BEDFORDSHIRE, LUTON AND MILTON KEYNES AREA PRESCRIBING COMMITTEE

Final Meeting Notes

Date: 03 May 2023
Time: 12.30- 3.00pm
Venue: Microsoft Teams

Attendees:

Name	Initial	Role
Dr Muhammad Nisar	MN	Chair (Medical Representative, Bedfordshire Hospitals NHS Trust)
Yolanda Abunga (until 14:36)	YA	CCS Pharmacy Representative (Community Services Pharmacist, Beds and Luton)
Nicola Ainsworth (from 13:00)	NA	Consultant in Public Health
Pritesh Bodalia (from 12:50 – 14:16)	PB	Bedfordshire Hospitals Trust Pharmacy Representative (Chief Pharmacist, Bedfordshire Hospitals Trust)
Jacqueline Clayton	JC	Chair of Wound Care Group
Janet Corbett (from 12:40)	JCo	Milton Keynes Hospital Pharmacy Representative (Pharmacy Programme Manager, Milton Keynes Hospital)
Dr Mya Aye (from 12:50)	MAy	Medical Representative, Milton Keynes Hospital
Matt Davies	MD	Place Based Lead Pharmacist – Central Bedfordshire
Dupe Fagbenro (until 14:25)	DF	ELFT Pharmacy Representative (Deputy Chief Pharmacist (Luton and Bedfordshire), ELFT)
Dr John Fsadni	JF	Chair of Formulary Subgroup
Fiona Garnett	FG	Associate Director and Head of Medicines Optimisation BLMK ICB
Anne Graeff	AG	Commissioning Lead Pharmacist, BLMK ICB (Professional Secretary)
Cheryl Green	CG	Patient Representative
Dr Jonathon Walter	JWa	Place Based Lead GP – Milton Keynes
Dr Jenny Wilson	JW	Place Based Lead GP - Bedford
Dona Wingfield	DW	Chair of Medicines Safety Group /

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

		Bedfordshire Hospitals Trust Pharmacy Representative (Medicines Use and Quality Manager, Bedfordshire Hospitals Trust)

In attendance:		
Rafal Ali	RA	Commissioning Pharmacist, BLMK ICB
Dr Marian Chan	MC	Medical Representative, Bedfordshire Hospitals NHS Trust
Candy Chow	CC	Commissioning Lead Pharmacist, BLMK ICB
Dawn Hawes	DH	Representative, St John's Hospice
Taiya Large	TL	Formulary and Medicines Safety Pharmacist, BLMK ICB
Dr Joy Mutitika	JM	Medical Representative, Keech Hospice
Kike Pinheiro (from 13:10)	KP	Representative, Willen Hospice
Raye Summers	RS	PA to MOT, BLMK ICB (admin support)
Shyaam Teli	ST	ELFT Pharmacy Representative – Community Services (Beds)/Mental Health Services (Beds and Luton)
Nikki Woodall	NW	Lead Medicines Optimisation Technician, BLMK ICB
Andrew Tse	AT	Milton Keynes Hospital Pharmacy Representative (Medication Safety Officer, Milton Keynes Hospital)
Huseyin Huseyin (for agenda item 5.6)	HH	Clinical Operational Lead - Neurology, Bedfordshire Hospitals NHS Foundation Trust
Sarah Florey (for agenda item 5.6)	SF	Senior Commissioning Manager, BLMK ICB
Iffah Salim (for agenda item 5.7)	IS	CAMHS Directorate Lead/ MI Pharmacist, East London Foundation Trust

Apologies:		
Sally Cartwright	SC	Consultant in Public Health
Helen Chadwick	HC	Milton Keynes Hospital Pharmacy Representative (Chief Pharmacist, Milton Keynes Hospital)
Dr Andrew Cooney	AC	Medical Representative, Milton Keynes Hospital
Naomi Currie	NC	Place Based Lead Pharmacist - Bedford
Carole Jellicoe	CJ	Nurse Representative (Independent Prescriber)
Sandra McGroarty	SMcG	Commissioning Pharmacist, BLMK ICB
Dr Dush Mital	DM	Medical Representative, Milton Keynes Hospital
Dr Kate Randall	KR	Place Based Lead GP – Central Bedfordshire
Dr Mitan Sarkar	MS	Place Based Lead GP - Luton

No	Agenda Item	Action
1.	**Welcome, Introductions and Apologies** The Chair welcomed everyone to the meeting. Apologies were received and noted as above. The meeting was confirmed as quorate. The Chair thanked Dr Andrew Cooney, who is stepping down, for his service to the Committee. Thanks were also extended to Raye Summers for her excellent administrative support to the Committee, as this is her last meeting.	
2.	**Declarations of Interest** The Chair invited the members to reconfirm their current declarations on the Register of Interests and advise of any new declarations. All members confirmed their declarations were accurate and up to date. The Chair invited members to declare any declarations relating to matters on the agenda. JC declared a non-financial personal interest in relation to agenda item 5.1 and took no part in the discussion. All other members confirmed they have no declarations in relation to matters on the agenda.	
3.	**Minutes of 01 March 2023 APC meeting** The minutes of the meeting held on 01 March 2023 were approved.	
4.	**Matters Arising**	
4.1	**Feedback on miscellaneous actions not included on the agenda from APC meetings**	
4.1.1	**Localised Severe Psoriasis** Local review to be undertaken of PAC policy to include: number of lines of therapy available and choice of therapy (following comments received by local clinicians). **Update 13/04/2023** - PAC is reviewing the evidence for the therapies in response to the feedback from BLMK - the outcome of this is awaited and clinicians have been informed. This is therefore an ongoing action.	AG
4.1.2	**Icosapent Ethyl (NICE TA805)** Review of prescribing data over six months to review usage and uptake. **Update 03/05/2023** – data fed back to the Committee at the meeting. There is currently very low uptake and prescribing of icosapent ethyl	Close

No	Agenda Item	Action
	across BLMK. No further action required at the current time. It was proposed and agreed that this action could be closed.	
4.1.3	**BLMK ICB Hypertension Adult Treatment Guidelines** Link to be added to clarify the guidance in relation to patients with CKD. **Update 19/04/2023** – update complete – to be uploaded to the Medicines website. It was proposed and agreed that this action could be closed.	Close
4.1.4	**BLMK ICB Hypertension Adult Treatment Guidelines** Template/leaflet to be produced to provide information to patients and support the communication of the treatment plan (to be uploaded onto the Medicines website alongside the treatment pathways). **Update 19/04/2023** - draft leaflet complete, next step is to go to co-design for patient input. Links to resources for HCPs have been added to the Medicines website. This is an ongoing action.	MD
4.1.5	**Shared Care Patient Information Leaflet** For further consultation in the acute Trusts, including determining the need for approval via Trust Documentation Committees, logos to be used. **Update 18/04/2023** – not supported by MK Prescribing and Medicines Governance Committee - it was not felt to be needed in addition to specialist discussion with the patient and was an added administrative burden to the clinicians. BHFT - some feedback provided on leaflet contents, but no firm decision reached on introduction of the leaflet. The Committee discussed the importance of adequate provision of information to empower patients and that additional time spent at the initiation of shared care may save time in the long term. It was agreed that the leaflet would be reviewed with a view to making it less administration heavy for the clinical teams at the point of issue, and that it would be taken forward as an addition to the BLMK shared care guideline template which is optional to use. This is an ongoing action.	JC
4.1.6	**Sodium valproate** – key stakeholders e.g. iCASH and family planning clinic leads, PCN pharmacists to join discussions on sodium valproate at the Medicines Safety Group. **Update 18/04/23** – sodium valproate to be discussed at a future meeting (awaiting MHRA update) and stakeholders will be invited accordingly. It was proposed and agreed that this action could be closed.	Close
4.1.7	**Vitamins & minerals prescribing guidance** – guidance to be updated to incorporate input received at the meeting, and E&D comments received just prior to the meeting. **Update 07/03/23** – guidance updated as discussed at the meeting, finalised and uploaded onto the Medicines website. It was proposed and agreed that this action could be closed.	Close

No	Agenda Item	Action
4.1.8	**Patient Group Direction policy** – to share the terms of reference of the newly created PGD subgroup to the BHFT DTC, and a list of PGDs in use (to help inform the ICB work on PGDs). **Update 18/04/23** – terms of reference not yet finalised and will be shared when available. Spreadsheet list of PGDs shared. In addition, it has been agreed that individual PGDs will also be shared as required to help with the PGD subgroup reviews of submitted documents. It was proposed and agreed that this action could be closed.	Close
4.1.9	**Cortiment** (Formulary Subgroup recommendation) – number of courses which may be prescribed in primary care to be confirmed. **Update 07/03/23** – confirmed with gastroenterology: only ONE course of cortiment should be prescribed in general practice for PIFU patients. If the patient does not respond adequately, or a subsequent course is required, they should be referred back to the specialists. Wording on MK Formulary updated accordingly. It was proposed and agreed that this action could be closed.	Close
4.1.10	**Insulin degludec & insulin glargine recommendations** – Equality & Diversity lead comments to be fed back to specialist teams post meeting. **Update 18/04/23** – comments fed back via DSNs. Interpreters are used as required to assist with and ensure understanding when providing education on insulins. It was proposed and agreed that this action could be closed.	Close
4.1.11	**Cannabis-based products registry** – Trusts to update on progress with accessing the cannabis registry. **Update 13/04/23** – Cannabis Registry administrator agreed for MKUH and training to be arranged for clinicians. BHFT are identifying database administrators for the Trust and will roll out completion of the registry. It was proposed and agreed that this action could be closed.	Close
5.	**Items for consideration at meeting**	
5.1	**Primary Care psoriasis pathway** The Committee discussed the paper, and the following key points were raised: • Since the discussion at the last meeting in March, the pathway has been reviewed and updated to reflect the Committee's discussion. • The proposed BLMK ICB updated pathway follows the Milton Keynes guidance for management of trunk psoriasis, deviating from NICE and recommends once daily combined therapy first line. Recommendations for maintenance are also aligned and advise the use of Vitamin D preparations. • For scalp psoriasis: an updated pathway where potent topical steroid +/- a descaler for thick scales, followed by combined therapy with calcipotriol/betamethasone products as second line treatment have now been included for scalp psoriasis. Maintenance is aligned with the existing MK pathway.	

No	Agenda Item	Action
	• An additional statement has been added to the pathway to state that, for patients with psoriasis on both scalp and body, a single prescription of Enstilar foam may improve compliance. • Face, flexures and genitals (adults): The updated pathway for BLMK is aligned with the existing MK guidance (NB: maintenance twice weekly steroid advice has also been updated since March and now advises vitamin D preparation twice weekly as maintenance as per MK). Facial skin is very sensitive to steroid atrophy and NICE only recommend short term steroid use on face. • Pathway for children: the majority of the children's pathway remains unchanged however, calcipotriol has been added in line with NICE since the previous submission to APC in March (highlighted in red). • Psoriasis is uncommon in children (estimated 0.71% prevalence in UK population (source NICE CG153). • The pathway is anticipated to be cost neutral as Enstilar is already included on both formularies (Green on the Bedfordshire/Luton formulary, Amber on the Milton Keynes formulary) and used extensively across BLMK. The pathway clarifies the position in which it is appropriate to be prescribed and support clinicians with treatment choices. Decision: The Committee approved the pathway **EQIA Assessment:** No impact envisaged **BLMK ICB E and D Lead comment:** No additional comments from the Equality and Human Rights perspective	
5.2	**Position Statement on Shared Care with Private Providers** A new position statement has been developed to support Primary Care prescribers across BLMK to manage requests from private healthcare providers to take on shared care. This is intended to cover all shared care requests from private providers regardless of service or therapeutic area. The position statement outlines when it would be appropriate, or otherwise, to accept shared care with a private provider in the context of the principle of defining the boundaries between NHS and private healthcare in accordance with the respective BLMK policy. The statement also outlines what Primary Care prescribers should consider when deciding whether to accept shared care with a private provider. A template letter is included as an appendix within the position statement, which may be used to respond to private providers when declining a request for shared care. The Committee discussed the following points: • The BLMK Prescribing Committee were consulted on the guidance, to obtain wider GP opinion. The Prescribing Committee were very supportive of the additional guidance. • Right to choose – to be clarified whether this is only applicable to Mental Health services at the current time, or all services.	CC

No	Agenda Item	Action
	• The position statement was welcomed as clear and useful guidance and the template letter agreed to be helpful. Decision: The Committee approved the position statement **EQIA Assessment:** Positive potential impact – This position statement will ensure that the care of patients who have been seen by private healthcare providers is managed in an equitable manner and not favoured nor prioritised over the care of NHS patients. Equally, it ensures that patients who have been seen by private providers can access shared care with NHS Primary Care prescribers where it is appropriate to do so as outlined in the statement. The proposed position will also ensure consistency of approach to managing and responding to private providers regarding shared care requests, regardless of service or therapeutic area. **BLMK ICB E and D Lead comment:** Position statement document page 1, para 3. Could this be seen as indirect discrimination for those people who are looking to be prescribed meds not related to trans but other conditions and have been declined? Or add wording *"as per NHSE updated documents related to gender identity services".* So that it's not an ICB decision. (NB: This wording was included and an updated version circulated to the Committee)	
5.3	**Biologic Migraine Prevention Pathway for Adults** A new pathway has been developed, in consultation with local migraine specialists, to assist decision making and confirm the local commissioning position in this therapy area. The proposed pathway includes all NICE approved therapies and considers sequential use with a second line treatment option with a different mode of action. There are currently 4 biologic treatments recommended by NICE for the treatment of chronic and episodic migraine: Fremanezumab, Galcanezumab, Erenumab and Eptinezumab which belong to a class of monoclonal antibodies specific for calcitonin gene-related peptide (CGRP). Erenumab targets the CGRP receptor, whereas Fremanezumab, Galcanezumab and Eptinezumab target the CGRP ligand. In addition, botulinum toxin is recommended as a treatment option for chronic migraine (note: this is no longer an excluded high cost drug). The evidence for sequential use of the anti-CRGP biologics is limited, however emerging evidence suggests that switching from one CGRP inhibitor to another could be useful in some patients who have not responded to therapy. It was noted that neighbouring ICBs have migraine pathways which include second line treatment options. A pragmatic approach, in line with a similar approach taken in other therapy areas, was therefore proposed to allow a second line treatment to be used in the small cohort of patients emerging who have not responded to the first agent. It is anticipated that approximately 5 patients may require second line therapy across	

No	Agenda Item	Action
	BLMK. The associated cost is expected to be in the range of £10,140 to £14,625 per annum. The following additional points were raised and discussed by the Committee: • Clarity requested regarding the two commissioned lines of therapy – does this refer to two biologics, or botulinum toxin plus one biologic? It was clarified that the two lines of therapy refers to anti-CRGP biologics only. • Suggestion to remove direct arrow from the top box to botulinum toxin and retain the arrow from the chronic migraine box only. Agreed. • There is no specific requirement to trial botulinum toxin before anti-CRGP agents – the choice is dependent upon patient/clinical factors and clinician choice. • It is important to distinguish between chronic and episodic migraine in the upper part of the pathway. • The wording in the chronic and episodic migraine boxes was suggested to be changed to statements, rather than questions. Agreed. • Suggestion to add "Does the patient have chronic/episodic migraine and has tried at least 3 preventative drugs ……" in the top box. Agreed. • Combination treatment with botulinum toxin and anti-CRGP agents – to add a statement to say that combination treatment is not commissioned. • Front cover sheet to be added and include any additional information which may not fit within the flow chart. • Arrow to be added to flow from botulinum toxin to the anti-CRGP biologics to clarify that patients may be treated with botulinum toxin and then biologics. Decision: approved with amendments agreed at the meeting. **EQIA Assessment:** Yes, but in a positive way – the addition of a new drug and a 2nd line of treatment will benefit patients. The pathway will provide a consistent and rational approach ensuring equity and promoting an evidence based approach to prescribing. **BLMK ICB E and D Lead comment:** No additional comments from the Equality and Human Rights perspective.	RA
5.4	**Treatment Pathway for Moderate to Severe Atopic Dermatitis in Adults** A new treatment pathway has been developed for moderate to severe atopic dermatitis (AD). This is for use in adult patients who have had an inadequate response to topical treatments and conventional systemic therapies and is based on NICE technology appraisal guidance. The pathway covers use of Dupilumab, Baricitinib, Abrocitinib, Tralokinumab and Upadacitinib, and has been discussed and agreed with local dermatology specialists. There is currently very limited clinical data on sequential therapies and thus analysis of treatment sequences for clinical and cost	

No	Agenda Item	Action
	effectiveness would be uncertain. NICE have acknowledged that there is no typical treatment journey and there would likely be no 'standard' sequence. They have recommended that the choice of treatment and the clinical rationale for using various sequences of treatments would be based on individual patient circumstances, such as previous response to treatment, tolerability to potential adverse effects, comorbidities and contraindications. This recommendation is reflected in the pathway, allowing dermatologists the flexibility to prescribe the most appropriate treatment for each individual patient. A pragmatic approach was therefore recommended, in line with similar pathways from other therapy areas, to allow clinicians to trial a treatment from both available drug classes and therefore two lines of therapy. Approximately 10% of existing patients are estimated to require a second line treatment option, with a cost impact of between £35,000 - £73,726 per year. The pathway recommends use of the treatment option with the lowest acquisition cost, where there is more than 1 suitable treatment option, and lists the treatments in order of cost. Safety – NICE assess the safety, alongside the efficacy and cost-effectiveness of the recommended treatments, but the committee noted that the following additional MHRA alerts have been published for the AD treatments: • Dupilumab – risk of ocular adverse reactions and need for prompt management. • Baricitinib – risk of VTE and increased risk of diverticulitis particularly in patients with risk factors. • JAK inhibitors (includes abrocitinib, baricitinib and upadacitinib) - new measures to reduce risks of major cardiovascular events, malignancy, venous thromboembolism, serious infections and increased mortality. The Committee discussed the following additional points: • Acquisition costs (from least to most expensive) added to the pathway at the request of the clinicians. • Risk of ocular adverse reactions with dupilumab: the Dermatologists would not use dupilumab in patients with pre-existing eye disease, and for other patients no additional screening is required. Patients are counselled on the risk of ocular adverse reactions, and actions to take, on initiation of therapy. The cost order in the pathway refers to acquisition cost only. Decision: The Committee approved the pathway **EQIA Assessment:** The NICE TAs for each of the treatments for atopic dermatitis have already identified the potential impact for patients in regard to equality and diversity in relation to using the EASI score in assessing the severity of atopic dermatitis. NICE has therefore included recommendations for healthcare professionals to	

No	Agenda Item	Action
	take into account the impact of skin colour and how this could affect the score and to make any appropriate adjustments. The recommendations in the NICE TAs also state that, when using the DLQI, healthcare professionals should take into account any physical, psychological, sensory or learning disabilities, or communication difficulties that could affect the responses to the DLQI and to make any adjustments they consider appropriate. Moreover, the addition of new treatment options and an additional line of treatment will benefit patients with moderate to severe atopic dermatitis. **BLMK ICB E and D Lead comment:** No additional comments from the Equality and Human Rights perspective	
5.5	**Patient Group Direction policy** The Committee discussed the new Patient Group Direction (PGD) policy and PGD subgroup Terms of Reference (TOR). Following initial discussion at the March meeting, a revised document was presented to the Committee. This has been updated to take into account comments fed back at the last meeting, to reformat as an official organisational policy and to remove details of the PGD review group. The latter information is now included in the PGD subgroup terms of reference. Additional points discussed by the Committee: • JCo was thanked for all her input and help in the development of the policy. • The ICB governance team have advised that this must be a formal policy, due to the legal requirements for PGDs. The document has therefore been reformatted as a formal policy. • There is a mismatch between the policy and the terms of reference about who will approve the PGDs. It was clarified that the PGD subgroup will review the PGDs and the Medical Director (or deputy) will sign the PGDs. The decisions of the PGD subgroup will need to be ratified by the APC, in the same way as the output of other subgroups is ratified by the APC. Amendments will be made to the documents to clarify these points. • The person/organisation who submitted the document will not be notified of the PGD subgroup's decision until the APC has ratified the decision. • Concerns raised that the length of the process may mean that the information is out of date before the PGD is ratified by the APC. The process will be reviewed on an ongoing basis to assess how it is working, including the timeliness of the process. • Documents approved virtually by the APC still require formal ratification at the next meeting – it would require amendment to the APC terms of reference to change this.	FG

No	Agenda Item	Action
	Decision: Policy and TOR approved subject to minor amendments as discussed at the meeting **EQIA Assessment:** N/A	

5.6	**Sativex (THC:CBD) Oromucosal Spray**
	The Committee discussed a paper reviewing the prescribing status of Sativex within BLMK. The following key points were raised:
	
	• An overview of multiple sclerosis (MS) was presented, and the place of Sativex in therapy confirmed – it is indicated for symptom improvement in adult patients with moderate to severe spasticity due to MS who have not responded adequately to other anti-spasticity medication.
	• NICE recommends offering Sativex to patients in the above cohort, with restrictions, in NG144 Cannabis-based medicinal products.
	• The Bedfordshire and Luton Joint Prescribing Committee and Milton Keynes Prescribing Advisory Group (legacy BLMK APCs) both ratified the NICE recommendations in 2020, but restricted prescribing to specialists only (red traffic light status).
	• GP prescribing is not currently recommended.
	• Audits were intended to be conducted at 6-months, however the Covid pandemic disrupted this.
	• Many areas in England have introduced shared care arrangements for Sativex, including some neighbouring Integrated Care Systems, and NICE NG144 provides information on the safe introduction of shared care.
	• BHFT do not currently prescribe Sativex for their MS patients and refer any patients who require assessment for this treatment option to UCLH, their tertiary centre.
	• MK Hospital is prescribing Sativex and have approximately 8 patients on treatment.
	• Projected patient numbers are unchanged from those provided in 2020:
	  ○ 20 patients – Luton & Dunstable Hospital site, BHFT
	  ○ 10 patients – Bedford Hospital site, BHFT
	  ○ 8 patients – Milton Keynes University Hospital, MKUH
	• It was noted that a number of additional treatment options have been approved by NICE for relapsing-remitting and progressive multiple sclerosis since 2020. Though these do not relate specifically to spasticity management, improvement in overall disease management may reduce the need for symptom management especially end of line treatments such as Sativex.
	• Spasticity has a significant impact on NHS resources, and cost of admissions is likely to be much higher than the cost of treatment.
	• Sativex is a last line treatment and the only other option at this stage is a baclofen pump which is more invasive and more expensive. It is suitable for use in adults at any age.	

No	Agenda Item	Action

	• The introduction of Sativex shared care within BLMK would enable patients to receive treatment locally and this will have a positive impact on patient experience. Examples of patient experiences, from the MS Society, were presented to the Committee.
	• A phased approach was proposed:
	  ○ **Phase 1: Formation of subgroup** to incorporate individuals from ICS organisations – Acute trusts, community services and ICB.
	  ○ **Phase 2: Commission a local service.** Initial discussions taking place with ICB commissioning team, trust to set up a clinic at BHFT with potential shift in activity from tertiary centre (includes block allocation) – to include MKUH – models include BLMK hub or two ICP models, review of contract
	  ○ **Phase 3: Pathway development and MDT.** MDT approach as per NG220 recommendations with learning from other areas.
	  ○ **Phase 4: Shared care guideline development and launch.** Shared care guideline roll out following confirmation of pathway – training and education (Protected Learning Zones), patient contracts, MDT with practices.
	• A proposal has been submitted, by another region, that a national shared care guideline should be developed, though it is unclear if/when this will be taken forward.
	• Reallocation of funding from tertiary centres is being explored – any such reallocation will need to consider funding at both local Trusts. It was noted that MKUH have been providing the treatment without any additional funding since 2020.
	• Concerns were raised about pressure on primary care to prescribe, as there has been considerable demand in the past. However, patient selection and initiation would be restricted to specialists who are used to fielding requests from patients. Treatment will be declined for patients for whom Sativex is not suitable.
	• The patient experience is currently suboptimal, with patients being referred out of region in order to access treatment.
	
	Decision: The Committee supported the phased approach, as presented at the meeting
	
	EQIA Assessment: Yes, positive impact – it will enable patients to receive treatment locally rather than travel to London and other tertiary centres and this is moving to similar positions nationally.
	
	BLMK ICB E and D Lead comment: no additional comments from the EIHR perspective.	

5.7	**Biphasic MR Methylphenidate** The Committee considered a memo produced to aid clinicians prescribing biphasic methylphenidate MR products during periods of supply shortages. The background is a series of supply shortages which have created problems for both prescribers (including	

No	Agenda Item	Action
	specialists and general practice) and community pharmacists. The memo acknowledges the MHRA Drug Safety Update: Methylphenidate long-acting (modified-release) preparations: caution if switching between products due to differences in formulations and provides guidance on which MR methylphenidate products have demonstrated bioequivalence, and therefore may be considered for generic prescribing in times of shortages, and which do not. The memo is not intended to replace existing shared care guidelines for ADHD and will sit alongside these guidelines as a supporting document. The following points were raised: • Optimise Rx/Scriptswitch messages are in place which recommend Xaggitin as the most cost-effective choice. Moving away from this has a potential cost impact and manufacturers of Xaggitin have confirmed adequate supplies. • It is preferable if the brand is stated on letters from specialists to GPs. • Brand prescribing is safer, therefore on patient safety grounds is preferable. • Brand prescribing to be continued as the preferred option, with deviation from this only when necessary. Suggested that the brand should remain on the repeat template and the generic issued as an acute prescription, with a prescription note to advise of equivalence to/substitution for the usual brand. The wording in the memo recommends this approach. • Switching brands may destabilise patients and needs to be minimised. • Information on brand equivalence is already included in the paediatric shared care guideline. • The treatment choices listed in table 2 should be reordered to list the most cost-effective (Xaggitin) at the top and other options below. • A suggestion has also been received that all the methylphenidate options are listed in one table and included as an appendix to the memo. This will make it clearer, which brands are equivalent and which are not. • ELFT/CCS pharmacists are working to ensure that cost-effective brands are prescribed by the specialists. • Systems are in place locally to support communication between community pharmacies, so that if one pharmacy doesn't have a particular product then the patient may be referred to another pharmacy which has the product in stock. This has vastly reduced the need for stock shortages to be managed without the patient having to go back to their GP. Decision: Approved with changes agreed at the meeting: table format and order of product listings to be amended and included as an appendix to the memo.	IS

No	Agenda Item	Action
	EQIA Assessment: no impact anticipated – no change in current treatment options and/ or available interventions **BLMK ICB E and D Lead comment:** Section 3 states: No impact. Section 6 states that some clinicians have reported an issue with obtaining the branded products. Suggestion: Positive impact – Changing to generic prescribing will make the product more accessible to already vulnerable patients.	
6.0	**NICE Guidance – from 15 February to 19 April 2023** **The following NICE Technology Appraisal Guidance (ICB Commissioned) have been published:** **Semaglutide for managing overweight and obesity** Technology appraisal guidance [TA875] Published: 08 March 2023 https://www.nice.org.uk/guidance/ta875 Resource impact: currently unable to assess as the price of the product is not yet available **APC action**: created and added to Formularies (RED traffic light) **Finerenone for treating chronic kidney disease in type 2 diabetes** Technology appraisal guidance [TA877] Published: 23 March 2023 https://www.nice.org.uk/guidance/ta877 Resource impact: NICE do not expect this guidance to have a significant impact on resources. **APC action:** to be created and added to Formularies (AMBER/AMBER 3 traffic light) **Casirivimab plus imdevimab, nirmatrelvir plus ritonavir, sotrovimab and tocilizumab for treating COVID-19** Technology appraisal guidance [TA878] Published: 29 March 2023 Last updated: 05 April 2023 https://www.nice.org.uk/guidance/ta878 Resource impact: Minimal resource impact anticipated initially for non-hospitalised patients due to declining patient numbers being treated and availability remaining centrally purchased stock (purchased for the pandemic). Overall potential resource impact of £900k per annum for hospitalised and non-hospitalised patients, based on numbers of patients treated in BLMK in Q3 and 4 2022/23. **APC action:** link to be added to each formulary entry and traffic lights to be updated: Casirivimab plus imdevimab: DNP Nirmatrelvir plus ritonavir (Paxlovid): GREEN (with restrictions, in accordance with the NICE guidance) Sotrovimab: RED Tocilizumab: RED	AG/JCo AG/JCo

No	Agenda Item	Action
	The following COVID 19 related information has been produced/updated by NICE: **COVID-19 rapid guideline: managing COVID-19 NICE guideline [NG191]** Published: 23 March 2021 Last updated: 29 March 2023 https://www.nice.org.uk/guidance/ng191 **APC action:** as per TA878 **The following NICE Guidelines (NG) (Medicine related and ICB Commissioned) have been published / updated by NICE:** **Hypertension in pregnancy: diagnosis and management** NICE guideline [NG133] Published: 25 June 2019 Last updated: 17 April 2023 https://www.nice.org.uk/guidance/ng133 **APC action**: none – update relates to secondary care **The following NICE TAs are the commissioning responsibility of NHSE and are listed for information only:** **Mitapivat for treating pyruvate kinase deficiency (terminated appraisal)** Technology appraisal [TA867] Published: 16 February 2023 https://www.nice.org.uk/guidance/ta867 **APC action:** none (terminated appraisal) **Vutrisiran for treating hereditary transthyretin-related amyloidosis** Technology appraisal guidance [TA868] Published: 15 February 2023 https://www.nice.org.uk/guidance/ta868 **APC action:** none – no local use anticipated (specialist/tertiary centres only) **Teclistamab for treating relapsed or refractory multiple myeloma after 3 or more therapies (terminated appraisal)** Technology appraisal [TA869] Published: 16 February 2023 https://www.nice.org.uk/guidance/ta869 **APC action:** none (terminated appraisal) **Ixazomib with lenalidomide and dexamethasone for treating relapsed or refractory multiple myeloma** Technology appraisal guidance [TA870] Published: 22 February 2023 https://www.nice.org.uk/guidance/ta870 (NB: replaces TA505) **APC action:** link added to Formularies **Ataluren for treating Duchenne muscular dystrophy with a nonsense mutation in the dystrophin gene** Highly specialised technologies guidance Reference number: HST22 Published: 22 February 2023 https://www.nice.org.uk/guidance/hst22 **APC action:** none – no local use anticipated (specialist/tertiary centres only)	

No	Agenda Item	Action
	Axicabtagene ciloleucel for treating diffuse large B-cell lymphoma and primary mediastinal large B-cell lymphoma after 2 or more systemic therapies Technology appraisal guidance [TA872] Published: 28 February 2023 https://www.nice.org.uk/guidance/ta872 **APC action:** link added to Formularies **Cannabidiol for treating seizures caused by tuberous sclerosis complex** Technology appraisal guidance [TA873] Published: 01 March 2023 https://www.nice.org.uk/guidance/ta873 **APC action:** link added to Formularies **Polatuzumab vedotin in combination for untreated diffuse large B-cell lymphoma** Technology appraisal guidance [TA874] Published: 01 March 2023 https://www.nice.org.uk/guidance/ta874 **APC action:** link added to Formularies **Asfotase alfa for treating paediatric-onset hypophosphatasia** Highly specialised technologies guidance Reference number: HST23 Published: 01 March 2023 https://www.nice.org.uk/guidance/hst23 **APC action:** none – no local use anticipated (specialist/tertiary centres only) **Nivolumab with chemotherapy for neoadjuvant treatment of resectable non-small-cell lung cancer** Technology appraisal guidance [TA876] Published: 22 March 2023 https://www.nice.org.uk/guidance/ta876 **APC action:** link added to Formularies **Trastuzumab deruxtecan for treating HER2-positive unresectable or metastatic gastric or gastro-oesophageal junction cancer after anti-HER2 treatment (terminated appraisal)** Technology appraisal [TA879] Published: 06 April 2023 https://www.nice.org.uk/guidance/ta879 **APC action:** none (terminated appraisal) **Onasemnogene abeparvovec for treating spinal muscular atrophy** Highly specialised technologies guidance Reference number: HST15 Published: 07 July 2021 Last updated: 19 April 2023 https://www.nice.org.uk/guidance/hst15 **APC action:** none – no local use anticipated (specialist/tertiary centres only) (Note – this is a partial update as HST24 (see below) has replaced one of the recommendations originally made in HST15)	

No	Agenda Item	Action
	Onasemnogene abeparvovec for treating presymptomatic spinal muscular atrophy Highly specialised technologies guidance Reference number: HST24 Published: 19 April 2023 https://www.nice.org.uk/guidance/hst24 **APC action:** none – no local use anticipated (specialist/tertiary centres only) **Lumasiran for treating primary hyperoxaluria type 1** Highly specialised technologies guidance Reference number: HST25 Published: 19 April 2023 https://www.nice.org.uk/guidance/hst25 **APC action:** none – no local use anticipated (specialist/tertiary centres only) **Eladocagene exuparvovec for treating aromatic L-amino acid decarboxylase deficiency** Highly specialised technologies guidance Reference number: HST26 Published: 19 April 2023 https://www.nice.org.uk/guidance/hst26 **APC action:** none – no local use anticipated (specialist/tertiary centres only)	
7.	**Virtual Recommendations/Documents**	
7.1	**APC agenda cover sheet update** With input from the Equality and Diversity lead, the format of the Equality and Diversity (E&D) assessment template has been updated. The content and information requested is unchanged, but the updated format is anticipated to make the form more user friendly when completing the template and easier to follow by the Committee when reviewing agenda items. In addition, the E&D lead has produced an "Equality Impact Assessment Factsheet" to assist with completion of the assessment (this is embedded in the new format E&D assessment template). A specific agenda cover sheet has also been developed for shared care guidelines (SCGs), to ensure the relevant detail is gathered and available to the Committee when considering new/updated shared care guidelines Decision: The Committee approved the new format agenda cover sheet, and the SCG front cover sheet, which will be used for both the Area Prescribing Committee and the Formulary Subgroup. **EQIA Assessment:** N/A	
7.2	**APC Terms of Reference update** A minor update to the APC terms of reference has been undertaken as follows:	

No	Agenda Item	Action
	• To include Patient Group Directions within the key functions of the Committee (see agenda item 5.5). • To include the updated Equality and Diversity template in Appendix 1 (see agenda item 7.1) Decision: The Committee approved the updated terms of reference. **EQIA Assessment:** N/A	
8.	**Medicines Safety update** A Primary Care Medicines Safety Update and a Medicines Safety Group Update was presented to the committee. **<u>Primary Care Medicines Safety Update</u>** This update focussed on the primary care response to the MHRA Drug Safety Updates (November 2022 to March 2023). In particular: **November 2022: Dupilumab (Dupixent▼): risk of ocular adverse reactions and need for prompt management** Healthcare professionals prescribing dupilumab should be alert to the risks of ocular reactions. New onset or worsening ocular symptoms require prompt review. Referral for ophthalmological examination should be made as appropriate. **Action(s) taken:** Information has been circulated in the Primary Care Bulletin to raise awareness to GPs. It was identified that many patients do not reliably have red medications coded on the GP record and also that patients tend to receive dupilumab on Day care Units, for which discharge information may not always be sent to the GP. The item was discussed at MSG in January and actions taken away by the Trusts to explore effective communication channels with the GP to ensure they are aware of which patients have received dupilumab. **December 2022: Valproate: reminder of current Pregnancy Prevention Programme requirements; information on new safety measures to be introduced in the coming months** In view of data showing ongoing exposure to valproate in pregnancy, this article reminds healthcare professionals of the risks in pregnancy and the current Pregnancy Prevention Programme requirements. It also provides information about the potential risks of valproate in other patients following a review of the latest safety data. Following advice from the Commission on Human Medicines (CHM), new safety measures for valproate-containing medicines are to be put in place in the coming months. **Action(s) taken:** Data has been extracted from a pre-built SystmONE search (which accounts for male and female patients up to age 59). A paper was shared with APC regarding the above in March to raise awareness.	

No	Agenda Item	Action
	January 2023: Electronic Prescribing and Medicines Administration Systems: report adverse incidents on a Yellow Card We ask healthcare professionals to be vigilant to adverse incidents involving software, apps, and artificial intelligence (AI) as medical devices and to report incidents to us via the Yellow Card scheme. **Action(s) taken**: This item was discussed at April MSG, to raise awareness that e-prescribing systems are medical devices that are subject to MHRA yellow card reporting. **January 2023: Topical testosterone (Testogel®): risk of harm to children following accidental exposure** Premature puberty and genital enlargement have been reported in children who were in close physical contact with an adult using topical testosterone and who were repeatedly accidentally exposed to this medicine. To reduce these risks, patients are advised to wash their hands after application of topical testosterone, cover the application site with clothing once the product has dried, and wash the application site before physical contact with another adult or child. **Action(s) taken:** The Testosterone fact sheet for GPs was updated to include the information contained within the alert. This has now been published on the BLMK Medicines Management website and linked to the Formularies for reference. **January 2023: Xaqua® (metolazone) 5mg tablets: exercise caution when switching patients between metolazone preparations** Prescribers and dispensers should use caution if switching patients between different metolazone preparations as the rate and extent of absorption of metolazone are formulation dependent. This can impact the bioavailability of the product. Follow good practice in prescribing medicines by considering the licensed formulation (Xaqua®) in preference to unlicensed imported metolazone preparations in new patients. The product information for Xaqua® has been updated to clarify that references to comparative bioavailability with other metolazone products relate specifically to Metenix® and not to any other metolazone preparations. **Action(s) taken**: Communications have been sent out to the specialists and heart failure clinics. Messages have been built (awaiting deployment) that will fire when the drug is prescribed. Xaqua® is not yet available in wholesalers. **March 2023: Pholcodine-containing cough and cold medicines: withdrawal from UK market as a precautionary measure** Advice for healthcare professionals regarding the withdrawal of pholcodine-containing medicines from the market. **Action(s) taken**: The Formularies have been updated to reflect this information and communications have been circulated via the Primary Care Bulletin, to community pharmacies and the Medicines Optimisation team. **Medicines Safety Group (MSG) Update**	

No	Agenda Item	Action
	The ICS Community Pharmacy Clinical Lead has now joined the MSG, providing a valuable community pharmacy link. **The Safe Discharge Project** was taken forward as the main area of focus for the April meeting. Partners were requested to bring case studies of incidents for discussion and thematic analysis. Themes were identified in three key areas: • Theme 1: Interhospital transfer/transfer of care • Theme 2: Quality of documentation • Theme 3: Sound alike medicines and selection error on systems Learning from the themes will be shared via the Medication Safety Newsletter (planned for May 2023) – in particular – anticoagulation (specifically DOACs), medicines reconciliation and transfer of care. The **Patient Safety Incident Response Framework (PSIRF)** sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety. The group are in the planning and scoping phase, with all partners reporting attendance at webinars and workshops to support implementation. The new focus for incidents will be gathering of themes and identifying issues within a whole process which may lead to errors. After action reviews (AARs) will be the primary tool going forward for PSIRF workstreams and staff training is ongoing in this area. The MSG are planning to present examples of AARs as a learning exercise for the group. **Opioid framework** - NHS England, working in partnership with integrated care system (ICS) leads and representatives, has devised actions to help systems develop plans that can support people who are taking medicines associated with dependence and withdrawal symptoms. The actions will support ICSs to deliver on their 4 key objectives of: • improving outcomes in population health and healthcare • tackling health inequalities in outcomes, experience and access • enhancing productivity and value for money • helping the NHS support broader social and economic development The MSG explored a case study of an opioid related fatality to share learning and have begun discussions for how patients can be supported better as part of future projects e.g. increased domicillary visits and implementation of search engines within ECLIPSE to help identify those at most risk. **Other learning shared:** • A learning bulletin which reported several administration errors with glycopyrronium injection. • A case of lithium toxicity and associated actions, including the development of a bulletin with action points to be addressed.	

No	Agenda Item	Action
9.	**Formulary Update**	
9.1	**Formulary Subgroup Recommendations** The following recommendations were made by the Formulary subgroup at the 18 April 2023 meeting: • **Liraglutide for Type 2 diabetes and obesity in paediatric patients** - Request for inclusion of Saxenda and Victoza on the Formularies for paediatric use in obesity and type 2 diabetes respectively. Saxenda to be used from age 12 for obesity and Victoza from age 10 for T2DM (in accordance with the respective product licenses). Prescribing will be undertaken by the Trusts with recommendation and support from tertiary weight management centres (for Saxenda). Decision: Add both indications as RED to the Formularies until supporting information for GPs published, at which time prescribing for T2DM can move to AMBER/AMBER 1. Prescribing support document to be brought to APC in July. Cost impact is small and anticipated to be approximately £18,600. • **Emollients section review** – a whole section review of the emollient formulary subchapter to rationalise and align choices across BLMK. The changes are expected to be cost saving overall. • **Indapamide 1.5mg MR tablets for hypertension** – the position of modified release indapamide on the Formularies was discussed. Evidence suggests a similar reduction in blood pressure vs the standard release tablets, with less incidence of hypokalaemia as an unwanted side effect. The group concluded there was little value in addition to the Formulary, as anecdotally there appears to be a negative impact on serum sodium which limits use. In addition, prescribers favoured selection of an alternative medicine should electrolyte disturbance occur rather than switching to MR. The cost is also higher vs the standard release tablets (4-fold). Decision: place indapamide MR on the Non-Formulary sections. Existing patients (circa 2000) may remain on therapy. • **Metformin oral powder sachets for type 2 diabetes** – addition to the formularies (GREEN) as an alternative / preferred option for patients with swallowing difficulties. Cost saving vs liquid metformin (5-fold) however the group noted that each sachet (500mg) requires reconstitution in 150mL of water which may be a limitation for use in some patients. Cost impact: cost saving of £76k (assuming a 100% switch from metformin liquid). • **Alemtuzumab Shared Care Guidance update** – Cambridgeshire and Peterborough SCG update submitted for approval. It was confirmed there was no change to content, with the exception of the letter in the appendix. The purpose of the SCG is to avoid patients attending the tertiary centre at Addenbrooke's monthly for 4 years for blood test monitoring	

No	Agenda Item	Action
	(there is no primary care prescribing) as a requirement of therapy (two infusions given 1 year apart). Decision: The updated SCG was ratified for local use for patients under the care of Addenbrooke's Hospital. • **Latanoprost/timolol (Fixapost) Preservative free eye drops for glaucoma** – Fixapost is currently the most cost-effective preservative free (PF) combination preparation vs other PF combination drops. The use of preservative free eye drops is to be reserved for: young patients, those with significant ocular inflammation, intolerance to preservatives and individuals who are expected to have ophthalmic surgery in the near future. Wording is in development for inclusion in the Formularies. Cost impact: approximately £29k. Decision: Fixapost to be added (AMBER/AMBER 1) with restrictions on use as per the above. • **BLMK ICB azathioprine and mercaptopurine Shared Care guidance update** – the Milton Keynes shared care guideline (SCG) has been updated and expanded for use across BLMK ICB, with retirement of the Beds/Luton SCG. Previous SCGs were for inflammatory bowel disease only, but the updated SCG also includes autoimmune hepatitis. Decision: the updated SCG was approved for use across BLMK. • **Melatonin tablets (Adaflex)** for insomnia associated with Attention Deficit Hyperactivity Disorder (ADHD) in children aged 6-17 years old – addition of an additional, licensed, cost-effective melatonin product choice. Adaflex is licensed for ADHD and available in a range of dosages to provide flexibility. Specialists support the addition. Decision: approved for formulary addition. No cost impact anticipated. • **Tiogiva inhaler** – Submission from BHFT for noting – addition of cost-effective device type (near identical to Spiriva Handihaler) for addition to the Formularies in line with Trust contract NHS supply chain. Decision: Add to both Formularies (GREEN). • **Otigo ear drops** – Recommendation made to change from DNP (previous decision was made due to weak evidence to support efficacy of the preparation) to GREEN with messaging on GP support systems to highlight use solely as an antibiotic sparing therapy. Antibiotics should NOT be co-prescribed with Otigo. This will bring recommendations in line with NICE (consider option) and with National Ardens templates for otitis media, which suggest Otigo as an option. Decision: The change was approved. • **Symbicort 200/6 turbohaler** – Now has a reliever license for Asthma patients. Request to add a statement to highlight extra license – "Symbicort Turbohaler is also indicated as reliever therapy for adults and adolescents (12 years and older) with mild asthma". Decision: The change was approved.	

No	Agenda Item	Action

	• **Minor amendments log** – the FSG noted the log of minor amendments made to the Formularies between meetings, including:
	  ○ Addition of Budelin Novolizer and Budesonide Easyhaler added (Green) as low carbon options for treatment of asthma.
	  ○ Salofalk® suppositories and foam enema added to Beds/Luton to align with MK (Green)—cost-effective choice vs Pentasa® brand.
	• **RedRed and Black designation update to Formularies** – alignment of categories across BLMK to the new "Do not prescribe" category (DNP). Changes have been actioned on both Formularies and any medicines in this section with historically differing decisions have been added to the workplan for formal review. Work is ongoing with the GP decision support messaging to update and align advice in accordance with these changes.
	
	The Committee ratified the recommendations of the Formulary Subgroup.	

9.2	**Wound Management Formulary Steering Sub-Group Recommendations**
	
	The following changes have been made to the wound care formularies:
	• Addition of Hidrawear to the main formulary as SPECIALIST ONLY prescribing (as agreed at March APC).
	• Addition of:
	  ○ Suberabsorbent: Cutimed Sorbact
	  ○ Honey dressings: Algivon, Algivon Plus, Activon Tube
	  ○ Bandages: Urgo K2 latex free (18-25cm kit, 10cm bandage; 25-32cm kit, 10cm bandage).
	
	A piece of work is being undertaken to upload the MK formularies on to the same platform as the Bedfordshire and Luton Wound Management Formulary. This will begin in May with a basic usable issue expected mid-June.
	
	The Committee ratified the recommendations of the Wound Management Formulary Steering Group.	

10.	**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		
11.	**East of England Priorities Advisory Committee (PAC) – items for noting/approval**	
11.1	EoEPAC Meeting Notes – November 2022 The committee noted the minutes for information.	
11.2	EoEPAC draft Meeting Notes – January 2023 The committee noted the minutes for information.	

No	Agenda Item	Action
12.	**Bedfordshire, Luton and Milton Keynes Local Prescribing Committee Minutes.** The Committee noted the following minutes for information.	
12.1	Minutes of the Bedfordshire Hospitals Foundation Trust DTC meeting – February 2023	
12.2	Minutes of the Milton Keynes Hospital Prescribing & Medicines Governance Committee (PMGC) – January 2023	
12.3	Minutes of the BLMK Wound Management Formulary Steering Group – January 2023	
12.4	Minutes of the BLMK Formulary Subgroup – February 2023	
12.5	Minutes of the BLMK Medicines Safety Group – January 2023	
12.6	ELFT Medicines Management Committee Minutes (Mental Health) – January 2023	
12.7	Minutes of the Cambridgeshire Community Services Medication Safety and Governance Group – November 2022	
12.8	Minutes of the CNWL Trustwide Medicines Optimisation Group (MOG) – No Minutes for November 2022	
12.9	Minutes of the Circle/MSK Medicines Management Committee – January 2023	
13.	**Papers for information**	
13.1	**Treatments for COVID-19** A paper was presented to brief the Committee on the transition out of pandemic specific arrangements for the treatment of COVID-19. Previous usage/activity data was also shared. NICE has now published initial guidance on some Covid treatments in TA878 (see also agenda item 6.0). These will be adopted into practice and added to both joint Formularies as follows: • Nirmatrelvir plus ritonavir (Paxlovid®), 1st line for patients who do not need supplemental oxygen and at increased risk of progression to severe disease – formulary status to move to GREEN with FP10 prescribing from July 23. • Sotrovimab (Xevudy®) – 2nd line for patients who do not need supplemental oxygen and at increased risk of progression to severe disease, if Paxlovid® contraindicated – formulary status RED – hospital only IV therapy. (NB: workforce with appropriate knowledge and skills to deliver monoclonal antibody infusions is not available within community settings). • Tocilizumab (RoActemra®) – hospitalised patients only on oxygen / mechanical ventilation – formulary status RED. • Casirivimab plus imdevimab (Ronapreve®) – negative NICE TA recommendation – non-formulary (DNP) status. • Any treatment provided by Hospital Trusts will require submission of the relevant Blueteq form. Blueteq forms will	

No	Agenda Item	Action
	not be required for treatments supplied via FP10 in the community (ePACT data to be used to monitor use). The use of Sarilumab and Baricitinib are not covered by NICE as they fall outside of the scope of the multi technology appraisal as off-label treatment options. They are covered by the Central Alerting System (CAS) alert and access to these medicines are subject to local decision making. In order to support ICSs within England, and to reduce duplication of work, NHS England has also made available a template policy for Baricitinib which may be considered by systems for discretionary consideration and local adoption. Three other treatments (Molnupiravir, Remdesivir and Tixagevimab plus Cilgavimab (Evusheld®)) are subject to formal appeal, and NICE TA recommendations for these medicines will not be available until later in the year. In the meantime, NICE's COVID-19 rapid guideline covers the use of these medicines. The cohorts at risk of progression to severe COVID-19 have also been updated by the Independent Advisory Group (IAG), although there are no plans to digitally identify the new cohort of patients as the transition out of pandemic specific arrangements begins. The future model for supply of Covid treatment (Paxlovid) in the community is currently under review and discussion. However, the current BLMK model of triage and supply already allows implementation of the NICE TA recommendations and therefore are no concerns that the guidance will not be implemented within the statutorily required period of 3 months. The following additional points were discussed: • Stock of Paxlovid has now moved to Alliance healthcare and is showing in the Alliance system. This is a change from the previous supply route via Foundry to enable wider community pharmacy supply from 1st July. Molnupiravir stock has also moved to Alliance but is not showing in the system at the current time. • The Drug Tariff price for Paxlovid is not yet available but it is anticipated to be a nominal charge to pharmacies to cover administration. Existing stock of Paxlovid, purchased for the pandemic, is expected to last until approximately December 2024 when this stock expires. • With the move to supply via Alliance, there will be an increase in the number of pharmacies who can supply. An NHS prescription will be required before community pharmacies can dispense i.e. Paxlovid will not be available via private prescription or be able to be exported. • An options paper will be going to the ICB exec for consideration, with the recommendation that a central triage system is maintained on grounds of patient safety. The team at MK Urgent Care already have the expertise in triaging patients and prescribing Paxlovid.	

No	Agenda Item	Action
	• Work is being undertaken to determine whether a list of patients who fall into the highest risk categories, identified by the IAG, may be obtained for BLMK patients in order to facilitate a targeted communication to patients containing details of the local arrangements for access to treatment (from July 2023). If this is not possible patients will only receive the national letter, the draft of which recommends contacting their hospital consultant, NHS 111 or GP. • Development of a template is being undertaken by Ardens to assist with consistency and safety of prescribing. This is expected to be a tool to assist with decision making and identifying of potential drug interactions/appropriate actions to be taken e.g. drug holidays. Further information will be provided at the July APC meeting to update the Committee on the implementation of the NICE TA recommendations and transition out of pandemic specific arrangements. The Committee noted the update.	
14.	**Any other business** None	
15.	**Future Dates for BLMK APC 2023 Meetings (all to be held from 12:30-15:00 via Microsoft Teams):** Wednesday 5th July 2023 Wednesday 27th September 2023 Wednesday 6th December 2023	

Approval of minutes:

Chair: Dr Muhammad Nisar

Signed: 

Date: 24 Jul 2023

Appendix 1 – Approved 18 April 2023 Formulary Subgroup Minutes:

FSG Minutes April 2023 FINAL signed.dc