BEDFORDSHIRE, LUTON AND MILTON KEYNES AREA PRESCRIBING COMMITTEE

FINAL Meeting Notes

Date: 2nd March 2022
Time: 12.30- 3.00pm
Venue: Microsoft Teams

Attendees:

Name	Initial	Role
Alison Borrett	AB	Chair (Non-Executive Director BLMK CCG)
Pritesh Bodalia	PB	Bedfordshire Hospitals Trust Pharmacy Representative (Chief Pharmacist, Bedfordshire Hospitals Trust) (present from 12.42 – 13.41)
Helen Chadwick	HC	Milton Keynes Hospital Pharmacy Representative (Clinical Director of Pharmacy, Milton Keynes Hospital)
Yolanda Abunga	YA	CCS Pharmacy Representative (Community Services Pharmacist, Beds and Luton)
Dr Muhammad Nisar	MN	Medical Representative, Bedfordshire Hospitals Trust
Dr Dushyant Mital	DM	Medical Representative, Milton Keynes Hospital (12.30pm – 2pm)
Dr Andrew Cooney	AC	Medical Representative, Milton Keynes Hospital (2pm – 2.45pm)

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 Kate Randall	KR	Place Based Lead GP – Central Bedfordshire
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	Chair of Wound Care Group
Anne Graeff	AG	Commissioning Lead Pharmacist, BLMK CCG (Professional Secretary)
Dr John Fsadni	JF	Chair of Formulary Subgroup
Zainab Alani	ZA	Chair of Medicines Safety Group
Mary Evans	ME	Interim Integrated Care System (ICS) Chief Pharmacist, BLMK
Shyaam Teli	ST	ELFT Pharmacy Representative – Community Services (deputising for Suraiya Chandratillake)
Alex Hill	AH	Community Pharmacy Representative
Carole Jerrico	CJ	Nurse and Non-Medical Prescribing Representative (Secondary Care)
Nikki Woodall	NW	Formulary Lead Pharmacy Technician, BLMK CCG
Dr Richard Simpson	RS	Place Based Lead GP – Milton Keynes (deputising for Dr Nigel Fagan)

In attendance:		
Candy Chow	CC	Principal Pharmacist, Formulary and Interface, MKUH
Dona Wingfield	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 (admin support)
Taiya Large	TL	Formulary and Medicines Safety Pharmacist BLMK CCG
Dr Marian Chan	MC	Medical Representative, Bedfordshire Hospitals NHS Trust
Rafal Ali	RA	Place Based Pharmacist, BLMK CCG
Joy Mooring	JM	Lead Pharmacy Technician, BLMK CCG
Mr Ammar Miri for agenda items 5.2 – 5.4	AM	Consultant Ophthalmologist, Milton Keynes Hospital
Dr Roshan Jayalath for agenda item 5.7	RJ	Mental Health Lead GP, BLMK CCG
Lorna Bass for agenda item 5.8	LB	Paediatric Respiratory Nurse Specialist, MKUH

Zubeir Nurgat for agenda item 7.2	ZN	Cancer Lead Pharmacist, MKUH
Leah Anthony (observer)	LA	Lead Nurse for Diabetes and Endocrinology Luton and Dunstable Hospital
Vilma Ramos (observer)	VA	Diabetes Specialist Nurse at Luton and Dunstable
Rahena Choudhury (observer)	RC	Pharmacy Administrator, Milton Keynes Hospital
Maire Stapleton (observer)	MS	Formulary Manager, Buckinghamshire Integrated Care Partnership

Apologies:		
Dr Nigel Fagan	NF	Place Based Lead GP – Milton Keynes
Dr Mya Aye	MAy	Medical Representative, Milton Keynes Hospital
Anshu Rayan	AR	CNWL Pharmacy Representative (Community and Mental Health Services Milton Keynes)
Sandra McGroarty	SMcG	Commissioning Pharmacist, BLMK CCG
Suraiya Chandratillake	SC	ELFT Pharmacy Representative – Community Services (Beds)

No	Agenda Item	Action
1.	**Welcome, Introductions and Apologies** The Chair welcomed everyone to the meeting, with particular welcome to the observers and persons present for the specific agenda items, as noted above. Apologies were received and noted as above. The Chair thanked Kike Pinheiro for her service to BLMK committees, including the BLMK APC, the Milton Keynes Prescribing Advisory Group and the Bedfordshire and Luton Joint Prescribing Committee. 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.	12.35pm

No	Agenda Item	Action
	The Chair invited members to declare any declarations relating to matters on the agenda. JC declared an interest in relation to agenda item 10.3 and took no part in this discussion. There were no other declarations of interest relating to the agenda	
3.	**Minutes of the previous meetings**	
3.1	**Minutes of 1st December 2021 APC meeting** It was noted that there is an outstanding action to update the EQIA statement for the "Strategies to support reduced inhaler carbon emissions" agenda item from the December APC meeting. This action will be moved to matters arising and reviewed at the next meeting. The minutes were approved.	DW
3.2	**Minutes of 9th November 2022 Formulary Subgroup meeting** The minutes were approved	
4.	**Matters Arising** All JPC and MKPAG legacy actions are now closed	
4.1	**Feedback on miscellaneous actions not included on the agenda from APC meetings**	
4.1.1	**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 08/02/2022 - 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
4.1.2	**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. This item will be discussed at the 4th May APC. This is an ongoing action.	AG
4.1.3	**Antimicrobial prescribing guidelines for primary care (BLMK) – Update and alignment.** 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	Close

No	Agenda Item	Action
	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. **Update 08/02/22** – Summary sheet of antibiotic guidelines – agreed that MK GPs will be advised that all guidelines are available electronically and that the guidelines will also be available by app. We will not develop a new summary sheet due to the risk of out of date versions being printed and used in practice. H. pylori – agreed that this will not be added to Community Antimicrobial guidelines – appropriate links to PHE guidance will be added to MK formulary to signpost to national H. Pylori guidance. It was proposed and agreed that this action could be closed.	
4.1.4	**Antimicrobial prescribing guidelines for primary care (BLMK) – Update and alignment** - 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. **Update 08/02/22** - these updates are covered in the Formulary paper circulated for virtual approve. It was proposed and agreed that this action could be closed.	Close
4.1.5	**BLMK Shared Care Guideline Template (revised)** - amendments agreed at the December APC meeting. **Update 08/02/22** - These updates have been undertaken. It was proposed and agreed that this action could be closed (see also agenda item 13 – AOB).	Close
4.1.6	**BLMK Shared Care Guideline Template (revised)** – at the December meeting, 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. **Update 08/02/22** - This is an ongoing action	DW
4.1.7	**Interim BLMK Primary Care Guidelines for the management of chronic non- cancer pain in adults -** 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.	Close

No	Agenda Item	Action
	Update 08/02/22 - These updates are covered in the Formulary paper circulated for virtual approve. It was proposed and agreed that this action could be closed.	
4.1.8	**Interim BLMK Primary Care Guidelines for the management of chronic non- cancer pain in adults** - amendments agreed at the December meeting. **Update 08/02/22** - These updates have been undertaken. It was proposed and agreed that this action could be closed.	Close
4.1.9	**Transgender Shared Care Guidelines** - these guidelines were ratified with amendments agreed at the December meeting. **Update - 08/02/22** - These actions were completed but just before publication, further updates to the SCGs were undertaken by the tertiary centre. A verbal update was given at the meeting: **Transfeminine SCG changes (i.e. transitioning from male to female)** • Change to target testosterone level for testosterone suppression – this was changed from 1-3 nmol/L to 0-3 nmol/L, to make it clear that continued administration of GnRH analogue is required to keep testosterone suppressed. • Additional GnRH analogue formulations added (i.e. Nafarelin nasal spray) – added to offer a nasal spray option for patients who cannot tolerate injections – The SCG is used by multiple CCGs with different formulary positions) – to be taken to the next Formulary meeting (NB Off label use). • Change to the initial dose and titration of Sandrena gel – this change reflects how Tavistock now titrate Sandrena gel, as some patients get good levels on relatively small doses, and the clinicians try to dose-titrate to achieve target oestradiol levels slowly every 3 months over the course of 2 years. **Transmasculine SCG changes (i.e. transitioning from female to male)** • Removal of testosterone virormone – Tavistock do not routinely use this any more in the UK • Additional GnRH analogue formulations added (i.e. Nafarelin nasal spray) - rationale as above Nafarelin will be reviewed and considered for addition to the joint Formularies at the Formulary subgroup meeting in April. Cross check of Tavistock website with BLMK Medicines website to be undertaken prior to each Formulary subgroup meeting to identify any further updates. The committee ratified the changes and updated guidelines.	SMcG / TL SMcG
4.1.10	**Transgender Shared Care Guidelines** - It was noted at the December meeting that some amendments to the BLMK Medicines Formularies may be required as a result of the update to the	Close

No	Agenda Item	Action
	hormonal product choices. It was agreed that this could be discussed outside of the meeting and Chair's action sought for any changes required. **Update 08/02/22** - These updates are covered in the Formulary paper circulated for virtual approve. It was proposed and agreed that this action could be closed.	
4.1.11	**Bariatric Surgery – Vitamins and minerals** - updates agreed at the December meeting. **Update 08/02/22** - These updates have been undertaken. It was proposed and agreed that this action could be closed.	Close
4.1.12	**Dapagliflozin and Type 1 Diabetes – licence change** - Concerns were raised at the December meeting 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. **Update 08/02/22** – TL/CC have completed their actions. MD informed the committee that the locality team are in the process of creating searches to support practices with identifying relevant patients and this will be implemented. It was proposed and agreed that this action could be closed.	Close
4.1.13	**Dapagliflozin and Type 1 Diabetes – licence change** - Dapagliflozin to be removed from the Beds and Luton 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. **Update 08/02/22** - Updates undertaken It was proposed and agreed that this action could be closed.	Close
4.1.14	**Dapagliflozin and Type 1 Diabetes – licence change** - Patient letter to include information for GPs. Update 17/2/22 – the MK diabetes team add entries directly onto SystmOne and then task the GP directly to look at the letter / agreement and the entry. It was proposed and agreed that this action could be closed.	Close
4.1.15	**Dapagliflozin and Type 1 Diabetes – licence change** - CCG Lead Diabetes Pharmacist to produce information/flow chart to guide GPs on which patients should or should not receive the combination. **Update 08/02/22** - MA had put together an optimisation guide for dapagliflozin but did not publish in view of the ongoing review relating to review of the T2DM and CKD in T2DM pathways so as not to confuse clinicians. This is therefore an ongoing action.	MA

No	Agenda Item	Action
4.1.16	**Nintedanib for treating progressive fibrosing interstitial lung diseases, Technology appraisal guidance [TA747] Published: 17 November 2021 –** Tertiary Care Prescribing only? - Secondary Care representatives to confirm. **Update 15/2/22** - No initiation at MK, clarification awaited from BHFT – MN to check with chest physicians and confirm, but it is likely that there may be prescribing at the Trust and if this was the case, there would need to be a change to the current Formulary wording.	MN/TL
4.1.17	**Infliximab s/c – approved December 2021 – standard doses only**. HCD pathways to be updated to include infliximab s/c – The APC agreed that these could be updated and approved by Chair's action. **Update 08/02/22** - This is an ongoing action	SMcG
4.2	**Feedback on miscellaneous actions not included on the agenda from Formulary Subgroup meetings.**	
4.2.1	**JPC Legacy - Gonadorelin Formulary Review** **Update 09/02/22** - Added to workplan. It was proposed and agreed that this action could be closed.	Close
4.2.2	**JPC Legacy - NICE HST - Volanesorsen for treating familial chylomicronaemia syndrome** Update 02/02/22 - Not expected to be used locally. Specialist centres only. Propose close action.	Close
4.2.3	**JPC Legacy - Ceyesto Formulary Application** Ceyesto added to the Bedfordshire/Luton formulary (Amber SCG). Local Amendment to 'Choice of Melatonin Bulletin' to be undertaken to take account of Ceyesto addition to Formulary. **Update 02/02/22** – this is an outstanding action.	SMcG
4.2.4	**JPC Legacy - Biosimilar Formulary Listings** Listings to be updated to reflect changes to choice of biosimilar and to update entries in line with SPC where necessary. **Update 02/02/22** – action completed. It was proposed and agreed that this action could be closed.	Close
4.2.5	**MKPAG Legacy - RMOC Guidance: Buvidal (Buprenorphine prolonged-release injection)** Formulary application submitted and approved. Added to both joint formularies (red traffic light). P2R and ARCMK contacted to notify GPs if they prescribe. No further action. It was proposed and agreed that this action could be closed.	Close
4.2.6	**MKPAG Legacy - GP prescribing of some specialist medicines – Proposal for amendment to the formulary status** All actions completed – revised status approved by MK Prescribing Committee and amendments completed on the MK joint Formulary. It was proposed and agreed that this action could be closed.	Close

No	Agenda Item	Action
4.2.7	**Omega-3-Fatty Acids (Omacor) - treatment of severe hypertriglyceridemia audit** Approval subject to audit across all three BLMK Lipid Clinics with 12 month review. Added to both joint formularies. Audit noted to be a long-term action and added to long term workplan. It was proposed and agreed that this action could be closed.	Close
4.2.8	**Denosumab SCG** SCG agreed with the amendments discussed. The suggested wording around acceptance of shared care by GPs is to be discussed and agreed by the BLMK Area Prescribing Committee. Actions – to update the guideline to reflect the discussion and 'tidy up' typos, punctuation and transfer the guidance onto the BLMK template (once agreed). **Update 09/02/22** – still to be finalised – ongoing action.	SMcG
4.2.9	**Cinacalcet Formulary Application and SCG** To confirm Formulary status: • Bedfordshire and Luton – Amber (shared care) • Milton Keynes – Amber 3, to be amended to Amber (shared care) when the final Cinacalcet Shared Care Guideline is available **Update 09/02/22 –** update to joint formularies completed. Shared care guideline to be finalised and published – this is an ongoing action.	SMcG
4.2.10	**Subcutaneous infliximab** Addition to both formularies following approval at November meeting. Added to both joint formularies. It was proposed and agreed that this action could be closed.	Close
4.2.11	**Melatonin liquid** GP and secondary care representatives not in the last (November) Formulary meeting – post-meeting, the information was circulated by email for approval and quoracy. Quoracy for decision obtained. Formularies updated and template letter for SystmOne produced. It was proposed and agreed that this action could be closed.	Close
4.2.12	**Melatonin liquid** Review of patients under 5 to ensure propylene glycol free liquid is being prescribed. NB – likely to be a short-term addition of Kidmel liquid due to the anticipated licensing of a new melatonin liquid product in the next few months. MD confirmed that this work has been delayed due to redeployment – review to be completed. This is an ongoing action.	MD
4.2.13	**Testosterone for low sexual desire in post-menopausal women** Testosterone factsheet - To confirm blood testing between Hospital Pathology Departments. Milton Keynes Hospital routinely run SHBG and FAI whereas Bedfordshire Hospital Foundation Trust only run them if testosterone levels are high. Further discussion with Bedfordshire Hospital Foundation Trust re possible alignment.	TL

No	Agenda Item	Action
	Update 09/02/22 - Review of SHBG / FAI testing at Bedfordshire Hospitals – awaiting comments from clinician. This is an ongoing action.	
4.2.14	**BLMK Formulary Subgroup – Terms of Reference.** Minor amendment to change 'Chairman' to 'Chair'. **Update 09/02/22** – action completed. It was proposed and agreed that this action could be closed.	Close
4.2.15	**SGLT2 Inhibitors – change in Formulary Status** Update formulary entries for SGLT2 inhibitors (GREEN) with to include wording from the recommendations. **Update 09/02/22** – action complete. It was proposed and agreed that this action could be closed.	Close
4.2.16	**SGLT2 inhibitors - Scriptswitch and Optimise messages** Messages needed to indicate change in Formulary status, when to refer patients & signpost to DKA leaflet. Messages are currently very long – to be reviewed and then deployed	NW/JM
4.2.17	**Bydureon B-Cise pen** Formulary amendment – original pen discontinued and to be replaced straight switch with B-Cise pen. **Update 02/02/22** – action complete It was proposed and agreed that this action could be closed.	Close
4.2.18	**Tocilizumab supply disruption (now ceased)** Review and update rheumatology guidance with cover sheet highlighting the supply disruption alert. **Update 09/02/22** – action complete It was proposed and agreed that this action could be closed.	Close
4.2.19	**Eyeaze (sodium hyaluronate acid) 0.1%, 0.2% and 0.4% preservative free eye drops** To be added to the joint Formularies – GREEN status. **Update 02/02/22** – action complete It was proposed and agreed that this action could be closed.	Close
5.	**Items for consideration at meeting**	
5.1	**Summary of National Guidance for Lipid Management for Primary and Secondary Prevention of CVD (Update)** To support delivery of the NHS Long-Term Plan, the Accelerated Access Collaborative (AAC) Lipid Management Rapid Uptake Product (RUP) Working Group had developed a NICE-endorsed clinical pathway for the management of lipids in primary and secondary prevention. The APC adopted the original pathway and the companion pathway for statin intolerance in 2021. The pathway has been updated by the AAC to include Inclisiran ▼ (Leqvio®) following the release of its positive NICE TA for treating primary hypercholesterolaemia or mixed dyslipidaemia. The APC is being asked if they will endorse the updated pathway and use it across BLMK ICS.	

No	Agenda Item	Action
	Clarification was requested regarding whether the prescribing of inclisiran will occur in primary or secondary care. It was acknowledged that the local implementation of the NICE TA for inclisiran / lipid pathway is an ongoing piece of work, but that the majority of prescribing will need to take place in primary care. There are lots of options including practices, PCNs, community pharmacies. CC requested to be kept informed of the pathway implementation discussions going forward so that she can feedback to the specialist in the hospital and MD agreed to include her. DW advised that there is currently a review of the primary care specification for drugs which require monitoring being undertaken and this may include inclisiran going forward. Consultation will take place once the review of the specification has been completed. **The committee agreed to ratify the pathway**. **EQIA Assessment:** this is a national policy and will have been subject to Equality Analysis and Due Regard.	MD
5.2	**Dry Eye Guidance – BLMK alignment** A review of the dry eye guidance from Bedfordshire/Luton and Milton Keynes has been undertaken and merged to create one document and align both joint Formularies. 1st, 2nd, and 3rd line options have been removed to give more choices. Traffic lighting on the joint Formularies has been rationalised and a number of products have been moved from Amber to Green status. Further details about contact lens suitability and preservatives have been included in the aid section. Single use ampoules have been removed where possible/alternative products exist – this is to support the sustainability agenda and reduce packaging and plastic waste. Summary of product/formulary changes associated with the review of the dry eye guidance: • Hypromellose 0.3% eye drops – no change - MK noted no place for this anymore with carbomer being the preferred 1st line option. Evolve brand to be noted on the MK Formulary as a cost-effective option. • Carbomer 0.2% eye gel – no change - Evolve brand can be noted on both Formularies as a cost-effective option. • Carmellose 0.5% - no change • Carmellose 1% - no change - VIZcellose brand can be noted on the MK Formulary as a cost-effective option. • Hyaluronate 0.1% pres free - Amber 2 on MK Formulary-change to GREEN. Propose move to moderate dry eye (from severe) and add self-care label. Remove the HyloTear brand from the MK Formulary and keep the Eyeaze brand only on MK Formulary as a cost-effective option. • Hyaluronate 0.2% pres free - Amber 2 on MK Formulary-change to green. Remove the HyloForte brand from the MK Formulary and keep the Eyeaze brand only on MK Formulary as a cost-effective option.	

No	Agenda Item	Action
	• Hyaluronate 0.4% pres free - Remove the Clinitas SDU brand from the MK Formulary and keep the Eyeaze brand only on MK Formulary as a cost-effective option. MK Remove Sjogrens dry eye only restriction on indication for the 0.4% strength. Amber 2 on MK Formulary- change to green. • Thealoz Duo - Non-Formulary at MK. Add to formulary-GREEN. • VisuXL gel – no change. • VisuXL drops - NF at Beds/Luton. Add as a 2nd line option where gel not tolerated - AMBER RESTRICTED. • Hylonight – no change. • N-acetylcysteine 5% - Change Green to Amber at Beds/Luton to align with MK. This is also more reflective of how it is prescribed. • N-acetylcysteine 10% - Add to Beds/Luton-RED RESTRICTED- to align with MK. Little usage at either site - keep as an option where 5% N-acetylcysteine has failed. • Systane - MK happy to remove. Beds/Luton - some patients prefer. Propose remove from guidance - existing patients only. • Optive - MK happy to remove. • Optive Fusion - MK happy to remove. • Optive plus - MK want to keep. Add to Beds/Luton to align with MK - AMBER. • Sodium chloride 0.9% minims – remove - for contact lens moistening. Lots of other options available. • Ciclosporin - Propose to make AMBER3 at MK in line with Beds/Luton - amber. • Evolve Revive - Application received. Add to both Formularies - AMBER restricted 2nd line where hyaluronate products have failed (see agenda item 5.3). • VisuEvo - Application for meimobian gland dysfunction (see agenda item 5.4). **The committee ratified the guidance and the Formulary amendments agreed as proposed**. TL/CC to make the relevant amendments to the joint Formularies. **EQIA Assessment:** most cost-effective products chosen. Some of the more expensive preparations may be easier to use due to device type – specific brand names removed from guidance with intention that prescribing will default to most cost-effective brand. Mitigations - For individual cases where the device type is unsuitable, other brands may be selected. **BLMK CCG E and D Lead comment -** Alternatives for mitigation documented. Ensure appropriate communication for patients that may be affected negatively.	TL/CC
5.3	**Evolve® Revive PF eye drops** Request for addition to both Joint Formularies: Evolve® Revive PF eye drops (Sodium Hyaluronate 0.2% w/v, Carbomer 980 0.2% w/v, Glycerol 0.9% w/v) – for the relief of symptoms of moderate to severe dry eye.	

No	Agenda Item	Action
	AM presented the application to the committee. Evolve Revive is indicated for the relief of symptoms of moderate to severe dry eye and intended for use in patients where sodium hyaluronate alone no longer provides adequate control. Due to the glycerol component, this combination product has shown to be more effective in enhancing the therapeutic effect and co-polymer effect in patients with severe dry eye when compared with a combination of carbomer and sodium hyaluronate used separately. Evolve Revive are preservative free and phosphate free eye drops. The ophthalmologists prefer phosphate free eye drops due to concerns regarding risk of band keratopathy/ corneal deposits in dry eye patients who already have compromised corneas. Can't directly compare Evolve Revive with e.g. HyloForte/Eyease (as these only contain sodium hyaluronate). Evolve Revive was stated to be cheaper, and more convenient to patients, than separate eye drops of sodium hyaluronate and carbomer. The company have offered the drops at a discounted rate to secondary care. Primary care, where the majority of prescribing would sit, would be as per the drug tariff price. There is no comparable product on the market currently. Estimated patient numbers for BLMK - 150-200 patients with an absolute cost of approximately £8k - £11k/year. It is likely that there will be offsetting against other alternatives which would have been prescribed. It was clarified that the data presented regarding the benefit of glycerol in the formulation, and the number of drops per bottle of different eye drop preparations, was from the product manufacturer of Evolve Revive. The committee noted that Evolve Revive is likely to be cost neutral, due to reduced prescribing of component / alternative eye drops, and that using a single product supports the sustainability agenda and may result in significant improvements in patient adherence when using the product. **The committee agreed the following recommendations:** Addition to the Formularies with the following traffic light status: Bedfordshire and Luton – Amber Milton Keynes – Amber 1 **EQIA Assessment:** No - No issues identified **BLMK CCG E and D Lead comment -** There is a positive impact for the older age group as they are higher users of dry eye treatments.	
5.4	**VisuEvo® Eye Drops** Request for addition to both Joint Formularies: VisuEvo® PF eye drops – for evaporative dry eye associated with moderate to severe meibomian gland disease (MGD). AM presented the application to the committee. VisuEvo eye drops are a unique new treatment containing Omega 3, vitamin D3, vitamin A and phospholipids liposomes, which improves/thickens the lipid	

No	Agenda Item	Action
	layer in the eye. It is indicated and intended for patients with evaporative dry eye associated with moderate to severe meibomian gland disease/dysfunction. It is preservative free and contact lens friendly. Two thirds of patients with dry eyes have evaporative dry eye disease. VisuEvo would be first line for patients with MGD. MGD will need to be diagnosed by a specialist and requires the use of a lit lamp. More cost effective than Optive plus and Systane balance which are the potential comparators. Estimated patient numbers – 180 patients across BLMK with an absolute cost of just over £11k, but this is likely to be offset by other drops which the patient would have used. A query was raised about whether patients could be treated with Thealoz Duo (green on the joint Formularies) prior to treatment with VisuEvo. AM confirmed that VisuEvo is superior to Thealoz Duo and would be used in preference for patients with MGD. **The committee agreed the following recommendations:** Addition to the formularies with the following traffic light status: Bedfordshire and Luton – Amber Milton Keynes – Amber 1 **EQIA Assessment:** No - No issues identified **BLMK CCG E and D Lead comment -** May be worth mentioning (minuting at APC) to clinicians completing the forms that positive impacts can/should also be included to demonstrate that all considerations have been taken into account & for a complete audit trail?	
5.5	**RA Biological Algorithms Update (including 5th line use)** BLMK APC Treatment Pathway for Rheumatoid Arthritis (after inadequate response to DMARDs):- based on NICE TAs and locally agreed APC guidance – Treatment pathway redesign to separate moderate and severe disease pathways and the inclusion of a fifth line treatment options. Historically, the JPC (Bedfordshire and Luton Joint Prescribing Committee) approved a treatment pathway for the management of Severe Rheumatoid Arthritis. This main pathway was subdivided into 2 separate algorithms A and B: algorithm A was applicable to most patients and algorithm B detailed treatment options for a subset of patients who were not suitable for treatment with TNF inhibitors. The current algorithm A includes all NICE approved drug treatment option. Algorithm B reflects NICE guidance and also includes the use of rituximab + / - methotrexate (local agreement). Algorithm A was updated to incorporate a 4th line agent (pragmatic decision) in December 2020. Further updates have been made to incorporate the use of a select number of both TNFi and JAK inhibitors as per NICE TA 715 and 744, and the pathway was approved for use across BLMK in December 2021.	

No	Agenda Item	Action

	In general, NICE do not provide guidance on the total number of lines of therapy that can be used per se, only which medicines are clinically and cost-effective for the indication in question. Several NICE TAs have been published relating to RA over the last 10 years. There is NICE support for the use of IL-6 inhibitors, and some select JAK inhibitors at the 3rd line stage however NICE make no recommendations around 4th and 5th line usage. As a result, treatment options beyond the 3rd line stage need to be agreed as part of local decision-making and commissioning. RMOC, issued advice on the Sequential use of biologic agents in May 2020 advising that prescribing choices should be made on the grounds of clinical and cost-effectiveness and that patients have the right to drugs and treatments that have been recommended by NICE subject to being clinically appropriate, and patients have the right to expect local decisions on the funding of drugs and treatments to be made rationally and following the proper consideration of evidence. Clinical assessment of the appropriateness of treatments should be the overriding factor rather than the implementation of policies for costs saving reasons. The BLMK APC (and its legacy organisations) applies these principles when considering commissioning of local pathways and has always been responsive to requests from local specialists for updates to pathways.
	
	There are currently 5 separate classes of agents with different modes of action approved by NICE for the treatment of Rheumatoid Arthritis.
	
	• TNF inhibitors (approved for severe RA, select few approved for moderate RA)
	• JAK inhibitors (approved for severe RA, select few approved for moderate RA)
	• IL-6 inhibitors (approved for severe RA)
	• Abatacept (approved for severe RA)
	• Rituximab (approved as a second line option for severe RA)
	
	Due to the emergence of JAK inhibitors and the NICE approval of certain agents for the treatment of moderate RA, the following changes were proposed:
	
	1) Split the pathway into 2 separate pathways:
	  • Moderate disease pathway
	  • Severe disease pathway
	2) The addition of a fifth line treatment stage – this will allow the option for all modes of action to be tried. Further treatment requests after this 5th line stage would require an IFR.
	
	Summary of evidence (MI response): As noted in previous MI enquiries in the past, good evidence for clinical and cost-effectiveness is generally lacking for agents after patients fail on the second- or third-line choice. Recommendations on drug of choice are also difficult to find. The increasingly wide variety of different agents on the market makes establishing choice of 4th-5th line agents particularly difficult, as they must be compared to a wide variety of	

No	Agenda Item	Action
	other treatments, and in increasingly complex combinations. NICE guidance notes that RA is heterogeneous and different people may respond differently to a given treatment, and it is difficult to predict whether an individual's disease will respond to any given treatment. Local clinicians estimate up to 10-15 patients per year with maximum of 63 patients over a five-year period (timescale to account for clinic backlogs) will reach treatment line 5 across BLMK. Local clinicians note that these predicted numbers will likely be reduced by around 50% as patients will now be eligible to start treatment with a TNFi / JAKi while at the moderate disease stage**.** Early disease management will result in less likelihood of progressing to require a 5th line agent. Additional cost impact - This is dependent on sequencing of drugs within the pathway and what is used as comparator. Sequencing of treatments for RA is difficult to generalise as it is individualised for patients based on concurrent comorbidities however typically an IL-6 inhibitor or abatacept are used at the 4th line stage. Based on current costs of IL-6 inhibitors and abatacept, a switch from 4th to 5th would in effect be cost neutral as these agents are of a similar cost. **The Committee was asked and agreed to approve the update.** **EQIA Assessment:** Yes – but in a positive way. The extension of treatment options of adding a 5th line of therapy within the commissioned pathway will benefit patients. Patients who reach the end of the pathway can be considered for additional treatment options via the CCG Individual Funding Route. **BLMK CCG E and D Lead comment -** With considerations documented in the form I don't believe an EIA would be required.	
5.6	**BLMK APC Treatment Pathway for Active Psoriatic Arthritis (after inadequate response to DMARDs) – Update** BLMK APC Treatment Pathway for Active Psoriatic Arthritis (after inadequate response to DMARDs): based on NICE TAs and locally agreed APC guidance – Update to include Upadacitinib as per NICE TA 768, published 2 February 2022 and Fourth Line treatment options. The Bedfordshire, Luton and Milton Keynes (BLMK) Area Prescribing Committee (APC) approved a Treatment Pathway for Active Psoriatic Arthritis (after inadequate response to DMARDs) at the first BLMK APC in September 2021. The treatment pathway is based on NICE TAs and previously agreed APC guidance (Bedfordshire and Luton Joint Prescribing Committee). As treatment modalities have developed, the pathway (in common with similar biologicals pathways for other indications) has been updated and extended. Updates have been undertaken with the publication of new NICE Technology Appraisal Guidance but NICE does not provide guidance on number of lines of therapy, only that the medicines are clinically	

No	Agenda Item	Action
	and cost-effective for the indication. For some of the pathways, NICE has given advice that certain treatments should not be used in the first line setting, but rarely goes beyond 2nd line treatment option recommendations. Therefore, treatment recommendations beyond 2nd line and number of lines of therapy need to be made as part of local decision-making and commissioning. RMOC, issued advice on the Sequential use of biologic agents in May 2020 advising that prescribing choices should be made on the grounds of clinical and cost-effectiveness and that patients have the right to drugs and treatments that have been recommended by NICE subject to being clinically appropriate, and patients have the right to expect local decisions on the funding of drugs and treatments to be made rationally and following the proper consideration of evidence. Clinical assessment of the appropriateness of treatments should be the overriding factor rather than the implementation of policies for costs saving reasons. The BLMK APC (and its legacy organisations) applies these principles when considering commissioning of local pathways and has always been responsive to requests from local specialists for updates to pathways. The APC was asked to consider the following proposed updates to the Psoriatic Arthritis Pathway: **Proposal 1** Upadacitinib is to be added to the treatment options in accordance with the recommendations of NICE TA 768 (Upadacitinib for treating active psoriatic arthritis after inadequate response to DMARDs), published 2nd February 2022. **Proposal 2** The pathway is to be extended to allow 4th line treatment options as requested by local specialists as it has been established that there is now a cohort of patients reaching this stage in the treatment pathway and therefore an unmet clinical need. **Evidence:** In **summary**, treatment guidelines published by the British Society or Rheumatology and American College of Rheumatology do not discuss further that second-line options. Treatment guidelines by the European League Against Rheumatism do not limit the number of biologics that can be used, but does state that "Studies addressing the best possible strategy after failure(s) of bDMARDs other than TNFi are lacking to date". Some citations does discuss the general use of fourth-line biologics, however these are restricted to observational studies. In addition, 2 of the citations for are conference studies, whereby data is limited to the abstract submitted. One conference abstract found that, although clinical response is greatest with the first biological, improvements in outcomes did not diminish up to the fifth-line therapy. Another conference abstract found that disease activity scores were lower for those receiving first-line therapy relative to the fourth-or-higher line group. Due to the number and nature of the studies, it is difficult to make general decisions based on these.	

No	Agenda Item	Action
	Patient numbers Local clinicians estimate up to 30 patients per year will reach treatment line 4 across BLMK **<u>Cost Effectiveness</u>** As per the relevant NICE TAs (all recommended treatment options included in the pathway have been assessed by NICE and are considered to be cost-effective in this patient population). The pathway also states the following: 'Drug with the lowest acquisition cost should be used first line if possible; this may vary from person to person because of differences in how the drugs are taken and treatment schedules, and patient/clinical factors.' The addition of a 4th line treatment option is likely to be cost neutral overall. As evidence is limited at this stage in therapy, the decision to approve a fourth line treatment option is a pragmatic one. **The Committee was asked and agreed to approve the update.** **EQIA Assessment:** Yes – but in a positive way. The extension of treatment options (as per new NICE TA for upadacitinib) and lines of therapy within the commissioned pathway from 3 to 4 will benefit patients. Patients who reach the end of the pathway can be considered for additional treatment options via the CCG Individual Funding Route. **BLMK CCG E and D Lead comment -** With considerations documented in the form I don't believe an EIA would be required.	
5.7	**ADHD Shared Care Guideline for Adults** The adult shared care guidelines for ADHD have been updated – this update has been conducted by ELFT and the Lead Mental Health GP for BLMK. CNWL have not been involved with this review/ update, as they are not the provider of ADHD adult services in MK, and therefore the shared care will apply within Bedfordshire and Luton only. Discussions are ongoing to agree a service across BLMK. The previous guideline was produced in 2018 and since then there has been an increase in demand on secondary care services, an increased number of referrals and longer waiting times for initial diagnosis. It also includes a new referral process and clear guidance and support to primary care. This updated guidance includes a change in commissioning position to include *transfer* of care to GPs, not just shared care as was previously agreed. There are a high number of referrals to secondary care services and a long waiting list – waiting times are currently about 18 months (Bedfordshire). This is the rationale for proposing transfer of care for stable patients. RJ acknowledged the comments which had been fed back in advance of the meeting and agreed the guideline would be updated accordingly – this is to include increasing the titration period to 8-12	

No	Agenda Item	Action
	weeks, to ensure that patients are stable on treatment before requesting shared care with the GP. A separate template will be used for transfer of care. The GP has the right to refuse shared care or transfer of care (with rationale). When requesting transfer of care, very specific information will be provided to the GP, with easy access back to the specialist service if required. This will include both telephone and email contact information (preferably generic team contacts for longevity). RJ clarified that the patient will be under shared care between the specialist and the GP for the first 12 months. The first annual review will be with a specialist. Provided the patient is stable, after the first annual review with the specialist, patients will be transferred to the care of their GP and receive their annual reviews from their GP. Annual reviews will need to include a discussion with the patient about whether they wish to continue treatment. If the patient wishes to consider stopping treatment, the GP should contact the secondary care specialists via rapid access using the contact details which will be provided. A query was raised about how the care arrangements will be communicated to patients. RJ confirmed that when an initial diagnosis is made by the specialist, a treatment decision is made with the patient. Within the 12-week stabilisation period the patient will have a number of appointments with the specialist, during which time the ongoing care, including shared care, will be discussed with them. The committee discussed the practicality and suitability of GPs switching the brand of medication prescribed. It was noted that modified release products are not all bioequivalent and that the shared care document includes some information on bioequivalency of products. Information is available on Scriptswitch/Optimise about switching for methylphenidate, but this is not undertaken very often as it is not an easy piece of work and there is some hesitancy in primary care. The GP representatives confirmed that they would be happy to switch if the work has been done to reassure that the switch is safe, and information has been communicated to GPs about this. JW queried how rapid access to adult specialist services can be achieved for patients who were discharged to the GP as a child but are now an adult. These patients will be unknown to adult services, but it would be inappropriate for them to join the end of the waiting list. RJ to discuss with adult secondary care specialists and confirm. Clarification is required regarding the issues raised about shared/ transfer of care, and referral routes back into the specialists for patients who have had their care transferred. Updates to the guideline are required to encompass the comments fed back at, and advance of, the meeting **The committee agreed the following recommendations:** Approved with the clarifications and amendments as discussed at, and in advance of, the meeting to include:	RJ RJ

No	Agenda Item	Action
	• Add information to clarify the responsibility for care at each stage: specialist only, shared care, transfer of care. • Review of wording throughout to provide clarity regarding shared care / transfer of care. • Clarification of the wording of the SCG pertaining to the NICE ADHD guidance. • Amend period of stabilisation on treatment to 8-12 weeks and associated wording at the time shared care is requested. • Add "Attend appointments and comply with medication and any monitoring requirements" to patient responsibilities. • Additional information to be added to clarify the GP responsibilities at the annual review following transfer of care, to include discussion with the patient about whether they wish to continue treatment and the effects of missed doses, planned dose reductions, and periods of no treatment should be evaluated. • Section 12 – information to be included to clarify that, if a brand switch of medication is being proposed for GPs to take forward, sufficient information will be provided to enable the switch to be undertaken. • Separate template to be produced for transfer of care to GPs. • Contact information for rapid access to specialists to be included (telephone and email, preferably generic). **EQIA Assessment:** Yes it is going to have a positive impact on adult patients already on ADHD treatment as they will be able to be seen locally by their GP for annual review. This will provide continuity of care with a quick route back into CMHT should any issues arise. This will also have a positive impact on the adult patients waiting for assessment as stable patients whose care has been transferred to GP will no longer take up appointments for annual review leading to more assessments and throughput. This will improve the patient experience for those patients requiring ADHD assessment. **BLMK CCG E and D Lead comment -** According to the form, EQIA not required as there is a positive impact which seems reasonable. However, would suggest taking the following into account: - ADHD is often found with other learning disabilities so would expect the accessible information standard (AIS) to have been considered. Is the policy/information available in accessible formats such as easy read? There may be a different version shared with patients & carers? - Although this isn't a service spec, probably need specific reference to AIS in the guidance in terms of compliance at point of service delivery?	
5.8	**Vitamins for Cystic Fibrosis (Paravit CF and clarification of Deka Plus Vitamin Formulary Status)** Children with CF may become deficient of fat soluble vitamins (A, D, E and K) due to fat malabsorption. Vitamin A and D capsules are a non-formulary Drug. Vitamin K tablets are used for CF patients and parents are having problems obtaining them in the community setting. Paravit CF is a multivitamin containing the four fat-soluble	

No	Agenda Item	Action
	vitamins A, D, E and K thereby reducing the number of alternative tablets/capsules otherwise required. The addition of Paravit CF liquid and capsules to the formulary was requested, in line with the formulary choice of the tertiary centres in Oxford and the Royal Brompton Hospital. Paravit will be cheaper than individual vitamin supplements. This will help address local health priorities by seeing less frequent pharmacy collections, and by seeing an increase in compliance to treatment. Additionally, it was proposed that both DEKAs plus (currently on the Bedfordshire and Luton joint formulary restricted to the dietary management of cystic fibrosis on the specific recommendation of a specialist in cystic fibrosis) and Paravit CF should be added to both joint formularies. This allows for the prescribing preferences of the different tertiary centres by which patients may be managed. **The committee agreed the following recommendations:** Addition of Paravit CF to the formularies with the following traffic light status: Bedfordshire and Luton – Amber (restricted) Milton Keynes – Amber 1 Addition of DEKAs plus to the Milton Keynes joint formulary – Amber 1 status **EQIA Assessment:** Yes this has been reviewed, no issue identified **BLMK CCG E and D Lead comment -** Positive impact of adding this therapy could include the consideration of age and religion as there is a liquid capsule formulation available to ensure young patients and adults who may request an option which is suitable for vegetarians for religious reasons (not sure if this use will be approved?)	
5.9	**Update to BLMK APC Terms of Reference (TOR)** Minor amendments to the TOR were proposed to the committee to include: • Formalising use of 'Chair's action' where necessary • Approving and adopting national Clinical Commissioning Policies The updates seek to formalise the use of Chair's action for ratification of urgent business and/or minor amendments between meetings, and to allow for the approval and adoption of national Clinical Commissioning Policies (in a similar manner to NICE Technology Appraisal Guidance). Any Chair's action will be in collaboration with the Chair of the Formulary sub-group when formulary amendments are required. Any such business agreed by Chair's actions will be documented and either circulated for virtual approval or shared at the following meeting for ratification by the committee. **The Committee was asked and agreed to approve the amendments**.	

No	Agenda Item	Action
	EQIA Assessment: Not assessed	
	COMFORT BREAK	
6.0	**NICE Guidance 18th November 2021 until 16th February 2022 The following NICE Technology Appraisal Guidance (CCG Commissioned) have been published:** Cenobamate for treating focal onset seizures in epilepsy, Technology appraisal guidance [TA753] Published: 15 December 2021. https://www.nice.org.uk/guidance/ta753 No significant resource impact is anticipated by NICE. **APC action** – created and link added to Formularies. The formulary status was reviewed by the committee - in view of the complicated dose titration that this should be categorised to restricted **Amber** (patient's dosage to be stabilised before asking GPs to take over prescribing) on the Beds and Luton Formulary and **Amber 3** in Milton Keynes. Solriamfetol for treating excessive daytime sleepiness caused by narcolepsy Technology appraisal guidance [TA758] Published: 05 January 2022 https://www.nice.org.uk/guidance/ta758 Resource impact statement (NICE) - no significant resource impact is anticipated. **APC action** – created and link added to Formulary. The formulary status was reviewed by the committee – red traffic light on both joint formularies (temporarily at present while the pathway is confirmed via East of England PAC and also traffic light status. Appendix 1 updated – proforma required – added to proforma work plan. Fostamatinib for treating refractory chronic immune thrombocytopenia Technology appraisal guidance [TA759] Published: 07 January 2022 https://www.nice.org.uk/guidance/ta759 **Not recommended -** no APC action Sodium zirconium cyclosilicate for treating hyperkalaemia Technology appraisal guidance [TA599] Published: 04 September 2019 Last updated: 24 January 2022 https://www.nice.org.uk/guidance/ta599 **APC action** – this is an update to existing guidance. Acute Trust representatives to advise their clinicians of update.	

	Fremanezumab for preventing migraine Technology appraisal guidance [TA764] Published: 02 February 2022 https://www.nice.org.uk/guidance/ta764 Resource Impact Statement – NICE advises that no significant resource impact is anticipated. **APC action -** this is an update to NICE TA 613 – Fremanezumab is now recommended to prevent chronic and episodic migraine. Link in Formularies updated. Proforma to be updated and Appendix 1 updated. Upadacitinib for treating active psoriatic arthritis after inadequate response to DMARDs, Technology appraisal guidance [TA768] Published: 02 February 2022 https://www.nice.org.uk/guidance/ta768 Resource impact statement – NICE does not anticipate a significant resource impact as a result of the introduction of the TA. **APC action –** Update PsA Pathway (see agenda item 5.6). New proforma required. Appendix 1 updated~~Update Appendix 1~~. Link added to Formularies. Palforzia for treating peanut allergy in children and young people, Technology appraisal guidance [TA769] Published: 02 February 2022 https://www.nice.org.uk/guidance/ta769 **The NICE Resource Impact Report states -** This technology is commissioned by clinical commissioning groups. It is expected to be provided in allergy clinics within NHS hospital trusts. **APC action** – No addition to Joint Formularies (as prescribing will take place in specialist allergy services) **The following NICE Guidelines (NG) (Medicine related and CCG Commissioned) have been published / updated by NICE:** Acute heart failure: diagnosis and management, Clinical guideline [CG187] Published: 08 October 2014 Last updated: 17 November 2021 https://www.nice.org.uk/guidance/cg187 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. Type 2 diabetes in adults: management, NICE guideline [NG28] Published: 02 December 2015 Last updated: 24 November 2021 https://www.nice.org.uk/guidance/ng28 In **November 2021**, we reviewed the evidence on SGLT2 inhibitors for adults with type 2 diabetes and chronic kidney disease, and made new recommendations. See the section on chronic kidney disease for more information. **Recommendations –** To CCG Long term condition group – May 2022 APC agenda	MA / long term condition s group

No	Agenda Item	Action
	Chronic kidney disease: assessment and management, NICE guideline [NG203] Published: 25 August 2021 Last updated: 24 November 2021 https://www.nice.org.uk/guidance/ng203 In **November 2021**, we updated our guidance on SGLT2 inhibitors for adults with type 2 diabetes and chronic kidney disease. For the new recommendations, see managing chronic kidney disease in the NICE guideline on type 2 diabetes in adults. – To CCG Long term condition group – May 2022 APC agenda Fever in under 5s: assessment and initial management, NICE guideline [NG143] Published: 07 November 2019 Last updated: 26 November 2021. https://www.nice.org.uk/guidance/ng143 In **November 2021**, we added a definition of sepsis to recommendation 1.2.2. We also added a cross reference to table 2 to guide users to the risk stratification tool for children aged under 5 years with suspected sepsis (table 3 in the NICE guideline on sepsis). **APC action – none** – There is no section relating to the treatment of sepsis in adults or children in the community antimicrobial guidelines. Prescribers would refer to national guidance which instructs them to refer to secondary care immediately if sepsis was suspected. Therefore no action required in terms of antibiotic guidelines. Tobacco: preventing uptake, promoting quitting and treating dependence, NICE guideline [NG209] Published: 30 November 2021 https://www.nice.org.uk/guidance/ng209 In **November 2021**, varenicline was unavailable in the UK. See the Medicines and Healthcare products Regulatory Agency (MHRA) alert on varenicline. Pelvic floor dysfunction: prevention and non-surgical management, NICE guideline [NG210] Published: 09 December 2021 https://www.nice.org.uk/guidance/ng210 This guideline covers the prevention, assessment and non-surgical management of pelvic floor dysfunction in women aged 12 and over. It aims to raise awareness and help women to reduce their risk of pelvic floor dysfunction. For women who have pelvic floor dysfunction, the guideline recommends interventions based on their specific symptoms. NICE has also produced a guideline on urinary incontinence and pelvic organ prolapse in women aged 18 and over. This guideline uses the term 'women' throughout, but this should be taken to include those who do not identify as women but who have female pelvic organs. Headaches in over 12s: diagnosis and management, Clinical guideline [CG150] Published: 19 September 2012 Last updated: 17 December 2021. https://www.nice.org.uk/guidance/cg150 In **December 2021**, NICE changed the strength of our recommendation on metoclopramide or prochlorperazine for acute migraine from ‘offer’ to ‘consider’, to better reflect the balance of benefits and risks of these treatments.	MA / long term condition s group

No	Agenda Item	Action
	Glaucoma: diagnosis and management, NICE guideline [NG81] Published: 01 November 2017 Last updated: 26 January 2022. https://www.nice.org.uk/guidance/ng81 In **January 2022**, NICE reviewed the evidence and updated the recommendations on treatment for ocular hypertension and chronic open-angle glaucoma and organisation of care. For more information, see update information. Type 2 diabetes in adults: management, NICE guideline [NG28] Published: 02 December 2015 Last updated: 15 February 2022 https://www.nice.org.uk/guidance/ng28 In **February 2022**, NICE reviewed the evidence on drug treatment and made new recommendations. See update information for more details. **APC/Formulary Subgroup Action –** Review existing local Diabetes Guidance in the light of the updated NICE Guideline, making appropriate updates as necessary. **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: 22 November 2021 https://www.nice.org.uk/guidance/ng191 On **22 November**, NICE added a new recommendation on ivermectin. On **14 December**, NICE added a statement to the recommendation on casirivimab and imdevimab about the Omicron variant. On **16 December**, NICE added new recommendations on COVID-19-associated pulmonary aspergillosis. We revised our statement about the Omicron variant in the recommendation on casirivimab and imdevimab. **The following NICE TAs are the commissioning responsibility of NHSE and are listed for information only.** Givosiran for treating acute hepatic porphyria**,** Highly specialised technologies guidance, Reference number:HST16, Published: 24 November 2021, https://www.nice.org.uk/guidance/hst16 **APC Action - none -** Both acute Trusts have confirmed that patients requiring this drug would be referred to a tertiary centre, therefore not added to either Joint Formularies. Mexiletine for treating the symptoms of myotonia in non-dystrophic myotonic disorders, Technology appraisal guidance [TA748] Published: 01 December 2021. https://www.nice.org.uk/guidance/ta748 **Recommended, moved from Non-Formulary to Formulary and TA link added.**	JC / MA

	Liraglutide for managing obesity in people aged 12 to 17 years (terminated appraisal), Technology appraisal [TA749] Published: 01 December 2021. https://www.nice.org.uk/guidance/ta749 **APC – no action – Terminated appraisal** Dupilumab for treating severe asthma with type 2 inflammation, Technology appraisal guidance [TA751] Published: 08 December 2021 https://www.nice.org.uk/guidance/ta751 **Recommended - APC action – added to respiratory section and link added to Formularies** Olaparib for maintenance treatment of BRCA mutation-positive metastatic pancreatic cancer after platinum-based chemotherapy (terminated appraisal) Technology appraisal [TA750] Published: 08 December 2021. https://www.nice.org.uk/guidance/ta750 **APC – no action – Terminated appraisal** Belimumab for treating active autoantibody-positive systemic lupus erythematosus, Technology appraisal guidance [TA752] Published: 15 December 2021. https://www.nice.org.uk/guidance/ta752 **Recommended - APC action – link added to Formularies** Risdiplam for treating spinal muscular atrophy, Technology appraisal guidance [TA755] Published: 16 December 2021 https://www.nice.org.uk/guidance/ta755 **Recommended - Consult with Acute Trusts before adding to Joint Formularies** **APC action** – no addition to Joint Formularies at this time, as no prescribing expected locally Fedratinib for treating disease-related splenomegaly or symptoms in myelofibrosis, Technology appraisal guidance [TA756] Published: 16 December 2021. https://www.nice.org.uk/guidance/ta756 **Recommended (Cancer Drugs Fund)– APC action – created and link added to Formularies** Cabotegravir with rilpivirine for treating HIV-1, Technology appraisal guidance [TA757] Published: 05 January 2022 https://www.nice.org.uk/guidance/ta757 **Recommended - APC action – created and link added to Formularies** Selpercatinib for previously treated RET fusion-positive advanced non-small-cell lung cancer Technology appraisal guidance [TA760] Published: 12 January 2022. https://www.nice.org.uk/guidance/ta760 **Recommended via Cancer Drugs Fund – APC action - link added to Formularies (for Beds and Luton Formulary – wording amended in entry to accommodate the publication of this additional NICE TA).** Osimertinib for adjuvant treatment of EGFR mutation-positive non-small-cell lung cancer after complete tumour resection	

No	Agenda Item	Action
	Technology appraisal guidance [TA761] Published: 19 January 2022. https://www.nice.org.uk/guidance/ta761 **Recommended via the Cancer Drugs Fund – APC action – link added to Formularies** Olaparib for treating BRCA mutation-positive HER2-negative metastatic breast cancer after chemotherapy (terminated appraisal) Technology appraisal [TA762] Published: 02 February 2022. https://www.nice.org.uk/guidance/ta762 **APC action - none – terminated appraisal** Daratumumab in combination for untreated multiple myeloma when a stem cell transplant is suitable, Technology appraisal guidance [TA763] Published: 02 February 2022. https://www.nice.org.uk/guidance/ta763 **APC action – recommended - link added to Formularies (for Beds and Luton – slight amendment to wording as other TAs are funded via the Cancer Drugs Fund)** Venetoclax with azacitidine for untreated acute myeloid leukaemia when intensive chemotherapy is unsuitable, Technology appraisal guidance [TA765] Published: 02 February 2022. https://www.nice.org.uk/guidance/ta765 **APC action – recommended - link added to Formularies.** Pembrolizumab for adjuvant treatment of completely resected stage 3 melanoma, Technology appraisal guidance [TA766] Published: 02 February 2022. https://www.nice.org.uk/guidance/ta766 **APC action – recommended - link added to Formularies.** Ponesimod for treating relapsing–remitting multiple sclerosis, Technology appraisal guidance [TA767] Published: 02 February 2022 https://www.nice.org.uk/guidance/ta767 **APC action – recommended – created and link added to Formularies.** Pembrolizumab with carboplatin and paclitaxel for untreated metastatic squamous non-small-cell lung cancer Technology appraisal guidance [TA770] Published: 09 February 2022. https://www.nice.org.uk/guidance/ta770 **APC action - Link added to Formularies** Daratumumab with bortezomib, melphalan and prednisone for untreated multiple myeloma (terminated appraisal) Technology appraisal [TA771] Published: 09 February 2022. https://www.nice.org.uk/guidance/ta771 **APC action - none as terminated appraisal**	
7.	**Virtual Recommendations/Documents – for discussion/ratification**	
7.1	**Forceval soluble –** addition to MK (already on Bedfordshire and Luton formulary)	

No	Agenda Item	Action
	Approved virtually and ratified by the committee.	
7.2	**Rituximab Biosimilar** This agenda item was circulated for virtual approval but clarified at the meeting. The originator product for rituximab (RTX) is Mabthera, and originally MKUH used Truxima as their biosimilar of choice. This proposal is to switch to Rixathon as a more cost-effective biosimilar. The costs of the biosimilars are part of a national tender, but there may also be regional arrangements in place. To note – MKUH and BHFT sit in different procurement hubs and therefore do not necessarily have access to the same prices. MN informed the committee that the Rheumatology team at BHFT are in discussion about this but have not yet reached an agreement about doing a biosimilar to biosimilar switch. 20% of BHFT patients had nasty reactions when they originally switched to biosimilar RTX from Mabthera (paper published) and this is the reason for caution. ZN confirmed that the Rheumatology team in MK did not raise any objections to the switch and it is intended that Rixathon will be used for all indications at MKUH. Patients will be monitored closely when they are switched to the new biosimilar. The Committee approved addition to the MK joint Formulary.	
7.3	**Formulary Update** Approved virtually and ratified by the committee	
7.4	**Sanatogen –** first choice for MK formulary in view of cost. Approved virtually and ratified by the committee	
7.5	**Pancrex V -** addition to MK (already on Bedfordshire and Luton formulary) Approved virtually and ratified by the committee	
8.	**Medicines Safety – items for noting / ratification**	
8.1	**Minutes from the BLMK Medicines Safety Group – February 2022** The Committee noted these minutes for information	
8.2	**Medicines Safety Update** ZA and DW gave a Medicines Safety Group Update and a Primary Care Medicines Safety Update. **Medicines Safety Group Update** The BLMK ICS Medicines safety group (MSG) was held on Tuesday 8th February 2022. The key areas of focus were: Medicines Safety Improvement Programme (MedSIP)	

No	Agenda Item	Action
	https://www.england.nhs.uk/patient-safety/patient-safety-improvement-programmes/#MedSIP The Medicines Safety Improvement Programme (MedSIP) addresses the most important causes of severe harm associated with medicines, most of which have been known about for years but continue to challenge the health and care systems in England. The key ambitions for MedSIP are as follows: • to reduce medicine administration errors in care homes by 50% by March 2024 • to reduce harm from opioid medicines by reducing high dose prescribing (>120mg oral Morphine equivalent), for non-cancer pain by 50%, by March 2024 • to reduce harm by reducing the prescription and supply of oral methotrexate 10mg by 50%, October 2021. Initial discussions taken place with MSG to scope and share existing work taking place to support the key ambitions. With regards to care homes – establishing a baseline reporting rate is essential, and going forward, collaborative partnership working with CCG care homes team, acute trust frailty and discharge teams and community providers will support this ambition. With regards to opioid reduction, this will be discussed as an agenda at a future MSG in detail as existing workstream within primary care at practice level and system wide MDTs in place as well as provider-based pathways and initiatives. Methotrexate already in progress, managed by locality teams within CCG and will be discussed in detail at the next MSG. **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. Follow up workshop held with CCG safeguarding, CCG medicines optimisation and the fire service from Bedfordshire and Buckinghamshire. Consultation with providers within the ICS with regards to information given out to patients in relation to emollients, information to raise awareness has been circulated to care homes. This has moved to the MSG action plan as this is a system wide project. Next steps: to agree 'at risk' groups including those currently prescribed home oxygen. https://www.gov.uk/drug-safety-update/emollients-and-risk-of-severe-and-fatal-burns-new-resources-available **BLMK MSG project plan – review and prioritisation of Sodium Valproate and pregnancy prevention programme** Audit to be conducted initially (phase 1) with inpatient data on risk acknowledgement form adherence, primary care data to be reviewed (via CCG locality team) for reconciliation (phase 2) and phase 3 to compare current systems in place to improve compliance, phase 4: to raise awareness and promote quality improvement outcomes. **Other key update(s):**	

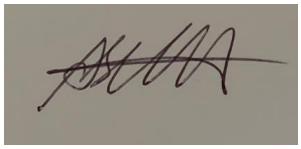
No	Agenda Item	Action
	BLMK Medicines Safety Group Website Section and system wide newsletter To be hosted on the BLMK CCG website – work in progress, partners section to be included and currently compilation of key information to be included. BLMK MSG quarterly newsletter to be compiled to raise awareness of system wide cross sector safety issues and quality improvement projects. To be launched April 2022. **Patient involvement** The chair and secretariat are, via the BLMK CCG communications team, primary care commissioning and Healthwatch, investigating the prospect of greater engagement with patients / patient group upon the development of medicines safety initiatives and projects, following the return of business as usual from the national 'call to action' in December 2021 and January 2022. **Primary Care Medicines Safety Update** This update focussed on the primary care response to the MHRA Drug Safety Updates (December 2021, January 2022 and February 2022). In particular: **Haloperidol (Haldol): reminder of risks when used in elderly patients for the acute treatment of delirium (December 2021)** **Action(s) taken:** Communication via BLMK CCG Care Home Newsletter which goes to all practices the local authorities and CQC registered care homes within BLMK and circulated in the quarterly medicines safety update in the BLMK primary care newsletter uploaded to Teamnet. **Dapagliflozin (Forxiga): no longer authorised for treatment of type 1 diabetes mellitus (December 2021)** **Actions taken:** As per BLMK APC meeting notes – 1st December 2021. DSU featured on both Bedfordshire and Milton Keynes medicines formularies. **Brolucizumab (Beovu▼): risk of intraocular inflammation and retinal vascular occlusion increased with short dosing intervals (January 2022)** **Action(s) taken:** Confirmation that DSU noted at local Acute Trust medicines committees, consultation commenced with ophthalmologists at MKUH and BHFT with regards to dosing intervals and adjustments to proforma to include DSU. MKUH have now confirmed that although they have not yet treated any patients with Brolucizumab, they are likely to adhere to the recommended dose intervals. Response from BHFT awaited. **COVID-19 antivirals: reporting to the UK COVID-19 Antivirals Pregnancy Registry (February 2022)** **Actions taken:** DSU circulated to the BLMK CMDU clinical triage team on 23rd February 2022, noted that the current CMDU clinical policy choice of drug for pregnant women or women likely to be pregnant is IV sotrovimab. Oral antivirals have not been issued to any pregnant patients by the CMDU.	

No	Agenda Item	Action
	Hydroxychloroquine, chloroquine: increased risk of cardiovascular events when used with macrolide antibiotics; reminder of psychiatric reactions (February 2022) **Actions taken:** The CCG will be looking to update the relevant DMARD shared care guidance and COPD guideline to include the DSU. Working is being undertaken with the locality team reviewing practice data to identify any patients on this combination and putting a warning on the practice prescribing systems. Confirmation of circulation to clinical teams sought via provider MSOs and formulary pharmacists. The committee noted and ratified the information presented.	
9.	**Antimicrobial Resistance Update** – *no update as there have been no meetings since the last APC meeting.*	
All other papers (from this point in the agenda) are for noting/information by the Committee		
10.	**East of England Priorities Advisory Committee (PAC) – items for noting/approval**	
10.1	EoEPAC Meeting Notes – September 2021 The committee noted the minutes for information.	
10.2	EoEPAC draft Meeting Notes – November 2021 The committee noted the minutes for information.	
10.3	**Localised Severe Psoriasis** EoE PAC has developed guidance on the use of biologic and oral therapies in adult patients with severe localised psoriasis, involving high impact or difficult to treat sites, which does not meet NICE criteria. The committee was asked to approve the PAC recommendations, noting that there are some minor amendments currently being made to the guidance with reference to the review / continuation criteria to clarify wording for the assessment of response. Comments were received from dermatologists at both local trusts in relation to: • numbers of line of therapy available within the policy • choice of biologic available within the policy (with reference to recommendations from the British Association of Dermatologists) The committee agreed to ratify the recommendations as an interim arrangement, with any minor changes to be agreed by Chair's action. Review of the policy, in line with clinician comments, will be added to the APC workplan (aim – June meeting). **EQIA Assessment:** Yes – positive impact – approval of this policy allows more people to be treated within routine commissioning without need to use the Individual Funding Request route. **BLMK CCG E and D Lead comment -** Agree with comments as documented on the Formulary application form.	

No	Agenda Item	Action
11.	**Bedfordshire, Luton and Milton Keynes Local Prescribing Committee Minutes.** The Committee noted the following minutes for information.	
11.1	Minutes from the Bedfordshire Hospitals Foundation Trust DTC meeting – November 2021	
11.2	ELFT Medicines Management Committee Minutes (Mental Health) - November 2021	
11.3	Minutes of Circle/MSK MMC Meeting – May 2021, July 2021, September 2021, November 2021 and January 2022.	
11.4	Minutes of the Bedfordshire and Luton Wound Management Formulary Steering Group – November 2021	
11.5	Minutes of the Cambridgeshire Community Services Medication Safety and Governance Group – November 2021	
11.6	CNWL - Trustwide Medicines Optimisation Group (MOG) Meeting – September 2021	
11.7	Prescribing & Medicines Governance Committee (PMGC) Minutes (Milton Keynes NHS Hospital Trust) – December 2021	
12.	**Papers for information/ratification**	
12.1	**New treatments for COVID-19** Neutralising monoclonal antibodies (nMABs) or antivirals for non-hospitalised patients with COVID-19 Policy (approved via Chairs action) In addition to the paper approved by virtual consideration, the Committee was asked to ratify the 27/1/22 Update (circulated virtually and approved by chair's action) and the consequent Formulary additions made as a result of this update, and the 24/2/22 update to the policy. AG outlined the amendments made in version 5 of the policy, published 24/2/22: • Exclusions and discontinuation criteria for remdesivir updated, alongside confirmation that any additional testing during treatment with remdesivir is at the clinician's discretion. • Reference to 'PF-07321332' removed now the naming convention of nirmatrelvir plus ritonavir (Paxlovid) has been agreed. • Confirmation that patients treated by a CMDU can be considered for all treatment options, as appropriate, if they re-present in the future with a new COVID infection (new PCR / LFD positive test after a period of at least 30 days from the originally captured positive PCR / LFD test) • Confirmation that other treatment options may be considered if initial treatment with Paxlovid is not tolerated, as long as the patient continues to meet the policy criteria.	

No	Agenda Item	Action
	The committee agreed to ratify all the updates to the national Interim Commissioning Policy published since the last meeting.	
12.2	**Updated APC and Formulary Subgroup Paperwork** Approved virtually and ratified by the committee	
12.3	**Commissioning recommendations for national procurement for DOACs January 2022, Version 1** The committee noted the commissioning recommendations for information.	
12.4	**Perinatal Mental Health Prescribing Document - Approved by BLMK Prescribing Committee (Feb 2022)** The attached document was put together by two GPs who are both perinatal mental health (MH) spotlight champions. It was brought to the last BLMK Prescribing Committee for discussion and approved by the committee. The resource is to support GPs with managing medications for women who have MH issues when they are pregnant or breastfeeding. The committee noted the prescribing document for information.	
13.	**Any other business** Proposed update to the wording of the shared care guideline template - minor amendment to the form to remove the requirement for a signature if the Specialist is communicating via letter. The current agreed template requires a consultant's signature. The committee discussed the practicalities and some medicolegal considerations. It was proposed that the Appendix 1, section A should be removed as completion of this requires significant additional work by the specialists and the information is included in the clinic letters which accompany the shared care guideline, however some medicolegal concerns remain from primary care representatives. There is a governance framework within the Trusts to ensure that clinic letters have an audit trail documenting their electronic approval. It was requested by primary care representatives that GP actions, including the request to undertake shared care, should be made extremely clear within the clinic letter. The committee agreed that further discussion is required and that this will be brought back to the next meeting on 4th May for further consideration.	SMcG
14.	**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 Anne Graeff of any apologies on 07557 076941 or email anne.graeff@nhs.net. Circulation: BLMK APC Members, BLMK Medicines Optimisation Team (not APC members)		

Approval of minutes:
Chair: Alison Borrett

Signed: 

Date: 11/05/22