AREA PRESCRIBING COMMITTEE MEETING
Birmingham, Sandwell, Solihull and environs
Minutes of the meeting held on
Thursday 10th March 2016
Venue – Birmingham Research Park, Vincent Drive,
Birmingham B15 2SQ – Conference Room A

PRESENT:

Dr Lisa Brownell	LB	BSMHFT (Chair)
Dr Paul Dudley	PD	Birmingham CrossCity CCG
Alima Batchelor	AB	Birmingham South Central CCG
Dr Neil Bugg	NB	Birmingham Children's Hospitals NHSFT
Dr Timothy Priest	TP	HEFT NHS FT
Jonathan Horgan	JH	Midlands & Lancashire CSU
Mark DasGupta	MD	Birmingham CrossCity CCG
Prof Robin Ferner	RF	Sandwell & West Birmingham Hospitals NHST
Satnaam Singh Nandra	SSN	Birmingham CrossCity CCG
Kalpesh Patel	KP	Midlands & Lancashire CSU
Carol Evans	CE	HEFT NHS FT/ Solihull CCG
Elizabeth Walker	EW	Sandwell & West Birmingham CCG
Tania Carruthers	TC	HEFT NHS FT
Inderjit Singh	IS	UHB NHS FT
David Harris	DH	Birmingham Community Healthcare NHST
Dr Reshma Gandecha	RG	Midlands & Lancashire CSU
Sulthana Begum	SB	ROH NHS FT
Gemma Holder	GH	Birmingham Women's NHS FT

IN ATTENDANCE:

Patricia James	PJ	Minute taker, Midlands & Lancashire CSU
Miss P Pradhan		HEFT NHS FT (for item 0316/08)
Shabanna Ali	SA	Sandwell & West Birmingham CCG (observer|)

No.	Item	Action

0316/01 **Apologies for absence were received from:**

- Prof Jamie Coleman, UHB NHS FT
- Kate Arnold, Solihull CCG
- Mandy Matthews, NHSE
- Nigel Barnes, BSMHFT
- Dr Sangeeta Ambegaokar, Birmingham Children's Hospitals NHS FT
- Isabelle Hipkiss, Midlands & Lancashire CSU
- Alima Batchelor to join the meeting later.

0316/02 **Items of business not on agenda** (to be discussed under AOB)

- Office 365 issues – CSU
- Wound Management – SSN/CSU
- Rotigotine in RLS HEFT/CSU
- Fostair NEXThaler®–CSU
- Public patient representative – advert/replacement- CSU

0316/03 **Declaration of Interest (DoI)**

Declarations of Interest are on file for all attending the meeting.
The APC secretary confirmed that the consultant presenting the new drug application for Esmya® had submitted a form indicating no interests to declare.

0316/04 **Welcome and Introductions**

The chair welcomed everyone to the meeting. Introductions were undertaken for the benefit of new attendees.

The chair reminded everyone present that, in line with policy, the meeting was digitally recorded for the purpose of minute taking and that, once the minutes are approved, the recording is deleted by the APC secretary.

0316/05 **Minutes of the meeting held on Thursday 11th February 2016**

The minutes of the meeting held on Thursday 11th February 2016 were discussed for accuracy. The following amendments are required:

- Page 1: Emma Suggett – displaying incorrect initials – *change IS to ES*
- Page 4: Para 5 should read: *"Although it is very unlikely APC correspondence with Professor Haslam will prompt NICE* ***to*** *review their decision around naloxegol, it was felt it would be beneficial to get NICE thinking about better CCG involvement during technology appraisals"*

The chair confirmed that, subject to the above amendments, the minutes were approved as a true and accurate record.

A member enquired whether the dental formulary had been discussed at the last meeting as not mentioned in the minutes.

The chair stated that treatment for dry mouth preparations was discussed at the January meeting as part of Chapter 12 ratification but that the Dental Formulary as such would be discussed at a future APC meeting.

Magnaspartate® - DST for ratification

The chair asked the committee to ratify the DST for the Magnaspartate®. The members had no comments to add and agreed the content. The chair confirmed this was now ratified and can be uploaded to the APC website.

0316/06 Matters arising – Action Table

The Chair moved onto the action table for comments and updates:
(please refer to separate document for updated version)

Item 0215/05: Anal irrigations application-
Colorectal services are to be contacted to draw up a business case.

Item 0216/11: Feedback from December Away Day

It was confirmed that the CSU has emailed the dermatologists requesting clarification around the drug choices for actinic keratosis. Feedback received from one trust to date indicates Zyclara® in preference to Actikerall®. An evidence review for both agents will be prepared by the CSU for the away day in March where this topic can be further discussed in the presence of the specialists.

Item 0216/13 NOAC APC Preferred agent

The Lancashire NOAC Decision tool will be circulated once ratified at the LMMG meeting which is taking place on the same day as this APC meeting.

The consultation with haematology specialists on the proposed APC preferred agents was only initiated recently with a closing date of 23 March. The APC secretary will collate the comments in a document to be discussed at the April meeting.

Item 0216/15:Deferred items from January APC meeting (collaborative review of ADHD shared care agreement)

It was confirmed that a meeting was scheduled on the 26th April to discuss the collaborative review of current ADHD shared care documents between HEFT, Solihull and Forward Thinking Birmingham.
The chair requested that the Shared Care agreement for ADHD covers an age range for both children and adults. The collaborative review will need to include psychiatrists who manage treatment of ADHD in adults over 25 year olds.
The Chair is aware of variations in the licensed treatments for ADHD for adults over 18 years of age.

Item 0216/15 - Deferred items from January APC meeting
(Palliative care group rationale to include alfentanil and fentanyl in the SLA formulary)

The CSU contacted the Palliative care specialists in the week preceding this

meeting requesting the rationale for including alfentanil and fentanyl in the Service Level Agreement (SLA) formulary. The response stated that alfentanil and fentanyl are required for patients with renal impairment. Two clinical papers were attached to the response to support their rationale.

In the discussion which followed, it was confirmed that the proposed SLA drug list is an extended list to cover a geographical footprint larger than the area covered by BSSE APC, and that the drug list is not new but has been used in Birmingham area previously.

NHSE is looking to launch the Out of Hours Community Pharmacy SLA scheme on the 1st April 2016. Therefore it was agreed that, in order to avoid delaying this launch, the core list of drugs were approved but that a more detailed rationale for the inclusion of alfentanil, fentanyl and oxycodone (new request) was still required for further consideration.

The committee is planning to review the palliative care formulary as a whole at a future meeting.

ACTIONS:

- **Write to the colorectal services and advise that a business case is to be drawn up and submitted to the commissioners via the service development process.** **CSU**
- **Prepare evidence review for Zyclara® and Actikerall® for consideration at March away day.** **CSU**
- **Collate comments from haematology specialists from consultation on NOAC preferred agent and add to April agenda.** **CSU**
- **Feedback APC members' comments to Palliative care specialists and request more detailed rationale for inclusion of alfentanil, fentanyl and oxycodone in SLA formulary.** **CSU**

0316/07 Practicalities of ESCAs and RICaDs

The chair sought views/options around the practicalities of ESCAs and RICaDs with a view to reduce the need for the large volume of paperwork flowing between primary and secondary care (printing, scanning, emailing etc.)

The discussion which followed included the following points:

- ESCAs support complex drugs where the clinical responsibility is shared between a specialist and a GP, are not patient specific (with the exception of the last page which the GP signs to accept shared care) and require more detailed information.
- In contrast RICaDs support transfer of care and responsibility of less complex drugs which GPs may be less familiar with but are patient specific in that the specialist has to complete a number of sections with clinical results, tick boxes and supplementary information if necessary.
- The current documents are quite lengthy and could be more reader friendly with the essential information more readily accessible but taking care not to remove so much information that they no longer serve their purpose. The purpose is to facilitate the GP to take on prescribing and the clinical responsibility that it implies.
- The existing process of issuing ESCAs and RICaDs for individual

patients is bureaucratic and needs to be reviewed. Currently all ESCAs and RICaDs are uploaded on the APC website. Secondary care colleagues could be signposted to these documents via a web link.

- A committee member stated the need for version control is important.
- There needs to be an audit trail of which patients are having on-going supplies of medication from their GP under shared care. GMC and LMC have stated that ESCAs and RICaDs can only be requested and not enforced. The specialists need to be aware of cases where the GP has declined to prescribe so that there are no issues with continuity of supply.
- The current template is based on MTRAC and HEFT templates which had GP input; the members had ample time to comment on the format during the consultation on the proposed format and during the process of ratifying 50+ documents to date.
- Some GPs are not prepared to take on any prescribing whereas some are willing to take on prescribing provided appropriate guidance is provided. There is some evidence that the presence of ESCAs facilitates GPs taking on prescribing under shared care agreements.

Possible solutions were proposed :

- ESCA to have a section at the end to include the contact details and GP to sign if willing to accept shared care.
- Reduce RICaD clinical information to minimum (i.e. single side of A4 sheet, maximum 2 sides) and GP to refer to SPC and appendix for product details.

- All ESCAs and RICaDs will be available in editable PDF once the format has been agreed.
- GPs and secondary clinicians should be surveyed/ invited to comment on the format and usefulness of these documents as more likely to accept shared care if engaged in the development of these documents.

The chair concluded that this item merits more than the time allocated on the agenda and invited members to give these issues further thought.

It was agreed to continue with the existing templates until the APC members agree a revised version.

ACTION: Bring back to a future meeting to allow further thought/discussion. **CSU/ all**

0316/08 New drug application- Esmya® (ulipristal acetate) - Miss P.Pradhan (HEFT)

The chair welcomed Miss Pradhan who presented the new drug application for Esmya® (ulipristal acetate) and confirmed she has been a consultant at HEFT for around 11 years.

Ulipristal acetate is indicated for pre-operative treatment and intermittent treatment of moderate to severe symptoms of uterine fibroids in adult women of reproductive age.

Miss Pradhan presented the following points about ulipristal acetate in the new licensed indication of intermittent use:-

Mechanism of action:

- The only drug out in the market use to manage fibroids.
- Acts centrally on the hypothalamus and locally on the fibroids. It causes cell apoptosis, inhibits cell proliferation, decreasing fibroid size however does not get rid of the fibroid.
- Has a direct effect on the endometrium and a huge benefit to the patient as it stops the bleeding within 9-10 days of starting treatment.

Trials:

- There are 4 trials (PEARL I, II, III and IV) and all these trials report consistent amenorrhoea rate; reduction in menstrual blood loss and reduction in fibroid volume.
- Trials have looked at outcomes from recurrent doses of treatment. Patients who had four cycles shown consistent improvement in symptoms.

Adverse effects:

- Adverse effects include amenorrhoea which is a positive desired effect and also hot flushes reported.
- There have been some reports in literature that progesterone is associated with changes to the endometrium.

The effects are reversible and the intention is to stop bleeding pre-operatively. Alternatives include gonadorelin analogues (goserelin and leuprorelin).

Benefits: Gonadorelin analogues are injections used to down regulate the ovaries however Esmya® is a tablet form (5mg tablet daily for 3 months) which is used to stop bleeding and also, helps build up haemoglobin and iron stores before operating on these patients.

Patient selection:

- Ulipristal acetate would be used is for a select group of patients: those unfit for major surgery, concerns about surgery i.e. to prevent thrombus going through to the lungs.

- Young patient who is planning to maintain her fertility – alternative is myomectomy.
- Peri-menopausal women with bleeding close to menopause (around 50-51 years).

Not suitable for patients with fibroids within the cavity of the uterus which can be resected or for patients with large fibroids (use embolisation or myomectomy).

Local observational study: there is experience of Esmya® use for the above indication at HEFT in 134 patients who were given a 3 month course. The patients in this study were prescribed Esmya® for symptom control; a few were prescribed this to shrink fibroids so that surgery can be performed (laparoscopically or vaginally).

The chair invited questions from the members present.

A member asked about the likelihood of patients' symptoms returning to pre-treatment levels after 4 cycles of treatment over 12 months, and requiring a further 4 cycles. Miss Pradhan stated that Esmya® provides consistent symptomatic improvement and reduction in the size of the fibroids. At present treatment consists of 4 treatment cycles, however across the continent they have unlimited usage - no restrictions. There is no long term data available; therefore whether fibroids will grow back in 5 or 10 years is not known.

Miss Pradhan was asked for an estimated number of patients eligible for the proposed treatment indication compared to the formulary approved indication which is for reduction of fibroids prior to surgery. Miss Pradhan stated that 134 patients have been treated for over 18 months across the 3 sites (Solihull, Good Hope and Heartlands).A vast majority of the above cohort will require some sort of surgery (e.g. hysteroscopical removal of fibroids and some patients will have embolisation). She suggested the number would be small, say 20 patients.
This caused confusion as the application stated 200 to 250 patients, which is significantly different from 20 or 134. Miss Pradhan clarified that 200 to 250 patients refers to all patients eligible for pre-surgical treatment. The number of patients eligible for recurrent treatment is smaller selected patients. It includes (i) patients unfit for surgery who have fibroids (ii) young people who want to maintain fertility and (iii) women 51 years of age approaching menopause.

A committee member commented that iron tablets were relatively cheap, and could be used to correct the anaemia instead of the more costly ulipristal acetate. Miss Pradhan stated that giving only iron supplements in a bleeding patient is not beneficial; replacing the iron faster than it is lost is not an option. Ulipristal stops the bleeding.

Prior to ulipristal acetate, gonadorelin analogues (goserelin and leuprorelin) were used and these agents are half the cost of ulipristal acetate. Miss Pradhan stated that gonadorelin analogues are injections and they have menopausal side effects. It was pointed out that the side effects of Esmya® include hot flushes. Miss Pradhan stated the side effects were similar but less severe, and compliance was better with Esmya®.
It was questioned whether this was effective use of NHS resources considering one cycle costs £300 plus surgery which total to approximately £3500 ; Esmya® treatment costs represent 10% of surgery costs.

Miss Pradhan was asked if there was evidence/experience of recurrent treatment of ulipristal acetate resulted in avoidance of surgery. It was pointed out by a member that the outcome of trial data does not include patients going on to surgery after the recurrent dose treatment.

Miss Pradhan stated reasons are that post recurrent dose treatment there is a 30% reduction in size of fibroid and induced amenorrhoea and most patients will avoid surgery.

A member pointed out that the above recurrent dose treatment is not being used in line with the ESCA approval which was to use Esmya® for one cycle pre- operatively. There will cost implications in approving the recurrent use considering use is already happening.

The chair thanked Miss Pradhan for attending, and confirmed that the APC's decision will be relayed to her within 7 days by email.

Discussion points/concerns raised:

- The rate of regression after 12 months' treatment at £1369.56 is not clear.
- At present there is no long term data and whether patients avoid surgery after a treatment course for 4 cycles is completed.
- There is no clarity around the relapse rate hence a finasteride like effect that once treatment is stopped then symptoms will appear.
- The only cohort of patients Esmya® was relevant in Miss Pradhan's presentation was in women over 50yr of age.
- £1300 for treatment cost, recurrent treatment costs have to be taken into consideration as well as surgery cost and this may lead to £12000 in total costs.
- NICE guidance is expected in April 16 (Clinical effectiveness of progesterone receptor modulators).
  SMC has accepted ulipristal as appropriate for second-line use by the NHS in Scotland within the licensed indications.
  There was no discussion earlier with Miss Pradhan's patients using other agents like tranexamic acid.
- There was discussion whether approval of new indication was relevant for patients who are unsuitable for surgery as a treatment alternative.

The chair directed the members to the Decision Support Tool for completion

Patient safety: No long term safety data.

Clinical effectiveness: No long term effectiveness data. Moderately effective in the short term (reduction in size of fibroids and reduction in symptoms) No evidence whether surgical intervention is prevented or delayed.

Strength of evidence: Two small 20 week trials.
Cost-effectiveness or resource impact: The comparator tranexamic acid is £6.60 per month. Esmya® is approximately 17 times more expensive at £114.13 per month. There is no data from comparative/head to head trials.

Place of therapy relative to available treatments: N/A

National guidance and priorities: NICE clinical guidance on the management of Heavy Menstrual Bleeding is due April 2016. SMC has approved use 2nd line.

Local health priorities: CCG Views: Potential costs are high; therefore commissioners will challenge if use is inappropriate. Not supported

Equity of access: N/A

Stakeholder views: N/A

Implementation requirements: None

Decision summary: **Not approved**
Rationale: lack of data on safety, effectiveness and cost effectiveness. The clinician should also be reminded of the APC approved use (i.e. one cycle prior

to surgery) as there is evidence of creep beyond this approved use.

ACTION: inform Miss Pradhan of the decision of the APC as not approved.

A group member requested clarity around the remit of the APC with regards to telling secondary care organisations what they can or can't prescribe within their own premises. The chair reminded the committee that if a drug is prescribed in secondary care but will never leave the premises, the APC has no remit. Where NHS Trusts maintain prescribing of drugs for patients to take in the community outside the hospital, the APC needs only be informed so that these can be listed as RED on the formulary. However if secondary care is seeking funding from the commissioners for on-going prescribing than the APC's approval is required.
APC has also requested secondary care to inform APC about one-off use of non-formulary drugs. Non-formulary use of drugs should not be routine but for exceptional circumstances only.
Primary Care commissioners will decline to fund non-formulary use of drugs.

0316/09 NOAC RICaDs for ratification

The APC was asked to ratify three RICaDs: edoxaban in DVT/PE, edoxaban in AF and rivaroxaban post ACS.

The draft RICaDs presented now incorporate all the amendments requested to date.

The chair invited comments:

The first section for the edoxaban RICaDs states 'A copy of the checklist is enclosed'. Members requested clarity as the list below the statement is the checklist or if there is a separate checklist.

Trusts may use their own checklist; therefore it was agreed to amend the sentence to read 'See checklist below/enclosed* (*delete as applicable)' for both the edoxoban RICaDs.

The chair confirmed that, subject to the above amendments, the 3 RICaDs are ratified and can be published on the APC website.

ACTION: Finalise and upload 3 NOAC RICaDs to the APC website CSU

0316/10 Naloxegol- draft guidance

The APC secretary reported that the draft naloxegol guidance was circulated to the members on 22nd Feb and no comments had been received.

MD declared his interest as attending an advisory board for this agent.

It was confirmed that this document is for guidance only around appropriate use of this drug in-line with NICE TA, not an ESCA or RICaD. It is quite common to have guidelines attached to drugs on the formulary, however it was stated that these can sometimes have an adverse effect. It was questioned

whether this be adopted at APC or CCG level. It was felt that it was not for this committee to approve, but could be a useful document for DTCs or CCGs to base local advice on i.e. via newsletters etc. Naloxegol is GREEN on the formulary.
It was suggested to amend the table on page 1, first line, to read "not recommended in …" then circulated to members for information, but not to be published on the website.
ACTION: **Amend guidance on page 1 to read 'Not recommended in' and then circulate to members for information only.** **CSU**

0316/11 **Anthelios® XL cream** – out of pocket expenses claimed by community pharmacies

The APC approved Anthelios® XL cream in December 2015 based on low acquisition cost compared to Uvistat® and Sunsense®. However the out of pocket expenses claimed by community pharmacies to obtain this product has increased the net ingredient cost per ml significantly (two or three times more than the other products), no longer making Anthelios® XL cream a cost effective option.
Out of pocket expenses are charges claimed by community pharmacies to obtain individual products. Major wholesalers will stock most products but smaller wholesalers may need to obtain products directly from the manufacturers and levy a handling charge to the community pharmacies.

CCGs are aware of the variation in pharmacies claiming out of pocket expenses; this may sometimes result in an investigation by counter fraud.

The DST states Anthelios® XL cream has low acquisition compared to other sunscreen products, this may need to be amended. However APC decisions are made on cost effectiveness and Drug Tariff prices.

It was commented that as Anthelios® XL cream may be more widely used over the next 6 months it will become more readily available; possibly resulting in a reduction in out of pocket expenses being claimed.

However the CCGs' experience is that availability of the product or familiarity with wholesaler are not drivers to claiming out of pocket expenses.

There are other products e.g. vitamin D, tramadol which CCGs have been monitoring.
It was suggested that a more complete list of out of pocket expenses around certain drugs would be useful so that the proportion of costs attributable to these expenses can be brought to the APC's attention at a later date to ensure NHS resources are utilised appropriately for better patient care.

The members agreed that the formulary status of Anthelios® XL cream will remain unchanged and the CCGs will monitor the out of pocket expenses.

ACTION: Circulate a more comprehensive list of drugs which incur out of pocket expenses **MD**

0316/12 NICE Technology Appraisal (TAs)

There were 3 NICE TAs published for February 2016.

Two NICE TAs listed are relevant to primary care commissioning.

NICE TA 385: Ezetimibe for treating primary heterozygous-familial and non-familial hypercholesterolaemia Providers are GPs and secondary care providers (cardiologists and lipidologists). Ezetimibe is already GREEN on the formulary. The formulary status to remain GREEN.

NICE TA383 Adalimumab, certolizumab pegol, etanercept, golimumab and infliximab for treating severe active ankylosing spondylitis in adults. Primary Care commissioned drug. Providers are NHS hospitals. Members agreed status as RED on the formulary.

It was pointed out that in Sandwell, TNF- alpha inhibitors are administered at a specialist clinic in the community.

NICE TA384: Nivolumab for treating advanced (unresectable or metastatic) melanoma**.** NHSE is the responsible commissioner. As available in the NHS through the EAMS, NHS England has committed to fund this treatment within 30 days of publication. RED status

Early Access to Medicines Scheme (EAMS) for Sacubitril/valsartan:

The APC was made aware of EAMS for Sacubitril/valsartan in November 2015 and the letter stated that "CCGs and Trusts will be expected to implement the NICE TA within a 30 day period" 30 days for existing patients and day 0 for new patients. Although there is not much interest from the secondary care clinicians to date, there will be an expectation to adopt this quickly if NICE approved.

As the NICE TA is expected in May/June 2016, it would be prudent to develop a RICaD as soon as possible in view of the time taken to ratify these documents.

ACTION: Develop draft RICaD for Sacubitril/valsartan and start agreed process. **CCG/CSU**

0316/13 Trust Chairs non-Formulary approvals – For information

No information had been received from Trusts this month.

0316/14 Pregabalin/Gabapentin- ACMD advice- For information

The ACMD letter regarding pregabalin and gabapentin was circulated for information and to raise awareness. The Minister for Preventing Abuse and Exploitation has advised to make pregabalin and gabapentin a schedule 3 controlled drug. The misuse potential of pregabalin and gabapentin are well known. It was also noted that when the section for pregabalin and gabapentin was reviewed the abuse potential of these two drugs was taken into consideration. No further action is required at present.

0316/15 Decline to prescribe forms

UHB NHS FT is preparing a summary of decline to prescribe forms received to bring to the APC in the near future.

However the CSU team is aware that Trusts are receiving a significant number of decline to prescribe forms for low molecular weight heparins i.e. enoxaparin. The committee has been asked to review the RAG rating. It is important that supply of drugs like enoxaparin is not interrupted. GPs should be able to carry on prescribing. This has been raised previously as requiring a commissioning discussion.

ACTION: Add enoxaparin to next meeting's agenda. **CSU**

Any Other Business :

- **Office 365 log in issues – CSU**
  Some members are still experiencing issues with accessing documents, particularly excel spread sheets. . The CSU will look at uploading any excel documents in pdf format. It appears online excel is not good at handling multiple tables in excel spread sheets.

ACTION: CSU to upload the excel as pdf documents **CSU**

- **Wound Management working group update– SSN/CSU**

  Wound Management working group have now met with tissue viability specialists to finalise the rational for formulary choices.
  SSN stated that a microbiologist attended the January meeting to discuss the value of antimicrobial dressings. The harmonisation process was completed at the February meeting. The next step is giving rationale for formulary choices, how to use them, when to use them, how long they can remain on the wound. This is work under way with the next meeting scheduled on 15th March 2016. This meeting will be focused on the final formulary to be presented at the next meeting in April. The chair has requested the Wound Care Formulary choices to be discussed at the May or June APC meeting. A member stated that Sandwell hospital has independently carried out an evaluation and the tissue viability lead there has reviewed the effectiveness and cost of these wound dressings. The review is based on like for like dressings as well as effectiveness, including product evaluations of the dressings. The chair was concerned that there were now 2 separate groups looking at wound dressings, not engaging with each other.

  A member was concerned that the wound management working group was just considering products they were familiar with and not looking at newer and more cost effective wound care products which the tissue viability nurse at Sandwell is doing.

It was proposed that the chairs write to the working group advising the expectations of the APC that they look at cost-effectiveness as well as clinical effectiveness. Secondly one of the chairs should consider attending the meeting to reinforce and support the group.

It was agreed by the members that the APC will consider the rationale for the wound care formulary choices and this will be reflected in revised APC formulary.

It was commented that there is work under way at a national level looking at procuring dressing centrally for wound care. The tissue viability lead at Sandwell is on this national working group, so will be able to bring information back.

ACTION: Joint Chairs to write to Wound management working group in relation to APC expectations. One of the chairs should consider attending the meeting to reinforce the message and support the group. **Joint chairs**

- **Rotigotine in RLS. HEFT / CSU**

The CSU have received a query from HEFT pharmacist regarding treatment for restless leg syndrome. There is an ESCA for ropinirole in RLS but not for rotigotine patches which are also licensed for RLS. The committee was asked if this was an oversight when reviewing this section at the away day. Rotigotine was only approved in the indication for Parkinson's and not for Restless Leg Syndrome, but this would need to be confirmed by checking the away day notes and decisions.

ACTION: Check away day notes and decision around rotigotine patches for use in RLS. **CSU**

- **Fostair NEXThaler® CSU**

In December 2014 the APC harmonised chapter 3 where it was agreed Fostair® MDI would be rated as GREEN. Fostair NEXThaler® was licensed for asthma in October 2013. Fostair NEXThaler® is now licensed for asthma and COPD – price is cost effective. The chair confirmed formulary status for Fostair NEXThaler® as GREEN.

ACTION: Add Fostair NEXThaler® to the formulary as GREEN **CSU**

- **Patient Public representative recruitment**

Recruitment for the above has been advertised through the CSU channels twice and to date the CSU has not received any responses. A member suggested advertising through Healthwatch.

There is a forum called "People's Health Council" which could be considered as another possibility and it represents 2,200 patients across Birmingham.

It was confirmed that a patient representative is required.

APC to discuss at a later date to consider LMC representation

ACTION: CSU to contact "People's Health Council" and Healthwatch to advertise vacancy. **CSU**

- **Regional Medicines Optimisation Committees**

There is a letter in circulation that suggests establishment of regional medicines optimisation committees to reduce unnecessary duplication of such committees throughout the NHS. Paragraph 2 of the letter states the best way to eliminate the duplication is to have all activities carried out at regional level and to ensure any medicines evaluation is co-ordinated and shared across the 4 regions. This will free up pharmaceutical and other staff at CCG and trust level to facilitate implementation duties. The letter proposed to disband APC and Regional Drug and Therapeutic committees. For information only.

The chair thanked the members for their input today. The meeting closed at 16:41 pm

Date of next meeting:

Thursday 14th April 2016 14:00 – 16:45
Conference Room A
Birmingham Research Park,
Vincent Drive,
Birmingham B15 2SQ