Bedfordshire, Luton and Milton Keynes Area Prescribing Committee – Formulary Subgroup meeting
Final Meeting Notes – February 2023

Date: 7th Feb 2023
Time: 12.30- 3.00pm
Venue: Microsoft Teams

The following organisations contribute to and participate in the BLMK APC – Bedfordshire, Luton and Milton Keynes Integrated Care Board; Bedfordshire Hospitals NHS Foundation Trust; Cambridgeshire Community Services NHS Trust; Central and North West London NHS Foundation Trust; East London NHS Foundation Trust; Milton Keynes University Hospital NHS Foundation Trust

Name	Initial	Role	Present	Absent
Dr John Fsadni	JF	GP (Retired), Committee Chair	✓	
Taiya Large	TL	Professional Secretary/Commissioning Lead Pharmacist, NHS BLMK ICB	✓	
Janet Corbett	JCo	Pharmacy Programme Manager MKUH	✓	
Saema Arain	SA	ELFT Pharmacy Representative – Community Services (Beds)/Mental Health Services (Beds and Luton)		✓
Anshu Rayan	AR	CNWL Pharmacy Representative (Community and Mental Health Services Milton Keynes)		✓
Dr Mya Aye	MA	Medical Representative, Milton Keynes University Hospital		✓
Dr Eleanor Tyagi	ET	Medical Representative, Milton Keynes University Hospital	✓	
Carole Jellicoe	CJ	Nurse and Non Medical Prescribing Representative (Secondary Care)		✓
Dr Muhammad Nisar	MN	Medical Representative, Bedfordshire Hospitals NHS Foundation Trust	✓	
Nikki Woodhall	NW	Formulary Lead Pharmacy Technician, BLMK ICB	✓	
Dr Kate Randall	KR	GP Representative, Bedfordshire and Luton	✓	
Dr Jenny Wilson	JWi	GP Representative, Bedfordshire and Luton	✓	
Reginald Akaruese	RA	CNWL Pharmacy Representative (Community and Mental Health Services Milton Keynes)	✓	
Reena Pankhania	RP	Pharmacy Representative, Bedfordshire Hospitals NHS Foundation Trust		✓
Mojisola Adebajo	MA	Place Based Lead Pharmacist BLMK ICB	✓	

Matt Davies	MD	Place Based Lead Pharmacist BLCK ICB	✓	
Alex Hill	AH	Community Pharmacy Representative	✓	
Dr Dush Mital	DM	Medical Representative, Milton Keynes University Hospital NHS Trust		✓
Yolanda Abunga	YA	Pharmacist Representative, Cambridgeshire Community Health Services		✓
Marian Chan	MC	Consultant, Bedfordshire Hospitals NHS Foundation Trust		✓
Naomi Currie	NC	Place Based Lead Pharmacist BLMK ICB	✓	
Anne Graeff	AG	Commissioning lead Pharmacist BLMK ICB	✓	
Joy Mooring	JM	Primary Care Specialist Pharmacy Technician, BLMK ICB	✓	
Dona Wingfield	DW	Medicines Use and Quality Manager, Bedfordshire Hospitals NHS Foundation Trust	✓	
Iffah Salim	IS	Interim Tower Hamlets Lead Pharmacist, ELFT BLMK ICB		✓
Jacqueline Clayton	JCl	Commissioning lead pharmacist	✓	
Nicholas Beason	NB	Procurement technician MKUH	✓	
Jennis Cain	JCa	Administrative support BLMK ICB	✓	
Candy Chow	CC	Commissioning Lead Pharmacist BLMK ICB	✓	
Jonathan Walter	JWa	Milton Keynes GP representative	✓	
George MacFaul	GM	For Item 5.7	✓	
Lianne Lewis	LL	For item 5.7	✓	

Summary of acronyms used in the document

Acronym	Explanation
MKF	Milton Keynes Formulary
B&LF	Bedfordshire and Luton Formulary
FSG	Formulary subgroup
SS/Orx	Scriptswitch/Optimise GP messages
SCG	Shared care guidance

No	Agenda Item
1.	**Welcome, Introductions and Apologies** TL welcomed everyone to the meeting and introduced Candy Chow – New Commissioning Lead Pharmacist for the ICB. Welcome to LL and GM for agenda item 5.7 Apologies received from MC and CJ The meeting was confirmed as quorate.
2.	**Declarations of Interest** All annual written declarations of interests are up to date. Members were invited to declare any declarations relating to matters on the Agenda. There were no conflicts of interest raised.
3.	**Minutes of the previous meeting** The November 2022 FSG meeting notes were approved as accurate.
4.	**Action Log** Actions were noted in accordance with the action log 00 BLMK Formulary Subgroup Action log I
5.	**Items for consideration**
5.1	**Salbulin Novolizer inhaler for asthma** Salbulin Novolizer (dry powder inhaler) requires less inspiratory flow than Easyhaler, so is easier to use, which may enable more patients to be switched from high carbon inhalers. The device is replaced after 2000 inhalations (10 cartridge life) or annually. (Unlike Easyhaler which is single use). NB: The refill cartridge and pot are also made of plastic therefore plastic waste is comparable to Easyhaler.

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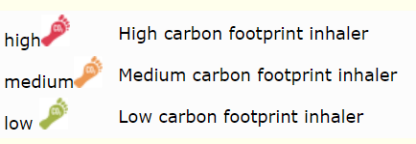
	Carbon footprint of the Novolizer is 0-4kg/Co2 per inhaler (MIMS) and is intrinsically low. Salbutamol easyhaler is carbon neutral through offsetting. There is no impact overall on plastic waste, as the refills contain a similar amount of plastic as Easyhaler. The group discussed the need for clear prescribing directions on SystmOne to avoid a new inhaler being re-issued each time instead of the refill cartridges, as this adds unnecessary waste and would represent a cost-pressure over other inhaler options. The refills are cheaper vs Easyhaler however the Salbulin starter pack costs more than Easyhaler. The possibility of a starter pack being prescribed as acute with refills on repeat was considered. Patients could also be offered a new device at annual respiratory review. Patient education is also key as some may discard the inhaler when it is empty. NW raised that consistency of device is desirable. The Novolizer only comes as salbutamol and budesonide which limits its use where patients want to keep the same device type across all their inhalers. Easyhaler is a similar device type to a wider range of inhaled corticosteroid devices. Sizing of the inhaler versus other options was also discussed however the group concluded it is not detrimentally larger versus Easyhaler. Budesonide Novolizer is on the MKF (not on Beds/Luton) – for review and alignment as part of future work. **The request to add Salbulin Novolizer to the Formularies (Green) as an alternative choice of salbutamol inhaler was approved.** The group also agreed to utilise the footprint icons as indicators for high, medium and low carbon footprint inhaler options. 
5.2	**Lacosamide for epilepsy** Review of Non-Formulary drug applications highlighted omission of lacosamide from the Formularies. The updated NICE NG 217 recommend its use and data suggests it is being prescribed. The paper notes tertiary centre only use which is not deemed necessary or practical. **The proposal to add lacosamide as Amber/Amber 3, for use in line with NICE NG217 was approved.**
5.3	**Tacalcitol lotion for scalp psoriasis** Tacalcitol lotion was requested for addition to the Formularies as part of the wider topical psoriasis pathway review (to be submitted to APC). PrescQipp review of shampoos and scalp preparations Oct 2022 states**:** If a single-component vitamin D preparation for the scalp is indicated: consider tacalcitol lotion, if suitable and acceptable for the patient, in preference to calcipotriol scalp solution which currently costs significantly more than tacalcitol lotion. Tacalcitol and calcitriol may be less irritating than calcipotriol. As a vitamin D

No	Agenda Item
	analogue, tacalcitol could be used where steroid therapy is not appropriate or where a break from steroids are needed. **The group approved the addition of tacalcitol lotion with a Green designation for scalp psoriasis.**
5.4	**Liothyronine review for hypothyroidism indication** It was proposed that the national recommendations from RMOC for the prescribing of liothyronine are adopted across BLMK to align and ensure clear and equitable access for the small group of patients who may benefit from treatment. Milton Keynes already endorse RMOC guidance therefore the proposal is to align Beds/Luton with this. **Key points from the RMOC guidance:** • Prescribing of liothyronine is only supported if initiated by, or considered appropriate following a review by, an **NHS** consultant endocrinologist • Withdrawal or adjustment of liothyronine treatment should also only be undertaken by, or with the oversight of, an NHS consultant endocrinologist • Where General Practitioners (GPs) are involved in such treatment changes this should be with NHS consultant endocrinologist support • If a decision is made to embark on a trial of L-T4/L-T3 combination therapy in patients who have unambiguously not benefited from L-T4 then this should be reached following an open and balanced discussion of the uncertain benefits, likely risks of over-replacement and lack of long-term safety data • Shared care may be appropriate - If a patient is initiated on treatment, prescribing responsibility should remain with the hospital consultant for at least 3 months. There are currently 107 patients receiving liothyronine in BLMK. This number is not expected to change as a result of this alignment work and prescribing trends will be closely monitored for increases to mitigate the risk of overprescribing following the change to allow GPs to prescribe. NB: The 20 microgram tablet and 5 & 10 microgram capsule strengths have been selected for prescribing and SS/Orx messages deployed to highlight these cost-effective choices. The minimum number of tablets or capsules should be prescribed (no doubling up of strengths) to ensure cost-effectiveness. For oncology and psychiatry indications liothyronine will remain Red (for secondary care use only) as per RMOC recommendations. **The recommendations within the paper were approved. Liothyronine to be amended from Red to Beds/Luton as Amber with reference to RMOC national recommendations, in line with MK monograph which is Amber 3 and already endorses RMOC.**
5.5	**Minor amendments to the Formulary Policy** Development of a formalised process for making minor amendments to the formularies with the aims of: -Removing the need for unnecessary applications for all minor changes -Enable Formulary alignment work to be completed in a timely fashion -Generate timely cost-savings by updating preferred brands as they arise

No	Agenda Item
	-Provide clarity of process and ensure appropriate governance across BLMK for Formulary changes DW raised the policy will be useful for shortages and contract changes and is in support of the paper providing changes will not have an impact on service provision. Bedfordshire hospitals have also been exploring and developing a similar process and have suggested a risk assessment grid which DW will share for inclusion as an appendix in the policy. It was also suggested to have a list of named key stakeholders to ensure appropriate consultation where necessary. It was noted that any changes requiring more significant input or wider discussions will be taken through the normal process i.e. consultation and Formulary subgroup. **Action TL**: Re-word MedsOpt team to ICS MedsOpt teams **The document was approved.**
5.6	**Request for amendment to the Formularies updated form** This form replaces the short form and has been developed to allow a mechanism for external applicants to request minor changes to the Formularies. This will also be used where a more significant exploration of a Formulary change is warranted. JCo requested amendment of the font and removal of the pre-fixed text boxes **Action TL**: To update in line with the above and upload onto BLMK website
5.7	**Cortiment MMX for Ulcerative colitis** Application from MK gastroenterology team for budesonide 9mg multi matrix tablets for the treatment of Ulcerative colitis (UC). These are prescribed as an 8 week course for induction of remission for patients with mild to moderate UC where 5-ASA treatment is not sufficient or where patients are unsuitable for oral prednisolone. Currently Cortiment is Red on BLF and Non-formulary on MKF. The application requests addition to MKF, with enablement of GP initiation in Milton Keynes where patients are under the PIFU service. Cortiment undergoes 88% first pass metabolism & milder steroid vs prednisolone. Trend to use budesonide in Crohns and Colitis before prednisolone where possible. Cortiment has near pancolonic distribution therefore particularly useful for left sided colitis. IOWNA system in place at MKUH (web based and interactive patient led care). Service development in progress to relieve pressure on secondary care. Patient initiated follow up service (PIFU) in place to enable patient led care. The process is proposed as: Patient deteriorates in the community. Patient holds a cover letter to present to the GP in the event of this which requests the GP to provide a course of Cortiment. GP can then Cortiment in a timely fashion vs needing to refer to secondary care for initiation. It was noted that hospitals are currently in block therefore cost savings as detailed in the paper will not be realised. Caseload estimated to be approximately 20 patients.

No	Agenda Item
	Review of the PIFU pathway alludes to medicines not included on the Formulary and pricing information is also included which may not be appropriate for patients and may change month on month. LL stated all preparations were listed to cover all medicines and provide information on how to uptitrate so that information is complete for patients who are self-managing their condition. Costing information and non-formulary medicines will be removed. Concerns raised over designation – Green may enable wider and inappropriate use. Cortiment would be better placed under specialist advice with GP initiation (Amber 1). Only patients who have been assessed as appropriate for PIFU will be able to access Cortiment via GP. Other patients will be retained by secondary care. JWi noted that not all practices have access to IOWNA and there may be specialist nurses recommending initiation of Cortiment if it becomes available in Primary Care. Patients can access 1 course per year under PIFU. Patients should seek input from secondary care following the course if calprotectin levels remain elevated above 200ug/g. PIFU plans have been shared with Beds/Luton and Northampton hospitals for possible future service development. **Cortiment to be added to the MKF as Amber 1 for patients under PIFU (Red for Non-PIFU patients in BLMK) with additional guidance notes on restrictions for initiation on the monograph and on Orx.**
5.8	**Spironolactone 12.5mg tablets** JCo presented the application to include 12.5mg strength spironolactone tablets on the Formularies on behalf of the Milton Keynes cardiology team. Current practice is to cut the 25mg tablets however due to tablet thickness and film coating the tablets are fragmenting (even when using a pill cutter), which makes it difficult to dose patients accurately. Some patients with frailty and renal impairment may remain on the 12.5mg dose long term, whereas others it may be an intermediate dose during titration. Patient numbers estimated approximately 30-40 across primary and secondary care. Currently, Non-Formulary request forms need to be completed each time which is causing an increased workload. Liquid preparations are available however measuring the dose is difficult and one bottle will not last for many days due to the strengths available. The tablets do carry a cost pressure – 28 x Spironolactone 12.5mg = £20.76 125ml Spironolactone 25mg/5ml Oral suspension = £19.59 28 x Spironolactone 25mg = £1.36 (assuming that spare halves are not used) AG raised concerns regarding up titration – patients must not be prescribed two of the 12.5mg tablets to make up a 25mg dose as this would result in a significant cost pressure. **Action NW/TL**: SS/Orx messages to be developed to ensure no doubling up of 12.5mg tablets. MD: Searches for this on SystemOne are possible to help avoid doubling up of doses. It was discussed and noted that liquids are less suitable for use in older adults but that they do have a place for children and those with swallowing difficulties. NW noted that there is already some prescribing of 12.5mg tablets in Primary Care – approximately 117 patients in last 3 months (approx. £9000) from EPACT2 data. Numbers are not expected to be dramatically affected by the addition of the 12.5mg tablet to the Formularies.

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<tr><th>No</th><th>Agenda Item</th></tr>
<tr><td></td><td>DW raised that work would need to be done around procurement and set up of 12.5mg tablets on JAC dispensing system at Bedfordshire Hospitals NHSFT as well as education to the dispensaries about when to supply to ensure 12.5mg are not provided for 25mg doses.
JCl suggested 6 months of monitoring to track usage patterns.
Action NW/TL: Align strengths of spironolactone liquids across the Formularies as minor amendment

Decision: Add spironolactone 12.5mg to both Formularies with Green status, with wording around appropriate usage and cost.

Action NW/TL: Develop SS/Orx messages to prevent doubling up of doses.</td></tr>
<tr><td>5.9</td><td>Minor amendments log

An example of the minor amendments log was presented to the committee. The log will be a standing agenda item in line with the minor amendments policy (item 5.5). It was agreed that all minor amendments would be collated into a paper and circulated prior to the meeting for comment. Approval of the changes will be made in the meeting and noted in the minutes.

The committee noted the summary of minor amendments made from October 2022 to Jan 2023:

<table>
<tr><th>Date</th><th>Item</th></tr>
<tr><td>Oct-22</td><td>Evolve Hypromellose 0.3% added as preferred brand of eye drop (cost effective brand) following removal of usual brand from Drug Tariff. Subsequent high cost pressure for unspecified item therefore Evolve added as the preferred brand.</td></tr>
<tr><td>Oct-22</td><td>Nicotine replacement therapy - wording added to stipulate patients must be engaged in a smoking cessation programme</td></tr>
<tr><td>Nov-22</td><td>Indomethacin is 1st choice for gout wording removed</td></tr>
<tr><td>Nov-22</td><td>Testosterone injections and gels - Designations amended to split apart SCG (gender dysphoria) and Amber indications (hypogonadism) for clarity</td></tr>
<tr><td>Nov-22</td><td>Addition of information to sildenafil - SLS no longer required for generic preparations</td></tr>
<tr><td>Nov-22</td><td>Note added to prochlorperazine: Stemetil 5mg/5mL syrup has been discontinued due to excess levels of a nitrosamine compound following lab tests</td></tr>
<tr><td>Nov-22</td><td>Freestyle Libre discontinued - updated to Freestyle Libre 2</td></tr>
<tr><td>Nov-22</td><td>Ephedrine nasal drops removed from Drug Tariff & only OTC products available, therefore self-care indicator added</td></tr>
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No	Agenda Item	
	Oct-22	Note added to paroxetine: Seroxat 20mg/10mL oral suspension will be discontinued from October 2022.
	Nov-22	Trimbow inhalers - addition of 172 strength and wording to say which devices are licensed for asthma and COPD
	Nov-22	Oseltamivir and zanamavir monographs updated with 2023 PHE advice for flu
	Nov-22	Coal tar shampoos - combine monographs in to one and tidy up old entries. Age ranges added to advise prescribers which shampoos are licensed as per PrescQipp bulletin info.
	Dec-22	Fluoxetine wording 1st line for depression removed
	Dec-22	Dermax assigned Green status (previously designation unspecified)
	Dec-22	Actasolve smoothies - links to alternative diluents guide added
	Dec-22	NICE CG180 retired by NICE and replaced with NG196 - links updated
	Dec-22	NICE CG108 retired and replaced by NG106- links updated
	Dec-22	NICE CG127 now NG136- links updated
	Dec-22	NICE CG107 now NG133- links updated
	Dec-22	NICE CG172 now NG185- links updated
	Dec-22	NICE CG92 now NG89- links updated
	Dec-22	NICE CG144 now NG185- links updated
	Jan-23	Ryeqo moved section from HRT to drugs affecting gonadoptrohins as per pharma rep email
	Jan-23	Fidaxomicin 3rd to second choice. DTC wording removed.
	Jan-23	Hepsal and Canusal brands removed from formulary heparin flush monograph - brands discontinued 2009
	Jan-23	Supplementary Preparations Addiphos® hide and tidy
	Jan-23	Supplementary Preparations Additrace® hide and tidy
	Jan-23	Supplementary Preparations Cernevit® hide and tidy

No	Agenda Item

Jan-23	Supplementary Preparations Decan® hide and tidy
Jan-23	Supplementary Preparations Dipeptiven® hide and tidy
Jan-23	Supplementary Preparations Glycophos® Sterile Concentrate hide and tidy
Jan-23	Supplementary Preparations Peditrace® hide and tidy
Jan-23	Supplementary Preparations Solivito N® hide and tidy
Jan-23	Supplementary Preparations Vitlipid N® hide and tidy
Jan-23	Intralipid 20% hide and tidy
Jan-23	Babiven start up hide and tidy
Jan-23	Parenteral Nutrition (TPN or PN) moved to Red from Non-Formulary
Jan-23	Nutryelt® hide and tidy
Jan-23	Susocotog alfa Obizur® hide and tidy

AOB

Methotrexate 10mg tablets Incident

Occurrence of a never event – patient received high dose methotrexate and was admitted to hospital with side effects. Approval sought to immediately remove 10mg strength from Milton Keynes Formulary in light of this error (already NF on Beds/Luton Formulary). Historical resistance from patients to switch as it will increase pill burden, however the group agreed that risk outweighs the benefits and the 10mg tablets will subsequently be removed and patients actively switched to 2.5mg.

JCl – Beds/Luton have Shared Care with only 2.5mg strength in it. This was put in place in response to a past incident (Cambridgeshire enquiry).

DW suggested information could be included in the MSG newsletter if of benefit

It was noted that a number of other areas have enforced removal of the 10mg tablets due to the risks.

Patient numbers (EPACT2 data) March – May 2022:

HS Practice	Items	Identified Patient Count [1 of 2]
MK Practices 1 Total	104	89

No	Agenda Item		
	Cent. Beds Practices Total	12	12
	Beds Borough Total	3	3
	Grand Total	119	104

Action NW: To add 10mg methotrexate to RedRed list on Optimise and remove 10mg methotrexate tablets from MK Formulary. To explore with MD possibility of patient letter.

Future meeting dates are published and available via https://medicines.bedfordshirelutonandmiltonkeynes.icb.nhs.uk/categories/formulary/

Approval of minutes:
Chair: Dr John Fsadni

Signed: 

Date: 20th April 2023