AREA PRESCRIBING COMMITTEE MEETING
Birmingham, Sandwell, Solihull and environs
Minutes of the meeting held on
Thursday 9th June 2016
Venue – Birmingham Research Park, Vincent Drive,
Birmingham B15 2SQ – Conference Room A

PRESENT:

Dr Paul Dudley	PD	Birmingham CrossCity CCG (Chair)
Dr Neil Bugg	NBu	Birmingham Children's Hospital NHS FT
Dr Sangeeta Ambegaokar	SA	Birmingham Children's Hospital NHS FT
Karen Ennis	KE	Birmingham CrossCity CCG
Satnaam Singh Nandra	SSN	Birmingham CrossCity CCG
Alima Batchelor	AB	Birmingham South Central CCG
Nigel Barnes	NBa	BSMHFT
Dr Timothy Priest	TP	HEFT NHS FT
Tania Carruthers	TC	HEFT NHS FT
Carol Evans	CE	HEFT NHS FT/ Solihull CCG
Kalpesh Patel	KP	Midlands & Lancashire CSU
Isabelle Hipkiss	IH	Midlands & Lancashire CSU
Shabana Ali	SAL	Sandwell & West Birmingham CCG
Prof Robin Ferner	RF	Sandwell & West Birmingham Hospitals NHST
Kate Arnold	KA	Solihull CCG
Dr John Wilkinson	JW	Solihull CCG
Prof Jamie Coleman	JC	UHB NHS FT
Emma Suggett	ES	UHB NHS FT

IN ATTENDANCE:

Pravin Pandey	PP	BMEC for item 0616/08
Melanie Hart	MH	Birmingham Community Healthcare NHS FT for item 0616/09
Lesley McDonagh	LM	Sandwell & West Birmingham Hospitals NHST for item 0616/09
Rebecca Martin	RM	Birmingham Community Healthcare NHS FT for item 0616/09
Joanna Swan	JS	UHB NHS FT for item 0616/09
Claire Manzotti	CM	Midlands and Lancashire CSU

No.	Item	Action

0616/01 **Apologies for absence were received from:**

- Dr Lisa Brownell, BSMHFT
- David Harris, Birmingham Community Healthcare NHS FT
- Elizabeth Walker, Sandwell & West Birmingham CCG- deputy attended
- Jonathan Horgan, Midlands & Lancashire CSU
- Maureen Milligan, ROH NHS FT
- Mark DasGupta, Birmingham CrossCity CCG- deputy attended
- Inderjit Singh, UHB NHS FT- deputy attended

0616/02 **Items of business not on agenda** (to be discussed under AOB)

- Ciclesonide - IH
- Zaluron® - IH
- Feedback from Dermatology specials meeting - IH
- Nadolol discontinued - IH
- Pregabalin - NBu

0616/03 **Declaration of Interest (DoI)**

It was noted that DoI forms were circulated by the secretariat recently for the members' annual declaration. Some forms have already been returned, but the Chair gave a polite reminder to submit completed DoI forms. Blank DoI forms were available at the meeting for members to complete.

It was also confirmed that DoI forms have been received for all the guest clinicians attending the meeting.

0616/04 **Welcome and Introductions**

The chair welcomed everyone to the meeting today. Introductions round the table were carried out for the benefit of Shabana Ali, who has replaced Sumaira Tabassum at Sandwell & West Birmingham CCG.

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

0616/05 **Minutes of the meeting held on Thursday 12th May 2016**

The minutes of the meeting held on Thursday 12th May 2016 were discussed for accuracy. No amendments were required.

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

It was established that secondary care clinicians can prescribe sacubitril valsartan (Entresto®) following discussions at the last APC meeting on 12th May 2016. It was also pointed out that sacubitril valsartan should be prescribed for at least three months by the specialist to ensure dose and clinical stability is reached before prescribing can be transferred to primary care.

Decision Support Tool for APCBSSE/00027 Soolantra® (Ivermectin 1% cream)

- DST for Soolantra® 1% cream (APCBSSE/00027) was approved for publication on the APC website.

0616/06 Matters arising – Action Table

The Chair moved onto the action table for comments and updates:

(See separate document attachment for updated version)

Updates and discussions:

- 0516/08 – Feedback from March 2016 Away Day.
  Update: Chapter 13 and 14 uploaded. Chapter 15 being uploaded. Chapter 14 - All the immunoglobulins have been changed to RED from GREEN as they will not be prescribed in primary care. All other vaccines GREEN as per Green Book.
  ACTIONS:
  Circulate updated chapters 13, 14 and 15 to members to update their internal formularies. **APC secretary**

- 0516/10 – Review of decline to prescribe form.
  Update: UHB and HEFT have submitted summary of 'decline to prescribe' forms. BSMHFT reported they had none this month and one the previous month. Awaiting summary from Sandwell & West Birmingham Hospitals NHST.
  ACTION: SWB Hospitals to send summary of "decline to prescribe" forms received. **SWB NHST**

- 0516/14 – AOB Stiripentol.
  Update: APC secretary has received application from UHB. The intention was for BCH to bring to APC first to consider use in children, then for UHB to submit application for APC to consider using in adults transitioning from BCH. BCH to discuss with UHB.

- 0516/14 – AOB Orphenadrine tablets discontinued
  Update: A Trust has challenged the decision to make orphenadrine BLACK when a licensed liquid formulation is available. The consensus view was that the majority of the patients would be prescribed tablets which are now discontinued. The liquid formulation is expensive and prescribed to a small number of patients. BSMHFT has been reviewing patients on orphenadrine and switched to alternative anticholinergics e.g. procyclidine and trihexyphenidyl (benzhexol), or stopped altogether without any issues. It was concurred that orphenadrine should remain BLACK as the liquid formulation is indicated for a very small number of patients. In addition the formulary only applies to prescribing for new patients only.

- 0416/06 – Patient Public Representative recruitment.
  Update: Received link to advertise from Birmingham South Central CCG. To date the APC secretary has received no response to adverts. It was agreed to extend the closing date for the advert on Solihull and CrossCity CCG in view of new posting for BSC CCG.
  ACTION: Extend closing date for PPR advert. **APC secretary**

- 0216/15 – Collaborative review of current ADHD shared care documents between HEFT, Solihull and FTB.
  Update: All shared care documents have been shared for review – action now closed.
- 0416/AOB – Contact with Pharma industry. Add guidance for pharmaceutical organisations on APC website for contacting members of the APC, including CSU staff acting in a secretariat capacity.
  Update: Added a statement on the APC website – action now closed.

- 0416/AOB – Discrepancy between two guidelines endorsed by APC.
  Write to antimicrobial group as experts and requests consensus of opinion.
  Update: APC secretary wrote to Dr Das Pillay and Dr Alice Turner. Received a response from Dr Turner stating the discrepancy is minor. Not received a response from the antimicrobial group to date.
  ACTION: Contact Dr Pillay for a response. **APC sec.**

- 0216/AOB – Chairs to draft a letter to ophthalmologists outlining the points discussed at the APC meeting.
  Update: The draft letter was circulated to members with the papers for the meeting. It was proposed to amend the sentence to read: 'Rather than leave this decision to the APC, the committee members would invite the local ophthalmology departments to get together and come up with their consensus view about which two preservative containing agents they feel would be appropriate.' It was also suggested to underline "two preservative-containing agents; a first-line option and a second line option".
  It was agreed that subject to the above amendments the letter can be sent out to the ophthalmologists.
  ACTION: Finalise and send letter to ophthalmologists **APC sec.**

- 1115/12 – Liaise with renal team on iron dextran injection (CosmoFer®) to clarify RAG status and need for supplementary documentation.
  Update: UHB indicated they no longer use CosmoFer®, but use Venofer® or Ferinject®. Other trusts to check and confirm at next meeting.
  ACTION: Other Trust leads to check with respective organisations and confirm at next meeting **HEFT and SWB leads**

0616/07 Sacubitril valsartan (Entresto®) draft RICaD

The APC secretary stated the draft RICaD circulated incorporated the comments received following the consultation:

- As Entresto® is a new black triangle drug, the SPC is likely to change regularly and therefore it was proposed that the RICaD should refer to the SPC and remove the Appendix detailing information from the SPC.
- The washout period has been increased from 36 hours as stated in the SPC to 48 hours on the advice of cardiologists, to minimise the risk of angioedema.

Members were concerned with use of the words "heart failure specialists" in the RICaD as it could include non-medical prescribers and non-prescribers.

The members were reassured that Independent Prescribers and Non-Medical Prescribers were carefully assessed and their prescribing restricted to their area of competency. One scenario that CCG representatives definitely wanted to avoid was for the request to GP to pick prescribing to come from a non-prescriber, albeit a specialist in that field.
Following further discussion it was established that as Entresto® needs to be prescribed for 3 months before transfer to primary care, the heart failure specialist would need to be a prescriber. Secondly secondary care non-medical prescribing committees review any request to prescribe any additional groups of drugs by non-medical prescribers.

A member pointed out a discrepancy: under the continuation criteria section it states 'Following stabilisation – potentially up to 3 months'. Under the review section it states that 'Heart failure specialists to review at 3 months before transfer to primary care'. It was emphasised that Entresto® should be prescribed for three months before transfer to primary care.

The following amendments to the RICaD were agreed:

- Text under continuation criteria needs to be amended to reflect it should be prescribed for three months.
- Text highlighting that it should be prescribed for three months before transferring to primary care should be added to the first page before patient details.
- Refer to the SPC and remove appendix.

ACTION: Amend the RICaD with the agreed changes and circulate. **APC secretary**

0616/08 New Drug application - Simbrinza® (brimonidine 2mg/ml and brinzolamide 10mg/ml), Alcon laboratories (UK) Limited. Mr P. Pandey (Birmingham and Midland Eye Centre)

The chair welcomed Mr Pandey to the meeting and invited him to present the new drug application for Simbrinza®.

Mr Pandey stated that Simbrinza® is a combination eye drop and is the only combination drop without a beta blocker, and contains a carbonic anhydrase inhibitor and an alpha-2-agonist. Other combination eye drops contain a beta blocker with carbonic anhydrase inhibitors or prostaglandin analogues/ prostamides.

Simbrinza® is useful as an adjunctive option in patients who cannot tolerate or have a contraindication to beta-blockers.

NICE guidelines recommend prostaglandin analogues or beta blockers followed by carbonic anhydrase inhibitors. Therefore it is useful as a third or fourth line add-on drug.

Mr Pandey added that Simbrinza® is useful because:

- patients with combination eye drops are more likely to be compliant as they are less drops to administer,
- less preservative in the combined product versus the individual products – thus better tolerated and less side effects
- reduce possibility of washout effect from using two different eye drops
- clinicians are familiar with both components in the eye drops

A study comparing the combination product with the individual drops administered concomitantly showed it was non-inferior and the side effect profile was similar.

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

1) Mr Pandey clarified that preservative load (BAK in this case) is important as it can cause inflammation, red eye and scarring. A combination eye drop will contain less preservative compared to two individual eye drops. He added that by the time patients are considered for this preparation, they can tolerate the preservative. This is because there are no preservative-free versions of brinzolamide or brimonidine drops available. The only preservative-free alpha-agonist is Iopidine® 1% (apraclonidine) but this is only used before and after surgery and laser treatment and not intended for long term use.
2) It was pointed out that using two individual eye drops (brinzolamide and brimonidine separately) costs £5.72 whereas the cost of the combination eye drops is £9.23. This equates to extra £50 costs per patient per year.
3) A member enquired what the commissioners get for the extra £50 per patient per year. This amount may not seem a lot but when multiplied by the possible number of patients; this could represent a substantial amount of money. Mr Pandey confirmed that only a small number of patients will require the combination eye drops. He added that the European Glaucoma Society recommends combination eye drops to improve compliance, reduce wash out effect and reduce side effects. Concern was expressed that European Glaucoma Society is funded by all the pharmaceutical companies that manufacture eye drops.
4) A member requested clarification of the proposed place in therapy as the application form suggested this as second line therapy. Mr Pandey confirmed second line therapy referred to the individual agents, third line would be the combination of these agents.

The chair thanked Mr Pandey for his presentation and advised him that the decision would be relayed to him with 7 days, in line with APC policy.

Further discussion points raised in the absence of Mr Pandey included:

- Lack of evidence that combination eye drops are better than two individual eye drops.
- Although Mr Pandey indicated that combination eye drops were required for a small cohort of patients there is a risk that use of combination eye drops will creep up because it is easier to use.
- This is a third or fourth line agent; therefore from a patient perspective number of drops is important. These patients are likely to be elderly, self-care is important and the drop burden should be considered.
- HEFT has considered this preparation and would support it as AMBER.
- A member reminded the committee that this was the only beta-blocker free combination, and the clinician suggested it as an option for patients for whom beta-blockers are unsuitable, not tolerated or fail to control IOP sufficiently.

It was deliberated that the decision should be deferred and considered after the ophthalmologists respond to the queries below:

1. Evidence that 1 drop is better than 2 drops.
2. Algorithm for treatment; what is first line, second line, third line etc.

3. Approximate number of patients at each step of the algorithm.

ACTION: Advise Mr Pandey the decision is deferred pending response to the above questions. **APC secretary**

0616/09 Wound formulary review

The chair welcomed the 4 representatives from the wound care formulary working group to the APC meeting and invited them to present an overview of their work.

Introductions were made: Melanie Hart, chair of the working group for the last 12 months and Principal Nurse Medicines Management and Medication Safety Officer (Birmingham Community Healthcare NHS FT); Rebecca Martin, Service Lead Tissue Viability (BCHC); Lesley McDonagh, Tissue Viability Clinical Lead Nurse (SWB Hospitals NHS Trust); Joanna Swan, Lead Tissue Viability Nurse (UHB NHS FT).

Rebecca gave an overview of the process they followed to get to the proposed draft wound care formulary. A multidisciplinary wound subgroup was formed including various healthcare professionals from all the local trusts and CCGs. Healthcare professionals included in the subgroup include tissue viability nurses (TVN) from each of the Trusts, district nurses (DN), practice nurses, matrons, acute hospital nurses, podiatry, lymphoedema nurses, burns and plastics teams and pharmacists. The subgroup met monthly and in-between meetings the TVN and DN wrote the rationales. Due to the plethora of wound care dressings and timeframe, not all were evaluated. Clinical evaluations that had been completed previously were considered.

A spread sheet was compiled using all the trust formularies to start the harmonisation process. A consensus decision regarding which products to add to the formulary was made by the subgroup based on:

- NICE guidance, Cochrane and PrescQIPP reviews
- Product evaluations
- Cost-effectiveness:
    - drug tariff price was taken into consideration as majority of the dressings are prescribed in primary care
    - some dressings have been added as some trusts obtain dressings at significantly lower procurement prices
- Personal preferences were not taken into account, the consensus of the group was reached and evidence of these discussions is noted in the minutes of the subgroup meetings.

The discussions on antimicrobials dressings spanned over 3 months at least, as it is recognised to be a contentious area, especially with regards to silver dressings.
Dr Pillay, chair of the Birmingham Antibiotic Advisory Group and consultant microbiologist at HEFT, was consulted during the three month development phase of the antimicrobial dressings' section of the formulary. An algorithm for antimicrobial dressings was developed based on the guidance from PrescQIPP and NICE evidence summary on advanced wound dressings and antimicrobial dressings issued in 2016, together with advice from Dr Pillay. It was noted that the evidence for silver, honey and iodine dressings is lacking.

As part of the harmonised formulary, the subgroup has recommended iodine based dressings as the first line option as there is no risk of resistance developing or cellular damage, with other antimicrobial dressings being considered as an alternative option (Amber RAG rated), based on specialist advice.
It was advised that antimicrobial dressings had a place on the formulary to manage clinical wound infections as it would restrict/ avoid the use of oral antibiotics and support antimicrobial stewardship. It was agreed that antimicrobial dressings should not be routinely used when antibiotics are prescribed unless there are co-morbidities or this has been recommended by a microbiologist.

The harmonisation process focused on restricting the number of dressings to 1 to 3 products in each section. These were selected for different wound types and management of different exudate levels. First line and second line options would be based on cost-effectiveness. Second-line options are required as alternatives in case of allergies or sensitivities developed with first line products.

All products were RAG rated GREEN, AMBER and RED as per APC formulary.
Green: first line or second line products for use by all healthcare professionals
Amber: specialist use by clinicians with advanced wound care knowledge to justify their use.
Red: prescribed by Trust only, if sent into the community must be provided by the Trust.

A rationale for the choice of each product has been provided by TVN, with input from podiatry and lymphoedema nurses for their specific dressings. This is added to the proposed wound care formulary and includes:

- What type of wound to use the dressing on,
- frequency of change
- maximum duration of application before changing
- cautions and contraindications
- reason why product was included in the formulary

This is really important for nurses or other healthcare professionals who don't have great wound care knowledge.

Once the wound care formulary is approved by the APC, the subgroup plan to meet every 3 months to review each section so that the wound care formulary is evolving with new developments and not a static document, to continue to meet the needs of the patients and keep up with the market place.

This project has been a great opportunity to work collaboratively across the Trusts and CCGs, for the benefit of patient care as they move across the different care settings. Patient outcomes will also improve as a result of this harmonisation exercise and on-going review.

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

- The wound care subgroup acknowledged that costs associated with DNs carrying home visits to change dressings (national average £60 per visit) are an important consideration. The rationale included in the formulary will guide any nurse on duration a dressing can be left on,

and enable them to make an informed choice when selecting dressings.

- A member clarified that the remit of the sub group was wound care formulary harmonisation; a task they have delivered. Review of the all the formulary dressings is the next step.
- It was pointed out the subgroup is advisory and APC will decide the RAG rating.
- A member commented that Dr Pillay has confirmed that the evidence base for silver, honey and iodine dressings is meagre to none. The rationale for proposing the use of these costly dressing on the NHS when there is no evidence of benefit was questioned.
- Lack of Randomised Controlled Trials (RCTs) for wound care products was discussed. A member reported that an RCT was published in the British Medical Journal recently involving clean surgical wounds and this study failed to find any benefit for dressings. It was pointed out that the numbers of patients in this trial were very small and the surgery involved was abdominoplasty or paediatric laparoscopic appendectomy, which is not representative of the chronic wound patients TVN are dealing with, with multiple co-morbidities. The trial involved clean surgery on patients that haven't got diabetes or vascular issues, and cannot be compared with these chronic wound patients. However it was clarified that this particular RCT was brought up in the discussions to highlight the fact that RCTs can be done on wound care products, not to discuss the findings.
- In some cases, inadequate hygiene measures in the patients' home hinder the healing process further.
- RCT for wound care in the community is difficult as it is not ethical to randomise a patient with an infected wound to potentially receive a placebo i.e. not to be treated. A member of the wound care sub group informed members they were undertaking a feasibility study for wound care products in their trust.
- It was accepted that in the absence of data from RCT, case controlled studies should be considered.
- According to the APC's harmonisation principles silver dressings need to be included in the APC formulary because silver, iodine and honey dressings were included in all the formularies previously.
- A member stated that manufacturers of dressings do not undertake clinical trials because they either know their dressings will sell anyway or manufacturers may be aware that clinical trials may prove their dressings are not beneficial.
- One of the wound subgroup stated that their review included a paper on evaluation of silver dressings, but because it was sponsored by a drug company, it was discarded.
- It was pointed out that many dressings are classed as appliances and therefore do not have to go through the rigorous approval process medicines have to go through for approval.
- A member of the wound care sub group stated that SWB Hospitals NHST and SWB CCG stopped using silver dressings some time ago and suggested that the prescribing trends of antibiotics for infected wounds in Sandwell with limited silver dressing use should be compared with antibiotic prescribing trends for infected wounds in neighbouring areas where silver dressings are being used.
- It was highlighted that in the algorithm for antimicrobial dressings the referral to specialists comes after use of silver or iodine dressings. Another member commented that it is difficult to identify infections and the algorithm needs to be further developed.

- SWB CCG want it to be noted that it has disagreed with the positioning of silver dressings throughout the harmonisation process as it has restricted the use of silver dressings in the CCG to the tissue viability nurses' advice only, and has had no reports of negative outcomes. This decision was driven by the need to reduce costs and the lack of evidence for silver dressings.

  This was challenged and attendance of the Trust/ CCG at the subgroup meetings was questioned to warrant this level of disconnection. It was clarified that the SWB CCG representative attended 95% of the meetings.
- A comment was made that there has been occasions during previous harmonisation work where a consensus was reached without a unanimous vote but a majority supported the decision.
- The subgroup representatives conveyed their thanks to SSN for his support throughout the harmonisation process.

The chair thanked the wound care subgroup for their presentation and advised them that the APC secretary would give them feedback on any outcomes from the meeting.

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

- Several members raised concerns about the algorithm for antimicrobial dressings. The main issues were that it has been lifted from a secondary care sepsis algorithm where patients are already in hospital. It was suggested that the wording be reviewed and tightened up with more appropriate primary care criteria for identification of an infected wound, and should also identify the appropriate place in therapy for oral antibiotics. Sepsis is a life-threatening condition, and the members were concerned about the algorithm suggesting referral to a GP in such a case. The members could not endorse the algorithm in its current format.
- A member felt that it was not equitable that dressings not on any previous formularies have been added to the draft harmonised formulary when dressings evaluated by the Sandwell trust have not been considered. It was declared that there was a consensus agreement among the subgroup members in relation to new dressings added to the formulary. Subgroup members had evaluated the new products within their own trusts and agreed the new products were advantageous over the older formulary products. It was noted that SWB NHST were requested to add the new dressings to their formulary as a cost saving initiative. The SWB subgroup members were requested to present their product evaluations to the rest of the working group for review/ discussion. The committee was informed that these new dressings will be reviewed by the subgroup at their July meeting.
- It was noted that when the subgroup was set up, consultant representation was sought but no one came forward. This may have been due to time commitments (monthly meeting for a year). However it was noted that the specialist consultants/ team views' were requested to support the harmonisation process. Due to the lack of consensus among APC members it was deemed essential wider expertise is consulted.
- A member added that product evaluations were undertaken following a

nationally agreed proforma.

- It was agreed that the wound care formulary should be re-considered at away day after the July sub group meeting. This will allow the subgroup to review the additional products reviewed by Sandwell trust.
  The revised wound care formulary incorporating all the products that have been evaluated will be discussed at the away day, together with a revised algorithm.
- A member stated that declaration of interests were not made verbally at the wound care sub group meetings, or requested in writing, and suggested this should be requested of them. The APC secretary stated that this had not been requested of the diabetes network, the respiratory network or the Birmingham Antibiotic Advisory Group, but it was confirmed that those networks do collate their members' DoI. The clinicians attending the meeting today had completed a DoI form.
- It was pointed out that some products in the wound care formulary are already on the formulary e.g. dermatological products. Members were assured that formulary status for products already included in the dermatology section match the wound care formulary status.
- It was suggested that in the absence of any evidence for dressings the choice of dressings should be made solely on cost.
- It was reiterated that there was no evidence either way, but we do have one locality across the APC footprint where it has practically looked at NOT using silver dressings. It would be wise therefore to gather some of the information associated with this piece of work because that is probably the best evidence we can get. It would be very important for the benefit of patients to find out if it did demonstrate that patients who didn't get silver dressings were more likely to get infections or not; were more likely to have sequelae or not.
- It should be fedback to the representatives who attended that the wound care subgroup should be commended for undertaking this substantial harmonisation exercise on behalf of the APC.

ACTIONS:

• **Give feedback to the wound care subgroup.**	**APC sec**
• **Dressings previously evaluated by SWB to be considered at July subgroup meeting and added to draft formulary or declined, as appropriate**	**Wound care subgroup**
• **Updated version of draft harmonised formulary to be considered by APC**	**All**
• **Arrange an away day (half a day) in Sept/ October 2016 and invite microbiologists, dermatologists and other expertise.**	**APC sec**
• **Members to email questions/ bullet points for consideration at the away day to the APC secretary.**	**All**
• **Chair and another member of the APC to meet with the wound care subgroup to discuss expectations of the APC.**	**Chair**
• **Discuss 'declaration of interests' for subgroups/ clinical network members at the next APC governance subgroup meeting.**	**APC sec**

0616/10 Antipsychotics ESCA (for ratification)

Members were informed this is a group ESCA for antipsychotics rather than individual drugs and covers all indications for this group of medication rather than a single indication. Monitoring requirements for antipsychotic drugs are the same irrespective of the drug. Purpose of ESCA is to support better prescribing and monitoring of antipsychotics drugs in primary and secondary

care.

It was reported that GPs are comfortable with generic ESCA covering all antipsychotics.

Two members questioned the need to have a current medication table in the ESCA. Current medication is already included in the clinical letter, thus unnecessary duplication. Secondly the list of current medication in the ESCA is only accurate at time of issue as it not updated following medication changes.

The oral antipsychotics ESCA was approved subject to removal of the current medication table and correction of minor typo errors.

ACTION: Amend ESCA and add to APC website. **NB and APC sec**

0616/11 Summary of decline to prescribe forms (May 2014 – April 2016)

A summary of decline to prescribe forms received at UHB NHS FT between May 2014 and April 2016 was circulated with the papers for the meeting. A summary of decline to prescribe forms received at HEFT (January – May 2016) was tabled at the meeting. The APC secretary commented that these summaries had not been analysed yet to identify recurrent themes, but were mainly for the benefit of the CCGs. These were circulated for information. It was the members' view that requests for RED drugs to be prescribed by GPs would be dealt with by the Trusts internally.

0616/12 Drug Safety Update – Retigabine (Trobalt®)

A letter from the manufacturer regarding the risk of acquired vitelliform maculopathy in patient taking retigabine, together with the approved ESCA for its use were sent to trust leads for a clinical opinion.
The APC secretary stated that only the mental health trust had responded and that their clinicians were of the view that only few patients were on this drug and suggested changing the RAG rating to RED status from the current AMBER status because of this risk.

Members agreed it very rarely used and should be moved to RED status.

Action: Change formulary status of retigabine to RED and remove ESCA from APC website. **APC sec**

0616/13 NICE Technology Appraisal (TAs)

It was confirmed that three NICE TAs were published in May 2016. Two of the TAs is primary care commissioned.

- TA217 has been updated. Donepezil, galantamine and rivastigmine are now recommended as options for managing mild as well as moderate Alzheimer's disease and memantine is now recommended as an option for managing moderate Alzheimer's disease for people who cannot take AChE inhibitors and as an option for managing severe Alzheimer's disease. Currently all RED in the APC formulary. Formulary status will be reviewed once commissioning arrangements are in place to allow safe transfer of patient care.

- TA390: Canagliflozin, dapagliflozin and empagliflozin as monotherapies: options for treating type 2 diabetes in adults for whom metformin is contraindicated or not tolerated and when diet and exercise alone do not provide adequate glycaemic control, only if:
    - a dipeptidyl peptidase 4 (DPP 4) inhibitor would otherwise be prescribed and
    - a sulfonylurea or pioglitazone is not appropriate.

  Primary care commissioned. Currently all GREEN in APC formulary.

- TA391: Cabazitaxel for hormone-relapsed metastatic prostate cancer treated with docetaxel. This is commissioned by NHS England. RED on the formulary.

0616/14 Trust Chairs non-Formulary approvals – For information

Non-formulary approval for UHB and HEFT were circulated with the papers for the meeting for information.

ACTION: Circulate SWB Hospitals NHST non-formulary approvals with the draft minutes of the meeting. **APC secretary**

Any Other Business :

1. Birmingham Children's Hospital: pregabalin has recently been added to its formulary for neuropathic type pain. Amitriptyline, gabapentin and pregabalin are on the formulary. Duloxetine is not licensed for use in children. Pregabalin is favoured instead of gabapentin. Gabapentin is associated with a vile taste and some children cannot tolerate it. Therefore it is being used as third line in children who cannot tolerate gabapentin rather than fourth line as in the formulary.
   ACTION: annotate formulary that duloxetine is not licensed in children. **APC sec**

2. Zaluron® -Branded generic modified release quetiapine is now the preferred brand for the mental health trust. It was proposed that the ranking in the formulary is removed as a lot of work has already been undertaken to switch patients to Biquelle® XL.
   ACTION: Remove ranking from APC formulary and list as APC preferred brands: Biquelle® XL, Sondate® XL and Zaluron® XL and add choose most cost-effective option. **APC sec**

3. Ciclesonide – during chapter 3 harmonisation ciclesonide was only listed in the UHB formulary and not in the HEFT or SWB Hospitals formularies. It is used for the treatment of brittle asthma. Colonel Wilson was going to audit ciclesonide use to establish evidence that it reduces oral steroid burden in patient taking ciclesonide. As the decision was pending it was listed non-formulary. UHB were unaware of this and continued to prescribe. Ciclesonide is also included in the draft asthma guidelines that will be coming to the APC shortly. HEFT also confirmed they are using ciclesonide. Col. Wilson asked the APC to sanction use on specialist advice from the Birmingham Region Severe Asthma Service. In view of severe brittle asthma patients will be regularly reviewed in hospital, it was agreed to add it to the formulary as RED pending audit outcomes and APC will review the audit when they consider the draft asthma guidelines.

ACTION: Change formulary status for ciclesonide to RED: specialist in Birmingham Region Severe Asthma Service sites initiation and continuation pending outcome of the audit. Emphasise that prescribing can only take place in secondary care. **APC sec**

4. Feedback following dermatology specials meetings: local trusts are investigating the feasibility of setting up a model for specials' supply similar to BCH model depending on the costing information provided by the CCGs. SWB Hospitals NHST has set up a one-year project and is going to share their project with the members.

5. Nadolol 40mg tablets were discontinued some time ago. Nadolol 80mg tablets have also now been discontinued. There is no licensed alternative available but an unlicensed special tablet formulation is available. UHB would like to use the unlicensed special in new patients and particularly patients already stabilised on nadolol. Concern was expressed regarding the cost of the specials in primary care. A member commented that nadolol was added to the formulary on the basis of its cost-effectiveness, if this was no longer the case, then the formulary status needs review. Although the formulary applies to new prescribing, UHB are already receiving decline to prescribe forms from GPs due to its unlicensed status. UHB will look into suitable alternatives for new patients but were more concerned for their current stabilised patients.
   ACTION: UHB to bring back to next meeting number of patients who will need to be prescribed nadolol unlicensed special tablets and revisit. **UHB lead**

6. The consensus of the members that the meeting scheduled for 11th August should be cancelled in view of holiday period and high number of apologies.
   ACTION: Cancel August APC meeting **APC sec**

The chair thanked the members for their input today. The meeting closed at 17:10 pm.

Date of next meeting: Thursday 14th July 2016 14:00 – 16:45
Conference Room A,
Birmingham Research Park,
Vincent Drive.
Birmingham B15 2SQ