

AREA PRESCRIBING GROUP/COMMITTEE IN COMMON

Wednesday 20th July 2022

2.00-4.00

Via MS Teams

CONFIRMED MINUTES

			Quoracy	20.07.22						
Members										
John Gilby (Chair)	GP & Clinical Director - North Staffordshire & Stoke-on-Trent CCGs	JG	For the meeting to be quorate there should be the attendance of 4 members, which must include a minimum representation from 1 commissioner and 1 provider and include at least 1 pharmacist and 2 GPs for the south and 2 GPs for the north	√						
Mark Stone	GP & Clinical Lead - Stafford & Surrounds	MS		A						
Amin Mitha	Acting Deputy Director of Primary Care – Medicines Optimisation	AM		√						
Jane Rosam	Head of Medicines Optimisation - North (Medicines Commissioning)	JR		√						
Samantha Buckingham	Head of Medicines Optimisation– South	SBu		A						
Amanda Lovatt	Head of Medicines Optimisation - North Locality	AL		√						
Sharuna Reddy	Senior Medicines Optimisation Pharmacist CCG SW Locality	SR		√						
Susan Bamford	Senior Medicines Optimisation Pharmacist CCG SE Locality	SBa		√						
Sue Thomson	Clinical Director of Pharmacy – UHNM	ST		√						
Helen Sweeney	Chief Pharmacist - NSCHT	HS		√						
Andrew Campbell	Clinical Director of Pharmacy & Medicines Optimisation - MFPT	AC		√						
Georgina Moore	Assistant Director of Pharmacy - RWT	GM		x						
Dominic Moore	Deputy Chief Pharmacist – Clinical Services & ePMA UHDB	DM		x						
Mukesh Singh	GP Representative, Cannock Chase CCG	MSi		x						
Marianne Holmes	GP Representative, Stafford & Surrounds CCG	MH		A						
Satveer Poonian	GP Representative, East Staffordshire CCG	SP		√						
Claire Pilkington	GP Representative, South-East Staffs & Seisdon CCG	CP		x						
Karthik Bhat	GP and LMC Representative – Stoke-on-Trent	KB		A						
Zia Din	Senior Consultant - UHNM	ZD		A						
Bindu Poornamodan	Consultant Psychiatrist - NSCHT	BP		√						
Tania Cork	Chief Officer Local Pharmaceutical Committee- North Staffs	TC		A						
Peter Prokopa	Chief Officer Local Pharmaceutical Committee- South Staffs	PP		A						
Tracy Hall	Medicines Optimisation Nurse/Non-Medical Prescribing Lead – MPFT	TH		A						
Emma Dasey	Senior Pharmacist Medicines Optimisation CCG	ED		√						
Hardip Kalirai	Senior Pharmacist Medicines Optimisation CCG	HK		A						
Emma Bryant	Senior Pharmacist Medicines Optimisation CCG	EB		√						
Denis Kanu	Medicines Optimisation Pharmacist (Interface) CCG	DK		√						
Claire Dearden	Medicines Optimisation Delivery Manager CCG	CD		√						
Ben Eapen	Governance and Community Pharmacist, MPFT	BE		A						
Daniel Clarke	Secondary/ Primary Care Interface Pharmacist – UHNM	DC		√						
Richard Lewis	Advanced Clinical Pharmacist -UHNM	RL		A						
Richard Sutton	High-Cost Drugs Pharmacist- UHDB	RS		A						
Nicholas Carre	Assistant Director of Pharmacy and Integration - RWT	NC		A						
Sukvinder Sandhar	Deputy Head of Medicines Optimisation, Wolverhampton CCG	SS		√						
Chandra Kaneganti	LMC and GP Representative – Stoke-on-Trent	CK		x						
Gurpreet Chattha	NHS Black Country and West Birmingham CCG	GC		x						
Simon Barber	Specialist Pharmacist - UHNM	SB		√						

In Attendance								
Dr Brendan Davies	Consultant Neurologist, Joint Clinical Lead for Neurology & Clinical & Research Lead Headache Disorders team – UHNM	BD		√				
Fiona Porter	Administrator/Minutes	FP		√				

		Action
1.0	Welcome	
	JG welcomed all to the meeting.	
2.0	Apologies	
	Apologies were received and noted above.	
3.0	Declarations of Interest and Actions to Mange Conflicts	
	There were no declarations of conflict of interest	
4.0	Quoracy	
	The meeting was not quorate	
5.0	Minutes of the Meeting held on 22nd June 2022	
	Peter Prokopa has sent apologies for the meeting however he had made some suggested amendments around the wording of item 14. The Chair agreed these and the minutes were re-worded accordingly. The minutes were then agreed as a true and accurate record.	
6.0	Action Tracker	
	<ul style="list-style-type: none"> Penthrox (NMC) – Update from last meeting/no action - AM and HS had a conversation outside of the meeting as to whether it was appropriate for drugs not associated with Primary Care to come to APC/G and if APC/G discussions are necessary. ST clarified that there is no internal UHNM route for ratification, and UHNM refer to and use the net.formulary as the joint formulary within UHNM. Therefore, drugs are appropriate to come to APC/G. In summary it was agreed that for transparency throughout the system that drugs such as this come to APC/G. <p>27 <u>AEDs</u> (Anti-Epileptic Drugs)– item 10 on main agenda</p> <p>30 <u>Edoxoban</u> – haematology are in favour of this as first line on the formulary, but renal are not happy with the criteria. DC said the next step was to produce a document to try and pull everyone's comments together. It is quite complex, because there is a lot of different views on the safety and effectiveness. RWT cardiologists do not support edoxoban switching. The situation with UHDB and Chester differs, they are both already well advanced in its use first line. ST said that there was commitment for this to be resolved as soon as possible as there was conflict in the system with GPs already switching as per PC DES.</p> <p>32 <u>IMOC T&F Group</u> – The group met and the Terms of Reference have been amended and circulated, AM asked for comments on next steps. ST suggested accepting comments from the pharmacy leadership group which were meeting next Tuesday and then bring this back for ratification. The national guidance has not yet been issued; however, amendments can be made further down the line as necessary.</p>	<p>DC/ST</p> <p>AM</p>

6.0	Health Economy NICE Implementation Group (HENIG)	
	<p data-bbox="158 304 762 338">NHSE & CCG Funded NICE HTAs (August 2022)</p> <p data-bbox="158 365 432 398">JR presented the items</p> <ul style="list-style-type: none"> <li data-bbox="158 427 1426 674"> <p data-bbox="158 427 932 461">• <u>TA 791 – Romosozumab for treating severe osteoporosis</u></p> <p data-bbox="252 461 1426 674">Romosozumab is recommended as an option for treating severe osteoporosis in people after menopause who are at high risk of fracture, only if: they have had a major osteoporotic fracture (spine, hip, forearm or humerus fracture) within 24 months (so are at imminent risk of another fracture) and the company provides romosozumab according to the commercial arrangement. Romosozumab is recommended for patients at imminent risk of fracture and can be used prior to bisphosphonates. NICE predicts that uptake will be 50%, costs could be higher if actual uptake is higher than NICE predicts.</p> <li data-bbox="158 703 1426 1010"> <p data-bbox="158 703 1161 736">• <u>TA 792 – Filgotinib for treating moderately to severely active ulcerative colitis</u></p> <p data-bbox="252 736 1426 1010">Filgotinib is recommended, within its marketing authorisation, as an option for treating moderately to severely active ulcerative colitis in adults: when conventional or biological treatment cannot be tolerated, or if the disease has not responded well enough or has stopped responding to these treatments, and if the company provides filgotinib according to the commercial arrangement. Filgotinib is the 7th approved treatment option for ulcerative colitis and it is an alternative oral treatment option fitting alongside tofacitinib and apremilast. As it is an additional treatment option, NICE anticipates that there will be no additional patient numbers or spend resulting from this guidance. Current patient numbers are 318 being treated at a cost of £1.4million, the current annual costs are fairly static but are reviewed frequently.</p> <li data-bbox="158 1039 1426 1323"> <p data-bbox="158 1039 922 1072">• <u>TA 799 - Faricimab for treating diabetic macular oedema</u></p> <p data-bbox="252 1072 1426 1323">Faricimab is recommended as an option for treating visual impairment due to diabetic macular oedema in adults, only if: the eye has a central retinal thickness of 400 micrometres or more at the start of treatment the company provides faricimab according to the commercial arrangement. Because faricimab has been recommended through the fast track appraisal process, NHS England and commissioning groups have agreed to provide funding to implement this guidance 30 days after publication. Faricimab is an alternative treatment option alongside previously approved NICE treatments. As it is an additional option no additional patient numbers or costs are anticipated. Currently there are 601 patients being treated for DMO at an annual cost of £1,703,826</p> <li data-bbox="158 1352 1426 1715"> <p data-bbox="158 1352 1074 1386">• <u>TA 800 - Faricimab for treating wet age-related macular degeneration</u></p> <p data-bbox="252 1386 1426 1715">Faricimab is recommended as an option for treating wet age-related macular degeneration in adults, only if: the eye has a best-corrected visual acuity between 6/12 and 6/96, there is no permanent structural damage to the central fovea, the lesion size is 12 disc areas or less in greatest linear dimension, there are signs of recent disease progression (for example, blood vessel growth as shown by fluorescein angiography, or recent visual acuity changes) the company provides faricimab according to the commercial arrangement. Again, because faricimab has been recommended through the fast track appraisal process, NHS England and commissioning groups have agreed to provide funding to implement this guidance 30 days after publication. Faricimab is an alternative treatment option alongside previously approved NICE treatments. As it is an additional option no additional patient numbers or costs are anticipated. Currently there are 2326 patients being treated for AMD at an annual cost of £6,305,796</p> <li data-bbox="158 1744 1426 2110"> <p data-bbox="158 1744 1410 1778">• <u>TA 803 -Risankizumab for treating active psoriatic arthritis after inadequate response to DMARDS</u></p> <p data-bbox="252 1778 1426 2110">Risankizumab, alone or with methotrexate, is recommended as an option for treating active psoriatic arthritis in adults whose disease has not responded well enough to disease-modifying antirheumatic drugs (DMARDs) or who cannot tolerate them. It is recommended only if they have: peripheral arthritis with 3 or more tender joints and 3 or more swollen joints moderate to severe psoriasis (a body surface area of at least 3% affected by plaque psoriasis and a Psoriasis Area and Severity Index [PASI] score greater than 10) had 2 conventional DMARDs and at least 1 biological DMARD. Risankizumab is recommended only if the company provides it according to the commercial arrangement. Because risankizumab has been recommended through the fast track appraisal process, NHS England and commissioning groups have agreed to provide funding to implement this guidance 30 days after publication. Risankizumab is an alternative treatment option alongside previously approved NICE options. As it is an additional option no additional patient</p> 	

numbers or costs are anticipated.

ST made an observation about the biosimilars for ophthalmology and wet AMD - interesting that the date of issue that we're expecting is the 1st of August and all the new contract prices come in on the 1st of August. It will be interesting to see regarding cost effectiveness and the first choice what comes out in the guidance. JR agreed and stated that we have asked NHS England for some pre guidance to help the system preparation.

There were no further comments and the APC/G recommends that the above ICB-funded NICE TAs are added to the two Staffordshire formularies (RAG ratings RED) as listed in-line with statutory requirements.

HENIG Minutes (June 2022)

The HENIG minutes were noted.

7.0

New Medicines Committee (NMC)

ED presented the item.

A formulary application for an oestrogen spray for HRT was received and from this, discrepancies in the North Staffs and South Staffs formularies were noted in the HRT section. Within the BNF formulary sections for North Staffordshire, the formulary does not list any specific HRT preparations/products. In contrast, the South Staffordshire Formulary lists some particular HRT preparations, but is not a comprehensive list and the origins of preparations chosen for inclusion on the formulary is also not obvious.

There have been various HRT preparation shortages, with press coverage of these ongoing stock problems. There are concerns that if each separate HRT preparation has a separate formulary application and subsequent entry on each formulary, it dictates a full review of all HRT preparations during a time of limited and variable product availability. Also, if all preparations are not included/listed in the formularies, these "missing items" might be interpreted as non-formulary, therefore, not prescribable, so a women's choice of HRT becomes limited. This is especially true if a new brand name comes to market but is not added to the formularies in a timely manner, therefore appearing that it is not prescribable/non-formulary.

The NMC agreed that the Staffordshire Health Economy does not currently support separate formulary applications for individual HRT preparations, especially at a time of HRT product shortages. The NMC agreed that the review of the HRT section of the formularies and the future of HRT formulary applications would be re-considered in 6 months

In the immediate term the NMC recommended that links to the British Menopause Society be added to each formulary as a solution to the formulary review and product shortages. Links provided a wealth of information to Health Care clinicians, classifying HRT products by drug group, and suggesting alternatives to products that go out of stock by recommending product/preparation interchangeability within a drug group.

APC/G were asked to agree the proposal from the NMC in July 2022:

1. Add links to the British Menopause Society (BMS) for prescribing guidance in times of product shortages onto the two formularies
2. Not to review the HRT sections of the Staffordshire formularies as a current priority
3. Not to currently accept individual HRT product formulary applications
4. Revisit the HRT section in 6 months with a view reviewing content/applications.

JG asked if there had been any reference made about testosterone which was becoming a significant issue in primary with women asking for testosterone, and it seems that these are being referred on which will create a problem for you UHNM in the clinics and waiting times.

ED responded that testosterone was not specifically discussed at NMC and was just a general discussion for HRT medications as a whole and one application for oestrogen spray and so could not comment.

	<p>AM asked what the rationale was for not accepting any formally applications for HRT preparations as NMC.</p> <p>ED responded that if a product goes out of stock, then there are products on the formulary that are not available. If we start to list/review all different individual HRT preparations and we miss one, then it looks like that product is non formulary and therefore a women's choices are reduced. So, for the time being, this is only a temporary proposal, NMC are not accepting any specific HRT applications because there's a risk that products might go out to stock and become unavailable again e.g., when pressure on one product happens, pressure to have another one occurs and that can go out of stock. In six months' time we would look at stock pressures and see exactly how we harmonise the formulary and what the best way would be to present the HRT section.</p> <p>AM understood the practical decision; however, we haven't had the process completed to include all the HRT products available on the formulary because we haven't looked at the evidence for clinical effectiveness, cost effectiveness, etc. so wording should sign post to advice from the Menopause Society.</p> <p>Based on AMs comments it was agreed that ED would prepare a statement to be included on the formularies and to bring back to the next meeting. The Menopause Society weblink would also be added to the net.formularies</p>	ED
8.0	Formulary Harmonisation Group (FHG)	
	Nothing this month	
9.0	ESCA - Task and Finish Group (T&F) Recommendations	
	<p>JR reminded the Group that a Shared Care T&F Group meets each month to discuss ESCAs and the process is to carry out an initial medicine assessment at the two different clinical technical groups; either the mental health ESCA harmonisation group or the non-mental health ESCA harmonisation group and the discussion results to fall into two brackets. One bracket is that an ESCA status is absolutely where we need to be, and then we progress on to develop the new ESCA in line with the RMOC standard approach and the RMOC standard template, or the other option is that this is an opportunity to review the RAG classification of the medicine totally.</p> <p>The ESCA T&F group for medicines used to treat mental health conditions have provided the following recommendations to the APC/G in Common:</p> <p>Dementia Drugs</p> <p>The initial assessments have been completed for the medicines for the treatment of dementia:</p> <ul style="list-style-type: none"> • Donepezil • Galantamine • Memantine • Rivastigmine <p>Current RAG Rating:</p> <ul style="list-style-type: none"> • South Staffordshire Formulary: MPFT ESCA – drugs for dementia (one ESCA with details for the above medicines contained within) • North Staffordshire & Stoke-on-Trent Joint Formulary: Amber <p>Recommendation of the ESCA T&F Group:</p> <p>The Task and Finish Group recommended the classification of an AMBER-I status for all four medicines with the following agreements:</p> <ul style="list-style-type: none"> • Clear information is provided in the hospital discharge letter, for example discontinuation criteria (MPFT & NSCHT). • Contact details need to be provided for rapid access and specialist advice. • Change in formulary status to be supplemented with a fact sheet specifying the details for memory services and access to these services from primary care. <p>There was general consensus that an Amber-I status would be appropriate for these four medicines, provided we worked on three particular criteria. One was to ensure that there was clear information between hospital discharge letters or outpatient letters through to general practice, with examples of</p>	

discontinuation criteria for these medicines, that they were really clear and specific around contact details for rapid access and specialist advice. If there was a change in formulary status, this would be supplemented by a fact sheet for primary care giving all the details of the memory services and the rapid access etc. and the type of ongoing support needed from the memory services team. JR paused for questions.

JG had a question about rivastigmine, which was an issue because there's a huge cost differential between the rivastigmine patch and the rivastigmine tablet and there seems to be no sensible way that the prescribing is done.

JR responded that this falls slightly outside the scope of the terms of reference of the ESCA T&F group and asked HS if it was something that could be discussed going forward.

HS said that rationale for the chosen formulation can either be included in the fact sheet or could be part of the agreement structure within the letter. JG felt that this would be helpful as the patients' expectations are around what the letter says, also the consultants need to know that there is a significant cost variation that they may not be aware of. SP agreed.

DK mentioned that there the formulary does mention patches for patients with swallowing issues and ST asked if that could be highlighted on the net.formulary. JG stated there were no issues around swallowing difficulties, prescribing was very random and not just based on this. ST felt it was important to put some comms out regarding the cost differential and ensuring that prescribers in secondary care are cited because General Practice have the software that states the price and unfortunately secondary care don't have this facility. All Partners need to be mindful of cost now that all were working as a system.

JR would work with HS to include something in the GP and Consultant bulletins.

JR

The APC/G recommends that donepezil, galantamine, memantine and rivastigmine are harmonised across both Staffordshire formularies as AMBER-I drugs.

Anagrelide

The ESCA T&F group for non-mental health medicines after completing the initial assessment for anagrelide has provided the following recommendations to the APC/G in Common:

Current RAG Rating:

- South Staffordshire Formulary: Red
- North Staffordshire & Stoke-on-Trent Joint Formulary: Amber-E

The ESCA T&F Group recommend a harmonised RAG rating of RED drug, alongside completion of the actions specified in the ESCA checklist with regard to a safe, patient-centred repatriation process.

There were no comments from the Group.

The APC/G recommends that anagrelide is harmonised as a RED drug across both Staffordshire formularies.

Demeclocycline

The ESCA T&F group for non-mental health medicines after completing the initial assessment for demeclocycline have provided the following recommendations to the APC/G in Common:

Current RAG Rating:

- South Staffordshire Formulary: Non-Formulary
- North Staffordshire & Stoke-on-Trent Joint Formulary: Amber E

The ESCA T&F Group recommend a harmonised RAG rating of RED drug, alongside completion of the actions specified in the ESCA checklist with regard to a safe, patient-centred repatriation process.

There were no comments from the Group.

	The APC/G recommends that demeclocycline is harmonised as a RED drug across both Staffordshire formularies.	
10.0	Principles of prescribing antiepileptic drugs (AEDs) for adults, including formulary RAG classification review (classification covers both adults and children).	
	<p>ED presented the item supported by Dr Brendan Davies.</p> <p>Patients with epilepsy have been cared for jointly between Consultants and GPs for many years with GPs taking prescribing responsibility. With the introduction in recent years of a number of newer drugs that GPs may be unfamiliar, this has led to concern about clinical responsibility. A Formulary Harmonisation Group (FHG) review of the RAG classifications of the AEDs has been undertaken and a prescribing support/principles fact sheet for adults has been produced.</p> <p>The outcome recommendation for the following drugs was an Amber I status:</p> <ul style="list-style-type: none"> • Cenobamate • Brivaracetam • Eslicarbazepine (Zebinix®) • Lacosamide (Vimpat®) • Perampanel (Fycompa®) • Zonisamide <p>Sodium valproate was recommended as an Amber I status in women and women in childbearing age and Amber R in everybody else. For note: the RMOC has now released a proposed National ESCA for sodium valproate, and so it was noted that the recommended Amber I/R status would be a developing/rolling review on release of the proposed RMOC ESCA.</p> <p>The outcome recommendation for the following drugs was an Amber R status:</p> <ul style="list-style-type: none"> • Carbamazepine • Clobazam • Clonazepam • Ethosuximide • Gabapentin • Lamotrigine • Levetiracetam • Oxcarbazepine • (Trileptal®) • Phenobarbital • Phenytoin • Pregabalin • Primidone • Topiramate <p>Green status for:</p> <ul style="list-style-type: none"> • Diazepam Rectal Tubes • Midazolam (Buccolam) <p>Red status for:</p> <ul style="list-style-type: none"> • Rufinamide (Inovelon®) • Tiagabine (Gabitril®) • Vigabatrin (Sabril®) <p>BD asked for clarification of RMOC and the ESCA. ED advised that this was the Regional Medicines Optimisation Committee that discusses and produces guides and templates for national shared care protocols and ESCAs. These are reviewed in the local ESCA T&F Group and this review would then include sodium valproate.</p> <p>BD commented that although there may be unfamiliarity with some of these drugs that have been around for years it would be useful to know how many years after licensing approval does a drug move from</p>	

	<p>Amber I into Amber R. ST agreed this was a valid point.</p> <p>AM replied that when the team introduced these differential amber categories, APC/G had advised that we should have a principle document that explains why something is rated for example, Amber I and that was still in process.</p> <p>In terms of length of time and experience with the product, some drugs could be very complex regardless of how long they had been available for. As a suggestion, the black triangle attached new drugs is removed after 5 years and that could be a yardstick for a RAG rating review.</p> <p>BD would be happy with this proposal, however, feels that auditing of the amount of prescriptions for a drug is not a proactive way of moving forward. Some of these drugs require no monitoring from primary care and as such are not complex.</p> <p>HS felt this was an important debate that needs discussion from a systems transparency point of view and evaluation needs to be for the patient benefit. BD acknowledged that as a Neurology department they have to be prepared to provide more support and respond quicker to queries about these drugs from primary care prescribers.</p> <p>JG acknowledged that a lot of work had been put into these RAG rating reviews and they may well be revisited at some point.</p> <p>SBa pointed out that AEDs (Anti-Epileptic Drugs) were now to be referred to as ASMs (Anti-Seizure Medications) as per NICE guidance new wording.</p> <p>The APC&G considered and approved two items:</p> <ol style="list-style-type: none"> The recommended FHG RAG classifications for AEDs for both the North Staffordshire and South Staffordshire Formularies. These classifications cover both adults and children. Classifications have been discussed at FHG with Provider Consultants, pharmacists, Lead GPs and Medicines Optimisation Pharmacists. The AED prescribing principles document, for adults only, giving guiding principles for epilepsy prescribing, formulary classifications and typical adult doses. The document covers only AEDs that would be typically prescribed in primary care, i.e., amber I or amber R classifications. This document aims to help primary care clinicians to understand typical initiation doses and typical stable doses they might be asked to prescribe for adults, along with any pertinent prescribing points for AEDs. <p>The APC/G recommends that the FHG RAG classifications for antiepileptic drugs (AEDs) in adults and children are approved.</p> <p>Likewise, the APC/G recommends the approval of the AEDs principles document (in adult patients only) for use in the Staffordshire Health Economy</p>	
11.0	<p>Drug safety update (MHRA) June 2022</p> <p>JG commented about the article on decreased vitamin B12 levels, or vitamin B12 deficiency, now considered to be a common side effect in patients on metformin treatment, especially in those receiving a higher dose or longer treatment duration and in those with existing risk factors. MRHA is therefore advising checking vitamin B12 serum levels in patients being treated with metformin who have symptoms suggestive of vitamin B12 deficiency. They also advise that periodic monitoring for patients with risk factors for vitamin B12 deficiency should be considered.</p> <p>JG said that his Practice had now incorporated this into annual diabetic reviews for patients on metformin, but felt that some comms was needed for practices to encourage them to make sure that this piece of information is taken up. SR flagged up health inequalities and socioeconomic effects and how well food and diet supplement for vitamin B.</p> <p>Communication to be sent to all PCN/Practices</p>	DK

12.0	<p>RWT and JAPC</p> <ul style="list-style-type: none"> • RWT APC confirmed minutes – (none available) • JAPC May 2022 Bulletin and confirmed minutes (none available) 	
13.0	<ul style="list-style-type: none"> • PSD aQIV 65 years and over 2022-2023 • PSD Zostavax PSD 2022-2023 • PSD Valent pneumonoccal vaccine PSD 2022-2023 • PSD Quadrivalent Influenza vaccine PSD 2022-23 <p>These were for information only</p> <p>MPFT have already approved through their MOpC and so no further action is required</p>	
14.0	<p>Any Other Business</p> <p>Metolazone</p> <p>Ben Eapen had sent apologies however he had sent an e-mail yesterday afternoon to highlight a branded licensed version of metolazone that MPFT Heart Failure Team had raised as they have been using an unlicensed version. Some initial concerns around the licensed product was it having a significantly different absorption profile to the unlicensed products, it would potentially need to be used in almost half the strength of the unlicensed product that are available. DC has also had discussions with the cardiologists at UHNM who had seen the same message.</p> <p>We have to look on ePACT to see the potential numbers of patients that we have in the system because it is an amber medicine. There is already a BNF warning that has been put in place to be clear that these two medicines are not bioequivalent and that if we were to prescribe the new licensed metolazone it would have to be prescribed by brand. Initial comms coming out from specialist teams within the system suggests that they would feel more comfortable remaining with the unlicensed product until regional specialist teams have had a chance to speak about it in more detail.</p> <p>JR asked the Group whether a message needed to go out to Primary Care and Community Pharmacy to warn them about this and ask for thoughts on whether we an interim message needed to be sent stating to stay with the unlicensed preparation to allow a wider discussion regionally.</p> <p>JG questioned if metolazone was prescribed generically, what stops the pharmacist issuing the branded preparation which is twice as potent. JR responded that the branded preparation was a higher cost and so they would be dissuaded from doing so because they wouldn't get the money back on that product. However, AM pointed out that a pharmacy could issue any drug that meets the description. ST agreed this was a risk across the system in different interface situations plus the community pharmacy which is highly unlikely, but still potentially possible which was of concern. JG was still concerned that there remained a possibility that any pharmacy could issue the new licenced version which could be catastrophic. As a safety net JG asked AC to include in letters to GPs that they asked the GP to prescribe 2.5 milligram tablets, like we do with methotrexate, until the issue is sorted.</p> <p>The APC/G agreed:</p> <ol style="list-style-type: none"> 1. To send out an email to GPs today providing interim advice not to accidentally switch 2. To contact Tania and Peter from the LPC to ask them to share a bulletin with community pharmacists and use our ePACT dispenser report to identify those pharmacies who have recently dispensed the medicine 3. To consider a final recommendation with the specialist team and bring recommendations to the APC/G meeting in September <p>ADHD Medicines</p> <p>HS recalled challenging and frank conversations over the last year about ADHD medicines and to have ESCAs in place until the new ICS was in place. Although NSCHT are working furiously through the worklist, unfortunately all haven't been reviewed. HS would like to ensure support for ESCAs to be extended and be absorbed into the work stream as they progress.</p>	JR

	<p>JG responded the problem with these drugs is that patients are often discharged from secondary care, leaving the GP with no shared care. Effectively, the GP has just got the drug and the patient and it becomes very difficult at that point. We have got to find a solution to the regular three monthly and 12 monthly monitoring of these drugs, either the system pays for GPs to do it, if they're willing, if the GPs aren't willing to do it, then there has to be something somewhere that picks this up whether it be at PCN level or whether it continues to sit with a hospital or some other system. The document is currently out for discussion.</p> <p>HS said that she wasn't specifically referring to adult ADHD but also CAHMS. HS acknowledges that it is particularly tricky regarding ADHD and that has been escalated to Commissioners because NSCHT also have concerns about private providers making diagnosis and requesting shared care from GPs because ultimately there needs to be a commissioned service.</p>	
	<p>Meeting Effectiveness -</p>	
	<ul style="list-style-type: none"> • <i>Did we achieve what we set out to do; linking back to the Agenda?</i> • <i>Were the Nolan Principles adhered to during the meeting?</i> • <i>Was the meeting ran effectively, in line with the Meetings Charter?</i> • <i>Do we need to escalate any issues or inform anyone of our decisions?</i> 	
	<p>AM informed the Group that as the organisation was now ICS that governance arrangements were still being put into place. At the moment there was no committee for outputs of discussions and agreements made at the APCG. He would be having discussions with the Chief Medical Officer and the Chief transformation officer together about our governance. The next meeting would be September giving time for conversations and IMOC guidance.</p> <p>ST said that the issue around edoxaban needed to be picked up during August and the Medicines Optimisation Team would arrange a meeting.</p>	<p>DK</p>
	<p>Date and Time of the Next Virtual Meeting</p> <p>Friday 23rd September 2022 2.00-4.00pm via MS Teams</p> <p>Please send apologies to fiona.porter@staffsstoke.icb.nhs.uk</p>	