

Amy Fox or Kanwal Sheikh	ESHUT – Formulary and Medicines Optimisation Pharmacist	√	√	√										
Alison Marshall (AM)	SABPFT - Formulary Pharmacist	√	√	√										
Simon Whitfield (SWH)	Chief Pharmacist – Surrey & Borders Partnership NHS Foundation Trust	√	√	A										
	CSH - Lead Pharmacist	√	√	√										
Temitope Odetunde (TO)	FCH&C - Lead Pharmacist	X	X	X										
Dr Anthony Parsons	ASPH Specialty Lead for Intensive Care Medicine	A	√	√										
Dr James Clark (JC)	SASH – Consultant Endocrinology & Diabetes Mellitus	√	√	√										
Vacant position	ESHUT - Medical Director / Chair of DTC or nominated Consultant	X	X	X										
Dr Raja Badrakalimuthu	SABPFT – Chair of Medicines Optimisation Committee	√ (left 15 1530)	X	X										
Vacant position	GP prescribing Lead (SD place) vacant position from July 2025	X	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)	√	√	A										
Sunita Duggal (SD)	Multiprofessional prescribing representative – Advanced Nurse Practitioner	A	√	A										
Julia Powell (JP)	Chief Executive, Community Pharmacy Surrey & Sussex, on behalf of Sussex and Surrey Local Pharmaceutical Committees	√	√	√										
Dr Janice Kirby- Smith (JK-S)	Patient representative	√	√	√										

Mohamed Kharbouch	Patient representative	A	X	√									
Shani Corb (SC)	Chief Pharmacist - SECAMB	A	A	A									
Andy Law (AL)	Surrey Heartlands ICS finance representative	X	X	X									
Dr Ruchika Gupta (RG)	Surrey Heartlands ICS Clinical Director for Long Term Planning Delivery	A	X	A									
Vacant position	Surrey Heartlands ICS quality directorate representative	X	X	X									
Dr Andreas Pitsiaeli	LMC representative	√	A	√									
Liz Saunders (LS)	Surrey County Council - Public Health Consultant	X	X	X									
Non-voting members													
Catrin Thomas (CT)	Medicines Management Pharmacist Kingston Hospital NHS Foundation Trust	X	X	X									
Judith Foy (JF)	Chief Pharmacist, Kingston Hospital NHS Foundation Trust	A	X	X									
TakHo Cheung or Amy Herbert	Medicines Governance and Value Pharmacy Representative - NHS Sussex ICB	A	√	A									
Phillipa Blatchford (PB)	Principal pharmacist Commissioning (Croydon) – Interim professional secretariat of SWL IMOC	X	√	XX									
	Representative from QVFH	X	X	X									
Mohammed Asghar (MA)	Formulary Pharmacist Frimley Park Hospital NHS Foundation Trust	X	X	X									
	Public Health Consultant, West Sussex County Council	X	X	X									
	Pharmacy Lead Practice Plus Group	X	X	X									
	Surrey Heartlands Clinical Academy Representative	X	X	X									
Clare Johns (CJ)	Lead Pharmacy Technician – Medicines Resource Unit (MRU) – NHS Surrey Heartlands APC Secretariat	√	√	√									

Tejinder Bahra (TB)	Lead Pharmacist (MRU) Operational	√	√	√									
Georgina Randall (GR)	Senior Pharmacy Technician - MRU	A	√	√									
In attendance													
Rachel Claridge	Lead Pharmacy Technician – Primary Care – Surrey Heartlands (for JF papers only)	√	√	√									
Helen Marlow	Lead specialist Pharmacist for Respiratory medicines (for respiratory papers only)			√									
Helen Garrood	Lead specialist Pharmacist for Cardiovascular medicines (for respiratory papers only)			√									

Item No.	Discussions and New Actions
1	<p>Introduction The Chair welcomed members, new 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. Astra Zeneca shares were noted for the Chair of the APC for the SGLT2 change in traffic light status paper.</p>
4	<p>Minutes from previous meeting & matters arising The lead author for the denosumab paper, discussed at the APC in February, requested an amendment to the minutes for that item. In relation to Zadenvi®, (preferred denosumab preparation being used in the local hospitals) the company do have experience in the UK in the primary care setting and so reference made that they do not have experience will be removed from the minutes. It was noted that this would not affect the decision made at the APC as that decision was related to cost effectiveness of products used in primary care not in hospitals.</p> <p>ACTION:</p> <ul style="list-style-type: none"> • Amend minutes as agreed and upload to PAD for reference (PAD admin) <p>Matters Arising Governance arrangements for April 2026 onwards The Director of Pharmacy informed the members that the governance structures for the new organisation, Surrey & Sussex ICB, is in the process of being established. It is proposed therefore that the APC does not meet in April 2026 whilst the new structures are being developed. The intention is to move towards a Surrey & Sussex ICB Area Prescribing Committee in due course, but this could take some time, and so it may be that in the interim, separate APCs are held, but this is still unknown at the current time. Any items that need urgent virtual agreement will be circulated to the members for consideration if needed. It was noted that there are discussions taking place across the South-East region, about macro ICB working and so there is also a potential for a wider regional APC at some point. Acknowledgement was given to the wider team that manage the APC and the lead authors of papers who work hard to ensure that the APC members can make robust decisions and that the APC runs smoothly each month.</p> <p>Targeted release budesonide for treating primary IgA nephropathy – NICE TA1128 (Published 04 February 2026, replaces TA937) Members were informed that NICE have reviewed and replaced NICE TA937. NICE TA1128 will extend the cohort of eligible patients, by reducing the threshold for eligibility, so that patients will be treated earlier in the pathway. From a financial perspective this could mean that more patients would be treated with targeted release budesonide and so the associated costs would increase over time, but NICE anticipate that this would be under £100,000 per place. The traffic light status for this treatment is currently RED, and the lead author recommended that this status remains in place. It was noted this treatment is not provided by the Trusts in Surrey Heartlands but is on formulary at other local Trusts who provide renal services. Prescribing should remain with the specialist teams. It was highlighted that consideration needs to be given to inclusion in horizon scanning for acute trust budgets but to note that none of our hosted Trusts provide this service.</p>

Item No.	Discussions and New Actions
	<p>The APC members were informed that the Blueteq forms will be updated to reflect the new guidance.</p> <p>ACTION:</p> <ul style="list-style-type: none"> • Update Blueteq forms as per NICE TA1128 (GR)
5	<p>Action log</p> <p>The Secretariat asked the APC members to consider the outstanding actions within the action log as follows:</p> <p>ADHD in adults shared care review:</p> <ul style="list-style-type: none"> • APC members agreed to close this action • Work is progressing but the actions do not sit with APC <p>ACTION CLOSED</p> <p>Audit of outpatient communication standards – Report from DTCs</p> <ul style="list-style-type: none"> • DTCs have considered the results of the audit and will provide their plans to the next APC <p>ACTION</p> <p>Formulary Pharmacists to provide update to next APC (Formulary Pharmacists)</p> <p>IPP</p> <ul style="list-style-type: none"> • IPP has been considered at the MOB for ratification • Current IPP will remain on the PAD/JF until Sussex colleagues have taken reviewed IPP through governance processes <p>ACTION CLOSED</p>
6	<p>Medicines safety highlight report</p> <p>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"> • National Patient Safety Alert (NPSA) – Harm from incorrect recording of penicillin allergy as penicillamine allergy (November 2025). All partner organisations are feeding back on their actions to the Medicines Safety team. • Supporting public health team on services where people are obtaining supplies of drugs from a questionable source
7	<p>NICE Guidance</p> <p>The APC noted the NICE guidance published since the last APC and agreed to add the proposed holding statements to the drug profiles on the Joint Formulary for the NICE terminated appraisals.</p> <p>ACTION:</p> <ul style="list-style-type: none"> • Add holding statements to profiles on JF as proposed (PAD admin)
8	<p>Urgent AOB: None to note</p>
9	<p>Horizon scanning and formulary updates – Formulary management</p> <p>A standing agenda item for the APC is to update members on minor formulary amendments including new formulations that maybe considered more cost effective than currently agreed formulations on the Joint Formulary (JF).</p> <p>Holding statements:</p> <p>Holding statement for potassium citrate (modified release tablets) (Renodyra®) and mepolizumab (Nucala®) were noted as proposed</p> <p>Discontinuations:</p> <p>The proposed amendments to the JF/PAD were agreed as follows:</p> <p>Buprenorphine/Naloxone (Suboxone®)</p> <ul style="list-style-type: none"> • To note that the alternative brands are not bioequivalent • Brand removed from JF <p>Buprenorphine (Subutex®)</p> <ul style="list-style-type: none"> • To note that the alternative brands are not bioequivalent

Item No.	Discussions and New Actions
	<ul style="list-style-type: none"> Brand removed from JF <p>Nifedipine 30mg & 60mg (Adipine XL®)</p> <ul style="list-style-type: none"> Brand options are currently limited, so the lead requested a change to the PAD narrative to recommend any available brand or twice daily preparations. The PAD narrative below was agreed by the APC members <ul style="list-style-type: none"> <i>Nifedipine once-daily tablets: there are limited options available on the market following the discontinuation of Adalat LA, Adipine XL and Fortipine LA. Prescribers should consider a twice-daily nifedipine or a once-daily capsule. Additional information is available here Discontinuation of Nifedipine (Adipine XL) 30mg and 60mg modified-release tablets – NHS SPS - Specialist Pharmacy Service – The first stop for professional medicines advice</i> <p>Lusutrombopaq (Mulpleo®)</p> <ul style="list-style-type: none"> Profile removed from JF <p>Additions to the Joint Formulary The proposed amendments to the JF/PAD were agreed as follows:</p> <p>Aflibercept biosimilar</p> <ul style="list-style-type: none"> Two new biosimilars (Yesafili® & Vgenfli®) have been added to the JF <p>Potassium chloride 375mg/5ml (potassium 5mmol/5ml) oral solution sugar free</p> <ul style="list-style-type: none"> Licensed liquid is now available This is the recommended referred option as there are a number of unlicensed products being prescribed in primary care. APC members agreed a BLUE (on specialist team recommendation) traffic light status <p>ACTION</p> <ul style="list-style-type: none"> Upload decisions to JF (PAD admin)
10	<p>Joint Formulary – Devices</p> <p>The lead presented the chapter review to the APC members. It was noted that there are numerous prescribable devices available. The lead requested and the APC agreed that the following holding statement be added to the JF for Neuropad, IQoro, Needle free insulin devices (InsuJet, Injex, Eziautojector), Knee pressure offloading devices (Action Reliever, Clima-Flex OA, Formfit OA Ease, medi Soft OA light, OA Reaction Web), RESPeRATE & Noctura 400</p> <ul style="list-style-type: none"> <i>This device has not been assessed or agreed for inclusion on the formulary. Primary Care must not be asked to prescribe until a place in therapy has been agreed by the APC. Contact your pharmacy / medicines optimisation team for advice.</i> <p>ACTION</p> <ul style="list-style-type: none"> Upload statement to JF device profiles (PAD admin)
11	<p>Joint Formulary – Vaccines</p> <p>The lead presented the chapter review to the APC members and the traffic light statuses that were agreed as presented</p> <p>To note that updates to the vaccines used in the national immunisation programme will be brought to APC for noting as required. Links to national PGDs and the Green book will be provided on the JF to make the entries as comprehensive as possible.</p> <p>ACTION</p> <ul style="list-style-type: none"> Upload decisions to JF (PAD admin)
12	<p>Guidance to support the appropriate use of home nebulisers for adult respiratory patients in the community</p>

Item No.	Discussions and New Actions
	<p>The guidance was originally developed to support the Surrey-wide procurement for home nebulisers issued to adult respiratory patients in 2009. The current model is being reviewed and from September 2026, the providers will hold the contract for the home nebuliser service. The reviewed guidance will support the new model and also support appropriate referrals from primary care. The members requested clarification about referrals from a tertiary centre to Respiratory Care Teams (RCTs) and it was noted that in Surrey, most of the RCTs are in the community and so it would be appropriate for a tertiary centre to liaise with the patients GP to refer into the appropriate RCT locally. The APC agreed the reviewed guidance as presented.</p> <p>The Surrey Heartlands Integrated Care System Area Prescribing Committee has agreed the guidance to support the appropriate use of home nebulisers for adult respiratory patients in the community</p> <p>ACTION</p> <ul style="list-style-type: none"> • Upload guidance to PAD (PAD admin)
13	<p>Change in traffic light status application for nebulised colistimethate</p> <p>Historically nebulised colistimethate was given a BLUE traffic light status for patients with bronchiectasis, but the APC have not considered the appropriateness of the BLUE status. It was noted that the patient cohort that would be treated with colistimethate should remain under the care of the specialist and so an AMBER traffic light status would be more appropriate. Colistimethate is used off-label for the long-term management of lung infections caused by Pseudomonas aeruginosa in adult patients with non-cystic fibrosis bronchiectasis, administered via a nebuliser. Patients need to be reviewed every 6 – 12 months depending on their response to treatment</p> <p>The patient numbers being treated with nebulised colistimethate is small in Surrey. AMBER shared care is considered more appropriate than a BLUE traffic light status as GPs would not be reviewing these patients or checking that the patient is using their nebuliser appropriately. The current process is that a decision is made at the APC and if agreed a shared care document is brought to the next APC for agreement. However, the lead considered it more prudent to include information about monitoring in the presented paper so that the members could see the monitoring requirements for the specialist teams and also primary care.</p> <p>The members agreed with the proposals and acknowledged that by changing the traffic light status to AMBER, this would ensure that patients currently being treated with nebulised colistimethate would be regularly reviewed by the specialist team. The proposed shared care document will be circulated to the APC members for virtual agreement so that an agreed document with prescribing responsibilities for all stakeholders can be added to the PAD for reference.</p> <p>The Surrey Heartlands Integrated Care System Area Prescribing Committee has agreed the change in traffic light status for colistimethate from BLUE to AMBER</p> <p>ACTION:</p> <ul style="list-style-type: none"> • Secretariat to circulate AMBER shared care document to APC members for virtual agreement (CJ) • Update PAD/JF with decision (PAD admin)

Item No.	Discussions and New Actions
14	<p>Sodium Chloride Nebules</p> <p>The lead author presented a paper to the APC proposing traffic light statuses and preferred brands for nebulised sodium chloride as follows:</p> <p>Sodium chloride 0.9% Two products are prescribable in primary care. Sodium chloride 0.9% nebuliser liquid 2.5ml unit dose ampoules is a medicinal product, licensed for dilution of solutions for nebulisation. e.g. colistimethate. Sodium Chloride 0.9% inhalation solution (in vials) is a medical device, licensed for the humidification of the airways. The majority of prescribing in primary care is for the medicinal product (sodium chloride 0.9% nebuliser liquid 2.5ml unit dose ampoules), being used off-label for patients requiring humidification of the upper and lower airways.</p> <p>It was also noted that the 0.9% sodium chloride nebuliser liquid 2.5ml unit dose ampoules licensed for the dilution of solutions for nebulisation are more expensive than the product licensed for humidification of the airways. The lead recommended that the JF is made clearer to highlight the licensed use for each preparation.</p> <p>A BLUE (on specialist team initiation) for each product was proposed and agreed as follows</p> <p>Sodium chloride 0.9% nebuliser liquid 2.5ml unit dose ampoules</p> <ul style="list-style-type: none"> • Licensed indication - Dilution of solutions for nebulisation • BLUE (with specialist team initiation) as diluent for nebulisation of drugs <p>Sodium chloride 0.9% inhalation solution 2.5ml vials</p> <ul style="list-style-type: none"> • Prescribe by brand – Medical device • The most cost-effective brand is PulmoClear 0.9% inhalation solution • Licensed indication – Humidification of the upper and lower airways • BLUE (with specialist team initiation) as nebulised therapy <p>By ensuring clarity on the JF it is anticipated that the correct product will be prescribed for the indication being treated. OptimiseRx messages will be strengthened to facilitate this. A switch programme is being considered for next year to ensure that patients will be switched to the most appropriate product for the indication being treated.</p> <div style="background-color: yellow; border: 1px solid black; padding: 5px;"> <p>The Surrey Heartlands Integrated Care System Area Prescribing Committee has agreed the following for Sodium Chloride 0.9% nebuliser liquid 2.5ml unit dose ampoules as follows:</p> <p>Sodium chloride 0.9% nebuliser liquid 2.5ml unit dose ampoules</p> <ul style="list-style-type: none"> • BLUE (with specialist team initiation) for dilution of solutions for nebulisation <p>Sodium chloride 0.9% inhalation solution 2.5ml vials</p> <ul style="list-style-type: none"> • BLUE (with specialist team initiation) for humidification of the upper and lower airways as nebulised therapy • Prescribe by brand – Medical device • The most cost-effective brand is PulmoClear 0.9% inhalation solution • Licensed indication – Humidification of the upper and lower airways </div> <p>Sodium chloride 3%, 6% and 7% inhalation solutions The traffic light status for these products is currently RED for mobilisation of lower respiratory tract secretions but there is a substantial amount of prescribing in primary care. To reflect current practice the lead proposed that the traffic light status for these inhalation solutions is changed to BLUE (with specialist team initiation).</p>

Item No.	Discussions and New Actions
	<p>It was proposed that the most cost-effective brand PulmoClear is used. These are medical devices and Surrey Heartlands trusts will prescribe generically, as they may not be purchasing the most cost-effective brand from a primary care perspective.</p> <p>OptimiseRx messages will be used to support the correct product choice.</p> <p>A switch programme is being considered for next year to ensure that patients will be switched to the most appropriate product for the indication being treated.</p> <p>The Surrey Heartlands Integrated Care System Area Prescribing Committee has agreed the following for Sodium Chloride higher strength nebulas as follows:</p> <p>Sodium chloride 3%, 6% and 7% inhalation solutions</p> <ul style="list-style-type: none"> • BLUE (with specialist team initiation) for mobilisation of lower respiratory tract secretions as nebulised therapy • Prescribe by brand – Medical device • The most cost-effective brand is PulmoClear 3%, 6% or 7% inhalation solution <p>ACTION</p> <ul style="list-style-type: none"> • Update PAD/JF with decision (PAD admin)
15	<p>Change in traffic light status application for azithromycin</p> <p>It was noted that azithromycin is unlicensed for the long-term use in respiratory disease for the prevention of infection, but it is recommended in British Thoracic Society (BTS) guidance and in NICE guidance.</p> <p>The recommendations in the BTS guidance are clear that there should be an ECG, sputum culture and measurement of LFTs before initiation, with a repeat ECG and LFTs after one month of treatment and then LFTs again after 6 months. This monitoring schedule is to ensure that the use of long-term azithromycin is safe.</p> <p>The specialist teams highlighted at a recent meeting (post consultation) that there is no capacity in secondary care to monitor this patient cohort. The APC members acknowledged the specialist teams concerns but noted that if a clinician makes a decision to initiate a treatment and as part of that initiation there is a need, because of safety concerns, to perform an ECG and measure LFTs at initiation and after an initial treatment period as the monitoring schedule, then it is the initiating clinician who should be responsible for the monitoring.</p> <p>A BLUE (with specialist team initiation) traffic light status was proposed. The specialist team should undertake the repeat ECG & LFT monitoring (at 1 month) as per the BTS guidance. The specialist team should continue to prescribe treatment until the ECG & LFT results have been reviewed as normal, and time given to communicate this in writing to primary care, with a request to transfer prescribing responsibilities.</p> <p>The APC members were very clear that from a safety perspective that the initial monitoring needs to be completed by the specialist team and that capacity issues with the system would need to be discussed outside of the APC.</p> <p>The APC members agreed with the proposed traffic light status</p> <p>The Surrey Heartlands Integrated Care System Area Prescribing Committee has agreed a traffic light status for patients being treated long-term with azithromycin for the prevention of exacerbations and infections in adults with severe respiratory disease.</p>

Item No.	Discussions and New Actions
	<p>A BLUE (with specialist team initiation) traffic light status was agreed.</p> <p>The specialist team should initiate treatment and then undertake the repeat ECG & LFT monitoring (at 1 month) as per the BTS guidance. The specialist team should continue to prescribe treatment until the ECG & LFT results have been reviewed as normal, and time given to communicate this in writing to primary care, with a request to transfer prescribing responsibilities.</p> <p>ACTION</p> <ul style="list-style-type: none"> • Update PAD/JF with decision (PAD admin)
16	<p>Oscillating Positive Expiratory Pressure (OPEP) devices</p> <p>The lead author presented a paper requesting consideration for preferred OPEP devices. OPEP devices are medical devices that can be prescribed on FP10. Pharmacy departments in the hospitals do not supply them and therefore they do not go through the DTC governance process like medicines.</p> <p>There are seven devices available currently, used for airways clearance. In patients with severe respiratory disease, airways clearance techniques are recommended in national and international guidelines.</p> <p>The lead requested that three OPEP devices (Acapella, Aerobika and Flutter) are made available to give options to patients needing to use them. The initial device would be supplied by the specialist respiratory service, who would teach the patient how to use the device and then assess response. If the patient needs repeat devices it may be appropriate to ask the GP to prescribe on an ongoing basis. Devices should be replaced every 6-12 months depending on the device.</p> <p>The APC members agreed with the proposal but emphasised the importance and responsibility of the specialist (respiratory) team initiating these devices of teaching the patient to use the device and also assessing response before asking primary care to continue prescribing.</p> <p>The Surrey Heartlands Integrated Care System Area Prescribing Committee has agreed a traffic light status for Oscillating Positive Expiratory Pressure (OPEP) devices</p> <p>Acapella, Aerobika and Flutter are the preferred devices in Surrey Heartlands ICB.</p> <p>A BLUE (with specialist (respiratory) team initiation) traffic light status was agreed. The initial device will be supplied by the specialist respiratory service, who will teach the patient to use the device and then assess response.</p> <p>After assessment and if the patient needs repeat devices, primary care can be asked to prescribe on an ongoing basis.</p> <p>ACTION</p> <ul style="list-style-type: none"> • Update PAD/JF with decision (PAD admin)
17	<p>Change in Traffic Light Status for SGLT2s in heart failure</p> <p>The lead author presented a paper requesting a change in traffic light status for the SGLT2s (dapagliflozin & empagliflozin), from BLUE to GREEN. The NICE heart failure guidelines</p>

Item No.	Discussions and New Actions
	<p>(NG106) have recently been updated, and they have removed the requirement for GPs to seek specialist advice from a heart failure specialists before prescribing SGLT2 inhibitors.</p> <p>Dapagliflozin and empagliflozin have a GREEN traffic light status for patients living with type 2 diabetes and CKD. Changing the traffic light status for patients with heart failure would improve patient access and promote earlier intervention.</p> <p>The GREEN traffic light status is welcomed by the heart failure specialist teams, and NHS England and the Primary Care Cardiovascular Society specifically requested a GREEN traffic light status during the NICE guidance consultation.</p> <p>To note, dapagliflozin is the preferred SGLT2 inhibitor in Surrey Heartlands based on a decision made at the APC in September 2025</p> <p>The proposed change in traffic light status would also bring Surrey Heartlands ICB in line with our colleagues in Sussex</p> <p>The APC members agreed with the change in traffic light status and the PAD admin will remove documents as proposed from the PAD and add links to NICE visual summaries for reference.</p> <div style="background-color: yellow; border: 1px solid black; padding: 5px;"> <p>The Surrey Heartlands Integrated Care System Area Prescribing Committee has agreed a change in traffic light status for dapagliflozin & empagliflozin for the treatment of symptomatic chronic heart failure</p> <p>A GREEN traffic light status was agreed for dapagliflozin & empagliflozin</p> <p>Dapagliflozin is the preferred SGLT2 inhibitor based on a decision made at the APC in September 2025</p> <p>ACTION</p> <ul style="list-style-type: none"> • Update PAD/JF with decision (PAD admin) • Remove documents from PAD as proposed (PAD admin) • Add links to NICE visual summaries for reference (PAD admin) </div>
18	<p>SSRIs in Post Traumatic Stress Disorder (PTSD)</p> <p>At the September 2025 APC the formulary status of oral antipsychotics was changed from BLUE on specialist initiation with stabilisation by a SABP specialist for a minimum of 3 month to a minimum of 1 months before a request to transfer prescribing responsibility to primary care</p> <p>This was because at the time of the decision the impact of this change had not been fully assessed by SABP colleagues and therefore did not inform the decision-making process.</p> <p>The lead author requested that the treatments used in PTSD were also given the same status as the anti-psychotics i.e. in that transfer of care could be requested after 1 month, rather than 3 months.</p> <p>The members were clear that as per previous discussions it is important that a patient is stable on the dose being prescribed prior to requesting a transfer of care to primary care. That stability was defined by the lead author in that a request for transfer of care to primary care could be made after monitoring for treatment efficacy has been completed and the patient has been stable, defined such that symptoms are not interfering with daily life for at least 1 month.</p>

Item No.	Discussions and New Actions
	<p>Taking all of the above factors into consideration, the APC members agreed to change the length of prescribing from 3 months. However, it was requested that the PAD narrative is made very clear about the expectations of prescribers from both primary and secondary care. The patient should be taking the optimal treatment dose, and their mental health should be stable prior to the request for transfer of care to primary care</p> <p>A request for transfer of care to primary care could be made after monitoring for treatment efficacy has been completed, the patient is on the optimal treatment dose and has been stable, defined such that symptoms are not interfering with daily life for at least 1 month.</p> <p>The Surrey Heartlands Integrated Care System Area Prescribing Committee has agreed to change the length of prescribing of citalopram, escitalopram, sertraline, fluoxetine and paroxetine for the treatment of PTSD.</p> <p>BLUE (with specialist team initiation). A request for transfer of care to primary care can be made after monitoring for treatment efficacy has been completed, the patient is on the optimal treatment dose and has been stable, defined such that symptoms are not interfering with daily life for at least 1 month.</p> <p>ACTION</p> <ul style="list-style-type: none"> • Update PAD/JF with decision (PAD admin)
19	<p>Venlafaxine for PTSD (as per CKS)</p> <p>The APC members considered adding venlafaxine to the products available for the treatment of PTSD. Venlafaxine is included in CKS for this indication and so the APC agreed that this should be added to formulary.</p> <p>Members discussed the need to screen for high blood pressure prior to initiation and requested that the specialist team communicate the results to primary care prior to the request for transfer of care.</p> <p>A BLUE (with specialist team initiation) traffic light status was agreed. A request for transfer of care to primary care could be made after monitoring for treatment efficacy has been completed, the patient is on the optimal treatment dose and has been stable, defined such that symptoms are not interfering with daily life for at least 1 month.</p> <p>The Surrey Heartlands Integrated Care System Area Prescribing Committee has agreed the addition of venlafaxine for the treatment of PTSD to the Joint Formulary.</p> <p>BLUE (with specialist team initiation). A request for transfer of care to primary care can be made after monitoring for treatment efficacy has been completed, the patient is on the optimal treatment dose and has been stable, defined such that symptoms are not interfering with daily life for at least 1 month.</p> <p>ACTION</p> <ul style="list-style-type: none"> • Update PAD/JF with decision (PAD admin)
20	Biological Biosimilar of Best Value Framework – update

Item No.	Discussions and New Actions
	<p>The policy has been reviewed and will now be called a framework. There are minimal changes to the document but those include the reference to a framework rather than a policy and an overarching statement to outline the expectations of uptake of biosimilars in primary care.</p> <p>The framework will be available for hospitals to adopt or adapt as required.</p> <p>The APC members agreed with the reviewed document, and this will replace the policy on the PAD</p> <p style="background-color: yellow;">The Surrey Heartlands Integrated Care System Area Prescribing Committee has agreed the Biological Biosimilar of Best Value Framework</p> <p>ACTION</p> <ul style="list-style-type: none"> • Update PAD/JF with framework (PAD admin)
21	<p>Items not to be routinely prescribed – Category 2 (Recommendations 1 (paper 1) & 2 (paper 2))</p> <p>The APC members were presented with a review of the latest version of the NHS policy guidance for items that should not be prescribed in primary care. The guidance has 2 categories and the APC have already considered items in category 1.</p> <p>Category 2 is split into 2 sets of recommendations, and the lead author asked the APC to consider each set of recommendations in turn.</p> <p>Recommendation 1: Items where prescribing may be appropriate in some exceptional circumstances.</p> <ul style="list-style-type: none"> • Do not initiate in primary care. • Deprescribe in patients currently prescribed this item. • Prescribe only if no other item or intervention is clinically appropriate. • Prescribe only if no other item or intervention is available. <p>The lead author had reviewed all products listed in recommendation 1 on the JF and made recommendations to the APC for each item as follows:</p> <ul style="list-style-type: none"> • Aliskerin <ul style="list-style-type: none"> ○ Add NON-FORMULARY traffic light status • Bath and Shower Preparations <ul style="list-style-type: none"> ○ Add NON-FORMULARY traffic light status ○ Add following commentary to restrictions/comments section: • Dosulepin <ul style="list-style-type: none"> ○ No change required on PAD/JF • doxazosin (prolonged release) <ul style="list-style-type: none"> ○ No change required on PAD/JF • Lutein and antioxidants <ul style="list-style-type: none"> ○ Add NON-FORMULARY traffic light status • oxycodone and naloxone combination product <ul style="list-style-type: none"> ○ No change required on PAD/JF • paracetamol and tramadol combination product <ul style="list-style-type: none"> ○ No change required on PAD/JF

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	<ul style="list-style-type: none"> • perindopril arginine <ul style="list-style-type: none"> ○ No change required on PAD/JF • rubefacients, benzydamine, mucopolysaccharide and cooling products (excluding NSAIDs and capsaicin) <ul style="list-style-type: none"> ○ No change required on PAD/JF • trimipramine <ul style="list-style-type: none"> ○ No change required on PAD/JF <p>Recommendation 2: Items where prescribing may be appropriate in some <u>exceptional circumstances</u>.</p> <ul style="list-style-type: none"> • Do not initiate in primary care. • Deprescribe in patients currently prescribed this item. • Prescribe only if no other item or intervention is clinically appropriate. • Prescribe only if no other item or intervention is available • Prescribe only if for an indication named in this guidance. <p>The lead author had reviewed all products listed in recommendation 2 on the JF and highlighted to APC that no changes were required on the JF/PAD at this time.</p> <p>For all profiles in category 2 (recommendations 1 & 2) the following updates will be applied to each profile</p> <ul style="list-style-type: none"> • Add 'Items which should not routinely be prescribed in primary care: items-which-should-not-routinely-be-prescribed-in-primary-care-v2.1 - Jun 2019.pdf • Add following narrative to Restrictions/comments section - <i>Listed in 'Items which should not routinely be prescribed in primary care: policy guidance'. Click drug name for details and exceptions.</i> • Remove all policy statements. • Remove 'SDCCG - Low value medicines implementation resources - Apr 2018' where applicable as weblinks incorrect and information available under 'Patient resource' <p>The APC members agreed with all proposals as presented</p>
AOB	The APC members acknowledged the team members who have chosen to leave the organisation as part of the current restructure. Members also reflected on the great work and the robust decisions made over time for our patients in Surrey Heartlands.
Future meeting dates: (2.30pm to 5pm) via Microsoft teams calls <ul style="list-style-type: none"> • TBC 	
Signed and agreed by: Date: DD MMM YYYY Chair Name, Chair Title (Chair)	
Minutes agreed for publication by: Date: DD MMM YYYY Exec Lead name, Exec Lead Title (Exec Lead)	