AREA PRESCRIBING COMMITTEE MEETING
Birmingham, Sandwell, Solihull and environs
Minutes of the meeting held on
Thursday 11th January 2018
Venue – Birmingham Research Park
Vincent Drive, Birmingham, B15 2SQ

PRESENT:

Dr Paul Dudley	Birmingham CrossCity CCG (Chair)
Dr Lisa Brownell	BSMHFT
Prof Mark DasGupta	Birmingham CrossCity CCG
Satnaam Singh Nandra	Birmingham CrossCity CCG
Kate Arnold	Solihull CCG
Dr John Wilkinson	Solihull CCG
Dr Gwyn Harris	Sandwell and West Birmingham CCG
Tania Carruthers	HoE NHS FT
Carol Evans	HoE NHS FT
Melanie Dowden	Birmingham Community Healthcare NHS FT
Dr Emma Suggett	UHB NHS FT
Dr Angus Mackenzie	Sandwell and West Birmingham Hospitals NHSFT
Dr Sangeeta Ambegaokar	Birmingham Women's & Children's NHS FT
Yusuf Asif	Birmingham Women's & Children's NHS FT
Nigel Barnes	BSMHFT
Ravinder Kalkat	Midlands & Lancashire CSU
Isabelle Hipkiss	Midlands & Lancashire CSU
Kuldip Soora	Midlands & Lancashire CSU

IN ATTENDANCE:

Prof Wasim Hanif for item 0118/07	UHB NHS FT
Dr Parth Narendran for item 0118/07	UHB NHS FT

No.	Item	Action

0118/01 Apologies for absence were received from:

Hannah Peach, Sandwell & West Birmingham CCG
Inderjit Singh, UHB NHS FT, deputy attended
Maureen Milligan, The ROH NHS FT
Dr C. Kartsios HoE NHS FT

It was confirmed that the meeting was quorate.

0118/02 Items of business not on agenda (to be discussed under AOB)

- NICE draft dementia guidelines
- Supply issue with Colifoam® (hydrocortisone 10%)
- Supply issue with Bactroban® nasal ointment
- Definition of the term 'Specialist' with reference to initiating treatment.

0118/03 Declaration of Interest (DoI)

There are some outstanding annual declarations of interest and members were reminded to submit these at the earliest opportunity. There were no interests to declare relating to items on the agenda.

0118/04 Welcome and Introductions

The Chair welcomed everyone to the meeting today. Introductions around the table were carried out.

The Chair reminded members, that the meeting is digitally recorded for the purpose of accurate minute taking and once the minutes are approved, the recording is deleted by the APC secretary.

0118/05 Eclypse® Wound Care Group recommendation – Wound product evaluation - Advancis Medical.

It was established that there were no Declarations of Interests for Advancis Medical.
The wound product evaluation for Eclypse® was circulated with the papers for the meeting. It was established that the comparison product is Flivasorb®, currently listed as Green on the BSSE APC formulary.

<u>The Chair invited questions or comments from members. Discussion points/concerns raised included:</u>

- Under Wound Group recommendations, it is recommended that Eclypse® should not replace another formulary dressing and the rationale is that "*there is not currently any super-absorbent dressing for use under compression on the formulary*". A member highlighted that the comparison product, Flivasorb®, is on the formulary and described as a superabsorbent dressing which can be used under compression bandages, therefore this information is incorrect.
- It was proposed that the application goes back to the Wound Care Group to request clarification and to review their recommendation in light of this.

Decision Summary: Recommendation/application to go back to the Wound

Care Group Rationale: Reassess with regards to Flivasorb®.

ACTIONS:

- **Relay decision to Wound Group by 18th January 2018** **APC sec**

0118/06 UCS® Debridement Wound Care Group recommendation – wound product evaluation – medi UK Ltd

It was established that there were no Declarations of Interests for medi UK Ltd. The wound product evaluation for UCS® Debridement was circulated with the papers for the meeting. It was established that the comparison product is Debrisoft®, currently listed as Amber £££ on the BSSE APC formulary.

The Chair invited questions or comments from members. Discussion points/concerns raised included:

- The Wound group has evaluated UCS® Debridement to be better compared to Debrisoft® as it is more cost effective and it evaluated well in the community.
- They have proposed UCS® Debridement has GREEN formulary status.
- It is not recommended as a replacement product but as an alternative because Debrisoft® is used widely in acute trusts.
- A member questioned if acute trusts would not also want to use the less expensive UCS® Debridement.
- BCHC and Solihull have evaluated this product
- A member asked if, as debridement dressing, it is likely to be used in community. A member stated that it is likely that this dressing would need to be prescribed in primary care.
- A member highlighted that Secondary care are likely to procure dressings at advantageous rate due to contract pricing and should be allowed to carry on using these as long as they are not recommended on discharge.

Decision Summary: UCS® Debridement to be added to formulary as GREEN. Debrisoft® RAG status to be changed to Red to allow acute Trusts to carry on using it while implementing the formulary change. Review Debrisoft® in 6 months with a view to remove from formulary.

ACTIONS:

- **Relay decision to Wound group by Thursday 18th January 2018.** **APC sec**
- **Add UCS® Debridement to the APC formulary as Green drug.** **APC sec**
- **Change RAG status of Debrisoft® to Red. Review in 6 months.** **APC Sec**

0118/07 DMMAG recommendation on FreeStyle® Libre® monitoring system

The chair welcomed Professor Wasim Hanif (Consultant Physician and Head of Diabetes Service, UHB NHS FT) and Doctor Parth Narendran (Diabetes Consultant, UHB NHS FT) to the meeting and invited them to present the Diabetes Medicines Management Advisory Group's (DMMAG) recommendation on the FreeStyle® Libre® monitoring system.

Dr Narendran explained that FreeStyle® Libre® is a device that is worn on the arm for two weeks. It can be scanned to give a current glucose reading, it can produce a graph of blood glucose levels over a period of time (as long as a reading is taken at least every 8 hrs) and a trend can be seen.

There is currently no clinical trial showing any HbA1c benefit.

There is only one trial that was carried out in patients with good glucose control which showed that FreeStyle® Libre® improved hypoglycaemia. There is no trial in the "real world" being carried out in the UK.

Dr Narendran continued to say that the criteria for initiation and use of FreeStyle® Libre® in patients with Type 1 Diabetes is outlined in the draft recommendation and that it is in line with the RMOC recommendation, with the exception of the criterion relating those patients who require third parties to carry out monitoring and where conventional blood testing is not possible, which has not been included in DMMAG's statement.

DMMAG's recommendation also includes discontinuation criteria following assessment of patients every six months.

Dr Narendran wanted to note that, although this is not mentioned in the draft statement, if removing the FreeStyle® device results in patients self-testing more than eight times a day, the patient should be continued on FreeStyle® Libre®.

The Chair invited questions or comments from members. Discussion points/concerns raised included:

- A member asked for clarification on the discontinuation criteria "*Baseline HbA1c <7.5% and maintain at 6 months".* The member had interpreted the guideline to mean that patients with baseline HbA1c <7.5% would not have been initiated on FreeStyle® Libre® in the first instance. Dr Narendran explained that one criterion for initiation is patients who undertake intensive monitoring 8 times or more a day and some of these patients could be achieving good glucose control by doing this. These patients would be eligible for FreeStyle® Libre®. Dr Narendran gave an example of a patient testing 10 times per day achieving an HbA1c of 7% who would be eligible. Dr Narendran mentioned his earlier point again; that for these patients they would like to continue FreeStyle® Libre® and not discontinue it.
- A member asked how likely it was that a patient would be testing that many times a day. Dr Narendran confirmed that, generally, the more times a patient monitor their glucose level, the better controlled it is.
- A member commented that the DMMAG recommendation initiation criteria links in with the discontinuation criteria and that perhaps this format would make it easier for people to understand. Dr Narendran explained that they stuck closely to the RMOC criteria. The member explained that the initiation and discontinuation criteria could be tied together and presented better.
- A member drew attention to the Discontinuation criteria "*If patients are not regularly scanning, accurately interpreting and acting appropriately on bio feedback information from the Libre"* and stated that *or* instead of *and* would be more appropriate.
- A member asked if members of APC could propose some changes to the wording of the discontinuation section as discussed in the meeting and whether the presenters would consider getting these changes ratified. Prof Hanif agreed to this.
- A member asked if all DMMAG members were consulted on this proposed statement. Prof Hanif assured the committee that all members of DMMAG were invited to comment on the recommendation.
- It was acknowledged that there were a few grammatical and typographical errors that would need correcting.

- A member questioned how a 3-6 month trial period agreement was made as it was unlikely to be prescribed by hospital. Prof Hanif explained that he anticipated the recommendation would come from specialist in hospital but the prescription would be provided by primary care.
- A member asked if seasonality was likely to occur with diabetic ketoacidosis (DKA) and hospital admissions; Dr Narendran was not aware of any seasonal variation in these areas.
- A member questioned the statement that the starter pack is provided free of charge (FOC) from the company so would be provided through the specialist. The APC secretary confirmed that meter and first sensor would be provided FOC by the drug company.
- Dr Narendran stated that an app was available on android mobile phones which can scan the sensor and that the patient would not need a meter as such. This app is not currently available for IOS phones.
- A member wanted clarification on the frequency of patient review to assess continuation or discontinuation of use of this technology. Dr Narendran confirmed that patients would be reviewed every six months.
- A member asked what the rationale was for a proposed AMBER RAG rating which implies transfer from secondary care prescribing in clinics to primary care. Prof Hanif stated that a number of routes for funding are being considered and that there is still some movement with this recommendation.
- Secondary care representatives commented that a RED RAG status is unlikely to be viable. This is due to the lack of evidence, cost impact to NHS trusts and the impact on patients' access to this device. The Trusts would not be in a position to provide this product without any additional resource.
- It was confirmed that, following a request from secondary care representatives, an application for Freestyle® Libre® would need to go through secondary care's internal Drug and Therapeutic committees for consideration before its formulary status can be confirmed and whether prescribing would occur in secondary or primary care. Although the patient cohort was already clearly identified within the draft statement, it is vital that the application includes patient numbers to allow the commissioners to estimate the potential financial impact on this health economy.
- Dr Narendran explained that there has been unprecedented public demand for FreeStyle® Libre® to be made available.
- An APC interim position statement on FreeStyle® Libre® is published on the APC formulary website and should be referred to by all prescribers.
- Prof Hanif asked for a timeline for when patients can expect to be able to receive FreeStyle® Libre®. It was confirmed that it would take at least 8 weeks in view of the formulary application process.
- The clinicians were informed that the APC has some delegated authority to make decisions where there is a relatively small financial impact but this is clearly not going to be the case in this situation. APC will be able to come to a point where it can make a clinical recommendation to commissioners for consideration. The commissioners have a duty to ensure that commissioning decisions are not taken in isolation and will have to apply their prioritisation process to the recommendation from the APC.

ACTIONS:

- **A revised position statement taking account feedback given during the meeting to be drafted.** **APC sec/ DMMAG**
- **DMMAG to submit a full application form, including patient numbers, to a Trust's DTC or equivalent decision making body.** **DMMAG**

- **Any recommendation to go through commissioners' prioritisation process once patient numbers and potential financial impact has been confirmed.** **Commissioners**

0118/08 BSSE APC Opicapone ESCA – for ratification

Opicapone was approved onto the formulary following a resubmission of the application in November 2017. Opicapone was approved as Amber with ESCA, for second-line therapy to entacapone in patients who fail to respond to, or are intolerant of, entacapone in situations where apomorphine therapy has been considered.

The APC secretary commented that this ESCA was briefly discussed under matters arising in the last meeting, that only a couple of positive comments were received from a Trust and that no other feedback had been received. Although, It was agreed that the ESCA should be finalised and published, the APC secretary was aware that the document had not been available to refer to in the meeting.

The APC secretary referred members to the Decision Support Tool that was completed in November 2017.

The Chair invited questions or comments from members. Discussion points/concerns raised included:

- A member mentioned that the new online BNF has recategorised drug interactions in terms of severity of and evidence for interaction (e.g. theoretical or study) and asked if the opicapone ESCA complied with this. It was confirmed that the ESCA is compliant with the new BNF classification.
- The APC secretary asked if members considered Parkinson's disease (PD) specialist nurses as Specialists in respect of initiation of treatment. It was confirmed that they are as long as they have an Independent Prescribing qualification in this clinical area.

ACTION: **Finalise and publish Opicapone ESCA** **APC sec**

0118/09 BSSE APC Brivaracetam ESCA – for ratification

APC secretary explained that no comments or feedback has been received following the consultation with member organisations.

The Chair invited questions or comments from members. Discussion points/concerns raised included:

- A member raised concerns about the patient cohort as there is very little evidence that brivaracetam is effective in individuals that have failed to respond to levetiracetam. It was added that this group of patients are predicted *not* to respond to brivaracetam, and it was questioned why this is a criteria for initiation.
- The member went on to say that there is very little evidence that brivaracetam should be used in preference to levetiracetam in patients with psychiatric symptoms. There is very minimal evidence that brivaracetam is less likely to cause neuropsychiatric complications than levetiracetam. Furthermore, in the special precautions for brivaracetam it states that it has been reported to produce suicidal behaviour and ideation and that patients

should be closely monitored for this during treatment. It was highlighted that many epileptic patients have established psychiatric/neuropsychiatric problems so the patient cohort could potentially be quite broad leading to cost implications.

- A members recalls that during the application presentation, the clinician confirmed that brivaracetam would be used in place of another 3rd line agent (e.g. lacosamide, perampanel, eslicarbazepine or zonisamide), and as such the cost implications would be minimal. The member would therefore prefer if the ESCA excluded patients already on a third line agent to avoid the possibility of a patient being on two 3rd line agents.
- It was agreed that point 2 under specialist responsibilities should be changed to read as: "Confirm the patient has used levetiracetam (at maximum tolerated dose), responded to treatment but has documentation of intolerance" and remove the rest of the sentence referring to established psychiatric/ neuropsychiatric symptoms.
- The APC secretary confirmed that APC had requested that a rationale for patient selection be included to this ESCA.
- Feedback when initially discussed under local health priorities: CCGs are supportive if used as described in application as third line and if rationale for use over other AEDs is clearly outlined to GPs if transfer to primary care deemed appropriate.
- If brivaracetam was used in place of levetiracetam, which is often used as a second line agent, patients could potentially be on two expensive AEDs as second line and third line. There is likely to be less evidence of benefit for these third line agents but there will be cost implications. The member added that in initial discussions the consultant had stated that they were unlikely to use two third line AEDs, so this should be avoided and made clear in the ESCA.
- A member requested that the word "generally" be removed in point one of the ESCA to read "*Confirm the diagnosis of severe refractory epilepsy warranting specialist tertiary specialist input for patient who has tried three or more AEDs."*
- A member wanted clarification whether Learning Disabilities (LD) specialists could initiate brivaracetam. It was confirmed that only tertiary centre specialists could initiate treatment as defined in the ESCA.

ACTIONS:

- **Patient cohort definition to be further reviewed by APC secretary with input from members, to incorporate points raised at this meeting.** — **APC sec / Chair**
- **Revised ESCA to be forwarded to clinician for approval.** — **APC sec**

0118/10 BSSE APC Eluxadoline RICaD – for ratification

The APC secretary directed members to the MHRA Drug Safety Update Dec 2017 – Eluxadoline Risk of pancreatitis. This update was released after the RICaD was ratified at the December meeting, and asked members if this would need reviewing in light of this information.

<u>The Chair invited questions or comments from members. Discussion points/concerns raised included:</u>

- It was agreed that the RAG status AMBER with RICaD should remain unchanged.
- It was agreed that the MHRA warning should be added to the RICaD and

clearly highlighted on the front page.

- A member suggested adding alcohol history to the section on pre-treatment test results.

ACTION: Add details of the MHRA update to the RICaD for eluxadoline and publish on website. **APC Sec**

0118/11 Medicines of low clinical value – NHSE recommendations following national consultation – For discussion

Following public consultation, NHS England and NHS Clinical Commissioners published "Guidance for CCGs on items which should not be routinely prescribed in primary care" on 20th December 2017. The document makes it clear that CCGs are expected to take the guidance into account in formulating local policies.

A paper drafted by a member of the APC summarises the current position of the 18 affected products in the APC Formulary, and forms a proposal to update it so it is in line with the guidance.
The paper also briefly touches on implementation resources that are, or will become, available, and invites a discussion on how the APC can support implementation of the guidance across the Health Economy.

As with all Formulary amendments, it will be important that all clinicians working with patients who may previously have received these products are aware of the change of status, and understand the rationale for changes so they are able to respond to patient enquiries in a supportive manner. Patient information leaflets for each of the eighteen products have been developed, and whilst these have been drawn up with a primary care setting in mind, it is recommended that consideration is given to making them aware in a secondary/tertiary care environment.

The usage of most of these products in primary care is already relatively low. It is anticipated that most of de-prescribing will be undertaken in primary care, although support from secondary care may be sought in some cases. Primary care medicines teams will appreciate the support of APC colleagues in working through some specifics of the guidance.
This guidance provides an opportunity for BSSE APC to develop its role into implementation of guidance as well as development and implementation of the Formulary. In order to support this, it is proposed that each APC partner nominates a lead contact person to facilitate communication and expedite implementation of the guidance, and that APC retains this item on the agenda for regular progress reports.

<u>The Chair invited questions or comments from members. Discussion points/concerns raised included:</u>

- A member commented that as a result of the consultation there were some amendments to the recommendations from NHS England and NHS Clinical Commissioners, particularly around liothyronine.
- CCGs have to provide valid reasons for non-compliance with this guidance.
- The APC secretary highlighted that co-proxamol is not listed currently as BLACK on the APC formulary; however BLACK status with reference to guidance will be added as per the recommendation.
- A member asked whether a patient that is stabilised on a drug such as

dosulepin would be taken off this medicine. It was clarified that this document is guidance and does not supersede individual clinician decision. The recommendations acknowledge that there are exceptional circumstances where these items may still be prescribed.

- It was agreed that any drug newly assigned as BLACK status will have a link to NHSE guidance as rationale.
- Secondary care representatives commented that their respective organisations were already considering the potential impact of these recommendations and were willing to support these for the benefit of the wider health economy.
- The APC members support the recommendations made in the document.

ACTION: Update APC formulary in line with recommendations made in NHSE guidance for CCGs. **APC Sec**

0118/12 Feedback from Midlands & East RMOC

A member gave a verbal update on the discussions at the last Midlands and East RMOC meeting in early December 2017. This was their second meeting; the next meeting is scheduled for early April.

Items on the agenda for discussion included medicines optimisation in care homes, homely remedies policies for use in care home, an update on biosimilars and on antimicrobial resistance.

By the end of the meeting, RMOC members had reached a recommendation for their modus operandi for future meetings; the members need to have a clear question that needs answering, the Specialist Pharmacy Service needs to find the evidence, a draft statement should then come to the RMOC for consideration. The time in the meeting will be used to discuss and refine this statement so that it is ready for publication.

A member asked if the longevity of this APC would be affected by the work of RMOCs. The view was that APCs' role will be to act on behalf of the health economy to implement the RMOCs' recommendation, in a similar way this APC is supporting the implementation of NHSE's recommendations on items less suitable for prescribing in Primary Care.

ACTION:

- **Add RMOC update to May agenda** **APC Sec**

0118/13 Minutes of the meeting held on 14th December 2017 – for ratification

The minutes of the meeting held on Thursday 14th December 2017 were discussed for accuracy.

- Page 8: last bullet point at the bottom of the page: remove the first sentence.

It was confirmed that subject to the above amendment, the minutes are approved, can be uploaded to the APC website and the recording deleted

The DSTs for Feraccru®, Sialanar® and Invicorp® were also approved for publication.

0118/14 Matters Arising

The Chair moved onto the action table for comments and updates:
(See separate document attachment for updated version). Consider actions closed if not discussed.

The outstanding actions include:

- 1217/05- Feraccru® NDA- update: a first draft RICaD is ready for circulation and consultation.
  ACTION: Circulate draft Feraccru® RICaD for wide consultation **APC sec**

- 1217/07- Invicorp® injection NDA-Request a separate Declaration of Interest form to be filled out by Prof Hackett. Update: not received yet
  ACTION: Contact Prof Hackett to chase up DOI **APC sec**

- 1117/07- DMARD ESCAs revised format- outcome of consultation. All 3 actions are still outstanding.

- 1117/AOB- Formulary for patients in transition from paediatric to adult services- Assess differences between the paediatric formularies (BCH and HoE FT) and APC formulary. Update: Work in progress

- 1117/AOB- Formulary for patients in transition from paediatric to adult services- Pharmacists from CCGs and Trusts to meet outside of APC. Update: The meeting is yet to take place as there is a wider discussion in place between commissioners and the provider Trust's senior contracts team.

- 1017/13- Matters arising- Write to the Mental Health Commissioners outlining the APC discussions to date and frustrations at the delay in resolving the historical commissioning arrangements for ADHD and dementia services. Update: an acknowledgment has been received stating the content of the letter will be discussed with their Chief Medical Officer, Medicines Management and Primary care leads. Progress is being made in relation to ADHD, looking at a pilot scheme similar to the dementia drugs pilot. Action now closed.

- 0917/10- Oral antipsychotic drugs ESCA- queries/feedback from practices: Guidelines for monitoring developed by CrossCity CCG to support the audit to be brought to APC with a view to add as an appendix to the ESCA for oral antipsychotics. Update: It was confirmed that no such guidelines were circulated for the audit and that GPs were directed to the BNF and the ESCA for guidance on monitoring. Action now closed

- 0717/05- Nebivolol 5mg tablet- New drug application- Feedback Prof Martin's reply to APC members at next meeting. Update: Feedback from Prof Martin to be discussed at February 2018 meeting.

- 0517/09- Availability of licensed preparations for formulary products: Sod Chloride Oral Sol and acetylcysteine sachets. Secondary care clinicians to submit an abbreviated application form. Update: Remove action from this table and wait for application to come to APC.

0118/15 NICE Technological Appraisals (TAs)

In December 2017, there were 5 TAs published; one of these was not recommended by NICE (naltrexone/ bupropion combination for managing overweight and obesity (TA494), the other four are NHSE commissioned. Red RAG status was agreed for all four.

ACTION:

- **Update APC formulary with decisions on NICE TAs.** **APC sec**

Any other business:

- **NICE draft dementia guidance –** A member commented that the draft revised NICE guidance for dementia is currently out for consultation. The revised guidance suggests that acetylcholinesterase inhibitors may be initiated in primary care with regards to the first prescription; it also suggests that specialist assessment is not required. This is very different to current practice within this health economy and it is suggested that APC members consider this before the guidance is finalised. Although NICE guidance is not mandatory, it could put this health economy at further distance to what is accepted as good practice. This development would add weight to the points put forward to the Mental Health Commissioners around the disparity in commissioning arrangements around dementia.

  ACTION: Bring back to APC when final draft guidance is published. **APC sec**

- **Bactroban® nasal ointment supply issue -** UKMi has produced a memo confirming the long term disruption to supply of Bactroban® nasal ointment (mupirocin 2%), and proposes alternative agents and management options. One of the alternatives suggested is Naseptin® Nasal cream (currently Green on APC formulary), and Octenisan® Nasal gel; Octenisan® is on APC formulary in chapter 13, for MRSA skin decolonisation, if chlorhexidine sensitivity is a problem, but does not specify nasal gel. A member highlighted that Naseptin® contains arachis oil and is therefore not suitable for patients with allergy to peanuts. It was agreed to add Octenisan® nasal gel to the formulary

  ACTION: Add Octenisan® nasal gel to the formulary as 2nd line agent in MRSA decolonisation. **APC sec**

- **Colifoam® enema supply issue –** the APC secretary has been made aware of a longstanding supply issue with Colifoam® (hydrocortisone) enema. The current formulary entry for prednisolone foam enema recommends Colifoam® be used instead as Predfoam® has been discontinued and the generic prednisolone foam enema 20mg is very expensive (£187.00 for 14 doses compared to £9.33 for 14 doses of Colifoam®**).** Due to the supply issues, clinicians have no alternative but to recommend prednisolone foam enemas. A secondary care colleague fedback that Budenofalk® foam is being considered as an alternative by GI specialists. It was agreed that the current annotation to the formulary should be amended to reflect the longstanding supply issue, and that a more cost-effective alternative should be investigated.

  ACTIONS:

- **Amend current formulary annotation to reflect high cost of prednisolone foam enema, and current supply issue with Colifoam®** **APC sec**
- **Request an abbreviated application form for Budenofalk® foam enema if clinicians would wish to use as a more cost-effective** **APC sec**

alternative.

- **Definition of the term 'Specialist' with reference to initiating treatment** The APC secretary sought clarification whether heart failure (HF) specialist nurses are considered to be Specialists in terms of initiating Entresto® (sacubitril/ valsartan) for example, as required by the RICaD in place. It was agreed that provided the nurse has an IP qualification in an appropriate speciality, they are 'Specialist'. It was also confirmed that when the APC members discussed the RICaD for Entresto® in June 2016, Specialist HF nurses were approved as specialists for initiating treatment as they have an IP qualification.

The Chair thanked the members for their input today. The meeting closed at 16:55.

Date of next meeting: Thursday 8th February 2018 14:00 – 16:45
Birmingham Research Park