

Surrey Heartlands Integrated Care System Area Prescribing Committee (APC)



MINUTES

Date	6th August 2025	Time	1430 - 1700
Venue	Microsoft teams invitation		

Name (Initials)	Role	Attendance /apologies												
		Jan Virtual	Feb	Mar	Apr	May	May 14th	Jun	Jul	Aug	Sep	Oct	Nov	Dec
APC voting members														
Dr Stephen Cookson (SC)	RSFT – Consultant Cardiologist (Chair)		√	√	A	√	√	√ left at 1512	√	√				
Sarah Watkin (SWa)	Head of Medicines Resource Unit – Surrey Heartlands Integrated Care Board (Deputy Chair)		√	√	√	A	√	√	A	√				
Linda Honey (LH)	Director of Pharmacy - Surrey Heartlands Integrated Care System		√ (left at 4pm)	√	A	√	√	√	√	√				
Sarah Flack	Primary Care Pharmacist, Surrey Downs Place representative								√ (from 3pm)	X				
Tara Bahri	Deputy Chief Pharmacist Out of Hospital, Surrey Downs Place		√	√	√	√	√	A	A	√				
Tim Dowdall	Deputy Chief Pharmacist Out of Hospital - Guildford & Waverley		√	√	√	√	√	A	√	√ (left at 1622)				
Lis Stanford	Deputy Chief Pharmacist Out of Hospital – North-West Surrey		A	√	√	√	√	√	√	√				
Monika Cunjamalay	Deputy Chief Pharmacist Out of Hospital – East Surrey		√	A	√	√	A	√	√	√				
Nikki Smith (NS)	Head of Medicines Safety / Patient Safety Specialist		√	√	√ (left at 15:43)	√	√	√	√	√				
Veronica Davis	RSFT – Formulary Pharmacist		√	√	√	√	√	√	A	√				
Jemma Hives	Clinical Lead Pharmacist - ASPH		√	X	X	X	A	X	X	X				

Asad Qureshi	Formulary Pharmacist - ASPH		A	√	√	√	√	√	√	X				
Nicky Leitch (NL)	SASH – Formulary Development Pharmacist		√	√	√	√	√	A	√	A				
Amy Fox or Kanwal Sheikh	ESHUT – Formulary and Medicines Optimisation Pharmacist		√	X	√	X	X	√	√	√				
Alison Marshall (AM)	SABPFT - Formulary Pharmacist		√	√	√	A	A	√	√	√				
Simon Whitfield	Chief Pharmacist – Surrey & Borders Partnership NHS Foundation Trust		A	X	X	X	√	√ left at 4pm	√	X				
	CSH - Lead Pharmacist		√	X	√	√	X	√	√	√				
Temitope Odetunde (TO)	FCH&C - Lead Pharmacist		X	√	X	X	X	X	X	√				
	ASPH - Medical Director or nominated representative		X	X	X	X	X	X	X	X				
Dr James Clark (JC)	SASH – Consultant Endocrinology & Diabetes Mellitus		X	X	√	√	√	√	√	√				
	ESHUT - Medical Director / Chair of DTC or nominated Consultant		X	X	X	X	X	X	X	X				
Dr Raja Badrakalimuthu	SABPFT – Chair of Medicines Optimisation Committee		√ (left at 3.23pm)	√	√	√	X	X	√	X				
	GP prescribing Lead (SD place) vacant position from July 2025		√	√	√	√	√	√	X	X				
Dr Darren Watts	GP prescribing Lead (Guildford & Waverley place)		√	√	√	√	√	√	√	√				
Dr Rebecca Rogers	GP prescribing Lead (North West Surrey place)		√	√	√	√	√	√	√	√				
Dr Claire Badawi	GP prescribing Lead (East Surrey place)		√	X	√	√	A	√	√	√				
Sunita Duggal (SD)	Multiprofessional prescribing representative – Advanced Nurse Practitioner		√	√	√	√	√	X	√	A				
Julia Powell (JP)	Chief Executive, Community Pharmacy Surrey & Sussex, on behalf of Sussex and Surrey Local Pharmaceutical Committees		√	√	√	√	A	A	A	√				

Dr Janice Kirby- Smith (JK-S)	Patient representative		√	√	√	√	A	√	√	√				
Mohamed Kharbouch	Patient representative		√	√	√	√	X	A	√	√				
Shani Corb (SC)	Chief Pharmacist - SECAMB		A	A	A	A	A	A	A	A				
Andy Law (AL)	Surrey Heartlands ICS finance representative		X	X	X	X	X	X	X	X				
Dr Ruchika Gupta (RG)	Surrey Heartlands ICS Clinical Director for Long Term Planning Delivery		√	√	A	A	X	√ from 1544	√	A				
Richard Barnett (RB)	Surrey Heartlands ICS quality directorate representative		√	√	√	√	X	√	√	√				
Liz Saunders (LS)	Surrey County Council - Public Health Consultant		X	X	X	X	X	X	X	X				
Non-voting members														
Dr Andreas Pitsiaeli	LMC representative								A	√				
Catrin Thomas (CT)	Medicines Management Pharmacist Kingston Hospital NHS Foundation Trust		X	X	X	X	X	X	X	X				
Judith Foy (JF)	Chief Pharmacist, Kingston Hospital NHS Foundation Trust		A	A	A	X	X	X	A	X				
TakHo Cheung or Amy Herbert	Medicines Governance and Value Pharmacy Representative - NHS Sussex ICB		X	X	X	X	X	X	X	√ from 1504				
Phillipa Blatchford (PB)	Principal pharmacist Commissioning (Croydon) – Interim professional secretariat of SWL IMOC		X	X	√	√	X	X	X	X				
	Representative from QVFH		X	X	X	X	X	X	X	X				
Gillian Ells (GE)	Acute/Interface Specialist Pharmacist NHS Sussex Commissioners		X	X	X	X	X	X	X	X				
Mohammed Asghar (MA)	Formulary Pharmacist Frimley Park Hospital NHS Foundation Trust		X	X	X	X	X	X	X	X				
	Public Health Consultant, West Sussex County Council		X	X	X	X	X	X	X	X				
	Pharmacy Lead Practice Plus Group		X	X	X		X	X	X	X				

	Surrey Heartlands Clinical Academy Representative		X	X	X	X	X	X	X	X				
Clare Johns (CJ)	Lead Pharmacy Technician – Medicines Resource Unit (MRU) – NHS Surrey Heartlands APC Secretariat		√	√	√	√	√	√	√	√				
Carina Joanes (CJo)	Lead Pharmacist - MRU (Clinical)		√	√										
Tejinder Bahra (TB)	Lead Pharmacist (MRU) Operational		√	√	√	√	X	√	√	√				
Georgina Randall (GR)	Senior Pharmacy Technician - MRU		√	√	√	√	X	√	√	√				
In attendance														
Jayesh Shah	Lead Primary Care Pharmacist for Mental Health Surrey Heartlands ICB									√	√			
Helen Garrod	Lead Cardiovascular Specialist Pharmacist NHS Surrey Heartlands ICB										√			

Item No.	Discussions and New Actions
1	<p>Introduction The chair welcomed members, presenters and all observers to the APC</p>
2	<p>Quorum The chair noted that the meeting was quorate</p>
3	<p>Declarations of Interest Members were asked if there were any declarations of interest for the agenda items that had not already been declared. The Chair confirmed shares in Astra Zeneca. Astra Zeneca are the manufacturers for dapagliflozin, which is on the APC agenda for NICE implementation. It was agreed that the chair would not take part in any discussion related to this item.</p>
4	<p>Minutes from previous meeting The final minutes from July APC were noted by the members.</p> <p>Matters Arising Cenobamate for treating focal onset seizures in epilepsy At the APC in July, the members agreed in principle for a change in traffic light status from RED to Blue (with specialist initiation). However, the APC requested more information about the monitoring requirements and timeframes if dose adjustment is required. The lead liaised with the local specialist teams and the information received was presented to the APC members. There were no further questions from the APC and the traffic light status was changed as proposed. It was proposed that in the PAD narrative, it was made clear that only specialist prescribers could initiate treatment, this clarification was requested by some of the local specialist teams.</p> <div style="border: 1px solid black; padding: 5px; margin: 10px 0;"> <p>The Surrey Heartlands Integrated Care System Area Prescribing Committee have agreed a change in traffic light status for Cenobamate for treating focal onset seizures in epilepsy in line with the review of NICE TA753.</p> <p>Cenobamate will be given a BLUE (with specialist prescriber initiation) with 12 weeks prescribing by the specialist team prior to transfer of care</p> </div> <p>ACTION:</p> <ul style="list-style-type: none"> • Add information to PAD/JF for reference (PAD admin)
5	<p>Action log The members were informed of updates to the following actions:</p> <ul style="list-style-type: none"> • Cenobamate for treating focal onset seizures in epilepsy <ul style="list-style-type: none"> ▪ Action will be closed • GnRH agonists in Breast Cancer and in Endometriosis <ul style="list-style-type: none"> ○ Finance are in discussion with trusts about a contract variation which will likely take about 6 months. ○ Leads are working with the primary care team to amend the Locally Commissioned service to include funding for administration for breast cancer and for endometriosis. <ul style="list-style-type: none"> ▪ Actions will remain open for further updates.
6	<p>Medicines safety highlight report Head of Medicines Safety shared a highlight report with the members, prior to the meeting. Points to note were as follows:</p> <ul style="list-style-type: none"> • Review of Paramedic Controlled Drug prescribing and 30 day deprescribing in GP practices. The information from that review will be shared with the MOB.

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	<ul style="list-style-type: none"> Second phase of the Medicines Waste campaign took place in June and July and featured a local community Pharmacist. The campaign has been shared on social media and on local news channels. Phase three will be launched in October 2025.
7	<p>NICE Guidance The APC noted the NICE guidance published since the last APC.</p>
8	<p>Urgent AOB: None to note</p>
9	<p>Catheter Formulary – update</p> <p>The Surrey Heartlands Continence Appliance Formulary was approved by APC in May 2025.</p> <p>Following input from local Infection Control teams, an amendment has been made to the statement around night bags. This is due to growing concerns regionally and nationally on the rise of Gram-negative bacteria and the fact that poor practice may result in infections.</p> <p>It was recommended that it should be made clearer that single use night bags should be the first line choice for all patients but that some patients may prefer/require drainable night bags. These should be changed at least weekly and if they become disconnected or contaminated.</p> <p>The updated proposed wording was agreed, and the updated formulary document will be added to the PAD/JF for reference</p> <div style="border: 1px solid black; padding: 10px; margin: 10px 0;"> <p>The Surrey Heartlands Integrated Care System Area Prescribing Committee has agreed amended wording in the guidance in relation to night bags as follows:</p> <p>Night Bags</p> <ul style="list-style-type: none"> Single use night bags should be the first choice for all patients Some patients may prefer/require drainable night bags but it should be noted that organisational policies may vary so take advice from infection control if you have any queries All drainable night bags must be changed at least every seven days, in line with manufacturer’s guidelines. It should be noted some drainage bags are designed for longer use (up to 28 days for some belly bags). If the bag is contaminated or becomes disconnected, it must be changed for a new product even if this is earlier than the scheduled change Drainable products should not be rinsed/washed out. Night bag stands are supplied free of charge and should be requested at time of first order </div> <p>ACTION:</p> <ul style="list-style-type: none"> Upload the amended catheter formulary to PAD (PAD admin)
10	<p>Stoma Formulary – update</p> <p>The Stoma accessories formulary and guidance on quantities prescribed were agreed by the APC in 2024. The lead provided information to the members on prescribing information since the formulary was launched with an overall reduction in cost and reduction in the number of items.</p> <p>The APC members were presented with the reviewed and updated formulary for agreement. It was noted that where non-formulary choices are requested, the centralised prescribing service</p>

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	<p>may refer back to the local specialists for advice. Guidance around stoma underwear and support has also been clarified.</p> <p>The updated and reviewed formulary was agreed as presented</p> <div data-bbox="264 427 1544 499" style="border: 1px solid black; background-color: #f9e79f; padding: 5px;"> <p>The Surrey Heartlands Integrated Care System Area Prescribing Committee has agreed the updated stoma formulary and guidance on quantities to prescribe</p> </div> <p>ACTION:</p> <ul style="list-style-type: none"> ○ Update the JF with the changes to the formulary (PAD admin) ○ Update the PAD with the new formulary document (PAD admin)
11	<p>Tirzepatide in Surrey Weight Management Service</p> <p>Following on from the implementation of tirzepatide for overweight and obesity management in primary care and the launch of the Locally Commissioned Service), the proposals to APC are to enable the SWMS service to initiate tirzepatide for the same cohort of patients eligible for treatment in primary care (cohort I as stated in the NHS E commissioning guidance .)</p> <p>Patients would continue to be referred to the service for assessment and for appropriate treatment (which will include bariatric surgery and medical options) under current referral criteria.</p> <p>In addition, there will be some patients discussed in the SWMS MDT who despite bariatric surgery being the preferred treatment option, are deemed too high risk to be offered this. In these patients' alternative treatment options including semaglutide (Wegovy) and tirzepatide (Mounjaro) will be considered where appropriate. The number of patients is anticipated to be low.</p> <p>The lead proposed a BLUE (with specialist initiation) traffic light status with specialists able to transfer care to the patients GP after 12 months treatment. It was noted that this is in line with the LCS in primary care, where annual reviews of associated co-morbidities will continue to take place in primary care.</p> <p>Members highlighted the need for support with patient communication in primary care and to ensure appropriate referrals into SWMS. There was concern that primary care could be in a position whereby a patient did not meet cohort I in the NHSE commissioning guidance and not initiated with tirzepatide in primary care or referred to SWMS if the GP considered that the patient may not be eligible for bariatric surgery due to risks.</p> <p>The leads agreed with work with the primary care leads on communication to support primary care.</p> <div data-bbox="264 1581 1544 1767" style="border: 1px solid black; background-color: #f9e79f; padding: 5px;"> <p>The Surrey Heartlands Integrated Care System Area Prescribing Committee has agreed a change in traffic light status for tirzepatide initiation in secondary care for overweight and obesity management.</p> <p>A BLUE (with specialist initiation from the SWMS) was agreed with prescribing by the SWMS for 12 months prior to transfer of care to primary care prescribers.</p> </div> <p>ACTION:</p> <ul style="list-style-type: none"> ○ Leads to liaise with SWMS and Primary Care to support communication to patients (GPs, SWM Service & LH) ○ Update JF with decision (PAD admin)

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12	<p>Inclisiran Quick Reference Guide</p> <p>The APC members were presented with an updated inclisiran quick reference guidance that had been reviewed with</p> <ul style="list-style-type: none"> ○ Updated links to resources section ○ Update to pricing structure and mechanism of supply for inclisiran ○ Update to inclisiran initiation checklist point 4 removing the preference to start ezetimibe before considering inclisiran in individuals eligible for injectable therapies as per the Summary of National Guidance for Lipid Management. <p>Members discussed the last point in relation to ezetimibe and it was highlighted by the lead author the importance for prescribers to understand the treatments, how far the patient is from target (at the point of maximally tolerated statins) and the percentage LDL-C reductions of the non-statin lipid lowering treatments to inform the shared decision making conversation with patients who are still not to target (at the point of maximally tolerated statin) in line with the Summary of National Guidance for Lipid Management</p> <p>The author considered it would be useful for prescribers to add in a table to the quick reference guide showing percentage reductions for each treatment to help prescribers make decisions for their patients.</p> <div style="border: 1px solid black; padding: 5px; margin: 10px 0;"> <p>The Surrey Heartlands Integrated Care System Area Prescribing Committee have agreed the updated Inclisiran Quick Reference Guide</p> </div> <p>ACTION:</p> <ul style="list-style-type: none"> ○ Add percentage reduction table into inclisiran Quick Reference Guide (HG) ○ Upload to PAD when completed (PAD admin)
13	<p>National Commissioning Guidance (NHS England): Medical Retinal Treatment Pathway in Wet Age-related Macular Degeneration (wet AMD)</p> <p>The APC members were presented with the NHS England national commissioning guidance and pathway for wet AMD. The guidance had wide consultation with local stakeholders and the local specialists were in agreement to adopt the pathway.</p> <p>The lead presented a comparison between the local wet AMD pathway and the national pathway and asked the APC to agree to some local adaptations which were based on previous decisions made at the APC. These were discussed and agreed as follows:</p> <p>Faricimab</p> <ul style="list-style-type: none"> ○ This treatment will continue to be offered at 2nd line after aflibercept 2mg (biosimilar when available) has been trialed. <p>Early AMD</p> <ul style="list-style-type: none"> ○ The current Surrey Heartlands wet AMD pathway supports the use of off label bevacizumab (Avastin®) intravitreal injection for use where a patients Best Corrected Visual Acuity (BCVA) is better than 6/12. This was a decision that the APC made, based on cost effectiveness in 2016. ○ The NHS England wet AMD pathway supports the use of biosimilar ranibizumab and biosimilar (when available) aflibercept 2mg. ○ The APC were in agreement that the biosimilar preparations should be used for this patient cohort but only ranibizumab biosimilar will be funded until the aflibercept 2mg biosimilar is available from December 2025. ○ It was agreed that bevacizumab (Avastin) would no longer be offered as an option <p>Aflibercept 8mg</p>

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	<ul style="list-style-type: none"> ○ This treatment will continue to be offered after use of aflibercept 2mg for those patients where dose intervals of greater than 8 weeks have not been achieved with aflibercept 2mg. <p>Late AMD</p> <ul style="list-style-type: none"> ○ Surrey Heartlands has previously funded patients with bevacizumab (Avastin®) for patients with a BCVA of worse than 6/96. ○ The NHS E commissioning guidance does not consider the use of any treatment where the visual acuity has reached this point. ○ The APC members noted the specialist comments received and the patient cohort who would most benefit from treatment after patients' eyesight has deteriorated beyond 6/96. However, they agreed that without considering the clinical evidence for use at this point in the pathway, they were unable to make a decision. ○ It was agreed that by the APC members that they could not continue to offer bevacizumab (Avastin®) to this cohort of patients because of the medico legal implications. ○ However, they agreed that on an interim position (for 6 months only) where patients with late AMD, defined as a BCVA of worse than 6/96, will be funded with ranibizumab biosimilar. This would allow the local clinicians time to prepare an evidence review for consideration of the biosimilar preparations (ranibizumab and aflibercept 2mg (available from December 2025) for this patient cohort. ○ After the 6 months has been reached the APC will withdraw funding for this patient cohort if an evidence review has not been prepared for consideration. <p>Based on the above discussions, bevacizumab (Avastin®) will be given a NON-FORMULARY traffic light status for use in wet AMD on the Joint Formulary</p> <p>The agreed local adaptations will be added to the pathway and will be circulated along with the APC minutes for agreement prior to PAD/JF upload and final ratification of the APC minutes.</p> <div style="border: 1px solid black; padding: 5px;"> <p>The Surrey Heartlands Integrated Care System Area Prescribing Committee have agreed to adopt the NHS England National Commissioning Guidance: Medical Retinal Treatment Pathway in Wet Age-related Macular Degeneration (wet AMD) [published in May 2025]</p> <p>Local adaptations were agreed as follows:</p> <p>Faricimab</p> <ul style="list-style-type: none"> ○ This treatment will continue to be offered at 2nd line after aflibercept 2mg (biosimilar when available) has been trialed. <p>Early AMD</p> <ul style="list-style-type: none"> ○ Only ranibizumab biosimilar is funded until the aflibercept 2mg biosimilar is available from December 2025. When biosimilar aflibercept 2mg is available, this too will be funded. <p>Aflibercept 8mg</p> <ul style="list-style-type: none"> ○ This treatment will continue to be offered after aflibercept 2mg has been used for those patients where dose intervals of greater than 8 weeks have not been achieved with aflibercept 2mg. <p>Late AMD (BCVA 6/96)</p> <ul style="list-style-type: none"> ○ On an interim basis (for 6 months only) patients' with late AMD with late AMD, defined as a BCVA of worse than 6/96, will be funded with ranibizumab biosimilar will be funded (or biosimilar aflibercept 2mg when available). After the 6 months has been reached the APC will withdraw funding for this patient cohort if an evidence review has not been prepared for consideration. </div>

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	<p>Bevacizumab (Avastin®)</p> <ul style="list-style-type: none"> ○ A NON-FORMULARY traffic light status for use in wet AMD was agreed. <p>ACTION:</p> <ul style="list-style-type: none"> ○ Send the adapted wet AMD pathway to APC members for agreement and comment (CJ) ○ Update JF for bevacizumab (Avastin) status (PAD admin) ○ Evidence review for treatment in late wet AMD to be added to APC workplan (CJ)
14	<p>APC appeals process and TOR – yearly review</p> <p>The APC Appeals Panel process and TOR were presented to the APC following an annual review. The members of the panel from the ICB will be taken from members of the senior leadership team that were not present at the APC where the decision being appealed was considered. The documentation was agreed as presented for upload to the PAD/JF for all appeals received moving forward.</p> <p>The Surrey Heartlands Integrated Care System Area Prescribing Committee have agreed the annual review of the APC appeals panel TOR & process</p> <p>ACTION:</p> <ul style="list-style-type: none"> ○ Add to PAD for reference (PAD admin)
15	<p>Dapagliflozin for treating chronic kidney disease (NICE TA1075)</p> <p>The APC members were presented with a briefing paper following the NICE publication TA1075 for dapagliflozin for treating chronic kidney disease. A NICE TA for dapagliflozin in CKD had previously been published and implemented in Surrey Heartlands in 2022. This new reviewed NICE TA has broader recommendations for eGFR and which mirrors the NICE TA recommendations made for empagliflozin for CKD in December 2023.</p> <p>The APC members noted the important information which has already been assigned to this treatment on the JF</p> <ul style="list-style-type: none"> ○ <i>'If a patient with diabetes were on insulin and on multiple other treatments, a discussion with the specialist team may be prudent prior to dapagliflozin initiation'.</i> <p>Traffic light status is already GREEN for dapagliflozin in CKD and the APC were in agreement that this GREEN status still applies. The APC did note that if the patient with diabetes is initiated on treatment by a prescriber that has no clinical knowledge of diabetes, there could be a potential risk of diabetes related problems. The APC considered that discussion at the MOOG about implementation and potential communications needed to support other specialists initiating treatment may be useful</p> <p>The Surrey Heartlands Integrated Care System Area Prescribing Committee agrees the implementation of dapagliflozin for treating chronic kidney disease in line with NICE TA 1075.</p> <p>Dapagliflozin will be considered GREEN on the traffic light system.</p> <p>Important information</p> <p>If a patient with diabetes were on insulin and on multiple other treatments, a discussion with the specialist team may be prudent prior to dapagliflozin initiation.</p> <p>ACTION:</p> <ul style="list-style-type: none"> ○ Upload briefing to PAD for reference (PAD admin)

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	<ul style="list-style-type: none"> ○ Link to NICE Guidance (TA1075) to PAD/JF for reference (PAD admin) ○ Consider through the MOOG, communication tools to support implementation in those patients initiated by other specialists outside endocrinology and primary care (TB)
16	<p>Joint Formulary – Skin Chapter The lead presented the proposed traffic light status for this chapter review. The lead asked the APC to agree to the proposed traffic light statuses for outstanding queries as follows:</p> <p>Topical erythromycin – NON- FORMULARY</p> <ul style="list-style-type: none"> ○ This is not recommended in NICE guidance but local specialists at Ashford & St Peters have requested that it remains as an option for patients with acne who do not meet NICE guidance ○ Topical erythromycin (either alone or in combination with oral antibiotics) is a NICE "DO NOT USE" as there is a risk of resistance with topical use. ○ APC agreed a NON-FORMULARY status <p>Glycopyrronium for hyperhidrosis</p> <ul style="list-style-type: none"> ○ The APC members were asked to consider a change in traffic light status from RED to BLUE (with specialist initiation and stabilisation), in line with the traffic light status of this product in the hypersalivation guidance. ○ Costs have reduced in primary care but are still higher than in secondary care, with tablets more expensive than solution. ○ It was noted that the 1mg/5ml oral solution (off-label use) is less costly than the tablets and so the APC agreed the proposed traffic light status (see below) ○ The APC agreed that the 400mcg/1ml oral solution (off-label use) should be non-formulary because it is much more costly than the other oral solution. <p>POST MEETING NOTE: This is in line with the hypersalivation guidance re transfer of care after 1 month</p> <ul style="list-style-type: none"> ○ Glycopyrronium oral solution (1mg/5ml) (off-label use) - BLUE (with specialist initiation) with transfer of prescribing responsibility to primary care after initiation and stabilisation of treatment - minimum of 1 month supply from the specialist team ○ Glycopyrronium tablets (off-label use) – NON-FORMULARY. The 1mg/5ml oral solution is a more cost-effective alternative preparation. ○ Glycopyrronium 400mcg/1ml oral solution (off-label use) – NON-FORMULARY <p>Products available Over the Counter (OTC) for self-care The APC members considered the traffic light status for the products below. A prescriber could advise that a patient purchases a treatment OTC but where this is not appropriate then the primary care prescriber may prescribe. The APC members agreed the following traffic light statuses below and it was noted that the JF could highlight that these preparations are available to purchase OTC.</p> <ul style="list-style-type: none"> ○ Amorolfine nail lacquer for fungal infection – GREEN ○ Clotrimazole for fungal infection - GREEN ○ Undecylenic acid with zinc undecenoate powder (Mycota®) for fungal infection – NON-FORMULARY <ul style="list-style-type: none"> ○ Treatment for athletes foot is listed in the NHS England guidance as a treatment that should not be routinely prescribed in primary care and is available OTC. ○ Aluminium chloride for hyperhidrosis – GREEN

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	<ul style="list-style-type: none"> ○ Crotamiton for pruritis - GREEN <p>Topical clindamycin for use in hidradenitis suppurativa This will be added to the APC workplan for consideration with all treatments for hidradenitis suppurativa at a future APC. Dermatology at ASPH to lead and MRU will support their application through APC process.</p> <p>ACTION:</p> <ul style="list-style-type: none"> ● Add all decisions to JF/PAD for reference (PAD admin) ● Add topical clindamycin for use in hidradenitis suppurativa to APC workplan (CJ)
17	<p>Joint Formulary – Antidepressants</p> <p>The lead presented the proposed traffic light status for this chapter review. The lead asked the APC to agree to the proposed traffic light statuses as follows:</p> <p>Fluvoxamine - GREEN</p> <ul style="list-style-type: none"> ● It has been highlighted that primary care may have less experience of using this treatment for this indication. ● The APC members agreed a GREEN traffic light status as proposed. <p>Venlafaxine – GREEN</p> <ul style="list-style-type: none"> ● It was noted that the NICE Clinical Knowledge Summaries (CKS) highlights that there is a potential risk of death from overdose with this treatment and tricyclic antidepressants. CKS also highlights the need to match the choice of antidepressant to the patient’s needs. ● The APC members agreed a GREEN traffic light status as proposed, <p>Dosulepin – NON-FORMULARY</p> <ul style="list-style-type: none"> ● Dosulepin will continue to be NON-FORMULARY for new initiations. There are patients that have been on this treatment for many years who are stabilised on treatment and for that small cohort of patients, there should be an attempt to deprescribe (if appropriate) and consideration for cardiac risk and toxicity, if treatment is to continue. ● It was noted by APC that for this cohort of patients staying on this treatment, there is unlikely to be MDT consideration, however primary care prescribers may liaise with specialists if needed. ● The APC members agreed NON-FORMULARY as proposed and PAD narrative will be amended to make allowance for continuation clearer <p>ACTION:</p> <ul style="list-style-type: none"> ● Dosulepin PAD narrative to be reviewed and updated (JS/PAD admin) <p>Trazodone – BLUE (with specialist initiation) – 3 months prescribing by specialist team prior to transfer of care</p> <ul style="list-style-type: none"> ● There was no traffic light status for this treatment previously. ● Primary Care leads agreed that this was an appropriate traffic light status although in some areas the mental health team would recommend that a GP initiate trazodone, so this traffic light status would be an active change for that area. <p>Agomelatine – AMBER</p> <ul style="list-style-type: none"> ● It was noted that a previous GREEN decision had been made by APC but this drug is not included in NICE guidance.

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	<ul style="list-style-type: none"> The APC members considered that AMBER would be a more appropriate traffic light status for this treatment. Place in therapy would be 2nd line where there have been side effects from initial treatment or 3rd line where depression has not improved after other antidepressants. It was noted from the Summary of Product Characteristics (SPC) that there is a requirement for regular liver function tests up to 24 weeks and then periodically as clinically indicated. <p>ACTION:</p> <ul style="list-style-type: none"> Develop an AMBER shared care information sheet for APC consideration prior to PAD upload (JS) <p>POST MEETING NOTE - On request of SABPT, agomelatine will not yet be added to joint formulary whilst SABPT further consider the impact of the amber decision. For update in October.</p> <p>Bupropion – RED</p> <ul style="list-style-type: none"> Originally recommended as non-formulary but following consultation within Surrey & Borders the traffic light status will be classified as RED. APC members agreed a RED traffic light status. <p>Fluoxetine tablets – NON-FORMULARY</p> <ul style="list-style-type: none"> APC members agreed as tablets are not a cost effective treatment option PAD narrative to include that the fluoxetine oral solution and dispersible tablets are clinically interchangeable for oral use, and the dispersible tablets are suitable for patients without dysphagia. The dispersible tablets are more cost effective <p>Sertraline Oral Solution</p> <ul style="list-style-type: none"> Both 100mg/5ml concentrate for oral solution and 50mg/5ml oral suspension are licensed preparations for depression. The 50mg/5ml oral suspension is more costly than the 100mg/5ml concentrate for oral solution but is a recommended product for use in paediatrics. The 100mg/5ml concentrate for oral solution is a concentrate which needs to be diluted with a 120ml of specified liquids only. It was highlighted that this could cause confusion for some patients. It was highlighted that the 100mg/5ml concentrate for oral solution is on formulary at Royal Surrey Hospital currently for short term use where a patient is unable to swallow. The APC discussed crushing of the tablets for patients who are fed through a tube (PEG/NG/Jejunostomy) and the risks involved with that. <p>It was agreed that the APC were unable to agree a traffic light status at this point in time and that more consideration would need to be given to treatment of the small group of patients who may be unable to swallow tablets for clinical reasons.</p> <p>Pregabalin for Generalised Anxiety Disorder (GAD) - GREEN</p> <ul style="list-style-type: none"> Used as monotherapy as a third line treatment option for GAD in line with NICE guidance APC members agreed a GREEN traffic light status <p>Clomipramine for Obsessive Compulsive Disorder – GREEN</p> <ul style="list-style-type: none"> Presented to APC with the indication of phobic obsessional states an indication which the APC considered would confuse prescribers. It was agreed that GREEN would be suitable if OCD is used as the indication instead, and also include the narrative from CKS, which would provide clarity.

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	<p>As a general point the APC were informed that the Joint Formulary can be used to provide clarity by highlighting preferred options in the 'important information' section. It can also be used to highlight place in therapy (1st or 2nd line etc) at a glance.</p> <p>ACTION:</p> <ul style="list-style-type: none"> • Add all decisions to JF/PAD for reference (PAD admin)
18	<p>Joint Formulary – Hypnotics & Anxiolytics</p> <p>This agenda item has been deferred for discussion at the September APC, however it was agreed that the following item would be considered because of safety concerns</p> <p>Propranolol for anxiety – NON-FORMULARY</p> <ul style="list-style-type: none"> • No longer recommended for use in anxiety • Risks associated with patients that may self-harm. • The Medicines Safety Committee have developed a poster highlighting the risk of overdose with this treatment, which will be uploaded to PAD/JF following agreement at APC. • It was agreed that the PAD/JF narrative would highlight that patients on treatment should be reviewed with a risk assessment for continued treatment. • APC members agreed a NON-FORMULARY traffic light status. <p>ACTION:</p> <ul style="list-style-type: none"> • Amend PAD narrative re review of patients on treatment (JS/ safety team) • Add decision to JF/PAD for reference (PAD admin)
19	<p>PAD holding statements</p> <p>The PAD holding statements were noted and agreed as presented</p>
20	<p>Wound Management Products on FP10 - Principles for Primary Care</p> <p>This reviewed and updated document was noted by the APC members</p> <p>ACTION:</p> <ul style="list-style-type: none"> • Upload document to JF/PAD for reference (PAD admin)
21	<p>AOB</p>
<p>Future meeting dates: (2.30pm to 5pm) via Microsoft teams calls</p> <ul style="list-style-type: none"> • Wednesday 3rd September 2025 	
<p>Signed and agreed by:</p> <p>Date: DD MMM YYYY Chair Name, Chair Title (Chair)</p>	
<p>Minutes agreed for publication by:</p> <p>Date: DD MMM YYYY Exec Lead name, Exec Lead Title (Exec Lead)</p>	