts r.e. Ertugliflozin for information from the Trust around position in therapy to help budget planning. **Certolizumab pegol for treating moderate to severe plaque psoriasis,** Technology appraisal guidance [TA574] Published date: 17 April 2019, https://www.nice.org.uk/guidance/ta574 No significant resource impact is anticipated. NICE TA to be added to psoriasis pathway as discussed at April 2019 meeting for consultation with dermatologists and addition onto joint formulary. **Tildrakizumab for treating moderate to severe plaque psoriasis** Technology appraisal guidance [TA575] Published date: 17 April 2019, https://www.nice.org.uk/guidance/ta575	GMcG/ JP AG AG

	No significant resource impact is anticipated. NICE TA to be added to psoriasis pathway as discussed at April 2019 meeting for consultation with dermatologists and addition onto joint formulary. **The following NICE Guidelines (Medicine related and CCG Commissioned) have been published/updated and were noted for information and action as appropriate:-** Intrapartum care for women with existing medical conditions or obstetric complications and their babies NICE guideline [NG121] Published date: March 2019, https://www.nice.org.uk/guidance/ng121 Delirium: prevention, diagnosis and management, Clinical guideline [CG103] Published date: July 2010 Last updated: March 2019 https://www.nice.org.uk/guidance/cg103 Urinary incontinence and pelvic organ prolapse in women: management, NICE guideline [NG123] Published date: April 2019. https://www.nice.org.uk/guidance/ng123 This guideline would be for consideration alongside current JPC guidance and the latest Priorities Forum Guidance at the June 2019 JPC meeting. **The following Medical Technology Guidance has been published by NICE:-** The Debrisoft monofilament debridement pad for use in acute or chronic wounds Medical technologies guidance [MTG17] Published date: March 2014 Last updated: March 2019, https://www.nice.org.uk/guidance/mtg17 The Chair of the Bedfordshire and Luton Wound Care Group has confirmed that this product is on the formulary and routine practice across BCCG and LCCG. **The following NICE Key Therapeutic Topics (Medicine related), have been published (NB – These are not formal NICE Guidance):-** Shared decision making Key therapeutic topic [KTT23] Published date: March 2019, https://www.nice.org.uk/advice/ktt23 Suicide prevention: optimising medicines and reducing access to medicines as a means of suicide Key therapeutic topic [KTT24] Published date: March 2019, https://www.nice.org.uk/advice/ktt24	

	Chemotherapy dose standardisation, Key therapeutic topic [KTT22] Published date: February 2018 Last updated: March 2019 https://www.nice.org.uk/advice/ktt22 Multimorbidity and polypharmacy, Key therapeutic topic [KTT18] Published date: January 2017 Last updated: March 2019 https://www.nice.org.uk/advice/ktt18. Psychotropic medicines in people with learning disabilities whose behaviour challenges, Key therapeutic topic [KTT19] Published date: January 2017 Last updated: March 2019, https://www.nice.org.uk/advice/ktt19. Safer insulin prescribing, Key therapeutic topic [KTT20] Published date: January 2017 Last updated: March 2019, https://www.nice.org.uk/advice/ktt20. Medicines optimisation in chronic pain, Key therapeutic topic [KTT21] Published date: January 2017 Last updated: March 2019 https://www.nice.org.uk/advice/ktt21 . Acute kidney injury (AKI): use of medicines in people with or at increased risk of AKI, Key therapeutic topic [KTT17] Published date: February 2016 Last updated: March 2019. https://www.nice.org.uk/advice/ktt17 . Type 2 diabetes mellitus: medicines optimisation priorities, Key therapeutic topic [KTT12] Published date: January 2015 Last updated: March 2019. https://www.nice.org.uk/advice/ktt12 . Wound care products, Key therapeutic topic [KTT14] Published date: January 2015 Last updated: March 2019. https://www.nice.org.uk/advice/ktt14 . Asthma: medicines safety priorities, Key therapeutic topic [KTT5] Published date: January 2015 Last updated: March 2019. https://www.nice.org.uk/advice/ktt5 . Hypnotics, Key therapeutic topic [KTT6] Published date: January 2015 Last updated: March 2019. https://www.nice.org.uk/advice/ktt6 Antipsychotics in people living with dementia, Key therapeutic topic [KTT7] Published date: January 2015 Last updated: March 2019 https://www.nice.org.uk/advice/ktt7	

	Antimicrobial stewardship: prescribing antibiotics, Key therapeutic topic [KTT9] Published date: January 2015 Last updated: March 2019 https://www.nice.org.uk/advice/ktt9 . **The following Technology Appraisal Guidance are the commissioning responsibility of NHSE and were noted by the Committee for information:-** Bevacizumab with carboplatin, gemcitabine and paclitaxel for treating the first recurrence of platinum-sensitive advanced ovarian cancer (**terminated appraisal**) Technology appraisal [TA560] Published date: 20 February 2019, https://www.nice.org.uk/guidance/ta560 Venetoclax with rituximab for previously treated chronic lymphocytic leukaemia Technology appraisal guidance [TA561] Published date: 27 February 2019, https://www.nice.org.uk/guidance/ta561 - **Recommended** Encorafenib with binimetinib for unresectable or metastatic BRAF V600 mutation-positive melanoma Technology appraisal guidance [TA562] Published date: 27 February 2019, https://www.nice.org.uk/guidance/ta562 - **Recommended** Abemaciclib with an aromatase inhibitor for previously untreated, hormone receptor-positive, HER2-negative, locally advanced or metastatic breast cancer Technology appraisal guidance [TA563] Published date: 27 February 2019, https://www.nice.org.uk/guidance/ta563 - **Recommended** Dabrafenib with trametinib for treating advanced metastatic BRAF V600E mutation-positive non-small-cell lung cancer (terminated appraisal) **Technology appraisal** [TA564] Published date: 27 February 2019, https://www.nice.org.uk/guidance/ta564 Benralizumab for treating severe eosinophilic asthma, Technology appraisal guidance [TA565] Published date: 06 March 2019, https://www.nice.org.uk/guidance/ta565 - **Recommended** Tisagenlecleucel for treating relapsed or refractory diffuse large B-cell lymphoma after 2 or more systemic therapies Technology appraisal guidance [TA567] Published date: 13 March 2019, https://www.nice.org.uk/guidance/ta567 - **Recommended** Pertuzumab for adjuvant treatment of HER2-positive early stage breast cancer, Technology appraisal guidance [TA569] Published date: 20 March 2019, https://www.nice.org.uk/guidance/ta569 - **Recommended** Brigatinib for treating ALK-positive advanced non-small-cell lung cancer after crizotinib	

	Technology appraisal guidance [TA571] Published date: 20 March 2019, https://www.nice.org.uk/guidance/ta571 – **Recommended** Daratumumab with bortezomib and dexamethasone for previously treated multiple myeloma Technology appraisal guidance [TA573] Published date: 10 April 2019, https://www.nice.org.uk/guidance/ta573 **Recommended via the Cancer Drugs Fund at present.** Bosutinib for untreated chronic myeloid leukaemia (terminated appraisal) Technology appraisal [TA576] Published date: 17 April 2019, https://www.nice.org.uk/guidance/ta576 **NICE is unable to make a recommendation** about the use in the NHS of bosutinib (Bosulif) for untreated chronic myeloid leukaemia in adults because no evidence submission was received from Pfizer. We will review this decision if the company decides to make a submission.	
6.2	**NICE Guidance Summary – Anticipated Guidance – April - June 2019** This paper was noted by the Committee for information only	
7	**Virtual Recommendations/Documents – for discussion/ratification:- None**	
8	**Drug Safety Updates – March 2019** The MHRA Drug Safety Update for March 2019 was noted by the Committee for information and action:- https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/787952/March-2019-PDF-final.pdf • Fluoroquinolone antibiotics: new restrictions and precautions for use due to very rare reports of disabling and potentially long-lasting or irreversible side effects. • Onivyde (irinotecan, liposomal formulations): reports of serious and fatal thromboembolic events. • Medicines with teratogenic potential: what is effective contraception and how often is pregnancy testing needed? Fluoroquinolone warnings to be included throughout Community Antimicrobial Guidelines and use to be reviewed specifically:- • for non-severe or self-limiting infections, or non-bacterial conditions	DW

	• for some mild to moderate infections (such as in acute exacerbation of chronic bronchitis and chronic obstructive pulmonary disease; please refer to revised indications in the Summary of Product Characteristics) unless other antibiotics that are commonly recommended for these infections are considered inappropriate (see below) • ciprofloxacin or levofloxacin should no longer be prescribed for uncomplicated cystitis unless other antibiotics that are commonly recommended are considered inappropriate.	
9	**Formulary Update** This section has been changed to reflect all Formulary updates (not just wound care). When the Bedfordshire and Luton Joint Formulary has been formally launched (Anticipated June 2019), this paper will summarise any Formulary decisions taken outside of the JPC meeting e.g. Hospital only drugs from the hospital DTCs or changes to cost-effective product choices from the CCG Prescribing Committees and recommendations made by the Wound Care Formulary Subgroup. The JPC was asked to support the following Formulary Changes:- **1.** Both CCGs are proposing that the 'True Result' Blood Glucose Testing Meter/strips is removed from the Formulary (and the corresponding JPC Bulletin) as the testing strips are now no longer considered to be cost-effective as lower acquisition cost products are now available. The committee agreed for these choices to be removed **2.** Wound Care Formulary Update - Request to change from the Profore system to the Jobst Comprifore range – Luton only as BCCG currently use K range. The committee agreed for this change to be made. **Equality and Diversity -** No equality impact assessment required. Proposal is to change two currently provided products are replaced with two similar, but more cost effective, products. There will be no difference in the outcome for the patients.	FG/ SMcG FG/TD
10	**East of England Priorities Advisory Committee (PAC) – items for noting.**	
10.1	**Draft PAC Minutes - January 2019** The minutes were noted for information.	
11	**Bedfordshire Local Prescribing Committee Minutes for information**	
	11.1 Minutes from the Luton and Dunstable Hospital DTC meeting – December 2018 and March 2019	

	11.2	Minutes of the Bedford Hospital DTC meeting – February 2019	
	11.3	ELFT Medicines Management Committee Minutes (Mental Health) - January 2019	
	11.4	Minutes of Circle/MSK MMC Meeting - **None**	
	11.5	Minutes of the Bedfordshire and Luton Wound Management Formulary Steering Group – March 2019	
	11.6	Minutes of the Cambridgeshire Community Services Medication Safety and Governance Group – January 2019	
12	**Additional Documents for information**		
12.1	**RMOC Update** The latest RMOC meeting update is available at https://www.sps.nhs.uk/articles/regional-medicines-optimisation-committee-newsletter-issue-2-2019/ Key points to note:- **Biosimilar Insulins** Biosimilar insulins had been prioritised as the next topic for the RMOC BVB group to look at. **Sequential Use of Biologicals** The RMOC has been asked to provide evidence for sequential biologic therapy. This issue concerns the number of cycles of biologicals used before use is limited. This is a difficult area with a limited evidence base. Limited sequential use of biologics has been covered to varying degrees in NICE guidance although no definitive answer reached due mainly due to the lack of evidence. The RMOC will explore the evidence base in this area. **Antimicrobial Resistance and Stewardship** The UK 5-year action plan for antimicrobial resistance 2019-to-2024 has been published along with the long term strategy UK 20 year vision for antimicrobial resistance. The Midlands and East RMOC are taking an overarching role for antimicrobial resistance and stewardship within the RMOC system **Liothyronine** Clarification of the RMOC Guidance is anticipated. In addition, the JPC was asked to note that the Secretary has responded to RMOC regarding its proposed workplan and was in the process of responding to a survey re topics for deprescribing on behalf of the Committee.	
12.2	**Horizon Scan and work plan** The paper came to the Committee for information and noting.	
13	**Any other Business -** Osteoporosis Guideline included table of drugs and licensed indications. Ibandronic acid has been moved as second line	SMcG

	based on experience from local clinicians. The committee agreed with change.	
14	**Dates of future 2019 meetings - all at Endeavour House (Building 50), Wrest Park, Silsoe, Bedfordshire, MK45 4HS.** • **Wednesday 19th June 2019** • **Wednesday 18th September 2019** • **Wednesday 4th December 2019**	
Please inform Jacqueline Clayton or Dona Wingfield of any apologies on 01525 624382 or 01525 624385 respectively or email Jacqueline.clayton@nhs.net or dona.wingfield1@nhs.net Circulation: JPC Members, BCCG Medicines Optimisation Team (not JPC members)		

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