Bedfordshire, Luton and Milton Keynes Area Prescribing Committee – APC meeting
Meeting Notes

Date: 29th September 2021
Time: 12.30- 3.30pm
Venue: Microsoft Teams

The following organisations contribute to and participate in the BLMK APC – Bedfordshire, Luton and Milton Keynes Clinical Commissioning Group; 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

Attendees:-

Name	Initial	Role
Alison Borrett	AB	Chair (Non-Executive Director BLMK CCG)
Pritesh Bodalia	PB	Bedfordshire Hospitals Trust Pharmacy Representative (Chief Pharmacist, Bedfordshire Hospitals Trust)
Helen Chadwick	HC	Milton Keynes Hospital Pharmacy Representative (Clinical Director of Pharmacy, Milton Keynes Hospital)
Suraiya Chandratillake	SC	ELFT Pharmacy Representative – Community Services (Beds)
Yolanda Abunga	YA	CCS Pharmacy Representative (Community Services Pharmacist, Beds and Luton)
Kike Pinheiro	KP	CNWL Pharmacy Representative (Community and Mental Health Services Milton Keynes)
Dr Muhammad Nisar	MN	Medical Representative, Bedfordshire Hospitals Trust
Dr Andrew Cooney	AC	Medical Representative, Milton Keynes Hospital

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 (starting 1/10/21)
Dr Jenny Wilson	JW	Place Based Lead GP - Bedford
Dr Kate Randall	KR	Place Based Lead GP – Central Bedfordshire
Dr Mitan Sarkar	MS	Place Based Lead GP - Luton
Dr Samantha Chepkin	SC	Consultant in Public Health (present for part of meeting)
Cheryl Green	CG	Patient Representative
Jacqueline Clayton	JC	Commissioning Lead Pharmacist, BLMK CCG (Professional Secretary)
Anne Graeff	AG	Chair of Wound Care Group
Dr John Fsadni	JF	Chair of Formulary Subgroup
Zainab Alani	ZA	Chair of Medicines Safety Group
Mary Evans	ME	Interim Integrated Care System (ICS) Chief Pharmacist, BLMK

In attendance:		
Natasha Patel	NP	ELFT Pharmacy Representative –Mental Health Services (Beds and Luton)
Reena Pankhania	RP	Formulary Pharmacist, Bedfordshire Hospitals Trust
Candy Chow	CC	Principal Pharmacist, Formulary and Interface, MKUH
Sandra McGroarty	SMcG	Commissioning Pharmacist, BLMK CCG
Dona Wingfield	DW	Commissioning Lead Pharmacist
Dr Joy Muttika	JM	Medical Representative, Keech Hospice
Dr J Cross	JCr	Medical Representative, St John's Hospice
Raye Summers	RS	PA to MOT,BLMK CCG (Note taking)
Jacqui Johnson	JJ	Practice Nurse, Watling Vale Medical Centre
Nikki Farrell	NF	Practice Nurse, Watling Vale Medical Centre
Nikki Woodhall	NW	Medicines Optimisation Lead Technician, BLMK CCG
Dr Marian Chan	MC	Medical Representative, Bedfordshire Hospitals NHS Trust

Rafal Ali	RA	Place Based Pharmacist, BLMK CCG

Apologies:		
Dr N Fagan	NF	Place Based Lead GP – Milton Keynes
Dr Dush Mital	DM	Medical Representative, Milton Keynes Hospital (Dr Cooney in attendance)
Carole Jellicoe	CJ	Nurse Representative (Independent Prescriber)
Dr Tejal Shah	TS	Medical Representative, St John's Hospice (Dr Cross deputising)

No	Agenda Item	Action
1.	**Welcome, Introductions and Apologies** The Chair welcomed everyone to the meeting and all members present introduced themselves. Apologies were received and noted as above. 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. CG declared an interest re agenda item 5.5 and JC declared an interest re agenda item 5.6 and both agreed not to contribute to the discussion on the relevant agenda item. There were no other declarations of interest relating to the agenda	

No	Agenda Item	Action
3.	**Minutes of the previous meeting – Milton Keynes Prescribing Advisory Group (MKPAG) and Bedfordshire and Luton Joint Prescribing Committee (JPC)** As this is the inaugural meeting of the group, there were no meeting minutes to be confirmed. Both Legacy Groups (MKPAG) and JPC) had minutes of their previous meetings approved. These minutes were therefore noted for information only.	
4.	**Matters Arising** The matters arising from MKPAG and JPC have been split between the Formulary Subgroup and APC depending on the nature of the action.	
4.1	**MKPAG - New BLMK Medicines Optimisation Committee (MOC) or Area Prescribing Committee (APC) – Terms of Reference (ToR)** Awaiting ratification by BLMK APC. The committee agreed that action could be closed– see agenda item 7.1.	Close action
4.2	**MKPAG - New BLMK Formulary Subgroup to the BLMK APC – Terms of Reference (ToR)** Awaiting ratification by BLMK APC. The committee agreed that action could be close – see agenda item 7.2.	Close action
4.3	**JPC – Lay Representative** Now not required as Committee no longer exists and we have appointed a Lay Representative to the BLMK APC. The committee agreed that the action could be closed.	Close action
4.4	**JPC - Interim Iontophoresis Commissioning Policy (applies across BLMK)** The lack of provision of Iontophoresis machines for patients who could not afford to buy them should be referred to CCG Planned Care. CCG Planned care has been contacted and has advised that this project is being reviewed. This is therefore an ongoing action for CCG Planned Care. To remain on Matters Arising for the purposes of follow-up with Planned Care only.	JC
4.5	**JPC – Implementation of NICE Chronic Pain Guideline- NG 183** This guideline will take some time to implement as there is a change in direction from pharmacological to non-pharmacological methods of managing chronic pain. The Community Chronic Pain Guideline (BLMK) is currently being updated and is scheduled for consideration at the December APC meeting. This work is proceeding with CCG Planned Care involvement. This is therefore an ongoing action.	Omos Olunloyo/CCG Planned Care

No	Agenda Item	Action
4.6	**JPC - RMOC Shared Care Guideline Template** To be brought to the first meeting of BLMK APC for consideration alongside the current MKPAG and JPC Shared Care Guideline Template. The committee agreed that this action could be closed as it was being considered as agenda item 5.7.	Close action
5	**Items for consideration at meeting**	
5.1	**Primary Care Guideline for Adults with Asthma Update** This guideline has been reviewed as part of the BLMK Integrated Care System (ICS) policy alignment within primary care. The APC was being asked to ratify the updated document, which included additional information with regards to pandemic recovery and restoration, updated national guidance recommendations, embedding of NHS sustainability agenda (lowering of carbon footprint), reconciliation of treatment options against local formularies and inclusion of recently approved treatment options. The following information was noted: • Alignment of primary care guideline across BLMK ICS • The author worked closely with MK colleagues on ensuring most-up-to-date clinical management in line with British Thoracic Society (BTS), National Institute for Health and Care Excellence (NICE) and Global Initiative for Asthma (GINA). • Building on the NHS environmental sustainability agenda – phased approach - reconciliation of Integrated Care Partnership (ICP) formulary inhalers, ensuring low carbon footprint choice is available (Soft Mist Inhaler or Dry Powder Inhaler) alongside Metered Dose Inhaler with spacer) Not first or second line – need to use to suit patient. Looking to reduce carbon footprint but gradually in line with national guidance. PrescQIPP guidance not included as it is currently being reviewed. Discussions on the use of easyhalers to be conducted with PCNs. • Short reference guide to be produced (4-5 pages) based on the prescribing pathway, ICS dosing, diagnostic chart and inhaler range • Section on COVID and post discharge management included	

	• Haven't gone for first/second line choices as choice is dependent on what the patient can use. • Section 3a has been revised – agreed that montelukast should remain; Tiotropium to be given on specialist advice. Low Inhaled Corticosteroid section has been expanded. • Section 3b is a new section where we reconciled the two Joint Formulary choices which were in act very similar. Sereflow® to be added as this section as this is a cost-effective preparation. • As the two Joint Formularies have different traffic light designations particularly as regards 'amber', it was agreed that information on this needed to be added. • Locality teams are looking at environmental issues re use of salbutamol and beclometasone Metered Dose Inhaler, but 'blanket switching' was not proposed. With the amendments outlined above, the guidelines were approved. DW expressed her thanks to Dr Dayo Kuku, NW and and Ruth Thomas in the production of the guidance	DW
5.2	**Oxygen for Cluster Headache** The committee was being asked to ratify the minor update to the 'Oxygen for cluster headaches' bulletin as part of the policy alignment workstream for BLMK ICS. The Bedfordshire and Luton Joint Prescribing Committee (JPC) had previously endorsed the following the regional East of England Priorities Advisory Committee Statement on Oxygen for Cluster Headaches (JPC Bulletin 252) Click here to access the bulletin. Bulletin 252 has been discussed with Dr Butterworth, Consultant Neurologist, Milton Keynes University Hospital Trust who is supportive of the document and has asked for two local amendments to be made. **Proposed change(s) to front page of bulletin:** **Recommendation 2** 'When using oxygen for the acute treatment of cluster headache, use 100% oxygen at a flow rate of at least 12 litres per minute with a non-rebreathing mask and a reservoir bag.' Through consultation with the neurology teams, Dr Butterworth has advised that it is his practice to use a nasal cannulae at 15 Litres/minute instead of a non-rebreathing mask and reservoir bag and asked that this should be included as an option. It was noted that this is in line with BTS guidelines 2017, https://bmjopenrespres.bmj.com/content/4/1/e000170 issued post PAC statement production)	

	Smoking and Oxygen Use Dr Butterworth has asked that it should be highlighted that patients should be informed of the dangers of smoking while receiving oxygen therapy. The BLMK ICS 'Prescribing of Home Oxygen' policy produced in 2021, promotes patient safety and prevent avoidable harm associated with smoking and using home oxygen therapy. The risks associated with fire and personal safety also affect family, health care professionals and the public. https://www.blmkccg.nhs.uk/wp-content/uploads/2021/06/Home-Oxygen-Therapy-BLMK-Policy-June-2021-FINAL.pdf This policy applies to all Healthcare Professionals (HCPs) and sets out the procedure for prescribing home oxygen to patients who are registered with a General Practitioner (GP), within the BLMK ICS area. The committee supported the addition of the use of a nasal cannulae as a treatment option in addition to the non-rebreathing mask and a reservoir bag to deliver oxygen (details as outlined above) and the extension of the policy across all BLMK. It was agreed that Dr Butterworth(or a member of his team) would be given time (post meeting) to confirm that they were happy with the amendment prior to issuing the updated policy as they had not had time to review pre meeting due to clinical commitments. This information would be added as a post meeting note in the minutes. **Post meeting note:-** Dr Jane Cross commented - Apologies for not commenting on high flow oxygen 15l/min via nasal specs for cluster headaches in time-my understanding has always been that a maximum flow of 6l/min of oxygen is able to be administered via nasal specs hence the BTS guidelines suggestion of a mask and rebreathe bag to deliver this amount. Clarification as suggested from MK neurology would be good. **Milton Keynes Hospital Neurology Department: - feedback awaited** **EQIA Assessment:-**. Yes – the impact of the update will enable standardised approach to care across BLMK ICS, and in line with regional position. Local amendments have been made to reflect exceptions and there is a positive impact on patient safety due to the development and inclusion/ signposting of the BLMK ICS 'Prescribing of Home Oxygen' policy produced in 2021, which promotes patient safety and prevent avoidable harm associated with smoking and using home oxygen therapy. **BLMK CCG E and D Lead comment** This is a patient safety amend, only consideration might be thinking about the communication needs of patients. (something for those communicating the change to consider) (language, BSL etc)	DW JC
5.3	**Treatment Pathway for Active Psoriatic Arthritis Update**	

	The JPC treatment pathway for Active Psoriatic Arthritis (after inadequate response to DMARDs) has been updated to include Guselkumab following the publication of NICE Technology Appraisal Guidance 711 - Guselkumab for treating active psoriatic arthritis after inadequate response to DMARDs. https://www.nice.org.uk/guidance/ta711 and extended to become a BLMK Pathway. The pathway was agreed at the Rheumatology pre-meeting which included representatives from the Bedfordshire Hospital and Milton Keynes Hospital with the following amendment and ongoing action:- • Addition of '**discussion'** as an option as well as referral to dermatologist where adequate PASI 75 response is achieved but PsARC score has not met required threshold. • **Ongoing Action:-** NICE TA 711 was reviewed again re Guselkumab additional criteria for assessing the PASI score in addition to the assessment of body surface area of at least 3% affected by plaque psoriasis. The Rheumatology teams advised that they do not usually assess PASI but instead assess via joint swelling and joint tenderness as the priority within Rheumatology to meet NICE criteria. If there is no improvement in the skin – the patient is referred/discussed with a dermatology. This information has been fed back to NICE and a response is awaited around the need to assess the PASI score in addition to the Body surface area. The APC was asked support the pathway and to give permission to make amendments (if necessary) post meeting to the pathway following response from NICE by chairman's action. The committee supported the pathway and the agreement that it could be amended by chairman's action in accordance with the NICE response if required. **EQIA Assessment:-**. **Yes -** a positive impact due to the availability of another patient option in this patient group. **BLMK CCG E and D Lead comment -** Change is in line with NICE guidance. No concerns.	JC
5.4	**Ankylosing Spondylitis – Biologics Treatment pathway for Ankylosing Spondylitis and Non-radiographic Axial Spondyloarthritis (nrAxial SpA) – Update** The biologics Treatment pathway for Ankylosing Spondylitis and Non-radiographic Axial Spondyloarthritis (nrAxial SpA) has been updated following publication of two new NICE technology appraisal guidance. As this was previously a Bedfordshire and	

	Luton pathway, it has also been amended to incorporate the whole of Bedfordshire, Luton and Milton Keynes. Additionally, amendments have been made to add 'infliximab IV'* when infliximab appears in the pathway and to allow a third line treatment option for patients who have treatment with ixekizumab or secukinumab second line**.** ***intravenous** Relevant NICE technology appraisal guidance: • Ixekizumab for treating axial spondyloarthritis (TA718, Published: 21 July 2021) • Secukinumab for treating non-radiographic axial spondyloarthritis (TA719, Published: 21 July 2021). The pathway was agreed at Rheumatology pre-meeting which included representatives from the Bedfordshire Hospital Trust and Milton Keynes Hospital (with no follow-up/changes required). The committee supported the pathway. **EQIA Assessment:-**. No issues have been identified. Recommendations are in line with NICE guidance, with the exception of a pragmatic local amendment which will allow greater access to treatment for the relevant patient cohort. **BLMK CCG E and D Lead comment -** In line with NICE – no issues identified.	
5.5	**Treatment Pathway for Rheumatoid Arthritis Update** The committee was asked to consider an update to the main JPC approved Rheumatoid Arthritis Treatment Pathway (Algorithm A) – Treatment of Moderate to Severe Rheumatoid Arthritis (after inadequate response to DMARDs) The main pathway was previously updated to facilitate the use of filgotinib at the moderate disease stage as per NICE TA 676.The moderate disease options have now been extended to include the use of the 3 specific TNF inhibitors (s/c adalimumab , s/c etanercept and IV infliximab) following the publication of NICE Technology Appraisal Guidance 715 – 'Adalimumab, etanercept, infliximab and abatacept for treating moderate rheumatoid arthritis after conventional DMARDs have failed' www.nice.org.uk/guidance/ta715. The pathway has also been extended to include Milton Keynes and is proposed as a BLMK pathway for consideration. The pathway was considered at the Rheumatology pre-meeting (which included Rheumatology representatives from both acute Trusts) and approved as written with clarification of wording on number of lines of therapy proposed by SMcG. It was agreed that	

	the option to treat with another TNF inhibitor if there was an ADR in first 6 months would remain in both the moderate and severe parts of pathway. The following future actions were agreed:- 5th line therapy in Algorithm A to be added and Algorithm B to be reviewed. Work to start before Christmas but with likely APC consideration on 2nd March 2022. SMcG to confirm that Dr Banerjee (Consultant Rheumatologist at MKUH) would be happy to endorse the current algorithm B pending the review outlined above so that the full pathway (algorithms A and B) could be 'rebadged' as a BLMK pathway. The committee supported the updated pathway. **EQIA Assessment:-**. **Yes -** a positive impact due to the availability of another patient option in this patient group. **BLMK CCG E and D Lead comment -** Specific intervention, no impact seen.	SMcG SMcG
5.6	**Severe Psoriasis Pathway Update** The Severe Psoriasis pathway has been updated following publication of new NICE technology appraisal guidance (Bimekizumab for treating moderate to severe plaque psoriasis, TA723, Published: 01 September 2021). It has also been amended to add 'IV' when infliximab appears in the pathway and the layout of the pathway has been updated. This pathway was a Bedfordshire and Luton pathway but agreed with Milton Keynes dermatologists as part of the BLMK policy alignment work. The updated pathway was:- • Circulated to Dermatologists at both Trusts for comment. • Clinicians were in agreement with the pathway. • A comment was received from MKUH regarding dose escalation. It was agreed that this will need to be considered fully at a future meeting. The committee supported the updated pathway. **EQIA Assessment:-**. No issues have been identified. Recommendations are in line with NICE guidance. **BLMK CCG E and D Lead comment** - This update is in line with NICE and to make a BLMK wide policy.	AG
5.7	**Shared Care Guideline Template** **Background:** • A BLMK-wide Shared Care Guideline (SCG) template has	

	been produced following publication of the *Shared Care for Medicines Guidance* from RMOC (February 2021) and the decisions previously made at the legacy prescribing committees (MKPAG and JPC). • To replace the existing shared care guideline templates from Milton Keynes and Bedfordshire & Luton. **Benefits and Importance**: • Brings BLMK in line with national recommendations and guidance in regard to shared care for medicines. • Enables a consistent approach to requests of shared care for prescribing medicines between Specialists and Primary Care prescribers across the BLMK ICS. • Promotes standardised practice in relation to shared care for medicines across the BLMK ICS. • Ensures equity of patients' access to treatment/medicines of which the prescribing can be shared between the Specialist and the GP under the agreed SCG specific for the medicine across BLMK. • Enables Specialists and Primary Care prescribers across BLMK to have the same access to prescribing and monitoring guidance for the relevant medicines. The following changes to the existing template have been made:- • **General SCG principles and requirements** have been added and summarised on page 1 in accordance to the RMOC guidance. • **Wording around GP acceptance** of SCGs has also been updated in consultation with MK and Bedfordshire & Luton colleagues in view of the difference in approach historically. • The **14-day requirement** for the GP to respond to the request for shared care is as per the RMOC guidance. Noted that this could be challenging in a busy GP practice but that practices needed to have processes in place to support the acceptance of shared care and that it was not always GPs who had to action patient prescribing and monitoring under shared care. • The **areas of responsibility** for the Specialist, GP and patient/carer have been updated in line with RMOC. Further responsibilities that are specific and relevant to the medicine of topic can be added. • The '**Dose Regime & Route of administration**' section has been updated and broken down to: Initial stabilisation, Maintenance and Conditions requiring dose adjustment. • **Reporting via the Yellow Card** – note and link added. • **Monitoring requirements by Specialist** – updated to include different stages of therapy (baseline, initiation and maintenance).	

	• **Ongoing monitoring requirements by GP** – updated to include prompts and subheadings for ease (monitoring, frequency, result and action for GP). • **Advice to patients and carers** – new section added as per RMOC guidance template, includes when the patient should report their signs/symptoms to their GP immediately. • **Pregnancy, paternal exposure and breastfeeding** – new section added as per RMOC guidance template. • **Shared Care Prescribing Agreement** (Appendix 1) – updated to include how long patient has been on an optimised dose for, a checklist of actions that the Specialist should confirm they have undertaken before requesting shared care, and a list of possible reasons for GP to decline shared care. As the paper was circulated quite close to the meeting, the chair advised that extensive discussion time would be available so that everyone could have input. The information below includes points raised pre-meeting (with the author's responses in red) and points raised at the meeting:- • Insertion of a section on Community Pharmacy responsibilities? Concerns were raised that acute Trusts did not normally communicate with Community Pharmacies directly and patients were not always registered with the same pharmacy, we were therefore setting Community Pharmacists up to fail. The committee was also advised however that encouraging more clinical involvement in patient care by Community Pharmacists was essential to future care. It was noted that Community Pharmacies do receive the APC newsletter which signposts to updated revised shared care guidelines (noted that Newsletter distribution needed to be extended to include Milton Keynes Community Pharmacies – JC/RS to liaise with NW). Noted that there was Community Pharmacy representation on the Formulary Subgroup where shared care guidelines would normally be considered. **It was agreed that a Community Pharmacy responsibility section would be added and updated as appropriate depending on the drug under consideration.** • The section on initiation and ongoing dose and route of administration – suggest that the very small type in red, is moved to the box on the right and made bigger as this is key information. **Guidance notes that are currently in small red font will be moved into the box on the right**	JC/RS/NW

	and the font made bigger.
	• **Specialist Responsibilities -** Transfer of Prescribing to GP within 28 days is often not reasonable (and conflicts with the paragraph re stabilisation of patient) – that said, the information does say that further prescriptions can be issued. **The transfer of prescribing to GP can occur within 28 days OR once the patient is stabilised on the medication will be made clearer.**
	• **GP Responsibilities –** To ensure that the patient is attending appointments – presumably primary care rather than secondary care appointments? **It would be primary care appointments for the GP responsibilities, and secondary care appointments for the Specialist responsibilities. This will be clarified in the document.**
	• **GP – responsibilities** - GPs are not expected to be asked to participate in a shared care arrangement where:
	  • no locally approved SCG exists, or the medicine or condition does not fall within the criteria defining suitability for inclusion in a shared care agreement
	  • the prescriber does not feel clinically confident in managing this individual patient's condition, and there is a sound clinical basis for refusing to accept shared care **Comment -** Formal shared care guidelines are not required for everything as long as the specialist provides the information in line with the principles in the template (This information is in all of the Trust Prescribing Specifications) **Agreed**
	
	• RMOC recommends that GPs should be asked to formally respond to a specialist request to share care before a shared care agreement can commence. This is current practice in MK (where there is strong support for this to continue) but not in Beds and Luton where it is anticipated that GPs will undertake shared care when working within a shared care guideline produced by the APC, noting that GPs are never obliged to share care and have the option to notify the Specialist if they do not feel competent to undertake shared care. The major reason that the Beds and Luton had taken this view was to reduce the administrative burden on both primary and secondary care. It was suggested that 'grading' of drugs could occur e.g. where shared care was common (e.g. DMARDS) then shared care could proceed without GP confirmation) and where uncommon, the specialist would need to await the response from the GP but this suggestion was discarded as thought that it may complicate the process. It wasn't clear how often MK GPs responded to Specialists – a 'straw poll' suggested a mixed picture. It was noted that the GMC Guidance covered shared care where there was an expectation that GPs would take on shared care unless they had a specific reason to refuse, when it would be up to the APC/CCG/Secondary Care to work with the GP to provide additional information, work with the specialist to support the GP. **Agreed that the shared care guideline template was to be updated to state that it would be anticipated that**	

	primary care will accept shared care and that they should respond the Secondary/Tertiary Care Clinician if they do not wish to do this in a timely manner (confirmation of response time to be confirmed during final consultation noting that views expressed at the meeting suggested that 14 days was thought to be too tight a timescale) of receipt of the request from the Specialist in line with RMOC Guidance and that this information needed to be included on the front of the document. It was agreed that a link to the GMC Guidance could be added. It was further agreed that the wording of the document would make it clear that Specialists were happy to be contacted and to support GPs with any questions if they were unsure about taking on shared care. • Noted that the section entitled GP, should be amended to state Primary Care Clinician as it may not be the GP who undertakes the prescribing and monitoring. References to GP should be amended to read 'primary care clinician' where appropriate throughout the document. • The Principles of shared care at start of the document were important but it was acknowledged that this section was 'wordy' and GPs may not read it. It was therefore suggested (and agreed) that this section should be reduced in size. • A FAQ section was suggested and it was agreed that this may be helpful to support clinicians who were unsure about the shared care process. This could be included at the back of the document but referred to on the front page. The need for this was to be considered after the rewording of the shared care guideline had been undertaken. • Patient handheld booklets – the need for the GP to keep these up to date was debated. While these were the subject of Patient Safety Alerts in the past, practice had moved on and patients were often not seen by GPs when prescriptions were issued as prescriptions went directly to Pharmacies. **This was an outstanding question for further clarification as the Committee did not make a formal decision on this point.** It was agreed that the above amendments would be made to the shared care guideline template which would then be re-circulated for final comment (clarification to be sought on timescales for GP response to specialist and patient hand held booklets as part of this consultation) prior to adoption by the committee. This would ensure that those who had not had an opportunity to comment in advance of the meeting could so. **EQIA Assessment:-**. Yes – the impact of the Shared Care Guideline template will enable a standardised approach to requests for shared care for prescribing medicines between Specialists and Primary Care prescribers across the BLMK ICS, and in line with national recommendations/guidance. This will have a positive impact on the equity of patients' access to treatment that can be	CC CC

	shared between the Specialist and the GP. This will also enable Specialists and Primary Care prescribers across BLMK to have the same access to prescribing guidance for the affected medicines. **BLMK CCG E and D Lead comment –** Not assessed	
5.8	**Transgender Shared Care Guidelines – Update** The committee was being asked to review the draft updated transgender shared care guidelines produced by the Tavistock and Portman NHS Foundation Trust (tertiary centre); for transmen (female to male transitioning) and for transwomen (male to female transitioning). **Background** The Bedfordshire and Luton Joint Prescribing Committee agreed to adopt the transgender shared care guidelines written by the Charing Cross Gender identity clinic back in 2017. This centre is now under the management of the Tavistock and Portman Foundation Trust. The shared care guidelines have been updated by the original Charing Cross clinicians and the same clinicians still run the Tavistock centre. Since the version approved by the JPC back in 2017, there appears to have been several updates of which we were not notified of. As a result, the summary of comparisons was prepared comparing the original 2017 versions with the now proposed updated versions. The committee was asked to note that the two shared care guidelines were originally updated in 2019, with minor update to wording Sept 2020 and retrospective approval was now being sought. Governance – SMcG had confirmed that the original shared care guidelines had been approved by the West London Mental Health Trust and ratified by the Bedfordshire and Luton Joint Prescribing Committee. SMcG advised that a September 2021 updated version of the guidelines would be available shortly but that no major update was anticipated. The new guidelines were expected to clarify Specialist responsibilities in more detail and include information on 'bone' health for GPs. The committee agreed to retrospectively approve the 2019/20 updates and agreed that the 2021 updates could come to the committee for virtual approval when they were finalised. It was confirmed that the shared care guidelines related to the treatment of adult patients only. Prescribing for children/adolescents should not be passed to GPs as per current guidance. **EQIA Assessment:-** No – update to current guidelines.	SMcG

	BLMK CCG E and D Lead comment - I am not clear where this will be used, due to the sensitivity of this area further EIA work may be considered. I need to understand more. If this doesn't go through it will need to be looked at again to identify what can be done to support patient access to prescribing.	
5.9	**Inclisiran for Primary hypercholesterolaemia or mixed dyslipidaemia** **The following information was received in the CCG on Wednesday 22nd September:-** On Wednesday 1 September 2021, NICE published a positive final appraisal document (FAD) for Inclisiran. The commercial deal agreed with NHS England (NHSE) meant that this treatment is now a clinically and cost-effective treatment option for a broader patient population. Inclisiran is recommended as an option for treating primary hypercholesterolaemia (heterozygous familial and non-familial) or mixed dyslipidaemia as an adjunct to diet in adults. It is recommended only if: • There is a history of any of the following cardiovascular events: ○ Acute coronary syndrome (such as myocardial infarction or unstable angina needing hospital admission). ○ Coronary or other arterial revascularisation procedures. ○ Coronary heart disease. ○ Ischaemic stroke or ○ Peripheral arterial disease and • Low density lipoprotein cholesterol (LDL-C) concentrations are persistently 2.6 mmol/l or more, despite maximum tolerated lipid lowering therapy. Inclisiran is given by subcutaneous injection (pre-filled syringe) - The recommended dose is 284 mg inclisiran administered as a single subcutaneous injection: initially, again at 3 months, followed by every 6 months. **Key points for information:** • NHSE is making central funding available for inclisiran from the release of the NICE FAD (01.09.2021) so that local finances are not a barrier to the local uptake of inclisiran. • Although mainly funded centrally, a 'nominal' price (charge)	

	has been agreed that will be funded from the CCG budget. • The Accelerated Access Collaborative and Academic Health Science Networks will work with system leaders to support the implementation of inclisiran within the primary care setting. **Key Points for action:** • Rapid convening of local area prescribing committees to review and adopt inclisiran. • Listing inclisiran within the local formulary in line with NICE guidance set out in the FAD • Listing inclisiran with green status on your local formulary to allow prescribing by GPs and independent prescribers in the primary care team. • Allocation of funding to GP budgets to fund inclisiran at the nominal price in line with anticipated uptake. The APC was asked (and agreed) to approve the addition of inclisiran to the two joint formularies as mandated by NHSE. Implementation will be led by the Primary Care Teams e.g. at the October Prescribing Committees. PCN chairs to be advised at future appropriate meetings. MD advised that the CCG had received transformation (additional) funding to set up specialist lipid clinics in the community. Initial funding was for 1 year with a potential extension of funding for a further year. MD advised that this will be a good place to implement a clear lipid pathway which would include inclisiran. **EQIA Assessment -** Not assessed as subject of a NICE Technology Appraisal Guidance and mandated by NHSE. **BLMK CCG E and D Lead comment -** EQIA assessment is the responsibility of NHSE given the mandate outlined above.	JC/CC FG/MD/ NC/MA
6.0	**NICE Guidance – 17th June – 15th September inclusive** **The following NICE Technology Appraisal Guidance (CCG Commissioned) have been published:-** Budesonide orodispersible tablet for inducing remission of eosinophilic oesophagitis Technology appraisal guidance [TA708] Published: 23 June 2021 https://www.nice.org.uk/guidance/ta708 No significant resource impact is anticipated This technology is commissioned by integrated care systems / clinical commissioning groups. Providers are NHS hospital trusts. **APC action –** New entry created in Formularies and link added to both Joint Formularies. Formulary Subgroup has confirmed 'red' (hospital only) designation on Formulary. Guselkumab for treating active psoriatic arthritis after inadequate	

	response to DMARDs, Technology appraisal guidance [TA711] Published: 30 June 2021 https://www.nice.org.uk/guidance/ta711 No significant resource impact is anticipated Guselkumab is commissioned by integrated care systems and clinical commissioning groups. Providers are NHS hospital trusts. **APC Action** – created in Musculoskeletal part of Formularies and link added to Joint Formularies. PsA Pathway updated to include Guselkumab (see agenda item 5.3). 'Live' Appendix 1 updated. Dabigatran etexilate for the prevention of stroke and systemic embolism in atrial fibrillation, Technology appraisal guidance [TA249]Published: 15 March 2012 Last updated: 02 July 2021. https://www.nice.org.uk/guidance/ta249 Rivaroxaban for the prevention of stroke and systemic embolism in people with atrial fibrillation, Technology appraisal guidance [TA256]Published: 23 May 2012 Last updated: 02 July 2021. https://www.nice.org.uk/guidance/ta256 Apixaban for preventing stroke and systemic embolism in people with non-valvular atrial fibrillation, Technology appraisal guidance [TA275]Published: 27 February 2013 Last updated: 02 July 2021. https://www.nice.org.uk/guidance/ta275 Edoxaban for preventing stroke and systemic embolism in people with non-valvular atrial fibrillation, Technology appraisal guidance [TA355]Published: 23 September 2015 Last updated: 02 July 2021. https://www.nice.org.uk/guidance/ta355 In **July 2021**, NICE updated recommendation 1.2 in all four NICE TAs (outlined above) to include the other anticoagulants approved by NICE. Please see the NICE guideline on atrial fibrillation for further guidance on using this treatment. Adalimumab, etanercept, infliximab and abatacept for treating moderate rheumatoid arthritis after conventional DMARDs have failed, Technology appraisal guidance [TA715]Published: 14 July 2021. https://www.nice.org.uk/guidance/ta715 **Financial Impact using NICE and local assumptions:-** Bedfordshire - £51,940 Luton - £22,596 Milton Keynes - £29,887 **APC Action –** Links added to both Joint Formularies RA Pathway to be updated (see agenda item 5.5). 'Live' appendix 1 updated. Secukinumab for treating non-radiographic axial spondyloarthritis, Technology appraisal guidance [TA719]Published: 21 July 2021. https://www.nice.org.uk/guidance/ta719 Ixekizumab for treating axial spondyloarthritis, Technology appraisal guidance [TA718]Published: 21 July 2021. https://www.nice.org.uk/guidance/ta718	

	APC Action (for TA 718 and 719) – AS pathway to be updated (see agenda item 5.4). Links added to both formularies. **Total financial impact** (using NICE and local assumption) for TA 718 and TA719: Bedfordshire:- £52,086 Luton - £22,660 Milton Keynes - £29,997 Continuous positive airway pressure for the treatment of obstructive sleep apnoea/hypopnoea syndrome Technology appraisal guidance [TA139]Published: 26 March 2008 Last updated: 20 August 2021. https://www.nice.org.uk/guidance/ta139 **August 2021 Update**: The recommendation on continuous positive airway pressure (CPAP) for mild obstructive sleep apnoea/hypopnoea syndrome (OSAHS) has been updated and replaced by recommendation 1.5.2 on CPAP for mild OSAHS in the NICE guideline on obstructive sleep apnoea/hypopnoea syndrome and obesity hypoventilation syndrome in over 16s. Bimekizumab for treating moderate to severe plaque psoriasis Technology appraisal guidance [TA723]Published: 01 September 2021 https://www.nice.org.uk/guidance/ta723 No significant resource impact is anticipated **APC Action –** created and added to both Formularies and update the Severe Psoriasis Pathway (see agenda item 5.6) noting that this TA has a 30 day implementation. Live appendix 1 updated. **The following NICE Guidelines (NG) (Medicine related and CCG Commissioned) have been published / updated by NICE:**	

	Shared decision making, NICE guideline [NG197] Published: 17 June 2021, https://www.nice.org.uk/guidance/ng197 This guideline covers how to make shared decision making part of everyday care in all healthcare settings. It promotes ways for healthcare professionals and people using services to work together to make decisions about treatment and care. It includes recommendations on training, communicating risks, benefits and consequences, using decision aids, and how to embed shared decision making in organisational culture and practices. Acne vulgaris: management, NICE guideline [NG198] Published: 25 June 2021, https://www.nice.org.uk/guidance/ng198 This guideline covers management of acne vulgaris in primary and specialist care. It includes advice on topical and oral treatments (including antibiotics and retinoids), treatment using physical modalities, and the impact of acne vulgaris on mental health and wellbeing. **APC Action –** Update to Community Antimicrobial Guidelines – Scheduled for the Dec 2021 APC meeting. Atrial fibrillation: diagnosis and management, NICE guideline [NG196]Published: 27 April 2021 Last updated: 30 June 2021 https://www.nice.org.uk/guidance/ng196 On **30 June 2021**, we amended our recommendation on using the ORBIT score to assess bleeding risk to reinstate the previous link to an appropriate calculation tool, which was removed in error on 10 June 2021. 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 In **July 2021**, we reviewed the evidence and updated the recommendations on long-acting insulin therapy. **APC Action -** EoEPAC Secretary to review PAC Guidance. Clostridioides difficile infection: antimicrobial prescribing, NICE guideline [NG199]Published: 23 July 2021. https://www.nice.org.uk/guidance/ng199 This guideline sets out an antimicrobial prescribing strategy for managing *Clostridioides difficile* infection in adults, young people and children aged 72 hours and over in community and hospital settings. It aims to optimise antibiotic use and reduce antibiotic resistance. The recommendations do not cover diagnosis. **APC Action -** Update Community Antimicrobial Guidelines – Scheduled for the Dec 2021 APC meeting Bronchiolitis in children: diagnosis and management NICE guideline [NG9]Published: 01 June 2015 Last updated: 09 August 2021, https://www.nice.org.uk/guidance/ng9 In **August 2021**, NICE reviewed the evidence and updated the recommendations on oxygen saturation thresholds for referral to hospital, admission, management and timing of discharge. For more information, see update information.	NC/JC JC/AG/Jo Lowe NC/JC

	Antenatal care, NICE guideline [NG201]Published: 19 August 2021. https://www.nice.org.uk/guidance/ng201 This guideline covers the routine antenatal care that women and their babies should receive. It aims to ensure that pregnant women are offered regular check-ups, information and support. We have also published a guideline on postnatal care, which covers the topics of emotional attachment and baby feeding. Chronic kidney disease: assessment and management, NICE guideline [NG203]Published: 25 August 2021 https://www.nice.org.uk/guidance/ng203 This guideline covers care and treatment for people with, or at risk of, chronic kidney disease (CKD). It aims to prevent or delay the progression, and reduce the risk of complications and cardiovascular disease. It also covers managing anaemia and hyperphosphataemia associated with chronic kidney disease. **APC Action -** There are recommendations on the use of SGLT2 inhibitors, but these recommendations have gone out for further consultation. To bring back to the APC when further information is available. Result of consultation is due to be published at the end of November so likely consideration at the 2nd March APC Babies, children and young people's experience of healthcare, NICE guideline [NG204]Published: 25 August 2021 https://www.nice.org.uk/guidance/ng204 This guideline describes good patient experience for babies, children and young people, and makes recommendations on how it can be delivered. It aims to make sure that all babies, children and young people using NHS services have the best possible experience of care. It is recognised that parents and carers play a key role, and where appropriate, we took their views into account when developing the recommendations. **The following COVID 19 – Rapid Reviews and other information have been produced/Updated by NICE:-** COVID-19 rapid guideline: haematopoietic stem cell transplantation, NICE guideline [NG164]Published: 01 April 2020 Last updated: 22 July 2021. https://www.nice.org.uk/guidance/ng164 On **22 July 2021**, we made changes to recommendations on testing patients for viruses, including SARS-CoV-2 and repeating respiratory review in patients who test positive for, or are suspected of having COVID-19. See update information for further details. COVID-19 rapid guideline: vaccine-induced immune thrombocytopenia and thrombosis (VITT) NICE guideline [NG200]Published: 29 July 2021, https://www.nice.org.uk/guidance/ng200 This guideline covers vaccine-induced immune thrombocytopenia and thrombosis (VITT), a syndrome which has been reported in rare cases after COVID-19 vaccination. VITT may also be called vaccine-induced prothrombotic immune thrombocytopenia (VIPIT)	JC/AG

	or thrombotic thrombocytopenic syndrome (TTS). Because VITT is a new condition, there is limited evidence available to inform clinical management, identification and management of the condition is evolving quickly as the case definition becomes clearer. This guideline was produced to support clinicians to diagnose and manage this newly recognised syndrome. COVID-19 rapid guideline: managing COVID-19, NICE guideline [NG191]Published: 23 March 2021 Last updated: 10 August 2021 https://www.nice.org.uk/guidance/ng191 On **10 August 2021**, NICE corrected an error in the practical info section of the recommendations on corticosteroids. The dose of prednisolone for children with a greater than 44-week corrected gestational age is 1 mg/kg. On **2 September 2021**, we added new recommendations on non-invasive respiratory support and doxycycline, and updated existing recommendations on heparins. **The following NICE TA's are the commissioning responsibility of NHSE and are listed for information only.** Pembrolizumab for untreated metastatic colorectal cancer with high microsatellite instability or mismatch repair deficiency. Technology appraisal guidance [TA709] Published: 23 June 2021 https://www.nice.org.uk/guidance/ta709 **Recommended – APC Action – Link added to Joint Formularies** Ravulizumab for treating atypical haemolytic uraemic syndrome, Technology appraisal guidance [TA710] Published: 23 June 2021 https://www.nice.org.uk/guidance/ta710 **Recommended - APC Action – created and link added to Joint Formularies** Nivolumab for advanced non-squamous non-small-cell lung cancer after chemotherapy, Technology appraisal guidance [TA713]Published: 07 July 2021. https://www.nice.org.uk/guidance/ta713 **Recommended - APC Action – link added to both Formularies** Enzalutamide for treating hormone-sensitive metastatic prostate cancer, Technology appraisal guidance [TA712]Published: 07 July 2021. https://www.nice.org.uk/guidance/ta712 **Recommended - APC Action – link added to both Formularies** Onasemnogene abeparvovec for treating spinal muscular atrophy, Highly specialised technologies guidance, Reference number:HST15, Published: 07 July 2021. https://www.nice.org.uk/guidance/hst15 **Recommended – APC Action – MK Hospital has added this and the NICE HST link to their Joint Formulary (for information only), but also noted that this is only for use in highly specialised service/tertiary centre in line with NICE HST and that it is not used in MK Hospital.**	

	Bedfordshire Hospital reps confirmed that addition to the Beds and Luton Joint Formulary was not required. Dasatinib for treating Philadelphia-chromosome-positive acute lymphoblastic leukaemia (terminated appraisal) Technology appraisal [TA714]Published: 14 July 2021, https://www.nice.org.uk/guidance/ta714 **APC Action – none as terminated appraisal** Duvelisib for treating relapsed follicular lymphoma after 2 or more systemic therapies (terminated appraisal) Technology appraisal [TA717]Published: 21 July 2021. https://www.nice.org.uk/guidance/ta717 **APC Action – none as terminated appraisal** Nivolumab with ipilimumab for previously treated metastatic colorectal cancer with high microsatellite instability or mismatch repair deficiency Technology appraisal guidance [TA716]Published: 28 July 2021. https://www.nice.org.uk/guidance/ta716 **Recommended - APC Action – link added to both Formularies** Abiraterone for treating newly diagnosed high-risk hormone-sensitive metastatic prostate cancer Technology appraisal guidance [TA721]Published: 18 August 2021 https://www.nice.org.uk/guidance/ta721 **Not recommended - APC Action - none** Pemigatinib for treating relapsed or refractory advanced cholangiocarcinoma with FGFR2 fusion or rearrangement Technology appraisal guidance [TA722]Published: 25 August 2021 +https://www.nice.org.uk/guidance/ta722 - **APC action - created and added to both Formularies** Chlormethine gel for treating mycosis fungoides-type cutaneous T-cell lymphoma Technology appraisal guidance [TA720]Published: 18 August 2021 https://www.nice.org.uk/guidance/ta720 - **APC Action – created and added to both Formularies** Nivolumab with ipilimumab and chemotherapy for untreated metastatic non-small-cell lung cancer Technology appraisal guidance [TA724]Published: 08 September 2021 https://www.nice.org.uk/guidance/ta724 - **APC Action – none as negative recommendation** Abemaciclib with fulvestrant for treating hormone receptor-positive, HER2-negative advanced breast cancer after endocrine therapy Technology appraisal guidance [TA725]Published: 15 September 2021 https://www.nice.org.uk/guidance/ta725 - **APC Action - link added to both Formularies and link removed to TA579 as it is replaced by TA725.**	

7	**Virtual Recommendations/Documents – for discussion/ratification:-**	
7.1	**Committee Terms of Reference** Approved virtually and ratified by the committee with the addition of the ICS Interim Chief Pharmacist to the membership.	JC Action completed
7.2	**Formulary Subgroup Terms of Reference** Approved virtually and ratified by the committee.	
7.3	**Medicines Safety Subgroup Terms of Reference** Approved virtually and ratified by the committee. ME raised the issue that there was no lay representative on this group. DW/ZA agreed to work with ME around this issue and bring back a revised TOR, when resolved, to the committee.	ME/DW/ ZA
8	**Medicines Safety** DW reported the following key information to the Committee around the work of the Medicines Safety Subgroup: • BLMK ICS medicines safety group now formed. • Co-chairs: Zainab Alani (MSO, MKUH) and Laura Watson (Luton site MSO, BHFT) – 6 month term each • Secretariat: Dona Wingfield (interim) BLMK CCG • Three projects based on MHRA DSUs – sodium valproate, starch based thickeners, adrenal crisis steroid card, followed by annual report • All primary care related MHRA DSUs are sent through following reconciliation by medicines safety lead to BLMK primary care newsletter • BLMK CCG MSO registration with MHRA and new email Blmkccg.mso@nhs.net • Monthly updates sent to CCG medicines optimisation team and sent to ICS MSOs • Risk register co-managed with locality team to ensure system wide and local risks captured	
9	**Formulary Update**	
9.1	**Formulary Subgroup Recommendations** JC asked for and received ratification of the recommendations proposed by the Formulary Subgroup. See appendix 1 (minutes of the Formulary subgroup meeting) for more detail. The committee was asked to note that the two shared care guidelines that were discussed at the Formulary Subgroup (Cinacalcet and Denosumab) would be issued on legacy paper work (with the BLMK APC logos added) and the wording amended re GP/Specialist communication (prior to the start of shared care)	

<table>
<tr><td></td><td>amended in line with the agreement reached under agenda item 5.7.
The committee was also asked to note for information, the following additional changes to the Formularies made by the acute Trusts since the Formulary Subgroup meeting:
Addition by Bedfordshire Hospitals Trust –
• Pegasparagase (Oncospar®) – moved from Non-Formulary to Formulary (NICE TA)
Addition by both Acute Trusts:
• Ronapreve (casirivimab + imdevimab) – Covid 19 treatment</td><td></td></tr>
<tr><td>9.2</td><td>Wound Management Subgroup Recommendations
The following information was reported to the committee:
• The Term of Reference for the Wound Management subgroup are currently being updated and will come for ratification at the December APC meeting.
• Proposed additions to the wound care formulary
1. Eakin Wound Drainage Pouches (agreed by wound care subgroup)
2. Urgo Clean Hydrocolloid Dressing (decision deferred)
3. Urgo Start Protease Modulating Matrix Dressing (decision deferred)
• The decision regarding Urgo Clean and Urgo Start has been deferred to the next Wound Care meeting pending further discussion and agreement of their place in therapy.
• The foam dressings available via the NHS Supply Chain is being amended from 1st November – no significant impact expected (possibly cost saving).

The committee ratified the recommendations as proposed and noted the information re terms of reference and Urgo Clean and Urgo start.</td><td>AG</td></tr>
<tr><td>10</td><td>Antimicrobial Resistance Update

The following information was brought to the committee for noting:
• Minutes of the BLMK antimicrobial pharmacist network (June 21)
• BLMK ICS HCAI / AMR steering group due to meet in October 21 following extended delay due to COVID
• Letter from Kieran Hand - NHS System Oversight Framework (SOF) Antimicrobial Prescribing Metrics for 2021-22. This advises that the following metrics in relation to antimicrobial prescribing will be introduced for 21/22:
<table>
<tr><th>SOF Indicator</th><th>AMR Metric Description</th><th></th></tr>
<tr><td>44a</td><td>The number of antibiotic (antibacterial) items prescribed in primary care, divided by the item-based Specific Therapeutic group Age-Sex related Prescribing Unit STAR-PU per annum</td><td>At or less than 0.871</td></tr>
<tr><td>44b</td><td>The number of broad-spectrum antibiotic (antibacterial) items from co-amoxiclav, cephalosporin class and fluoroquinolone class</td><td>At or less</td></tr>
</table></td><td></td></tr>
</table>

	drugs as a percentage of the total number of antibacterial items prescribed in primary care.	than 10%

NC advised that the information outlined above would be taken to the next BLMK antimicrobial pharmacist network meeting but that the GP practices in BLMK were already at the 0.871 target outlined above.
NC asked if the BLMK antimicrobial pharmacist network should now report into the APC. NC was advised that there was no proposed change to reporting arrangements. The information from the group came to the APC for information only.
ME asked if she could be invited to the next meetings of the BLMK antimicrobial pharmacist network and the BLMK ICS HCAI/AMR steering group. NC agreed to action. — NC

11 — **East of England Priorities Advisory Committee (PAC) – items for noting/approval**

11.1 — **EoEPAC Meeting Notes – May 2021 (approved) and July 2021 (draft)**
The Committee noted these minutes for information

11.2 — **EoEPAC Meeting Notes - July 2021 (draft)**
The Committee noted these minutes for information

11.3 — **Thuasne ActionReliever® Off-loading Knee Brace for Osteoarthritis Bulletin and Recommendations**

The Thuasne ActionReliever® Off-loading Knee Brace for Osteoarthritis Bulletin and Recommendations were ratified by the Committee.

EQIA Assessment:- No impact as this product remains available for use, but must be prescribed and supplied in secondary care as fitting and support from a trained orthotist or physiotherapist or other specialist healthcare professional is essential to ensure maximum benefit is achieved.

BLMK CCG E and D Lead comment - *Routine use of Thuasne ActionReliever® off-loading knee brace is not recommended.*
It may have a limited place in therapy for some patients including those where
surgery is contra-indicated. However, fitting and support from a trained orthotist
or physiotherapist or other specialist healthcare professional is essential to ensure
maximum benefit is achieved.

I think the key will be this decision making, I am guessing its quite clearly clinical not cost based.

I am always cautious when something refers to limited evidence, we had this on cough machines and it was found that they were of benefit its just lack of research.

	I think the condition would count as a disability under EA 2010 so depending on patient feeling they could challenge, it would be down to evidence.	
12	**Bedfordshire, Luton and Milton Keynes Local Prescribing Committee Minutes -** all were noted by the committee for information.	
12.1	Minutes from the Bedfordshire Hospitals Foundation Trust DTC meeting – May 2021	
12.2	ELFT Medicines Management Committee Minutes (Mental Health) – May 2021	
12.3	Minutes of Circle/MSK MMC Meeting –**- none**	
12.4	Minutes of the Bedfordshire and Luton Wound Management Formulary Steering Group - May 2021	
12.5	Minutes of the Cambridgeshire Community Services Medication Safety and Governance Group – June 2021	
12.6	CNWL - Trustwide Medicines Optimisation Group (MOG) Meeting – April 2021	
13	**Any other business** The committee noted (for information), the National Overprescribing Review Report.	
14	**Future Dates for BLMK APC 2021/22 Meetings:-** Wednesday 1st December 2021 – 12.30-3.00pm Wednesday 2nd March 2022 – 12.30-3.00pm Wednesday 4th May 2022 – 12.30- 3.00pm Wednesday 29th June 2022 – 12.30-3.00pm Wednesday 28th September 2022 - 12.30-3 pm Wednesday 7th December 2022 - 12.30-3 pm	
Please inform Jacqueline Clayton of any apologies by email Jacqueline.clayton@nhs.net Circulation: BLMK APC Members, BLMK Medicines Optimisation Team (not APC members)		

Approval of minutes:
Chair: Alison Borrett

Signed:

Date:

Appendix 1 – Approved 7th September 2021 Formulary Subgroup Minutes:-

BLMK Forumulary Sub-group Septemb

B:\Primary Care\Medicines Optimisation\BLMK Commissioning\BLMK APC FROM SEPT 2021\December 2021\BLMK APC Sept 2021 Approved meeting notes.docx