BEDFORDSHIRE, LUTON AND MILTON KEYNES AREA PRESCRIBING COMMITTEE

Meeting Notes

Date: 27 September 2023
Time: 12.30- 3.00pm
Venue: Microsoft Teams

Attendees:

Name	Initial	Role
Dr Muhammad Nisar	MN	Chair (Medical Representative, Bedfordshire Hospitals NHS Trust)
Yolanda Abunga (from 12:50pm)	YA	CCS Pharmacy Representative (Community Services Pharmacist, Beds and Luton)
Reginald Akaruese	RA	CNWL Pharmacy Representative (Community and Mental Health Services, Milton Keynes)
Sally Cartwright (until 1:53pm)	SC	Consultant in Public Health
Dr Marian Chan	MC	Medical Representative, Bedfordshire Hospitals NHS Trust
Candy Chow	CC	Chair of Wound Care Group
Jacqueline Clayton	JC	Deputy for Associate Director and Head of Medicines Optimisation BLMK ICB (until 1.25pm) / Commissioning Lead Pharmacist, BLMK ICB
Janet Corbett	JCo	Milton Keynes Hospital Pharmacy Representative (Pharmacy Programme Manager, Milton Keynes Hospital)
Naomi Currie	NC	Place Based Lead Pharmacist – Bedford
Matt Davies	MD	Place Based Lead Pharmacist – Central Bedfordshire
Fiona Garnett (from 1:25pm)	FG	Associate Director and Head of Medicines Optimisation BLMK ICB
Anne Graeff	AG	Commissioning Lead Pharmacist, BLMK ICB (Professional Secretary)
Gemma McGuigan	GMcG	Bedfordshire Hospitals Trust Pharmacy Representative (Deputy Chief Pharmacist, Bedfordshire Hospitals Trust)

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

Quynh Nguyen	QN	ELFT Pharmacy Representative – Community Services (Beds)/Mental Health Services (Beds and Luton)
Dr Kate Randall	KR	Place Based Lead GP – Central Bedfordshire
Dr Mitan Sarkar	MS	Place Based Lead GP – Luton
Dr Jonathon Walter	JWa	Place Based Lead GP – Milton Keynes
Dr Jenny Wilson	JW	Place Based Lead GP – Bedford

In attendance:		
Dorothy Aladejobi (until 2:00pm)	DA	Pharmacist Representative, NHS Northampton Hospital Foundation Trust Secure Services
Rafal Ali	RA	Commissioning Pharmacist, BLMK ICB
Taiya Large	TL	Formulary and Medicines Safety Pharmacist, BLMK ICB
Sandra McGroarty	SMcG	Commissioning Pharmacist, BLMK ICB
Dr Joy Muttika	JM	Medical Representative, Keech Hospice
Kike Pinheiro (from 12:46pm)	KP	Representative, Willen Hospice
Natalie Smith (until 1:47pm)	NS	Representative, St John's Hospice
Sharon Wilmore	SW	PA to MOT, BLMK ICB (admin support)
Nikki Woodall	NW	Lead Medicines Optimisation Technician, BLMK ICB
Iffah Salim (for agenda item 5.8)	IS	Specialist CAMHS Pharmacist, East London Foundation Trust

Apologies:		
Mojisola Adebajo	MA	Place Based Lead Pharmacist – Luton
Nicola Ainsworth	NA	Consultant in Public Health
Pritesh Bodalia	PB	Bedfordshire Hospitals Trust Pharmacy Representative (Chief Pharmacist, Bedfordshire Hospitals Trust)
Helen Chadwick	HC	Milton Keynes Hospital Pharmacy Representative (Chief Pharmacist, Milton Keynes Hospital)
Alice Green	AGr	Representative, St John's Hospice
Cheryl Green	CG	Patient Representative
Carole Jellicoe	CJ	Nurse Representative (Independent Prescriber)
Dr Dush Mital	DM	Medical Representative, Milton Keynes Hospital
Dona Wingfield	DW	Chair of Medicines Safety Group / Bedfordshire Hospitals Trust Pharmacy Representative (Medicines Use and Quality Manager, 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 Jacqueline Clayton for her long, dedicated service to the Committee, and the legacy group, the Bedford and Luton Joint Prescribing Committee. Jacqueline is a long standing and highly valued member of the team, and the Chair wished her all the best for her retirement. The Chair welcomed Dorothy Aladejobi, who has replaced Janice Jones as the representative for the NHS Northampton Hospital Foundation Trust Secure Services, 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. All members confirmed they have no declarations in relation to matters on the agenda.	
3.	**Minutes of 05 July 2023 APC meeting** The minutes of the meeting held on 05 July 2023 were approved.	
4.	**Matters Arising**	
4.1	**Feedback on miscellaneous actions not included on the agenda from APC meetings**	
4.1.1	**Localised Severe Psoriasis** Local review to be undertaken of PAC policy to include: number of lines of therapy available and choice of therapy (following comments received by local clinicians). **Update 13/09/2023** – PAC has carried out a review, as requested by BLMK, but the Priorities Advisory Committee decided not to proceed with it as a PAC policy. This will therefore need to be taken forward locally and has been added to the APC work plan. It was proposed and agreed that the action could be closed.	Close
4.1.2	**Somatostatin analogues bulletin** Document to be updated and traffic lights to be amended to reflect the newly implemented SpIS formulary status. **Update 13/07/23** – the document and formulary traffic lights have been updated. The bulletin has been uploaded to, and is available to view on, the Medicines website. It was proposed and agreed that the action could be closed.	Close

No	Agenda Item	Action
4.1.3	**Liraglutide for CYP under 18 years with Type 2 Diabetes (T2DM)** Formulary status of liraglutide (Victoza) to be updated to SpIS on both formularies once the prescribing guidance has been uploaded to the Medicines website. **Update 10/08/23** – the prescribing guidance document has been uploaded to, and is available to view on, the Medicines website. Formulary statuses subsequently updated on both formularies, and links to the prescribing guidance added. It was proposed and agreed that the action could be closed.	Close
4.1.4	**Finerenone formulary status** Formulary status to be updated on both formularies from Amber/Amber 3/SpIS to SpA. **Update 12/07/23** - both formularies have been updated to SpA formulary status. It was proposed and agreed that the action could be closed.	Close
4.1.5	**Shared care patient information leaflet (PIL)** Further work to be done to consider the co-production of leaflets with patients. **Update 27/09/23** – a meeting has taken place with the ICB co-production lead and suggestions received regarding actions to take to undertake co-production for PILs going forward. NA has offered to be the champion for co-production with service users / carers in the future. The Committee discussed the possible production of a policy to outline the process / expectations around the production of PILs in the future and agreed that this would be a valuable piece of work. The Committee agreed that this action can be closed, the production of a policy will be added to the APC workplan, and the Committee's discussion to be fed back to NA. **Post meeting note**: feedback received during the meeting from the CCS co-production lead, with regards to the shared care patient information leaflet. These comments will be considered alongside any other feedback from the trial of the PIL in Rheumatology (see action 4.1.6 below).	Close AG
4.1.6	**Shared care patient information leaflet** Patient information leaflet to be trialled, and feedback from patients sought, at BHFT prior to full adoption of the leaflet within BLMK. **Update 18/09/23** - MC/CG met and discussed the trial of the leaflet within BHFT Rheumatology. The trial introduction of the leaflet has been delayed due to capacity/staffing issues in the trust, but it is hoped that it will commence within the next few months. This is an ongoing action.	MC/CG
4.1.7	**Medical devices** Formulary status recommendations to be update from Amber / Amber1 to SpA, in line with the recently updated formulary traffic light designations, and document to be updated to reflect the decisions reached at the July meeting. **Update 12/07/23** – document, and uploaded to the Medicines website, and formulary statuses updated as agreed at the July meeting. It was proposed and agreed that the action could be closed.	Close

No	Agenda Item	Action
4.1.8	**Medical devices / dry mouth products** Optimise Rx message to be created to support appropriate prescribing, and text to be added to the Formularies. **Update 13/09/23** – this has been added to the Formulary and Optimise Rx workplans and will be actioned as part of the workplan. It was proposed and agreed that the action could be closed.	Close
4.1.9	**Medical devices** Formulary statuses to be reviewed post meeting and any further recommendations for changes to be taken to the Formulary Subgroup for agreement. **Update 05/09/23** – a paper on the formulary inclusion and status of medical devices was discussed at the Formulary Subgroup on 05/07/23 and traffic lights agreed (see also agenda item 9.1). It was proposed and agreed that the action could be closed.	Close
4.1.10	**Dapagliflozin for treating chronic heart failure with preserved or mildly reduced ejection fraction** Prescribing support information to be produced to aid primary care prescribers (green traffic light agreed for this indication, with production of the support information). **Update 18/09/23** – awaiting input from secondary care. This is an ongoing action.	MD
4.1.11	**Patient Group Directions (HCRG Care Group)** PGDs to be finalised with the changes agreed prior to/at the meeting. **Update 26/07/23** - PGDs finalised and shared with the provider. It was proposed and agreed that the action could be closed. NB: see also agenda item 13.1	Close
4.1.12	**CGM choices for pregnant people** Clarification of second line choices of CGM for pregnant patients with T1DM. **Update 24/07/23** – an omission to the presentation of CGM choices to the Committee at the July meeting was observed: FreeStyle Libre 3 is a recommended second line CGM option for pregnant patients with T1DM (as agreed by the CGM Diabetes Working Group) alongside Dexcom G7, but was omitted from the presentation. This addition was approved by Chair's action on 12/07/23 and has been added to the Chair's action log. The committee ratified the addition and agreed that the action may be closed.	Close
5.	**Items for consideration at meeting**	
5.1	**Dapagliflozin for treating chronic heart failure with preserved or mildly reduced ejection fraction: prescribing support information** Deferred to December meeting (see also 4.1.10)	
5.2	**Severe psoriasis pathway update** The existing severe psoriasis pathway has been updated to include a new agent, deucravacitinib, and other amendments as follows: • Addition of a front sheet to include additional information / prescribing notes.	

No	Agenda Item	Action
	• Inclusion of a statement to indicate that adalimumab is the usual first line, cost-effective treatment choice (unless contra-indicated or the patient has a preference for oral therapy). • Inclusion of information regarding patient groups in which TNF inhibitors should be avoided. • Inclusion of a statement regarding the cost-effectiveness of deucravacitinib in comparison to adalimumab, bimekizumab or tildrakizumab (as per NICE TA907, point 3.18). The Committee noted the following key points: • NICE recommended deucravacitinib, in TA907, for use in the same way as other agents at the same stage of the treatment pathway. • Stopping criteria are also similar to other TAs for moderate to severe psoriasis. • Deucravacitinib could be used at any point in the order of treatments at the same stage, but adalimumab is normally used first unless it is clinically unsuitable. • Deucravacitinib is less effective than most biological treatments, and is less effective and more expensive than adalimumab, bimekizumab and tildrakizumab. • Deucravacitinib would not be a cost-effective use of NHS resources if used when adalimumab, bimekizumab or tildrakizumab were considered to be suitable treatment options. • No significant resource impact is anticipated as a result of the introduction of deucravacitnib as an additional treatment option. The resource impact is expected to be approximately £88,000 for the BLMK population. This is because the technology is a further treatment option and the overall cost of treatment for the patient group will be similar. A suggestion was received to amend 'systemic treatments' to 'standard systemic treatments' in the title of the document – this change was agreed. **Decision**: The Committee approved the updated severe psoriasis pathway for use across BLMK, with the minor amendment agreed at the meeting. **EQIA Assessment:** Positive impact – the introduction of a new treatment will improve the range of options available to patients. This is particularly relevant to patient groups more commonly affected by psoriasis e.g. people of white ethnicity and/or with a positive family history, or those who have contraindications to biologics or prefer oral therapy. NB: NICE TA907 includes considerations for specific patient populations when assessing PASI and DLQI scores (points 1.5 and 1.6 of the recommendations). **BLMK ICB E and D Lead comment:** No further comments in relation to equality.	AG

No	Agenda Item	Action
5.3	**Paediatric Type 2 Diabetes – updated NICE guidance (NG18) / use of dulaglutide & empagliflozin** NICE NG18 has recently been updated to include new recommendations on the use of GLP 1 receptor agonists (liraglutide or dulaglutide) and an SGLT2 inhibitor (empagliflozin) in children and young people (CYP) with type 2 diabetes (T2DM). NG18 recommends an offer of a GLP 1 receptor agonist or consideration of a SGLT2 inhibitor, depending on the person's preference, in addition to metformin +/- insulin therapy, to CYP aged 10 or over with T2DM if they have: • an HbA1c level of more than 48 mmol/mol (6.5%) or • a plasma glucose level of more than 7 mmol/litre, on 4 or more days a week, when fasting or before meals or • a plasma glucose level of more than 9 mmol/litre, on 4 or more days a week, 2 hours after meals. The Committee considered the addition of dulaglutide (liraglutuide has been considered previously by the APC and agreed for inclusion in the formularies) and empagliflozin to the formularies, as recommended by NG18. A formulary status of SpIS (specialist initiation and stabilisation prior to continuation in Primary Care) was proposed and prescribing support documents have been developed to support primary care prescribers. The Committee noted the following key points: • T2DM in children CYP is a more aggressive form of diabetes, as it is associated with greater insulin resistance and more rapid deterioration of beta cell function decline than adults with T2DM. • Because this population will live with the condition for longer, timely intervention is important to reduce the risk of developing severe micro and macrovascular complications likely to affect quality of life. • There is a limited range of safe and effective medicines to manage blood glucose levels for children and young people with T2DM, with metformin and insulin being the mainstays of treatment. • The financial impact of adopting the NG18 recommendations is expected to be small, due to the small size of the eligible paediatric population (approximately £18,000 per 1 million population). The Committee discussed the paediatric obesity pathway and whether this sits with the secondary care paediatric teams. It was noted that BHFT is a tertiary centre for adult obesity, but not paediatric obesity. Management of paediatric patients with T2DM sits with the secondary care paediatric teams, and the consultants have been consulted in the development of the prescribing support documents. Although obesity and T2DM are interlinked, treatment of T2DM is the focus of the proposal and documents presented to the Committee, in line with NICE NG18.	

No	Agenda Item	Action
	Decision: The Committee approved the addition of dulaglutide and empagliflozin to the formularies, with SpIS traffic light status. The prescribing support documents were also approved. **EQIA Assessment:** According to the National Diabetes Audit (NDA) 2019/20 data -Link the following characteristics play a key role in the incidence of type 2 diabetes (T2DM) in young people. • Family background -minority ethnicity • Lower socioeconomic status – living in area of social deprivation. • Being overweight or obese But there were no equality considerations that were specifically applicable to the recommendations by NICE, but this will have a positive impact on the currently unmet need as outlined in section 3. **BLMK ICB E and D Lead comment:** 1. *"But there were no equality considerations that were specifically applicable to the recommendations by NICE, but this will address an unmet need as outlined in section 3."* o I would add that this will have a positive impact on the currently unmet need…. 2. Please also consider either in the EIA or minuted in the discussion the accessible information standard (AIS) and how you will be meeting this in the patient materials. Follow up comment regarding point 2 above: I thought I'd read in one of the documents that patient materials will also be developed? Apologies if I've mis-read. If it's just for AHPs then it should be ok. **Action:** The paper has been updated, with regards to the point 1, to include the suggested addition. To confirm regarding point 2: the prescribing guidance is for HCPs, and not patients, and therefore the AIS is not applicable.	
5.4	**Crohn's Disease Treatment Pathway Update** Since the BLMK Crohn's Disease treatment pathway was last updated in March 2023, NICE has published 2 further technology appraisals recommending treatment with risankizumab (TA888) and upadacitinib (TA905). An updated pathway has been developed to incorporate these two new drugs, taking into account the individual NICE TA recommendations, and was presented to the committee for consideration. Risankizumab (an interleukin-23 inhibitor) and upadacitnib (a Janus Kinase inhibitor (JAKi)) offer two new treatment options with distinct modes of action. There are now 6 treatments recommended by NICE for the treatment of moderate to severe Crohn's disease and, although NICE makes recommendations on individual drugs, they do not provide guidance regarding the sequential use of any of the 6 individual drugs for patients who have previously tried 2 other separate agents. As a result, treatment options beyond 2nd line	

No	Agenda Item	Action
	needs to be agreed as part of local decision-making and commissioning. The Committee noted the following proposed changes to the existing pathway, and other key points: • To add risankizumab and upadacitinib as treatment options to the pathway as per the NICE recommendations. • To allow clinical freedom of choice when selecting a third line agent and beyond (to a potential of a maximum of 6 lines of therapy). This flexible approach recognises that each of the available drugs have a different mode of action and that the suitability of each drug will differ between patients depending on clinical disease presentation and presence /absence of other comorbidities. • Addition of prescribing information regarding upadacitinib, including a link to the MHRA drug safety update, regarding points to consider before prescribing a JAKi. • Clinical evidence for switching between agents at fourth line and beyond is limited, and therefore a pragmatic approach is required. • The cost impact of introducing 5th and 6th line therapy options is difficult to quantify but, based on feedback from clinicians and drug acquisition costs, is estimated to be between £30,000 - £80,000 per year. There are potential cost savings from avoidance of admissions, surgery and the need for total parenteral nutrition (TPN). • It was noted that biosimilars are in development for ustekinumab, which is expected to offset additional costs associated with the extension of the pathway. • An amendment to the Individual Funding Request (IFR) statement at the end of the pathway was proposed at the request of the IFR panel. The wording regarding IFRs is therefore proposed to be amended and updated to highlight that the IFR route should only be used if exceptionality can be demonstrated. Additional, strengthened, wording was also proposed to be added to clarify the commissioning for ustekinumab dose escalation beyond the recommended licensed doses. **Decision**: The updated pathway was supported, with the amended wording around IFRs to be added on all high cost drug pathways when they are next updated. This includes the severe psoriasis pathway (agenda item 5.2), migraine pathway (agenda item 5.7) and Rheumatology pathways (agenda item 7.4) considered at this meeting. **EQIA Assessment:** Positive impact anticipated due to extension of the pathway, and proposed increase in the number of treatment options available. **BLMK ICB E and D Lead comment:** No further comments in relation to equality.	SMcG/ AG/RA

No	Agenda Item	Action
5.5	**Hypertension patient leaflet** To support patients with newly diagnosed hypertension, a patient leaflet "I've been told I have high blood pressure" has been developed by the CVD long term conditions group. The leaflet is intended for use across BLMK practices and to be used in conjunction with the new BLMK hypertension pathways. The leaflet differs from leaflets produced by e.g. the British Heart Foundation as it strengthens the messages around the risk of untreated high blood pressure and reinforces key messages form the local hypertension pathway e.g. people commonly need two medications to control their blood pressure (BP). It is hoped that if provided to a patient before a BP review appointment it will support conversations around the risks of hypertension, starting BP medication and adding additional medication. The Committee discussed the following addition points: • The leaflet was welcomed as a well-designed, useful tool for clinicians to provide to patients. • The content has been reviewed by the BLMK ICB communications team, who have contributed to the content to ensure appropriate, patient friendly language is used. • Once finalised the leaflet will go for professional design via Arden and GEM CSU. • It is planned that the leaflet will be translated into different languages once it has been finalised. • Feedback was received from the equality lead regarding production of an easy read version of the leaflet and this will be explored with the communications team. • A question was raised regarding inclusion of some information regarding the potential for low blood pressure in the future, and risk of falls. It was clarified that the leaflet is aimed at newly diagnosed patients, to help their understanding of what high blood pressure is, what the consequences may be, and how it is managed. There are care plans built into SystmOne to support ongoing management of the patient, and it was agreed that it was not necessary to include information about low blood pressure in the leaflet, as it falls outside of its intended use. To be confirmed whether management of patients presenting, at a later time, with hypotension is included in the S1 care plan. **Decision:** The Committee approved the hypertension patient leaflet. **EQIA Assessment:** No impact anticipated. Currently the leaflet is only in English, once approved, formatted and piloted, we would look to role out in other languages. **BLMK ICB E and D Lead comment:** Please also document that these have been checked for AIS, if they will also be available in easy read format or rationale for not.	MD

No	Agenda Item	Action
5.6	**Guideline for Treatment and Prevention of Migraine / Tension-Type Headache** The Committee considered a revised and updated guideline for the treatment and prevention of migraine / tension-type headache (excluding anti-CGRP drugs). The guideline was originally developed and used within Milton Keynes, as an aid to GPs managing patients with migraine, but is now proposed for adoption across BLMK. The document includes guidance on the management of acute attacks, and also management options for the prevention of migraine / tension-type headache. As the guideline is intended for use within primary care, it does not include anti-CGRP drugs which are hospital only medicines. The Committee discussed the following key points: • The guidance covers the management of acute attacks, as well as advice on the management of migraine, and treatments for prevention of migraine. • A range of therapeutic options allow choice to be tailored to individual patient needs. • The recommendations are in line with NICE CG 150 Headaches in over 12s: Diagnosis and Management and NHSE Guidance on Items which should not be routinely prescribed in primary care. • A question was raised regarding how the guideline aligns with the Ardens template available within GP prescribing systems. This is unclear, as Ardens templates have not been used extensively within Milton Keynes in the past and feedback from primary care is awaited. • Domperidone is included within the document, but it was agreed this is no longer appropriate and it will be removed from the guideline as an anti-emetic option. • Clarification was requested regarding at the point at which a triptan should be taken – when the first aura symptoms are experienced, or at the start of the headache. To be confirmed with neurology and clarified. **Decision:** to be brought back to the next meeting once the points raised have been reviewed. **EQIA Assessment:** The guidance presents national guidance in the format of a local guideline. No impact anticipated. **BLMK ICB E and D Lead comment:** No further comments in relation to equality.	JCo
5.7	**Migraine pathway update** The existing migraine pathway has been updated to include a new NICE approved agent, rimegepant. The addition of rimegepant to the pathway will allow all NICE approved treatment options to be considered for migraine prevention. Rimegepant is the first oral anti-CGRP treatment option to be available for prescribing for patients, and therefore offers a novel choice for clinicians and patients. All	

No	Agenda Item	Action
	currently available choices are administered by subcutaneous or intravenous infusion. The Committee noted that the NICE TA specifies that rimegepant is recommended as an option for preventing episodic migraine and not chronic migraine, and it has therefore been added to the existing pathway as an option for preventing episodic migraine only. No cost impact is expected from this additional treatment option within the pathway, as the cost is comparable to other treatment options. The Committee discussed the potential for primary care prescribing of rimegepant: • The NICE TA discusses the potential for rimegepant to be prescribed in primary care but recognises that specialist referral and treatment management would likely be needed before rimegepant could be used in primary care. • Rimegepant acts against the CGRP receptor in a similar way to the injectable treatment options. • There is no Patient Access Scheme (PAS) price in place for rimegepant and therefore the acquisition cost is the same in both primary and secondary care (the other treatment options available at this stage of the treatment pathway all have PAS prices and prescribing is restricted to secondary care). • Local specialists have highlighted long waits to access migraine clinics in secondary care and that primary care prescribing of rimegepant may help to alleviate the current waiting time. • Rimegepant also has a license for treating acute migraine, and a NICE TA is expected to be published for this indication in October. • No monitoring is recommended for the ongoing use of rimegepant, beyond the NICE recommended 12 week review for efficacy. • It is an unknown treatment to the GPs, and reservations were expressed about using this new treatment. More information and guidance would be needed. • Recommendation to remain Red on the formularies, to allow specialists to gain some experience with the use of rimegepant before considering whether it may be appropriate for primary care prescribing. **Decision:** The Committee approved the updated migraine pathway and agreed that prescribing of rimegepant should remain within secondary care (Red formulary traffic light designation). **EQIA Assessment:** Positive impact– the addition of a new oral drug will benefit patients. The other drugs in this pathway are all injections, therefore this addition to the pathway will increase treatment options and improve access and patient care. The pathway will provide a consistent and rational approach ensuring equity and promoting an evidence-based approach to prescribing.	

No	Agenda Item	Action
	BLMK ICB E and D Lead comment: No further comments in relation to equality.	
5.8	**Atomoxetine memo** A memo has been produced by ELFT to provide advice on the prescribing of Atomoxetine capsules and liquid, due to the ongoing variable supply available across the UK. Atomoxetine is licensed for the management of attention deficit hyperactivity disorder (ADHD) in children aged 6 years and over, adolescents and adults. Atomoxetine belongs to a class of medication referred to as 'non-stimulants' which are generally used where there has been a poor response and/ or tolerability to stimulant medication. An initial supply shortage notification was published, in relation to the 40mg and 60mg capsules, in July 2023 however in practice there has been a variable and intermittent supply for all strengths of capsules and the liquid. Supply constraints are expected to continue until the end of 2023. The memo was therefore produced to provide guidance to clinicians on prescribing for new and existing patients, and also to provide information on possible alternatives. It was initially produced for circulation within ELFT mental health services, but it was presented to the APC with a view to adding additional information for primary care prescribers and community pharmacists and extending its use into primary care. The Committee discussed the following key points: • Atomoxetine liquid should be reserved for patients who are not suitable for other treatment options. • Pharmacies are managing the supply issues well, making use of the place WhatsApp groups to determine where stock is available. • Supply issues with various medicines are taking up large amounts of time in GP practices and therefore it is not feasible to call pharmacies each time before a prescription is issued. • The shortage is also creating significant additional workload within CCS, with requests for advice from patients / families and GP practices. CCS are also developing a memo to support their clinicians with managing the shortage including taking the opportunity to review the ongoing need for atomoxetine in existing patients, and not initiating treatment in new patients. **Decision:** the memo does not need to be circulated within primary care at the current time. The shortages will continue to be managed by community pharmacists and practices via WhatsApp groups to make the best use of time and stock available in the system. **EQIA Assessment:** Positive impact as it will aid clinicians with appropriate management of patients during the period of shortages.	

No	Agenda Item	Action
	BLMK ICB E and D Lead comment: No further comments in relation to equality.	
6.0	**NICE Guidance – from 23 June 2023 to 13 September 2023** **The following NICE Technology Appraisal Guidance (ICB Commissioned) have been published:** **Deucravacitinib for treating moderate to severe plaque psoriasis** Technology appraisal guidance [TA907] Published: 28 June 2023 https://www.nice.org.uk/guidance/ta907 **Resource Impact**: NICE do not expect this guidance to have a significant impact on resources (less than £8,800 per 100,000 population – approximately £88,000 for the BLMK population). This is because the technology is a further treatment option and the overall cost of treatment for this patient group will be similar. **APC actions:** created and link added to Formularies (RED traffic light). Severe psoriasis pathway updated (see agenda item 5.2). **Rimegepant for preventing migraine** Technology appraisal guidance [TA906] Published: 05 July 2023 https://www.nice.org.uk/guidance/ta906 **Resource Impact:** NICE do not expect this guidance to have a significant impact on resources (less than £8,800 per 100,000 population – approximately £88,000 for the BLMK population). This is because rimegepant is a further treatment option. Uptake of rimegepant would displace other calcitonin gene-related peptide (CGRP) receptor antagonists, and the overall cost of treatment for this patient group will be similar. **APC actions:** created and link added to Formularies (RED traffic light). Migraine treatment pathway updated (see agenda item 5.7). **Semaglutide for managing overweight and obesity in young people aged 12 to 17 years (terminated appraisal)** Technology appraisal [TA910] Published: 13 July 2023 https://www.nice.org.uk/guidance/ta910 **APC action:** none – terminated appraisal. **Semaglutide for managing overweight and obesity** Technology appraisal guidance [TA875] Published: 08 March 2023 Last updated: 04 September 2023 https://www.nice.org.uk/guidance/ta875	

No	Agenda Item	Action
	Resource Impact: From the NICE resource impact template, estimated cost impact is £142k in 2023/24, rising to £706k by 2027/28. **APC actions:** none. Previously added to both formularies with RED traffic light. The Committee noted an update regarding the implementation of TA875. Semaglutide (Wegovy) is now available in the UK, with limited stocks only – these stocks have been divided between NHS and private services. Within the NHS, it is only available in specialist NHS weight management services for people who meet the NICE criteria including conventional treatment has been unsuccessful. It is RED on the local formularies and therefore supply is via specialist services only (no primary care prescribing). For information, it was shared with the Committee that the DHSC has recently produced a blog "Accessing Wegovy for weight loss: Everything you need to know" to help patients and clinicians understand the current position and availability. This information has also been shared with practices via the Primary Care Bulletin. **The following NICE Guidelines (NG) (Medicine related and ICB Commissioned) have been published / updated by NICE:** **Obesity: identification, assessment and management** Clinical guideline [CG189] Published: 27 November 2014 Last updated: 26 July 2023 https://www.nice.org.uk/guidance/cg189 **APC action**: none – the updated recommendations refer to surgical interventions only. **Venous thromboembolic diseases: diagnosis, management and thrombophilia testing** NICE guideline [NG158] Published: 26 March 2020 Last updated: 02 August 2023 https://www.nice.org.uk/guidance/ng158 **APC action:** none – guidance has been updated in line with previous issued guidance for COVID-19. **Otitis media with effusion in under 12s** NICE guideline [NG233] Published: 30 August 2023 https://www.nice.org.uk/guidance/ng233 **APC action:** none – no changes to prescribing guidance. **Spinal metastases and metastatic spinal cord compression** NICE guideline [NG234] Published: 06 September 2023 https://www.nice.org.uk/guidance/ng234 (NB: replaces NICE guideline CG75 (published November 2008)) **APC actions:** none required. **Cirrhosis in over 16s: assessment and management** NICE guideline [NG50] Published: 06 July 2016 Last updated: 08 September 2023 https://www.nice.org.uk/guidance/ng50	

No	Agenda Item	Action
	APC action: to be reviewed for consideration of addition of carvedilol and propranolol to the formularies for patients with cirrhosis. **The following NICE TAs are the commissioning responsibility of NHSE and are listed for information only:** **Olaparib for maintenance treatment of relapsed, platinum-sensitive ovarian, fallopian tube or peritoneal cancer after 2 or more courses of platinum-based chemotherapy** Technology appraisal guidance [TA908] Published: 05 July 2023 https://www.nice.org.uk/guidance/ta908 **APC actions:** link added to Formularies (RED traffic light) **Lorlatinib for untreated ALK-positive advanced non-small-cell lung cancer** Technology appraisal guidance [TA909] Published: 12 July 2023 https://www.nice.org.uk/guidance/ta909 **APC actions:** none – not recommended. **Afamelanotide for treating erythropoietic protoporphyria** Highly specialised technologies guidance Reference number: HST27 Published: 26 July 2023 https://www.nice.org.uk/guidance/hst27 **APC action:** none – not recommended. **Selpercatinib for untreated RET fusion-positive advanced non-small-cell lung cancer** Technology appraisal guidance [TA911] Published: 26 July 2023 https://www.nice.org.uk/guidance/ta911 **APC actions:** link added to Formularies (RED traffic light) **Cipaglucosidase alfa with miglustat for treating late-onset Pompe disease** Technology appraisal guidance [TA912] Published: 15 August 2023 https://www.nice.org.uk/guidance/ta912 **APC actions**: None – no local use expected (NHSE designated specialist centre only). **Mavacamten for treating symptomatic obstructive hypertrophic cardiomyopathy** Technology appraisal guidance [TA913] Published: 06 September 2023 https://www.nice.org.uk/guidance/ta913 **APC actions:** None – no local use expected (NHSE designated specialist centre only).	
7.	**Virtual Recommendations/Documents – for discussion/ratification:**	
7.1	**Patient Group Directions (PGDs)** The Committee considered four PGDs submitted via the PGD subgroup. The following PGDs were submitted to the subgroup by the MK Urgent Care Service: • Macrogol for treatment of constipation in children from 2 years to 18 years (no clinical changes). • Nystatin oral suspension for oral candidiasis in infants aged	

No	Agenda Item	Action
	from 1 month up to 2 years (no clinical changes). • Dexamethasone oral solution for the treatment of moderate to severe croup (no clinical changes). • Diclofenac IM injection for the treatment of renal colic (clinical changes made from the previous version of the PGD: alignment of storage advice with the latest SPC; addition of warning about injection site reactions after inadvertent sc injection). The PGD template has been reviewed by the MKUCS Clinical Governance Lead. Most PGDs have been in use for many years (since the opening in 2009). They cover standard medicines and conform to the local formulary and best practice. As the medicines are usually well established, changes to their clinical use may not be needed at the time of review. Clarifications on the following points were requested and provided, during the virtual consultation period, as follows: • Paediatric PGDs – assurance provided that MKUCS work closely with the paediatric team at MKUH. • Macrogol PGD – suggestion received that information on mixing with e.g. juice could be included. This was noted by the author and will be considered as an amendment for the next update (the PGD is clear about the need to mix with water and appropriate quantities to be used). • Dexamethasone PGD – query regarding supply problems with dexamethasone. It was clarified that MKUCS have not experienced supply problems, but if they did arise then prednisolone soluble tablets, or a FP10 prescription, could be issued as an alternative. • Diclofenac IM injection PGD: ○ Risk of sterile abscess with IM injection – reports of sterile abscesses are linked to poor injection technique. The PGD contains information about safe administration and the site mirrors the information in the SPC. ○ The template used for the PGD is a nationally recognised template which sets out the inclusion and exclusion criteria for the treatment. ○ Query raised regarding the management of patients with severe renal colic within Urgent Care, and whether they should instead be referred to A&E for onward urgent referral to the Urology team. It was discussed that these patients present at both walk in centres and Urgent Care services locally and will be assessed and treated in accordance with local procedures.	

No	Agenda Item	Action
	○ The PGD is the legal mechanism to allow the relevant section of the care pathway (provision of medication/ treatment) to be actioned, it does not cover the whole treatment pathway. The Committee therefore agreed it was appropriate to have a PGD in place to facilitate the use of diclofenac, where appropriate, within the treatment pathway. **Decision**: The APC ratified the PGDs, as recommended by the PGD subgroup.	
7.2	**Position Statement on Shared Care with Private Providers (update)** The BLMK position statement on shared care with private providers was approved by the APC in May 2023. It was developed to support Primary Care prescribers in the decision making process with requests they receive for shared care from private healthcare providers (regardless of service or therapeutic area). Further enquiries have since been received by the ICB Medicines Optimisation Team from GP practices relating to specific shared care requests that they have received from private providers. As a result, the position statement has been updated to cover the scenarios for which the enquires have been raised, in order to add clarity and to future-proof the statement. The following additions have been made: • Guidance on requests received from non-medical healthcare professionals (HCPs), such as specialist Nurse or Pharmacist, working for private providers. • Information added to cover scenarios where shared care requests are coming from private providers based outside of England but within the UK. • The template letter in Appendix 1 updated to include the considerations above as additional possible reasons for a Primary Care prescriber to decline a shared care request from a private provider. **Decision**: The Committee approved the updated position statement. **EQIA Assessment:** Positive impact – This position statement will ensure that the care of patients who have been seen by private healthcare providers is managed in an equitable manner and not favoured nor prioritised over the care of NHS patients. Equally, it ensures that patients who have been seen by private providers can access shared care with NHS Primary Care prescribers where it is appropriate to do so as outlined in the statement.	

No	Agenda Item	Action
	The proposed position will also ensure consistency of approach to managing and responding to private providers regarding shared care requests, regardless of service or therapeutic area, the profession of the specialist HCP requesting shared care (medical or non-medical), and the geographical area/nation of the UK in which the private provider is based (subject to the other relevant conditions being met). The underpinning principle and reasons for declining shared care with private providers are in keeping with those in the BLMK Shared Care Guideline Template and the general principles of shared care as previously agreed by the BLMK Area Prescribing Committee. This means that the principles of provision of shared care between Primary Care prescribers and specialists, whether private or NHS, is equitable for all patients and does not favour those who have been seen by private providers. **BLMK ICB E and D Lead comment:** No further comments from an equality perspective	
7.3	**Risk Sharing and Patient Access Schemes for Medicines Policy update** The Risk Sharing and Patient Access Schemes for Medicines Policy has previously been approved by both of the legacy APCs. Version 1.0, aside from some minor updating (to reflect changes to organisations), was unchanged and had gone through the BLMK ICB ratification process. The document therefore came to the September 2022 APC for information only. The RMOC Free of charge (FOC) scheme was a document to be read in conjunction with the policy. The RMOC Free of Charge document has been superseded by a national policy. The BLMK Risk Sharing and Patient Access Schemes for Medicines Policy has therefore been updated to reflect this change. In addition, at the September 2022 APC, there was a request that Early Access to Medicines schemes should be classified as out of scope of the policy when it was next updated. This amendment has been made, alongside an amendment that also takes the 'European Medicines Agency (EMA) access for compassionate use in certain scenarios' out of scope (see section 4.5). The ICB and Provider Acute Trusts are developing local processes / standard operating procedures to support the implementation of the new Free of Charge policy. **Decision**: The Committee approved the updated policy. Post meeting note: a minor amendment was made to the document in relation to the directorate under which the policy document sits.	

No	Agenda Item	Action
	This now reads 'Primary Care' as per the previous version of the policy. **EQIA Assessment:** Not assessed – addition of national policy	
7.4	**High cost drug pathway minor updates** The following rheumatology pathways have been updated to include reference and links to the MHRA Drug safety update advice regarding JAK inhibitors: • Rheumatoid arthritis pathways (Moderate and Severe disease). • Psoriatic arthritis pathway. • Ankylosing Spondylitis / Non-radiographic Axial Spondyloarthritis pathway In addition to the inclusion of the MHRA information, in line with the other rheumatology pathways, a 'General prescribing notes' section has been added to the psoriatic arthritis pathway. **Decision**: The Committee approved the updated pathways. **EQIA Assessment:** Not assessed.	
8.	**Medicines Safety update** A Primary Care Medicines Safety Update and a Medicines Safety Group Update was presented to the committee. **<u>Primary Care Medicines Safety Update</u>** This update focussed on the primary care response to the MHRA Drug Safety Updates (May – July 2023). In particular: **Febuxostat: updated advice for the treatment of patients with a history of major cardiovascular disease (May 2023)** Caution is required if prescribing febuxostat in patients with pre-existing major cardiovascular disease, particularly, in those with evidence of high urate crystal and tophi burden or those initiating urate-lowering therapy. **Action(s) taken:** The DSU has been linked to the Formulary entries and supportive messaging deployed to GP practices recommending allopurinol as first line therapy for patients with major cardiovascular disease. Whilst the restrictions have relaxed somewhat following the publication of the FAST study, the ICS have not made any changes and continue to endorse allopurinol first line, consistent with NICE NG219 – management of gout. **Direct-acting oral anticoagulants (DOACs): paediatric formulations; reminder of dose adjustments in patients with renal impairment (May 2023)** Risk minimisation materials are available to support the safe use of new paediatric formulations of rivaroxaban (Xarelto) and dabigatran etexilate (Pradaxa). In addition, we ask healthcare professionals to	

No	Agenda Item	Action
	consult the current advice to ensure that all patients with renal impairment receive an appropriate dose of DOAC medicines. **Actions(s) taken:** Paediatric formulations are non Formulary products in BLMK, so the DSU has not been added to the Formularies. The team have reviewed EPACT2 data confirms there is no significant prescribing of liquid preparations, therefore no further action will be taken for paediatric formulations. Accurate dosing of DOACs for adults is an ongoing workstream and there is a suite of messages deployed on Optimise Rx to support prescribers with monitoring and dose adjustments in Primary care. In addition, a DOAC dashboard (via Eclipse) went live in April 2023 to help practices identify patients who may require further monitoring or dose adjustments of their DOAC. **Adrenaline auto-injectors (AAIs): new guidance and resources for safe use (June 2023)** The MHRA has launched new guidance to highlight the latest safety advice on the steps to take during anaphylaxis. This new guidance includes an easy step-by-step guide on what to do in an emergency and provides updated advice on body positioning. **Actions(s) taken**: The new resources have been linked to the Formulary entries and the information has also been disseminated via newsletters. The information is also linked from Optimise Rx, which covers information to support prescribers with the Class 1 patient level recall of Emerade (MHRA DSU launched May 2023). The message recommends patients are switched to EpiPen or Jext as alternatives, following reports that Emerade devices failed to deliver the product or activated prematurely. The recall information is also available on the Formulary entries. **Non-steroidal anti-inflammatory drugs (NSAIDs): potential risks following prolonged use after 20 weeks of pregnancy (June 2023)** A review of data from a 2022 study has identified that prolonged use of NSAIDs from week 20 of pregnancy onwards may be associated with an increased risk of oligohydramnios (low levels of amniotic fluid surrounding the baby) and fetal renal dysfunction. Some cases of constriction of the ductus arteriosus (narrowing of a connecting blood vessel in the baby's heart) have also been identified at this early stage. **Action(s) taken**: The DSU has been linked to the Formularies for information. NSAIDS in later stages of pregnancy are already a known risk, however scoping and ideas for improvement workstreams are planned for inclusion at the next locality meeting. **Codeine linctus: public consultation on the proposal to reclassify to a prescription-only medicine (July 2023)** F For noting. Consultation closed 15th August 2023. The outcome will be monitored and discussed at a future MSG when available. **Hyoscine hydrobromide patches (Scopoderm 1.5mg Patch or Scopoderm TTS Patch): risk of anticholinergic side effects, including hyperthermia (July 2023)**	

No	Agenda Item	Action
	There have been a small number of reports of serious and life-threatening anticholinergic side effects associated with hyoscine hydrobromide patches, particularly when used outside the licence. Healthcare professionals, patients, parents and carers should be aware of the signs and symptoms of serious side effects and the need to seek medical help if they occur. **Action(s) taken**: The DSU has been linked to the Formulary entries for the patches. A review of EPACT2 data suggests low numbers of patients prescribed hyoscine patches. Further review to identify at risk patients is planned to identify patients who are using the patches outside of the license, as the DSU indicates this cohort are most at risk. Usage outside the licence includes: • indications other than motion or travel sickness (e.g. hypersalivation). • use in children younger than 10 years of age. • cutting patches (this may adversely affect the bioavailability of the drug). • application of more than one patch at a time. • continuous use without a break. • long-term use. **<u>Medicines Safety Group (MSG) Update</u>** **System wide review of interface incidents (discharge):** The MSG have been collaborating across the system to identify and mitigate against risks as patients move across the interface. A workshop was held whereby a collation of recent interface incidents were reviewed collaboratively amongst ICS partners and the following three key themes for action/ further review were identified: • Completion of documentation • DOACs & anticoagulation • Medicines reconciliation The findings were shared in the ICS newsletter in July 2023 **System wide reconciliation of shortages:** The Medication Safety Group have begun to include high impact shortages where appropriate on the agenda for discussion, as it has been identified that non-availability of some of the products may generate Medication Safety risks. • **GLP1 agonists shortage** Alongside the national shortage of all medicines in this class, the MHRA have also announced review of the safety of GLP1 agonists following reports of suicidal ideation. Further information will be discussed via MSG as it emerges. Information on the shortage and action to be taken has been widely disseminated across the ICS through a variety of channels following publication of an NPSA Alert on 18th July 2023. • **Ketamine 10mg/mL shortage** This was highlighted to the group for dissemination as the shortage suggests the use of concentrate vials as an alternative. There are patient safety considerations with using ketamine 50mg/1ml solution	

No	Agenda Item	Action
	for injection as an alternative. The high strength product may not be appropriate for delivery of lower doses, particularly when used in paediatrics and for analgesia in adults or paediatrics. In addition, the vial is only intended for single use, with any unused product discarded at the end of each operating session. The information regarding the shortage has been included on the Formulary for reference. • **Tresiba (insulin degludec) shortage** The national shortage of Tresiba disposable pens has required patients to be switched to penfill cartridges, posing a potential medication safety risk through lack of familiarity with the alternative device. Practical information including dose increments of the replacement device and app compatibility have been highlighted on the Formularies, alongside links to user guides for both the Novopen and Novopen Echo Plus devices. Optimise Rx messages have also been deployed to support prescribers and highlight the alternative product. **Patient Safety Incident Response Framework (PSIRF) workstream:** PSIRF has been discussed at the MSG including the dissemination of information from national workshops and sharing of good practice including how to conduct an After Action Review (AAR). The group have also been reviewing the actions of early adopters to help with implementation across the system. The PSIRF project implementation lead for the ICB attended MSG in September to provide an update to partners on the progress. Examples of real time use of AARs (anonymised) from BHFT are also being shared at MSG to guide ICS partners with implementation. The Committee noted the medicines safety update.	
9.	**Formulary Update**	
9.1	**Formulary Subgroup Recommendations** The following recommendations were made by the Formulary subgroup at the 05 September 2023 meeting: • **Etoricoxib 30/60/90mg for rheumatology indications.** Etoricoxib to be added to the Formularies (SpA) to be used in preference to celecoxib for inflammatory arthritis including psoriatic, spondylo, reactive, IBD related and sero -ve disease. Etoricoxib has a number of clinical advantages including the ability to adjust the dose (range of strengths available) and ability to administer once a day. Experience with use suggests better tolerability vs celecoxib in particular for axial spondylarthritis and a 2015 Cochrane review found clinically relevant (although statistically insignificant) benefits vs celecoxib. The safety alerts associated with etoricoxib are thought to be related to the higher use and experience with the drug over others. *Cost impact of decision:* Neutral – use is already widespread.	

No	Agenda Item	Action
	• **Ryaltris (olopatadine hydrochloride and mometasone furoate monohydrate) nasal spray for allergic rhinitis**. To be added to the formulary (GREEN) with restriction to adults and adolescents ≥ 12 years for the relief of symptoms of moderate to severe seasonal and perennial allergic rhinitis if monotherapy with either intranasal antihistamine or glucocorticoid is not considered sufficient. Some patients dislike the taste of Dymista, therefore Ryaltris provides an alternative cost-effective option. The preparation is also alcohol free and makes it a more suitable option for people who do not wish to intake alcohol. *Cost impact of decision:* Small cost saving where used in place of Dymista – overall likely neutral. • **Viscose garments for atopic eczema.** The most used products appear to be base layers – Tubular stockinettes, leggings, vest and gloves. There is a lack of good quality evidence of efficacy, however there is support among specialists who observe benefits in practice. The group discussed the application and raised concerns over the lack of good quality evidence for the garments. The application was **not approved** – further investigation needed as to the frequency of patient reviews undertaken by dermatology specialists as this will define the traffic light position on the Formulary. • **Recommendations for medical devices.** The APC reviewed and approved the medical devices paper in July 2023, however some items which were proposed to not be listed on the Formularies will now be included following feedback that it would be useful to have all items reflected on the Formularies for ease of reference. The proposals therefore for items originally not planned for Formulary inclusion are: ○ Accel-Heal – Do not prescribe (DNP) ○ Cost effective hypertonic saline: ▪ 3% & 6% Bronchoclear and Pulmoclear ▪ NB: 6% not currently included on Formulary – propose add ▪ 7% - Pulmoclear, Respi-clear, Salineb ○ Insert for stress incontinence – DNP ○ Needle free insulin delivery system – Non-Formulary (NF). ○ OPEP within AIRS service was granted RED Formulary status at APC however post-meeting there have been reports of the AIRS service being unable to prescribe for their patients. OPEP to remain RED as following discussions with AIRS a cost code is being set up to enable prescribing directly from the clinic. ○ Ostomy support – NF for parastomal hernia (PH) prevention, SpIS for management of PH ○ Pelvic toners – DNP ○ ActiPatch – DNP ○ Lymphoedema garments – RED, with SpIS for basic re-supply of worn-out garments where complete	

No	Agenda Item	Action
	information including sizing is provided to the GP. It was noted that for cancer related lymphoedema these are supplied by hospices and for wound healing the TVNs prescribe and supply. BLMK ICB are working on a commissioned pathway to enable prescribing of the garments for a range of indications beyond the two noted above. *Cost impact of decision*: Neutral or cost saving – discouragement of the use of devices may prevent NHS prescribing. • **Anticholinergics and mirabegron Formulary alignment**. Rationalisation and alignment of Formulary choices in line with NICE guidance and harmonisation to the two local pieces of guidance into a BLMK wide document. It was noted that much of the evidence was based on use in women however as the choices are based on cost in the main (NICE do not specify clinical advantage of one over another), the guidance is also applicable to men. It was agreed that the existing local pathways could be retired. **Formulary Choices (GREEN):** ○ **First Line Choices -** Oxybutynin (immediate release) **or** Solifenacin **or** Tolterodine ○ **Second Line Choices** - One of the alternative first line choices not tried already **or** Fesoterodine M/R **or** Tolterodine M/R (Tolthen XL®) **or** Trospium **or** Darifenacin ○ **Third Line Choice -** Mirabegron ○ **Difficulty in swallowing –** Oxybutynin transdermal patch ○ **Tolterodine M/R 4mg -** Tolthen X/L® to replace Neditol X/L® ○ **Liquid Medicines** - Solifenacin 5mg/5ml suspension to replace oxybutynin 5mg/5ml oral solution (to include active switching) – to be reviewed in more detail at a future meeting. ○ **Vesomni® 6mg/0.4 mg modified release tablets (solifenacin/tamsulosin)** - non-Formulary with active switching, where clinically appropriate, to the two single components (it was noted that this would have a financial impact on patients who pay prescription charges). *Cost impact of decision*: Some savings are possible with greater use of the more cost-effective product choices. • **Hydrocortisone products for adrenal insufficiency in adults and children.** Review of hydrocortisone preparations to add a range of strengths that support accurate dosing for adults and children. Products added as green unless otherwise stated. ○ 10mg and 20mg tablets can be halved (suitable for the majority and cost-effective). ○ Where 10mg tablets cannot be halved e.g. children in schools and those with dexterity problems, 5mg	

No	Agenda Item	Action
	tablets and 5mg soluble tablets added to the Formulary under these restrictions. ○ 2.5mg tablet added for use in children to ensure dosing accuracy. ○ In addition, Alkindi granules (0.5mg, 1mg and 2mg) added (SpIS) for use in younger children where small increments of dosing are required. Of note the 5mg strength is non-formulary due to disproportionately high cost and availability of other suitable options on Formulary. ○ The liquid was discussed for its place in therapy as an unlicensed special. The paper proposed to retain on Formulary for use where all the other above options are unsuitable. *Cost impact of decision:* Likely neutral overall – there is already some use of the products proposed to be added. Alkindi addition may present a small cost pressure however this is anticipated to be minimal due to the expectation that only a very small number of patients will be prescribed the medicine. • **Lithium Shared Care Guidance.** The updated lithium SCG was reviewed and approved for use across BLMK. • **Hydroxycarbamide liquid.** Application to amend traffic light designation of liquid for treatment of paediatric patients with sickle cell from RED to SpIS. The group noted the presence of a national SCG for treatment of adult patients and nationally there is very little prescribing in Primary Care. The proposal was for GPs to prescribe with monitoring to be retained by the specialist. A review of all hydroxycarbamide preparations and rationalisation of the pathway for adults needs to be undertaken, accounting for both capsules and liquid and transition from child to adult services in relation to prescribing. Due to the frequent monitoring and nature of the disease it is likely that patients are seen regularly by the specialist, therefore retention of prescribing until holistic review of all hydroxycarbamide preparations was agreed by the group to be the safest option. The application was declined – retain status quo – liquid to remain RED. • **Calcium acetate formulary alignment for hyperphosphatemia in chronic renal insufficiency in patients undergoing dialysis**. Proposal to add calcium acetate (Renacet®) to MKF as SpA for use within licensed indication (alignment with B&LF) – approved. *Cost impact of decision:* Likely neutral as already in use in MK. • **Famotidine formulary alignment**. Change in formulary states for famotidine from non-formulary to GREEN status on Beds/Luton Formulary for use within licensed indications. It was noted that usage is increasing, however addition to Formulary is not expected to bring about any additional cost pressure to the system as usage is already widespread. Rationalising the restrictions may support a reduction in	

No	Agenda Item	Action
	usage and with usage increasing over time clear guidance on place in therapy is essential to manage the cost pressure. Restrictions were added to famotidine to recommend use only after multiple PPIs (minimum two) have been trialled and failed, or where a contraindication to PPIs exists. Approved, with GREEN traffic light. *Cost impact of decision:* Cost impact is significant: the average cost per patient to treat with famotidine is £30-40, versus Formulary choice PPI at an average of £2-3. No additional impact expected as use already widespread. • **Altraplen compact daily**. Proposal to add to Formularies (in place of Altraplen Compact) for use 2nd line where powdered ONS are not suitable was approved. Designation is GREEN (as per other preparations) restricted to use under guidance of a dietician. It is the equivalent of two "compact" ONS in one carton at a much lower cost. Approved. *Cost impact of decision*: Likely cost saving through use of a more cost effective product. • **Liothyronine national recommendations**. The NHS England prescribing guidance on liothyronine has been adopted in place of the previously adopted RMOC guidance (now retired). The Formularies were also aligned with a traffic light status of SpIS for all indications except for oncology and psychiatry which remain RED. *Cost impact of decision*: n/a. • **Oral iron preparations.** Promotion of the usage of ferrous fumarate over ferrous sulphate was endorsed alongside re-enforcement of once-a-day dosing regimen for treatment of anaemia as per updated CKS guidance. The poor tolerability of oral iron is leading to an increase in the use of IV products, which carry a high cost and safety concerns. The change was approved, noting that ferrous sulphate would remain on Formulary as a choice due to widespread prescribing, but with promotion of fumarate salt as first line option. *Cost impact of decision*: Likely cost saving (mainly to secondary care) through reduction in use of IV products. Small cost saving to primary care as fumarate salt is slightly more cost effective vs sulphate. • **Gliclazide and metformin MR amendment for Type 2 diabetes.** Amendments to help improve concordance and HbA1C control for patients within BLMK. Up to 25% of patients experience side effects on the immediate release leading to poor compliance and increased cost as a result of repeat GP visits and reviews. ○ **Metformin MR** – removal of restriction on MR tablets (Continued restriction on metformin 750mg MR (approx. 4X cost of metformin 500mg MR). ○ **Gliclazide MR** – alignment of MK formulary with Beds/Luton formulary, with careful selection of patients, dose, and clear patient directions to reduce the risk of hypoglycaemic episodes. *Cost impact of decision:* the difference in cost between the metformin 500mg preparations is small in absolute terms.	

No	Agenda Item	Action
	Therefore, the cost impact is expected to be minimal if the 500mg strength is used. This will be offset by encouraging better medication adherence, lower health care usage/costs of appointments needed due to intolerance and improve outcomes/ attainment of individualised treatment targets. Cost impact for gliclazide MR small due to small numbers of patients who will be clinically appropriate and the wider use of other glycaemic agents. In addition, the Formulary Subgroup terms of reference were updated to include the updated EQIA paperwork, as approved at APC. **Decision:** The committee ratified the recommendations of the Formulary Subgroup.	

9.2	**Wound Management Formulary Steering Subgroup Recommendations**
	A report from the wound management subgroup meetings in July and September 2023 was presented to the Committee:
	
	• It was noted that CC has taken over from JC as Chair of the wound management steering group. Thanks were extended to JC for her hard work for, and on behalf of, the group.
	• Proposal to add **Jobst Ulcercare Kit** to the wound management formularies:
	  ○ Compression system for management of venous leg ulcers.
	  ○ Jobst products provide a much wider selection of sizes to accommodate larger and taller patients who require compression therapy. Ensures equity of access for those with larger, taller limbs.
	  ○ Available on ONPOS (procurement platform) for MK/CNWL.
	  ○ Patient numbers 5-10 per month.
	  ○ Cost saving compared to current product Actilymph.
	• **Update on alignment of formularies in MK for Practice Nurses/CNWL:** New DRAFT MK PN Formulary available on Microguide - draft version being reviewed. Some technical issues, work is ongoing.
	• **"TVN Use Only"** to be replaced by "**Restricted use – preferably on the advice of a TVN: ensure relevant pathways are consulted**" on wound formularies.
	• **Waste reduction in wound care:** Environmental impact will be considered with each product as part of rolling programme of updating the formulary.
	
	Decision: The Committee ratified the recommendations of the Wound Management Steering group.	

10.	**Antimicrobial Resistance Update** The Committee received an update on antimicrobial stewardship (AMS) / antimicrobial resistance (AMR):	

No	Agenda Item	Action
	The next AMR / HCAI group has been postponed to November to allow the ICB team, working with infection control colleagues, time to review the system compliance with NHS England Quality Functions relating to AMR. Total antibiotic prescribing remains raised following the Group A Strep outbreak in the winter of last year. This is a national trend, however BLMK prescribing is higher than the England average. This is primarily driven by a sustained increased in amoxicillin and phenoxymethylpenicillin prescribing. Broad spectrum prescribing remains below NHS England targets, but this is mainly due to the continued higher levels of overall antibiotic prescribing. The Committee noted the antimicrobial stewardship update.	
All other papers (from this point in the agenda) are for noting/information by the Committee		
11.	**East of England Priorities Advisory Committee (PAC) – items for noting/approval**	
11.1	EoEPAC Meeting Notes – May 2023 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 of the Bedfordshire Hospitals Foundation Trust DTC meeting – May 2023	
12.2	Minutes of the Milton Keynes Hospital Prescribing & Medicines Governance Committee (PMGC) – July 2023	
12.3	Minutes of the BLMK Wound Management Formulary Steering Group – May and July 2023	
12.4	Minutes of the BLMK Formulary Subgroup – June 2023	
12.5	Minutes of the BLMK Medicines Safety Group – May 2023	
12.6	Minutes of the ELFT Medicines Management Committee – May and July 2023	
12.7	Minutes of the Cambridgeshire Community Services Medication Safety and Governance Group – May 2023	
12.8	Minutes of the CNWL Trustwide Medicines Optimisation Group (MOG) – June 2023	
12.9	Minutes of Circle/MSK Medicines Management Committee – May 2023	
13.	**Papers for information / ratification**	
13.1	**Patient Group Direction Subgroup Recommendations** The following recommendations were made by the Patient Group Direction subgroup:	

No	Agenda Item	Action
	HCRG Care Group PGDs: The following PGDs were approved by the PGD subgroup, and ratified by the APC, in June/July 2023. Minor amendments have been made to align the expiry dates of the three PGDs. There have no changes to clinical content. 1. Depo-medrone with lidocaine injection (Methylprednisolone acetate 40mg/ml with lidocaine 10 mg/ml) 2. Lidocaine 1% injection 3. Triamcinolone acetate (Adcortyl and Kenalog) PGD subgroup recommendation: approved. MK Urgent Care Service: The following PGDs were submitted to the subgroup for review and approval. All are reviews of existing PGDs, in use within the service for many years (changes to clinical content as outlined below): 1. Aspirin 300mg for Myocardial Infarction– no clinical changes 2. Beclometasone Nasal Spray Allergic Rhinitis for use in children and young people – additional wording to Pharmaceutical Form: In 30ml polypropylene bottle fitted with a tamper-resistant metering atomising pump and Frequency of administration: Once control has been established it may be possible to maintain control with fewer sprays. A dosage regimen of one spray into each nostril morning and evening has been shown to be efficacious in some patients. However, should symptoms recur, patients should revert to the recommended dosage of two sprays into each nostril morning and evening. The minimum dose should be used at which effective control of symptoms is maintained. 3. Benzylpenicillin for meningitis – adoption of national PGD template. 4. Diazepam rectal for seizures – adoption of national PDG template. 5. Docusate sodium for constipation in children – removal of inclusion of children over 12 and adults – directed to self-care and OTC purchase. 6. Fluorescein 1% eye drops – addition to warnings: May cause transient blurring of vision. 7. Zerobase cream for eczema and psoriasis – addition to Pharmaceutical form: White, soft cream. Contains liquid paraffin 11% w/w. PGD subgroup recommendation: approved. A revised approach for reviewing PGDs was proposed to the Committee: • Renewal of existing PGDs – proposal for the recommendations of the PGD subgroup to be ratified by the Committee, without further scrutiny, in the same way as recommendations from other subgroups e.g. Formulary.	

No	Agenda Item	Action
	• New PGDs – to be reviewed in more detail by the full Committee to allow greater scrutiny of new documents. **Decision:** The Committee ratified the PGDs, as recommended by the PGD subgroup, and approved the proposed approach for the review of PGDs going forward.	
14.	**Any other business** None raised	
15.	**Future Dates for BLMK APC 2023 / 2024 Meetings (all to be held from 12:30-15:00 via Microsoft Teams):** Wednesday 6th December 2023 Wednesday 28th February 2024 Wednesday 1st May 2024 Wednesday 3rd July 2024 Wednesday 25th September 2024 Wednesday 4th December 2024	

Approval of minutes:

Chair: Dr Muhammad Nisar

Signed: 

Date: 27/12/2023

Appendix 1 – Approved 05 September 2023 Formulary Subgroup Minutes:

FSG Final Minutes September 2023.pdf