BEDFORDSHIRE, LUTON AND MILTON KEYNES AREA PRESCRIBING COMMITTEE

Final Meeting Notes

Date: 4th May 2022
Time: 12.30- 3.00pm
Venue: Microsoft Teams

Attendees:

Name	Initial	Role
Alison Borrett	AB	Chair (Non-Executive Director BLMK CCG)
Yolanda Abunga	YA	CCS Pharmacy Representative (Community Services Pharmacist, Beds and Luton)
Dr Marian Chan	MC	Medical Representative, Bedfordshire Hospitals Trust
Dr Mya Aye	MAy	Medical Representative, Milton Keynes Hospital
Dr Andrew Cooney	AC	Medical Representative, Milton Keynes Hospital (2pm – 2.45pm)
Fiona Garnett	FG	Associate Director and Head of Medicines Optimisation BLMK CCG
Naomi Currie	NC	Place Based Lead Pharmacist - Bedford
Matt Davies	MD	Place Based Lead Pharmacist – Central Bedfordshire
Mojisola Adebago	MA	Place Based Lead Pharmacist – Luton
Dr Jenny Wilson	JW	Place Based Lead GP - Bedford
Dr Kate Randall	KR	Place Based Lead GP – Central Bedfordshire
Dr Samantha Chepkin	SC	Consultant in Public Health
Cheryl Green	CG	Patient Representative
Jacqueline Clayton (until 2.20pm)	JC	Chair of Wound Care Group

Anne Graeff	AG	Commissioning Lead Pharmacist, BLMK CCG (Professional Secretary)
Dr John Fsadni	JF	Chair of Formulary Subgroup
Carole Jerrico	CJ	Nurse and Non-Medical Prescribing Representative (Secondary Care)
Nikki Woodall	NW	Formulary Lead Pharmacy Technician, BLMK CCG
Dr Richard Simpson	RS	Place Based Lead GP – Milton Keynes (deputising for Dr Nigel Fagan)
Candy Chow	CC	Principal Pharmacist, Formulary and Interface, MKUH
Reginald Akaruese (until 2.10pm)	RA	CNWL Pharmacy Representative

In attendance:		
Dona Wingfield	DW	Commissioning Lead Pharmacist, BLMK CCG
Janice Jones	JJ	Pharmacist Representative, NHS Northampton Hospital Foundation Trust
Dr Joy Muttika (from 1.30pm)	JM	Medical Representative, Keech Hospice
Raye Summers	RS	PA to MOT, BLMK CCG (admin support)
Sandra McGroarty (from 1pm)	SMcG	Commissioning Pharmacist, BLMK CCG
Taiya Large	TL	Formulary and Medicines Safety Pharmacist BLMK CCG
Rafal Ali	RA	Commissioning Pharmacist, BLMK CCG
Richard Jones (agenda items 5.1 – 5.4)	RJ	Programme Director for Medicines Optimisation
Dr Chirag Bakhai (agenda items 5.1 – 5.4)	CB	BLMK CCG GP and CCG strategic lead for long-term conditions
Dr Shiu-Ching Soo (agenda items 5.1 – 5.4)	SCS	Consultant Diabetologist, Bedfordshire Hospitals Trust
Juliet Davies (agenda items 5.1 – 5.4)	JD	Diabetes CNS, Luton ICDS
Mary Ann Canares (agenda items 5.1 – 5.4)	MAC	Diabetes CNS, Bedfordshire Hospitals Trust
Sharon White (agenda items 5.1 – 5.4)	SW	Diabetes CNS, Bedfordshire Hospitals Trust
Manmeet Anand (agenda items 5.1 – 5.4)	MA	Diabetes Lead Pharmacist, BLMK CCG
Nadine Hall (agenda items 5.1 – 5.4)	NH	Diabetes Lead Pharmacist, BLMK CCG
Aneet Judge (agenda items 5.1 – 5.4)	AJ	Medicines Optimisation Programme Lead, BLMK CCG

Jane Hayter (agenda items 5.1 – 5.4)	JH	Contracts Officer, BLMK CCG
Denise Macey (for agenda item 5.4)	DM	Paediatric diabetes CNS, Bedfordshire Hospitals Trust
Dr Keya Ali (for agenda item 5.4)	KA	Consultant Paediatric Diabetologist, Milton Keynes Hospital
Dr James Bursell (for agenda 5.4)	JB	Consultant Paediatric Diabetologist, Milton Keynes Hospital
Meeta Patel (for agenda item 5.4)	MP	Paediatric diabetes CNS, Bedfordshire Hospitals Trust
Claire Springall (for agenda item 5.4)	CS	Diabetes CNS, Bedfordshire Hospitals Trust

Apologies:		
Pritesh Bodalia	PB	Bedfordshire Hospitals Trust Pharmacy Representative (Chief Pharmacist, Bedfordshire Hospitals Trust)
Helen Chadwick	HC	Milton Keynes Hospital Pharmacy Representative (Clinical Director of Pharmacy, Milton Keynes Hospital)
Mary Evans	ME	Interim Integrated Care System (ICS) Chief Pharmacist, BLMK
Dr Nigel Fagan	NF	Place Based Lead GP – Milton Keynes
Dr Mitan Sarkar	MS	Place Based Lead GP - Luton
Dr Dushyant Mital	DM	Medical Representative, Milton Keynes Hospital (12.30pm – 2pm)
Dr Muhammad Nisar	MN	Medical Representative, Bedfordshire Hospitals Trust
Zainab Alani	ZA	Chair of Medicines Safety Group
Suraiya Chandratillake	SC	ELFT Pharmacy Representative – Community Services (Beds)
Lesley Bates	LB	Representative, St John's Hospice

No	Agenda Item	Action
1.	**Welcome, Introductions and Apologies** The Chair welcomed everyone to the meeting. Reginald Akaruese, new Mental Health lead for CNWL (replacement for Kike Pinheiro), was introduced to the committee and welcomed to the meeting. Apologies were received and noted as above. The meeting was confirmed as quorate.	12.30pm

No	Agenda Item	Action
2.	**Declarations of Interest** The Chair invited the members to reconfirm their current declarations on the Register of Interests and advise of any new declarations. All members confirmed their declarations were accurate and up to date. The Chair invited members to declare any declarations relating to matters on the agenda. There were no other declarations of interest relating to the agenda. The Chair thanked Raye Summers for her hard work ensuring that committee members' declarations of interest are up to date and reminded members to return their declarations in a timely fashion when requested to do so.	12.35pm
3.	**Minutes of 2nd March 2022 APC meeting** The minutes were approved.	
4.	**Matters Arising**	
4.1	**Feedback on miscellaneous actions not included on the agenda from APC meetings**	
4.1.1	**Type 1 diabetes in adults: diagnosis and management, NICE guideline [NG17] Published: 26 August 2015 Last updated: 21 July 2021. https://www.nice.org.uk/guidance/ng17** EoEPAC Secretary to review PAC Guidance. Update 20/04/2022 - 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	**Dapagliflozin and Type 1 Diabetes – licence change** CCG Lead Diabetes Pharmacist to produce information/flow chart to guide GPs on which patients should or should not receive the combination. **Update 08/02/22** - MA had put together an optimisation guide for dapagliflozin but did not publish in view of the ongoing review relating to review of the T2DM and CKD in T2DM pathways so as not to confuse clinicians. This is therefore an ongoing action.	MA
4.1.3	**Nintedanib for treating progressive fibrosing interstitial lung diseases, Technology appraisal guidance [TA747] Published: 17 November 2021** Tertiary/secondary Care Prescribing to be confirmed **Update 16/3/22** - No initiation at MK or Bedfordshire Hospitals (BHFT seeking specialist centre status, but until authorised by	Close

No	Agenda Item	Action
	NHSE, no initiation will take place locally). Formularies updated accordingly. It was proposed and agreed that this action could be closed.	
4.1.4	**Infliximab s/c – approved December 2021 – standard doses only**. HCD pathways to be updated to include infliximab s/c – The APC agreed that these could be updated and approved by Chair's action. **Update 07/04/22** - This is an ongoing action	SMcG
4.1.5	**BLMK Shared Care Guideline Template (revised)** At the December meeting, it was noted that there were still communication issues relating to blood test results, between primary and secondary care within BLMK and also for patients being seen outside of area. There were also issues in secondary care where e.g., blood tests undertaken at Bedford Hospital could not be accessed at the L & D Hospital and vice versa. It was agreed that while this sat outside of the ability of the committee to resolve (IT and commissioning of services), it was still a medicines safety issue. DW therefore agreed to raise with planned care at her next scheduled meeting and to report back. **Update 20/04/22** - This is an ongoing action	DW
4.1.6	**Strategies to support reduced inhaler carbon emissions** EQIA statement to be updated, as agreed at the December APC meeting. **Update 20/04/22** – This is an ongoing action	DW
4.1.7	**Transgender Shared Care Guidelines** Cross check of Tavistock website with BLMK Medicines website to be undertaken prior to each Formulary subgroup meeting to identify any further updates. This was undertaken prior to the April Formulary subgroup meeting and will continue as a matter of routine. It was proposed and agreed that this action could be closed.	Close
4.1.8	**Transgender shared care guidelines** Nafarelin to be reviewed and considered for addition to the joint Formularies at the Formulary subgroup meeting in April. No addition to the formulary required as Tavistock confirmed that they don't routinely use Nafarelin. It was proposed and agreed that this action could be closed.	Close
4.1.9	**Lipid pathway implementation** Contract is being finalised, to start taking referrals in May with clinic beginning in June. This is an ongoing action.	MD
4.1.10	**Dry eye guidance** Relevant amendments to be made to the joint Formularies – both the Milton Keynes Formulary and the Bedfordshire and Luton Formulary have been updated. It was proposed and agreed that this action could be closed.	Close
4.1.11	**Adult ADHD shared care guideline** Updates to be undertaken as identified prior to, and discussed at, the March APC meeting.	RJa/ELFT

No	Agenda Item	Action
	Update 07/04/22 – the update of the SCG is underway. This is an ongoing action.	
4.1.12	**Localised Severe Psoriasis** The PAC localised severe psoriasis policy was considered at the March APC meeting. The committee approved the policy pending publication of the final version of the policy. The policy has been published by PAC, with no changes from the March APC. The policy has been approval by Chair's action. It was proposed and agreed that this action could be closed.	Close
4.1.13	**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 07.04.22** - planned for review and consideration at the June APC meeting. This is therefore an ongoing action.	AG
4.1.14	**Shared Care Guideline Template** Review of appendix 1, part A to consider communication between the specialist and the GP. **Update 07.4.22** - this is an ongoing action	JC
5.	**Items for consideration at meeting**	
5.1	**NICE Diabetes / CKD Guidance – Review of local Guidelines (overview of papers to be amended/written)** There have been a number of updates to published NICE Guidelines relating to Diabetes and CKD. This has required a review of current local guidelines (Bedfordshire and Luton/Milton Keynes) which may require an update. Some updates have come to this meeting – see agenda items 5.2, 5.3 and 5.4. Future updates are planned for consideration at subsequent APC and Formulary Subgroup meetings including review of GLP1 agonist shared care guideline, Formulary choice of blood glucose testing strips and meters, and guidelines on self-monitoring of blood glucose in non-insulin treated type 2 diabetic patients. The Committee noted the information and approved the recommended actions.	
5.2	**Management of Type 2 Diabetes (T2DM) in adults – SGLT2 inhibitors for people with cardiovascular disease and heart failure** The focus of the February update of the NICE guideline (NG28) for the management of type 2 diabetes(T2DM) in adults shifted to management of cardiovascular (CV) risks. There are no changes made to previous recommendations on patient education, dietary and lifestyle advice, diagnosing and managing hypertension, self-monitoring of blood glucose, antiplatelet therapy and use of metformin as first-line treatment unless contraindicated. There have however been changes made to recommendations for individualised treatments goals, assessing for diabetic ketoacidosis (DKA) and medicines optimisation options for reviewing treatments, with emphasis on stopping /switching before adding new medicines.	

No	Agenda Item	Action
	Recommendations for drug treatment based on a person's CV disease and heart failure (HF) status now gives a wider role for sodium glucose transporter 2 inhibitors (SGLT2i) than in previous NICE technology appraisals (TAs). Evidence from cardiovascular outcome trials (CVOTs) have shown how SGLT2i affect major adverse CV outcomes such as CV mortality, myocardial infarction (MI), and stroke. NICE recommends the use of the 'SGLT2 inhibitor with proven cardiovascular benefit', and choice of SGLT2i based on CVD risk and licensed indications. There is less uncertainty about CV benefits associated with ertugliflozin than for empagliflozin, canagliflozin and dapagliflozin. Wider use of SGLT2i will likely increase SGLT2i prescribing at the beginning of a patient's treatment or in addition to existing drug treatments. Based on the NICE resource template, the eligible BLMK population is approximately 27,000. Currently 18% of patients with T2DM receive SGLT2i (with or without CVD). NICE estimates that for every 1% of eligible BLMK population who starts SGLT2i, the resource impact will be under £100k. If 100% of the 5-year implementation plan is assumed, this would be at a cost pressure of £8.2M. However, implementing NICE recommendations may generate savings downstream if there is some delay in escalating patients to more expensive medicines and also from improved cardiovascular outcomes. SGLT2i for CVD and /or HF are included in the Prescribing Incentive Scheme for 2022/23 with the goal of increasing prescribing to a 40% target. Work is also being undertaken to optimise use of the most cost-effective DPP4-inhibitor and cost savings realised from the (sitagliptin) switch will help off-set some of the SGLT2i cost pressure. The choice of SGLT2i requires consideration for multimorbidity and licensed indications; chronic kidney disease (CKD) and heart failure (HF), and renal function criteria for initiating and discontinuing treatment (refer to individual SmPC). For the heart failure indication, a previous NICE TA679 was issued in February 2021 - dapagliflozin for treating symptomatic chronic heart failure with reduced ejection fraction (HFrEF) in adults as an add-on to optimised standard care. In March 2022, a new NICE TA773 was issued for empagliflozin and empagliflozin is now recommended for HFrEF in adults as an add-on to optimised standard care. It has a similar place in therapy as dapagliflozin and falls within NICE acceptable use of NHS resources with no anticipated cost impact. The committee discussed the NICE guidance, and the traffic light status on the formulary for the different indications, with the following agreement: • SGLT2i for wider use in patients with T2DM (patients with chronic heart failure, established atherosclerotic cardiovascular	

No	Agenda Item	Action
	disease or are at high risk of developing cardiovascular disease) – GREEN status on both joint Formularies (retaining current safety advice/messages). • Empagliflozin for HFrEF (without co-existing T2DM) – AMBER and AMBER 1 respectively (Bedfordshire/Luton and Milton Keyes joint Formularies). • Retain similar pathway for HFrEF in both T2DM and non–T2DM The committee approved the proposals as outlined above. FG informed the committee that the financial impact of implementing the guidance is above the delegated funding responsibility of the APC. A paper will be presented to the ICS Transitional Interim Leadership Team (TILT) to seek funding approval for implementing the guideline. The decision from TILT may affect prioritisation and speed of implementation of the guideline. FG to update at the next committee meeting, following consideration by TILT. **EQIA Assessment:** Yes (likely to have an impact), but in a positive way. The use of SGLT2 inhibitors is expected to affect major adverse cardiovascular (CV) outcomes such as CV mortality, myocardial infarction (MI), and stroke. **BLMK CCG E and D Lead comment:** Could include headline data that certain ethnicities and men are more at risk of developing diabetes and the co-morbidities associated with the condition? It strengthens the case and demonstrates that there has been due consideration to protected characteristics and will support to reduce health inequalities.	FG
5.3	**SGLT2 inhibitors for chronic kidney disease** Type 2 diabetes (T2DM) is a leading cause of kidney failure worldwide, but there are few effective long-term treatments available to stop disease progression. Standard pharmacological management to reduce risk of chronic kidney disease (CKD) particularly in patients with T2DM have been angiotensin converting enzyme (ACE) inhibitors and angiotensin-receptor blockers (ARBs), but these only slow disease progression. There is therefore an unmet need for more effective therapies for treating CKD which is a significant burden for people. SGLT2 inhibitors were previously contraindicated in CKD but new cardiovascular outcome trials (CVOTs) have shown SGLT2i improved renal outcomes in patients with or without diabetes and NICE now recommends SGLT2i for people with proteinuria and T2DM. Data from the CREDENCE trial (a designated kidney outcome trials in patients with diabetes) showed significant reduction in the risk of disease progression and that canagliflozin is the dominant option for reducing disease progression in adults with CKD and T2DM. Similarly, data from the DAPA-CKD trial for dapagliflozin showed a significant reduction in risk of CKD progression in patients with or without T2DM.	

No	Agenda Item	Action
	NICE NG28 states broadly that for people with T2DM and CKD, in addition to an ARB or an ACE inhibitor, a SGLT2i should be considered if their uACR is 3 - 30 mg/mmol and offered if their uACR is >30 mg/mmol. They must also meet the criteria in the marketing authorisation (including relevant eGFR thresholds). This was because people with a baseline uACR of 3 - 30 mg/mmol were more likely to experience fewer cardiovascular events and events relating to CKD progression than people with a higher ACR. Although, having a SGLT2i would prevent fewer events in this sub- group in absolute terms, a consideration for a SGLT2i could be cost effective. NICE TA 775 recommends dapagliflozin as add-on therapy to standard of care unless contraindicated, and for people with eGFR 25 – 75ml/min/1.73 m² at the start of treatment and also have type 2 diabetes (T2DM) or have an uACR of 22.6 mg/mmol or more (NB, patients with polycystic kidney disease or on immunological therapy for renal disease were not included in the DAPA-CKD trial). Canagliflozin and dapagliflozin are the only SGLT2i licensed for CKD and T2DM and local MDT discussion with the renal team has determined that SGLT2i are not generally recommended in patients with functioning kidney transplant (any use of SGLT2i to treat diabetes mellitus in a kidney transplant recipient should be evaluated by multi-disciplinary discussion with a Nephrology team). Renal Function monitoring - It is not necessary to monitor renal function for 4-6 weeks after starting an SGLT2i because on average, SGLT2i cause a modest initial reduction in eGFR that is hemodynamic in nature and reversible. Long-term benefits regarding GFR preservation are observed despite this initial decline, and a reversible decrease in eGFR with commencement of SGLT2i would generally not be an indication to discontinue therapy. BLMK cost impact of implementing the guidance is approximately £64,000 total cost in 2022/23 (£54,000 net resource impact), increasing to £768,000 by 2026/27 (£266,000 net resource impact). The committee discussed the guidance, differences in licensing and NICE guidance recommendations, referral pathways for patients with CKD (without T2DM) and traffic light status for the Formularies with the following points raised: • Differences in licenses and NICE recommendations for the different indications for which SGLT2i are now recommended may be confusing for primary care prescribers. • Specific initiation thresholds for each licensed SGLT2i for T2DM and CKD are: ○ Canagliflozin – if eGFR >30ml/min; offer as add on to standard of care (SoC) (ACEI or ARB) unless contraindicated, if uACR>30mg/mol and can be considered if their uACR is 3 - 30 mg/mmol.	

No	Agenda Item	Action
	○ Dapagliflozin – if eGFR >25ml/min, add on to SoC unless contraindicated, no uACR threshold and licensed for continuation if eGFR >15ml/min. • The criteria for referral to nephrology for patients with CKD (without T2DM) need to be confirmed as concerns were raised that referrals may not be accepted and may introduce unnecessary delays to patient care. • All SGLT2i will be available on the Formularies, for the indications for which they are licensed and, where relevant, in accordance with the NICE technology appraisal guidance. • Dapagliflozin to be first choice SGLT2i as it has the widest license and evidence base, and simpler initiation criteria. This should reduce the possibility that a patient's SGLT2i treatment will need to be changed if they develop new co-morbidities and make treatment selection simpler for prescribers. • Treatment choices will still need to be made on an individual patient basis and may varying depending on other co-morbidities. • Dapagliflozin and canagliflozin to be listed on the Formularies with GREEN traffic light status as treatment options, in accordance with NICE NG and TA recommendations, for T2DM and CKD (with input from nephrology if required). • Dapagliflozin to be added to the Formularies with AMBER and AMBER 1 status (respectively) on the Bedfordshire/Luton and Milton Keynes joint Formularies - for initiation (Bedfordshire/ Luton) or recommendation (Milton Keynes) by renal specialists in patients with eGFR 25-75ml/min (at the start of treatment) and uACR >22.6mg/mol in accordance with NICE TA775. • Clear information will need to be provided on the Formularies, and via Scriptswitch/Optimise messages, to support prescribers making treatment choices. The committee approved the recommendations, in accordance with the points raised above. **EQIA Assessment:** Yes (likely to have an impact), but in a positive way. The use of SGLT2 inhibitors is expected to slow CKD disease progression and reduce the number of cardiovascular and end-stage renal events. **BLMK CCG E and D Lead comment:** Could include headline data that certain ethnicities and men are more at risk of developing diabetes and the co-morbidities associated with the condition? It strengthens the case and demonstrates that there has been due consideration to protected characteristics and will support to reduce health inequalities.	MA CC/TL/ NW
5.4	**Blood glucose monitoring in the treatment of diabetes** The monitoring of blood glucose in patients with diabetes is currently commissioned in accordance with national and local guidance. On the 31st March 2022, NICE issued updated guidelines relating to the monitoring of blood glucose monitoring in all patients (adults and children; type 1 and 2 diabetes mellitus). The NICE recommendations significantly extend the number of patients eligible	

No	Agenda Item	Action
	to receive both intermittent and real time continuous glucose monitoring. This is likely to have an impact on both the medicines and devices budgets and in terms of staff resource to implement in primary and secondary care. With respect to intermittent glucose monitoring (isCGM), the major differences to current practice are in summary: • The technology is expanded to include some insulin treated type 2 diabetes patients. • All adults with type 1 diabetes are to be offered a choice of real-time continuous glucose monitoring (rtCGM) or intermittently scanned continuous glucose monitoring (isCGM, commonly referred to as 'flash'), based on their individual preferences, needs, characteristics, and the functionality of the devices available. • Children and young people with type 1 diabetes aged 4 years and over who are unable to use rtCGM or who express a clear preference for isCGM should be offered isCGM. With respect to real-time continuous glucose monitoring (rt-CGM), the major differences to current practice are in summary: • For Type 2 diabetic patients - Consider real-time continuous glucose monitoring (rtCGM) as an alternative to isCGM for adults with insulin-treated type 2 diabetes if it is available for the same or lower cost. (NB – NICE 'consider' recommendation and dependent on cost) • For Type 1 diabetic patients (adults, children and young people) – rtCGM is to be offered to all patients. Currently BLMK CCG does not commission rtCGM for all type 1 diabetic patients. NICE has advised that all recommendations contained in the updated guidance fall within the range of what is considered to be a cost-effective use of NHS resources. However, there will be a high budgetary impact as a result of implementing the guidance with total approximate cost pressure (assuming product of lowest acquisition and no offsetting reduced use of capillary blood testing strips and meters {as difficult to quantify accurately}) is £2.8 million (NB – this is a conservative financial impact) increasing to approximately £10 million if alternative products are used. The ICS needs to consider affordability alongside the NICE guidelines and although the APC has delegated funding to make decisions, for these NICE guidelines, the likely cost pressure exceeds the delegated funding limit and therefore the APC will only be able to make recommendations on implementation. The ICS Transitional Interim Leadership Team (TILT) will consider the recommendations made by the APC following the meeting. NICE is aware that NHS England are currently involved in discussions about pricing with various manufacturers of continuous glucose monitoring devices. The NICE costing template is also now available but there are still a lot of unknowns.	

No	Agenda Item	Action
	Additional considerations for implementation include: • New real time CGM devices have come to market and are available for the first time on prescription via FP10. • As well as the additional device cost pressures, there are implications for workload for Primary and Secondary Care which need to be considered in the implementation of the guidance. The committee discussed the updated NICE guidelines, and a number of points were raised and discussed: • The technology can be life-transforming for patients but won't be suitable for all. Consideration needs to be given to patient and clinician education and training. Who will be reviewing the readings and making sure that patients are getting the most from the technology? • Training and upskilling will be required for both specialist teams and primary care clinicians. Specialist teams are currently struggling to get the information they need from device manufacturers/providers in order to upskill the team (likely due to the volume of requests the companies are receiving). • It will not be practical for the specialist team to continue to care for all patients (likely to maintain care for T1, but T2 likely to need to have ongoing care in primary care). • Primary care clinician training may potentially be via the training hub, or a diabetes PLT. There may also be the possibility to involve the voluntary / charity sector to help support with training. • Further work will need to be done to consider the different devices which are, or soon will be, available – this will be carried out by a separate working group. • Not all devices offer the same features/functionality, which will need to be taken into account when considering which devices should be used. Using the most cost-effective, suitable, device will allow the technology to be offered to more patients. Frequent changes of device, based on cost, would not however be desirable. • Hybrid closed loop systems for managing blood glucose levels in type 1 diabetes are on the NICE workplan (no date for publication currently available). • Patients will need to be shown how to use the technology to get the most out of it, however thought needs to be given about how best to implement especially given the existing pressures on the system/workforce. • Long-term outcome evidence is lacking, however initial indicators are strong enough to indicate that the technology will provide the assumed benefits. Implementation will be time consuming, but there may be a case to indicate that there are direct savings to be made e.g. reduced usage of BGTS/lancets, reduced progression to pumps, reductions in DKA/hypos.	

No	Agenda Item	Action
	• There is an issue with Health Inequalities and digital poverty which needs to be considered carefully given that many companies are looking to deliver online training. • Across the patch there are already marked, statistically significant, differences between different ethnicities accessing diabetes technologies. If criteria are introduced, this is likely to exacerbate existing inequalities. • NICE was aware of the issues relating to health inequalities and put the onus on 'commissioners, providers and healthcare professionals' to address the inequalities in CGM access and uptake via audit and active engagement with these groups. A robust audit process will need to be developed. • The current approval pathway for initiation / continuation of rtCGM, and payment of associated invoices, will need to be reviewed as this will not be sustainable for the larger cohort of patients included in the NICE guidelines. • Another local ICS has identified a high cost pressure which is not affordable for the system. They are therefore reviewing the evidence from NICE to identify priority groups to fund. • Registering patients on Blueteq will not be required (due to increased patient numbers) but specialists will likely need to do the initial supply (28 days) and advise GP in writing of product choice and details of review requirements. Audit requirements to discussed and agreed. • Add products available on FP10 (Specialist input required) to both joint Formularies with an additional note that FreeStyle Libre 3 is not available for GP prescribing. • The Addenbrookes Hospital diabetes team are trialling the use of GlucoRx Aidex and Dexcom One and BLMK may be able to obtain some shared learning. As for agenda item 5.2, FG informed the committee that the financial impact of implementing the guidance is above the delegated funding responsibility of the APC. A paper will be presented to ICS Transitional Interim Leadership Team (TILT) to seek funding approval for implementing the guideline. The decision from TILT may affect prioritisation and speed of implementation of the guideline. FG to update at the next committee meeting, following consideration by TILT. The committee agreed the following: • To support the use of isCGM and rtCGM in line with the updated NICE Guidelines. • Recommend that the products with the lowest acquisition (where suitable) are used in order to treat the maximum number of patients and increase the affordability to the NHS. ○ At the current time the most cost-effective product is GlucoRx AiDEX but it is not suitable for all patients. • If a non drug tariff product is chosen (e.g. patients on an insulin pump) – Specialist teams will need to retain prescribing.	FG

No	Agenda Item	Action
	• Choice of technology and practicalities to be discussed and taken forward by a separate working group (initial meeting on 5/5/22). **In addition, the following interim statement was agreed:** 'BLMK APC supports the implementation of the NICE Guidelines relating to blood glucose monitoring in the treatment of diabetes accepting that the speed of implementation may be affected by information still awaited (real time Continuous Glucose Monitoring costs {rtCGM} and new products coming to market) and affordability across the Integrated Care System (ICS). No change in practice is currently recommended pending ongoing discussions with specialist teams, clarification of CGM costs/information on new products and clarification of the BLMK ICS funding position.' **EQIA Assessment:** Not assessed – NICE Guidance. Assessment will be required if the CCG decides not to implement the guidance in full due to affordability issues. Current proposal is to support implementation of NICE Guidance. **BLMK CCG E and D Lead comment:** Could include headline data that certain ethnicities and men are more at risk of developing diabetes and the co-morbidities associated with the condition? It strengthens the case and demonstrates that there has been due consideration to protected characteristics and will support to reduce health inequalities. Greater accessibility of the devices will facilitate placing the patient in control of their condition.	RJ/AJ
5.5	**Hydroxychloroquine fact sheet update** The hydroxychloroquine fact sheet (included in the Bedfordshire and Luton Rheumatology DMARD shared care guideline) has been updated following the publication of the Drug Safety Update February 2022. This DSU addresses the following two issues: • Increased risk of cardiovascular events when using hydroxychloroquine and a macrolide antibiotic • A reminder regarding psychiatric reactions associated with hydroxychloroquine The fact sheet has been updated with the header below, and links to the DSU incorporated in relevant sections throughout the fact sheet. "MARCH 2022 Update Following the publication of the MHRA Drug Safety Alert (Feb 2022): Hydroxychloroquine, chloroquine: increased risk of cardiovascular events when used with macrolide antibiotics; reminder of psychiatric reactions" and a link to the full DSU has been added." The committee discussed whether a line should be added to the fact sheet advising patients to report any new or worsening mental health problems to their doctor. The committee agreed that this was not required as psychiatric reactions to hydroxychloroquine are rare and it may cause anxiety to patients.	

No	Agenda Item	Action
	A query was raised about the risk factors for retinal adverse effects with hydroxychloroquine could be listed clearly within the fact sheet. SMcG confirmed that this information is already clearly documented. Scriptswitch / Optimise Rx messages to be deployed to highlight the drug safety alert. The committee approved the update to the hydroxychloroquine fact sheet as written.	NW
6.0	**NICE Guidance – from 17th February 2022 until 20th April 2022 inclusive** **The following NICE Technology Appraisal Guidance (CCG Commissioned) have been published:** **Solriamfetol for treating excessive daytime sleepiness caused by obstructive sleep apnoea** Technology appraisal guidance [TA777] Published: 09 March 2022 https://www.nice.org.uk/guidance/ta777 **APC action:** none – not recommended **Pitolisant hydrochloride for treating excessive daytime sleepiness caused by obstructive sleep apnoea** Technology appraisal guidance [TA776] Published: 09 March 2022 https://www.nice.org.uk/guidance/ta776 **APC action:** none – not recommended **Dapagliflozin for treating chronic kidney disease** Technology appraisal guidance [TA775] Published: 09 March 2022 https://www.nice.org.uk/guidance/ta775 Using NICE assumptions, the BLMK cost impact of introducing the guidance is approximately £64,000 total cost in 2022/23 (£54,000 net resource impact, taking into account potential resources released), increasing to £768,000 by 2026/27 (£266,000 net resource impact). **APC action –** link added to Formularies. Discussed under agenda item 5.3. The formulary status was reviewed by the committee and the following was agreed: • AMBER on the Bedfordshire and Luton formulary/AMBER 1 on the Milton Keynes formulary – initiation by nephrology team in patients with CKD, eGFR 25 to 75 ml/min and proteinuria (uACR >22.6mg/mmol) • GREEN on both formularies in CKD and T2DM (with input from nephrology if required) **Empagliflozin for treating chronic heart failure with reduced ejection fraction** Technology appraisal guidance [TA773] Published: 09 March 2022 https://www.nice.org.uk/guidance/ta773 Resource impact statement (NICE) - no significant resource impact is anticipated.	

No	Agenda Item	Action
	APC action – link added to Formularies. Discussed under agenda item 5.2. The formulary status was reviewed by the committee - AMBER on the Bedfordshire and Luton formulary/AMBER 1 on the Milton Keynes formulary (as for dapagliflozin for the same indication) for patients with chronic heart failure in the absence of diabetes (GREEN for T2DM patients). **The following NICE Guidelines (NG) (Medicine related and CCG Commissioned) have been published / updated by NICE:** **Otitis media (acute): antimicrobial prescribing**; NICE guideline [NG91] Published: 28 March 2018 Last updated: 11 March 2022 https://www.nice.org.uk/guidance/ng91 In **March 2022**, NICE reviewed the evidence and added a recommendation on eardrops containing an anaesthetic and an analgesic because a licensed preparation is now available in the UK. For more information, see update information. **APC action** – no changes to the antimicrobial prescribing guidelines at the current time. Submission to be made to the next Formulary subgroup meeting for eardrops containing an anaesthetic and an analgesic. **Hypertension in adults: diagnosis and management**, NICE guideline [NG136] Published: 28 August 2019 Last updated: 18 March 2022 https://www.nice.org.uk/guidance/ng136 In **March 2022**, NICE updated the guideline. NICE: • reviewed the evidence and made a new recommendation on blood pressure targets for people who have both hypertension and cardiovascular disease. • reassessed evidence on antihypertensive drug treatment from the previous version of this guideline (without a new evidence review) and made a new recommendation to cover people who have both hypertension and cardiovascular disease. The update information provides full explanation of what has been updated. **APC actions** – none. Recommendations reflect current practice, therefore no change in practice or increase in resource use expected. **Type 2 diabetes in adults: management**, NICE guideline [NG28] Published: 02 December 2015 Last updated: 31 March 2022 https://www.nice.org.uk/guidance/ng28 In **March 2022**, NICE reviewed the evidence and made new recommendations on continuous glucose monitoring (CGM). **APC actions** – see agenda item 5.4 **Diabetes (type 1 and type 2) in children and young people: diagnosis and management**, NICE guideline [NG18] Published: 01 August 2015 Last updated: 31 March 2022 https://www.nice.org.uk/guidance/ng18	NC

No	Agenda Item	Action
	In **March 2022**, NICE reviewed the evidence and updated the recommendations on continuous glucose monitoring (CGM), replacing existing recommendations on CGM. **APC actions** – see agenda item 5.4 **Type 1 diabetes in adults: diagnosis and management**, NICE guideline [NG17] Published: 26 August 2015 Last updated: 31 March 2022 https://www.nice.org.uk/guidance/ng17 In **March 2022**, we reviewed the evidence and updated the recommendations on diagnosis and continuous glucose monitoring (CGM), replacing existing recommendations on diagnosis and CGM. **APC actions** – see agenda item 5.4 **Stroke and transient ischaemic attack in over 16s: diagnosis and initial management**, NICE guideline [NG128] Published: 01 May 2019 Last updated: 13 April 2022 https://www.nice.org.uk/guidance/ng128 In **April 2022**, NICE reviewed the evidence and made new recommendations on blood pressure control for people with acute intracerebral haemorrhage. **APC actions** – none. Updated recommendations relate to acute care only. **Medicines associated with dependence or withdrawal symptoms: safe prescribing and withdrawal management for adults** NICE guideline [NG215] Published: 20 April 2022 https://www.nice.org.uk/guidance/ng215 This guideline covers general principles for prescribing and managing withdrawal from opioids, benzodiazepines, gabapentinoids, Z-drugs and antidepressants in primary and secondary care. It does not cover gabapentinoids prescribed for epilepsy, nor opioids prescribed for acute or cancer pain, or at the end of life, nor management of illicit drug dependence. **APC actions** – tbc. For review by the pain specialist pharmacist. **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: 23 February 2022 https://www.nice.org.uk/guidance/ng191 This guideline covers the management of COVID-19 for children, young people and adults in all care settings. It brings together our existing recommendations on managing COVID-19, and new recommendations on therapeutics, so that healthcare staff and those planning and delivering services can find and use them more easily. On **23 February 2022**, NICE added recommendations on molnupiravir and remdesivir for people with COVID-19 who do not need supplemental oxygen.	

No	Agenda Item	Action
	On **10 March 2022**, NICE added a new recommendation on awake prone positioning and updated existing recommendations on non-invasive respiratory support. On **13 April 2022**, NICE added a new recommendation on nirmatrelvir and ritonavir (Paxlovid) for people at high risk of progression to severe COVID-19. **The following NICE TAs are the commissioning responsibility of NHSE and are listed for information only:** **Odevixibat for treating progressive familial intrahepatic cholestasis;** Highly specialised technologies guidance: HST17; Published: 22 February 2022 https://www.nice.org.uk/guidance/hst17 **APC action:** MK no prescribing expected; BHT – no initiation but may be asked to continue prescribing if deemed suitable to do so. To be added to both Formularies as RED with specialist centre initiation only (pending confirmation that NHSE will reimburse secondary care trusts for the medication). **Pembrolizumab for treating relapsed or refractory classical Hodgkin lymphoma after stem cell transplant or at least 2 previous therapies** Technology appraisal guidance [TA772] Published: 23 February 2022 https://www.nice.org.uk/guidance/ta772 **APC action:** link added to Formularies. **Pegcetacoplan for treating paroxysmal nocturnal haemoglobinuria** Technology appraisal guidance [TA778] Published: 09 March 2022 https://www.nice.org.uk/guidance/ta778 **APC action**: none. No addition to local Formularies. **Lenalidomide for relapsed or refractory mantle cell lymphoma (terminated appraisal)** Technology appraisal [TA774] Published: 09 March 2022 https://www.nice.org.uk/guidance/ta774 **APC: no action –** Terminated appraisal **Dostarlimab for previously treated advanced or recurrent endometrial cancer with high microsatellite instability or mismatch repair deficiency** Technology appraisal guidance [TA779] Published: 16 March 2022 https://www.nice.org.uk/guidance/ta779 **APC action**: created and link added to Formularies **Nivolumab with ipilimumab for untreated advanced renal cell carcinoma** Technology appraisal guidance [TA780] Published: 24 March 2022 https://www.nice.org.uk/guidance/ta780 **APC action:** link added to Formularies **Atidarsagene autotemcel for treating metachromatic**	

No	Agenda Item	Action
	leukodystrophy Highly specialised technologies guidance: HST18; Published: 28 March 2022 https://www.nice.org.uk/guidance/hst18 **APC action:** MK no prescribing expected; BHT – no initiation but may be asked to continue prescribing if deemed suitable to do so. To be added to both Formularies as RED with specialist centre initiation only (pending confirmation that NHSE will reimburse secondary care trusts for the medication). **Sotorasib for previously treated KRAS G12C mutation-positive advanced non-small-cell lung cancer** Technology appraisal guidance [TA781] Published: 30 March 2022 https://www.nice.org.uk/guidance/ta781 **APC action:** created and link added to Formularies **Tagraxofusp for treating blastic plasmacytoid dendritic cell neoplasm** (terminated appraisal) Technology appraisal [TA782] Published: 30 March 2022 https://www.nice.org.uk/guidance/ta782 **APC action**: none as terminated appraisal **Daratumumab monotherapy for treating relapsed and refractory multiple myeloma**, Technology appraisal guidance [TA783] Published: 13 April 2022 https://www.nice.org.uk/guidance/ta783 **APC action**: link added to Formularies. **Nivolumab with cabozantinib for untreated advanced renal cell carcinoma (terminated appraisal)**, Technology appraisal [TA785] Published: 20 April 2022 https://www.nice.org.uk/guidance/ta785 **APC action**: none as terminated appraisal **Niraparib for maintenance treatment of relapsed, platinum-sensitive ovarian, fallopian tube and peritoneal cancer**, Technology appraisal guidance [TA784] Published: 20 April 2022 https://www.nice.org.uk/guidance/ta784 **APC action**: link added to Formularies. **Elosulfase alfa for treating mucopolysaccharidosis type 4A**, Highly specialised technologies guidance Reference number: HST19 Published: 20 April 2022 https://www.nice.org.uk/guidance/hst19 **APC action:** none. No addition to local Formularies.	
7.	**Medicines Safety update** DW gave a Primary Care Medicines Safety Update and a Medicines Safety Group Update. **Primary Care Medicines Safety Update** This update focussed on the primary care response to the MHRA Drug Safety Updates (March and April 2022). In particular:	

No	Agenda Item	Action
	Cladribine (Mavenclad): new advice to minimise risk of serious liver injury **Action(s) taken:** DSU included in BLMK primary care newsletter to inform primary care to refer in patients to their specialist if they contact the GP with symptoms as described in the DSU and confirm they are on cladribine. Confirmation at next MSG r.e. dissemination of information from acute trust MSOs to neurology team (multiple sclerosis indication) and haematology oncology teams (cancer indication). **Amiodarone (Cordarone X): reminder of risks of treatment and need for patient monitoring and supervision** **Actions taken:** DSU included in BLMK primary care newsletter to remind primary care clinicians to monitor amiodarone toxicity (through CTs, LFTs and TFTs) to be included as part of the primary care commissioning workstream currently taking place on the prescribing of specialist drugs in primary care and formulary alignment. Commissioning team to review relevant guidance and include link accordingly. To confirm at the next MSG that DSU has been circulated to cardiology and accident and emergency/acute medical teams within BLMK ICS. **Metformin in pregnancy: study shows no safety concerns** No actions required at this time. **Pregabalin (Lyrica): findings of safety study on risks during pregnancy** **Actions taken:** Pregabalin DSU included in BLMK primary care newsletter to inform primary care clinicians of the study and to counsel patients on use of effective contraception during treatment, to discuss at pre-pregnancy stage (establish treatment plan) and consider use on risk versus benefit / case by case whereby clinically appropriate in conjunction with specialist teams if required. The recent MHRA updates on metformin and pregabalin and reminder of sodium valproate to be considered as the main theme subject particularly the safety of antiepileptic drugs in pregnancy, including pregabalin, in January 2021: new safety advice in Drug Safety Update with patient advice, and a Public Assessment Report, for the prospective BLMK medicines safety newsletter – to be discussed at the next MSG. **<u>Medicines Safety Group Update</u>** The BLMK ICS Medicines safety group (MSG) was last held on Tuesday 8th February 2022. The BLMK medicines safety website and ICS wide newsletter has now been launched:	

No	Agenda Item	Action
	Link to website https://medicines.blmkccg.nhs.uk/categories/medicine-safety/ Link to newsletter: https://medicines.blmkccg.nhs.uk/document/medicines-safety-newsletter-feb-2022/ The committee discussed the items included in the updated, with the following points raised: • It may be appropriate for brand names to be removed from the safety warnings. This will be reviewed by the Medicines Safety Group and actioned as appropriate (depending on the wording of the MHRA warnings). • Pregabalin – rarely used as an anti-epileptic, and far more commonly used for chronic pain of psychiatric indications. It is therefore likely to be appropriate to review the MHRA DSU with reference to all indications, not just epilepsy. CJ confirmed that in their pain clinic, if a patient wishes to become pregnant, they will stop pregabalin prior to the pregnancy if possible. The committee noted the information and consideration will be given to the above points raised at the next meeting of the Medicines Safety Group.	ZA/DW
8.	**Formulary Update**	
8.1	**Formulary Subgroup Recommendations** The following recommendations were made by the Formulary subgroup at the April meeting: <u>Hyperhidrosis Pathway:</u> • Add Anhydrol forte and Driclor to Formularies (GREEN) as the preferred self-care 1st line option • Addition of oxybutynin tablets to Formularies (GREEN) first line off-label choice • Addition of propantheline to Formularies (GREEN) as alternative first line licensed choice. • Trospium 20mg twice daily (GREEN RESTRICTED) as a second line option to the pathway • Do not endorse the use of oral glycopyrronium due to cost and weak evidence to support. • Do not support the use of glycopyrronium powder for iontophoresis. • Do not include glutaraldehyde or formaldehyde or methenamine products. <u>Rituximab business case:</u> • Approve for use for primary warm AIHA, mixed AIHA and paroxysmal cold haemoglobinuria: rituximab (biosimilar) as a second line treatment if no response to prednisolone 1mg/kg/day	

No	Agenda Item	Action
	after three weeks or relapse during or after steroid reduction (RED RESTRICTED). • Approved for use for primary cold haemagglutinin disease (CHAD): first line treatment with rituximab (biosimilar) if symptomatic anaemia, severe circulatory symptoms or transfusion dependence (RED RESTRICTED). <u>Cobicistat</u>: Approve addition of cobicistat 150mg tablets to both Formularies – (RED RESTRICTED) in line with NHSE guidance which specifies that combination branded HIV products be split into individual components as it is more cost-effective. <u>Ceyesto (melatonin):</u> Approve addition of Ceyesto (melatonin) to Milton Keynes Formulary in line with Bedforshire/Luton with the same restrictions (AMBER 1) <u>Trimbow</u>: • Add Trimbow NEXThaler to both Formularies (GREEN RESTRICTED) for COPD • Add wording on Formularies for COPD: Triple therapy should be reserved for patients who have failed to achieve or maintain an adequate response to an appropriate course of dual therapy (a combination of an inhaled corticosteroid and a long-acting beta2-agonist). <u>Statins</u>: • Addition of rosuvastatin hard capsules to both Formularies (GREEN RESTRICTED) as alternative preparation to patients with swallowing difficulties or feeding tubes. • Change rosuvastatin tablets from Amber restricted / Amber 2 to GREEN on both Formularies • Assign statin priority order to Formulary entries: 1st line Atorvastatin 2nd line Rosuvastatin 3rd line Simvastatin and remove others – high intensity statins now recommended as per guidance NICE CG181 <u>Ethosuximide (Emeside) application</u>: Add both capsule and syrup to Milton Keynes Formulary (AMBER 3) and the capsule to Beds/Luton (syrup already listed) with addition of wording to specify Emeside is the most cost-effective brand to both Formularies. Active switching of patients to be added to workplan to realise cost saving benefit. The committee ratified the recommendations of the Formulary Subgroup.	
8.2	**Wound Management Formulary Steering Sub-Group Recommendations** <u>Update to the Terms of Reference</u>	

No	Agenda Item	Action
	The terms of reference of the BLMK APC Wound Management Formulary Steering Sub-Group have been updated to include Chair's action. The APC approved the updated terms of reference. <u>Addition of Cavilon Advanced to the MK Formulary</u> Proposal for addition of Cavilon Advanced to the MK Formulary: Cavilon Advanced Skin Protectant is intended to cover and protect intact or damaged skin. The protective barrier reduces pain associated with Incontinence Associated Dermatitis (IAD) and prevents, stops and reverses the effects of IAD and all forms of Moisture Associated Skin Damage (MASD). Cavilon Advanced can also be used in areas exposed to friction and sheer from bedding, clothing, shoes or any other material that would rub against the skin allowing / enabling the skin to heal. Cavilon Advanced will be used when skin damage is too severe for the standard of care to be appropriate or when the standard products are failing to provide a clinical resolution. Temporarily stepping up to this treatment when needed and then reverting to standard care has both clinical and cost benefits This, in conjunction with a defined protocol for prevention and management of Moisture Associated Skin Damage (MASD) will bring about significant quality improvement, direct benefits to the patient, improved healing times, reduction of the incidence and severity of MASD and thereby realising cost savings. The recommendation of the Wound Management Formulary Steering Group was that Cavilon Advanced should be removed from the non-formulary section but should not be actively included in the formulary. It should be prescribed only on Tissue Viability Nurse (TVN) recommendation. This is in line with the Formulary position in Bedfordshire and Luton. Following the Wound Management Formulary Steering Subgroup meeting, discussions with the MKUH Formulary Lead Pharmacist indicated that this approach would not work effectively in MK, therefore it is suggested that Cavilon Advanced is added to MK Formulary – AMBER 1- to be prescribed by TVN or GP on recommendation of TVN only. This will be a temporary measure pending alignment of Wound Care Formularies across BLMK. The Optimise message will also need to be updated accordingly. The committee approved the addition of Cavilon Advanced to the Milton Keynes Formulary, with AMBER 1 designation – to be prescribed by TVN or GP on recommendation of TVN only.	CC
9.	**Antimicrobial Resistance Update** – *no update as there have been no meetings since the last APC meeting.*	
All other papers (from this point in the agenda) are for noting/information by the Committee		

No	Agenda Item	Action
10.	**East of England Priorities Advisory Committee (PAC) – items for noting/approval**	
10.1	EoEPAC Meeting Notes – November 2021 The committee noted the minutes for information.	
10.2	EoEPAC draft Meeting Notes – January 2022 The committee noted the minutes for information.	
11.	**Bedfordshire, Luton and Milton Keynes Local Prescribing Committee Minutes.** The Committee noted the following minutes for information.	
11.1	Minutes from the Bedfordshire Hospitals Foundation Trust DTC meeting – December 2021, February 2022	
11.2	ELFT Medicines Management Committee Minutes (Mental Health) – January 2022, March 2022	
11.3	Minutes of the Cambridgeshire Community Services Medication Safety and Governance Group – March 2022	
11.4	CNWL - Trustwide Medicines Optimisation Group (MOG) Meeting – November 2021	
12.	**Papers for information / ratification**	
12.1	**BLMK APC / legacy committees Annual Report** As a result of the CCG merger, the previous Bedfordshire and Luton Joint Prescribing Committee (JPC) and Milton Keynes Prescribing Advisory Committee (MKPAG) have been replaced with the BLMK wide Area Prescribing Committee (BLMK APC). The committee considered the first Annual Report of the BLMK APC, the contents of which reflect the output from the committee meetings on 29th September 2021, 1st December 2021 and 2nd March 2022. (NB. Due to Covid 19 staffing constraints, the 2nd March 2022 meeting was a combined meeting of the BLMK APC and the BLMK Formulary Subgroup.) The output from the JPC meeting held 23rd June 2021 and the MKPAG meetings held 26th May 2021 and 28th July 2021 are included in the Appendices. The report summarises the participating organisations, meeting attendance figures, the Committee's activities and achievements and the future work programme. With the addition of acknowledgement of the work of the legacy committees, commitment of Committee members to set up an effective committee under our new chair and acknowledgement of contribution of people who were 'in attendance' and observers, the Committee ratified the first APC annual report.	JC
13.	**Any other business** SMcG advised the committee that shared care guidelines (SCGs) which had amended frequency of blood test monitoring during the	

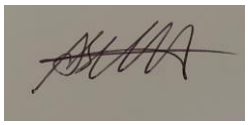
No	Agenda Item	Action
	COVID-19 pandemic are to revert to the original agreement within the SCGs. Input has been sought from the Rheumatology and Gastroenterology teams at the local trusts, with confirmation received from Rheumatology (to date) that they are happy with the proposal. It was queried whether it is necessary to revert to the original 3-monthly monitoring, as no additional safety concerns have been identified with the 4-monthly monitoring. BSR may be updating their guidance. The committee was informed that the COVID guidance on the BLMK Medicines website has now been archived and, as BSR guidance has not yet been updated, reverting to 3-monthly monitoring would be appropriate at the current time. Additionally, it was highlighted that there may be some patients, who were started on treatment during the pandemic, who may need some additional information/explanation to explain the change. This is only likely to apply to a small group of patients who were commenced on treatment at the start of the pandemic. Experience from primary care clinicians reported at the meeting indicated that most patients are likely to have reverted to 3-montly monitoring already. MC will check with the hospital team, for those patients being managed solely by the secondary care team e.g. patients on subcutaneous methotrexate regarding monitoring frequency. The shared care guideline, with respect to frequency of blood test monitoring, will be reviewed as part of the overall APC workplan, or when updated guidance from the BSR is published. The committee agreed the proposed changes.	MC
14.	**Future Dates for BLMK APC 2021/22 Meetings:** Wednesday 29th June 2022 – 12.30-3.00pm Wednesday 28th September 2022 - 12.30-3 pm Wednesday 7th December 2022 - 12.30-3 pm	

Appendix 1 – Approved 19th April 2022 Formulary Subgroup Minutes:

BLMK Formulary Subgroup April 2022

Approval of minutes:

Chair: Alison Borrett

Signed: 

Date: 06/07/22