North Central London
Joint Formulary Committee

JOINT FORMULARY COMMITTEE (JFC) – MINUTES

Minutes from the meeting held on Thursday 26 January 2017
Room 6LM1, Stephenson House, 75 Hampstead Rd

Present:	Prof R MacAllister	NCL JFC Chair	**(Chair)**
	Mr P Gouldstone	Enfield CCG, Head of Medicines Management	
	Ms P Taylor	Haringey CCG, Head of Medicines Management	
	Mr A Dutt	Islington CCG, Head of Medicines Management	
	Ms R Clark	Camden CCG, Head of Medicines Management	
	Ms K Landeryou	Patient Partner	
	Dr C McGuinness	Patient Partner	
	Dr R Urquhart	UCLH, Chief Pharmacist	
	Dr R Sofat	UCLH, DTC Chair	
	Dr M Kelsey	WH, Chair DTC	
	Dr S Ishaq	WH, Consultant Anaesthetist	
	Mr S Richardson	WH, Chief Pharmacist	
	Mr A Shah	RNOH, Chief Pharmacist	
	Ms W Spicer	RFL, Chief Pharmacist	
	Prof A Tufail	MEH, DTC Chair	
In attendance:	Mr J Minshull	NCL JFC, Support Pharmacist	
	Mr A Barron	NCL JFC, Support Pharmacist	
	Ms I Samuel	RFL, Formulary Pharmacist	
	Ms A Fakoya	NEL CSU, Assistant Director Acute Services	
	Ms H Mehta	NMUH, Formulary Pharmacist	
	Ms S Sanghvi	NICE, Clinical Fellow	
	Dr F Bennett	UCLH, Registrar	
	Mr P Bodalia	UCLH, Principal Pharmacist	
	Dr A Bakhai	RFL, Consultant Cardiologist	
	Dr N Goyal	NMUH, Consultant Endocrinologist	
	Ms M Kassam	MEH, Formulary Pharmacist	
Apologies:	Prof L Smeeth	NCL JFC Vice-Chair	
	Mr B Sandhu	NEL CSU, Assistant Director Acute Services	
	Mr C Daff	Barnet CCG, Head of Medicines Management	
	Mr G Kotey	NMUH, Chief Pharmacist	
	Dr P Hyatt	NMUH, DTC Chair	
	Dr S Shaw	RFL, DTC Chair	
	Ms K Delargy	BEH, Deputy Chief Pharmacist	
	Ms L Reeves	C&I, Chief Pharmacist	
	Prof D Robinson	UCLH, Consultant in Respiratory Medicine	
	Mr T James	MEH, Chief Pharmacist	
	Dr A Stuart	Camden CCG, GP Clinical Lead Medicines Management	
	Dr V Thiagarasah	Enfield CCG, GP	
	Dr R Fox	RNOH, DTC Chair	
	Dr R Kapoor	UCLH, Consultant Neurologist	

2. Meeting observers

Prof MacAllister welcomed Mr Richardson (WH, Chief Pharmacist) as a new member of the Committee, and welcomed Ms S Sanghvi back as a visitor to the meeting.

3. Minutes of the last meeting

These were accepted as accurate.

4. Matters arising

4.1 Inhalers for COPD

Prof MacAllister met with Dr Restrick (Lead Consultant for the London Respiratory Network) to discuss the strategy for managing the number of new inhaler devices in COPD. Dr Restrick was supportive of maintaining a restricted range of inhaler devices on the NCL Formulary to minimise the time required to retrain individuals on new devices, but highlighted the importance of having more than one inhaler type available for each drug/combination of drugs to ensure clinicians are able to meet patient needs when they struggle with a particular inhaler type. Dr Restrick will attend the February 2017 meeting to present the Adult COPD Inhaler Choice guideline.

5. Declarations of relevant conflicts of interest

There were no declarations of interest.

6. Local DTC recommendations / minutes

6.1 Approved by local DTC

DTC site	Month	Drug	Indication	JFC outcome
BEH	Sep-16	Aripiprazole LAR	Schizophrenia in patients already on oral aripiprazole.	No action – already on NCL Joint Formulary
C&I	Oct-16	Paliperidone LAI 3 monthly (Trevicta®)	Schizophrenia in patients with demonstrable non-compliance with the monthly depot.	Added to NCL Joint Formulary
RFL	Nov-16	Cabozantinib (FOC, Early Assessment Program)	Relapsed Renal Cell Carcinoma	RFL only
RFL	Nov-16	Nanoliposomal irinotecan (FOC)	Metastatic pancreatic cancer	Decision deferred
RFL	Nov-16	Riociguat (post trial compassionate access)	Chronic Thromboembolic, Pulmonary Hypertension and Pulmonary arterial hypertension	RFL only. Routine funding for CTEPH; PAH is not funded[†]
UCLH	Nov-16	Ferinject	Iron deficient anaemia in Obstetrics	Added to NCL Joint Formulary – individual Trust to make local decisions on parenteral iron
MEH	2008	Bevacizumab	Neovascular glaucoma (single-dose intravitreal) as an adjunct to panretinal photocoagulation	Added to NCL Joint Formulary[‡]

[†] Riociguat has previously been reviewed by the RFL DTC for use in CTEPH and approved in accordance with the NHSE clinical commissioning policy. A subsequent review in November 2016 for use in PAH was undertaken and approved as compassionate access (free of charge supply) for continuation in patients enrolled in a clinical trial (RESPITE), due to complete in December 2016. The compassionate access approval would be in place until an NHSE commissioning policy is issued.

Post-meeting update; NHSE published the clinical commission policy (16055/P) in January 2017 concluding that riociguat will NOT be routinely commissioned for PAH. Any proposed usage outside of the compassionate use agreement will require review by JFC / RFL DTC.

[‡] Bevacizumab for neovascular glaucoma is standard of care at MEH (since 2008) and RFL (since 2010) as adjunct to panretinal photocoagulation (PRP), predating the NCL Joint Formulary. Due to the expansion of

ophthalmology services at NMUH, NMUH suggested this be brought to JFC for discussion. Prof Tufail informed the Committee that a single dose of bevacizumab provided short-term reduction of neovascularisation and intraocular pressure (IOP). The reduction in IOP may reduce pain in the eye and facilitate PRP which may further reduce the requirement for pressure lowering surgery. Bevacizumab is low cost (approximately £30 per injection) and is included in tariff. The Committee agreed a single intravitreal injection of bevacizumab used as adjuvant to PRP was indeed standard of care for this indication. Bevacizumab (single dose) for neovascular glaucoma was therefore added to the NCL Joint Formulary.

6.2 Approved under evaluation (or an audit of outcomes requested by DTC)

DTC site	Month	Drug	Indication	JFC outcome
RFL	Dec-16	Ketoconazole	Metastatic hormone refractory prostate cancer (third-line and beyond)	Approved under evaluation at RFL*
UCLH	Nov-16	Blinatumomab	Relapsed or refractory Philadelphia negative B-precursor acute lymphoblastic leukaemia (ALL)	Approved under evaluation at UCLH

* Ketoconazole for metastatic hormone refractory prostate cancer (third-line and beyond) is relevant to multiple Trusts in NCL. Experts from other centres expressed uncertainty as to the overall benefit in the specified population. The supportive evidence for ketoconazole predates abiraterone which is used early in the management of metastatic hormone refractory prostate cancer. Ketonconazole and abiraterone have similar mechanisms of action therefore it is unclear if a patient who had failed abiraterone would benefit from ketoconazole. RFL plan to evaluate outcomes after 10 patients, or 1 year, whichever is sooner. The Committee agreed that experts in NCL should be consulted to advise on which outcomes would be most relevant for this audit (e.g. QoL, PSA, adverse effects) and request the RFL collect these outcomes. RFL would present the results from this evaluation period within 1 year.

Actions: Mr Barron to ask experts across NCL to establish which outcomes should be collected by RFL. Ms Samuel to present the results from this evaluation to JFC.

7. New Medicine Reviews

7.1 Vernakalant for new-onset atrial fibrillation – Pilot of 20 patients (Applicant: Dr A Bakhai, RFL)

The Committee discussed an application for a pilot study to use vernakalant as first-line therapy for rapid conversion of new onset atrial fibrillation (AF) to sinus rhythm (SR). It was noted that vernakalant received a CHMP positive opinion 2011 and was planned for review by NICE in May 2011 [GID-TAG428], although this was suspended as the manufacturer delayed the launch of the product in the UK.

Flecainide, amiodarone and vernakalant can be used for pharmacological cardioversion. The European Society of Cardiology recommends flecainide or vernakalant for patients *without* structural heart disease, and amiodarone or vernakalant for patients *with* structural heart disease. Flecainide and vernakalant both work quickly; however amiodarone requires admission for a 24 hour infusion via a central line.

The Committee reviewed the active-comparator evidence for vernakalant which was limited to one study vs. amiodarone (n=254). Adults patients with AF for <48 hours, who were eligible for cardioversion and were haemodynamically stable were included. Results showed significantly more patients met the primary endpoint of conversion within 90 minutes with vernakalant than amiodarone (51.7% vs. 5.2%; p<0.0001). SR was maintained for 4 hours in the majority of patients who achieved this endpoint (98.6% vs. 100%). Results from an analysis that was not pre-specified showed conversion rates within 4 hours was also superior with vernakalant (54.4% vs. 22.6%, p<0.0001). Trial limitations included inadequate description of both randomisation and blinding, and concerns over the generalisability to the local population. Amiodarone is known to have an onset of action >6hrs therefore the time cut offs used in the primary endpoint favoured of vernakalant.

With regards to safety, the incidence of related serious AEs with vernakalant was higher in the vernakalant group than in the placebo group (2.1% vs. 0.3%). A trial with safety as the primary outcome was discontinued due to one patient in the vernakalant arm experiencing clinically significant hypotension. A safety observational study is due to report in December 2017. Vernakalant costs £348 compared to approximately £5 for either flecainide or amiodarone. Central line administration of longer duration amiodarone however requires central line and cardiac monitoring during the 23 hour infusion

and this cost may be avoided if vernakalant was successful in amiodarone indicated patients. Funding for the pilot had been secured from the Friends of Barnet Charitable Trust.

Dr Bakhai explained AF was a difficult area for unified guidance and lacked large scale evidence based data other than in the field of anticoagulation. The data on Vernakalant is still not of definitve weight and only shows early stage promise. He also informed the Committee that admissions for AF have increased significantly; contributing factors were admissions for echocardiograms (echo), required for many patients before flecainide administration, and for 24hr amiodarone infusions. Vernakalant does not require an echo and is rapid to administer therefore may reduce admissions and length of stay. Patients who cardiovert before 24hrs with CHADSVASc score of 0 would not require anticoagulation for 8 weeks to facilitate an out-patient cardioversion. Those with higher CHADSVASc scores would still require usual consideration of anticoagulation. The pilot is specifically to use vernakalant as first-line pharmacological cardioversion in the A&E setting and expects to recruit 20 patients in 2 months. The pilot would only operate during normal working hours. Dr Bakhai intends to utilise the facilities within the Barnet Coronary Care Unit and adjacent Diagnostic Catheterisation Day Unit and provide post-discharge contact / follow-up.

Vernakalant success patients would not need subsequent out-patient cardioversion if patients remain in sinus rhythm in the first 30 days. The committee also suggested a phone call follow up of patients at 24-48 hours to see if patients remained in sinus rhythm symptomatically.

In camera, the Committee reviewed the Bart's Health NHS Trust 'Acute Atrial Fibrillation' guideline which confirms an echo is not required for all patients. The requirement to perform cardiac monitoring for 2 hours post vernakalant would likely require an admission from Resus therefore a reduction in admission rate may not be realised. The ESC guideline and absence of superiority data for vernakalant vs. flecainide confirmed flecainide remained a relevant treatment for this indication. There was concern about the low conversion rate, approximately 50%, which limits the usefulness of vernakalant. Furthermore, vernakalant would not avoid the cost of an echo, but enable the echo to be performed in the outpatient setting.

In summary, the Committee agreed there was a cohort of patients with recent-onset AF in whom pharmacological cardioversion was indicated and structural heart disease could not be excluded in A&E without an echo. For these patients, vernakalant may facilitate rapid cardioversion and early discharge therefore the Committee approved the pilot. Vernkalant would not be added to the NCL Joint Formulary.

Decision: Approved under evaluation (RFL only)
Prescribing: Secondary care only
Tariff status: In tariff
Funding: Friends of Barnet Charitable Trust
Fact sheet or shared care required: No
Audit required: Yes

Action: Prof MacAllister, Ms Spicer and Dr Bakhai to develop the data-collection form prior to the commencement of the pilot. Dr Bakhai to present the data back to JFC following the 20 patient pilot or within 1 year, whichever comes first.

7.2 Thyrotropin alfa for patients requiring ablation (Applicant: Dr N Goyal, NMUH)

The Committee discussed an application for thyrotropin alfa (Thyrogen), a recombinant human thyroid stimulating hormone (rhTSH), that can be used to stimulate uptake of iodine into the thyroid in patients with differentiated thyroid cancer undergoing radioiodine ablation or to detect thyroid remnants. It was also indicated to stimulate serum thyroglobulin (Tg) production from remnant thyroid cancer. In this indication it increased the sensitivity of thyroglobulin as a biomarker to detect residual cancer in patients who have undetectable Tg levels on thyroid hormone suppression therapy.

The basis for use of this drug in the requested application was that a high TSH is required to allow uptake of iodine into the thyroid tissue, which can be achieved via two possible methods: thyroid hormone withdrawal (THW) or administration of exogenous rhTSH. THW in patients without a thyroid gland will induce hypothyroid symptoms, whereas administration of rhTSH allows the patient to remain euthyroid.

The UCLH DTC has previously approved the use of rhTSH for ablation and detection of thyroid cancer remnants for *patients unable to safely withdraw levothyroxine therapy* (2011). This might be because of symptoms of hypothyroidism, or patients might have co-morbidity, e.g. unstable heart failure. An alternative is to use T3, since its shorter half-life compared to T4 meant that the duration of THW would reduce form 4 to 2 weeks, which might be more tolerable for certain patients.

The present application follows the 2014 British Thyroid Association Guidelines for the Management of Thyroid Cancer, where there is a 'recommendation' that rhTSH is not restricted to where THW is considered to be problematic. It was noted that use of T3 or rhTSH in place of T4 withdrawal would result in considerable cost to the local health economy. It was also noted that the American Thyroid Association proposes rhTSH as an alternative to THW in a cohort of patients: patients with significant morbidity (medical or psychiatric conditions that could be exacerbated by hypothyroidism) or where there is an inability to mount an adequate endogenous TSH response with THW.

The Committee discussed the findings of Mallick *et al (n=421),* who aimed to demonstrate the non-inferiority of rhTSH to THW in achieving ablation success, and concluded that rhTSH (success rate 87.1%) was non-inferior to THW (success rate 86.7%) with an absolute difference 0.4% [95% CI -6.0% to 6.8%], within the 10% pre-determined non-inferiority margins. Although improved quality of life with rhTSH use compared to THW was demonstrated in the SF-36 domains used (physical functioning, emotional problems, social functioning, energy/fatigue), given the open-label study design the results were accepted with some care due to the inherent risk of bias when interpreting subjective findings.

A small double-blind, placebo-controlled cross-over study was conducted by Nygaard *et al* (n=56) to assess the differences in quality of life by using either rhTSH or THW. Patients were randomised to receive either T3 treatment with rhTSH for the two days before radioiodine treatment before ablation, followed by placebo tablets and injection before a radioiodine measure 4 to 6 months later, or vice versa. Quality of life was improved in two of the four domains of the SF-36: social functioning (+7.2, p=0.008) and mental health (+6.6, p=0.02). Physical symptoms and psychological symptoms were improved with rhTSH use compared to THW, when measured on a VAS (-14/100 [p=0.004] and -10/100 [p=0.02] respectively). Although the study was not powered to detect a difference, the authors reported that THW was associated with a significantly lower TSH than observed with rhTSH (median serum TSH 56mU/1 vs. 88mU/1, p<0.001).

The Committee noted the significant cost impact from this treatment with two doses of rhTSH costing £583 + VAT. As rhTHSH is not classed as a PbR high cost drug, Acute Trusts will have to meet the cost of this intervention from activity tariffs. Patients will also require at least two extra hospital appointments to receive rhTSH; one Trust is using PbR tariff code KA06B to administer this drug, which is associated with a charge of £1,042 + MFF to commissioners. Assuming 140 patients per year receiving two appointments, this will have a commissioning budget impact of £291,760.

Dr Goyal explained to the Committee that rhTSH has been demonstrated to be equally efficacious to THW, but is useful to protect patients from hypothyroid side effects. A subset of patients with follicular cancer are more likely not to mount a response to the THW approach, perhaps because metastases are also producing thyroxine, therefore rhTSH would provide an improvement in their care.

In camera, the Committee questioned the variation in practice across NCL patch. Furthermore, there was concern that usage at UCLH was greater than the previous DTC approval, potentially creeping towards more widespread use.

In summary, although the Committee accepted rhTSH was as clinically effective as THW, there was uncertainty that the small and potentially variable improvement in THW related side-effects was justification for the significant cost increase. The Committee agreed with the UCLH DTC decision that rhTSH should be available for patients who cannot *safely* discontinue their levothyroxine therapy either due to physical or psychological illness.

Decision: Approved for patients unable to discontinue levothyroxine therapy due to physical or psychological illness
Prescribing: Secondary care only
Tariff status: In tariff
Funding: Hospital
Fact sheet or shared care required: No
Audit required: No

Action: Mr Minshull to liaise with clinicians at UCLH to understand driver for recent increased use of rhTSH. Ms Samuel to liaise with specialists at RFL to identify how they are using rhTSH in practice. Mr Minshull to summarise above for JFC if divergent from decision.

7.3 Ropivacaine for total hip replacement (THR) and total knee replacement (TKR) (Applicant: Mr J Donaldson, RNOH)

The Committee discussed an application for ropivacaine, a long-acting, local anaesthetic agent, to be administered as a single dose in an off-label manner as a local infiltration during THR and TKR surgery. This application was received from RNOH, where levobupivacaine is currently in use. It was noted that this practice is also standard of care at Whittington Hospital (ropivacaine) and at UCLH (levobupivacaine).

The applicant at RNOH wishes to switch to ropivacaine to reduce CNS and cardiac side effects, and to make administration easier. The Committee noted that ropivacaine is from the same drug class as bupivacaine and levobupivacaine, and was developed as an S(-)-isomer (like levobupivacaine) to reduce CNS and cardiac toxicity compared to bupivacaine.

The Committee considered systematic reviews of studies looking at the effectiveness of local infiltration of local anaesthetic agent in THR and TKR. The findings of Marques *et al* were discussed, noting that the 33 included studies had numerous differences as they used three different local anaesthetic agents (ropivacaine, bupivacaine, and levobupivacine), compared both types of surgery, and used various comparators. It was noted that ropivaciane was the agent most frequently quoted in systematic review, though Marques *et al* did not attempt to pool studies by intervention agent used. The Committee noted that in THR, pain scores at 24 hours (at rest and during activity) were lower for the infiltration group that for the control groups. A smaller reduction in pain scores was noted at 48 hours. TKR pain scores were lower at 24 hours and 48 hours in the infiltration arm compared to the control arm. TKR opioid consumption was reduced when patients received local anaesthetic infiltration. The Committee was satisfied that there may be some impact on length of stay in hospital, which was reduced by an average 0.83 days, though noted this may be driven by other elements of a patient's care. When compared to use of epidural, length of hospital stay may be reduced by an average of 2 days.

A second meta-analysis, Seangleulur *et al*, was also discussed, as it provided a more recent analysis of studies of infiltration analgesia in TKR. At 24 hours, pain was significantly reduced when infiltration analgesia was administered as compared to administration of placebo or no drug/placebo. Pain at 48 hours was not significantly reduced by anaesthetic infiltration. Considerable heterogeneity between studies was noted. Opioid consumption at 24 hours was noted to be reduced, but consumption at 48 hours was not affected. Length of stay was reportedly reduced by approaching one day when local anaesthetic infiltration was used.

The Committee noted the Patient Partner's comments that pain management options will need to be individualised to the patient; for example some patients may want to receive epidural pain control.

The committee discussed the potential risks associated with this intervention. It was noted that it represents an unlicensed use of the local anaesthetic agents, though the Committee has approved use of ropivacaine wound infiltration in the past. The application calls for use of a combination of ropivacaine with epinephrine and ketorolac; this is consistent with previous studies, but represents unlicensed use of the drug. Mr Shah asked for further confirmation that this combination is likely to be stable.

Accidental intravascular injection of local anaesthetics is thought to be the main cause of systemic toxicity, though because the hip and knee are not highly vascular areas, inadvertent intravascular administration is not considered a high risk. Infection of the joint was reported in 0.5% of TKR patients in one paper, though the majority of these patients had also had post-operative intra-articular catheter placement. No systemic toxicity was reported in the studies.

The applicant was not present to answer questions, but Dr Ishaq provided information about the WH use of this intervention. Analgesic strategy is discussed with patients before surgery. She reported that the surgeon administers this drug at the end of surgery. Use is associated with faster mobilisation.

In summary, the Committee was satisfied that this intervention was an effective option for the management of post-operative pain following TKR or THR. Although the joint reconstruction surgeons wish to use this intervention in the majority of cases, multi-modal pain control options should always be agreed in conjunction with the patient.

Decision: Approved pending confirmation of stability
Prescribing: Secondary care only
Tariff status: In tariff
Funding: Hospital
Fact sheet or shared care required: No
Audit required: No

Actions: Mr Minshull to confirm stability of ropivacaine, ketorolac and epinephrine combinations

8. Guidelines

8.1 Calcium + vitamin D supplementation for the prevention of osteoporotic fragility fractures

The Committee approved the guideline which was developed by UCLH and RNOH and reviewed by relevant stakeholders across NCL Acute Trusts and CCGs.

8.2 Bisphosphonates holiday

Mr Minshull presented a paper on deprescribing bisphosphonates in certain patients with osteoporosis. The discussion was triggered by the recent publication of NICE Guideline 56, which recommends that patients that have had at least 3 years of bisphosphonate therapy should be advised that there is no consistent evidence of either further benefit from continued treatment, or of harms from discontinuing. This advice is inconsistent with the National Osteoporosis Guideline Group, which recommends reviewing alendronate, risedronate and ibandronate after 5 years, and reviewing zoledronic acid after 3 years. It was noted that patients should continue to receive calcium and vitamin D supplementation when bisphosphonate therapy is withdrawn.

The evidence base considered by NICE in the development of this guideline was of studies powered to detect a change in bone mineral density (surrogate marker), rather than fracture rate (a patient focussed hard outcome measure) which was used in the NICE meta-analysis to demonstrate the lack of clinical impact from stopping bisphosphonate.

Mr Minshull explained that advice had been sought from clinicians at Dr R Keen (RNOH) and Dr J Lee (UCLH). Dr Keen noted that NICE had not taken account of the fact that patients in Black *et al* (2006) had received a mean of 5 years of bisphosphonate before having it withdrawn; therefore treatment with oral bisphosphonate for 5 years would be more in fitting with this evidence. Furthermore, following withdrawal of risedronate, bone markers and BMD appear to change more quickly, therefore this should be considered when monitoring patients "off-treatment". Zoledronic acid should be reviewed after three years of treatment.

Clinicians performing this review need to be able to identify if a patient is ineligible for discontinuation because they remain at high risk of fracture despite bisphosphonate therapy. Dr Keen highlighted the lack of consensus on what constitutes "high / moderate" risk, but acknowledged that the NOGG definition of high risk would seem reasonable to follow. If this is done by DXA scan, logistics and additional costs need to be accounted for.

The Committee were unable to determine whether a patient would be considered high risk due to continued treatment with corticosteroids. Whilst initial steroid therapy is associated with increased osteoclast activity, prolonged use is associated with osteoclast apoptosis and reduced osteoblast activity. For this reason, Dr Keen recommended that patients on long-term steroids should also have their bisphosphonate treatment reviewed.

Finally, Dr Keen advocated a need to monitor and agree on when to restart treatment if it has been deprescribed. If this is using DXA scan, this is likely to need repeating after 1 to 2 years (if risedronate stopped) or after 2 to 3 years (if alendronate stopped). Biochemical markers could also be used to guide decision making.

In summary, the Committee supported the rationale for reviewing bisphosphonates therapy after a specific time period and offering a break from treatment for low-risk individuals. However, it noted that more work was needed to agree how 'low-risk' patients are identified and how they are followed-up during the treatment break. Agreement on how to manage patients that experience a fracture during their treatment break needs to be achieved.

Decision: Deprescribing of bisphosphonates was not supported due to uncertainties on how to categorise low / moderate / high risk and how to ensure patients who have stopped therapy would be monitored

Action: JFC position statement on stopping and restarting bisphosphonate treatment to be developed.

8.3 Medical Management of Stable Angina pathway

The NCL angina pathway from 2013 was based on the existing NICE CG126 'Stable angina: management'. The NCL pathway had expired therefore an update was required. The update incorporated minor changes only; newly cross referencing the NCL lipid modification guidance and warning of the contraindication of concurrent ACEi and sacubitril/valsartan use. The Committee approved the update.

8.4 BRVO Pathway

The BRVO guideline had been updated to incorporate the NICE TA for first-line aflibercept (Eylea®). The Committee approved the update.

9. JFC Conduct Survey

Mr Minshull presented a summary of the JFC Conduct Survey that was carried out in November 2016. As a result of the survey, the Terms of Reference have been updated to clarify how members can work to ensure the Committee continues to work well. As the Committee relies on the attendance of external clinicians to support decision-making, members were reminded of the importance of introducing themselves before asking a question, and of ensuring seating are kept available for visitors. To reduce the printing burden, JFC Support Pharmacists were asked to produce slides containing key facts for presentation at the meeting.

Action: JFC Support to trial presenting selected evaluations on PowerPoint® to support decision-making. The additional administrative burden should be noted.

10. Guidance on being a Patient Partner

Ms Landeryou presented this guidance that had been developed jointly by the JFC Support and JFC Patient Partners. The purpose of the guidance was to support Patient Partners in fulfilling their role, and to clarify this role to other Committee members. The Committee approved the guidance.

11. Terms of Reference update

Following the outcome for the JFC Conduct Survey, the Terms of Reference had been updated to outline the roles and responsibilities of the JFC Chair and Vice Chair. The Committee approved the update.

12. JFC Work plan

This item was included for information only. Any questions should be directed to Mr Barron.

13. Next meeting

Thursday 23rd February 2017, Room 6LM1, Stephenson House, 75 Hampstead Rd.

14. Any Other Business

Nil