AREA PRESCRIBING COMMITTEE MEETING
Birmingham, Sandwell, Solihull and environs
Minutes of the meeting held on
Thursday 13th July 2017
Venue – Birmingham Chamber of Commerce
75 Harborne Rd, Birmingham, B15 3DH

PRESENT:

Dr Lisa Brownell	BSMHFT (Chair)
Dr Paul Dudley	Birmingham CrossCity CCG
Prof Mark DasGupta	Birmingham CrossCity CCG
Satnaam Singh Nandra	Birmingham CrossCity CCG
Alima Batchelor	Birmingham South Central CCG
Dr Waris Ahmad	Birmingham South Central CCG
Elizabeth Walker	Sandwell & West Birmingham CCG
Kate Arnold	Solihull CCG
Dr John Wilkinson	Solihull CCG
Prof. Robin Ferner	Sandwell &West Birmingham Hospitals NHST
Inderjit Singh	UHB NHS FT
Dr Tim Priest	HoE NHS FT
Katy Davies	HoE NHS FT
Carol Evans	HoE NHS FT/ Solihull CCG
Maureen Milligan	The ROH NHS FT
Nigel Barnes	BSMHFT
Dr Sangeeta Ambegaokar	Birmingham Women's & Children's Hospitals NHS FT
Melanie Dowden	Birmingham Community Healthcare NHS FT
Ravinder Kalkat	Midlands & Lancashire CSU
Isabelle Hipkiss	Midlands & Lancashire CSU
Jasprit Singh	Midlands & Lancashire CSU

IN ATTENDANCE:

Hanadi Alkhder (observer)	Solihull CCG
Dr Mark Pucci for item 0717/05	UHB NHS FT
Marie Orford for item 0717/06	Birmingham Community Healthcare NHS FT
Chloe Adams for item 0717/06	Birmingham Community Healthcare NHS FT
Sarah Monk for item 0717/06	Birmingham Community Healthcare NHS FT
Susan Mackie for item 0717/06	SWB CCG
Tracey Johnson for item 0717/06	Birmingham Women's and Children's NHS FT

No.	Item	Action

0717/01 Apologies for absence were received from:

Prof Jamie Coleman, UHB NHS FT
Dr Neil Bugg, Birmingham Women's & Children's NHS FT, deputy attended
Jeff Aston, Birmingham Women's & Children's NHS FT
Yusuf Asif, Birmingham Women's & Children's NHS FT
Jonathan Horgan, MLCSU
Tania Carruthers, HoE NHS FT, deputy attended

It was confirmed that the meeting was quorate.

0717/02 Items of business not on agenda (to be discussed under AOB)

- Inhalers supply in secondary care
- Quetiapine supply issues
- Management meeting in August
- RMOCs update

0717/03 Declaration of Interest (DoI)

It was confirmed that there were no outstanding DoI forms to be received from members attending the meeting. It was also confirmed that all clinicians attending the meeting had completed a DoI.
There were no other interests to declare relating to items on the agenda.

0717/04 Welcome and Introductions

The Chair welcomed everyone to the meeting today. Introductions around the table were carried out for the benefit of new attendees.

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.

0717/05 Nebivolol 5mg tablet- New drug application –

The Chair welcomed Dr Mark Pucci, Registrar in clinical pharmacology at UHB NHS FT to the meeting and invited him to present the application for nebivolol 5mg tablets.

Dr Pucci began by stating that he was representing Dr Una Martin and colleagues at the hypertension clinic at UHB. This application was for a nebivolol which, prior to the BSSE APC formulary, was used as a 4th-5th line agent in resistant hypertension. However during the harmonisation process it was decided to remove it from formulary; this was mainly due to the high cost of the 2.5mg tablets.

Nebivolol is a highly cardio selective beta-blocker; it has unique vasodilatory properties (via nitric oxide mediation) and was previously a preferred beta-blocker in resistant hypertension or in patients with multiple drug intolerances. It is acknowledged that beta-blockers are no longer first or second line options in hypertension; however this drug is also useful in atrial fibrillation and is licensed for heart failure.

There is also evidence that nebivolol has a neutral or potentially beneficial

effects on erectile function, contrary to other beta-blockers and antihypertensive agents which are often associated with erectile dysfunction (ED). Dr Pucci stated that this is an underestimated problem in hypertensive men and felt that it could benefit male patients of a specific age group. Statistically two-thirds of hypertensive males have a problem to maintain an erection. Hypertension, together with the medicines used to treat it, can exacerbate this problem which can lead to patients unwilling to continue their treatment; nebivolol would potentially help these patients and improve adherence.

Ideally Dr Pucci would like to use this drug as an option if a beta-blocker is indicated. The 5mg tablet is much cheaper than the 2.5mg tablet. Therefore he suggests that secondary care would only use and stock 5mg tablets. If a 2.5mg dose is needed then the patient would be told to split the tablet in half; the tablets are scored.

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

- A member requested clarification on the evidence underpinning the claim that nebivolol is beneficial or at least neutral on erectile function. Dr Pucci stated there are only a handful of small-scale trials where beta-blockers were compared with nebivolol. Other studies showed switching from another beta-blocker to nebivolol showed subjective improvements. Unfortunately the evidence for benefit is not very strong but more around that it doesn't make it worse.
- The member pressed on for the evidence to suggest that it doesn't make it worse. Dr Pucci referred the members to a systemic review looking at cardiovascular risk, drugs and erectile function submitted with the application which included 8 beta-blocker small scale trials with approximately100 patients each. Erectile dysfunction was not however a primary outcome and improvement in sexual function was based on follow up questionnaires.
- The member asked if the differences were clinically and statistically significant. Dr Pucci could not recall the exact figures.
- Another member stated that a trial included in the systematic review (*MR NOED study)* only showed a 3% benefit. Dr Pucci agreed that there is not enough high quality evidence.
- A member quoted the costs of bisoprolol as 75 pence for 28 days' supply making nebivolol 66.6% more expensive at £1.26 for 28 days.
- The member also suggested that a better strategy would be to use sildenafil, a phosphodiesterase inhibitor (PDE5i) which is available as a generic and not subject to SLS restrictions, to treat the ED. The member also pointed out that as it has vasodilatory properties, it may interact with nebivolol. Dr Pucci was not sure if the CCGs commissioned PDE5i for ED due to hypertension, and confirmed that the summary of product characteristics does not list an interaction between these two agents.
- A member asked Dr Pucci if bisoprolol would be the first line cardio selective beta-blocker in a patient attending clinic. Dr Pucci confirmed this as it was the only one currently available on formulary; nebivolol was previously used 1st line in men with ED until it was removed from the formulary. He stated that in cases of drug intolerance, the patient would be initiated on 2.5mg daily then titrated up if needed. The committee member was concerned that when the request for ongoing prescribing came out to primary care it would be difficult to ensure the patient was prescribed a

5mg tablet then getting them to halve it. The patient could inadvertently be switched to a 2.5mg tablet which is very expensive at approx. £30 per month, and would want to prevent this from happening. Dr Pucci stated that he and his colleagues would ensure that they would write to the GP specifying the dose explicitly.

- Another question was raised around the potential first line use should this drug be approved on the formulary. Dr Pucci stated it would only be used for men in a certain age group who would be at risk of ED and that a majority of men in this age group with comorbidities that could exacerbate ED such as cardiovascular events would be on nebivolol if a beta blocker was indicated. It was pointed out that this particular patient group wasn't clearly defined in the application.
- A member commented that a patient with resistant hypertension would also be on a thiazide diuretic and that thiazides themselves can contribute to erectile dysfunction. Dr Pucci was asked about any evidence that adding nebivolol would make any difference. Dr Pucci agreed that thiazide diuretics can cause ED, however he would need to check whether diuretics are indicated.
- A member noted that non-compliance may be the reason for resistant hypertension; Dr Pucci acknowledged compliance is an issue and the clinic would test urine to ensure medicines are being taken.
- A member asked Dr Pucci if colleagues in other trusts supported this application; he stated that colleagues at HoE FT and SWB Hospitals would welcome the addition to formulary and that MMAG at UHB NHS FT supported this application.
- A member commented that if nebivolol is added to current beta-blockers on formulary, it would be available to treat other indications such as following a myocardial infarct or heart failure (HF) and was concerned that cardiologists would be switching patients currently on bisoprolol to nebivolol. Dr Pucci stated it would be an option if compliance was an issue and that cardiologists indicated their support for addition to APC formulary.
- This could broaden its use and include significantly more patients than discussed so far. A secondary care member confirmed that their Trust supported the application as an option in men who had demonstrated ED on beta blockers, but anticipated this to a small number of patients.
- The APC secretary reminded committee members that there are currently eight beta-blockers on the formulary, one of these restricted to a specific indication. Atenolol is first line and is the least expensive; carvedilol is listed as second line. In relation to costs bisoprolol is second least expensive, nebivolol is in 4th place but if prescribed as 5mg.
- A primary care member was concerned that 5mg tablets would be changed to 2.5mg tablets, which will increase the price 20 fold. Also an advantage of using bisoprolol is the range of doses available giving the clinician more options to optimise the dose.

The chair thanked Dr Pucci for attending the meeting, answering the members' questions and advised him that the decision would be relayed within 7 days, in line with APC policy.

Further discussion points raised in the absence of the clinician included:

- Several primary care members have concerns in regards to compliance with cutting a tablet in half and risk of errors made in dosing due to poor communication. Practice staff or community pharmacists may also advise patients of the availability of a 2.5mg tablet not realising the cost implications.

The Chair directed the members to the Decision Support Tool for completion:

Patient Safety: No different to other beta blocker. Potential for confusion if dose is half a tablet. Increased risk of bradycardia and adverse effects if taken with other medicines which inhibit CYP2D6 isoenzyme. SPC does not mention interaction with PDE5 inhibitors such as sildenafil.

Clinical effectiveness: No direct comparison with bisoprolol. Evidence provided is not in patient population targeted.

Strength of evidence: Evidence of benefit or neutral effect on erectile dysfunction (ED) is weak.

Cost-effectiveness or resource impact:
Based on July 2017 Drug Tariff, 28 days' supply of nebivolol 5mg costs £1.26; this increases to £27.62 for 2.5mg tablets. Commissioners cannot guarantee that only 5mg tablets will used. Potential for much larger cohort of patients to be prescribed this drug which will have significant resource impact. Prescribing generic sildenafil to patients with ED due to beta blockers would be better use of resources.

Place of therapy relative to available treatments:
Fourth or fifth line. Already 8 beta blockers on formulary. RAG status needs careful consideration.

National guidance and priorities:
NICE CG 127 (2011) recommends the use of beta-blockers as an add-on in uncontrolled hypertension once a step-wise approach has been followed. However, beta-blockers may be used as first line for the following cohort: a) women who wish to or are highly likely to become pregnant, b) those who are under the age of 55 years and/or c) are intolerant to or contra-indicated for treatment with ACE-I or Angiotensin II Receptor Antagonists. NICE make no specific recommendations as to which beta-blocker to prescribe other than to choose one which is generic, cost effective and may be taken once-daily.

Local health priorities:
Primary care members are very concerned with keeping patients on the 5mg formulation. This does not offer as wide dose range as existing formulary options.

Equity of access: N/A

Stakeholder views:
The three local acute trusts support the application for nebivolol. A Red RAG status would incur significant costs around out-patient attendance to obtain further supplies which would limit the number of patients CCGs can fund.

Implementation requirements:
Depends on RAG status if approved.

Decision Summary: Decision deferred as committee members would require clarification on the patient group this would be used in as there has been interest from cardiologists for use in heart failure as well as patients with resistant hypertension.

Actions:

- **Relay deferred decision and rationale to Dr Pucci** **APC sec**
- **Ask Dr Una Martin to clarify the patient group this would be used in.** **APC sec**
- **Feedback Dr Martin's reply to APC members at next meeting.** **APC sec**

0717/06 Enteral Nutrition- Harmonisation of BNF section 9.4

The Chair welcomed representatives from the Dietetic group which was tasked with harmonising section 9.4 of the BNF and bringing their recommendations to the APC members.

Introductions were carried out before Marie Orford (BCHC prescribing support dietician and chair of the Dietetic group) began her presentation.

The dietetic group was brought together with representatives from each of the Acute and Non-Acute Trusts in Birmingham, Sandwell and Solihull as well as pharmacists from the respective CCGs. Each trust was requested to review a list of nutritional products, making reference to any current formularies and product use and provide a baseline position.

This was taken to the Dietetic group for discussion and harmonisation; a rationale for use was required for inclusion of each product and this was based on best practice and guidance published by NICE and British Dietetics Association.

The group also looked at cost effectiveness and clinical value. Where no clinical benefit could be found between two similar products, the most cost effective was included in the proposed formulary. Individual or personal preferences were not an option for inclusion; evidence and discussions were recorded in minutes of the dietetics meetings.

The harmonisation process focused on restricting the number oral nutritional supplements (ONS) to 2-3 products per category. These were selected based on their nutritional content, suitability for the patient group and cost effectiveness. Where two similar products were included they were made 1st and 2nd line. It was acknowledged that some Trusts have special procurement agreements which may have affected specialists' experience of using other products; however this was not taken into account. The group also looked nationally at what other primary care settings were doing and then reviewed.

All product choices within the formulary are colour coded in line with the APC RAG rating. Rationale has been given for individual products to use including nutritional content and the patient group it is aimed for.

Marie concluded by stating that this had been a great opportunity for specialist dieticians and pharmacists to come together and harmonise the formulary; this would benefit patient care and improve patient outcomes. It has also supported and promoted ongoing collaborative work between the stakeholders. The proposed formulary is a dynamic document which will be reviewed on an ongoing basis. The dietetic group has put into place a robust process to consider existing and new products as they become available, ensuring clinical and cost effectiveness. The group has already agreed to look at discharge processes and improving communication between the different care settings in the near future.
Once approved by the committee, the Trusts will be signposted to the APC

formulary to review and update their internal formularies. It was suggested that a launch event or educational events be developed to support the implementation of this section of the formulary.

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

- A number of committee members thanked the representatives of the Dietetic group for their hard work in preparing this excellent piece of work.
- A committee member stated that clinicians in primary care are not always aware when to stop these supplements and tend to carry on prescribing. There is also a potential issue of overstocking / overprescribing sip feeds to accommodate patients' varying tastes. There is a tendency to prescribe every flavour of sip feeds available to give the patient a choice; however a large number of these are left untouched in their homes leading to compliance problems.
- The dieticians replied that they have spent many years working with GPs to support the appropriate prescribing of these supplements, and recognise that GPs sometimes feel obliged to prescribe sip feeds when patients state that they have lost weight. There is an easy to use Malnutrition Universal Screening Tool (MUST), or equivalent, to ensure any ONS prescribing is appropriate and the target weight gives an indication of when to stop. They also suggest that all ONS prescribing is done on acute prescriptions and not put on repeats; this would allow review of ongoing need and check patient compliance. The dieticians would also recommend starting with minimal stock to avoid any wastage and suggest two supplements a day. The proposed first line agents are the most cost effective options.
- A member stated that on some occasions patients are discharged from secondary care/ community care without a MUST score or target weight and GPs are asked to carry on prescribing without this essential information. There was agreement that there is work to be done on discharge procedures and that there should be better communication between the different care settings with regards to ONS; the clinical reasoning should be an adjunct to the MUST score together with the expected patients outcomes.
- A member noted that the proposed formulary did not include any guidance on costs and, although the dieticians claimed to have reduced each of the categories to 1-3 agents, there is still a significant number of amber products listed and the member cannot see where rationalisation of the formulary has taken place.
- The Dietetic group representatives confirmed they have indeed removed a significant number of products and explained that they are not just standard meal replacements but are for multiple clinical indications such as rare inherited metabolic disorders, foods for special diets (e.g. PKU) and specialised infant formulas to name but a few.
- The member commented that some of these feeds are very specialised and questioned the relevance of this section of the ONS formulary to the APC and more specifically to general practice as GPs are very unlikely to come across these patients.
- The dieticians explained that these highly specialised paediatric products for rare metabolic disorders are the only treatment option for some of these children and when implemented at the earliest opportunity allow them to survive into adulthood and provide the chance to lead a normal life. These products are generally not very palatable so the formulary needs to provide a range to choose from as adhering to these diets is empirical.

- It was suggested that this section of the ONS formulary was relevant to the APC in that these specialised feeds are initiated or recommended by the specialists but GPs are often asked to pick up ongoing prescribing. Unlike gluten free products, these low protein feeds cannot be purchased from supermarkets and are only obtainable on prescriptions.
- A member wanted clarification on the section for specialised infant formulas and questioned the proposed Green RAG status for a couple of products used in cow's milk protein allergy for example. Green status implies GP initiation however the drug tariff states that these can only be prescribed on the NHS in circumstances approved by the Advisory Committee on Borderline Substances (ACBS). This requires proven allergy / intolerance to be established and implies specialist input. The dieticians acknowledged that there may be some delay in these children getting an appointment in the dietetic clinic and that in case of severe allergy GPs may need to start treatment before they are seen in the clinic. The APC member requested that the wording in the guidance be strengthened and be more directive towards a referral to confirm it is milk protein allergy and not another issue. The GP's prescription would only provide bridging until the clinic appointment.
- The member also wanted to know how long primary care would be expected to prescribe these products and would welcome clear guidance on what stage these products can be discontinued. The dietician representing the Children's hospital confirmed that these children would be under regular dietetic review and assessed for ongoing need or challenged at appropriate times depending on their symptoms. The infant formulas include age appropriate products i.e. from 1 year of age and children would be swapped to these when required. Some children may remain on formulas as an alternative to milk as opposed to those children who rely on these to provide their entire nutritional intake. This is done on an individual basis and children would be challenged at various points to determine when they can go on a normal diet.
- Marie Orford stated that the paediatric community dieticians and pharmacists from CrossCity CCG have produced some prescribing guidelines to support the practical implementation of this ONS formulary. It is ordered in a user friendly way by condition and guides the prescriber to relevant products for that condition. A member requested that this guidance be brought to the APC for ratification however it was acknowledged that the formulary needed to be approved first so that the guidance can be amended if required.
- A further request was made so that when an infant formula is stopped by the dieticians this s clearly communicated to the prescriber in primary care.
- Marie Orford stated that a new category needed to be added to the formulary where ready-made or ready to drink sip feeds would be recommended instead of powdered shakes: in cases where hygiene considerations (i.e. acute ward setting) or sanitary conditions in the community (i.e. no appropriate storage of fresh milk) would cause a risk.
- A member sought further clarification on the evidence for continuing PKU diet into adulthood as it was understood that this was only beneficial in the developmental years. The PKU society does advise continuation into adulthood but the APC would welcome evidence to support ongoing benefit. As this was not the attendees' area of expertise they would consult with their colleagues and come back to the APC with clarification.
- The dietetic group was made aware that if anything is to be added to the formulary in the future the APC would welcome their expertise in assessing the product and a recommendation coming to the committee but that the

final decision rests with the APC; this is the same process agreed for wound management products.

The chair thanked the representatives of the dietetic group for attending the APC meeting and for their helpful presentation.

Further discussion points raised in the absence of the dieticians included:

- Some members wanted reassurance that cost effectiveness had been considered in the selection of products put forward for inclusion and felt that adding the costs to the harmonised document would have been helpful. It was confirmed that the BNF cost was reviewed for all entries and where the nutritional content was the same but a product was more cost effective the dieticians were requested to review and choose the more cost effective option.
- A member commented that they would have expected more rationalisation and noted that some sections had more than 2-3 products as suggested by the dietetic group.
- There was a feeling that there were too many products for rare conditions and that having a specialist centre in the region may have introduced some bias in the draft formulary.
- Members are happy to adopt the ONS formulary as proposed by the dietetic group as a useful starting point to support primary care clinicians recognising the present lack of guidance on the APC formulary.
- However the APC would ask the dietetic group to continue to review this ONS formulary and rationalise it further to minimise the cost impact on the health economy.

Action:

- **Feedback to dietetic group that APC is happy to adopt the ONS formulary as presented with minor changes made as discussed.** — **CSU**
- **Carry out ongoing review and further rationalisation of this formulary over the next 6 months.** — **Dietetic Group**

0717/07 ESCAs – Drugs for ADHD

As discussed previously the commissioning of attention deficit hyperactivity disorder (ADHD) varies across the BSSE footprint and discussions are ongoing in some Birmingham CCGs. Solihull CCG already has shared care in place but clinicians are using out of date documents.

It was agreed therefore to bring these updated shared care documents to the APC members for review and ratification so that they would be available to clinicians where these services are commissioned.

A number of changes were put forward for the atomoxetine and dexamfetamine ESCAs such as adding the age range these were applicable to or clearly state the ages the drugs are licensed for if the plan is to be age inclusive.
With regards to dexamfetamine, the document needs to clarify what actions need to take once the patient reaches the age of 17 years.
The information on normal parameters does not need to include details for children under 6 years old.

The members agreed that these were approved subject to amendments discussed.

With regards to methylphenidate document, this requires further discussion.

Actions:

- **Make agreed changes to atomoxetine and dexamfetamine documents.** **APC sec**
- **Upload to website once finalised.** **APC sec**

0717/08 **Azithromycin-** long-term use in COPD/Bronchiectasis

The Primary Care Antibiotic guidelines are currently being reviewed by Public Health England however there has been some delay in publishing them.

Nevertheless respiratory clinicians are interested in using azithromycin long term in COPD and bronchiectasis patients who have 3 or more exacerbations per year. Unfortunately GPs are not willing to pick up ongoing prescribing without some supporting documentation and have declined to prescribe on numerous occasions.

The Birmingham Antibiotic Advisory Group (BAAG) has therefore developed some guidelines and a RICaD to support the respiratory use of long term azithromycin to support the safe transfer of prescribing to primary care clinicians.
The draft guidelines and RICaD were circulated to the members prior to the meeting.

A member suggested that the wording for the reason why azithromycin has been chosen needed strengthening and proposed the following:
Two randomised controlled trials[1,2] found that, compared with placebo, azithromycin reduced the rate of pulmonary exacerbations needing antibiotics in adults with non-cystic fibrosis bronchiectasis over 6 to 12 months. However, the improvement in exacerbations must be balanced against the risk of experiencing adverse events and the development of antibiotic resistance. In both trials azithromycin was generally well−tolerated and few people discontinued treatment due to adverse events." And listing the references in the appropriate section.

The members were happy to support the proposed wording to be added to the RICaD and endorsed the guideline put forward by BAAG. It was felt that BAAG would not have insuperable objections to this revision.

Actions:

- **Make changes to RICaD as discussed.** **APC sec**
- **Inform BAAG of APC decision and feedback** **APC sec**
- **Upload documents to APC website once finalised.** **APC sec**

0717/09 **NHS Standard contract changes- Primary- Secondary Care Interface Guidance launched**
This document was circulated for information only.
The section around shared care may have some impact on future ESCAs and decision making.

0717/10 **Amiodarone –** formulary status to be reviewed to specialist initiation

This came as a result of a GP declining to initiate amiodarone on the recommendation of a specialist in secondary care. The GP was concerned

about the risk pulmonary fibrosis.
NICE Clinical Knowledge Summary (CKS) guidelines state that initiation of amiodarone should only be done by a specialist. At present this is Amber on formulary.
It was acknowledged that this section of the BNF was harmonised in the early days of APC when Amber RAG status included specialist initiation OR recommendation with no further annotation.

It was agreed to add consultant initiation on the APC website.

Action:
- **Edit formulary entry for amiodarone and add "specialist initiation"** **APC Sec**

0717/11 **Pregabalin – Important information in relation to prescribing and dispensing pregabalin, effective from 17/07/17**

A letter from NHS England dated 21st June 2017 was sent to all CCGs and community pharmacies advising that their guidance issue on 2nd March 2015 pursuant to a patent dispute between the manufacturers of Lyrica® and a number of generic pharmaceutical suppliers was now withdrawn and replaced with the following:
- When prescribing pregabalin for the treatment of any condition, you should prescribe in accordance with your normal practice.
- When dispensing pregabalin for the treatment of any condition, you should dispense in accordance with your normal practice.

A member commented that the APC was vindicated by this new guidance.

Action:
- **Remove the requirement to prescribe pregabalin by brand for neuropathic pain from the APC formulary.** **APC sec**

0717/12 **For information:**

- **Protelos (strontium ranelate) 2g granules for oral suspension**- Servier has notified healthcare professionals that it will cease production and distribution of strontium ranelate at the end of August 2017. This worldwide and strategic decision has been taken for commercial reasons due to the restricted indication/limited use of strontium ranelate, and the continuous decrease in the number of patients being treated with it.
  Action: Remove strontium ranelate from formulary at end of August 2017. **APC sec**

- HEFT has added diazoxide liquid to the red section of the formulary for the treatment of Congenital Hyperinsulinism. This is not to be listed on the APC formulary as will not be coming out in the community.

0717/13 **Minutes of the meeting held on Thursday 8th June 2017 – for ratification**

The minutes of the meeting held on Thursday 8th June 2017 were discussed for accuracy.

Page 2: add Dr Tim Priest to the list of apologies received.
Page 5: under stakeholder views, remove comment on PD society.

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

The DST for pramipexole MR was also approved for uploading to the APC website.

0717/14 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.
No updates other than lack of responses on consultation for ESCAs on DMARDs, other than BSC and Solihull CCGs and UHB NHSFT. This has been extended to allow more time for response.

0717/15 NICE Technological Appraisals (TAs)

There were 6 NICE Technology Appraisals published in June 2017; all are commissioned by NHS England – Red status
Three TAs already published in July 2017 but all were terminated.

ACTION:

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

Any other business:

1. <u>Seretide Inhalers</u>

Inhalers such as Seretide®, Spiriva® and Symbicort® have been taken off the formulary; this is causing issues in secondary care as having to continue to supply these when patients are not bringing them in.

Primary care is looking at patients and attempting to review these and change to formulary options, however there is still a significant number on patients on these now non-formulary inhalers.
It was reminded that the formulary applies to new prescribing only.

2. <u>Quetiapine supply issues</u>

There are some ongoing supply issues with immediate release quetiapine. National Patient Safety Agency, and NICE Medicines and Prescribing Programme have released documentation to recommend a switch to modified-release preparations or alternative antipsychotic agents.

The supply issue will hopefully resolve by the end of August.

3. <u>Regional Medicines Optimisation Committees (RMOCs)</u>

Update on the Midlands and East RMOC: the first meeting is to be held on the 31st August. Three members of BSSE APC have been successfully appointed to the Midlands and East RMOC. A member asked that it be minuted that this was an excellent outcome for this health economy and offered a vote of confidence.
The Midlands and East RMOC membership includes a clinical pharmacologist post and a second clinical pharmacologist has been slotted into the secondary care consultant position.

4. The Joint chairs, CCG members and APC secretariat are planning a management development meeting on 15th August. Secondary care

members are welcome to join if appropriate. The proposed agenda will help to decide if their attendance is necessary.

Action: **APC secretary to circulate planned agenda for management development meeting scheduled for 15th August.** **APC sec**

The Chair thanked the members for their input today. The meeting closed at 17:00.

The chair reminded members that the August meeting was cancelled and that the September meeting would be in the same venue as today's meeting.

Date of next meeting: Thursday 14th September 2017 14:00 – 16:45
Birmingham Chamber of Commerce
75 Harborne Rd, Birmingham, B15 3DH