BEDFORDSHIRE, LUTON AND MILTON KEYNES AREA PRESCRIBING COMMITTEE

Final Meeting Notes

Date: 07 December 2022
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 14:12)	YA	CCS Pharmacy Representative (Community Services Pharmacist, Beds and Luton)
Mojisola Adebajo	MA	Place Based Lead Pharmacist – Luton
Reginald Akaruese	RA	CNWL Pharmacy Representative (Community and Mental Health Services Milton Keynes)
Pritesh Bodalia (until 13:00)	PB	Bedfordshire Hospitals Trust Pharmacy Representative (Chief Pharmacist, Bedfordshire Hospitals Trust)
Dr Samantha Chepkin	SC	Consultant in Public Health
Jacqueline Clayton	JC	Chair of Wound Care Group
Dr Dush Mital	DM	Medical Representative, Milton Keynes Hospital
Naomi Currie (absent 13:27-14:13)	NC	Place Based Lead Pharmacist - Bedford
Matt Davies	MD	Place Based Lead Pharmacist – Central Bedfordshire
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
Carole Jellicoe	CJ	Nurse Representative (Independent Prescriber)
Quynh Nguyen	QN	ELFT Pharmacy Representative – Primary Care
Natasha Patel (from 12:53-14:27)	NP	ELFT Pharmacy Representative – Mental Health Services (Beds and Luton)

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

Dr Kate Randall	KR	Place Based Lead GP – Central Bedfordshire
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 / Bedfordshire Hospitals Trust Pharmacy Representative (Medicines Use and Quality Manager, Bedfordshire Hospitals Trust)

In attendance:		
Rafal Ali	RA	Commissioning Pharmacist, BLMK ICB
Dr Maya Aye	MAy	Medical Representative, Milton Keynes Hospital
Janet Corbett	JCo	Milton Keynes Hospital Pharmacy Representative (Pharmacy Programme Manager, Milton Keynes Hospital)
Taiya Large	TL	Formulary and Medicines Safety Pharmacist, BLMK ICB
Sandra McGroarty	SMcG	Commissioning Pharmacist, BLMK ICB
Dr Joy Mutitika	JM	Medical Representative, Keech Hospice
Raye Summers	RS	PA to MOT, BLMK ICB (admin support)
Nikki Woodall	NW	Lead Medicines Optimisation Technician, BLMK ICB
Dr Chirag Bakhai (for agenda item 5.2 & 7.1)	CB	GP and BLMK ICB Strategic Lead for Long Term Conditions
Aneet Judge (for agenda item 7.1)	AJ	Medicines Optimisation Clinical Programme Manager, BLMK ICB
Iffah Salim (for agenda item 5.5)	IS	ELFT CAMHS Directorate Lead/ MI Pharmacist
Claira Ferreira (observer)	CF	Audit and Compliance Manager, BLMK ICB
Alisha Gandhi (observer)	AGa	Place Based Pharmacist- Luton, BLMK ICB

Apologies:		
Helen Chadwick	HC	Milton Keynes Hospital Pharmacy Representative (Chief Pharmacist, Milton Keynes Hospital)
Marian Chan	MC	Medical Representative, Bedfordshire Hospitals NHS Trust
Dr Mitan Sarkar	MS	Place Based Lead GP - Luton
Dr Sarah Whiteman	SW	Chief Medical Officer, BLMK ICB

No	Agenda Item	Action
1.	**Welcome, Introductions and Apologies** The Chair welcomed everyone to the meeting. Apologies were received and noted as above. The Chair thanked Dr Nigel Fagan (previous Place Based Lead GP – Milton Keynes) for his service to the Committee and welcomed Dr Jon Walter, who will be undertaking this role going forward. The Chair also thanked Alison Borrett, previous Committee Chair, for her service to the Committee. The meeting was confirmed as quorate.	
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. AJ declared a non-financial personal interest in relation to agenda item 7.1. A written declaration has been received and it was noted that AJ declares the interest in meetings of the CGM Diabetes Working Group and has no participation in the decision-making process. Expert opinion is provided on subject matter only. Agenda item 7.1 is for ratification only, and therefore no further action was required for this meeting. CB declared a non-financial professional interest in relation to agenda item 7.1. As above, no further action was required for this meeting. All other members confirmed they have no declarations in relation to matters on the agenda.	
3.	**Minutes of 28 September 2022 APC meeting** The minutes of the meeting held on 28 September 2022 were approved.	
4.	**Matters Arising**	
4.1	**Feedback on miscellaneous actions not included on the agenda from APC meetings**	

No	Agenda Item	Action
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 24/08/2022** - 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	**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 24/08/22** - 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
4.1.3	**Formulary subgroup report – agomelatine** RA to review position of agomelatine on the CNWL formulary and liaise with TL. **Update 10/11/2022** – it has been confirmed that agomelatine is currently non-formulary for CNWL, with no interest to change this position. It was proposed and agreed that this action could be closed.	Close
4.1.4	**COPD Guideline Update** Bevespi and signposting to interpreting services to be added to the guideline. **Update 04/11/2022** – the updates have been completed and the guidelines uploaded to the Medicines website. It was proposed and agreed that this action could be closed.	Close
4.1.5	**BLMK Infant Formulae Prescribing Guidelines** List of changes between the old guidelines and the current version to be produced. **Update 12/10/22** – summary of changes produced and circulated to formulary leads. It was proposed and agreed that this action could be closed.	Close
4.1.6	**Oral Nutritional Supplement Prescribing Guidelines** List of changes between the old guidelines and the current version to be produced. **Update 24/11/22** – list not yet produced due to difficulties with accessing lists of previous formulary choices. Updated ONS recommendations have been added to both the Bedfordshire/Luton Formulary and the MK Formulary, and the guideline has been uploaded onto the Medicines website. No further action required. It was proposed and agreed that this action could be closed.	Close
4.1.7	**Ophthalmology Intravitreal Injection pathway update** Table 1 to be updated, containing additional supportive information to the pathway, and references to CCG changed to ICB. **Update 24/11/22** – updates to the pathway completed and uploaded onto Medicines website. It was proposed and agreed that this action could be closed.	Close

No	Agenda Item	Action
4.1.8	**Ophthalmology Intravitreal Injection pathway update** AL to engage with clinicians at all hospital sites and feedback. **Update 24/11/2022** – update to the guidance shared with ophthalmology specialists across BLMK, but no feedback received, and no concerns raised. It was proposed and agreed that this action could be closed.	Close
4.1.9	**Icosapent Ethyl (NICE TA805)** Review of prescribing data over six months to review usage and uptake. **Update 10/11/2022** – to be fed back to the Committee at the relevant time. This is an ongoing action.	MD
4.1.10	**Icosapent Ethyl (NICE TA805)** Scriptswitch/Optimise messages to be developed to support appropriate prescribing of icosapent ethyl. **Update 22/11/22** – on Scriptswitch/Optimise short-term workplan - updated for Scriptswitch & requested from Optimise. It was proposed and agreed that this action could be closed.	Close
4.1.11	**Icosapent Ethyl (NICE TA805)** Icosapent ethyl to be added as GREEN on both joint Formularies. **Update 10/11/22** – action complete on both Formularies. It was proposed and agreed that this action could be closed.	Close
4.1.12	**Icosapent Ethyl (NICE TA805)** Local adaptation of national lipid pathway to be produced, to include icosapent ethyl, if not produced nationally within two months. **Update 07/12/22** – no update to the national pathway has been published and it is unclear whether this will take place as icosapent ethyl is used for triglyceride management, whereas the national pathway focuses on LDL and non-HDL management.	MD
4.1.13	**Ankylosing Spondylitis Pathway update** To check the final upadacitinib NICE TA and determine whether there are any changes to the FAD, then to finalise and publish the pathway. **Update 12/10/22** – no changes between NICE FAD and final TA. Pathway finalised and uploaded onto the Medicines website. It was proposed and agreed that this action could be closed.	Close
4.1.14	**Psoriatic arthritis pathway update** References to CCG to be updated to ICB. Pathway to be finalised and uploaded onto the Medicines website. **Update 28/10/22** – updates complete, pathway finalised and uploaded to the Medicines website. It was proposed and agreed that this action could be closed.	Close
4.1.15	**Anticoagulation for non-valvular Atrial Fibrillation (NVAF)** Front sheet, with recommendations/clarifications regarding bleeding risk, to be produced as additional information to the national recommendations. **Update 21/10/22** – front sheet with additional recommendations created. Recommendations uploaded to medicines website. It was proposed and agreed that this action could be closed.	Close

No	Agenda Item	Action
4.1.16	**Formulary Subgroup Recommendations** To implement the changes to the FSG recommendations made by the APC: (1) Prasterone pessaries and ospemifene tablets to be Amber 1 on the Milton Keynes joint Formulary. (2) Ogluo to be non-formulary, with no exceptions. Any requests for use will be considered on a case-by-case basis. FSG to be informed of the APC decisions. **Update 15/11/22** – formulary amendments actioned and FSG informed at the November meeting. It was proposed and agreed that this action could be closed.	Close
4.1.17	**Risk sharing / FOC policy update** Additional information to be added to the policy to confirm that it does not apply to Early Access to Medicines Schemes. It was agreed that this will be added to the policy the next time it is updated (as a non-urgent action). **Update 10/11/22** – added to APC workplan, as a non-urgent action. It was proposed and agreed that this action could be closed.	Close
5.	**Items for consideration at meeting**	
5.1	**Ulcerative Colitis Pathway Update** The Ulcerative Colitis pathway was last discussed at the June 2022 APC. Following on from this, a meeting with the gastroenterologists resulted in some minor changes which were agreed by Chair's action in August 2022. At the meeting with the gastroenterologists, it was agreed that the pathway would be revisited and the following additions to the pathway considered for review at the December 2022 APC meeting: • Addition of Ozanimod to the pathway in accordance with NICE TA828, published 5th October 2022. • Extension of the pathway from 4 to 5 lines of therapy to include TNF inhibitor switching as an additional line of therapy. • Dose escalation. Unfortunately, clinicians were unable to provide the required patient numbers to enable a costed paper to be provided relating to the extension of the pathway and dose escalation. NICE published a Final Appraisal Document (FAD) on 25 November 2022 – Upadacitinib for treating moderately to severely active ulcerative colitis. A further amendment has therefore been made to the pathway to incorporate upadacitinib, in accordance with the recommendations in the NICE FAD (final TA publication expected 11 January 2023). The Committee was therefore asked to consider the addition of ozanimod to the pathway in accordance with NICE TA 828, and upadacitinib in accordance with the FAD, only. The other proposed changes to the pathway will be brought back to a future meeting when the costing information is available.	

No	Agenda Item	Action
	The Committee approved the update to the pathway to include ozanimod and upadacitinib (the latter pending publication of the final NICE TA). **EQIA Assessment:** Not assessed – addition to pathway is in accordance with NICE TA. **BLMK ICB E and D Lead comment: N/A**	JC
5.2	**Hypertension guidelines** The Committee considered the revised local hypertension (HTN) guidelines prepared by the BLMK Cardiovascular Disease (CVD) Group and the Medicines Optimisation Team. The guidelines have been developed as the BLMK ICS remains one of the poorest performers in blood pressure management in England. Data from University College London Partners (UCL Partners) indicates that by the end of 2021/22 only 65.8% of patients in BLMK would have BP controlled to target (recorded within previous 12 months). This is 5% below the national average. If the NHS target of 80% was achieved this could prevent 118 heart attacks (up to £0.9 million saved) and 176 stroke (up to £2.4 million saved) in 3 years. New localised evidence-based guidelines have been developed for the management of hypertension in adults under 80 years of age and a separate guidance for those aged 80 years and over. The guidelines have been designed to support use of a simplified and streamlined algorithm for hypertension management across BLMK. The guidance incorporates nationally recommended treatment options for hypertension tailored to the needs of the local population, but taking into account individual patient factors e.g. age, comorbidities, renal function when applicable. The first draft of the local guidelines presented at the September APC differed from NICE Guidance in a number of aspects, but the revision of the recommendations since last meeting have brought the BLMK guidelines into alignment with the NICE guidance, but with additional guidance included on the choice of agents and recommended doses. The three key principles of the BLMK guidance are: • Standardising agents and doses can support more efficient treatment to target with better balance between efficacy and side effect burden. • While initial monotherapy is recommended, avoiding delay in escalating to dual therapy is encouraged (particularly in those with stage 2/3 HTN). • As appropriate, patients may be empowered to intensify treatment according to self-monitoring and tolerability (e.g. postural symptoms) Limited additional drug costs are anticipated however savings will be generated from reduced GP/HCP contacts, and also from reduced requirement for phlebotomy/pathology.	

No	Agenda Item	Action
	The Committee discussed the following points: • BLMK is under-resourced in terms of clinical workforce in comparison with many other areas, which impacts on the up titration of hypertension treatment. • CKD staging (as risk factor) – it was raised that the guidance recommends, in accordance with NICE CKD guidance, that ARB are titrated to maximum dose for those with CKD and that an eGFR < 90ml/min is classed as CKD 2. This could include a large cohort of patients. It was clarified that the latest CKD guidance only classifies a patient as being CKD and requiring ARB if they had an eGFR below 90ml/min and urine ACR > 30. A link will be provided in the guidelines to clarify. • Dosage recommendations are more cautious in the pathway for those aged 80 years or older, as there is more risk of frailty for this patient cohort. It is also recommended that individual patient circumstances, such as frailty and renal function, are taken into account when initiating treatment under both guidelines. • The approach proposed in the BLMK guidelines is likely to work best in patients who have a blood pressure monitor at home, so that they can measure and track their own blood pressure. Practices across BLMK have blood pressure monitors which they can lend to patients who need them. • The need for clear, accessible information for patients was discussed and it was agreed that a template/leaflet will be produced to provide information to patients and support the communication of the treatment plan. Consideration will also be given to making the information available in different languages. This will be uploaded onto the Medicines website alongside the pathways and other resources. • Further work is being undertaken on inequalities/inequities and hypertension. The Committee approved the hypertension guidelines, subject to an amendment being made to clarify the information in relation to CKD. Supporting associated documents will be produced to complement the guidelines and aid the provision of information to patients. **EQIA Assessment:** No impact anticipated – as the hypertension guidelines are not mandatory then clinicians can use their clinical discretion when following these guidelines. The age applicability of 80 years and less reflects current NICE and ESC recommendations on adopting different approaches / targets in managing hypertension. **BLMK ICB E and D Lead comment:** These guidelines are for treating people potentially already at risk of falls (protected characteristic of age/disabled?) and may not be able to comprehend fully the consequences of adding another treatment to their regime please consider the impact of this and how to ensure that the patient understands and perhaps have an easy read summary of when to	MD MD

No	Agenda Item	Action
	add the 2nd agent which may include informing the GP? – Please discuss and include conclusion of discussions.	
5.3	**GLP-1 Agonist Guideline** The existing Bedfordshire and Luton shared care guideline (SCG) for Glucagon-like Peptide 1 (GLP-1) Agonists is out of date and needed to be reviewed. The ongoing need for a SCG for GLP-1 agonists was reviewed and the following proposals were presented to the Committee, by the Medicines Optimisation team and Diabetes Long-Term Conditions Group, for consideration: • Retiring the current Bedfordshire and Luton SCG and adopting a guideline for use across BLMK to support clinicians prescribing GLP-1 agonists. • Review the GLP-1 agonist traffic light designations in the Bedfordshire and Luton Joint Formulary from SCG Amber to Green to align with Milton Keynes Joint Formulary (MK formulary status is Amber 2 for injectable GLP-1 agonists). • Oral semaglutide (Rybelsus®) to be included as first line choice with other formulary choice GLP-1 agonist injectables and change traffic light designation in MK Formulary to Amber 2, and Bedfordshire/Luton formulary status to Green. • Expand initiation of all GLP-1 agonists to include healthcare professionals (HCP) in GP Practice with relevant expertise and experience in management of type 2 diabetes(T2DM). • GLP-1 agonist and insulin combination use only with specialist care advice and ongoing support from a consultant-led multidisciplinary team or Diabetes Specialist Team. The following points were discussed: • Oral semaglutide is recommended to move to joint first line treatment for patients not suitable for injectables, or for patients who would prefer oral treatment. • The wording in relation to oral semaglutide is to be reviewed to ensure that it is clear that the same clinicians may initiate oral semaglutide as injectable GLP-1 agonists. • The guideline is supported by specialists across BLMK, within both primary and secondary care, and the Diabetes Long-Term Conditions group. • Clarification required within the Formulary monographs which clinicians may initiate GLP-1 agonists. • GLP-1 agonist/insulin combination – the use of this combination is associated with further restrictions i.e. *only offer combination therapy with a GLP-1 agonist and insulin along with specialist care advice and ongoing support from a consultant-led multidisciplinary team or* ***Diabetes Specialist Team.*** • Concerns were discussed in relation to the change from Amber SCG to Green status on the Bedfordshire/Luton Formulary, and that there could be an inequity between Green for Bedfordshire/Luton and Amber 2 for Milton Keynes.	MA MA/TL

No	Agenda Item	Action
	However, it was agreed that the connotation for each is the same – GLP-1 agonists may be prescribed by clinicians in both primary and secondary care in accordance with guidance. • Switching onto oral semaglutide from subcutaneous – concerns were previously raised in Milton Keynes about this switch which led to the current MK formulary status (Amber 3). This is due to the high pharmacokinetic variability of oral semaglutide. Information is included in the local guideline to support clinicians in this scenario and wording can be added to the formulary to highlight this to clinicians. • Optimise/Scriptswitch messages need to be added accordingly to aid clinicians with GLP-1 agonist initiation – MA to work with NW. • Exenatide/lixisenatide to be retained on the formularies as restricted items, rather than being moved to non-formulary to ensure it is clear that existing patients may remain on treatment. The guideline was approved subject to clarification of the wording in relation to oral semaglutide and addition of information to the Formularies and development of Scriptswitch/Optimise messages to provide support to clinicians prescribing GLP-1 agonists. **EQIA Assessment:** Not assessed. **BLMK ICB E and D Lead comment:** N/A	MA/TL MA/NW TL/JCo
5.4	**Management of Gout – NICE NG 219** The Committee reviewed and discussed the guidance issued by NICE in their guideline "Gout: diagnosis and management" (NG219). It was proposed that the NICE visual summaries are adopted and promoted by the APC, with the caveat that Prescribers should read the information alongside the Milton Keynes Joint Formulary and the Bedfordshire and Luton Joint Formulary selecting local Formulary choices from the NICE list of suitable medicines. Visual summary 1: Long-term management of gout with ULTs Visual summary 2: Management of gout The Committee noted the change in recommendations placing febuxostat alongside allopurinol as a joint first line urate-lowering therapy (ULT) treatment choice. The implementation of the recommendations may result in an increase in GP consultation appointments to monitor ULT, however these could be offset by a reduction in the number of appointments required to treat patients with acute flare attacks. Implementation of the guidance is estimated to cost around £36,000 in 2022/2023 rising to £180,000 by 2026/2027. Formulary amendments to the traffic light status of febuxostat and colchicine were agreed at the Formulary Subgroup meeting on 15 November 2022 (see agenda item 9.1).	

No	Agenda Item	Action
	The following points were discussed: • Annual urate monitoring is recommended to ensure treatment is effective and optimised and to help ensure adherence to treatment. • GP training – the NICE guidance reflects current training for GP trainees, with the exception of the inclusion of febuxostat as a first line ULT option. Adherence to ongoing treatment was noted to be problematic for this patient cohort as patients may not recognise the rationale for long-term treatment or the risks associated with gout e.g. long-term joint damage. • Patients with gout are often seen at the walk-in centre and may not be followed up adequately thereafter by their GP practice. • Clinicians are unlikely to start ULT following a first attack. The acute attack will be managed with consideration of other general wider co-morbidities e.g. screening for cardiovascular risk. • Of the 209 types of arthritis currently discovered, gout is the only curable arthritis. 50% of patients with gout die of cardiovascular disease, therefore gout should be seen as a likely marker for other underlying conditions. • If patients adhere to treatment and can maintain urate levels below 360 micromol/litre, or 300 micromol/litre for patients with tophi or other signs of complications, then it is likely that the patient may be cured. • Urate levels should be checked two weeks after an acute attack, not at time of attack, as urate levels may be falsely low at the time of the attack. • IL- inhibitors are secondary care only treatment options for gout: these are little used and expensive treatments, which are currently non-formulary (IFR would be required). Use is very uncommon and IL-1 inhibitors have generally only been used in the past in patients who have been in hospital for a long stay. The Committee ratified the NICE guideline and agreed that the NICE visual summaries should be used as a tool to promote the new guideline to primary care clinicians. **EQIA Assessment:** N/A as following NICE NG recommendations **BLMK ICB E and D Lead comment:** N/A	
5.5	**Paediatric ADHD shared care guideline** The paediatric ADHD shared care guideline (SCG) was originally presented to the Formulary subgroup for consideration in November 2021. Several amendments were requested at that time. The SCG has subsequently been reviewed and was presented to the Committee with amendments made to clarify wording, responsibilities, age range of persons covered by the guideline (6-17 years), and reference to transfer of care removed. A general review and update of drug table information has also been completed.	

No	Agenda Item	Action
	The following Key Points were noted: • Patients will only be referred into the medication pathway if family interventions and psychotherapy are not successful. Medication is not a first line treatment option for children and young people with ADHD – it is one part of a package of care, and there is currently a separate waiting list within ELFT CAMHS to commence medication. • Treatment with medication will not necessarily correspond to diagnosis rates as it is not first line, nor is it a suitable treatment for all patients. • At the current time monitoring of prescribing cohorts is difficult within ELFT as prescriptions are issued as paper FP10s. However, ELFT are trialling an e-prescribing module called Cleo will should help with gathering 'live' prescribing data in the future. • Accessible information – there is a quality standard used within CAMHS, and this is something which ELFT monitor. CAMHS have a range of leaflets available which have been designed for different populations, such as learning disabilities. There is accessible information available for use by children/families and ELFT are currently using some leaflets which were developed by CNWL. ELFT are also about to undertake a piece of work with parents/carer and young people to design more accessible information resources such as leaflets, animations or videos. • Wording to be added to state that it is a shared care guideline (this wording had previously been omitted) and also to stipulate that the SCG currently applies to Bedfordshire and Luton only (not Milton Keynes, though the goal going forward would be to work towards having one SCG across the whole of BLMK). • On some occasions, specialists are experiencing 'push back' from primary care on commencing shared care prescribing if a patient has been on treatment for less than 3 months. This is due to the wording in the SCG in relation to the stabilisation of the treatment prior to a request for shared care being made to the GP. It was agreed that the wording should be amended to make it clear that specialists should retain prescribing until the patient is stable, or for 3 months, whichever is sooner (minimum 28 days). • Requirement for patient to be stable applies to initial and subsequent mediation choices – wording to be amended to clarify this point. • The Committee discussed the treatment of 5-year-olds with ADHD medications, as the SCG currently covers children and young people aged 6-17 years of age. It was noted that this would be an off-label use, as the medications are licensed for use from age 6. It was agreed that a caveat should be added to the SCG regarding use of ADHD medications in 5-year-olds, but that prescribing for this patient cohort should be retained by the specialists until the child reaches the age of 6.	

No	Agenda Item	Action
	The Committee approved the shared care guideline with the amendments agreed at the meeting: • Addition of 'shared care guideline' in the document title. • Wording to be added to clarify that the SCG currently only applies to Bedfordshire and Luton. • Amendment to the wording in relation to the initial stabilisation period/commencement of shared care to clarify that it may be sooner than 3 months if the patient is stable on treatment. • Clarification to be added to ensure that patients are stabilised on treatment, prior to primary care clinicians undertaking prescribing/shared care, for first and subsequent medication choices. • Information to be added regarding prescribing for 5-year-olds. **EQIA Assessment:** No equality issues identified – ADHD SC for YP is as per national recommendations and no issues have been identified. Treatment should be offered to all CYP who meet the criteria for pharmacological intervention. **BLMK ICB E and D Lead comment:** • The guideline itself doesn't have a title stating 'Shared Care Guideline'. • Patients in this cohort may not be able to comprehend their treatment fully – ensure patients/carers have information in compliance with the accessible information standard. Will there be monitoring of prescribing to ensure that the higher prevalence of the diagnosis leads to a higher level of prescribing reflective of the evidence? This would be one way of identifying how to reduce health inequalities in young males.	IS
5.6	**Shared Care Patient Information Leaflet** When the latest update to the Shared Care Guideline Template was approved by the APC, it was agreed that a Patient Information Leaflet Template would be produced for Provider Trusts to use. As agreed by the APC, previous drafts of the leaflet went out to consultation by some GPs, a Secondary Care Consultant and the Committee Lay Representative. The APC was asked to review the 4th draft of the patient leaflet. The Committee discussed the following points in relation to the patient information leaflet: • The section containing pharmacy contacts is to be removed as it was agreed this information is not required. • Acute Trust representatives indicated that the leaflet would need to go through their Trust Documentation Committee (or equivalent) and if approved, may need to have the provider logo added instead of the NHS lozenge and instead of/in addition to the BLMK Health and Care Partnership logo. Acute Trust pharmacy representatives agreed to look into this and feed back.	

No	Agenda Item	Action
	• The leaflet is designed to be a back up for the discussion with the patient, to give the patient information to take away with them which could also be shared with families/carers to ensure it is understood what shared care is and how it works. • The Committee discussed the practicality of including a specific date for the initiation of shared care/commencement of primary care prescribing and it was suggested that the field which requires a date to be entered could be replaced with more generic text e.g. "when specialist considers it appropriate/safe to do so". Consultation on earlier drafts of the leaflet had indicated that it was likely to be more useful to the patient if a specific date is included and feedback from Rheumatology nurses had not indicated that including this information would be a problem. • One option is to change to a generic leaflet about shared care, to avoid the need to individualise the template each time it is issued to a patient, but it is likely to be more useful to the patient if it is more specific to their treatment. The Committee agreed that the leaflet would be taken back to the acute Trusts to get further formal feedback and can be brought back to the Committee when this has been undertaken. **EQIA Assessment:** Not assessed – procedural document **BLMK ICB E and D Lead comment:** N/A	JCo/DW
6.0	**NICE Guidance – 15th September to 23rd November 2022** **The following NICE Technology Appraisal Guidance (ICB Commissioned) have been published:** **Vedolizumab for treating chronic refractory pouchitis after surgery for ulcerative colitis (terminated appraisal)** Technology appraisal [TA826] Published: 21 September 2022 https://www.nice.org.uk/guidance/ta826 **APC action:** none – terminated appraisal. **Upadacitinib for treating active ankylosing spondylitis** Technology appraisal guidance [TA829] Published: 30 September 2022 https://www.nice.org.uk/guidance/ta829 Resource impact: NICE do not expect this guidance to have a significant impact on resources. **APC action:** link added to Formularies (RED traffic light). Ankylosing Spondylitis Treatment Pathway reviewed, and updated to include upadacitinib, at the September APC. NB: fast track appraisal with 30-day implementation.	

No	Agenda Item	Action
	Ozanimod for treating moderately to severely active ulcerative colitis Technology appraisal guidance [TA828] Published: 05 October 2022 https://www.nice.org.uk/guidance/ta828 Resource impact: NICE do not expect this guidance to have a significant impact on resources. **APC action:** created and link added to Formularies (RED traffic light). Ulcerative Colitis Treatment Pathway discussed under agenda item 5.1. **Relugolix–estradiol–norethisterone acetate for treating moderate to severe symptoms of uterine fibroids** Technology appraisal guidance [TA832] Published: 19 October 2022 https://www.nice.org.uk/guidance/ta832 Resource impact: NICE do not expect this guidance to have a significant impact on resources. **APC action:** for initiation and stabilisation by specialists prior to primary care prescribing. To be added to both joint Formularies with Amber (Bedfordshire and Luton) / Amber 3 (Milton Keynes) status. **Fostamatinib for treating refractory chronic immune thrombocytopenia** Technology appraisal guidance [TA835] Published: 19 October 2022 https://www.nice.org.uk/guidance/ta835 Resource impact: NICE do not expect this guidance to have a significant impact on resources. **APC action:** created and link added to Formularies (RED traffic light). **Slow-release potassium bicarbonate–potassium citrate for treating distal renal tubular acidosis (terminated appraisal)** Technology appraisal [TA838] Published: 02 November 2022 https://www.nice.org.uk/guidance/ta838 **APC action:** none – terminated appraisal. **The following NICE Guidelines (NG) (Medicine related and ICB Commissioned) have been published / updated by NICE:** **Osteoarthritis in over 16s: diagnosis and management** NICE guideline [NG226] Published: 19 October 2022 https://www.nice.org.uk/guidance/ng226 **APC action**: none – no significant changes to medicines recommendations. **Fractures (complex): assessment and management** NICE guideline [NG37] Published: 17 February 2016 Last updated: 23 November 2022 https://www.nice.org.uk/guidance/ng37	AG/JCo

No	Agenda Item	Action
	APC action: none – medicines recommendations link to 2016 guidelines: NICE guideline on major trauma. **The following NICE TAs are the commissioning responsibility of NHSE and are listed for information only:** **Avacopan for treating severe active granulomatosis with polyangiitis or microscopic polyangiitis** Technology appraisal guidance [TA825] Published: 21 September 2022 https://www.nice.org.uk/guidance/ta825 **APC action:** It was noted that the NICE guidance states that "Providers are specialist centres with expertise in the management of ANCA-associated vasculitis". The Committee heard that the decision to prescribe Avacopan would be made by a regional MDT but is likely to be administered locally. To be added to both joint Formularies as Red, in accordance with the NICE TA guidance and following recommendation by a regional specialist MDT. **Atezolizumab for adjuvant treatment of resected non-small-cell lung cancer** Technology appraisal guidance [TA823] Published: 28 September 2022 https://www.nice.org.uk/guidance/ta823 **APC action:** link added to Formularies **Olaparib for previously treated BRCA mutation-positive hormone-relapsed metastatic prostate cancer** Technology appraisal guidance [TA831] Published: 05 October 2022 https://www.nice.org.uk/guidance/ta831 **APC action:** link added to Formularies (NB – not recommended) **Oral azacitidine for maintenance treatment of acute myeloid leukaemia after induction therapy** Technology appraisal guidance [TA827] Published: 05 October 2022 https://www.nice.org.uk/guidance/ta827 **APC action:** link added to Formularies **SQ HDM SLIT for treating allergic rhinitis and allergic asthma caused by house dust mites (terminated appraisal)** Technology appraisal [TA834] Published: 12 October 2022 https://www.nice.org.uk/guidance/ta834 **APC action**: none – terminated appraisal **Zanubrutinib for treating Waldenstrom's macroglobulinaemia** Technology appraisal guidance [TA833] Published: 19 October 2022 https://www.nice.org.uk/guidance/ta833 **APC action:** created and link added to Formularies **Pembrolizumab for adjuvant treatment of renal cell carcinoma** Technology appraisal guidance [TA830] Published: 19 October 2022 https://www.nice.org.uk/guidance/ta830 **APC action:** link added to Formularies	AG/JCo

No	Agenda Item	Action
	Pembrolizumab for adjuvant treatment of resected stage 2B or 2C melanoma Technology appraisal guidance [TA837] Published: 26 October 2022 https://www.nice.org.uk/guidance/ta837 **APC action:** link added to Formularies **Palbociclib with fulvestrant for treating hormone receptor-positive, HER2-negative advanced breast cancer after endocrine therapy** Technology appraisal guidance [TA836] Published: 26 October 2022 https://www.nice.org.uk/guidance/ta836 **APC action:** link added to Formularies **Ruxolitinib for treating acute graft versus host disease refractory to corticosteroids (terminated appraisal)** Technology appraisal [TA839] Published: 16 November 2022 https://www.nice.org.uk/guidance/ta839 **APC action:** none – terminated appraisal **Ruxolitinib for treating chronic graft versus host disease refractory to corticosteroids (terminated appraisal)** Technology appraisal [TA840] Published: 16 November 2022 https://www.nice.org.uk/guidance/ta840 **APC action:** none – terminated appraisal **Tisagenlecleucel for treating follicular lymphoma after 2 or more therapies (terminated appraisal)** Technology appraisal [TA842] Published: 22 November 2022 https://www.nice.org.uk/guidance/ta842 **APC action:** none – terminated appraisal **Carfilzomib with daratumumab and dexamethasone for treating relapsed or refractory multiple myeloma (terminated appraisal)** Technology appraisal [TA841] Published: 22 November 2022 https://www.nice.org.uk/guidance/ta841 **APC action:** none – terminated appraisal	
7.0	**Virtual Recommendations/Documents**	
7.1	**Blood glucose monitoring update** Following the publication of NICE Guidance 17, 18 and 28, the BLMK Area Prescribing Committee supported the implementation of the NICE Guidelines relating to blood glucose monitoring in the management of diabetes but recommended no change in practice pending (1) ongoing discussions with specialist teams; (2) clarification of Continuous Glucose Monitoring (CGM) costs and information on new products; (3) clarification of the BLMK ICS funding position. The BLMK ICS Transitional Interim Leadership Team (TILT) supported the recommendation of the APC to implement the NICE guidelines and recognised the need to reduce health inequalities and make newer technology available to patients. Due to in-year budgetary constraints, implementation of the NICE guidelines will be phased. TILT has approved an in-year additional expenditure of £700,000 which should allow a steady implementation with	

No	Agenda Item	Action
	immediate effect. Patient groups were not defined within this decision. Trusts were asked to retain responsibility for initiation and to continue to prioritise those patients they feel would benefit most from the new technology. The BLMK CGM Diabetes working group has agreed the following recommendations: • Universal access to CGM technology for adults and children with type 1 diabetes. This will be implemented in a phased approach by diabetes specialist teams during the course of routine clinical care. • To provide access to CGM for people with type 2 diabetes on multiple daily injections. There is a single criterion for local initiation which is that there is a multi-disciplinary team (MDT) recommendation that CGM is clinically indicated for that individual. Initiation will occur during the course of routine clinical care. • Patients previously eligible for isCGM e.g. patients with cystic fibrosis or learning disabilities and on insulin treatment, under the NHS England criteria, continue to be eligible for CGM. • The working group has agreed on local preferences for CGM devices – see also agenda item 9.1. First and second line device choices reflect considerations such as licensing, affordability, insulin pump integration and the need for follow-on functionality. • For devices available on FP10 (Dexcom One, FreeStyle Libre 2 and GlucoRx Aidex), specialists will initiate the device and provide any necessary education, then send a letter to the GP communicating all the necessary details and request the GP take over prescribing. The template letter was circulated to the Committee for approval alongside the CGM Diabetes working group's recommendations. • For devices only available via the NHS Supply Chain (Dexcom G6, Dexcom G7 and Freestyle Libre 3), specialists will initiate the device, provide any necessary education and retain ongoing prescribing responsibility. A letter will still be sent to the patient's GP to inform them that CGM has been initiated. • Blood glucose testing strip choices should be reviewed on commencement of CGM, in line with BLMK Joint Formulary choices. • Blueteq funding forms will only be required for devices available via the NHS Supply Chain (NHSSC), to enable the payment of invoices and good financial governance. Completion of funding forms is not required for devices available on FP10. The Committee discussed the following points: • The BLMK CGM Diabetes working group is aware of this year's budgetary constraints and does not anticipate any overspend. To mitigate against any potential overspend	

No	Agenda Item	Action
	spend on devices expenditure will be monitored monthly, at place. • Discussions are ongoing in relation to the use of CGM in pregnant women with type 2 diabetes, who are on a basal bolus insulin regimen. • There are known health inequalities in relation to the uptake of isCGM (FreeStyle Libre 2) across BLMK, which has been identified from East of England and national prescribing data. Work is being undertaken with the business intelligence team within AGEM CSU to bring together data on all CGM prescribing (FP10 and NHSSC). This will allow tracking of all prescribing and analysis in relation to age, ethnicity, gender, deprivation and place. This can then be broken down to PCN and GP practice level to track uptake amongst different groups of patients and then work on identifying possible solutions to any variance in uptake. • Patient engagement work (with type 1 diabetic patients) is planned for late Spring 2023 which will seek to explore reasons for low CGM uptake and possible solutions which could help increase uptake and reduce inequalities. The Committee approved the CGM Diabetes working group's recommendations, and associated template letter. **EQIA Assessment:** A full EQIA is currently in progress.	
7.2	**BLMK APC Terms of Reference update** The Committee considered updates to the APC Terms of Reference (TOR) to include: • Amendments to membership section • Minor amendments for clarification of terms The above changes were approved virtually by the Committee (quorate response received). In addition, it was proposed during the virtual consultation period that an amendment to the membership section should be made to clarify the options for Chair of the APC. The Committee agreed that the Chair may be "Consultant in Public Health, Non-Executive Member, Lay member or BLMK ICS Clinician". The Committee approved the proposed amendments to the APC Terms of Reference.	AG
8.0	**Medicines Safety update** A Primary Care Medicines Safety Update and a Medicines Safety Group (MSG) Update was presented to the committee. **<u>Primary Care Medicines Safety Update</u>** This update focused on the primary care response to the MHRA Drug Safety Updates (August to October 2022). In particular:	

No	Agenda Item	Action
	Methylphenidate long-acting (modified-release) preparations: caution if switching between products due to differences in formulations Prescribers and dispensers should use caution if switching patients between different long-acting formulations of methylphenidate (Concerta XL, Medikinet XL, Equasym XL, Ritalin LA, and generics) as different instructions for use and different release profiles may affect symptom management. **Action(s) taken:** Review of Scriptswitch and Optimise entries to guide prescribers and raise awareness of the alert. Information added to the Formularies and the DSU will be included in the Primary Care Newsletter for dissemination. **MedSafetyWeek November 2022: Every Yellow Card report helps to improve patient safety** The seventh annual #MedSafetyWeek social media campaign took place 7 to 13 November 2022 and this year's focus was the importance of reporting suspected adverse reactions to medicines and vaccines. The MHRA encouraged the reporting of suspected problems with medical devices or other healthcare products to the Yellow Card scheme. Healthcare professionals were asked to support the campaign and talk to their patients and colleagues about side effects and how they can report suspected problems to the Yellow Card scheme. **Action(s) taken:** Information included in BLMK Primary Care Newsletter and discussed at the Medication Safety Group to raise awareness of the importance of Yellow Card reporting. The following NPSA alert was also released: **National Patient Safety Alert: Class 1 Medicines Recall Notification: Recall of Targocid 200mg powder for solution for injection/infusion or oral solution, Aventis Pharma Limited t/a Sanofi, due to the presence of bacterial endotoxins, NatPSA/2022/008/MHRA** **Action(s) taken:** Information has been included in the Primary Care newsletter advising on the alert, specifically signposting identified patients who may have suffered the symptoms to be reported via the yellow card system, removal of affected batches (if applicable) and seeking of microbiology advice, where clinically appropriate. The alert has also been discussed at MSG and the Trusts have confirmed the appropriate actions have been taken within secondary care. **Omnipod dash field safety notice** Notification received of battery packs overheating within the insulin management system Field Safety Notice - October 2022 | Omnipod. The team managing pumps have been made aware of this alert and the information disseminated via MSG to secondary care to monitor the situation and take action as appropriate.	

No	Agenda Item	Action
	Medicines Safety Group Update The last MSG was held on 3rd November 2022 with updates given on the following projects: **Sodium Valproate Pregnancy Prevention forms** The team are in the process of identifying the barriers to completion of the forms and are exploring new ways of working to increase compliance. An audit has been conducted which identified the need for more staff training and patient education. The group explored a potential GP and pharmacist led pilot scheme which will be taken forward as part of the project. **Insulin Incidents** The group have identified a new project for 2023 around insulin incidents. The MSG is scoping this system wide with the aim of reducing errors in relation to the prescribing and administration of insulins across BLMK. Next steps are to gather and collate types of incidents observed and develop a stakeholder list for the project. **MedSIP targets** Ongoing progress with MedSIP targets will be monitored via development of a dashboard and reported periodically at the MSG.	
9.0	**Formulary Update**	
9.1	**Formulary Subgroup Recommendations** The following recommendations were made by the BLMK Formulary subgroup at the 15th November 2022 meeting: • **Colchicine for acute gout designation change** – Request received to change the designation from Amber to Green for gout to align the Milton Keynes Formulary (MKF) with Bedfordshire & Luton Formulary. Green is also more reflective of current practice therefore the change was approved. No cost impact is envisaged. • **Febuxostat for gout designation change** – NICE guidance for management of gout was published in June 2022. The recommendations included febuxostat as joint first line therapy for treatment of gout alongside allopurinol. The request to amend febuxostat from Amber/Amber2 to Green on the Formularies was approved. No cost impact is envisaged. • **Flurbiprofen removal from Formulary** – Request to remove flurbiprofen from the MK formulary was approved. There is no prescribing of the medication according to data. • **Canakinumab for gouty arthritis** – Milton Keynes confirmed there is no use of the product therefore it was removed to align with Beds/Luton. No cost impact is envisaged. • **Fixkoh Airmaster for asthma and COPD** – Fixkoh was presented as a cost-effective alternative to Seretide accuhaler. The group concluded there were no significant cost savings to be made as there is no clear place for Fixkoh	

No	Agenda Item	Action
	on the Formularies. Fixkoh to be placed in the Non-Formulary section on both Formularies. • **Mefenamic acid for menorrhagia and dysmenorrhea designation change** – Request received to amend the traffic light from Amber2 to Green. The group agreed it would be restricted to first line use only in patients that require a reduction in blood flow, e.g. patient with both menorrhagia and dysmenorrhea and noted it would be for short term use. Due to cost differences, only the capsules would be included on the Formularies. • **Trurapi pre-filled pens - biosimilar insulin aspart** – Trurapi is a biosimilar insulin aspart with close similarity to Novorapid, with a 30% cost saving over the originator brand. Due to a shortage of Novorapid, leading to local reports of patients not being able to access their insulin, this was initially approved by Chair's action, and then followed up with full discussion at the Formulary Subgroup. The Formularies will recommend Trurapi as the preferred option for new patients, with opportunistic switching of existing patients where appropriate. Although the look, device operation & pharmacokinetics are highly similar, the group noted the requirement for closer monitoring of blood glucose following a switch as some patients may respond differently to the biosimilar. This requirement dissuaded the group from active switching due to the number of patients on Novorapid. Novorapid will remain on the Formulary alongside Trurapi. Cost impact of decision: Cost saving for switched patients – 30% reduction versus Novorapid. If 100% switch saving is in the order of £220,000 for BLMK. • **Softacort eye drops for dry eyes** – Softacort eye drops contain a weak steroid (hydrocortisone). It has the benefits of having a lower impact on intraocular pressure through a reduction in corneal penetration. It is also preservative free. Softacort is already on Bedfordshire & Luton Formulary (B&LF) so request is to add as Amber 3 to the Milton Keynes Formulary (MKF). The request was approved. Cost impact of decision: Cost saving through disinvestment in prednisolone drops (40% less). • **Azathioprine Shared Care Guidance (SCG)** – the Milton Keynes azathioprine SCG for inflammatory bowel disease was updated to include autoimmune hepatitis patients as an interim measure until such time as the national RMOC SCG is reviewed and adopted for use in BLMK. Bedfordshire Hospitals NHS Foundation Trust clinicians agreed to adopt the updated local guidance, which will be adapted and updated to apply across the whole of BLMK. There is a possible small cost pressure within primary care as patients move across under the new indication. • **Ethinylestradiol 30 mcg / drospirenone 3 mg tablets for contraception** – Request to amend the designation on B&LF from Red and remove wording to stipulate Yasmin and associated brands can only be prescribed by Luton Sexual Health Clinic. The group agreed a Green designation with	

No	Agenda Item	Action
	additional advice relating to brand prescribing and cost-effective choices. No cost impact is envisaged. • **Norditropin growth hormone designation change** – Request to change the designation of norditropin growth hormone on the Formularies from Red to Amber. Norditropin was noted to be more accepted by patients as the carrier does not result in as much stinging versus other preparations. There are a number of patients in MK who are receiving the preparation from their GP, outside of BLMK guidance, which stipulates this preparation is to be retained by secondary care due to a large cost difference for primary care (£8 more per dose). This is in line with PAC recommendations. The group concluded that existing patients may remain in primary care as to expedite back to secondary care would not be possible due to capacity issues. The application was not approved – remains Red on both Joint Formularies – any new patients must be retained in secondary care. The possibility of a rebate will be explored following on from this to attempt to align pricing. No cost impact is envisaged. • **Dexcom ONE & GlucoRx Aidex** – Application to add two cost-effective continuous glucose monitors, available on FP10, to the Formularies. Funding has already been approved by TILT and a working group formed to produce guidance on priority cohorts. Until guidance available, specialists initiate and decide on priority patients in the interim. Decision: Add both devices to the Formularies with designation Amber/Amber 3. • **Ephedrine 0.5% nasal drops** have been removed from the Drug Tariff (DT) – therefore amend Green to OTC on the Formularies. Action: To update Formularies. • **Hypromellose 0.3% eye drops** were removed from the DT, resulting in a high cost increase for prescribing as an unspecified item. Evolve brand has now been listed as the Formulary choice to avoid high charges. Action: To update Formularies. • **Denosumab SCG** – The group were requested to ratify some minor changes to the SCG. Removal of eGFR and replace with CrCl <30ml/min in the guidance and amend supply source in primary care as Movianto no longer supply denosumab. The changes were approved. The Committee ratified the recommendations of the Formulary Subgroup.	
9.2	**Wound Management Formulary Steering Subgroup Recommendations** The following products were proposed by the subgroup for addition to the Bedfordshire and Luton Wound Care Formulary for ratification by the APC: • UrgoClean AG, a silver hydrocolloid dressing (replacement for Kerracontact Ag, which was the first line silver dressing for Bedfordshire and Luton but is no longer available via NHS	

No	Agenda Item	Action
	Supplies). This is expected to be more cost effective than Kerracontact Ag, both in terms of actual dressing costs and in number of dressings required. • Debriclean, a more cost effective and efficient debridement pad, with potential to improve patient outcomes with faster debridement/healing (to replace Debrisoft). In addition, the APC noted an update on changes to the Bedfordshire and Luton Wound Management Formulary for information only. The Wound Care Subgroup is working towards aligning Formularies between Bedfordshire / Luton and Milton Keynes. Within Milton Keynes, MKUH and CNWL are meeting regularly to ensure that their formulary choices are aligned. The Committee ratified the recommendations of the Wound Management Formulary Steering Subgroup.	

10.	**Antimicrobial Resistance Update**
	An antimicrobial resistance (AMR) update was presented to the Committee:
	
	• There are two system oversight targets antibiotic prescribing in place for primary care:
	  ○ Total antibiotic usage: the current target is 0.871 items/STAR-PU (total antibiotic items issued adjusted for population units), which is proving difficult to meet. Only one system across the East of England is managing to achieve this. BLMK is currently achieving 0.939 items/STAR-PU.
	  ○ Broad spectrum antibiotics: the current target is <10% of total antibiotic prescribing. This is currently being achieved in BLMK with 8.5%.
	• A Regional Medicines Optimisation Committee (RMOC) Antimicrobial Prescribing Medicines Optimisation group has been formed, which NC is joining. The first meeting took place in September 2022 and any relevant updates will be shared with the APC going forward.
	• Sarah Whiteman is the senior responsible officer for AMR for BLMK.
	• A meeting is scheduled for the BLMK AMR group in January 2023.
	• Within secondary care, the focus is on IV to oral switching, which is being facilitated by the East of England regional AMR team.
	• BLMK Primary Care Guideline webpage - collaborative work has been undertaken with BLMK HCT to produce a BLMK Primary Care Antimicrobial Guideline webpage, which is available to use as a resource by all primary care clinicians. A link will be available to this webpage from the BLMK Medicines website.
	
	The Committee also discussed the following points in relation to Group A Streptococcus (GAS) infections:	

No	Agenda Item	Action
	• There is plenty of stock of penicillin in the system, but the challenge is ensuring it is in the right places. • Advise is being sent out to practices about issuing EPS tokens rather than sending prescriptions to individual pharmacies, as this will make it easier for patients to visit an alternative pharmacy in order to fill their prescription. • There is increased demand for antibiotic liquid supply, and a 5-fold increase in antibiotic liquid prescribing/ dispensing has been observed in one pharmacy. • SPS is producing guidance on using solid oral dosage form antibiotics in children to include guidance on crushing penicillin tablets and opening amoxycillin capsules (this guidance was issued by SPS during the APC meeting, and the link was shared with Committee members). • BHFT has produced guidance for alternative antibiotics which may be used if penicillin is not available. • National clinical guidance is imminently anticipated on the management of GAS. • Walk-in centre is extremely busy with potential GAS cases. • Links to useful guidance / webpages which contain information on the administration of solid dosage forms to children were shared with the Committee via the Teams 'chat' function. • Local guidance on GAS antibiotic choices, to include signposting to other relevant information, to be produced and circulated within primary care. The Committee noted the antimicrobial update and useful resources shared to support the management of GAS. **Post meeting note** – "BLMK Guidance (December 2022) – Management of confirmed and suspected Group A Streptococcus infection" document produced and circulated within primary care on 08/12/22. National "Interim clinical guidance summary: Group A streptococcus in children" was subsequently issued on 09/12/22, updated on 16/12/22 and 30/12/22, which superseded the local BLMK guidance.	NC
All other papers (from this point in the agenda) are for noting/information by the Committee		
11.	**East of England Priorities Advisory Committee (PAC) – items for noting/approval**	
11.1	EoEPAC Meeting Notes – July 2022 The committee noted the minutes for information.	
11.2	EoEPAC draft Meeting Notes – September 2022 The committee noted the minutes for information.	
12.	**Bedfordshire, Luton and Milton Keynes Local Prescribing Committee Minutes.** The Committee noted the following minutes for information.	

No	Agenda Item	Action
12.1	Minutes of the Bedfordshire Hospitals Foundation Trust DTC meeting – July 2022	
12.2	Minutes of the Milton Keynes Hospital Prescribing & Medicines Governance Committee (PMGC) – June 2022	
12.3	Minutes of the Bedfordshire and Luton Wound Management Formulary Steering Group – July 2022	
12.4	Minutes of the BLMK Formulary Subgroup – September 2022	
12.5	Minutes of the BLMK Medicines Safety Group – September 2022	
12.6	Minutes of the ELFT Medicines Management Committee – July 2022	
12.7	Minutes of the Cambridgeshire Community Services Medication Safety and Governance Group – July 2022	
12.8	Minutes of the CNWL Trustwide Medicines Optimisation Group (MOG) – June 2022	
12.9	Minutes of Circle/MSK Medicines Management Committee – July 2022	
13.	**Papers for information / ratification**	

13.1	**COVID-19 treatments / CMDU update**
	The Committee was provided with an update on the BLMK ICS service for community access to COVID-19 treatments, and to national policy in relation to this:
	
	• NHS England requested that the service continues until March 2023 with a transition to primary care:
	  ○ Oral antiviral supply commissioned under a local enhanced service from 9 community pharmacies across BLMK (supplies issued under a patient specific direction).
	  ○ Triage service commissioned form Milton Keynes Urgent Care for December 22 – March 23.
	• NICE are undertaking a multi technology appraisal on Covid drugs ('Therapeutics for people with COVID-19') - draft guidance published, the 'Appraisal Consultation Document', on 16 November 2022.
	• National clinical policy updated 28.11.2022; remains until NICE publishes the final Technology Appraisal guidance, anticipated date 29 March 2023.
	• Current clinical policy guidelines:
	  ○ Nirmatrelvir-ritonavir (Paxlovid) – first line (oral therapy) – NB this is the only therapy recommended in the NICE draft guidelines for non-hospitalised patients.
	  ○ Remdesivir – second line (IV every 24 hours for 3 consecutive days).
	  ○ Molnupiravir – third line (oral therapy).
	  ○ Sotrovimab – by exception only (IV single infusion).	

No	Agenda Item	Action
	The Committee noted the updated and ratified the national policy update for community access to COVID-19 treatments. **Post meeting note**: Remdesivir is in limited supply in the UK currently, and therefore will not be an option for use for non-hospitalised patients until the situation resolves. Advise from SPS states: "Consider nirmatrelvir/ritonavir (Paxlovid), which is the first line treatment option for adults with non-hospitalised patients at highest risk, or molnupiravir (Lagevrio), or sotrovimab (Xevudy) in line with the Interim Clinical Commissioning Policy: Treatments for non-hospitalised patients with COVID-19".	
14.	**Any other business** The "Testosterone for low sexual desire in women" factsheet has been updated to remove the requirement to undertake FAI and SHBG testing. This is in line with advice from British Menopause society. A positive experience of shared care working well was shared with the Committee. This was a patient's experience of commencement of new shared care for denosumab, with excellent communication and provision of information from both secondary and primary care clinicians.	
14.	**Future Dates for BLMK APC 2023 Meetings (all to be held from 12:30-15:00 via Microsoft Teams):** Wednesday 1st March 2023 Wednesday 3rd May 2023 Wednesday 5th July 2023 Wednesday 27th September 2023 Wednesday 6th December 2023	

Approval of minutes:

Chair: Muhammad Nisar

Signed: 

Date: 7/3/23

Appendix 1 – Approved 15 November 2022 Formulary Subgroup Minutes:

Final FSG minutes Nov 2022 signed.pdf