BEDFORDSHIRE, LUTON AND MILTON KEYNES AREA PRESCRIBING COMMITTEE

Final Meeting Notes

Date:	Wednesday 1st December 2021
Time:	12.30pm – 3.00pm
Venue:	**Virtual Meeting Using Microsoft Teams** **Link to Join Meeting - Click here to join the meeting**

Attendees:-

Name	Initial	Role
Dr John Fsadni	JF	Chair of Formulary Subgroup, deputising as chair to the APC
Pritesh Bodalia (from 2pm)	PB	Bedfordshire Hospitals NHS Foundation Trust Pharmacy Representative (Chief Pharmacist, Bedfordshire Hospitals Trust)
Helen Chadwick	HC	Milton Keynes University Hospital Trust Pharmacy Representative (Clinical Director of Pharmacy, Milton Keynes Hospital)
Suraiya Chandratillake	SC	ELFT Pharmacy Representative – Community Services (Beds)
Yolanda Abunga	YA	CCS Pharmacy Representative (Community Services Pharmacist, Beds and Luton)
Kike Pinheiro	KP	CNWL Pharmacy Representative (Community and Mental Health Services Milton Keynes)
Dr Marian Chan	MC	Medical Representative, Bedfordshire Hospitals NHS Foundation Trust
Fiona Garnett	FG	Associate Director and Head of Medicines Optimisation BLMK CCG
Naomi Currie	NC	Place Based Lead Pharmacist – Bedford
Matt Davies	MD	Place Based Lead Pharmacist – Central Bedfordshire
Mojisola Adebago	MA	Place Based Lead Pharmacist – Luton
Dr Jenny Wilson	JW	Place Based Lead GP – Bedford
Dr Mitan Sarkar	MS	Place Based Lead GP – Luton
Dr Samantha Chepkin	SC	Consultant in Public Health
Cheryl Green	CG	Patient Representative
Jacqueline Clayton	JC	Commissioning Lead Pharmacist, BLMK CCG (Professional Secretary)
Anne Graeff	AG	Chair of Wound Care Group
Zainab Alani	ZA	Chair of Medicines Safety Group
Carole Jellicoe	CL	Nurse Representative (Independent Prescriber), Milton Keynes University Hospital

In attendance:		
Reena Pankhania (Deputising for Pritesh Bodalia until 2pm)	RP	Formulary Pharmacist, Bedfordshire Hospitals NHS Foundation Trust
Candy Chow	CC	Principal Pharmacist, Formulary and Interface, Milton Keynes University Hospital
Sandra McGroarty	SMcG	Commissioning Pharmacist, BLMK CCG
Dona Wingfield (until 2.40pm)	DW	Commissioning Lead Pharmacist, BLMK CCG
Dr Joy Muttika	JM	Medical Representative, Keech Hospice
Lesley Bates	LB	Representative, St John's Hospice
Raye Summers	RS	PA to MOT,BLMK CCG (Note taking)
Taiya Large	TL	Formulary and Medicines Safety Pharmacist BLMK CCG
Nikki Woodall	NW	Lead Pharmacy Technician, BLMK CCG
Rafal Ali	RA	Commissioning Pharmacist, BLMK CCG
Janice Jones	JJ	Pharmacist, Northamptonshire Healthcare Trust
Helen McGowan for agenda item 5.7	HMcG	Place based Pharmacist, BLMK CCG
Iffah Salim for agenda item 5.1	IS	CAMH Lead Pharmacist, ELFT
Omos Olunloyo for agenda item 5.4	OO	Pharmacist, Programme Team, BLMK CCG
Dr Y Mehrez for agenda item 5.4	YM	Consultant in Pain Medicine, Anaesthesia and Intensive Care, Lead Clinician for The Pain Management Clinic, Milton Keynes University Hospital NHS Trust
Tessa Kidd for agenda item 5.8	TK	Lead Diabetes Nurse from MKIDS & MKUH

Apologies:		
Dr N Fagan	NF	Place Based Lead GP – Milton Keynes
Dr K Randall	KR	Place Based Lead GP – Central Bedfordshire
Alison Borrett	AB	Chair (Non-Executive Director BLMK CCG)
Dr Andrew Cooney	AC	Medical Representative, MKUH
Dr Dush Mital	DM	Medical Representative, MKUH
Mary Evans	ME	Interim Integrated Care System (ICS) Chief Pharmacist, BLMK

No	Agenda Item	Action
1.	**Welcome, Introductions and Apologies** The Chair welcomed everyone to the meeting. Apologies were received and noted as above. The meeting was confirmed as quorate.	12.30pm
2.	**Declarations of Interest** The Chair invited the members to reconfirm their current declarations on the Register of Interests and advise of any new declarations. All members confirmed their declarations were accurate and up to date. The Chair invited members to declare any declarations relating to matters on the Agenda. There were no other declarations of interest relating to the agenda	12.35pm
3.	**Minutes of the previous meeting – 29th September 2021** The minutes were approved.	12.40pm
4.	**Matters Arising** All MKPAG Legacy actions are now closed.	12.45pm
4.1	**JPC Legacy – Interim Iontophoresis Commissioning Policy** The update (16/11/21) from CCG Planned Care stated the following – 'Planned care have done some scoping looking at the various options available. The hyperhidrosis policy is due to be reviewed at the Priorities Forum in Feb 2022. It is suggested it may be best to wait for the full evidence review to be done before deciding on the best way forward.' It was therefore proposed (and agreed) that this action could be closed from an APC perspective as the project is now being managed by Planned Care.	**Close**
4.2	**JPC Legacy – Implementation of NICE Chronic Pain Guideline – NG193.** The Pharmacy team are working with CCG Planned Care in the implementation of the guideline which will take some time, due to	Close

No	Agenda Item	Action
	the requirement to review commissioned services. It was therefore proposed that this action was closed assuming that the interim pain guidelines were approved (agenda item 5.4) and returned to the agenda when updates were available e.g., final pain guidelines. The Committee agreed to close this action.	
4.3	**Primary Care Guideline for Adults with Asthma** - **Update** Updates agreed at the September 2021 meeting have been completed. It was proposed and agreed that this action could be closed.	Close
4.4	**Oxygen for Cluster Headaches** It was agreed (at the September 2021 meeting) that Dr Butterworth(or a member of his team) would be given time (post meeting) to confirm that they were happy with the amendment prior to issuing the updated policy as they had not had time to review pre meeting due to clinical commitments. This information would be added as a post meeting note in the minutes. Update 12/11/21 - Dr Butterworth's team had been contacted and the response was that Dr Butterworth's proposed amendment was withdrawn. DW to update the bulletin for publication based on this information. This is now a BLMK wide approved bulletin.	DW
4.5	**Treatment Pathway for Active Psoriatic Arthritis Update** At the September 2021 meeting, the Rheumatology teams advised that they do not usually assess PASI but instead assess via joint swelling and joint tenderness as the priority within Rheumatology to meet NICE criteria. If there is no improvement in the skin – the patient is referred/discussed with dermatology. This information has been fed back to NICE and the following response was received:- 'Guselkumab was cost effective only in that subgroup with moderate to severe psoriasis. It's therefore important that each individual is assessed according to the criteria in the guidance (to be in line with the evidence base from which the recommendation was derived).' The Rheumatology Team was contacted and informed of this information and have agreed to follow pathway as outlined by NICE and approved at the last meeting. This action could therefore be closed and the PsA pathway published.	Close
4.6	**Treatment Pathway for Rheumatoid Arthritis** For consideration at a future APC - addition of a 5th Line therapy to Algorithm A and algorithm B to be reviewed. This is an ongoing action – scheduled for consideration at the 4th March 2022 meeting.	SMcG

No	Agenda Item	Action
4.7	**Treatment Pathway for Rheumatoid Arthritis** SMcG was asked to confirm that Dr Banerjee (Consultant Rheumatologist at MKUH) would be happy to endorse the current algorithm B pending the review outlined above so that the full pathway (algorithms A and B) could be 'rebadged' as a BLMK pathway. Update 12/11/21 - Dr Banerjee has confirmed on behalf of the MK Hospital Rheumatology Department to endorse the current algorithm B, therefore the BLMK logo has been added to this pathway and it will shortly be published. It was therefore proposed and agreed that this action could be closed.	Close
4.8	**Severe Psoriasis Pathway** Dose escalation to be considered at a future meeting. This is an ongoing action which has been added to the APC work programme and therefore the action was closed.	Close
4.9	**Shared Care Guideline Template** It was agreed that the amendments agreed at the September 2021 meeting would be made to the shared care guideline template which would then be re-circulated for final comment (clarification to be sought on timescales for GP response to specialist and patient hand held booklets as part of this consultation) prior to adoption by the committee. This would ensure that those who had not had an opportunity to comment in advance of the meeting could so. Update 12/11/21 - Updates have been made and the document recirculated for final comment. For final discussion and approval at the 01/12/21 meeting (see agenda item 5.3) after which the action could be closed.	Close
4.10	**Transgender Shared Care Guidelines – Update** SMcG advised that a September 2021 updated version of the guidelines would be available shortly but that no major update was anticipated. The new guidelines were expected to clarify Specialist responsibilities in more detail and include information on 'bone' health for GPs. The committee agreed to retrospectively approve the 2019/20 updates and agreed that the 2021 updates could come to the committee for virtual approval when they were finalised. Update 12/11/21 - The workload of the MO team did not allow sufficient time for review and circulation of the updated 2021 shared care guidelines in advance of the meeting. These guidelines have therefore come to the 01/12/21 meeting for approval (see agenda item 5.6), after which the action could be closed.	Close
4.11	**Inclisiran for Primary hypercholesterolaemia or mixed dyslipidaemia** Inclisiran to be added to both Formularies in line with NHSE Direction. This action has been completed and therefore it can be closed.	Close

No	Agenda Item	Action
4.12	**Inclisiran for Primary hypercholesterolaemia or mixed dyslipidaemia** It was agreed at the September 2021 meeting that Implementation will be led by the Primary Care Teams e.g., at the October Prescribing Committees. PCN chairs to be advised at future appropriate meetings. The Locality Team had some initial discussions with the LMC. The LMC were currently unhappy about certain aspects of the TA e.g., no outcome data, administration issues, GP workload etc. It was agreed that this action could be closed as the implementation of the TA now sat with the Primary Care Teams.	Close
4.13	**NICE TA Formulary Updates - as per minutes** All updates had been completed; therefore, this action could be closed.	Close
4.14	**Acne vulgaris: management, NICE guideline [NG198] Published: 25 June 2021, https://www.nice.org.uk/guidance/ng198** To be included in the Community Antimicrobial Guideline Update. (see agenda item 5.1). It was proposed and agreed that this action could be closed.	Close
4.15	**Type 1 diabetes in adults: diagnosis and management, NICE guideline [NG17]Published: 26 August 2015 Last updated: 21 July 2021. https://www.nice.org.uk/guidance/ng17** EoEPAC Secretary to review PAC Guidance. Update 12/11/21 - PAC have reviewed current relevant bulletins in the light of this guidance and the revised bulletins will be brought to the Committee when published. This is therefore an ongoing action	AG
4.16	**Clostridioides difficile infection: antimicrobial prescribing, NICE guideline [NG199]Published: 23 July 2021. https://www.nice.org.uk/guidance/ng199** To be included in the Community Antimicrobial Guideline Update (see agenda item 5.1). It was proposed and agreed that this action could be closed.	Close
4.17	**Chronic kidney disease: assessment and management, NICE guideline [NG203]Published: 25 August 2021, https://www.nice.org.uk/guidance/ng203** There are recommendations on the use of SGLT2 inhibitors, but these recommendations have gone out for further consultation. To bring back to the APC when further information is available. While the result of the consultation was published at the end of November, there was insufficient time to consult with the service re implementation and therefore, this item will be discussed at the 2nd March 2022 APC. This is an ongoing action.	AG

No	Agenda Item	Action
4.18	**Medicines Safety Subgroup (MSG) Terms of Reference** ME raised the issue that there was no lay representative on this group. DW/ZA agreed to work with ME around this issue and bring back a revised TOR, when resolved, to the committee. Update 01/12/21 - With regards to action about Medicines Safety TOR. The group was looking to further optimise their consultation process and have commenced forming links with the place based Healthwatch leads for medicines safety related initiatives, so far agreement has been obtained from MK Healthwatch to attend their groups when the MSG are working on a medicine's safety quality project/ guidance. There is acknowledgement that we have lay rep on APC and PC, however as per Mary Evan's recommendation the MSG is looking to further build on patient engagement. MSG (within TOR) have delegated authority to action urgent initiatives (time dependant DSUs etc) and retrospectively report so engaging Healthwatch particularly for these sorts of actions will help. Currently there no anticipated changes to TOR – subject to discussions with Healthwatch. This action could be closed.	Close
4.19	**Wound Management Subgroup** The Terms of Reference to come to the December 2021 meeting for ratification. See agenda item 9b. It was proposed and agreed that this action could be closed.	Close
4.20	**Antimicrobial Resistance Update** At the September meeting, ME asked if she could be invited to the next meetings of the BLMK antimicrobial pharmacist network and the BLMK ICS HCAI/AMR steering group. NC agreed to action. This has been actioned and therefore the action could be closed.	Close
5	**Items for consideration at meeting**	
5.1	**Strategies to support reduced inhaler carbon emissions** The NHS Long Term Plan for England 2019 has committed the NHS to reducing greenhouse gas emissions from inhalers, with a target to reduce the carbon impacts of inhalers by 50% by 2030. A range of strategies can support a reduction in the inhaler carbon footprint including optimising prescribing, switching to lower carbon footprint alternatives where clinically appropriate, and reducing inhaler waste. Developing an inhaler carbon footprint reduction strategy should be a phased approach and considered on a case-by-case basis, where clinically appropriate to help prevent any stock shortages and adverse outcomes for patients, pharmacies, or healthcare professionals. The committee were asked to ratify the guidance for clinicians and background briefing paper to support local adoption of the NHS sustainability agenda. The briefing paper and guidance were discussed, and the following key points raised:-	

	This strategy was part of the wider programme *Delivering a 'Net Zero' National Health Service* Local guidance was based on *NHS Long term Plan, BTS SIGN guideline for Asthma, NICE patient decision aid, PrescQIPP with the following aims:* 1. Optimise asthma and COPD care through regular assessment of compliance (Right Device for Right Patient) 2. Use dry powder inhalers or soft mist inhalers as first choice, where clinically appropriate 3. If metered dose inhalers are needed, then choose brand and regime with care to minimise carbon footprint 4. Reduce the environmental impact of inhaler waste by effective management and disposal The paper has been widely disseminated for comment (in addition to the APC) to Trust Clinicians across the ICS, BLMK Long term conditions respiratory group (Beds and Luton GPs), Milton Keynes Prescribing Group. Positive feedback has been obtained from BLF Nurse, Advanced Respiratory Nurse, AIRS Clinic, Home oxygen assessment service, and Post-covid assessment service and this work is being done in partnership with locality prescribing teams. The guidance has been produced to support GPs and to help them prioritise a group of patients for initial review. This guidance is likely to be used in new patients so that GPs can select the most appropriate preparation at initial diagnosis. Scriptswich and Optimise messages are being developed for newly diagnosed patients to assist in implementation and also some Ardens searches are available to GPs to help with patient selection and prioritisation. It was emphasised that this was not about bulk switching, but instead individual patient review with an emphasis on ensuring that patients received the optimum device and that they could use it a phased approach. Prioritising the use of inhalers for MART was part of this initiative as there had been good clinical outcomes nationally when using this approach and also a focus on reducing the number of patients receiving SABAs as rescue therapy, from a safety perspective. The guidance also promotes regular follow-ups and checking of inhaler technique. Community Pharmacies will also be involved in the roll out of the guidance as they can assist GPs in reviewing patients under the New Medicines Service (NMS). Patients should also be encouraged to return inhalers to pharmacies for correct disposal. IS asked about whether it would be appropriate for patients to be reviewed and switched in Mental Health Trusts. On balance the view of the committee was that the reviews were best left to clinicians with experience in the treatment of respiratory diseases. It was also raised that as part of the sustainability agenda, it was important that patients were not switched to new inhalers until their current stock of inhalers was exhausted and hospitals may not be	

	in the best position to establish this. That said, the primary care team were starting to engage with secondary care Trusts on this agenda and there was no reason why secondary care clinicians could start this discussion with patients. Monitoring of the carbon footprint (how will we monitor the work we are doing re sustainability across the ICS) was raised. The committee was advised that there was a carbon footprint indicator, but we are still waiting to hear how this is to be measured. We are currently liaising with the interim ICS Chief Pharmacist on this. From ePACT data, we can also crudely measure our prescribing of Metered dose inhalers (MDIs) vs Dry Powder Inhalers (DPIs) and changes in prescribing which could be an indirect measurement. It was noted that although a full EQIA was not required (just strengthening of the current statement as outlined below), DW has agreed to undertake this to enable quality monitoring to take place. Training was also being rolled out to support the initiative across BLMK. The committee agreed to ratify the guidance for clinicians and background briefing paper to support local adoption of the NHS sustainability agenda. **EQIA Assessment:-** The guidance will have a positive impact on all patient cohorts from a sustainability perspective, individuals have a choice and the guidance does not endorse blanket switching – switching should be done at the review stage, face to face with inhaler technique assessed. There are certain cohorts included within the guidance whereby switching to a lower carbon footprint alternative i.e., MDI to DPI may not be clinically suitable. **This statement will be updated and has been added to the action log as an outstanding action.** **BLMK CCG E and D Lead comment -** I think this could cause some public concern if it is perceived that inhalers won't be prescribed to some patients – even if that is not the case. Noting it is national guidance. Changing suppliers for alternatives seems fine. I would say communication to patients is key. I considered an EIA, if this is going to see some stop treatment (even if that is potentially fine) it needs one. The author and E and D lead had some further discussion, and it was agreed that for the purposes of the meeting, the E & D section would be strengthened and that a EQIA would be completed to enable long term monitoring of the project by the Locality Team.	DW
5.2	**Antimicrobial prescribing guidelines for primary care (BLMK) – Update and alignment** Alignment of Bedfordshire and Luton and Milton Keynes antimicrobial prescribing guidelines has been undertaken to produce a BLMK Guideline taking into consideration the Public Health England (PHE) and NICE guidance.	

	Where differences existed (course length or antibiotic choice) the PHE/NICE position has been followed except for urinary tract infections. For urinary tract infections for non-pregnant women the first line local choice is nitrofurantoin or pivmecillinam (NICE recommends nitrofurantoin or trimethoprim). This is because of local resistance to trimethoprim being higher locally (23%) than nationally (21%). This deviation from national guidelines had the approval of our Consultant microbiologists. NICE guidelines for acne (NG 198) and Clostridioides difficile (NG 199) were published in the summer of 2021 and these updates have been incorporated into the aligned document**.** For Clostridioides difficile, vancomycin (oral) is now recommended as a first line choice in all cases. Metronidazole is no longer recommended. With respect to the acne guidance – a 12 week course of treatment is now recommended instead of the original 6 week recommended course. The guidelines have been updated to reflect this. In addition to the above, the following Formulary updates have been proposed as a result of the Formulary alignment/updates:- • **Tinidazole** for giardia - Non-formulary in both MK and B&L Joint Formularies (no licensed product available) • **Clotrimazole 100mg pessary** - Non-formulary in MK only (already on B&L Formulary) • **Hydrogen peroxide 1% cream** - Non-formulary in MK only (already on B&L Formulary) • **Benzoyl peroxide 5% gel** - Non-formulary in MK only (already on B&L Formulary) • **Oxytetracycline oral tablets** - Non-formulary in MK only (already on B&L Formulary) • **Co-trimoxazole** – B+L amber restricted. As a NICE option for COPD & others. Change to green (as per guidelines). • **Levofloxacin** – B+L red restricted. As a NICE option for COPD, acute exacerbation of bronchiectasis. Change to Green (as per guidelines) • **Vancomycin** capsules listed as restricted for micro recommendation only on TTAs & outpatient prescriptions. Change to green (as per guidelines) • **Fidaxomicin** – may potentially need change in the wording (NC to advise). • **Azithromycin** – recommended as an option for Chlamydia (on formulary as consultant recommendation only.) Change to green (as per guidelines) • **Fosfomycin** - This is listed as restricted, needs micro approval and last line therapy. Change to green (as per guidelines). The inclusion of Fosfomycin as ‘green’ on the Formulary was queried as we would not normally list a medicine so far down the	

	pathway (under the 80:20). It was noted however that the microbiology labs were already reporting sensitivities to this medicine and recommending that GPs prescribe. As a result of this and the fact that this has been recommended nationally, it was agreed that Fosfomycin should be retained in the guideline and the formulary status changed as outlined above. The inclusion of Fidaxomicin was queried but agreed for the reasons outlined for Fosfomycin. Milton Keynes GPs used to have a two sided summary sheet relating to the antimicrobial guidelines and the authors of the aligned guideline were asked if it would be possible for a similar document to be produced to accompany the full guideline. It was noted that there was a movement away from paper summary documents that go out of date quickly towards the use of apps and websites H.*Pylori* – not included in the guideline – link to BNF. This was previously discussed and agreed within Beds and Luton because the guidance changed so frequently. Agreed that discussions with NC and NW would take place outside of the meeting relating to the above to two issues and would be brought back to the meeting or agreed by chairman's action. NC agreed to work with CC and TL to ensure that all Formulary changes were made and seek chairman's action for changes if any additional significant changes to the information outlined above were required. The aligned BLMK guidelines and Formulary changes were approved. The committee thanked NC and HMcG for all of their hard work in aligning and updating the guidelines. **EQIA Assessment:-** No impact anticipated **BLMK CCG E and D Lead comment -** This is matching to NICE so is on a reasonable footing. I don't know the detail of all drugs. I note some harmonisation is down but is in line with NICE. I presume there is some option for managing exceptions?	NC/NW NC/CC/TL
5.3	**BLMK Shared Care Guideline Template (revised)** At the September 2021 meeting the committee discussed (in some detail) the proposed BLMK Shared Care Guideline template (which was largely based on the RMOC template). The SCG template has been updated as per those discussions. Aside from comments received during the consultation, there were only two remaining major issues for discussion:- • **Timescales for GPs to respond to specialists when they do not wish to undertake shared care** o RMOC Guidance states 14 days but comments received have said this is too tight a timescale. o Also need to balance the time needed for the Specialist to issue Rx and for the patient to collect	

	medication if initial supply was for 28 days (risk of patient running out of supply). **Proposal**: Response required as soon as possible with a maximum Timeframe of 14 to 21 days from receipt of request. • **Wording around patient held booklets (which has resulted in some suggestions re blood test monitoring communication).** o The need for the Primary Care prescriber to keep these up-to-date was debated. o Blood test results can usually be accessed electronically by both Secondary and Primary Care. o The option of a patient-held booklet is still available, where applicable, should the patient wish to use this, e.g., those on warfarin and lithium. **Proposal :**Added wording around agreeing a method of communication of blood test/investigation results between the Specialist, the Primary Care prescriber, the Community Pharmacist and the patient at the onset of shared care and having this documented in the patient's notes. The Committee agreed the proposed amended wording outlined above. It was further noted that there were still communication issues relating to blood test results, between primary and secondary care within BLMK and also for patients being seen outside of area. There were also issues in secondary care where e.g., blood tests undertaken at Bedford Hospital could not be accessed at the L & D Hospital) and vice versa. It was agreed that while this sat outside of the ability of the committee to resolve (IT and commissioning of services), it was still a medicines safety issue. DW therefore agreed to raise with planned care at her next scheduled meeting and to report back. Comments which arose from the consultation:- • MK Hospital Rheumatology comments (which they answered themselves :- "If GP refuses to prescribe the medications, is it going to be us taking over prescriptions and blood tests?" (Yes, but expected to be very low numbers as refusal of shared care was very unusual) "Issue with communication of results and lack of access to blood results from GPs in Buckingham, Leighton Buzzard and Northampton for Specialists at MKUH" (Contact GP by email or phone if necessary) • The specialist ought to complete this form legibly or even better typed. Nowadays it is very easy to save these documents on their computer and complete form electronically • "If the Primary Care prescriber is still not satisfied clinically to accept shared care, they should notify the Specialist clinician of their decision to decline in a timely manner, ensure the patient is aware of the change and make	DW

	appropriate arrangements for their continuing care. In this scenario, the prescribing responsibility for the patient remains entirely with the Specialist. --> What does this actually mean? How/why are we to make arrangements for continuing care if we are rejecting taking on responsibility for that care? Recommend delete/remove or clarify." The last comment came directly from the RMOC template and was based on the following GMC guidance:- **82** If you are uncertain about your competence to take responsibility for the patient's continuing care, you should ask for further information or advice from the clinician who is sharing care responsibilities or from another experienced colleague. If you are still not satisfied, you should explain this to the other clinician and to the patient, and make appropriate arrangements for their continuing care. The response to this comment was debated by the committee and the following major points raised:- • If shared care guidelines were approved via the Formulary Subgroup and APC, it would be anticipated that GPs would accept shared care except in exceptional circumstances. • If a GP was unhappy to pick up shared care, they could seek further information from the specialist or ask another colleague in their practice to undertake the shared care. In the event that the practice itself was declining shared care, they could seek assistance from their PCN. • If none of the above solutions worked, then the Specialist service would need to retain prescribing and monitoring. It was anticipated that this would be a very rare event. It was agreed that the above information would be included in the shared care guideline template. Noted that consultation should take place prior to shared care guidelines being developed as was the current process. With the agreed amendments the shared care guideline template was approved. Thank you to CC for updating and to DW/SMcG for input. **EQIA Assessment:-** Not assessed – process document.	CC
5.4	**Interim BLMK Primary Care Guidelines for the management of chronic non- cancer pain in adults** In April 2021, NICE issued new Chronic Pain Guidelines (Chronic pain {primary and secondary} in over 16s: assessment of all chronic pain and management of chronic primary pain	

	NICE guideline [NG193]Published: 07 April 2021)
	which will take time to implement as additional planned and commissioned services will be required. This work is currently in process across BLMK.
	
	As a result of the NICE Guideline publication, the current Pain Guidelines (those agreed by the Milton Keynes Prescribing Advisory Group and those agreed by the Bedfordshire and Luton Joint Prescribing Committee) needed to be revised. This is also a big undertaking which will need to be done in full alongside the commissioning of services. To withdraw the guidelines completely while the NICE implementation work is going would leave a substantial gap in the provision of information to GPs who are prescribing for patients. It was therefore proposed that **interim guidelines** are discussed and approved across BLMK.
	
	• <u>Benefits and Significance</u>: As a result of publication of NICE Guideline ,the current guidelines from both MK and Beds+ Luton are out of date. Production of new INTERIM guidelines will ensure a consistent approach towards the management of chronic pain in primary care across BLMK whilst a full re-write of the main guidelines is underway. Much of the Beds and Luton Guideline is still relevant and therefore the update was based on this guideline.
	• <u>Stakeholder involvement</u>:
	  • Interim guideline has been circulated to clinicians in primary care and across BLMK Trusts for comments.
	  • Clinicians in agreement with document as an interim pending full re-write of guidelines which will provide comprehensive details of pharmacological and non-pharmacological treatments available and commissioned for chronic non- cancer pain management across BLMK ICS.
	
	• <u>Overview of comments from stakeholders so far</u>:
	  • Side effects and contraindications/cautions of listed medications/antidepressants to be highlighted.
	  • Inclusion of all medications listed in the formulary.
	  • Alignment of service provision across BLMK ICS - *same contract/referral/pathway*
	  • Late comments – Acupuncture and CBT – in community setting.
	  • Information on NHS funded non pharmacological treatment in the community setting – e.g.: acupuncture, psychological therapy
	
	The draft interim guidelines and comments received were discussed, and the following key points raised:-
	
	• With respect to including information on side-effects/contraindications etc – agreed that as this information could soon be out of date, links to the BNF
		OO

	and/or Summary of Product Characteristics should be included. • Formulary updates to be discussed outside of the meeting with OO working with CC and TL. Proposed updates to the Formulary to be added with chair's approval. • Unfortunately, clarification and alignment of available non-pharmacological therapies couldn't be updated as this is the ongoing work being done by planned care. • Request for the change in status (from double red to amber 1) of nortriptyline to the Milton Keynes Formulary for patients who could not tolerate amitriptyline was approved in line with the current Bedfordshire and Luton Formulary position (i.e. restricted to prescribing on the recommendation of the Pain Specialists only, where amitriptyline has effectively controlled the neuropathic pain but where the patient is intolerant to the side effects).. • Noted that the use of anti-depressants is recommended by NICE Guideline 193 for the treatment of Primary Pain and that this needed to be differentiated within the guideline and separate from use of these medicines for neuropathic pain which was also in the guideline. With the amendments outlined above the INTERIM Guidelines were approved. The chair thanked OO for producing the guidelines and YM for attending to give Specialist input into the discussions. **EQIA Assessment:- Yes –** people with protected characteristics may be affected by the proposed changes, however the proposed changes are in line with national (NICE) guidance , the purpose of which is to improve the safety of the interventions being offered. **BLMK CCG E and D Lead comment -** Chronic pain can be an emotive area. There is a perception by some patients that the NHS is uncaring and is happy to see patients in pain. Pain is a disability where its long term and has debilitating impact. With NICE reviewing its clear interim guidance is needed, if this isn't restricting anything new (appears not to be) then I don't see an EIA required.	OO/TL/CC CC OO
5.5	**BLMK Rheumatoid Arthritis Pathway Update (Upadacitinib for moderate disease) and Tocilizumab Disruption of Supply** The Rheumatoid Arthritis Algorithm A has been updated to reflect the publication of NICE TA 744 (regarding the use of Upadacitinib as a treatment option for moderate disease). The rest of the pathway has been updated to reflect the fact that we currently do not support the switching between JAK inhibitors. Therefore, if a JAK inhibitor is used for moderate disease, it can't be selected for use further down the pathway. There has also been the addition of information to the front page regarding a supply disruption alert (SDA) recently issued relating to the need to prioritise the supplies of tocilizumab s/c for non covid 19 indications due to increased global demand in order to ensure adequate supplies available when needed.	

	With the correction of some minor formatting issues, the committee approved the update to the pathway. **EQIA Assessment:-**. Yes - a positive impact due to the availability of another patient option in this patient group. **BLMK CCG E and D Lead comment -** This is a force majeure situation, note position and planned reassurance for patients. EIA not required. Action to ensure GP practices / prescribers are urged to provide information and reassurance.	SMcG
5.6	**Transgender Shared Care Guidelines** At the Sept 2021 APC meeting, the committee agreed to ratify the Tavistock and Portman Transgender shared care guidelines for transmen (female to male transitioning) and for transwomen (male to female transitioning). Subsequent to this meeting, The Tavistock centre have issued an updated version of the 2 separate transgender guidelines and the committee were asked to review the recent changes. In summary the main changes are:- • Addition of information relating to bone health (in both transfeminine and transmen guidelines) • Addition of new bullet points on the shared care prescribing agreement page clarifying circumstances when shared care would be considered as appropriate. • Minor changes to some hormonal drug choices and doses • Included a link to the Government document on national screening guidance https://www.gov.uk/government/publications/nhs-population-screening-information-for-transgender-people In addition to the above information the committee was asked to agree the addition of the following links to the transgender shared care guideline page on the BLMK website • Link to the main GIC website • Link to the government screening information document • Link to the GP support section of the GIC website It was noted that the guidelines were for use in adults only and that this needed to be made clear. Shared care for children and adolescents is not supported within BLMK. The Committee ratified the updated guidelines (with the clarification that the guidelines were for use in adults only) and the addition of the information outlined above to the transgender shared care guideline page on the BLMK website. It was noted that some amendments to the BLMK Medicines Formularies may be required as a result of the update to the hormonal product choices. It was agreed that this could be	CC/TL/JF

	discussed outside of the meeting and chairman's action sought for any changes required. **EQIA Assessment**:-. Assessed at September 2021 meeting **BLMK CCG E and D Lead comment –** as above	
5.7	**Bariatric Surgery – Vitamins and minerals** A guidance sheet for BLMK GPs regarding vitamin and mineral preparations needed post bariatric surgery and whether they are for prescribing / OTC purchase has been produced. This has been developed following feedback to the CCG team that clear guidance was needed to consistently give patients the same message regarding which preparations they should receive and whether they should be prescribed or purchased. Clear management of patient expectation should occur across the primary and secondary care interface. The document also aligns with the self-care agenda. Specialist surgery is undertaken at L&D hospital locally, with approximately 400 procedures per year. The list of post-surgery preparations needed was obtained from the specialist pharmacist and is in line with BOMSS guidance. **The guidance sheet was discussed, and the following key points raised:** • A number of comments had been received but most were minor and had been incorporated into an updated version of the document. The main comments related to providing additional choices for calcium and vitamin D and making sure that the multivitamin preparations were up to date. • Noted that the information relating to multivitamins should be more generic in nature i.e., multivitamins containing the following constituents (and quoting the minimum quantity of copper and correct copper to zinc ratio) were recommended and could be purchased from a variety of sources (e.g., Tesco, Lloyds etc). It was agreed that the document would be updated accordingly. • This document was not new and a version of it has been in place for many years. • Patients had extensive counselling post-op which included the need to purchase vitamins and information on what to buy. • There was a patient information leaflet – HMcG had requested a copy, and this was awaited. • Some multivitamins have vitamin D contained in them. It was confirmed that patients required this component in addition to the vitamin D tablets listed as a separate entity on the list. With the incorporation of the comments as outlined above, the committee approved the guidance. **EQIA Assessment:-** NO - The decision has been reviewed with regard to Equality, Inclusion and Human Rights and no issues have been identified.	

	BLMK CCG E and D Lead comment -- Clear information provision is a correct aim. Some patients maybe concerned that they are having to purchase items which could for those from a low socio-economic income cause issues. Normally GPs have some discretion. If it became evident that patients were missing out the issue would have to be reviewed.	
5.8	**Dapagliflozin and Type 1 Diabetes – licence change** Dapagliflozin was licensed as an additional medication for people living with type 1 diabetes (T1 DM) as an adjunct to insulin to help with hyperglycaemia and weight loss, in those with a BMI over 27. On the 25th October 2021 AstraZeneca, in agreement with the European Medicines Agency and the MHRA took the decision to remove the T1DM indication for dapagliflozin 5mg. Following AstraZeneca's decision to remove the licence for dapagliflozin 5mg as a treatment for hyperglycaemia in T1D and a body mass index (BMI) of ≥ 27 kg/m2. It was expected that letter from AstraZeneca would be brought to the APC meeting and the decision to remove it from both formularies for the above indication would be ratified. However due to the request for its continued use as an off-label medication, the implication for primary care/GP prescribing and potential resistance from patients who have been successfully treated with dapagliflozin to discontinue it, it has been brought to the APC for further discussion on its place on the formulary. A briefing paper had been produced and the following options proposed:- • **Option 1:** Dapagliflozin to ***remain on both MK and Luton and Beds Formularies*** for the following indication: *as an option for the treatment of hyperglycaemia as an adjunct to insulin in adults with type 1 diabetes (T1D) and a body mass index (BMI) of ≥ 27 kg/m2*. No formulary changes to dapagliflozin for its other licensed indications. Traffic light status to be agreed • **Option 2:** Dapagliflozin to be ***removed from the Beds and Luton Formulary and remain on the MK formulary.*** As above. • **Option 3:** Dapagliflozin to be ***removed from the Beds and Luton Formulary and the MK formulary only for the above indication.*** The following additional points were raised during the discussion at the meeting: • The product was not being withdrawn due to any additional	

	safety issues, but the resources provided by the company to assist safe use of the combination of insulin and dapagliflozin had been withdrawn with the licence. • One of diabetologists at Milton Keynes had been involved in the trials using the combination and this was the reason that Milton Keynes Hospitals used the combination while the Bedfordshire Hospitals Trust didn't. • Benefit had been seen in patients treated by the combination, both physical and mental and the request was that the combination could be used in both existing and new patients. • All of these patients were seen regularly by the diabetes teams and trained to recognise signs and symptoms of Diabetic ketoacidosis (DKA) etc. • There were about 20 existing patients in Milton Keynes. No patients in Bedfordshire and Luton as the diabetologists at Bedfordshire Hospitals NHS Foundation Trust do not use this combination in Type 1 diabetes. • It was not unusual for diabetologists to use drugs and drug combinations outside of licence. • Concerns were raised that patients were being taken off dapagliflozin when it was being used for other indications or Type 2 diabetes, particularly as 'coding issues' had been raised. It was noted that any changes to the Formulary and communication with practices would need to clearly differentiate between this specific combination and indication and others. MD advised that practices would be supported identifying relevant patients and assisting the ensuring that the drug was not being withdrawn inappropriately. • Trusts have an unlicensed medicines policy and it would be generally inappropriate to have a drug used off label on the Formulary. • Small numbers of patients involved, and many GPs would pick up prescribing. For HC and FG to sort a solution where GPs were unhappy to takeover prescribing. • Only a small number of Milton Keynes GPs (2 or 3) had responded to the consultation and there was roughly a 50/50 split on whether they would be willing to take over prescribing. • The letter produced for patients, which they would need to sign in order to continue with therapy needed to include information to the GP. The committee agreed to the following:- • Dapagliflozin to be removed from the Beds and Luton	CC/TL MD

	Formulary and the MK formulary only for the following indication: as an option for the treatment of hyperglycaemia as an adjunct to insulin in adults with type 1 diabetes (T1D) and a body mass index (BMI) of ≥ 27 kg/m2. No formulary changes to dapagliflozin for its other licensed indications. • No new patient initiations unless under exceptional circumstances and agreed on a case per case basis in line with Trust unlicensed medicines policies. • Amber (Beds and Luton)/Amber 2 (MK) designation • Patient letter to include information for GPs • CCG Lead Diabetes Pharmacist to produce information/flow chart to guide GPs on which patients should or should not receive the combination The chair thanked TK for her input to the meeting. **EQIA Assessment:-** Not assessed	CC/TL TK MA
6.0	**NICE Guidance – 16th September – 17th November 2021** **The following NICE Technology Appraisal Guidance (CCG Commissioned) have been published:-** Inclisiran for treating primary hypercholesterolaemia or mixed dyslipidaemia, Technology appraisal guidance [TA733]Published: 06 October 2021, https://www.nice.org.uk/guidance/ta733 **This has a 30-day implementation.** **APC Action – FAD link replaced by NICE TA link on both Joint Formularies.** The following costing information is based on national guidance, local intelligence (as regards current and future prescribing patterns) and pricing of inclisiran as per NHSE interim funding arrangements. For clarity NHSE has confirmed the following information with respect to ongoing funding:- '*NHS England and Improvement has agreed to fund inclisiran centrally until the initial agreement review date (July 2024). At this point the agreement will be assessed to establish whether it has met its objectives and an assessment will take place to determine whether the current pricing approach should continue or whether a revised commercial agreement, reflective of the population treated at that time and anticipated for the future, is appropriate. In line with NICE's standard review timings, a review of the technology appraisal would be expected in 2024 which will ensure there is continued cost effectiveness. Any review of the pricing approach would be in the context of the NICE TA review to ensure that the cost effectiveness of inclisiran remains.'*	

	Total Estimated Additional Cost Impact across BLMK ICS (Primary and Secondary Care) at 5 years =£466,180 (Drug costs accounting for £419,729). Of these total costs - £310,743 are attributable to Primary Care and £155,437 to Secondary Care. Information on change in costs/year for 5 years is available on request. Upadacitinib for treating moderate rheumatoid arthritis Technology appraisal guidance [TA744]Published: 10 November 2021 https://www.nice.org.uk/guidance/ta744 **APC Action – added to the RA Pathway – see agenda item 5.5. 'Live' Appendix 1 updated. Link added to both Joint Formularies** NICE does not expect this guidance to have a significant impact on resources; that is, the resource impact of implementing the recommendations in England will be less than £5 million per year in England (or approximately £9,000 per 100,000 population, based on a population for England of 56.3 million people). This is because the technology is a further treatment option, and the overall cost of treatment will be similar. The Committee has already been advised of the impact of treating moderate RA with biological agents at a previous meeting. **The following NICE Guidelines (NG) (Medicine related and CCG Commissioned) have been published / updated by NICE:** Cardiovascular disease: risk assessment and reduction, including lipid modification, Clinical guideline [CG181]Published: 18 July 2014 Last updated: 06 October 2021 https://www.nice.org.uk/guidance/cg181 Recommendation 1.3.52 was added in response to the publication of the Inclisiran TA. Inducing labour, NICE guideline [NG207]Published: 04 November 2021. https://www.nice.org.uk/guidance/ng207 This guideline covers the circumstances for inducing labour, methods of induction, assessment, monitoring, pain relief and managing complications. It aims to improve advice and care for pregnant women who are thinking about or having induction of labour.	

	Heart valve disease presenting in adults: investigation and management, NICE guideline [NG208]Published: 17 November 2021. https://www.nice.org.uk/guidance/ng208 This guideline covers investigation and management of heart valve disease presenting in adults. It aims to improve quality of life and survival for people with heart valve disease through timely diagnosis and appropriate intervention. Acute heart failure: diagnosis and management, Clinical guideline [CG187]Published: 08 October 2014 Last updated: 17 November 2021. In **November 2021**, we withdrew the recommendations on valvular surgery and percutaneous intervention because they have been replaced by the NICE guideline on heart valve disease. **The following COVID 19 – Rapid Reviews and other information have been produced/Updated by NICE:-** COVID-19 rapid guideline: managing COVID-19, NICE guideline [NG191]Published: 23 March 2021 Last updated: 04 October 2021 https://www.nice.org.uk/guidance/ng191 On **4 October**, NICE added new recommendations on casirivimab and imdevimab. NICE has also updated the supporting evidence on the use of heparins with the peer reviewed REMAP-CAP trial results. This update does not change the current recommendations. **The following NICE TAs are the commissioning responsibility of NHSE and are listed for information only.** Daratumumab with pomalidomide and dexamethasone for treating relapsed or refractory multiple myeloma (terminated appraisal) Technology appraisal [TA726]Published: 22 September 2021, https://www.nice.org.uk/guidance/ta726 . **APC Action –** none as terminated appraisal Isatuximab with carfilzomib and dexamethasone for treating relapsed or refractory multiple myeloma (terminated appraisal) Technology appraisal [TA727]Published: 22 September 2021. https://www.nice.org.uk/guidance/ta727 **APC Action –** none as terminated appraisal Midostaurin for treating advanced systemic mastocytosis, Technology appraisal guidance [TA728]Published: 22 September 2021 https://www.nice.org.uk/guidance/ta728 **Recommended – APC action –** Link added to both Joint Formularies. Sapropterin for treating hyperphenylalaninaemia in phenylketonuria, Technology appraisal guidance [TA729]Published: 22 September 2021	

	nice.org.uk/guidance/ta729 **Recommended – APC action – moved from non Formulary to Formulary and link added to both Formularies.** Avapritinib for treating unresectable or metastatic gastrointestinal stromal tumours (terminated appraisal) Technology appraisal [TA730]Published: 29 September 2021 https://www.nice.org.uk/guidance/ta730 - **APC action –** none as terminated appraisal Vericiguat for treating chronic heart failure with reduced ejection fraction (terminated appraisal) Technology appraisal [TA731]Published: 29 September 2021. https://www.nice.org.uk/guidance/ta731 - **APC action –** none as terminated appraisal Baloxavir marboxil for treating acute uncomplicated influenza (terminated appraisal), Technology appraisal [TA732]Published: 06 October 2021 https://www.nice.org.uk/guidance/ta732 **APC Action – none as terminated appraisal.** Secukinumab for treating moderate to severe plaque psoriasis in children and young people, Technology appraisal guidance [TA734]Published: 07 October 2021 https://www.nice.org.uk/guidance/ta734 - **Recommended** **APC Action – link added to both Joint Formularies** Tofacitinib for treating juvenile idiopathic arthritis, Technology appraisal guidance [TA735]Published: 20 October 2021 https://www.nice.org.uk/guidance/ta735 - **Recommended - APC Action – link added to both Joint Formularies** Nivolumab for treating recurrent or metastatic squamous cell carcinoma of the head and neck after platinum-based chemotherapy Technology appraisal guidance [TA736]Published: 20 October 2021 https://www.nice.org.uk/guidance/ta736 - **Recommended - APC Action – link added to both Joint Formularies** Pembrolizumab with platinum- and fluoropyrimidine-based chemotherapy for untreated advanced oesophageal and gastro-oesophageal junction cancer, Technology appraisal guidance [TA737]Published: 20 October 2021, https://www.nice.org.uk/guidance/ta737 - **Recommended** **APC Action – link added to both Joint Formularies** Berotralstat for preventing recurrent attacks of hereditary angioedema, Technology appraisal guidance [TA738]Published: 20 October 2021, https://www.nice.org.uk/guidance/ta738 - **Recommended - APC Action – Created and link added to both Joint Formularies**	

	Atezolizumab for untreated PD-L1-positive advanced urothelial cancer when cisplatin is unsuitable, Technology appraisal guidance [TA739]Published: 27 October 2021, https://www.nice.org.uk/guidance/ta739 - **Recommended- APC Action – link added to both Joint Formularies** Apalutamide with androgen deprivation therapy for treating high-risk hormone-relapsed non-metastatic prostate cancer Technology appraisal guidance [TA740] Published: 28 October 2021. https://www.nice.org.uk/guidance/ta740 - **Recommended APC action – created and link added to both Joint Formularies** Apalutamide with androgen deprivation therapy for treating hormone-sensitive metastatic prostate cancer Technology appraisal guidance [TA741] Published: 28 October 2021, https://www.nice.org.uk/guidance/ta741 - **Recommended APC action – created and link added to both Joint Formularies** NBTXR-3 for treating advanced soft tissue sarcoma (terminated appraisal), Technology appraisal [TA745]Published: 10 November 2021 https://www.nice.org.uk/guidance/ta745 ' – **Terminated Appraisal – APC action - none** Nivolumab for adjuvant treatment of resected oesophageal or gastro-oesophageal junction cancer, Technology appraisal guidance [TA746]Published: 17 November 2021. https://www.nice.org.uk/guidance/ta746 - **Recommended – APC action – link added to both Joint Formularies** Nintedanib for treating progressive fibrosing interstitial lung diseases, Technology appraisal guidance [TA747]Published: 17 November 2021 https://www.nice.org.uk/guidance/ta747 - **Recommended – APC action – link added to both Joint Formularies – Tertiary Care only prescribing? To confirm with Secondary Care.**	HC/CC/RP
7	**Virtual Recommendations/Documents – for discussion/ratification:- NONE**	
8	**Medicines Safety** DW and ZA gave a Primary Care Medicines Safety Update and a Medicines Safety Group Update. The Primary Care Medicines Safety Update focussed on the primary care response to the MHRA Drug Safety Updates (September and October). In particular:- **Topical corticosteroids: information on the risk of topical steroid withdrawal reactions** **Action(s) taken:** Communication via BLMK Primary Care Newsletter which goes to all practices within BLMK (medicines safety team)	

Tofacitinib (Xeljanz▼): new measures to minimise risk of major adverse cardiovascular events and malignancies
Actions taken: Review of local pathways, updating of proformas and consultation with Trust clinicians (commissioning team)

Chloral hydrate, chloral betaine (Welldorm): restriction of paediatric indication
Action(s) taken: Review of primary use over BLMK, practices with cohort targeted, project management team (paediatric neurology pharmacist) has informed specialist teams. Discussed at BLMK medicines safety group to ensure ICS provider engagement. Included in BLMK primary care newsletter. Formulary Updated

Fire risk from use of emollient creams
There have been a few local and national incidents highlighted by the Fire Service in relation to the use of emollient creams within the community setting – domiciliary care and care homes. Initial workshop held with CCG safeguarding, CCG medicines optimisation and the fire service from Bedfordshire and Buckinghamshire. To raise awareness of MHRA resources, fire service to develop a referral pathway and key stakeholders – provider (community and acute) and local authorities to be engaged as workstream progresses. https://www.gov.uk/drug-safety-update/emollients-and-risk-of-severe-and-fatal-burns-new-resources-available

Other area(s) of progress
- BLMK CCG medicines safety and formulary pharmacist joined the organisation on 2nd November 2021
- BLMK CCG MSO dedicated email address set up and live – to receive serious incidents, quarterly quality reports from providers.
- Care home medicines optimisation and quality visits in progress – referral pathway approved at BLMK prescribing committee and circulated to key stakeholders

The BLMK ICS Medicines safety group (MSG) was held on 19th October 2021. The key areas of focus were:

MedSafetyWeek November 2021: support the safety of vaccines

Examples of #medSafetyWeek from BLMK ICS MSG: -

- MKUH shared messages internally in the Trust via intranet and newsletter, also arranged for a stand for the Medicines Safety team to answer any questions. Messages were sent via Twitter and Facebook.
- BHFT sent out a message within the weekly trust-wide comms newsletter at the start of #MedSafetyWeek and embedded all the links to MHRA resources and yellow card.
- The BLMK ICS MSG are launching a new medicines safety section via BLMK CCG website and a new quarterly BLMK ICS medicines safety newsletter to share learning from

	medication incidents and raise awareness on local and national safety initiatives to improve medicines safety. **Parkinson's medication – improving access to specialist advice** The group have explored the provision of Parkinson's specialist nurses across the ICS and are currently compiling a list of contacts and revisiting current commissioned specifications to ensure that there is access to specialist advice in relation to medication, throughout the patient journey (from admission to hospital, inpatient and at discharge) in addition to medicines information and related resources. It was noted that self-administration of medicines policy implementation could also be a key influential factor in optimising timely administration of medicines for patients with Parkinson's. **Patient involvement** The chair and secretariat are in the process of exploring via the BLMK CCG communications team, primary care commissioning and Healthwatch the prospect off greater engagement with patients / patient group upon the development of medicines safety initiatives and projects. MSO In addition to the information above, the committee were asked to note that the November 2021 Drug Safety Update had been published and the minutes of the October 2021 Medicines Safety Group.	
9	**Formulary Update**	
9.1	**Formulary Subgroup Recommendations** JC asked for and received ratification of the recommendations proposed by the Formulary Subgroup. See appendix 1 (minutes of the Formulary subgroup meeting) for more detail. Summarised below:- • Infliximab s/c – **approved** – standard doses only. HCD pathways to be updated to include – The APC agreed that these could be updated and approved by chair's action • Buprenorphine prolonged release solution for injection – **approved** – hospital only after initiation by addiction services – no GP prescribing. • Testosterone Fact Sheet - **approved** • BLMK Formulary Subgroup – Standard Operating Procedure – **approved** • SGLT2 Inhibitors – change in Formulary Status proposed – **approved with caveats and additional information** • Bydureon BCise® (exenatide) 2 mg prolonged release suspension for injection Pre-filled Pen – **approved (B and L)** • Eyeaze (sodium hyaluronate acid) 0.1%, 0.2% and 0.4% preservative free eye drops – **approved** (**MK)** • Simple Eye Ointment (Paraffin, Yellow Soft) - Deleted (MK) • Evolve Carbomer 980 0.2% w/w, Multi-dose Preservative Free Eye Gel – addition approved (MK) – only when a preservative free prep required.	SMCG

	• Supply disruption alert (SDA) – Tocilizumab – SDA actions ratified – information added to RA Pathway (unchanged) • Konakion – changed to generic Phytomenadione. • TOR – additional GP representation **Melatonin Liquid** JC advised the committee that the BLMK Formulary Subgroup had reviewed the choice of Melatonin Liquid and agreed the following recommendation:- Melatonin 10mg/5ml Oral Suspension (alcohol free, sugar free and propylene glycol free) Following the meeting it was discovered that this preparation could not be obtained easily. An informal meeting was convened (mainly primary and secondary care pharmacists as issues were mainly Pharmaceutical and related to supply) and the following change to recommendations were proposed:- • 5 Years and over – Colonis Brand (1mg/ml) • Under 5 years – Kidmel brand (1mg/1ml) Additional support from CCG Pharmacy team to assist GP and Community Pharmacy implementation was also agreed. This choice of products would ensure safe levels of propylene glycol in patients under the age of 5 years. (Kidmel does contain propylene glycol but at a much lower level {1/3rd of level} than in the Colonis Brand). The attendees at the informal meeting were happy with the revised proposal and all members of the Formulary Subgroup were contacted post meeting. No concerns were raised and the necessary approval for a quorate response was obtained. However, as this decision was taken outside the Formulary Subgroup meeting, for governance, the approval of the APC regarding the change in recommendation was requested and obtained.	
9.2a	**Wound Management Formulary Steering Sub-Group Terms of Reference (TOR)** • The TOR for the wound care subgroup has been updated to reflect the CCG merger and the move to ICS working. • The wound care subgroup has approved the updated TOR and the APC was asked to ratify them. The committee ratified the Terms of Reference.	
9.2b	**Wound Management Formulary Steering Sub-Group Recommendations – Formulary Additions:-** • Urgo Clean and UrgoStart Plus dressings are proposed to be added to the formulary primarily for the management of diabetic foot ulcers and venous leg ulcers. • TVN initial experience extremely positive – good wound healing and improved QoL.	

	• Cost modelling indicates use will be cost saving in comparison with usual standard of care The committee ratified the above recommendations	

10	**Antimicrobial Resistance (AMR) Update**
	
	NC gave the following update to the committee
	
	• East of England Regional Antimicrobial Stewardship Lead in post
	• BLMK SRO for Antimicrobial Stewardship – Dr Sureena Goutam
	• HCAI / AMR steering group met in October 2021
	• Emerging themes:
	  • AMS Workforce
	  • Align guidelines the use of digital technology (HBLICT app)
	  • Share staff training
	  • Benchmarking of data (available through regional team)
	  • Diagnostic stewardship	

All other papers (from this point in the agenda) are for noting/information by the Committee		
11	**East of England Priorities Advisory Committee (PAC) – items for noting/approval**	
11.1	EoEPAC Meeting Notes – July 2021 The committee noted the minutes for information.	
11.2	EoEPAC draft Meeting Notes – September 2021 The committee noted the minutes for information.	
12	**Bedfordshire, Luton and Milton Keynes Local Prescribing Committee Minutes.** The Committee noted the following minutes for information.	
12.1	Minutes from the Bedfordshire Hospitals Foundation Trust DTC meeting – July 2021	
12.2	ELFT Medicines Management Committee Minutes (Mental Health) - July 2021	
12.3	Minutes of Circle/MSK MMC Meeting – None	
12.4	Minutes of the Bedfordshire and Luton Wound Management Formulary Steering Group – July 2021	
12.5	Minutes of the Cambridgeshire Community Services Medication Safety and Governance Group – September 2021	
12.6	CNWL - Trustwide Medicines Optimisation Group (MOG) Meeting – June 2021	
13.	**Papers for information**	

13.1	**New treatments for COVID-19** AG had produced an information paper for the committee on new treatments for Covid 19 including:- • Neutralising monoclonal antibodies (nMABs) - Casirivimab and imdevimab (Ronapreve®) • Antivirals - Molnupiravir (Lagevrio®) It was also noted that the committee may be asked to ratify (virtually) some anticipated national polices which are expected before Christmas.	
13.2	**Blood glucose and steroid therapy in palliative care patients – ELFT** The paper was approved by ELFT Medicines Management Committee on Wednesday 10th November subject to the information being added to an ELFT approved template. The paper came to the APC for information only.	
14	**Any other business** JF thanked RS for organising Teamnet Clarity as a repository for APC papers and for her general support to the committee. This was JC's last meeting as Professional Secretary to the committee and JF thanked her for all of her work setting up the BLMK APC but also for her many years of service to the Bedfordshire and Luton Joint Prescribing Committee (JPC). JF welcomed AG as the new Professional Secretary.	
15	**Future Dates for BLMK APC 2021/22 Meetings:-** Wednesday 2nd March 2022 – 12.30-3.00pm Wednesday 4th May 2022 – 12.30- 3.00pm Wednesday 29th June 2022 – 12.30-3.00pm Wednesday 28th September 2022 - 12.30-3 pm Wednesday 7th December 2022 - 12.30-3 pm	
Please inform Jacqueline Clayton of any apologies on 01525 624382 or email Jacqueline.clayton@nhs.net Circulation: BLMK APC Members, BLMK Medicines Optimisation Team (not APC members)		

Approval of minutes:
Chair: Dr John Fsadni

Signed: 

Date: 3rd March 2022

Appendix 1 – Approved 7th September 2021 Formulary Subgroup Minutes:

BLMK Formulary Subgroup November