

Minutes of the Sussex Area Prescribing Committee

Date:	Tuesday, 27th January 2026
Time:	12:00 – 14:00
Venue:	Online MS Teams
Chair:	Micheal Okorie

Attendees:	
Amy Herbert (AH)	Head of Medicines Governance and Value, NHS Sussex ICB
Chirag Patel (CP)	Associate Director of Primary Care Medicines Optimisation, NHS Sussex ICB
Harriet Vogt (HV)	Patient Safety Partner & Strategic Community Ambassador, NHS Sussex ICB
Iben Altman (IA)	Chief Pharmacist, Sussex Community NHS Foundation Trust (SCFT)
Irma Murjikneli (IM)	Clinical Director, Prescribing Lead / GP representative
Janet Rittman (JR)	Sussex Public Health Representative, Brighton and Hove City Council
Judy Busby (JB)	Chief Pharmacist, Queen Victoria Hospital NHS Foundation Trust (QVH)
Kayley Taylor (KT)	Business Support Officer, NHS Sussex ICB
Mark Donaghy (MD)	Local Pharmaceutical Committee (LPC) representative
Michael Okorie (MO)	Consultant Physician and Associate Medical Director for Medicines Safety & Prescribing, University Hospitals Sussex NHS Foundation Trust (UHSx)
Samantha Lippett (SLi)	Principal Pharmacist - Medicines Safety, Quality and Governance, University Hospitals Sussex NHS Foundation Trust (UHSx)
Simon Badcott (SD)	Chief Pharmacist, Associate Director of Professions, Core Services Division, East Sussex Healthcare NHS Trust (ESHT)
Stephen Lytton (SLy)	Clinical Director, Prescribing Lead / GP representative (13:30 left the meeting)
Stephen Pike (SP)	Clinical Director Medicines Optimisation, NHS Sussex ICB
Tak Ho Cheung (Andy) (TC)	Deputy Head of Medicines Governance & Value, NHS Sussex ICB
Tejinder Bahra (TB)	Deputy Head of Medicines Resource Unit, NHS Surrey Heartlands ICB
Zenobia Dzisiewska-Smith (ZDS)	Lead Pharmacy Technician Medicines Optimisation, Strategy and Interface, NHS Sussex ICB
Guests/Presenters:	
Michael Tarzi (MT)	Senior Lecturer & Honorary Consultant Immunologist, University Hospitals Sussex NHS Foundation Trust (UHSx)
Pramit Patel (PP)	Head of Medicines Optimisation Service Development and Interfaces of Care, NHS Sussex ICB

Minutes taken by:	
Andy Cheung, Deputy Head of Medicines Governance and Value, NHS Sussex	
1. Welcome and apologies	
1.1 Welcome, apologies, and meeting etiquette	
The Chair welcomed the committee to the January Sussex Area Prescribing Committee (APC) meeting.	
<ul style="list-style-type: none"> Apologies received: Mairead O'Malley (UHSx), Russel Brown (LMC), Neveen Sorial (NHS Sussex ICB) 	
1.2 Conflicts of Interest	
Submitted electronically. Members were reminded to update their annual declarations. No conflicts were declared, and no action was taken.	

<p>2. Minutes and action log</p> <p>2.1 Minutes of last meeting The minutes of the previous Sussex APC meeting held in November 2025 were previously agreed and ratified virtually via FutureNHS platform. The minutes are available to view on the NHS Sussex website here.</p> <p>2.2 Action log The committee was informed that the seven outstanding actions are in progress. A record of complete and outstanding actions is available on FutureNHS platform.</p> <p>3. Meeting administration business</p> <p>3.1 APC Voting arrangement (AH/Chair) In November 2025, the committee reviewed a proposed APC voting framework, including one vote per organisation, a defined quorum with key role representation, and a 70% approval threshold. The committee also reiterated that consensus remains the preferred decision-making approach, with formal voting used only when needed. The committee continued the discussion on voting arrangements following feedback received regarding organisational voting rights and GP representation. It was noted that the Local Medical Committee (LMC) would hold one vote, while other GP members would collectively hold a single unified vote. All trusts were proposed to have one vote each. Concerns were raised regarding fair representation for large organisations like UHSx. The committee also emphasised the importance of maintaining balance between primary and secondary representation, especially considering upcoming system changes associated with the Sussex and Surrey merger. The committee reflected that formal votes are rare, as the committee typically works on consensus and adapts decisions when stakeholder groups express significant concerns. The committee also noted broader uncertainty around future GP participation and overall committee composition once Sussex and Surrey officially merge after 31st March 2025. After discussion, and with no objections raised, the committee agreed that UHSx would hold two votes for the time being, recognising this may be revisited once the new system is confirmed.</p> <p>4. Item for approval Standing item</p> <p>4.1 NHS Sussex Centre-Involving Diabetic Macular Oedema (DMO) with Visual Impairment high-cost drugs (HCDs) Pathway (PP) 4.2 NHS Sussex Macular Oedema Secondary to Retinal Vein Occlusion (RVO) high-cost drugs (HCDs) Pathway (PP) The committee was asked to approve the locally developed Sussex HCDs pathways for centre-involving DMO with visual impairment and macular oedema secondary to RVO. The committee heard that the national NHS England pathways are lengthy and include recommendations that fall outside existing NICE technology appraisals (TAs). To support timely implementation, particularly of biosimilar-first approaches, the Sussex pathways were intentionally streamlined and limited to treatments currently supported by NICE and local commissioning arrangements. Clinicians have expressed interest in extending dexamethasone implant use beyond current licensing (more than two implants per year), but this will require a separate provider-led application, due to cost-effectiveness and commissioning considerations. This submission is being prepared and will be brought to the future APC meeting. The committee discussed alignment with Surrey’s approach, noting that while Surrey has approved the national recommendations, Sussex will consider local business cases for any expansion beyond NICE TAs. The committee raised concern regarding the potential implications for patients not currently meeting commissioning criteria. Assurance was provided that no patients are being excluded from existing commissioned treatments and that work is underway to address additional cohorts identified in the national guidance. The committee also confirmed that stakeholder engagement was comprehensive, with input from retinal consultants and pharmacy teams, and no significant objections were raised during consultation. Acute providers confirmed clinical support for the proposed pathways, noting that biosimilar switches are already largely achieved. The committee acknowledged the significant progress made across Sussex.</p> <p>Decision: Approved</p> <p>ACTION 01/26 – 01 What: Upload the approved Sussex DMO and RVO pathway to the Sussex Formulary (under 11.6 Retinal disorders) and intranet. Who: APC Secretariate (ZDS) When: March 2026</p>

4.3 Itulazax® 12 SQ-Bet (Betula Verrucosa) – medicine colour status change application (MT)

The committee was asked to approve the colour change of Itulazax® 12 SQ-Bet (Betula Verrucosa) for moderate to severe birch pollen–induced allergic rhinitis and/or conjunctivitis (ARC) in adults from **RED** to **PURPLE** (specialist initiation for at least 3 months), while the use in children will remain **RED**.

The committee heard that desensitisation therapy is highly effective, generally requiring a single three-year course, and that Itulazax® sublingual tablets provide a safe, home-based alternative to injections, eliminating the risk of anaphylaxis and reducing the travel burden for patients. Initiation requires hospital-based supervision, but after three months, prescribing is suitable for transfer to primary care.

In the absence of an LMC representative in the meeting, the committee noted the written comments provided by LMC at the consultation stage, including GPs' unfamiliarity with this specialist treatment, the small patient cohort limiting opportunities to build expertise, and the need for allowing GPs to decline prescribing. MT reiterated that prescribing post 3-month initiation is straightforward, with side effects largely resolved by then. It was also highlighted that no additional monitoring is required in primary care, and the specialist service remains responsible for ongoing patient management, indicating that a local commissioning service (LCS) arrangement is not required. While the current cohort is small, the introduction of sublingual treatments will increase access and patient cohort is anticipated to grow. MT confirmed that GPs are entitled to decline prescribing where they lack confidence but highlighted that the secondary care clinic has received no GP decline in the case of Acarizax®, which is also a sublingual pollen desensitisation medicine that was previously approved as a **PURPLE** (specialist initiation) drug by the Sussex APC.

The committee acknowledged concerns about GPs' limited familiarity with the treatment but noted that this should not remain a long-term barrier, as clinical experience and access to comprehensive drug information resources support competence over time. The committee also discussed comparisons with Surrey, where the Surrey APC approved Itulazax® as a **PURPLE** (specialist initiation for at least one month) following LMC engagement and the provision of clear guidance on treatment discontinuation. The committee discussed strategies to support primary care, including the development of a medicine information sheet to provide clarity on prescribing, duration, follow-up and discontinuation. It was agreed that patient experience and access were key considerations, given the distances patients must travel for hospital-based management under the current **RED** formulary coding.

Decision: Provisionally approved, subject to further engagement with LMC to agree a feasible approach for primary care prescribing, including the use of a medicine information sheet.

ACTION 01/26 – 02

What: Once LMC engagement is undertaken, and the medicine information sheet is developed, update the Sussex Formulary by changing the formulary coding of Itulazax® 12 SQ-Bet (Betula Verrucosa) from **RED** to **PURPLE** (specialist initiation for at least 3 months) in adults / **RED** in children

Who: APC Secretariat (ZDS) **When:** March 2026

ACTION 01/26 – 03

What: APC secretariat to support the presenter in developing a medicine information sheet of Itulazax® for primary care clinicians, followed by APC virtual approval

Who: MT/AH/TC **When:** March 2026

ACTION 01/26 – 04

What: APC secretariat to support the discussion on local implementation of Itulazax® between the presenter and LMC colleagues

Who: MT/AH/TC **When:** March 2026

5. Virtually approved items

The committee noted the following applications have been submitted via virtual approval since the previous meeting:

5.1 Introduction of a **GREEN** formulary status for the use of continuous glucose monitor (CGM) in type 2 diabetes – virtually approved on 10/12/2025, for noting

5.2 Sussex type 2 diabetes treatment algorithm & guidance update – virtually approved on 09/12/2025, for noting

5.3 Minor update on inclisiran information sheet for clinicians – for noting

5.4 Rybelsus (oral semaglutide) formulary extension application – virtually approved on 30/12/2025, for noting

5.5 Sussex lipid lowering pathway: secondary prevention update – virtually approved on 13/01/2026, for noting

5.6 Co-proxamol position statement – For noting, position statement proposal aligns with current formulary status

6. Standing Items

6.1 National Institute for Health and Care Excellence (NICE) Technology Appraisals / Highly Specialised Technologies (MO)

Since November APC meeting, the Sussex APC Secretariat group have dealt with a total of 12 published NICE Technology Appraisals, noted 2 terminations and 0 Highly Specialised Technologies Guidance. All recommendations regarding formulary positioning and formulary colour coding of medicines were made by the APC secretariat group. These were implemented on time without variation across Sussex.

1. NICE TA1106 – Cabotegravir for preventing HIV-1 in adults and young people. Virtually approved with a **RED** formulary coding on 05/01/2026 for noting.
2. NICE TA1107 – Delgocitinib for treating moderate to severe chronic hand eczema. Virtually approved with a **RED** formulary coding on 05/01/2026 for noting.
3. NICE TA1108 – Cemiplimab with platinum-based chemotherapy for untreated advanced non-small-cell lung cancer (not recommended). For noting.
4. NICE TA1109 – Darolutamide with androgen deprivation therapy for treating hormone-sensitive metastatic prostate cancer. Virtually approved with a **RED** formulary coding on 11/12/25 for noting.
5. NICE TA1110 – Abiraterone (originator and generics) for treating newly diagnosed high-risk hormone-sensitive metastatic prostate cancer. Virtually approved with a **RED** formulary coding on 18/12/25 for noting.
6. NICE TA1111 – Nintedanib for treating fibrosing interstitial lung disease in people 6 to 17 years (terminated appraisal). For noting.
7. NICE TA1112 – Trastuzumab deruxtecan for treating hormone receptor-positive HER2-low metastatic breast cancer after 2 or more endocrine treatments (terminated appraisal). For noting.
8. NICE TA1113 – Glofitamab with gemcitabine and oxaliplatin for treating relapsed or refractory diffuse large B-cell lymphoma. Virtually approved with a **RED** formulary coding on 15/01/2026 for noting.
9. NICE TA1114 – Talquetamab for treating relapsed and refractory multiple myeloma after 3 or more treatments. Virtually approved with a **RED** formulary coding on 15/01/2026 for noting.
10. NICE TA1115 – Vutrisiran for treating transthyretin amyloidosis with cardiomyopathy. Virtually approved with a **RED** formulary coding on 15/01/2026 for noting.
11. NICE TA1116 – Obecabtagene autoleucl for treating relapsed or refractory B-cell precursor acute lymphoblastic leukaemia. Virtually approved with a **RED** formulary coding on 15/01/2026 for noting.
12. NICE TA1117 – Dostarlimab with platinum-containing chemotherapy for treating primary advanced or recurrent endometrial cancer with microsatellite stability or mismatch repair proficiency. Virtually approved with a **RED** formulary coding on 15/01/2026 for noting.

6.2 Horizon Scanning (PP)

The committee received an update on horizon scanning with confirmation that the annual review of upcoming HCDs had been completed. The expected cost pressures were outlined, including approximately 18 drugs likely to receive positive NICE TA guidance, with particular focus on emerging biologic therapies for COPD and several new dementia treatments. Recent cost savings were achieved through biosimilar switches, with further savings expected from aflibercept biosimilars, but no major new biosimilar launches are anticipated in the latter part of 2026-27. The committee discussed local uptake of biosimilar product, recognising Sussex's strong performance in secondary care implementation.

Upcoming biosimilar opportunities were noted, including denosumab, with Sussex and Surrey working jointly to review available products and ensure consistent formulary decisions. It was also noted that the upcoming denosumab switch will be the first biologic switch in primary care, requiring significant engagement and support, and will serve as a model for future initiatives.

The committee highlighted challenges around severe asthma commissioning arrangements and the need for improved local access. Consideration was given to the broader system impact of new HCDs, including activity and service-delivery costs, with NICE's updated resource impact templates expected to provide clearer modelling. The committee agreed to continue monitoring developments and incorporating system-wide considerations into future decisions.

6.3 Patient Safety & Medicines Safety Alerts

The committee discussed the dissemination of medicines safety alerts, prompted by the recent Medicines and Healthcare products Regulatory Agency (MHRA) alert on mesalazine and idiopathic intracranial hypertension. The committee considered whether current mechanisms sufficiently ensure that clinicians prescribing high-volume medicines are aware of rare but important adverse effects. While the Sussex APC does not routinely take responsibility for dissemination unless key actions are required,

it was noted that all prescribers should receive MHRA alerts directly, with additional reinforcement via GP bulletins and Care Quality Commission (CQC) expectations that practices demonstrate how they record and act on such updates. Provider representatives confirmed that internal governance structures, such as Medicines Governance Committees, also disseminate safety information. GP representatives described how practices receive and must action MHRA alerts, ensuring that important safety information is shared with all relevant staff. The committee agreed on the importance of ensuring consistent communication across primary and secondary care and noted that future reminders through APC channels may help strengthen assurance that alerts are being appropriately actioned.

6.4 Discontinuations

The committee noted the list of product discontinuations circulated with the papers. No formulary changes requiring APC discussion were identified. During discussion, it was highlighted that some discontinued items affecting secondary care (e.g. procyclidine injection) may not always be captured. The APC secretariat team confirmed that omissions are unintentional and requested that any such items be emailed for inclusion. The committee was advised that Surrey currently has a more comprehensive discontinuations process, which Sussex intends to adopt and supplement as required until future APC governance arrangements are clarified.

7. South East Regional Medicines Optimisation Group (SERMOG)

7.1 Latest SERMOG update (PP)

The committee received an update on the work of SERMOG, which has been developing regional policies and pathways for local system approval. 11 documents have been published to date, with Sussex having already adopted several, including position statements on dual biologic therapy in inflammatory bowel disease (IBD), use of medicine doses outside NICE TAs, biosimilar switching, compact ONS products, and HCDs for JIA. More substantial work is now underway on full clinical pathways, beginning with the regional IBD and rheumatoid arthritis pathway, which are being adapted to ensure alignment with local clinical need, cost-effectiveness, and existing commissioning arrangements. Engagement with local pharmacists and clinicians is ongoing, with an ambitious aim to finalise key pathways by March 2026 ahead of the Sussex/Surrey ICB merger. Additional pathways in development include psoriatic arthritis, psoriasis, atopic dermatitis, osteoporosis, and localised psoriasis. The committee also noted capacity constraints within Sussex compared with SERMOG dedicated team.

8. Subgroup reports

8.1 Formulary and pathways (governance) update (AH)

The committee received an update on the national work to develop a Single National Formulary (SNF), including a draft categorisation proposal circulated by the national group. The committee heard the concerns regarding the complexity of the proposed system, which replaces established colour-coding with multiple new prescribing categories. The committee expressed consistent reservations that the proposed categorisation is overly complicated, risks undermining long-established local colour systems, may impose significant workload on ICB medicine optimisation team to recode all formulary entries within tight timeframes, and has been developed without sufficient frontline prescriber input. Several members emphasised the need for a simple, well-established system that supports practical implementation and cross-boundary working. AH agreed to share the document and invited further feedback for submission to the national group.

9. Any other business

The committee discussed the potential impact of the upcoming Sussex and Surrey ICB merger on the Sussex APC and medicines optimisation. The committee heard that the merger structures are still under consultation, and many details remain uncertain, including delegated authority and clinical lead representation. The committee raised concerns about the ability to make balanced prescribing decisions during the transitional period, particularly given impending departures of key committee members. It was agreed that, in the interim, routine decisions would be deferred where possible, and urgent technology appraisals would be managed virtually. The committee acknowledged the significant contribution of Dr Stephen Pike, Dr Stephen Lytton, and Dr Irma Murjikelni as the GP representatives of the committee, with members expressing gratitude for their service and ongoing involvement in local formulary work.

Date of next meeting

Date: 31st March 2026
Time: 12:00 to 14:00
Venue: Online MS Teams
Chair: Michael Okorie

Meeting close.

