AREA PRESCRIBING COMMITTEE MEETING
Birmingham, Sandwell, Solihull and environs
Minutes of the meeting held on
Thursday 10th September 2015
Birmingham Medical Institute, 36 Harborne Rd, Birmingham, West Midlands B15 3AF.

PRESENT:

Dr Lisa Brownell	LB	BSMHFT (chair)
Alan Pollard	AP	Birmingham Women's NHS FT
Alima Batchelor	AB	Birmingham South Central CCG
Brian Smith	BS	The ROH NHS FT
Carol Evans	CE	HEFT NHS FT/Solihull CCG
Elizabeth Walker	EW	Sandwell & West Birmingham CCG
Inderjit Singh	IS	UHB NHS FT
Isabelle Hipkiss	IH	Midlands & Lancashire CSU
Dr John Wilkinson	JW	Solihull CCG
Jonathan Horgan	JH	Midlands & Lancashire CSU
Mark DasGupta	MD	Birmingham CrossCity CCG
Nilima Rahman-Lais	NRL	Solihull CCG
Dr Pallavi Latthe	PL	Birmingham Women's NHS FT
Prof Robin Ferner	RF	Sandwell & West Birmingham Hospitals NHST
Sangeeta Ambegaokar	SA	Birmingham Children's Hospital NHS FT
Satnaam Singh Nandra	SSN	Birmingham CrossCity CCG
Tania Carruthers	TC	HEFT NHS FT
Dr Timothy Priest	TP	HEFT NHS FT
Tony Green	TG	Patient representative

IN ATTENDANCE:

Patricia James	PJ	Minute taker, Midlands & Lancashire CSU

No.	Item	Action

0915/01 **Apologies for absence were received from:**

- Dr Paul Dudley, Birmingham CrossCity CCG
- Mandy Mathews, NHS England
- Dr Neil Bugg, Birmingham Children's Hospital NHSFT
- David Harris, Birmingham Community Healthcare NHST
- Prof. Jamie Coleman, UHB NHSFT
- Kate Arnold, Solihull CCG

0915/02 **Items of business not on agenda** (to be discussed under AOB)

- Midodrine (TC)
- Venue for the APC (IH)
- Chapter 11 Update (IS)

0915/03 **Declaration of Interest (DoI)**

The chair reminded members to submit their annual declarations to the APC Secretariat. She also asked the committee to declare any interests that may be relevant to the business to be discussed on the agenda.

MD and AB declared their interest in naloxegol (listed under NICE TA). Both attended an advisory board.

0915/04 **Welcome and Introductions**

The chair welcomed those present to the Area Prescribing Committee. In view of a new attendee representing the Birmingham Children's' Hospital, introductions around the table were carried out. LB also reminded the members present that, in line with policy, the meeting was digitally recorded for the purpose of minute taking and that, once the minutes were approved, the recording is deleted by the APC secretary.

0915/05 **Minutes of the Meeting held on Thursday 9th July 2015**

The minutes of the meeting of 9th July 2015 were discussed for accuracy. The minutes were approved with no further amendments and the recording of the meeting was to be deleted.

0915/06 **Matters arising – Action Table**

The chair turned to the action table for discussion. See appendix 1 for updated action table.

Discussions around action points are detailed below:

0715/06 Matters Arising – Action Table

- Investigate alternative delivery of/access to APC documents than email attachments and report back. See update below.

Update: IH summarised a recent demonstration of "Office 365" and suggested this could offer a solution to the problem of delivering and accessing APC documents without burdening email inboxes with sizeable attachments. This is Microsoft's cloud – based set of productivity tools which

allows file- sharing and multiple contributors to a single document, which would simplify the process of collating comments and manage version control. It is also accredited to store and communicate data securely up to the UK Government's Impact Level 2 classification, which secures patient identifiable data. Although this would not be a concern for APC documentation.
The majority of members appeared keen, although there were some concerns raised around Acute Trusts' IT policies, (in particular HEFT) and JH stated the CSU would be happy to liaise with individual IT leads to resolve any issues. Office 365 can be run on Internet Explorer 9 and above or Google Chrome.

Action: CSU to summarise proposal in an email to enable Trust leads to scope out the IT requirements/ restrictions of their organisations. **CSU**

0715/07 NICE TAs

- Schedule review of NOACs for October Meeting

Action: Move NOACs review to November APC meeting agenda and email out papers **IH/PJ**

0715/09 Feedback from APC Away Day – 26.06.15

- Report prescribing data on PF eye drops as percentage of total eye drops to APC secretary by 31.08.15 to be reviewed in September. **Ongoing**
  Update: only received data from BMEC to date

ACTION: **Trust leads**

- **Trust leads to send prescribing data to APC secretary asap**
- **Move to September Away day agenda** **IH/PJ**

- Specialists to come back to APC with consensus of opinion from Trust's glaucoma colleagues on second line agent (with preservative) bimatoprost OR travoprost
  Update: IH received an email from Lucy Titcomb, Lead Ophthalmic Pharmacist, Birmingham & Midlands Eye Centre (BMEC) confirming that the view of the pan- Birmingham glaucoma specialists was that, as per NICE guidelines, all the options should remain available. RF suggested that the response should be that since they were unable to make a decision on the second line agent, the APC decided on their behalf and chose the less expensive agent travoprost. **Closed**

Action: Draft response to glaucoma specialists informing them of APC's decision to use less expensive agent travoprost. LB will sign off as chair. **IH/LB**

0915/07 **Operational Issues**

- Draft minutes from management/ development meeting

JH advised that a Management/ Development meeting took place on Thursday 13th August between CSU team, Chairs and Lead CCGs members, to discuss operational / management issues. Subject to the Committee's approval today, it is proposed to make this a more formal meeting, to be held 2-4 times a year and to circulate minutes of these meetings to all members. Declarations/ conflicts of interest were discussed at length and how these

could be better managed. It is proposed to set up a separate sub-group, chaired by a lay person, whose remit would be to independently assess any conflicts/ declarations of interest of members and one-off attendees to ensure transparency. Draft TOR will be formulated for this sub group and emailed to members for comments. IS was concerned that there was no representation from Secondary Care and that this was moving away from the initial vision of the APC being a joint primary care/secondary care committee. MD pointed out that he is happy for any other member to join this management / development meeting but that the reason for not inviting Trust leads was that the CSU provide operational oversight and responsibility for running this APC, and this is commissioned by the CCGs. The purpose of this sub-group was to address process issues that may trip up the smooth running of this committee and take time away from discussing the core business. Any output from this sub-group would come to the whole committee for approval, and any decision rests with the APC committee.

RF reinforced the need for any specialist attending APC meetings, be it to present a new drug application or to support a harmonisation discussion/ review to complete a "declaration of Interest" form before the meeting. Any refusal to do so will be reported to the GMC. It may be helpful to draft a note for presenting clinicians to outline the requirement to submit a declaration of interest form.

RF pointed out that on ***Page 2 0815/5(Dev) – Operational Issues – MIR in support of drug applications;*** the last line of this paragraph reading "rather than the consultant" should be changed to "as well as the consultant". JH and MD agreed this was an unintentional mistake. All members agreed with this change. There was some further discussion around Medicines Independent Reviews (MIR) to supplement drug applications and the role of the pharmacist presenting this evidence review, and agreed this would feed into the decision support tool (DST). The chair reminded the members that drug applications should not be presented to the APC without the support of the Trust's D&TC.

Action: Draft TOR to be drawn up and circulated to members for comments **JH/CSU**

- Process for ESCAs ad RICaDs

The draft process and timescales for development of RICaDs and ESCAs paper was discussed. TC commented that with NICE TAs, there could be a delay in starting the process due to the timing of the APC meeting and used the cancelled August meeting as an example. JH stated that the process could be started before the next available meeting to avoid any delays, even if this was abandoned once discussed at APC. RF felt that Draft 0.3 "consultation of draft 0.2 with ***Acute*** clinicians should be changed to read "**wide** consultation of draft 0.2 with ***relevant primary and secondary care clinicians.*** Members were in agreement.

Action: Amend wording on draft document to reflect agreed changes for ratification at October meeting **IH/CSU**

- Addition of certain medicines subject to positive NICE TA to the formulary immediately upon publication

Draft timescales for addition of certain medicines subject to positive NICE TA to the formulary paper was discussed.

IH summarised the rationale for putting this paper together: although the policy states that, if adopted, NICE TAs will be implemented as soon as is practical and within 90 days, the fact that the APC formulary is not updated until discussed at the next available meeting was leading to confusion between the commissioners and providers around funding timescales. . IS reminded the members that unless a drug was on the PbR excluded list there was no funding associated with it (i.e. within tariff) and the Trusts would need to confirm the RAG status before publishing on APC website. TC also felt that the words "no implementation required" or "requires implementation" were not helpful. "No specific support/tools required for implementation" or "Specific support/ tools required for implementation" would be more appropriate. MD confirmed that the intention was to not delay hospitals using NICE approved drugs, and that if no infrastructure was needed to be in place to successfully use the drugs, funding would be available from day 1.
IS's thoughts were that points 1 and 2 should be brought together into one sentence as the outcome was the same for both. Wording "**fund from day 1**" should be changed to read "fund from **whenever the hospital is able to provide the drug**".
In conclusion, the sentences will read:
For all Primary Care commissioned drugs with a positive NICE TA:

1. For hospital only drugs, funding will be available from whenever the hospital is able to provide the drug. This will allow for any specific support that may be required for implementation. The drug will be added as RED status within 7 days of TA publication.
2. For any drug that may be prescribed in Primary care, funding will be available after the first APC meeting following publication once the RAG status, supporting documentation and implementation have been approved, within 90 days. The drug will be added to the formulary as GREY within 7 days of publication, and RAG status revised once discussed at APC

Action: Amend wording on draft document to reflect agreed changes for ratification at October meeting **IH/CSU**

0915/08 **Feedback from meeting with Birmingham Children's' Hospital**

LB reported that a formal discussion had taken place on Monday 7th September with Dr Neil Bugg , (Clinical Service Director, Surgical Care Birmingham Children's Hospital Foundation Trust), the joint chairs, AB, JH and IH which proved both informative and positive. He confirmed after discussions that it was appropriate for BCH to be represented at the APC and that although he himself may not always be available, BCH will have representation at all future meetings.

0915/09 **NICE Technology Appraisals** (TAs)

IH discussed the content of the formulary adherence checklist for NICE TAs published in July and August 2015.

Secukinumab in psoriasis (TA350) - agreed RED status, available via

Homecare.

Naloxegol for opioid-induced constipation (TA345).
Use in Primary care commissioned by CCGs, use in Secondary care will be within tariff as not PbR excluded.
AB stated she was disappointed by the NICE recommendation that naloxegol could be considered what she regards as quite early in that the patient had to have used at least one laxative for up to 4 days. The trials were against placebo and there was no indication that the patients had received what is considered gold standard treatment i.e. start 2 laxatives at therapeutics doses at the same time as the opioid. She advised caution with regards to RAG status and its place in therapy. CE enquired if there had been any interest from secondary care clinicians, the Trusts leads were not aware of any to date. TP commented that he had a number of patients on opioids with unresponsive constipation despite therapeutic doses of laxatives.

The chair suggested that the drug be added to the formulary as GREY and that, in view of the full agenda and time pressures, this be brought back to the October meeting to allow a full discussion to consider where as a health economy we would like to see this positioned. IS requested that the NICE TA 345 be circulated with the papers for October meeting.

Dexamethasone intravitreal implant in DMO (TA349)- agreed RED status
Aflibercept in DMO (TA346)- agreed RED status
Vedolizumab in active Crohn's after prior therapy (TA352)- agreed RED status

Edoxaban in DVT/ PE (TA354)
It was felt that RAG rating should be AMBER with a RICaD, in line with other NOACs on the formulary. RICaD to be developed; CSU is the appointed medicines lead.

Actions:

- **Add 6 drugs to formulary as per minutes** **IH**
- **Add naloxegol to agenda for October meeting, and circulate NICE TA 345 with meeting papers** **PJ**
- **Produce draft 0.1 of RICaD for edoxaban** **CSU**

0915/10 **Trust Chairs non Formulary approvals**

The chair confirmed that UHB NHS FT has submitted their recent non formulary approvals. No further submissions have been received. AP mentioned that he does have a list from D&TC chairs for The Women's Hospital. TC and LB also confirmed that they would send recent non formulary approvals for their respective Trusts to the APC secretary.

Action: Email Trust Chairs non formulary approvals to APC Secretary **AP/LB/TC**

0915/11 **Eslicarbazepine ESCA – revised** (final draft for approval)

IH outlined the revisions made to the ESCA as agreed at the June meeting. i.e.: remove monitoring requirements, include statement re eslicarbazepine should only be considered following referral to a tertiary care specialist and after oxcarbazepine has been tried, additional step for approval i.e. approval by Trust's DTC or equivalent decision making body. LB reminded the members that a tertiary care specialist could be a neurologist with a special interest in epilepsy to whom other neurologists would refer complex epilepsy patients.

MD queried the use of the word "prolongations" under cautions, 5th bullet point. It was agreed to reword as "prolonged PR interval has been observed".
NRL enquired about the use of shaded boxes under drug interactions. SSN confirmed these were significant drug interactions; NRL suggested this should be made clear.

Also on page 3. DTC approval box should be moved as a separate section and the wording "I confirm that the DTC of this Trust has approved the use of eslicarbazepine in this patient" needs to be inserted.
Subject to these amendments, the ESCA for eslicarbazepine is approved.

Action: Make final amendments to document and publish on APC website **IH**

0915/12 **Mycophenolate in connective tissue disease ESCA**

IH reminded the members that UHB FT currently have this drug listed as RED, it is within tariff and therefore does not need an application to come to APC. However, the Trust requested that the APC members consider whether this drug would be appropriate for shared care and submitted a draft ESCA to support the transfer of care.
Mycophenolate is used widely and successfully in trusts for the long term treatment of conditions such as lupus and vasculitis and is standard practice. Patients with stable disease do not need to keep attending out -patient clinics to obtain supplies of this medication.

JW thought the guidance on monitoring within the ESCA was vague in terms of the duration of monitoring as both the SPC and BNF suggest monitoring for the first year only, however this is not clear in the ESCA.

MD confirmed that mycophenolate is only licensed for prophylaxis of acute transplant rejection, is RED on the formulary and the SPC states this should be initiated and maintained by appropriately qualified transplant specialists, but acknowledged that this SPC was quite dated.

SSN recalled Mycophenolate being discussed as part of Chapter 8 harmonisation, but was not brought up during Chapter 10 review as it was not listed in Trusts' formularies. CE explained this was probably due to its unlicensed status. However it was confirmed it was standard practice and included in the national guidance (British Society for Rheumatology guidelines).

MD agreed it could be added as RED in Chapter 10 for connective tissue

diseases, but was concerned the majority of GPs would be uncomfortable taking on the prescribing, and the Trusts would be inundated with “decline to prescribe “forms. BS agreed this could be supplied in DMARD clinics by independent non-medical prescribers (senior pharmacist or nurse).
RF highlighted that 3 questions need to be considered; a) how unsafe is this drug b) how does it compare with other drugs such as MTX which GPs are already prescribing c) is it true these patients will be seen in hospital anyway for clinical review and therefore do not need to make additional visits just for blood tests.
RF suggested asking Dr P. Jobanputra (Rheumatology, UHB) these questions.
JH also mentioned that this shared care document was based on a previous version which was used as part of a local enhanced service with specially trained GPs, and therefore more comfortable taking on the clinical responsibility.

It was decided that the drug should stay RED until further clarification was received from Rheumatologists.
Action:

- **Seek clarification from Rheumatologists on 3 questions raised by RF, as well as clarity on monitoring requirements after 12 months.** **IH**
- **Add to Chapter 10 as RED drug for connective tissue diseases** **IH**

0915/13 **BNF Chapter 5: Infections**

IH went over the BAAG actions from the July meeting. All RED remove drugs have been changed to RED. After lengthy discussions with Rakhi Aggarwal (Interface pharmacist, BCC CCG) it was felt that the antimicrobial chapter was fundamentally a guideline as well as a formulary as it directs primary care clinicians to select the most appropriate antimicrobial in line with good locally agreed antimicrobial stewardship. There needs to be clear identification of first line/ second line options. IH proposed to add text to make it clear that the yellow colour for second line does not reflect the AMBER of APC formulary and requires no interventions from secondary care.
The guidelines are set out in condition order (e.g. upper respiratory tract infections, eye infections) as opposed to BNF sections (e.g. penicillins, macrolides etc.) so it was proposed to remove any drug included in the guideline from the RAG rated document as all will be GREEN by default. , and only RAG rate the remaining drugs.

JW commented that from a GP’s perspective the layout of the guideline was useful and clear. TP commented however that this would not be relevant to Secondary care clinicians who just wanted to know the formulary status of a drug.

It was agreed therefore to list all the GREEN drugs in the current formulary format with hyperlinks to Antimicrobial guidelines.

Chapter 5 was therefore approved.

MD highlighted an error on page 9 of the antimicrobial guidelines, under pivmecillinam, the duration of treatment for men should just read 7 days, and the words ”stat in women” to be deleted.

IH also pointed that, on page 9, the comment about fosfomycin support documentation is no longer required as a licensed preparation is now available.

RF highlighted a number of typos (page 5 should read Rhinosinusitis) and proposed some amendments to the Guidelines. SSN pointed out that the text was directly from the HPA guidance.

Actions:

- **Correct typos in guidelines documents.** **IH/RA**
- **Insert all green drugs back in RAG rated table and publish on APC website** **IH**
- **Link GREEN drugs to Primary Care Antimicrobial guidelines** **IH**

0915/14 **Utrogestan drug application: supporting documentation requested in June 2015**

LB reminded the members of the discussion in June 2015 and referred to an extract from the minutes:

The APC were of the view that Green was not appropriate given the cost and the potential for creating wider use of a product that has a smaller place. It may be more appropriate as AMBER with a defined place for the therapy. It was agreed that AP would contact Miss Lynne Robinson (Consultant Obstetrician and Gynaecologist, Birmingham Women's NHS FT) to review the application and develop a clearer protocol. The APC decision was deferred.

The decision tree prepared by BWH clinicians was discussed. LB confirmed that this decision tree would be used in Secondary care, reassuring GPs that if they were asked to pick up prescribing of Utrogestan a protocol had been followed; the decision tree was not for use in Primary Care.

Members suggested a couple of corrections: remove comma after medroxyprogesterone in second box, change text in box 2 and box 5 to read "norethisterone **and** medroxyprogesterone.
NRL queried the large cost figures; it was confirmed this was the monthly cost for 400 patients.

MD commented that the decision tree was in fact a RICaD (giving assurance to GPs that a process had been followed).

RF queried the place in the decision tree of the family history. PL confirmed that in the presence of a strong family history of breast cancer (e.g. BRCA1 and BRCA2 gene mutation), Utrogestan would be offered first line, i.e. earlier in the pathway.

It was agreed to develop a RICaD to incorporate a revised decision tree.
MD requested a revisit of the evidence around the first line use in women with strong family history of breast cancer.

Action:

- **Develop a RICaD and incorporate a revised decision tree** **AP/PL**
- **Resubmit evidence around first line use in patients with strong family history of breast cancer.** **AP/PL**
  Bring back to November meeting **IH/PJ**

0915/15 **HRT and OC review:** prescribing data analysis and evidence review documents

IH commented that the CSU had only been able to access prescribing data for 2 CCGs, and aware that there are 5 CCG members. The aim of the prescribing data tables was to identify the most commonly prescribed OC and HRT preparations but also give an idea of the costs associated with these. BWH had previously stated that they had no preference on which products were included on the formulary and supported the use of the preparations with lowest acquisition cost. However they were keen to keep a defined list of products due to their use for other clinical indications.
There was a discussion around generic prescribing, and it was noted that HRT and OC are prescribed more by brand due to patient familiarity. Branded generics were considered a cost effective option.
It was acknowledged that more time was required to harmonise these sections of the BNF and that CCG prescribing data could be used alongside Trust formularies to guide the formulary choices. LB suggested bringing this back at the December meeting. PL suggested adding the family planning prescribing data to the mix. Family planning clinics are currently provided by UHB.

Action:

- **Collate CCG and family planning clinics prescribing data and add to harmonisation process.** **IH/CCG /Trust leads**
- **BWH to send details of drugs to remain on formulary for specific indications (other than HRT and OC)** **AP/PL**
- **Bring back to December Away day** **IH/PJ**

0915/16 **Tapentadol:** letter from Industry

IH tabled copies of a letter from Grunenthal which highlighted their concerns over the potential impact the comments recorded in the minutes of the May meeting may have on patients taking or just started on tapentadol.

NRL commented that the minutes of the APC meetings are records of clinical discussions held on a broad scale, and although these are in the public domain, patients should not make decisions on their treatment based on comments recorded in meetings but should discuss any concerns with their prescriber. It was agreed that this statement should be added to the home page of the APC formulary website.

The committee members confirmed that the minutes were an accurate record of the discussions at the May meeting. The committee has now considered the points raised in Grunenthal's letter, however, this has not changed its decision.

All copies of the letter were returned to IH for shredding.

Action: Draft a response to Grunenthal; circulate to members before Chair's sign off. **JH/CSU**

0915/17 **Any other business:**

- Midodrine – Chapter 2
  TC – This is currently RED on the formulary, this was based on it being only available as an unlicensed preparation. As a licensed formulation is now available, TC was enquiring on the steps needed to review this RAG status, with a view to changing to AMBER. Members agreed an application was required.

Action: Submit as a new drug application for consideration. **TC**

- Venue for the APC
  IH stated that the October meeting would be the last one held at the BMI as it was relocating to the Chamber of Commerce premises. The 3 best alternate venues are:
  1. The Birmingham Research Park, Vincent Drive, Edgbaston – this is located adjacent to the main University campus and is only a few minutes' walk from the University station. This has ample parking. This would be our preferred venue option.
  2. The Birmingham Chambers of Commerce – located over the road from the BMI, again with parking.
  3. Menzies Hotel, Hagley Road (formerly the Strathallan) – limited parking is available.

Once a decision has been made this will relayed by email to members.

Action: Email out new venue once confirmed to all members **IH/PJ**

- Chapter 11Update

IS enquired on the timescale for the circulation of the revised Chapter 11 document following the June away day. IH stated that this had to be completely reformatted into BNF sections as it was originally listed in alphabetical order. SSN confirmed this will be completed by Friday 18th September. IH also pointed out that SSN had worked extremely long hours over a considerable period to rewrite the 46+ ESCA's and RICaDs to be able to upload them in first week of August. She went onto thank him on behalf of the members for all his hard work.

Action: Email Chapter 11 – Eye to APC Members by 18.09.15 **SSN/IH**

The chair thanked the members for their input today. The meeting closed at 16:23 pm

Date of next meeting
Thursday 8th October 14:00 – 16:45
Birmingham Medical Institute,
36, Harborne Road, Edgbaston B15 3AF
Solomon Wand Room, 1st Floor.

Please note this will be the final meeting at The Birmingham Medical Institute due to its relocation.

ACTION TABLE

Minute number	Description	Action by	Date due	Status at 17/09/15
0915/06	**0715/06 Matters arising- Action Table -** • CSU to summarise proposal in an email to enable Trust leads to scope out the IT requirements/ restrictions of their organisations. **0715/07 NICE TAs** • Move NOACs review to November APC meeting agenda and email out papers **0715/09 Feedback from APC Away Day – 26.06.15 (on-going)** • Trust leads to send prescribing data (PF eye drops) to APC secretary asap • Move to September Away day agenda • Draft response to glaucoma specialists informing them of APC's decision to use less expensive agent travoprost. LB will sign off as chair.	**CSU** **IH/PJ** **Trust Leads** **IH/PJ** **IH/LB**	**08/10/15** **01/10/15** **21/09/15** **21/09/15** **24/09/15**	**Open** **Open** **Open** **Open** **Open**
0915/07	**Operational Issues** <u>Draft minutes from management/ development meeting</u> • Draft TOR to be drawn up and circulated to members for comments <u>Process for ESCAs ad RICaDs</u> • Amend wording on draft document to reflect agreed changes for ratification at October meeting <u>Addition of certain medicines subject to positive NICE TA to the formulary immediately upon publication</u> • Amend wording on draft document to reflect agreed changes for ratification at October meeting	**JH/CSU** **IH/CSU** **IH/CSU**	**01/10/15** **01/10/15** **01/10/15**	**Open** **Open** **Open**
0915/09	**NICE Technology Appraisals (TAs)** • Add 6 drugs to formulary as per minutes • Add naloxegol to agenda for October meeting and circulate NICE TA345 with meeting papers • Produce draft 0.1 of RICaD for edoxaban	**IH** **PJ** **CSU**	**17/09/15** **01/10/15** **24/09/15**	**Open** **Open** **Open**
0915/10	**Trust Chairs non formulary approvals** • Email Trust chairs non formulary approvals to APC secretary	**AP/LB/TC**	**29/09/15**	**Open**
0915/11	**Eslicarbazepine ESCA – revised (final draft for approval)** • Make final amendments to document and publish on APC website	**IH**	**08/10/15**	**Open**

Minute number	Description	Action by	Date due	Status at 17/09/15
0915/12	**Mycophenolate ESCA** • Seek clarification from Rheumatologists on 3 questions raised by RF, as well as clarity on monitoring requirements after 12 months • Add to chapter 10 as RED status	**IH** **IH**	**24/09/15** **17/09/15**	**Open** **Open**
0915/13	**BNF Chapter 5: Infections** • Correct typos in guidelines documents. • Insert all green drugs back in RAG rated table and publish on APC website • Link GREEN drugs to Primary Care Antimicrobial guidelines	**IH/RA** **IH** **IH**	**24/09/15** **24/09/15** **24/09/15**	**Open** **Open** **Open**
0915/14	**Utrogestan drug application** • Develop a RICaD and incorporate a revised decision tree • Resubmit evidence around first line use in patients with strong family history of breast cancer. Bring back to November meeting	**AP/PL** **AP/PL** **IH/PJ**	**25/10/15** **25/10/15** **05/11/15**	**Open** **Open** **Open**
0915/15	**HRT and OC review:** prescribing data analysis and review documents • Collate CCG and family planning clinics prescribing data and add to harmonisation process. • BWH to send details of drugs to remain on formulary for specific indications (other than HRT and OC) • Bring back to December Away day	**IH/CCG/Trust leads** **AP/PL** **IH/PJ**	**14/10/15** **14/10/15** **21/10/15**	**Open** **Open** **Open**
0915/16	**Tapentadol:** letter from industry • Draft a response to Grunenthal; circulate to members before Chair's sign off.	**JH/CSU**	**24/09/15**	**Open**
0915/17	**Any other business** <u>Midodrine – Chapter 2</u> • Submit as a new drug application for consideration <u>Venue for the APC</u> • Email out new venue once confirmed, to all members <u>Chapter 11 Update</u> • Email updated Chapter 11 (Eye) to APC members	**TC** **IH/PJ** **SSN/ IH**	**TBC** **01/10/15** **18/09/15**	**Open** **Open** **Open**

UPDATED ACTION TABLE FROM PREVIOUS MEETING

0715/06	**Matters arising- Action Table** • IH to circulate final drafts of ESCAs and RICaDs • Members to relay comments to secretariat on any documents that should NOT be uploaded by 23rd July • Upload documents to APC website by first week in August • Investigate alternative delivery of / access to APC documents than email attachments and report back in September- see action under 0915/06	IH All IH JH	 10/09/15	Closed Closed Closed Closed
0715/07	**NICE TAs** • NICE TA adherence checklist: update RAG status of formulary entries • Schedule review of NOACs for October meeting- see new action under 0915/06 • Rifaximin RICaD: make final amendments and publish on website • Send final version to MM to share with Worcestershire Trust and CCGs	IH CSU team IH IH	 08/10/15 	Closed Closed Closed Closed
0715/09	**Feedback from Away Day, 26th June 2015.** • Add all actions from Away day to action table • Report prescribing data on PF eye drops as percentage of total eye drops to APC secretary by 31st August to be reviewed in September. see new action under 0915/06 • specialists to come back to APC with consensus of opinion from Trust's glaucoma colleagues on second line agent (with preservative)- bimatoprost OR travoprost • Simbrinza application- in process at SWB- bring to APC once considered • Circulate Dry eye disease: Ocular lubricants draft guideline • BMEC to investigate suitability of sod. Hyaluronate 4% multidose (Clinitas) and report back to APC • Inform LT and SR that new drug applications are required for any new ocular lubricants and other products to be considered for addition to formulary • Loteprednol- RICaD to be developed by BMEC • Send template RICaD to LT • Annotate formulary entry for dexamethasone as SDU • Add statement to formulary regarding antioxidant vitamins and eye lid wipes • MM to liaise with IH on list of CDF drugs to annotate on formulary	IH Trust Leads (incl BMEC) Glaucoma specialists BMEC IH BMEC IH BMEC IH IH IH MM	17/07/15 31/08/15 TBC TBC 16/07/15 TBC 17/07/15 TBC 17/07/15 31/08/15 31/08/15 17/07/15	Closed Ongoing Closed Open Closed Open Closed Open Closed Open Open Closed
0715/10	**COPD- applications for 6 new inhalers** • Inform Respiratory network consultants of APC decisions • Publish DSTs, update formulary.	IH IH	16/07/15 23/07/15	Closed Closed

0715/11	**BNF Chapter 5 – Antibiotics** • Change all RED remove to RED, unless not recommended at all, in which case BLACK. • Review colours to identify first line and second options in Primary Care Antimicrobial Guidance, and avoid duplication of RAG rating colours to avoid confusion. • Clarify differentiation between specialist / infection specialist in comments column. • Change wording to "in line with Primary Care antimicrobial guideline" instead of "formulary". • Confirm RAG status of benzathine benzylpenicillin, cefotaxime, and ceftriaxone injections.	BAAG BAAG BAAG BAAG BAAG		Closed Closed Closed Closed Closed
0715/12	**New drug application: Niquitin oral strips 2.5mg** • Inform clinician of APC decision • Publish DST, update formulary	IH IH		Closed Closed
0715/13	**Insulin degludec RICaD** • Make final amendments and publish	IH		Closed
0715/14	**Lidocaine 5% plasters- draft RICaD** • Comments on draft RICaD to be emailed to APC secretary	**All**	**27/08/15**	**Open**
0715/16	**Any other business** • **Circulate dates of APC meeting for 2016**	APC secretary	23/07/15	Closed
0615/03	**Declaration of Interest** • Members to submit their annual declaration for 2015/16 to APC secretary	**ALL**	**09/07/15**	**On-going**
0615/06	**Matters arising- Action Table** • Circulate by email CSU's review of HRT and OC to members (BNF section 6.4.1.1.) • Once received from Dr North, send copy of draft Grazax RICaD to Col Wilson and Dr Huissoon, Immunology (HEFT) **Update:** Dr North has sent guideline for immunotherapy selection for use in grass allergen policy, rather than RICaD. Resend RICaD template to Dr North and relay comments from APC members	IH **IH**	 **16/07/15**	Closed **Open**
0615/11	**New drug application: Utrogestan caps 100mg** • Liaise with Miss L Robinson regarding the utrogestan application and develop a decision tree.	AP	10/09/15	Closed/ On agenda
0615/12	**Eslicarbazepine:** • Circulate revised ESCA to APC members for ratification	IH	30/07/15	Closed

0615/13	**Generic sildenafil for digital ulceration** • add generic sildenafil for digital ulceration to APC formulary as RED status. Update: agreed to publish in Chapter 10 (Rheumatology)	**IH**		**Closed**
0615/14	**Stiripentol- transfer from BCH to UHB** • to be followed up in discussions with BCH	**Chairs/AB/JH**	**TBC**	**Open**
0615/16	**Ciclesonide evidence review:** • IH to request further evaluation from the Respiratory Network/Col Wilson.	**IH**	**18/06/15**	**Closed**
0615/15	**Any other business: Mycophenolate use in connective tissue disease** • **Circulate draft ESCA prepared by UHB NHS FT**	**IH**		**Closed/ On agenda**
1214/03	**Declaration of interest** • APC secretary to amend circulation list (remove 5 members) **Update:** LB to contact the Birmingham Children's Hospital regarding representation. **Update**: AB and JH have had discussions with BCH. LB to contact JH and AB to discuss next steps.	**LB**		**Closed**