Royal Surrey
NHS Foundation Trust

Meeting notes

Meeting	Drugs and Therapeutics Committee (DTC)	
Date and time	Friday 3rd October 2025; 08:15 – 10:00	
In attendance	**Presenters** 8:40 Dr Anna Rucker (AR) 8:50 Boby Philip (BP) / Tamar Pereira (TP) 9:00 Zarah Ahmed (ZA)	**Agenda item** 2.4 2.5 2.6
Apologies	Catrin Watkinson (CW) Sally Seymour (SS) Tim Dowdall (TD) Kathy Corking (KC) Marta Wojcik (MW)	
Attendees	Justin Kirk-Bayley (JKB) Anniela Etheridge (AE) Natalia Cartledge (NC) Darren Watts (DW) Tracy Labinjo (TL)	Veronica Davis (VD) Tamsin Enticknap-Green (TEG) Tomi Shitta (TS) Stephen Cookson (SC)

Summary of meeting outcomes

For a full list of APC outcomes please refer to APC minutes

Decision type	Drug	Indication / Place in Therapy	Decision
DTC (Oct 25)	Acarizax®	For paediatric patients (>5yrs) managed in the paediatric allergy service: for allergic rhinitis caused by house dust mite sensitisation	Approved: Red Drug
DTC (Oct 25)	Itulazax®	For paediatric patients (>5yrs) managed in the paediatric allergy service: for moderate-to-severe allergic rhinitis and/or conjunctivitis induced by pollen from the birch homologous group	Approved: Red Drug
DTC (Oct 25)	Mannitol (500ml) 10%	Intravenous Infusion for use as an Oral preparation for small bowel MRI - Radiology	Approved: Red drug
DTC (Oct 25)	IFR – Ustekinumab in Microcolitis	Gastroenterology	Approved for submission as IFR
DTC (Oct 25)	Leniolisib	For activated phosphoinositide 3-kinase delta syndrome (APDS) in people 12 years and over in Immunology	Approved: Red drug

Decision type	Document	Decision	Further actions
Noting	**Space pathways:** Use of Naloxone in opiate dependent patients Pre-op iron deficiency anaemia	Noted	
Approval	**DTC minutes on joint formulary**	Approved	
Approval	**Multivitamins: Choice for joint formulary**	Approved	
Approval	**Zoledronic acid : dosing options**	Not decided	To invite Dr Neville for next DTC
Approval	**PCA policy**	Approved for Ratification	
Approval	**Epidural policy**	Approved for Ratification	
Noting	**ASG ToR**	Noted	

Number	Item	
1 – Committee meeting		
1.1	**Welcome, introduction and apologies**	Attendees were welcomed as above. Apologies received from CW, TD, SS, MW and KC
1.2	**Declarations of interest for items on this agenda**	There were no declarations of interest.
1.3	**Minutes of the previous meeting:**	VD shared a summary of the minutes from September 2025 DTC meeting. VD asked whether GPs could prescribe Healthy Start vitamins. DW clarified that vitamins for under-fives on the Healthy Start scheme are not prescribable by GPs at present. He suggested updating the prescribing pad to reflect this use when Abidec and Dalivit are not available. VD noted the stock situation is fluctuating but agreed it would be helpful to keep the option available if shortages occur again. The replacement for Kate Witt as ADO for Clinical Governance and Risk will be Tracy Coulson, who is due to start at the beginning of November. No further issues raised. Minutes of the previous meeting were agreed as a true and accurate record.
1.4	**Action log**	 DTC Action log (master).xlsx

		The action log was reviewed and updated. See action log for full details.
1.5	**Relevant risks**	No relevant risks identified.
1.6	**Matters arising** **SPACE pathways:** • **Use of naloxone in opiate dependant patients** • **Pre-op iron deficiency anaemia**	 Pre- op iron deficiency anaemia.dc  SPACE pathway Use of naloxone in opiate  Supporting info NaloxoneProtocol(202 VD presented SPACE pathways for: - Use of Naloxone in opiate dependent patients - Pre-op iron deficiency anaemia <u>Naloxone regimen for opioid overdose in patients receiving opioids for pain or breathlessness</u> <u>Pre-op iron deficiency anaemia</u>: Naloxone is for life-threatening opioid overdose in patients on opioids for pain or breathlessness. Mild respiratory depression is managed by observation and adjusting opioid doses, while severe cases require titrated IV naloxone with monitoring. High boluses are for imminent arrest, higher doses for buprenorphine, and all cases should involve Supportive & Palliative Care or Pain Teams. JKB noted that these pathways had been presented before but are updated when they include medication input. He praised the iron deficiency pathway for appropriately restricting IV iron access and confirmed the other pathway for use of naloxone in opiate was non-contentious. Both pathways were noted.

<table>
<tr><th>Number</th><th>Item</th><th>Meeting notes</th></tr>
<tr><td>2.1</td><td>NICE TA tracker, summary and update</td><td>AE presented. The following NICE TAs have been added and noted.

<table>
<tr><td>TA924</td><td>Tirzepatide for treating type 2 diabetes</td><td>Recommended</td></tr>
<tr><td>TA1026</td><td>Tirzepatide for managing overweight and obesity</td><td>Recommended</td></tr>
<tr><td>TA1096</td><td>Benralizumab for treating relapsing or refractory eosinophilic granulomatosis with polyangiitis</td><td>Recommended</td></tr>
<tr><td>TA1097</td><td>Enfortumab vedotin with pembrolizumab for untreated unresectable or metastatic urothelial cancer when platinum-based chemotherapy is suitable</td><td>Recommended</td></tr>
<tr><td>TA1098</td><td>Isatuximab in combination for untreated multiple myeloma when a stem cell transplant is unsuitable</td><td>Recommended</td></tr>
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<tr><td>2.2</td><td>Specialist Commissioning circulars and Highly Specialised Technologies</td><td>2.1 and 2.2
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AE presented. The following specialised commissioning updates have been added and noted. See attached for further info. She noted that the urgent commissioning policy for Ropeg interferon (issued due to a peginterferon shortage) will be withdrawn, and patients established on Ropeg should revert to peginterferon by December. Haematology teams have plans for patients potentially needing local trust funding to continue Ropeg.
AE also highlighted some errors in NHSE circular dissemination of one of the NICE HSTs affecting the Southeast region and will provide a short form presentation later.

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<tr><td>SSC2881</td><td>Specialised Commissioning Update on future NICE Appraisals, published in August 2025, which are due to be commissioned in November 2025.</td><td>Noting</td></tr>
<tr><td>SSC2882</td><td>Peginterferon alfa-2a and ropeginterferon alfa-2b to treat myeloproliferative neoplasms - Update Re: NHS England Urgent Interim Clinical Commissioning Policy: peginterferon alfa-2a and ropeginterferon alfa-2b to treat myeloproliferative neoplasms (all ages)</td><td>Oncology</td></tr>
<tr><td>SSC2883</td><td>NICE Technology Appraisal Final Draft Guidance: Isatuximab plus bortezomib, lenalidomide and dexamethasone for untreated multiple myeloma when a stem cell transplant is unsuitable</td><td>Oncology</td></tr>
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		<table><tr><td>SSC2887</td><td>NICE Technology Appraisal Final Draft Guidance Durvalumab for treating limited-stage small-cell lung cancer after platinum-based chemoradiotherapy</td><td>Oncology</td></tr></table>
2.3	**APC update**	Not discussed. The committee agreed that the current APC update slides are too detailed for DTC meetings. It was suggested that a shorter, summarised version should be prepared, focusing on high-impact or contentious items, while the majority of information can be noted without discussion. Slimming down the update will save time, reduce duplication, and align with how other local DTCs receive the information. **ACTION: VD to coordinate with TD to streamlined APC updates for future meetings.**
2.4	For paediatric patients (>5yrs) managed in the paediatric allergy service. • ACARIZAX for house dust mite sensitisation • ITULAZAX for moderate-to-severe allergic rhinitis and/or conjunctivitis induced by	Acarizax Short-form.doc Itulazax Short-form.doc AR explained the proposal to switch from a non-licensed product for immunotherapy product to a newly licensed product for immunotherapy for the same indication, same patients (house dust mites and tree pollen allergic rhinitis). No new patients will be treated, existing patients in the paediatric allergy service will continue to be followed up. The licensed product now includes children over five years, allowing first-line use. VD confirmed that this is for allergic rhinitis children and noted a NICE TA is expected for children for Itulazax. AR emphasised the importance of timely approval as treatment must start before the tree pollen season (October-November). **APPROVED for over 5 years for the treatment of allergic rhinitis**

	pollen from the birch homologous group	**ACTION:** **VD to update the formulary next week to allow prescribing of the licensed product.**
2.5	MANNITOL (500ML) 10 % Intravenous Infusion for use as an Oral preparation for small bowel MRI	 DTC application mannitol 10% intrave  Small Bowel MRI Guidance - draft with BP presented an application for the use of diluted Mannitol 10% (500ml IV) as an oral drink for small bowel MRI, primarily for adults and children with conditions, such as inflammatory bowel disease, suspected obstruction, tumors, gastrointestinal bleeding, and malabsorption disorders. Mannitol has been used for small bowel MRI studies for 10-15 years. He highlighted that it is non-ionising, economical compared to commercial alternatives (costing £7 per patient versus £50-60), and typically used in 500ml bottles for two patients. Estimated annual use is 200-300 patients, with a financial impact of £1530. He also noted patient information leaflets had been prepared. JKB asked about flavouring for palatability, and BP confirmed patients can bring their own flavouring for paediatric use. JKB and VD both emphasised that the patient information leaflet and SOP need to be included in the trust template to avoid delays. **TP confirmed the leaflet amendments will follow the correct approval channel.** **APPROVED.**
2.6	IFR- Ustekinumab in Microcolitis	ZA, the gastroenterology pharmacist, presented on behalf of Dr Alexandropoulou. There have been discussions about this particular patient's submission and its suitability as an IFR but they believe it does fit the remit. She was previously misdiagnosed with Crohn's disease but repeat pathology revealed this not to be the case and was subsequently diagnosed with microscopic colitis. Due to the prior diagnosis of Crohn's she was given vedolizumab and she has also had budesonide but is non responsive with ongoing symptoms. The next step would usually be an immunomodulator such as azathioprine but given her previous CIN diagnosis this is not an option. The proposal is to use a biologic, none are approved for microscopic

		colitis but usually a TNF would be used like infliximab or adalimumab which have been given in some small case reports and studies In this case, due to her previous medical history, they are proposing ustekinumab The patient is unresponsive to budesonide and unsuitable for azathioprine due to CIN history. Due to the previous misdiagnosis they have already had vedolizumab. Ustekinumab is proposed as a biologic option because other biologics or immunomodulators are contraindicated or previously used. JKB queried whether the contraindications justified an IFR. ZA confirmed from a gastro perspective other disease-modifying agents had been exhausted. OS confirmed with ZA that no other disease modifying agents are an option. Mercaptopurine, as a prodrug of azathioprine, is also not an option. Unlike Crohn's where methotrexate and ciclsporin are options the next stage if azathioprine is unsuitable is a biologic. ZA mentioned that an update to treatment options is expected from the BSG within the next year but it is unlikely to change the course for tis patient as the ustekinumab offers the lower cancer risk. Normally patients would get vedolizumab but due to her previous misdiagnosis she has already had this. In response to a question on length of treatment ZA confirmed that review would be after induction and annually thereafter by MDT but if everything goes well this would be long term treatment. AE noted that this does not fall under specialised commissioning but from her knowledge of IFRs , either specialised commissioned or ICB, the fact that the British Society of Gastroenterology are developing guidelines for microscopic colitis suggests this is a cohort of patients rather than an exception, although there are specific circumstances in this case. She also raised a query about trust funding if the IFR is rejected. TS felt that this could be classified as an exceptional case and that the correct course is to push this forward to the ICB. However in parallel ZA should explore the option of funding internally should this be rejected and that trust funding would require a separate pink form submission; informal discussion with the division could gauge support. The pink form submission should be made, if required, once the outcome of the IFR is known. VD confirmed the IFR form requires approval by TS and Bill Dewsbury before submission. The information is submitted electronically with a blueteq. To prepare in case of rejection, and the possibility of needing a pink form, funding discussions should take place with the gastroenterology finance lead. JKB noted the process acts as a filtration to prevent overload. **APPROVED SUBJECT TO:** - **Sign off by TS and Bill Dewsbury before formally submitted through the IFR process.** - **Completion of a pink form if the IFR is rejected, to cover the trust funding pathway.**

2.7	**Leniolisib for Activated phosphoinositide 3-kinase delta syndrome (APDS) in people 12 years and over**	AE presented a "slimmed-down" short form application for Leniolisib 70mg film-coated tablets for treatment of Activated Phosphoinositide 3-Kinase Delta Syndrome (APDS), an ultra-rare primary immunodeficiency disorder in patients aged ≥12 years. She explained this was a trial of a simplified approach for Spec Comm drugs to reduce burden on clinicians. The condition is very rare (approx. 50 patients nationally), with costs of £116K per year per patient fully reimbursed by NHS England. Expected local use is less than one patient per year, and the drug will only be ordered against prescription (not held in stock). All supported the approach, and agreed this streamlined form could be used as an example for future similar cases. **APPROVED FOR FORMULARY INCLUSION.**

Number	Item	Meeting notes
3 – Document Ratification		
3.1		Nill submitted.

Number	Item	Meeting notes
4 – Sub-committee reports		
4.1	**Pharmacy Business and Transformation**	4.1 BT slide.pptx VD presented an update (on behalf of MW) covering: • Total CIP saving year-to-date: 638K; target 1.5M; 42% achieved • Off contract purchase: 16K; -3K compared to August3 • Medicines Shortage Notification (MSN): 4.8K YTD overspend on unlicensed lidocaine spray 10%; £61 vs. £7. • Pink Forms: Sept: 8 forms, one off costs £310. Ongoing £106 per month. TS noted reporting is working well and highlighted procurement team's work in challenging off-contract purchases. A reduction is being seen as processes tighten. JKB raised concerns about delays in pick form approvals due to SBU sign-off requirements and suggested considering thresholds for automatic approval. TS agreed to take this issue to the Medicines CIP meeting for divisions to consider whether to adopt a uniform or divisional approach to approvals, depending on CIP targets. VD added that while the new pink form system is clearer and more legible, consultant frustration persist around unclear approval responsibilities. She is working with Medical Computing to ensure mandatory entry of cost figures with details (e.g., pack size) to improve clarity. **ACTION: TS to raise pink form approval process at Medicines CIP meeting for divisional consensus.**

4.2	**Medicines Safety: Patient Controlled Analgesia (PCA) for adult patients and the Epidural policy**	 4.2 DTC feedback July 25 MSG.pptx  Epidural Infusions Policy EIA.docx  Epidural Infusions Policy MM-P-011.doc  Patient Controlled Analgesia (PCA) for ac VD presented two policies for noting: the Patient Controlled Analgesia (PCA) policy and the Epidural policy. Both policies had been reviewed by MSG. TEG confirmed the Epidural policy had minor updates and had been viewed via the Practice Development Group. No issues were raised.
4.3	**SACT Working Party**	None discussed.
4.4	**Antimicrobial Steering Group update: ASG ToR**	 4.4 ASG- Terms of reference (TOR) 2024 VD reported that the ASG terms of reference had no significant changes, with updates mainly to dates. No issued were raised.
4.5	**EPMA updates**	None discussed.

Number	Item	Meeting notes
5 – Any other business		
5.1	**DTC minutes on joint formulary**	VD raised that other trusts requested a dedicated page on the joint formulary to publish DTC minutes, with one page per trust, ensuring transparency and public access. She highlighted the need to redact personal information, IFR details, and sensitive cost data. **APPROVED.**
5.2	**Rybelsus bioavailability changes**	 European Medicines Agency.pdf  Novo nordisk info.pdf  Patient poster.pdf VD reported that the bioavailability of Rybelsus tablets has been altered by the manufacturer, with minimal changes to packaging, creating a risk of dosing errors during patient switching. The old 3 mg tablet is equivalent to 1.5 mg of the new formulation, meaning incorrect substitution could double patient dosing. This issue is being addressed at the Medicines Safety Group (MSG) level across Surrey Heartlands. Internal plans are being developed, with discussions with Medicines Safety. Nikki Smith will share updates from the APC, and ASPH has already issued guidance to their clinicians. The situation requires careful management in both dispensary supply and patient prescriptions. **NOTED.**

5.3	**Multivitamins: Choice for joint formulary**	 5.3 Multivitamins.docx VD raised a request to add Centrum and Forceval multivitamins to the formulary. This is to provide options for patients with conditions such as pancreatic enzyme insufficiency when Sanatogen is unavailable, without triggering the full Pink Form process. There is no significant cost implication, and the products are already commonly available. JKB confirmed that dietetics had suggested a substitution plan and noted that under supply constraints, internal switches do not require a full Pink Form. **APPROVED.**
5.4	**Zoledronic acid: dosing options**	VD highlighted ongoing supply issues with zoledronic acid: 5mg vials are £65 - £70 each, 4mg vials approx. £3.50. Previously, for frailty patients, the 4mg was agreed instead of 5mg to manage supply, with ongoing patient assessment. Doctor Neville has expressed concerns about using 4mg instead of the licensed 5mg dose for her patients. TS advised that is other trusts are using the 4mg dose due to stock/cost constraints, Dr Neville should document her rationale for continuing with 5mg and could present this to DTC. She emphasised the importance of formally documenting the rationale for recommending the unlicensed 4mg dose. AE noted that the shortage has yet been formally issued as a MSN. JKB suggested inviting Doctor Neville to explain why the 4mg dosing approach used in frailty patients may not be feasible, including implications for resources and patient risk. **ACTION: VD to invite Doctor Neville to present dosing rationale at the next DTC meeting.**

5.5	**Copilot**	It was found Copilot's meeting summaries too brief for accurate record-keeping, especially for complex discussions. **ACTION: VD to advise IT on Copilot's limitations before renewal to avoid unnecessary costs.**