BEDFORDSHIRE, LUTON AND MILTON KEYNES AREA PRESCRIBING COMMITTEE

Approved Meeting Notes

Date: 28 September 2022
Time: 12.30- 3.00pm
Venue: Microsoft Teams

Attendees:

Name	Initial	Role
Alison Borrett	AB	Chair (Non-Executive Member BLMK ICB)
Yolanda Abunga (until 14:45)	YA	CCS Pharmacy Representative (Community Services Pharmacist, Beds and Luton)
Mojisola Adebajo	MA	Place Based Lead Pharmacist – Luton
Reginald Akaruese	RA	CNWL Pharmacy Representative (Community and Mental Health Services Milton Keynes)
Saema Arain (until 13:00)	SA	ELFT Pharmacy Representative
Helen Chadwick	HC	Milton Keynes Hospital Pharmacy Representative (Chief Pharmacist, Milton Keynes Hospital)
Dr Samantha Chepkin (until 14:40)	SC	Consultant in Public Health
Jacqueline Clayton	JC	Chair of Wound Care Group
Naomi Currie	NC	Place Based Lead Pharmacist - Bedford
Matt Davies	MD	Place Based Lead Pharmacist – Central Bedfordshire
Dr John Fsadni	JF	Chair of Formulary Subgroup
Fiona Garnett	FG	Associate Director and Head of Medicines Optimisation BLMK ICB
Anne Graeff	AG	Commissioning Lead Pharmacist, BLMK ICB (Professional Secretary)
Laura Lorimer	LL	Chair of Medicines Safety Group
Dr Muhammad Nisar	MN	Medical Representative, Bedfordshire Hospitals NHS Trust
Dr Kate Randall	KR	Place Based Lead GP – Central Bedfordshire
Dr Mitan Sarkar	MS	Place Based Lead GP - Luton
Dr Jon Walter	JWa	Place Based Lead GP – Milton Keynes (deputy)
Dr Jenny Wilson	JW	Place Based Lead GP - Bedford

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

In attendance:		
Rafal Ali	RA	Commissioning Pharmacist, BLMK ICB
Janet Corbett	JCo	Pharmacy Programme Manager Milton Keynes University Hospital Foundation Trust
Taiya Large	TL	Formulary and Medicines Safety Pharmacist BLMK ICB
Sandra McGroarty	SMcG	Commissioning Pharmacist, BLMK ICB
Nikki Woodall	NW	Place Based Lead Pharmacy Technician – Milton Keynes
Dr Joy Mutitika	JM	Medical Representative, Keech Hospice
Raye Summers	RS	PA to MOT, BLMK ICB (admin support)
Dona Wingfield (absent between 13:55-14:30)	DW	Commissioning Lead Pharmacist, BLMK ICB
Helen McGowan (for agenda item 5.1)	HMcG	Place Based Pharmacist, BLMK ICB
Emma Cronly-Dillon (for agenda item 5.2)	ECD	Paediatric Lead and Prescribing Support Dietitian, Cambridge Community Services
Catie Blanchard (for agenda item 5.3)	CB	Food First Team Lead Dietitian, Cambridge Community Services
Naomi Scott (for agenda item 5.4)	NS	Clinical Effectiveness Manager, NHS South, Central & West Commissioning Support Unit
Katie Newens (for agenda item 5.4)	KN	Clinical Effectiveness Manager, NHS South, Central & West Commissioning Support Unit
Aneet Judge (for agenda item 5.5)	AJ	Medicines Optimisation Clinical Programme Manager, BLMK ICB
Eleanor Land (for agenda item 5.5)	EL	Programme Manager, Medicines Optimisation, BLMK ICB
Mr Aires Lobo (for agenda item 5.6)	AL	Consultant Ophthalmologist, Bedfordshire Hospitals NHS Trust

Apologies:		
Dr Marian Chan	MC	Medical Representative, Bedfordshire Hospitals NHS Trust
Dr Andrew Cooney	AC	Medical Representative, Milton Keynes Hospital
Dr Nigel Fagan	NF	Place Based Lead GP – Milton Keynes
Dr Dush Mital	DM	Medical Representative, Milton Keynes Hospital
Cheryl Green	CG	Patient Representative
Carole Jellicoe	CJ	Nurse Representative (Independent Prescriber)
Janice Jones	JJ	Pharmacist Representative, NHS Northampton Hospital Foundation Trust
Dr Richard Simpson	RS	Place Based Lead GP – Milton Keynes (deputy)

Absent:		
Dr Mya Aye	MA	Medical Representative, Milton Keynes Hospital

Pritesh Bodalia	PB	Bedfordshire Hospitals Trust Pharmacy Representative (Chief Pharmacist, Bedfordshire Hospitals Trust)
Dr Lindsay MacKenzie	LM	Place Based Lead GP Bedford (deputy to Dr Wilson)
Dr Eleanor Tyagi	ET	Medical Representative, Milton Keynes Hospital
Lesley Bates	LB	Representative, St John's Hospice
Gemma McGuigan	GMcG	Bedfordshire Hospitals Trust Pharmacy Representative (Deputy Chief Pharmacist, Bedfordshire Hospitals Trust)
Reena Pankhania	RP	Bedfordshire Hospitals Trust Pharmacy Representative (Formulary Pharmacist Bedfordshire Hospitals Trust)

No	Agenda Item	Action
1.	**Welcome, Introductions and Apologies** The Chair welcomed everyone to the meeting. Apologies were received and noted as above. The meeting was confirmed as quorate. The Chair thanked Dona Wingfield, Candy Chow, Zainab Alani and Dr Richard Simpson for their service to the Committee and extended best wishes to Laura Lorimer. The Chair welcomed Janet Corbett (MKUH Pharmacy representative) and Dr Jon Walter (Place Based Lead GP for Milton Keynes) to the Committee.	
2.	**Declarations of Interest** The Chair invited the members to reconfirm their current declarations on the Register of Interests and advise of any new declarations. All members confirmed their declarations were accurate and up to date. The Chair invited members to declare any declarations relating to matters on the agenda. AJ declared a non-financial personal interest in relation to agenda item 5.5. A written declaration has been received and it was noted that AJ declares the interest in meetings of the blood glucose monitoring working group and has no participation in the decision-making process. Expert opinion is provided on subject matter only. Agenda item 5.5 is for noting only, and therefore no further action was required for this meeting. All other members confirmed they have no declarations in relation to matters on the agenda.	

No	Agenda Item	Action
3.	**Minutes of 29 June 2022 APC meeting** The minutes of the meeting held on 29 June 2022 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 24/08/2022** - PAC have reviewed current relevant bulletins in the light of this guidance and the revised bulletins will be brought to the Committee when published. This is therefore an ongoing action.	AG
4.1.2	**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 19/07/22** – the work on this was delayed due to Covid Medicines Delivery Unit (CMDU) commitments within the Medicines Optimisation team. To be taken forward as part of the DMARD LES workstream by MD/TL. No further action for the committee. It was proposed and agreed that this action could be closed.	Close
4.1.3	**Strategies to support reduced inhaler carbon emissions** EQIA statement to be updated, as agreed at the December APC meeting. **Update 28/09/22** – A meeting was held with the Equalities team on 28/09/22 and an updated statement produced. DW advised during the meeting that the action could be closed. This action is closed.	Close
4.1.4	**Lipid pathway implementation** At the March APC meeting, it was agreed that the Committee would be kept informed of the progress of implementation of the lipid pathway/of the lipid clinic. **Update 08/09/22** - the lipid clinics have started taking referrals and the first clinics began in the 1st week of August. It was proposed and agreed that this action could be closed.	Close
4.1.5	**Adult ADHD shared care guideline** Updates to be undertaken as identified prior to, and discussed at, the March APC meeting. **Update 14/09/22** – update of the SCG is complete. Changes approved by ELFT Medicines Committee and the updated SCG has	Close

No	Agenda Item	Action
	been approved by Chair's action. Added to Chair's action log. It was proposed and agreed that this action could be closed.	
4.1.6	**Localised Severe Psoriasis** Local review to be undertaken of PAC policy to include: number of lines of therapy available and choice of therapy (following comments received by local clinicians). **Update 24/08/22** - PAC is reviewing the evidence for the therapies in response to the feedback from BLMK - the outcome of this is awaited and clinicians have been informed. This is therefore an ongoing action.	AG
4.1.7	**SGLT2 inhibitors for chronic kidney disease** Criteria for referral to nephrology for patients with CKD (without T2DM) to be confirmed. **Update 22/07/22** - referral pathway received from renal specialists, and a summary produced. The referral criteria were shared with the committee for information. It was proposed and agreed that this action could be closed.	Close
4.1.8	**Medicines Safety Group (MSG)** MSG to consider removal of brand names in the circulation of the MHRA drug safety updates, and the wider use of pregabalin (outside of the epilepsy indication) when considering the risks of use in pregnancy. **Update 19/07/22** – discussed at MSG meeting. Agreed to remove use of brand names, except when clearly relevant to the alert e.g. recent Denosumab alert, which related specifically to the Prolia brand. It was proposed and agreed that this action could be closed.	Close
4.1.9	**Ulcerative Colitis pathway update** MN to contact gastroenterology colleague (on behalf of the Committee) at Bedfordshire Hospital Trusts around patient numbers at different parts of the pathway. **Update 16/09/222** – the pathway has been finalised, but MN to contact the gastro team to promote closer working within BLMK. It was proposed and agreed that this action could be closed.	Close
4.1.10	**Ulcerative Colitis pathway update** To arrange a meeting with clinicians from Bedfordshire Hospitals Trust to review/discuss the pathway. **Update 24/08/22** – meeting held with BHFT, pathway amended (minor amendments) in response to comments and approved by Chair's action. Added to Chair's action log. It was proposed and agreed that this action could be closed.	Close
4.1.11	**Osteoporosis pathway update** Correction of minor typos and formatting issues. Investigate possibility of generic clinical team contact details, rather than individual clinicians. **Update 06/09/2022** – corrections made, contact details updated (where applicable) and uploaded to Medicines website. It was proposed and agreed that this action could be closed.	Close
4.1.12	**Osteoporosis pathway update**	Close

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	Scriptswitch/Optimise message wording to be agreed to ensure that the message regarding stopping bisphosphonates when romosozumab treatment is started is made clear. **Update 27/09/22 –** this has been added to the workplan for Scriptswitch/Optimise messaging and relevant information will be added, although romosozumab is unlikely to be prescribed in primary care. Relevant information is included in letters from secondary care teams to GP practices on commencement of treatment. It was proposed and agreed that this action could be closed.	
4.1.13	**Guidance on the recording of Hospital Only medicines** in GP records to be recirculated to all GP practices. **Update 06/09/2022** – guidance updated, shared via Primary Care bulletin on 30/8/22 and available on the Medicines website. The guidance was shared with the committee for information. It was proposed and agreed that this action could be closed.	Close
4.1.14	**Buccal midazolam prescribing guidance** Document to be reformatted and discussed with HC/CC, then approved by Chair's action. **Update 27/07/22** – guidance updated to remove the historical information, and a couple of minor amendments made to the content following minor comments received from BHFT following the meeting and approved by Chair's action. Added to Chair's action log. It was proposed and agreed that this action could be closed.	Close
4.1.15	**Shared Care Guideline template** Updates to be made as discussed at the June meeting. **Update 06/07/22** – SCG template has been updated with the changes discussed at the meeting. This has been finalised and uploaded to the Medicines website. It was proposed and agreed that this action could be closed.	Close
4.1.16	**Shared Care Guideline template** Patient information leaflet to be drafted. **Update 20/09/22** - a second draft of the patient information leaflet has been circulated for comment. This is an ongoing action.	JC
4.1.17	**NICE Guidance Update** Formulary status of anti-seizure medications to be reviewed. **Update 21/09/22** – added to the Formulary Subgroup workplan for future review. It was proposed and agreed that this action could be closed.	Close
4.1.18	**NICE Guidance Update** Gout pathway to be reviewed/updated (ref existing LDH gout treatment pathway and new NICE NG219 Gout: diagnosis and management). **Update 06/09/2022** – on forward work plan for December APC. It was proposed and agreed that this action could be closed.	Close
4.1.19	**Formulary subgroup report – agomelatine** RA to review position of agomelatine on the CNWL formulary and liaise with TL. **Update 14/09/22** – this is an ongoing action	RA/TL

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5.	**Items for consideration at meeting**	
5.1	**COPD Guideline Update** A review and harmonisation of COPD guidelines across BLMK was presented to the Committee (previous documents from Bedfordshire CCG /Luton CCG and Milton Keynes). The updated guideline includes information on services for COPD patients and referral pathways across the region e.g., current pulmonary rehabilitation pathways. It also includes updated links to other respiratory documents e.g., inhaled corticosteroid step down guidance and guidance on strategies to reduce carbon footprint. Additions to the guideline include an inhaler device decision aid and patient information leaflet for self-management of exacerbations. The inhaled therapy pathway remains largely the same and as per NICE / GOLD (Global Initiative for Chronic Lung Disease) guidance. An inhaler formulary has been included which details all the current inhalers on both regions' formularies. The Committee was also asked to approve minor changes to harmonise formulary choices between the Bedfordshire/Luton and Milton Keynes formularies. During development the guideline was circulated to Respiratory specialists, GPs with special interests and respiratory nurses. Comments received have been incorporated into the circulated guideline. However, two additional comments were subsequently received: • Bevespi® Aerosphere, a LAMA/LABA pMDI inhaler, has not been included in the inhaler choices listed on page 4 of the guidance although it is listed on the inhaler formulary on page 10. This is the same device as Trixeo® and therefore may be useful for patients stepping up to triple therapy and unable to use a DPI. It was therefore proposed that a minor amendment would be made to the guideline to include Bevespi® as a LAMA/LABA inhaler choice on page 4. • Discussion with the Equality team highlighted that it would be useful to include information on Interpreting services, to assist patients who may require an interpreter. Signposting information on Interpreting services will be added to the guideline. The Committee approved the guidelines with the above changes, as agreed at the meeting. **EQIA Assessment:** No impact expected – COPD guidelines are a reflection of current NICE and GOLD guidelines. They are not mandatory, and clinicians should use their clinical discretion when using. **BLMK ICB E and D Lead comment:** The guidelines have been updated to reduce the environmental impact. As such, clinicians may decide to change patients from MDI to DPI which involves patient counselling and ensuring good inhaler technique. Additional resources may need to be considered for those with limited grasp of	HMcG

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	the English language. This consideration needs to be documented in some form**.**	
5.2	**BLMK Infant Formulae Prescribing Guidelines** The existing guidance for the prescribing of infant formulae have been reviewed and updated as follows: • Previous versions were separate for Bedfordshire and Milton Keynes. These guidelines have been merged. • There are no first line recommendations for extensively hydrolysed formulas. • Follow-on formulas for cow's milk allergy have been removed from the summary guidelines. • Volumes for prescribing have changed due to the tin sizes changing for some formula i.e. pre-term. • Initial volumes for prescribing in early infancy have been extended to 7 months to account for the large volume of formula that infants are consuming at 6 months. • Amino acid based formulas are listed as 'second-line' rather than 'preferably started in secondary care' (GPs can initiate these formulas). • Infants discharged from MK Hospital will not need to be prescribed liquid formula by the GP. Children will be discharged from the neonatal unit with one month's supply and then will be prescribed powdered formula by the GP. • Information added on prescribing Instant Carobel to GORD section. • Two patient information leaflets have been developed and circulated for review and approval. These are currently in draft form as the content will be transferred into a standard template format. The following points were discussed: • A list of changes between the old guidelines and the current version will be produced, to aid Formulary updates and assist with Scriptswitch/Optimise messaging. • The author was thanked for producing the guidance – an extremely useful resource for GPs. The Committee approved the guidelines. **EQIA Assessment:** • Families eligible for income support - Products recommended for use over the counter can be purchased using the Healthy Start Scheme card if the formula is 'suitable from birth'. All of the over-the-counter products listed are suitable from birth. • Products have been denoted halal approved or suitable for vegetarians. No formula is suitable for vegans. • Children suffering with galactosemia (a rare metabolic condition where you cannot breakdown galactose) will require a lactose-free formula. They cannot breastfeed as an alternative. Families who do not qualify for the Healthy Start scheme and are on a low income may find paying for	ECD

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	formula difficult. Some local communities are more at risk of this condition i.e. Traveller community. **BLMK ICB E and D Lead comment:** Any considerations for mitigating the risk of impact on low-income families (to cover health inequalities) need to be documented. The impact is not deemed significant enough for a full EIA, however, need to document the options for mitigations.	
5.3	**Oral Nutritional Supplement Prescribing Guidelines** The existing Oral Nutritional Supplement (ONS) prescribing guidelines have been reviewed and updated. The recommendations are in accordance with NICE guidelines on treatment of malnutrition and in line with ACBS prescribing criteria. The most appropriate and cost-effective products have been recommended. The products now recommended are between 5-25% cheaper than on previous version of the guidelines. Appropriate treatment of malnutrition helps to reduce falls, pressure ulcers and hospital admissions. Key points presented included: • Similar 'traffic light' style layout • Non-prescribed treatment remains first line choice • General principle of powdered products being most cost effective • Changes to recommended products due to shift in prices • Highlights the most cost-effective product, then gives next best alternative • Now agreed with all Dietitians and extended across BLMK – there are therefore some places within the guideline which refer to the service available in the different localities. • Environmental impact of some packaging highlighted The following additional points were discussed: As for the infant formulae guidelines, a list of changes between the old guidelines and the current version will be produced, to aid Formulary updates and assist with Scriptswitch/Optimise messaging. The Committee approved the guidelines. **EQIA Assessment:** No impact anticipated **BLMK ICB E and D Lead comment:** Is there a plan to ensure dietician advice/leaflets etc will be available in different languages with options with diets incorporating different cultural preferences? No additional EIHR comments.	CB
5.4	**Hyperhidrosis Policy** A review of the existing Priorities Forum policy for the management of hyperhidrosis was conducted as a result of concerns about the ability of patients to access treatment with iontophoresis – this was included in the previous version of the pathway and there was a requirement to trial this before moving onto the next steps of the pathway. However, there is no local NHS provision for iontophoresis	

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	and therefore equity concerns had been raised as some people will not be able to afford to purchase an iontophoresis machine. The updated pathway is in line with the NICE Clinical Knowledge Summary for hyperhidrosis (with the exception that NICE state that iontophoresis is a treatment option within secondary care). Note that the requirement for patients to trial iontophoresis before secondary care referral has been removed. The review paper considered national guidance (NICE evidence summaries, CKS and IPG and BMJ best practice) and recently published clinical and cost-effectiveness literature. The pathway update includes several treatments for hyperhidrosis. Patients are required to step up through the pathway from the least invasive to more invasive treatment options. The pathway does not recommend the use of endoscopic thoracic sympathectomy as there is a significant risk of complications. The pathway does not require patients to trial iontophoresis as patients are required to purchase these machines and it was felt this could drive inequalities. All other routinely used treatments for hyperhidrosis are included within the pathway. The Committee noted the following pathway changes: • Removing the requirement for patients to trial iontophoresis before secondary care referral • Adapting the clinical criteria for secondary care treatment response from percentage sweat reduction to HDSS score improvement • Format update • Inclusion of a rationale for the changes. • Notes at the start of the policy included within the guidance • The existing BLMK commissioning statement on iontophoresis will be retired, as it has been superseded by the policy update. The Committee approved the Hyperhidrosis policy update. **EQIA Assessment:** A quality and equality impact assessment has been carried out as part of the Clinical Policy Review Group process, and therefore has not been reassessed for APC. **BLMK ICB E and D Lead comment:** Unable to view the original EIA attached in the document but no additional comments as the change has improved access in view to reducing health inequalities.	
5.5	**Blood glucose monitoring update** The Committee was presented with an update on the discussions on implementation of the NICE recommendations on blood glucose monitoring (originally discussed at APC in May 2022). Following the financial decision made by TILT, a Diabetes Working Group has been formed which consists of diabetes specialists from both primary care and secondary care as well as relevant individuals from the commissioning team. The purpose of this group is to:	

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	• Review available continuous glucose monitoring (CGM) devices and come to a decision which device(s) would be clinically and cost effective to use across BLMK.
	• Agree the criteria for which patient cohorts would most benefit from CGM technology.
	
	The working group has been presented with, and considered, a comprehensive review of the available devices on the market. The review included information on licensing, costing, pump connectivity, supply route and follow-on apps. A summary table was shared with the Committee. The adult and paediatric diabetes teams are currently trialling GlucoMen Day and Freestyle Libre 3, which are cost effective products available on FP10, and via the NHS Supply Chain respectively, and have been asked to trial other CGM products. An interim position statement has been agreed, although discussions are still in progress and another meeting of the working group is planned on 29th September 2022.
	
	The market for CGM constantly changing, with ongoing new developments e.g. availability on FP10, availability of apps on different types of smartphones. Population health data has been reviewed and a full EQIA/Equality assessment is in process.
	
	The following points were discussed:
	
	• There is an additional, one-off cost associated with the purchase of a reader – this may be needed for the small minority of patients who do not have a compatible smartphone or for whom use would not be appropriate e.g. young children. Some manufacturers may provide readers free of charge, for patients living in low-income areas, to reduce health inequalities.
	• Distribution of the agreed funding allocation, in the context of the current block contract for secondary care Trusts, and the expectation that specialists will initiate patients on CGM:
	  ○ Specialists have the best knowledge of the available products to ensure the patient gets the best product for them.
	  ○ An initial supply would be made by the specialist team, which would them be continued in primary care for products available on FP10. The majority of the cost is therefore expected to sit within primary care.
	  ○ Ongoing supply will need to remain with the Trusts for products available via the NHS Supply Chain (as these are not available within primary care).
	  ○ Systems are in place to allow direct invoicing to the ICB to ensure there is no budgetary impact on local Trusts.
	• Priority patient groups have been identified initially as paediatric patients aged under 6 years; paediatric patients aged 6 years and over; patients with type 2 diabetes, under the care of the Integrated Diabetes Services identified as 'high priority' e.g. patients on insulin with dementia requiring	

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	multiple health/social care visits each day to manage their diabetes care. • The choice of suitable products for use in children is limited by product licenses (i.e. the age from which the product is licensed) and availability of 'follow-on' apps. • Other patient groups are still under review and discussion by the working group. • Ongoing work is being undertaken to review uptake of intermittently scanned CGM (isCGM) based on ethnicity, age and place and it is planned this will be extended to look at the uptake of real time CGM (rtCGM) devices. The Committee noted the information presented and thanked AJ for her hard work. **EQIA Assessment:** A full EQIA is currently in progress.	
5.6	**Ophthalmology Intravitreal Injection pathway update** The existing BLMK intravitreal injection pathway has been updated with the following changes: • To include Faricimab for the treatment of diabetic macular oedema and wet age-related macular degeneration in accordance with NICE TA 799 and NICE TA 800 respectively. • To include Brolucizumab for the treatment of diabetic macular oedema in accordance with NICE TA 820. • To include amendment to the use of Dexamethasone implant for treating diabetic macular oedema in accordance with NICE TA 824. • Additional information (e.g. table 1) has been checked against the eBNF and Summary of Product characteristics and where not completely in line with these reference sources, confirmed with local ophthalmologists. Table 1 has also been reformatted to display the information more clearly. Ranibizumab biosimilar (Ongavia) has been added to the joint Formularies. There will be ongoing discussions around implementation and switching with the Trusts, which is dependent on capacity. The following points were discussed: • The positioning of dexamethasone in the pathway, following the recent publication of TA824, was confirmed to be correct. • The relative contraindication for the use of dexamethasone in phakic patients, listed in table 1, will be removed in view of recent changes to the product information and publication of NICE TA 824. • It was noted that two major risks of using dexamethasone implants are cataracts and glaucoma and therefore phakic patients are at risk of developing cataracts when treated with a steroid impact. Henceforth all patients must be counselled and consented to ensure that they are making a well-informed decision about their treatment choices.	

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	• Engagement from local clinicians, apart from AL, has been lacking, despite multiple efforts to seek opinions and responses on the pathway. AL undertook an action to liaise with local clinicians at all 3 local hospital sites, and feed back.
	• All references to 'CCG' in the pathway will be updated to 'ICB' to correspond with recent organisational changes.
	• Biosimilar ranibizumab:
	  ○ Moorfields in London have started using Ongavia, but there have been some issues with delivery (supply) of the biosimilar.
	  ○ Locally, the intention is to transfer patients on the originator product (Lucentis) onto the biosimilar where suitable, but this will require individual patients to be counselled and consented to the change.
	  ○ Due to duration of action and different treatment regimens available for use, few patients remain on treatment with ranibizumab, with approximately only 5% of patients at Bedford Hospital treated with it.
	  ○ Treating patients with longer acting medicines which can be given less frequently allows some patients to be taken off the medication and seen fewer times a year. Patients were being seen approximately 12 times a year, but this has been reduced to around 5 or 6 times a year.
	
	The Committee approved the guidelines with the amendments agreed at the meeting, and with the caveat that no concerns are raised by Ophthalmologists across the rest of BLMK.
	
	EQIA Assessment: No – additional treatment options have been added to the pathway in accordance with national guidance.
	
	BLMK ICB E and D Lead comment: Additional options added to treatment pathway so no further EIHR comments
		AL
		
		JC

5.7	**Icosapent Ethyl (NICE TA805)** Icosapent ethyl with statin therapy for reducing the risk of cardiovascular events in people with raised triglycerides was granted a positive NICE TA in July 2022. Icosapent ethyl is recommended as an option for reducing the risk of cardiovascular events in adults. It is recommended if they have a high risk of cardiovascular events and raised fasting triglycerides (1.7 mmol/litre or above) and are taking statins, but only if they have: • established cardiovascular disease (secondary prevention), • low-density lipoprotein cholesterol (LDL-C) levels above 1.04 mmol/litre and below or equal to 2.60 mmol/litre. Currently NHSE/AAC are reviewing the place of Icosapent Ethyl within the AAC National Pathway for Lipid Management. NICE	

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	expects a limited uptake of the treatment approximately 1% increase in the eligible population per year. Due to the complex initiation criteria for icosapent ethyl and as the vast majority of patients in primary care will have a non-fasting lipid test (this can cause a moderate 20-25% increase in TG levels) there is a risk that icosapent ethyl may be prescribed for patients who do not meet the NICE criteria. However, this needs to be balanced against the risk of patients not being able to access the treatment if it is restricted to specialist prescribing as many of these patients will not have lipid levels at the threshold for referral into the secondary care or Community lipid clinic. A prescribing guidance flow chart has been produced to aid clinicians who are considering prescribing icosapent ethyl. Comments and input have been received from specialists (lipidologists and cardiologists) across BLMK. The Committee was asked to place icosapent ethyl as green on the joint Formularies with additional prescribing guidance made available and messages added to ScriptSwitch/Optimise to mitigate the risk of inappropriate initiation. This decision will be reviewed dependent on its advised place in the national lipid pathway. The following points were discussed: • The 27% risk reduction quoted in the circulated paper is in addition to the risk reduction achieved with statins. • The estimates of local patient numbers / uptake were based upon NICE estimates and also local data generated for the potentially eligible patient population. • Assurance that prescribing is appropriate – the prescribing guidance which has been developed is designed to aid clinicians with their decision making, and to reduce the likelihood of inappropriate prescribing. Patient numbers will be monitored, and audit work carried out if necessary with GP practices to ensure that use is appropriate and in accordance with NICE guidance. • Icosapent ethyl sits slightly outside of the main lipid pathway, due to its tight initiation criteria. • Icosapent ethyl will not be an option for patients who are not taking statins. The cost-effectiveness assessment and NICE recommendations are based on combination therapy with statins. • From a primary care perspective, with all the new lipid lowering medications which have been introduced recently, the treatment options can be confusing. Treatment will commence with statins, but it can be confusing to understand what the most appropriate subsequent treatment is, and when to refer to the lipid clinic. • The updated national lipid pathway is expected within the next few months. If this is not published, work will be undertaken to produce a local adaptation of the guidance to aid prescribing clinicians.	

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	The Committee approved the addition of icosapent ethyl to the joint Formularies with GREEN traffic light status, and the prescribing guidance to support clinicians with decision making when considering prescribing. The following forward actions were agreed: • Review of prescribing data over six months to review usage and uptake. • Local adaptation of national lipid pathway to be produced, to include icosapent ethyl, if not produced nationally within two months. • Scriptswitch/Optimise messages to be developed to support appropriate prescribing of icosapent ethyl. **EQIA Assessment:** Not assessed – NICE guidance	MD MD MD/NW
5.8	**Ankylosing Spondylitis Pathway update** The existing BLMK Ankylosing Spondylitis (AS) / Non-radiographic Axial Spondyloarthritis (nrAxial SpA) pathway has been updated as follows: • Addition of upadacitinib, for Ankylosing Spondylitis only, in accordance with the recommendations laid out in the NICE Final Appraisal document (final TA publication expected 30th September 2022, with 30 day implementation). • Amendments to the 'Preferred treatment selection options' box, to include upadacitinib and reference to the license change for secukinumab for patients >90kg with moderate to severe psoriasis, or psoriatic arthritis with concomitant moderate to severe plaque psoriasis. The Committee noted that the final publication of the NICE TA guidance has been delayed from 21/09/22 and is now expected on 30/09/22, and that the TA will have a 30 day implementation period. The updated pathway has been agreed with local Rheumatologists. The updated pathway was approved pending final publication of the NICE guidance. If there are any differences between the final appraisal document and the final published NICE TA these will be reviewed, and the pathway amended accordingly. **EQIA Assessment:** None anticipated – updated in accordance with NICE guidance **BLMK ICB E and D Lead comment:** Additional options added to treatment pathway as per NICE guidance so no further EIHR comments	AG
5.9	**BLMK ICB Hypertension Adult Treatment Guidelines** The Committee considered local hypertension (HTN) guidelines prepared by the BLMK CVD Group and the Medicines Optimisation Team. The guidelines have been developed as BLMK ICS remains one of the poorest performers in BP management in England.	

<table>
<tr><th>No</th><th>Agenda Item</th><th>Action</th></tr>
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Data from UCLH indicates only 65.8% of patients in BLMK will have BP controlled to target
This is 4.5% below the national average and equates to more than 50,000 people with uncontrolled hypertension.
Treating 80% of HTN patients to target could prevent 118 hearts attacks and 176 strokes over 3 years

Barriers to effective management of hypertension include:

Lack of choices of medications within NICE guidelines, leading to a variation in prescribing, stepped titration of drugs which are not required leaving to loss of follow up.
Lack of use of combination therapy.
Clinician and treatment inertia leading to monotherapy.
Patient adherence to treatment.
High numbers of patients allocated per GP within BLMK (above national average).

The BLMK CVD Group and Medicines Optimisation Team have developed a new localised evidence-based guideline for the management of hypertension in adults under 80 years of age, and for those aged 80 years and over (NB: the guidance for over 80s follows NICE guidelines). The guidelines have been designed to support use of a simplified and streamlined algorithm for hypertension management across BLMK.
The guidance differs in some respects from the current NICE guidance:
<table>
<tr><th>BLMK HTN Guidance (Key Points)</th><th>NICE Guidance</th></tr>
<tr><td>Offer drug therapy to patients with stage 2 HTN and those with stage 1 HTN and Q-risk above 10%, diabetes, renal disease, CVD, and target organ damage.</td><td>NICE recommends offering drug therapy for patients with stage 2 HTN and discussing treatment for those with stage 1 HTN and Q-risk above 10%, diabetes, renal disease, CVD, and target organ damage.</td></tr>
<tr><td>1st line treatment is to start two medications at once in those with stage 2 HTN and those with stage 1 HTN and Q-risk above 10%, diabetes, renal disease, CVD, and target organ damage.</td><td>NICE does not use first line combination therapy</td></tr>
<tr><td>Utilisation of half maximal doses for medications requiring titration</td><td>NICE only recommends class of medications, no specified medication in class and no specific dosage.</td></tr>
<tr><td>Utilisation of medicines in class with lower side effect profile (e.g., losartan)</td><td>As above</td></tr>
</table>
The guidelines aim to simplify the management of hypertension by:

Providing specific medication choices to make selection simpler.

Use of lercanidipine as the calcium channel blocker of choice due to its better tolerability profile compared

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	with amlodipine (no statistical difference in terms of BP lowering between the two treatments). ○ Use of ARB in preference to ACEI (BP lowering effect of ARBs is modest and similar to ACEI as a class they have similar efficacy on major CV events and mortality outcomes; ARBs are associated with significantly lower treatment discontinuations rates for adverse events than all other antihypertensive treatments and similar rates to placebo). ○ Losartan recommended as the most cost-effective ARB. • Simplifying titration of medication by recommending use of half maximum doses. The following points were discussed: • Cost-effectiveness of the recommendations. NICE does a lot of work examining the evidence base when issuing their guidelines, and this includes cost-effectiveness, but the analysis dates back to 2011 with an update in 2019. It was highlighted to the committee that NICE considered that it probably was more cost effective to treat with combination therapy, but a recommendation was not made due to lack of trial evidence being published. As many antihypertensive medications are off-patent, publication of additional trials is not expected. Additionally, the cost of the medications has reduced significantly due to the availability of generics. • Lercanidipine is currently listed as non-formulary on both joint Formularies but is frequently used across BLMK. • The proposed guidelines represent significant change to current practice, as it is usual to start with amlodipine rather than lercanidipine, and an ACEI rather than an ARB, although it was noted that many patients will progress onto the second line treatment choices. • An amendment to the proposal could be made e.g to offer medication choices – amlodipine or lercanidipine, and ACEI or losartan. • Starting two medicines at once goes against the usual practice of starting one, assessing response and tolerability, then starting another. It was noted that the guideline does recommend starting medications 1-2 weeks apart with the patient self-monitoring their blood pressure. • Learning and development would be required in practices to implement the proposed local guidelines into use, as they differ from NICE and therefore current usual practice. • GP registrars are learning the treatment, as per the NICE guidance, to develop their practice and for their exams. • There is no intention that patients already being treated for hypertension would have their medication switched as a result of the local guideline – it will be for use for new patients. • It may be difficult for patients to accept the idea of starting two medicines - there is a need to consult with patients and consider how best they can be supported.	

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	• Adherence to medications also needs to be considered – if a patient's blood pressure isn't well controlled because they aren't taking one medicine, this is unlikely to be resolved by prescribing two medicines. • The guideline would not be mandated for use in every patient – there will be a need for individual patient discussions and clinician discretion in selecting medication choices. • A concern was raised, from a medicines' safety perspective, around the risk of falls and increase in polypharmacy for example in the care home population. It was noted that cohort age range in care homes for the elderly range from 65 years and above. The guideline will only apply to patients aged <80 years, with the recommendations for those over 80 following NICE guidance. Clinician discretion should also be used. • The cost of two prescription charges, for patients who pay for their prescriptions, may be prohibitive for some people. While the annual cost of a prepayment certificate is lower than the cost of the prescriptions across the year, some patients cannot afford the initial cost of the prepayment certificate (NB – the cost of a prepayment certificate does not have to be paid upfront. It can be paid monthly at a cost of £10.81 a month for 10 months. This still may be a challenge for some but is not much over a single prescription charge). • A similar approach has been adopted in West Yorkshire, although different medicine choices are recommended in that area e.g., thiazide diuretics in combination. • A QI project is planned to be conducted around deprivation and hypertension, including looking at the barriers to hypertension management. The Committee did not approve the Hypertension Guidelines – comments and Feedback from the APC to be reviewed by the CVD working group. **EQIA Assessment:** No impact anticipated – as the hypertension guidelines are not mandatory then clinicians can use their clinical discretion when following these guidelines. The age applicability of 80 years and less reflects current NICE and ESC recommendations on adopting different approaches / targets in managing hypertension. **BLMK ICB E and D Lead comment:** Additional options added to treatment pathway in addition to NICE guidance in order to 'level up' the health inequalities identified so no further EIHR comments.	MD / CVD working group
6.0	**NICE Guidance – from 16 June 2022 until 14 September 2022** **The following NICE Technology Appraisal Guidance (ICB Commissioned) have been published:** **Faricimab for treating diabetic macular oedema**	

No	Agenda Item	Action
	Technology appraisal guidance [TA799] Published: 29 June 2022 **https://www.nice.org.uk/guidance/ta799** Using NICE assumptions, the BLMK cost impact of introducing the guidance is approximately £26,000 - £57,000/year additional cost impact. **APC actions:** created and link added to Formularies (RED traffic light). Ophthalmology Intravitreal Injection Treatment Pathway review and updated and discussed under agenda item 5.6. **Faricimab for treating wet age-related macular degeneration** Technology appraisal guidance [TA800] Published: 29 June 2022 https://www.nice.org.uk/guidance/ta800 Using NICE assumptions, the BLMK cost impact of introducing the guidance is approximately £6,000 - £15,000/year additional cost impact. **APC actions:** created and link added to Formularies (RED traffic light). Ophthalmology Intravitreal Injection Treatment Pathway review and updated and discussed under agenda item 5.6. **Roxadustat for treating symptomatic anaemia in chronic kidney disease** Technology appraisal guidance [TA807] Published: 13 July 2022 https://www.nice.org.uk/guidance/ta807 Using NICE assumptions, the BLMK cost impact of introducing the guidance is approximately £80,000 in year 1, rising to £220,000 by year 3. This may however be an overestimate, based on information provided by East & North Herts Trust. Note, the following have been agreed with local specialist teams: • Roxadustat is recommended as an option in line with TA807. • Roxadustat to be added to the local pathways for treating symptomatic anaemia associated with CKD (action by specialist teams). • If ESAs and roxadustat are both considered suitable, taking into account individual patient factors, the least expensive should be chosen. **Icosapent ethyl with statin therapy for reducing the risk of cardiovascular events in people with raised triglycerides** Technology appraisal guidance [TA805] Published: 13 July 2022 https://www.nice.org.uk/guidance/ta805 Using NICE assumptions, the BLMK cost impact of introducing the guidance is approximately £111,600 in year 1 rising to £498,624 by year 5, although local data indicate this may be an overestimate. **APC action:** discussed under agenda item 5.7. GREEN traffic light status agreed and supporting guidance approved. To be added to both joint Formularies.	AG/JCo

No	Agenda Item	Action
	Risankizumab for treating active psoriatic arthritis after inadequate response to DMARDs Technology appraisal guidance [TA803] Published: 13 July 2022 https://www.nice.org.uk/guidance/ta803 Resource impact: NICE do not expect this guidance to have a significant impact on resources. **APC action:** link added to Formularies (RED traffic light). Psoriatic Arthritis Treatment Pathway update discussed under agenda item 5.8. **Abrocitinib, tralokinumab or upadacitinib for treating moderate to severe atopic dermatitis** Technology appraisal guidance [TA814] Published: 03 August 2022 https://www.nice.org.uk/guidance/ta814 Using NICE assumptions, the BLMK cost impact of introducing the guidance is approximately £255,000 in year 1, rising to £634,000 by year 5. **APC action:** created and link added to Formularies (RED traffic light). **Guselkumab for treating active psoriatic arthritis after inadequate response to DMARDs** Technology appraisal guidance [TA815] Published: 10 August 2022 https://www.nice.org.uk/guidance/ta815 Resource impact: NICE do not expect this guidance to have a significant impact on resources. **APC action:** link added to Formularies (RED traffic light). Psoriatic Arthritis Treatment Pathway update discussed under agenda item 7.1. **Brolucizumab for treating diabetic macular oedema** Technology appraisal guidance [TA820] Published: 31 August 2022 https://www.nice.org.uk/guidance/ta820 Resource impact: NICE do not expect this guidance to have a significant impact on resources. **APC actions:** link added to Formularies (RED traffic light). Ophthalmology Intravitreal Injection Treatment Pathway review and updated and discussed under agenda item 5.6. **Dexamethasone intravitreal implant for treating diabetic macular oedema** Technology appraisal guidance [TA824] Published: 14 September 2022 https://www.nice.org.uk/guidance/ta824	

Resource impact: NICE do not expect this guidance to have a significant impact on resources.

APC actions: link added to Formularies (RED traffic light). Ophthalmology Intravitreal Injection Treatment Pathway review and updated and discussed under agenda item 5.6.

The following NICE Guidelines (NG) (Medicine related and ICB Commissioned) have been published / updated by NICE:

Multiple sclerosis in adults: management NICE guideline [NG220] Published: 22 June 2022 https://www.nice.org.uk/guidance/ng220
This guideline covers diagnosing and managing multiple sclerosis in people aged 18 and over. It aims to improve the quality of life for people with multiple sclerosis by promoting prompt and effective symptom management and relapse treatment, and comprehensive reviews.
APC action: none required at the current time – confirmed with specialists.

Depression in adults: treatment and management NICE guideline [NG222] Published: 29 June 2022
https://www.nice.org.uk/guidance/ng222
This guideline covers identifying, treating and managing depression in people aged 18 and over. It recommends treatments for first episodes of depression and further-line treatments, and provides advice on preventing relapse, and managing chronic depression, psychotic depression and depression with a coexisting diagnosis of personality disorder.
APC action: none required at the current time – confirmed with ICB clinical lead for Mental Health.

Type 1 diabetes in adults: diagnosis and management NICE guideline [NG17] Published: 26 August 2015 Last updated: 29 June 2022
https://www.nice.org.uk/guidance/ng17
This guideline covers care and treatment for adults (aged 18 and over) with type 1 diabetes. It includes advice on diagnosis, education and support, blood glucose management, cardiovascular risk, and identifying and managing long-term complications.
In June 2022, we reviewed the evidence and made new recommendations on periodontitis.
APC action: None, as the new recommendations do not relate to medicines. To be discussed by the diabetes long term conditions group.

Type 2 diabetes in adults: management NICE guideline [NG28] Published: 02 December 2015 Last updated: 29 June 2022
https://www.nice.org.uk/guidance/ng28
This guideline covers care and management for adults (aged 18 and over) with type 2 diabetes. It focuses on patient education, dietary advice, managing cardiovascular risk, managing blood glucose levels, and identifying and managing long-term complications.

No	Agenda Item	Action
	In **June 2022**, we reviewed the evidence and made new recommendations on periodontitis. **APC action:** None, as the new recommendations do not relate to medicines. To be discussed by the diabetes long term conditions group. **Diabetes (type 1 and type 2) in children and young people: diagnosis and management** NICE guideline [NG18] Published: 01 August 2015 Last updated: 29 June 2022 https://www.nice.org.uk/guidance/ng18 This guideline covers the diagnosis and management of type 1 and type 2 diabetes in children and young people aged under 18. The guideline recommends how to support children and young people and their families and carers to maintain tight control of blood glucose to reduce the long-term risks associated with diabetes. In **June 2022**, we reviewed the evidence and made new recommendations on periodontitis. **APC action:** None, as the new recommendations do not relate to medicines. To be discussed by the diabetes long term conditions group. **Pneumonia in adults: diagnosis and management** Clinical guideline [CG191] Published: 03 December 2014 Last updated: 07 July 2022 https://www.nice.org.uk/guidance/cg191 This guideline was developed before the COVID-19 pandemic. It covers diagnosing and managing pneumonia in adults who do not have COVID-19. It aims to improve accurate assessment and diagnosis of pneumonia to help guide antibiotic prescribing and ensure that people receive the right treatment. **July 2022:** We reinstated this guideline, which was temporarily withdrawn in May 2020 because of the COVID-19 pandemic, and plan to update it. For more information see the surveillance decision. **Urinary tract infection in under 16s: diagnosis and management** NICE guideline [NG224] Published: 27 July 2022 https://www.nice.org.uk/guidance/ng224 This guideline covers diagnosing and managing first or recurrent upper or lower urinary tract infection (UTI) in babies, children and young people under 16. It aims to achieve more consistent clinical practice, based on accurate diagnosis and effective management. It does not cover babies, children and young people with urinary catheters in situ, neurogenic bladders, significant pre-existing urinary tract disorders (uropathies), underlying renal disease or immunosuppression, or recurrent UTI in sexually active girls and young women under 16. It also does not cover babies, children and young people in intensive care units. **APC action:** None. The NG does not cover antimicrobial prescribing therefore from an antimicrobial guideline perspective no change required. Link to be added to the antimicrobial guidelines when next updated.	

No	Agenda Item	Action
	Tobacco: preventing uptake, promoting quitting and treating dependence NICE guideline [NG209] Published: 30 November 2021 Last updated: 04 August 2022 https://www.nice.org.uk/guidance/ng209 This guideline covers support to stop smoking for everyone aged 12 and over, and help to reduce people's harm from smoking if they are not ready to stop in one go. It also covers ways to prevent children, young people and young adults aged 24 and under from taking up smoking. The guideline brings together and updates all NICE's previous guidelines on using tobacco, including smokeless tobacco. It covers nicotine replacement therapy and e-cigarettes to help people stop smoking or reduce their harm from smoking. It does not cover using tobacco products such as 'heat not burn' tobacco. In **August 2022**, we reviewed the evidence on Allen Carr's Easyway to stop smoking in-person seminar for people who smoke and updated recommendations on treating tobacco dependence in the section on stop-smoking interventions. In **August 2022**, varenicline was unavailable in the UK. See the MHRA alert on varenicline. **APC action**: none (noting MHRA alert on varenicline) **Type 1 diabetes in adults: diagnosis and management** NICE guideline [NG17] Published: 26 August 2015 Last updated: 17 August 2022 https://www.nice.org.uk/guidance/ng17 This guideline covers care and treatment for adults (aged 18 and over) with type 1 diabetes. It includes advice on diagnosis, education and support, blood glucose management, cardiovascular risk, and identifying and managing long-term complications. In **August 2022**, we amended our recommendations on blood pressure targets to make them consistent with our recommendations on blood pressure control in our guidelines on chronic kidney disease and hypertension. **APC action:** BLMK hypertension guidelines under development (see agenda item 5.9). **Self-harm: assessment, management and preventing recurrence** NICE guideline [NG225] Published: 07 September 2022 https://www.nice.org.uk/guidance/ng225 This guideline covers assessment, management and preventing recurrence for children, young people and adults who have self-harmed. It includes those with a mental health problem, neurodevelopmental disorder or learning disability and applies to all sectors that work with people who have self-harmed. In this guideline, self-harm is defined as intentional self-poisoning or injury, irrespective of the apparent purpose. The guideline does not cover repetitive, stereotypical self-injurious behaviour (such as head banging). **APC action:** none – referred to Medicines Safety Group for discussion. **Obesity: identification, assessment and management** Clinical guideline [CG189] Published: 27 November 2014 Last updated: 08 September 2022 https://www.nice.org.uk/guidance/cg189	

No	Agenda Item	Action
	This guideline covers identifying, assessing and managing obesity in children (aged 2 years and over), young people and adults. In **September 2022**, we reviewed evidence on anthropometric measures for assessing health risks associated with overweight and obesity in adults and updated the recommendations on identifying and assessing overweight, obesity and central adiposity. **APC action:** None, as the new recommendations do not relate to medicines. **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: 14 July 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. We are continually monitoring the evidence and updating the guideline as new information emerges. **14 July 2022**: We updated recommendations on using remdesivir in hospital, and added a recommendation on vitamin D for treating COVID-19 **COVID-19 rapid guideline: vitamin D** NICE guideline [NG187] Published: 17 December 2020 Last updated: 14 July 2022 https://www.nice.org.uk/guidance/ng187 This guideline covers vitamin D use in the context of COVID-19. It is for adults, young people and children in hospitals and community settings. Vitamin D is important for bone and muscle health. It may also have a role in the body's immune response to respiratory viruses. On **14 July 2022**, we removed the content on vitamin D for treating COVID-19 and added information on this into NICE's COVID-19 rapid guideline on managing COVID-19. **COVID-19 rapid guideline: delivery of systemic anticancer treatments** NICE guideline [NG161] Published: 20 March 2020 Last updated: 11 August 2022 https://www.nice.org.uk/guidance/ng161 The purpose of this guideline is to maximise the safety of patients with cancer and make the best use of NHS resources during the COVID-19 pandemic, while protecting staff from infection. It will also enable services to match the capacity for cancer treatment to patient needs if services become limited because of the COVID-19 pandemic. **11 August 2022:** we reviewed the evidence and made new recommendations on shared decision-making. We withdrew some recommendations that are no longer relevant to the current stage of the pandemic. **The following NICE TAs are the commissioning responsibility of**	

No	Agenda Item	Action
	NHSE and are listed for information only: **Durvalumab for maintenance treatment of unresectable non-small-cell lung cancer after platinum-based chemoradiation** Technology appraisal guidance [TA798] Published: 22 June 2022 https://www.nice.org.uk/guidance/ta798 **APC action**: link added to Formularies **Pembrolizumab plus chemotherapy for untreated, triple-negative, locally recurrent unresectable or metastatic breast cancer** Technology appraisal guidance [TA801] Published: 29 June 2022 https://www.nice.org.uk/guidance/ta801 **APC action**: link added to Formularies **Cemiplimab for treating advanced cutaneous squamous cell carcinoma** Technology appraisal guidance [TA802] Published: 29 June 2022 https://www.nice.org.uk/guidance/ta802 **APC action**: link added to Formularies **Teduglutide for treating short bowel syndrome** Technology appraisal guidance [TA804] Published: 30 June 2022 https://www.nice.org.uk/guidance/ta804 **APC action:** to be created and added to Formularies (RED traffic light – tertiary centre initiation) **Setmelanotide for treating obesity caused by LEPR or POMC deficiency** Highly specialised technologies guidance Reference number: HST21 Published: 06 July 2022 https://www.nice.org.uk/guidance/hst21 **APC action:** none – no addition to Formularies as local use not expected – discussed under agenda item 6, and to be reviewed if flagged by a local Trust. **Fenfluramine for treating seizures associated with Dravet syndrome** Technology appraisal guidance [TA808] Published: 08 July 2022 https://www.nice.org.uk/guidance/ta808 **APC action**: none - no local use expected – restricted to registered, specialist centres only. **Belimumab for treating lupus nephritis** (terminated appraisal) Technology appraisal [TA806] Published: 13 July 2022 https://www.nice.org.uk/guidance/ta806 **APC action:** none (terminated appraisal) **Abemaciclib with endocrine therapy for adjuvant treatment of hormone receptor-positive, HER2-negative, node-positive early breast cancer at high risk of recurrence** Technology appraisal guidance [TA810] Published: 20 July 2022 https://www.nice.org.uk/guidance/ta810 **APC action**: link added to Formularies	

No	Agenda Item	Action
	Imlifidase for desensitisation treatment before kidney transplant in people with chronic kidney disease Technology appraisal guidance [TA809] Published: 20 July 2022 https://www.nice.org.uk/guidance/ta809 **APC action:** none – no specialist kidney transplant units within BLMK. **Duvelisib for treating relapsed or refractory chronic lymphocytic leukaemia after 2 or more treatments** (terminated appraisal) Technology appraisal [TA811] Published: 27 July 2022 https://www.nice.org.uk/guidance/ta811 **APC action:** none (terminated appraisal) **Pralsetinib for treating RET fusion-positive advanced non-small-cell lung cancer** Technology appraisal guidance [TA812] Published: 03 August 2022 https://www.nice.org.uk/guidance/ta812 **APC action:** none (not recommended) **Asciminib for treating chronic myeloid leukaemia after 2 or more tyrosine kinase inhibitors** Technology appraisal guidance [TA813] Published: 03 August 2022 https://www.nice.org.uk/guidance/ta813 **APC action:** created and link added to Formularies **Nivolumab for adjuvant treatment of invasive urothelial cancer at high risk of recurrence** Technology appraisal guidance [TA817] Published: 10 August 2022 https://www.nice.org.uk/guidance/ta817 **APC action:** link added to Formularies **Alpelisib with fulvestrant for treating hormone receptor-positive, HER2-negative, PIK3CA-mutated advanced breast cancer** Technology appraisal guidance [TA816] Published: 10 August 2022 https://www.nice.org.uk/guidance/ta816 **APC action:** created and link added to Formularies **Sacituzumab govitecan for treating unresectable triple-negative advanced breast cancer after 2 or more therapies** Technology appraisal guidance [TA819] Published: 17 August 2022 https://www.nice.org.uk/guidance/ta819 **APC action:** created and link added to Formularies **Nivolumab with ipilimumab for untreated unresectable malignant pleural mesothelioma** Technology appraisal guidance [TA818] Published: 17 August 2022 https://www.nice.org.uk/guidance/ta818 **APC action:** link added to Formularies **Avalglucosidase alfa for treating Pompe disease** Technology appraisal guidance [TA821] Published: 24 August 2022 https://www.nice.org.uk/guidance/ta821 **APC action:** Specialist centre only. No addition to local formularies.	

No	Agenda Item	Action
	Melphalan for haematological diseases before allogeneic haematopoietic stem cell transplant (terminated appraisal) Technology appraisal [TA822] Published: 14 September 2022 https://www.nice.org.uk/guidance/ta822 **APC action:** none – terminated appraisal.	
7.0	**Virtual Recommendations/Documents**	
7.1	**Psoriatic arthritis update** The BLMK psoriatic arthritis pathway has been updated to incorporate the recommendations from the following NICE TAs: • Guselkumab for treating active psoriatic arthritis after inadequate response to DMARDs Technology appraisal guidance [TA815] First published in June 2021, NICE has undertaken a rapid review of the guideline published on 10th August 2022. The rapid review has extended the patient group that can be treated with Guselkumab, including first line use in some patients. The PASI criteria has been removed. • Risankizumab for treating active psoriatic arthritis after inadequate response to DMARDs Technology appraisal guidance [TA803] Published: 13 July 2022 Risankizumab is recommended as an additional treatment option for patients with active psoriatic arthritis and moderate to severe psoriasis, who have had 2 conventional DMARDs and at least 1 biological DMARD. The pathway update has been agreed with local specialists and was approved virtually by the committee (quorate response received). It was noted however that reference(s) to 'CCG' in the pathway need to be updated to 'ICB' to reflect organisational changes. The Committee ratified the Psoriatic Arthritis pathway update, subject to the minor terminology amendments being made. **EQIA Assessment:** Yes – but in a positive way – increase in the number of treatment options available **BLMK ICB E and D Lead comment: A**dditional options added to treatment pathway as per NICE guidance so no further EIHR comments.	JC
7.2	**APC Terms of Reference (update)** Minor amendments to the APC Terms of Reference (TOR) have been made to include: • Updating terminology to reflect organisational change (CCG to ICB) • Amendments to reflect changes to committee names, website address The above changes were approved virtually by the Committee	

No	Agenda Item	Action
	(quorate response received). In addition, it was proposed that the following additional amendments are made to the TOR, within the 'Membership' section: • Amendment of terminology of 'Non-Executive Director' to 'Non-Executive Member' to reflect the change in the title between the CCG and the ICB. • Addition of an additional option for the committee Chair to include 'BLMK General Practitioner' to futureproof for availability of individuals. The Committee approved the proposed amendments to the APC Terms of Reference.	AG
7.3	**Anticoagulation for non-valvular Atrial Fibrillation (NVAF)** The APC was asked to ratify the following nationally produced anticoagulation prescribing guidance for local use: • UKCPA/PCPAP/PCCS - Anticoagulation for non-valvular atrial fibrillation (NVAF) following NHSE DOAC commissioning recommendations There is a move across the NHS to offer edoxaban as the first line DOAC treatment choice for NVAF for most patients. This is supported by the local Prescribing Incentive Scheme and national Primary Care Network Directed Enhanced Service contract (PCN DES). The national prescribing guidance has been produced in response to requests for the provision of a prescribing support document for clinicians, including when initiating an anticoagulant or when switching patients between anticoagulants. The guidance was circulated for virtual approval but, although there were a number of supportive responses, quoracy was not achieved. It was noted that concerns were raised about prescribing edoxaban for those with high GI bleed risk and those at increased risk of a GI Bleed (e.g., patients on Dual Anti-Platelet Therapy (DAPT)) and the following was discussed: • These risks are acknowledged in the 'patients less suitable to switch' section of the guidance. • It was proposed to strengthen the message by ratifying the guidance but with a covering page to recommend apixaban 1st line in those with previous GI bleed and for those on co-prescribed anti-platelet therapy. The national guidance was ratified for local use, with the additional local clarification as described above.	MD

No	Agenda Item	Action
8.	**Medicines Safety update**	
8.1	**Primary Care Medicines Safety Update** A Primary Care Medicines Safety Update was presented to the Committee. This update focussed on the primary care response to the MHRA Drug Safety Updates (July and August 2022). In particular: **Topiramate (Topamax): start of safety review triggered by a study reporting an increased risk of neurodevelopmental disabilities in children with prenatal exposure** The MHRA have initiated a new safety review into topiramate as a result of an observational study reporting an increased risk of neurodevelopmental disabilities in children whose mothers took topiramate during pregnancy. Topiramate is known to be associated with an increased risk of congenital malformations and effects on fetal growth if used during pregnancy. Continue to counsel patients who can become pregnant on the known and emerging risks of topiramate for an unborn baby and on the need to use effective contraception throughout use. **Action(s) taken:** DSU included in BLMK primary care newsletter, DSU also linked to the Formulary to raise awareness. To be discussed at next MSG re dissemination to relevant clinical teams. The DSU has also been included in the latest issue of BLMK wide Medication Safety Newsletter as part of a 'pregnancy special' issue in September. **Nebulised asthma rescue therapy in children: home use of nebulisers in paediatric asthma should be initiated and managed only by specialists** Use of a nebuliser purchased independently of medical advice for use in the home to deliver nebulised asthma rescue medications to children can mask a deterioration in the underlying disease and may increase the risk of potentially fatal delays in seeking medical attention if asthma deteriorates. If home use of a nebuliser for the acute treatment of asthma in children under 18 years of age is considered necessary, this should be initiated and managed by an appropriate specialist. This is consistent with current clinical guidance. **Action(s) taken:** DSU included in BLMK primary care newsletter, DSU also linked to the Formulary to raise awareness. Planned to be discussed at BLMK Medication safety Group for onward dissemination to respiratory teams. The DSU will also be shared with the respiratory long term conditions group and included in the paediatric asthma guideline. **<u>Local safety initiatives</u>** **Peanut allergy - information on medicines** Milton Keynes locality team have been working closely with medicines safety team on sourcing information for medicines that	

No	Agenda Item	Action
	contain peanuts. To be brought to MSG for further discussion with view to highlighting via a future newsletter. **Metolazone – difference between preparations and safety considerations** The SPC for the new licensed metolazone 5mg tablet Xaqua states that it is "not directly interchangeable with other metolazone products due to higher bioavailability", and that this variability could be up to a two-fold difference in comparison to other metolazone products. Within primary care, there is a potential risk that patients prescribed metolazone are automatically switched to this new licensed product Xaqua. We are therefore highlighting this difference in addition to the recent NICE clinical awareness bulletin for consideration and to reduce associated risk. SPS have also issued guidance https://www.sps.nhs.uk/articles/differences-between-metolazone-preparations-and-safety-considerations/ **Action(s) taken**: Communication has been sent out to community pharmacies and guidance featured in the BLMK primary care news bulletin The ICB medicines optimisation team are currently working with heart failure teams within our local acute trust providers to manage this safety concern. The precautionary advice for patients newly started on Xaqua includes: • confirmation that additional monitoring including U&Es has been requested • advising patients to notify their specialist team, • counselling patients to seek medical advice if they experience any new onset of symptoms which may suggest electrolyte imbalance The Committee noted the Medicines Safety update.	
8.2	**Medicines Safety Group (MSG) annual report** The BLMK MSG commenced in June 2021 following endorsement by the BLMK APC. The report provided an annual summary of the MSG focus areas and medicines safety interventions actioned in the last 12 months. In summary, the following interventions were made during 2021/22: • Formed a collaborative, active and engaged network of 'medicines safety champions' from the Medicines Optimisation teams from partner organisations within BLMK ICS – co-chairs this year MKUH and BHFT MSOs. • The network has enabled a fluid conversation around sharing good practice following medication safety incidents, 'do it once… do it well'. • Initiatives include: set up of MSG website section and ICS wide newsletter, reconciling local and national patient safety guidance (NPSA alerts, MHRA DSUs) and action where appropriate. • Area of primary focus: sodium valproate and risk acknowledgement form compliance – this included	

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	conducting cross-sector audits; building elements into primary care incentive schemes, including raising awareness through the systemwide newsletter, sharing information amongst partners on pathways to help cohorts who are not under active specialist review, with the aim to improve overall awareness and compliance as a system. <u>Considerations for 2022/2023:</u> In addition to extending membership, exploring the prospect of MDT approach, continue focusing on MedSIP, and following feedback from BLMK IPMO in 2022, the MSG plan to: • Review the WHO medication without harm global strategy, in addition to local and national safety initiatives. • Consider whether quality improvement methodology can be applied where new projects are identified to further support delivery of outcomes. • Continue to explore/ build in patient and quality/ safeguarding involvement in MSG interventions. The Committee noted the MSG annual report.	
8.3	**Medicines Safety Group Terms of Reference update** Following review of attendance and quoracy the following minor amendments have been made to the TOR and agreed by the MSG at the recent meeting in September 2022: • Health and Justice and ambulance services now included within co-opted membership • ICB Care home medicines optimisation representative moved from co-opted to core membership • ICB locality medicines optimisation representative moved from co-opted to core membership • Quoracy (5 core members) to be retained The Committee ratified the update to the MSG terms of reference.	
9.	**Formulary Update**	
9.1	**Formulary Subgroup Recommendations** The following recommendations were made by the Formulary subgroup at the 6 September 2022 meeting: • **Ogluo (Glucagon) Autoinjector for Severe Hypoglycaemia** – Non-Formulary with by exception prescribing “where included in a child's individualised health care plan and an appropriately trained staff member is available to administer it”. • **Hormone Replacement Therapy Section Review** - Addition or change to GREEN – Femoston tablets, Elleste Duet Conti, Femoston Conti, Evorel conti patches, Elleste Solo, Femseven patches, Ovestin. Removals-Tridestra (Low prescribing rate and highest cost tablet with VTE risk being at the higher end), Premarin (Less suitable now as the oestrogen is equine based and the body-identical oestrogens are safer. Vagirux (branded generic) to replace Vagifem on	

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	the Formularies as a cost-effective (32% saving) and more environmentally friendly product (re-useable plastic applicator). • **Bijuve combined HRT capsules** – Add as Green, reserved for patients who are non-compliant with progesterone component. • **Prasterone (Intrarosa) pessaries and ospemifene tablets for Vulvar Vaginal atrophy** – Both added as Amber/Amber 3 last line therapies • **Methocarbamol for short term relief of muscle spasm** – non-Formulary stance formalised following identification of high prescribing rates in BLMK. Aim to reduce prescribing following decision. • **Cacit effervescent tablets for bone disease of prematurity** - added to MK Formulary to align with Beds/Luton. • **Ranibizumab biosimilar (Ongavia) for retinal eye conditions** – add to Formularies RED. • **Dymista nasal spray for perennial allergic rhinitis** – Designation changed from Amber to GREEN. • **Minor updates** – a large number of minor amendments have been made and were included in the report for information. The Committee discussed the following points in relation to the Formulary subgroup recommendations: • Prasterone (Intrarosa) pessaries and ospemifene tablets for Vulvar Vaginal atrophy should be Amber 1 on the Milton Keynes joint Formulary, not Amber 3, as no titration or stabilisation of dosing is required. • Ogluo – the Committee discussed whether it was appropriate for it to placed as non-formulary, but with an exception; whether it should be completely non-formulary; or whether it should be approved as a formulary choice with restrictions. It is accepted that Formularies cannot apply to 100% of patients and that there will be exceptions. It was agreed that Ogluo should be designated as non-formulary on both joint Formularies, without exceptions. The Committee was updated about the subgroup's traffic light merger project. In order to be able to move forward with alignment of the Milton Keynes and Bedfordshire/Luton joint Formularies, a project has been undertaken to merge the traffic lights in use on the formularies, as these currently differ. The following categories were reviewed, discussed and approved by the subgroup:	

Beds/Luton and Milton Keynes Traffic-Light Systems				
Current description	**Beds/ Luton**	**Milton Keynes**	**Proposed logo**	**Proposed descriptor**

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DNP RED GREEN SpA SpIS SCG DISCONTINUED SELF-CARE EXISTING	Prescribing not recommended	BLACK	REDRED/ double red	DNP	Do not prescribe. Assessed and not supported by BLMK	
	Consultant-only prescribing	RED	RED	RED	Secondary/tertiary care prescribing only	
	May be initiated and continued by GPs	GREEN	GREEN	GREEN	May be initiated in any care setting	
	Initiated by Specialist, may be continued by GPs	AMBER	----	SpA	Specialist advised, initiation as per local agreement, followed by continuation in primary care	
	Specialist advised, Followed by GP initiates and continuation	-----	AMBER 1	SpA	Specialist advised, initiation as per local agreement, followed by continuation in primary care	
	Specialist or GP initiation in line with local guideline after 1st line failure, followed by GP continuation	----	AMBER 2	---	Merge with other categories following audit-anticipated most will be Green	
	Specialist initiation and stabilisation, followed by GP continuation	----	AMBER 3	SpIS	Specialist initiates and stabilises, continuation in primary care	
	Initiated by Specialist, may be continued by GP under SCG arrangement	SCG	SCG	SCG	To be prescribed as per shared care guidance	
	The committee ratified the recommendations of the Formulary Subgroup with the changes as discussed: • Prasterone pessaries and ospemifene tablets to be Amber 1 on the Milton Keynes joint Formulary. • Ogluo to be non-formulary, with no exceptions. Any requests for use will be considered on a case-by-case basis. The Formulary subgroup will be informed of the APC decisions at the next meeting of the group in November.					TL TL
10.	**Antimicrobial Resistance Update** – *no update as there have been no meetings since the last APC meeting.*					
All other papers (from this point in the agenda) are for noting/information by the Committee						

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11.	**East of England Priorities Advisory Committee (PAC) – items for noting/approval**	
11.1	EoEPAC Meeting Notes – March 2022 and May 2022 The committee noted the minutes for information.	
11.2	EoEPAC draft Meeting Notes – July 2022 The committee noted the minutes for information.	
12.	**Bedfordshire, Luton and Milton Keynes Local Prescribing Committee Minutes.** The Committee noted the following minutes for information.	
12.1	Minutes from the Bedfordshire Hospitals Foundation Trust DTC meeting – May 2022	
12.2	Minutes of the BLMK Formulary Subgroup – June 2022	
12.3	Minutes of the Bedfordshire and Luton Wound Management Formulary Steering Group – May 2022	
12.4	Minutes of the BLMK Medicines Safety Group – May and July 2022	
12.5	Minutes of the ELFT Medicines Management Committee (Mental Health) – May 2022	
12.6	Minutes of the Cambridgeshire Community Services Medication Safety and Governance Group – May 2022	
12.7	Minutes of the Circle/MSK Medicines Management Committee – May 2022	
12.8	Minutes of the CNWL Trustwide Medicines Optimisation Group (MOG) – April 2022	
13.	**Papers for information / ratification**	
13.1	**Risk sharing / FOC policy update** This policy has previously been approved by both of the legacy APCs (the Bedfordshire and Luton Joint Prescribing Committee and Milton Keynes Prescribing Advisory Group). The current version, aside from some minor updating (to reflect changes to organisations), is unchanged and has gone through the BLMK ICB ratification process. The document therefore came to the APC for information only. The committee noted the policy and discussed that it may be appropriate to add additional information to the policy to confirm that it does not apply to Early Access to Medicines Schemes. It was agreed that this will be added to the policy the next time it is updated (as a non-urgent action).	JC
13.2	**Risankizumab EAMS** The aim of Early Access to Medicines Schemes (EAMS) is to provide earlier availability of promising new unlicensed medicines and medicines used outside their licence, to UK patients that have a high unmet clinical need. The Committee was asked to consider the	

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	EAMS for "Risankizumab for moderate to severely active Crohn's Disease" published by the MHRA in April 2022. The EAMS indication is: • treatment of adults with moderately to severely active Crohn's disease who have had an inadequate response to, lost response to, or were intolerant or contraindicated to tumour necrosis factor-alpha (TNFα) antagonist therapies, vedolizumab and ustekinumab. • treatment of adolescent patients aged 16 to 17 years with moderately to severely active Crohn's disease who have had an inadequate response to, lost response to, or were intolerant or contraindicated to TNFα antagonist therapies. Integrated Care Systems are the responsible commissioner for adult patients; NHS England are the responsible commissioner for adolescent patients. NHS England has adopted the scheme for adolescent patients and produced an eligibility proforma to be used for these patients. Interest has been expressed in the Risankizumab EAMS by a neighbouring Trust and therefore it was proposed that the scheme was ratified for local use in accordance with the processes and requirements laid out by the MHRA. There are no plans to add Risankizumab to the local Crohn's disease biologic treatment pathway at the current time, although this will be reviewed when the NICE TA is published in 2023. Local gastroenterologists have been consulted and also expressed an interest in, and supported the adoption of, the scheme. A Blueteq form will be made available for Trusts to complete when initiating the treatment. The Committee noted the EAMS and approved it for local use. **EQIA Assessment:** Yes, this is likely to have a positive impact for eligible patients as it is meeting an unmet need in those with moderate to severe disease who have had an inadequate response to, lost response to, or were intolerant or contraindicated to existing treatment options. **BLMK ICB E and D Lead comment:** Additional option added where there was a gap so no further EIHR comments.	
13.3	**Secukinumab – Dose escalation and rebate scheme** The marketing authorisation for Secukinumab has changed to include a recommendation that patients over 90 Kg with moderate to severe plaque psoriasis, and patients with psoriatic arthritis with concomitant moderate to severe plaque psoriasis, can benefit from a 2 weekly maintenance dosing. Secukinumab is recommended by NICE for both active Psoriatic Arthritis and Severe Plaque Psoriasis. In order to make the treatment cost effective both of the above technology appraisal guidance require that:	

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	• the company provides secukinumab with the discount agreed in the patient access scheme. The patient access scheme relates to a reduction in cost per dose and was written prior to the marketing authorisation change outlined above. The manufacturer has no plans to amend the NICE approved Patient Access Scheme but has offered a 3-year local rebate scheme which means that patients over 90 kg requiring the increased frequency will not cost the health economy any more than a patient receiving the normal dosing under the patient access scheme. Our rheumatology specialists (Bedfordshire Hospital NHS Trust) have indicated that they would like to take up the offer of the rebate scheme. It is proposed that the rebate scheme is supported for the following reasons: • The medicine and indication are NICE approved and already on our Formularies • Although there is some financial risk to the ICB when the rebate scheme ends, we would not expect this to be large as the patient numbers are likely to be low. The Trust has confirmed that it would be happy to keep a record of numbers of patients receiving treatment at the higher dosage frequency and advise the ICB Commissioning Pharmacy team so that the cost to the health economy can be monitored. This will be particularly important in the lead up to the end of the rebate (if it is not renewed). Bedfordshire Hospital Trust prescribing of Secukinumab accounts for about 80% of prescribing of the medicine and the clinicians anticipate a maximum of 4 or 5 patients annually would be suitable for treatment under the rebate scheme. This would equate to an additional cost of around £45,000 per annum if the rebate scheme were to end after 3 years. Clinicians at Milton Keynes University Hospital have been contacted to determine whether there is also interest from MK Trust. If the Trust does wish to take advantage of the rebate scheme, this would be approved as per the agreement with Bedfordshire Hospital Foundation Trust. The paper came to the Committee for information only. The Committee noted the information on the rebate scheme. **EQIA Assessment:** Yes – this will be advantageous for patients with moderate to severe plaque psoriasis 90kg in weight and over. **BLMK ICB E and D Lead comment:** Additional option added which will be an advantage – no further EIHR comments.	

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13.	**Any other business** The Committee noted that this may be the Chair's last meeting and extended their thanks for her service to the Committee.	
14.	**Future Dates for BLMK APC 2022 / 2023 Meetings (all to be held from 12:30-15:00 via Microsoft Teams):** Wednesday 7th December 2022 Wednesday 1st March 2023 Wednesday 3rd May 2023 Wednesday 5th July 2023 Wednesday 27th September 2023 Wednesday 6th December 2023	

Approval of minutes:

Chair: M Nisar

Signed: 

Date: 15/12/2022

Appendix 1 – Approved 6th September 2022 Formulary Subgroup Minutes:

FSG Final Minutes Sept 2022_JF signed.c