BEDFORDSHIRE, LUTON AND MILTON KEYNES AREA PRESCRIBING COMMITTEE

FINAL Meeting Notes

Date: 01 May 2024
Time: 12.30 - 2.35pm
Venue: Microsoft Teams

Attendees:

Name	Initials	Role
Dr Muhammad Nisar	MN	Chair (Medical Representative, Bedfordshire Hospitals NHS Trust)
Yolanda Abunga	YA	CCS Pharmacy Representative (Community Services Pharmacist, Beds and Luton)
Mojisola Adebajo	MA	Place Based Lead Pharmacist – Luton
Nicola Ainsworth	NA	Consultant in Public Health
Reginald Akaruese	RA	CNWL Pharmacy Representative (Community and Mental Health Services Milton Keynes)
Pritesh Bodalia (from 12.46-1.18pm)	PB	Bedfordshire Hospitals Trust Pharmacy Representative (Chief Pharmacist, Bedfordshire Hospitals Trust)
Dr Marian Chan (until 1.06pm)	MC	Medical Representative, Bedfordshire Hospitals NHS Trust
Candy Chow	CC	Chair of Wound Care Group
Janet Corbett	JCo	Milton Keynes Hospital Pharmacy Representative (Pharmacy Programme Manager, Milton Keynes Hospital)
Dr Dush Mital (from 1.30pm)	DM	Medical Representative, Milton Keynes Hospital
Naomi Currie	NC	Place Based Lead Pharmacist - Bedford
Matt Davies	MD	Head of Medicines optimisation, BLMK ICB
Fiona Garnett	FG	Associate Director: Pharmacy and Medicines optimisation, BLMK ICB
Anne Graeff	AG	Commissioning Lead Pharmacist, BLMK ICB (Professional Secretary)
Cheryl Green	CG	Patient Representative

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

Rajesh Jethwa (until 2pm)	RJ	ELFT Pharmacy Representative – Community Services (Beds)/Mental Health Services (Beds and Luton)
Dr Kate Randall (from 1.04pm)	KR	Place Based Lead GP – Central Bedfordshire
Dr Jonathon Walter	JWa	Place Based Lead GP – Milton Keynes
Dr Jenny Wilson	JWi	Place Based Lead GP - Bedford
Dona Wingfield (from 12.47-2.30pm)	DW	Chair of Medicines Safety Group / Bedfordshire Hospitals Trust Pharmacy Representative (Medicines Use and Quality Manager, Bedfordshire Hospitals Trust)

In attendance:		
Rafal Ali (from 1.55pm)	RA	Commissioning Pharmacist, BLMK ICB
Sandra McGroarty	SMcG	Commissioning Pharmacist, BLMK ICB
Dr Joy Mutitika	JM	Medical Representative, Keech Hospice
Kike Pinheiro (until 2.05pm)	KP	Representative, Willen Hospice
Nikki Woodhall	NW	Lead Medicines Optimisation Technician, BLMK ICB
Valerie Morgan (for agenda item 5.5)	VM	Continence Lead – Bladder and Bowel Nurse Specialist, CNWL
Saema Arain (for agenda item 5.5)	SA	Lead Pharmacist Bedfordshire Community Health Service, ELFT
Dr Farhan Ahmed (for agenda item 5.7)	FA	Consultant in Chemical Pathology and Metabolic Medicine, Milton Keynes Hospital
Samina Hassanali (observer, from 2-2.35pm)	SH	Place Based Pharmacist, BLMK ICB

Apologies:		
Dorothy Aladejobi	DA	Pharmacist Representative, NHS Northampton Hospital Foundation Trust Secure Services
Helen Chadwick	HC	Milton Keynes Hospital Pharmacy Representative (Chief Pharmacist, Milton Keynes Hospital)
Dupe Fagbenro	DF	ELFT Pharmacy Representative (Deputy Chief Pharmacist (Luton and Bedfordshire), ELFT)
Alice Green-Smith	AGS	Representative, St John's Hospice
Taiya Large	TL	Formulary and Medicines Safety Pharmacist BLMK ICB
Dr Mitan Sarkar	MS	Place Based Lead GP - Luton
Dr Sarah Whiteman	SW	Chief Medical Director, BLMK ICB

No	Agenda Item	Action
1.	**Welcome, Introductions and Apologies** The Chair welcomed everyone to the meeting. Apologies were received and noted as above. The meeting was confirmed as quorate. The Chair welcomed Valerie Morgan (in attendance for agenda item 5.5) and Dr Farhan Ahmed (in attendance for agenda item 5.7) to the meeting. The Chair thanked Dr Sarah Whiteman, who has recently retired, for her service to the APC. The committee noted that Dr Ian Reckless has been appointed 2 days a week as interim Chief Medical Director, supported by Dr Sanhita Chakrabarti (deputy MD).	
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 other members confirmed they have no declarations in relation to matters on the agenda.	
3.	**Minutes of 28 February 2024 APC meeting** The minutes of the meeting held on 28 February 2024 were approved.	
4.	**Matters Arising**	
4.1	**Feedback on miscellaneous actions not included on the agenda from APC meetings**	
4.1.1	**Shared care patient information leaflet** Leaflet to be introduced into practice with BHFT Rheumatology and feedback sought from patients to 'test' the patient acceptability and accessibility of the leaflet. **Update 17/04/24** – trials of the leaflet have not yet begun, but initial feedback from the Rheumatology nurses is that it will be time-consuming and not felt to be adding to the process of informing patients and obtaining consent for shared care. Meetings are planned between BHFT Rheumatology team and ICB Medicines Optimisation team. It was proposed that this item should be added	Close

No	Agenda Item	Action
	to the APC workplan, to be taken forward if/when appropriate, and closed from the APC action log. The proposal was accepted.	
4.1.2	**Osteoporosis guidelines** Working group to be formed to review the guidelines to include further information on when to refer to secondary care, counselling and links to patient information, and to consider the guidance needed for strontium (SCG, prescribing guidance, or alternative option) **Update 11/04/24** - this has been delayed due to other priorities. This is an ongoing action.	SMcG
4.1.3	**Pharmacy First** Concerns regarding knowledge base of participants with regards to the contraception service to be discussed as part of the work programme to develop local contraception guidance. **Update 01/05/24** – pharmacists offering the Pharmacy Contraception Service operate within very defined parameters and provide the medicines via Patient Group Directions. If a patient does not meet all the criteria within the PGD, then the pharmacist will refer the patient to their GP or local Sexual Health Service. The BLMK Contraception Guidance (see agenda item 5.4) will be circulated to local community pharmacists, alongside links to educational modules. It was proposed and agreed that the action could be closed.	Close
4.1.4	**Antimicrobial guidelines** To be confirmed if the safety warnings around the use of fluoroquinolones would also apply to topical use e.g. ciprofloxacin drops **Update 13/03/24** - the MHRA fluoroquinolone alert only relates to systemic use of fluoroquinolones, not topical use. It was proposed and agreed that the action could be closed.	Close
4.1.5	**Daridorexant prescribing support information** Signposting information to the nationally commissioned digital CBTi offering to be added once available. **Update 01/05/24** – announcement of the national commissioning of digital CBTi is still awaited. This is an ongoing action.	AG
4.1.6	**Rimegepant prescribing support information** To confirm whether there are any cautions when prescribing rimegepant for patients with glaucoma. **Update 29/02/24** - There are no ophthalmological adverse effects, cautions or contraindications listed in the product information for rimegepant and therefore there are no specific cautions for patients with glaucoma. It was proposed and agreed that the action could be closed.	Close
4.1.7	**Adult asthma guidelines** Guidelines to be updated to include the maximum daily dosages in the step 1 of the preferred (GINA) regimen and also to include information on alcohol (ethanol) content of inhalers. **Update 04/03/24** - the guideline has been updated accordingly. It was proposed and agreed that the action could be closed.	Close

No	Agenda Item	Action
4.1.8	**PGDs / anticoagulation for patients awaiting diagnostic confirmation of DVT** To investigate and confirm if GP practice anticoagulation hubs are adopting the same practice (i.e. use of apixaban instead of dalteparin in patients awaiting diagnostic confirmation of DVT) as MK Urgent Care Service. **Update 01/05/24** – a review is going to be undertaken of GP practice anticoagulation hubs, including pathways, by the primary care team, as part of the work reviewing locally commissioned services. It was therefore proposed and agreed that the action could be closed as it is outside of the remit of the Committee.	Close
4.1.9	**Guideline for the "Treatment and Prevention of Migraine / Tension Type Headache"** Title and document content to be amended to remove reference to tension type headache (as the majority of the guidance is applicable only to migraine). **Update 13/03/24** - the guideline has been updated to remove reference to tension type headache and is available on the Medicines website. It was proposed and agreed that the action could be closed.	Close
5.	**Items for consideration at meeting**	
5.1	**Severe localised (high impact site) psoriasis recommendations** The Committee discussed a proposal for an extension to the severe localised psoriasis recommendations to allow two lines of therapy, and increase the choice of treatments available at second line. High impact sites encompass the face, flexures, genitalia, scalp, palms and soles. There are no NICE Technology Appraisal recommendations for the use of biologics or small molecule treatments in severe localised (high impact / difficult to treat) psoriasis, and the patient cohort is usually not eligible under the TA recommendations for more generalised psoriasis, as their PASI (Psoriasis Area Severity Index) is less than 10 (the TA recommendations require PASI≥10). Existing (EoE PAC) guidance recommends one line of therapy with either biosimilar adalimumab (preferred) or apremilast. Local specialists have identified an unmet need for a further line of therapy for this patient cohort. There is a lack of robust clinical and cost effectiveness data for the use of biologics and small molecule therapies in this group of patients. The proposed recommendations are based upon: PAC evidence review, North Central London and South East London policies, and current national recommendations regarding biologic use in psoriasis. A review of funding applications via the Blueteq system identified that, since the existing recommendations were approved in May 2022, there have been 13 applications for treatment: 5 from Bedfordshire Hospitals Trust, 7 from Milton Keynes Hospital and 1 from West Herts Trust.	

No	Agenda Item	Action
	The Committee noted the following additional points: • Likely choices of second line treatments include secukinumab and risankizumab (IL-17 and IL-23 inhibitors, respectively). • Cost impact of recommendations: approximately £80,000 per year (cost impact for ten patients; lower in the first year, possibly rising in the future – dependent upon clinician choice of second line treatment). • Block funding arrangements are in place which means the guidance is subject to local trust financial approval. **Decision**: The Committee approved the recommendations clinically, but this is subject to local trust financial approval. **EQIA Assessment:** If approved, the recommendations will have a positive impact on patients with severe localised (high impact site) psoriasis. **BLMK ICB E and D Lead comment:** Not provided	
5.2	**Intravitreal injection ophthalmology algorithm update** The BLMK intravitreal injection ophthalmology algorithm has been updated to reflect recent changes to NICE guidance and the introduction of a new aflibercept preparation as follows: • To include amendment to the use of fluocinolone intravitreal implant for chronic diabetic macular oedema in accordance with NICE TA953. • To include the new aflibercept 8mg product as an option for AMD and DMO only (as per license), as recommended by the Formulary Subgroup (see also agenda item 8.1). • 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, previously confirmed with Mr Lobo (Consultant Ophthalmologist). • References to specific brands of ranibizumab have been removed due to the licensing of various biosimilar products, in addition to the originator product. The Committee noted that NICE estimates a resource impact of approximately £88,000 per year from the implementation of TA953, but this may be lower locally. **Decision**: The updated pathway was approved. **EQIA Assessment:** Positive impact with the introduction of new treatment options/expansion of eligible populations. **BLMK ICB E and D Lead comment:** Not provided	
5.3	**Faricimab for AMD and DMO audits** Agenda item withdrawn.	

No	Agenda Item	Action
5.4	**Contraception guidance** The Committee was presented with draft guidance documents for contraception and emergency contraception (EC). The draft documents are based on national Guidance (NICE and Faculty of Sexual and Reproductive Healthcare (FSRH)) and guidance produced by Mid and South Essex ICB (adapted with permission), December 2022 and input from local BLMK Specialists in Sexual and Reproductive Health (Primary and Secondary Care). They are designed to be a resource for healthcare professionals to summarise guidance on contraception and provide links to other resources for further information. The Committee noted and discussed the following points: • FSRH guidance is regarded as 'best practise'. • Several recommendations made by the FSRH differ from individual drug licenses and are therefore regarded as 'off label' use. This information has been denoted within the guidance documents with the statement (FSRH recommendation, off label use). • All formulary contraception is Traffic light Status GREEN, with the exception of drospirenone (see below). • Combined hormonal contraceptives (CHCs) and Intra-uterine Progestogen Only Contraceptives should be prescribed by brand name. • The most cost-effective brands of CHCs to be confirmed for Primary Care use via Optimise Rx (ORx). There is also a table detailing the cost-effective brands contained within the guidance document. • Oral Progestogen Only Contraceptives - certain branded and generic preparations are not suitable for people with nut or soya allergies. A statement is to be added to the formularies and ORx regarding peanut / soya allergies (to check SmPCs prior to prescribing as not all suitable for such patients). Prescribing of branded generics may need to be considered for patients with peanut / soya allergy. • Multiphasic CHCs and ED preparations to be removed from the formularies, as use of these products does not align with the recommended tailored use of oral contraceptives. • Ethinylestradiol / etonogestrel Vaginal Delivery System - SyreniRing to be added as a cost effective first line choice, in addition to NuvaRing which will remain on the formularies as a second line choice. • Copper (Cu) containing intra-uterine devices (IUDs) should be included in the Formularies but brand not specified because of the difficulties in obtaining the devices. First line choice should be a framed, banded copper arm device containing 380 mm2 copper. • Copper to be listed as a search term on the formularies. • Emergency contraception (EC) – based on the small number of issues in primary care for emergency contraception, it was proposed that clinicians should be able to choose either ulipristal **or** levonorgestrel in situations of unprotected sexual	JC/TL JC/TL

No	Agenda Item	Action
	intercourse / contraception failure - the choice being based on individual factors. Ulipristal is more expensive than levonorgestrel, but it was agreed that clinicians needed to have the flexibility to select the most suitable product for the patient. • It needs to be very clear in the EC guidance that there is free choice, based on individual patient/clinical factors, between the two choices of oral EC. • It was noted that some services, e.g. urgent care or emergency departments, may not be able to offer the copper IUD as a first line choice of emergency contraception but the Committee agreed that it should remain in the guidance as first line choice of emergency contraception. • Patient Group Directions for ulipristal and levonorgestrel in use in the community align with the proposed emergency contraception guidance. • 'Pill ladder' – JWi has developed a visual table detailing information on different contraceptive pills. This presents the information in a different way to the algorithm and will provide an additional resource. This is in the finishing stages of development and will be circulated via the virtual consultation process for the July meeting, with a view to incorporating into the contraceptive guidance document at a later date. • Formulary consideration of drospirenone (Slynd): drospirenone is a spironolactone analogue with anti-mineralocorticoid and anti-androgenic activity that provides contraception primarily by suppressing ovulation. It is more expensive than other oral progestogen-only pill options and was proposed to be included as a second line option, offering a different bleeding pattern and side effect profile (lower androgenic profile) for individuals who have had problematic bleeding or side effects with other oral progestogen-only contraceptives. The following points were discussed: ○ Drospirenone has additional cautions and contraindications to its use, due to its mode of action, which will need to be taken into consideration. Blood pressure and U&E monitoring is required for some individuals. ○ Formulary status of SpIS agreed for drospirenone – to be initiated by a specialist, defined as a "Sexual Health Specialist or a Primary care clinician who has relevant expertise and is clinically competent to prescribe" (holds the FSRH Diploma (DFSRH)). Initial 3 months' prescription, and follow up at 3 months, to be provided by the specialist. ○ The position in therapy of drospirenone was discussed and it was agreed that it should be a second line oral progestogen-only contraceptives for women in whom desogestrel is not appropriate after a suitable trial (minimum 3 months) and where other methods of contraception including long-acting	SMcG SMcG/ JWi

No	Agenda Item	Action
	reversible methods are contraindicated, have been declined or are not suited. ○ It is estimated that 3-5% of patients taking desogestrel may be eligible for drospirenone. This creates a cost pressure of approximately £20-£34k per year. ○ Prescribing guidance may be a useful support tool for prescribers in primary care. Nottingham APC has published a prescribing Information sheet which could be adapted for use in BLMK. **Decision**: The contraception and emergency contraception guidance documents were approved. Drospirenone (Slynd) to be added to formularies with SpIS traffic light designation. Prescribing guidance document for drospirenone to be developed and brought to the July APC. **EQIA Assessment:** Positive impact – standardisation of treatment protocols to ensure that patients who present to their GP receive the same approach and options offered from ICaSH and sexual health clinics. **BLMK ICB E and D Lead comment:** Not provided	SMcG
5.5	**Continence appliance prescribing guidelines** The continence appliance prescribing guidelines, originally approved for use in Bedfordshire and Luton in 2019, have been reviewed and updated for use across the whole of BLMK. Community services providers from Bedfordshire, Luton and Milton Keynes have collaborated and worked together to update the guidance to exclude redundant products, include new advances and evaluate costs of products recommended in the guidance. A limited range of products is recommended to ensure consistency of practice across the ICS. It was noted that 3 additional products need to be added to the section on intermittent self-catheters, as these are used by all services and had been omitted in error from the circulated document. **Decision**: The Committee approved the updated document, with the inclusion of the additional self-catheters as noted above. **EQIA Assessment:** Positive impact – helps to ensure continuity of care when transferred between secondary care and the community and ensures consistency in types of products used. **BLMK ICB E and D Lead comment:** Not provided	VM
5.6	**Ulcerative colitis pathway update** An update to the treatment pathway for Moderate to Severe Ulcerative Colitis after failure of conventional therapy has been undertaken to incorporate etrasimod in accordance with the newly published NICE TA 956. In addition, the following amendments have been made: • Minor formatting amendments, e.g. removed the numbering of treatment options, less prominence to JAK inhibitors in	

No	Agenda Item	Action
	view of MHRA safety advice (post-dates the TAs for JAK inhibitors). • Wording added regarding consideration of switching to an alternative drug with a **different mode of action** not yet tried by patient. • Clarity added around routine commissioning of treatment options with **different modes of action** per patient and not options within the same drug class. Local gastroenterologists have requested that an extension to the pathway is considered, to allow patients to have access to an additional line of therapy. Further information is being sought regarding likely patient numbers and sequencing of available treatments. **Decision**: The updated pathway was approved. **EQIA Assessment:** N/A (amendment as per NICE TA guidance only)	
5.7	**Icosapent ethyl for reducing the risk of cardiovascular events in people with raised triglycerides** The Committee considered a request to introduce non-fasting triglycerides (TGs) as an additional option to fasting triglycerides for initiation of Icosapent ethyl. NICE guidance (TA805), states that "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)". To improve patient compliance with lipid testing, current NHS practice, in-line with recommendation from NICE and AAC National Guidance for Lipid Management for Primary and Secondary Prevention of CVD, is to measure a non-fasting full lipid profile. The routine use of non-fasting lipid profiles means that some patients who are eligible for icosapent ethyl may not appear to qualify for treatment or require an additional fasting lipid profile before treatment initiation, in addition some patients may be initiated on the basis of a raised non-fasting TG level. The following points were discussed by the Committee: • The maximal mean changes in TG after habitual meals are not clinically significant at +0.3 mmol/L. • Introducing an additional non-fasting target (TG ≥ 2mmol/L) for initiation of icosapent ethyl would reduce the need for extra fasting bloods tests and improve access to treatment. Prescribing data indicates that only 19 people (0.3% of the eligible population) have been initiated on icosapent ethyl within BLMK, indicating that there are barriers in place to treatment uptake. • Icosapent ethyl has already been approved as GREEN on the BLMK formularies within its licensed indication and in	

No	Agenda Item	Action
	accordance with NICE recommendations. NICE TA805 considers icosapent ethyl a cost-effective use of NHS resources. • It is anticipated that removing the need for an additional fasting blood test will help reduce health inequalities across BLMK. Data from CVD Prevention indicates that people with CVD in our more deprived communities are less likely to have their lipids well managed than those in our least deprived communities. • Abnormal TG levels, unless grossly abnormal, are not highlighted in lipid profile results received by practices from the hospital laboratories. This is to ensure that any abnormal results are considered in the context of the patient's cardiovascular risk. Icosapent ethyl is only indicated for secondary prevention, in combination with a statin. • It was acknowledged that management of lipids and cardiovascular risk has become complex, and the committee was advised that a simplified lipid pathway / guidance document is in development and is planned to be presented at the next APC meeting in July. **Decision**: the proposal to include a non-fasting TG level of ≥ 2mmol/L, as an alternative to the existing recommendation contained within NICE TA805 of fasting levels ≥1.7 mmol/litre, when considering eligibility for treatment with icosapent ethyl, was approved. **EQIA Assessment:** Positive impact – increased access to treatment anticipated. **BLMK ICB E and D Lead comment:** Not provided	
6.0	**NICE Guidance – from 15 February 2024 until 17 April 2024** **The following NICE Technology Appraisal Guidance (ICB Commissioned) have been published:** • **Etrasimod for treating moderately to severely active ulcerative colitis in people aged 16 and over** Technology appraisal guidance Reference number: TA956 Published: 11 March 2024 https://www.nice.org.uk/guidance/ta956 **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). **APC actions:** created and added to the formularies (RED traffic light) and UC pathway updated (see agenda item 5.6). • **Nirmatrelvir plus ritonavir, sotrovimab and tocilizumab for treating COVID-19** Technology appraisal guidance Reference number: TA878 Published: 29 March 2023 Last updated: 13 March 2024 https://www.nice.org.uk/guidance/ta878	

No	Agenda Item	Action
	Resource impact: estimated impact, based upon current local referral and treatment rates, and estimated increased referrals following extension of the eligible cohorts: June 2024: Current average of 120 referrals with 30% treatment rate/month + additional estimated 30 referrals/month and 10 additional patients treated = additional cost of £25/month or £300/year. June 2025: approximately 260 additional referrals and 78 additional patients treated = additional cost of £195/month or £2,340/year. **APC actions:** NICE TA already linked to formularies. See also agenda item 13.1. Formulary status as previously agreed: Nirmatrelvir plus ritonavir – GREEN Sotrovimab: RED Tocilizumab: RED • **Fluocinolone acetonide intravitreal implant for treating chronic diabetic macular oedema** Technology appraisal guidance Reference number: TA953 Published: 13 March 2024 https://www.nice.org.uk/guidance/ta953 (NB: replaces NICE TA301 and TA613). **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). **APC actions:** to be added to/updated on the formularies (RED traffic light) and intravitreal injection pathway updated (see agenda item 5.2). • **Dupilumab for treating moderate to severe prurigo nodularis** Technology appraisal guidance Reference number: TA955 Published: 13 March 2024 https://www.nice.org.uk/guidance/ta955 **Resource impact:** N/A – not recommended. **APC actions:** link added to formularies (NOT RECOMMENDED). • **Ritlecitinib for treating severe alopecia areata in people 12 years and over** Technology appraisal guidance [TA958] Published: 27 March 2024 https://www.nice.org.uk/guidance/ta958 **Resource impact:** the NICE resource impact template indicates an impact of approximately £150,000 per year for the BLMK population.	

No	Agenda Item	Action
	APC actions: created and added to the formularies (RED traffic light). **The following NICE Guidelines (NG) (Medicine related and ICB Commissioned) have been published / updated by NICE:** **Tuberculosis** NICE guideline [NG33] Published: 13 January 2016 Last updated: 16 February 2024 https://www.nice.org.uk/guidance/ng33 **Fluoroquinolone antibiotics**: In January 2024, the MHRA published a Drug Safety Update on fluoroquinolone antibiotics. **APC actions:** none required (see also agenda item 7.0). **Vitamin B12 deficiency in over 16s: diagnosis and management** NICE guideline [NG239] Published: 06 March 2024 https://www.nice.org.uk/guidance/ng239 **APC actions:** none for APC – referred to shared transformation resource team for review. **Meningitis (bacterial) and meningococcal disease: recognition, diagnosis and management** NICE guideline [NG240] Published: 19 March 2024 https://www.nice.org.uk/guidance/ng240 **APC actions:** BLMK antimicrobial guidelines to be updated to reflect NICE recommendations. **Neonatal infection: antibiotics for prevention and treatment** NICE guideline [NG195] Published: 20 April 2021 Last updated: 19 March 2024 https://www.nice.org.uk/guidance/ng195 **APC actions:** no changes to medicines recommendations. Link to be added to BLMK antimicrobial guidelines. **Suspected sepsis: recognition, diagnosis and early management** NICE guideline [NG51] Published: 13 July 2016 Last updated: 19 March 2024 https://www.nice.org.uk/guidance/ng51 **APC actions:** none – changes are not medicine related. **Endometriosis: diagnosis and management** NICE guideline [NG73] Published: 06 September 2017 Last updated: 16 April 2024 https://www.nice.org.uk/guidance/ng73 **APC actions:** none – no medicines recommended in the updated section. **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: 13 March 2024 https://www.nice.org.uk/guidance/ng191	

No	Agenda Item	Action
	In **March 2024**, in the section on therapeutics, NICE updated recommendations on nirmaltrevir and ritonavir, sotrovimab, casirivimab and imdevimab, and tocilizumab in line with updated NICE technology appraisal guidance on nirmatrelvir plus ritonavir, sotrovimab and tocilizumab for treating COVID-19 (TA878). **APC actions:** see above re TA878 update and agenda item 13.1. **The following NICE TAs are the commissioning responsibility of NHSE and are listed for information only:** **Talazoparib for treating HER2-negative advanced breast cancer with germline BRCA mutations** Technology appraisal guidance Reference number: TA952 Published: 21 February 2024 https://www.nice.org.uk/guidance/ta952 **APC actions:** created and link added to formularies (RED traffic light) **Epcoritamab for treating relapsed or refractory diffuse large B-cell lymphoma after 2 or more systemic treatments** Technology appraisal guidance Reference number: TA954 Published: 06 March 2024 https://www.nice.org.uk/guidance/ta954 **APC actions:** created and link added to formularies (RED traffic light) **Momelotinib for treating myelofibrosis-related splenomegaly or symptoms** Technology appraisal guidance Reference number: TA957 Published: 20 March 2024 https://www.nice.org.uk/guidance/ta957 **APC actions:** created and link added to formularies (RED traffic light) **Daratumumab in combination for treating newly diagnosed systemic amyloid light-chain amyloidosis** Technology appraisal guidance Reference number: TA959 Published: 27 March 2024 https://www.nice.org.uk/guidance/ta959 **APC actions:** link added to formularies. **Satralizumab for preventing relapses in neuromyelitis optica spectrum disorders (terminated appraisal)** Technology appraisal Reference number: TA960 Published: 27 March 2024 https://www.nice.org.uk/guidance/ta960 **APC actions:** none – terminated appraisal. **Sebelipase alfa for treating lysosomal acid lipase deficiency that is not Wolman disease (terminated appraisal)** Technology appraisal Reference number: TA961 Published: 28 March 2024 https://www.nice.org.uk/guidance/ta961 **APC actions:** none – terminated appraisal. **Olaparib for maintenance treatment of BRCA mutation-positive advanced ovarian, fallopian tube or peritoneal cancer after response to first-line platinum-based chemotherapy** Technology appraisal guidance Reference number: TA962 Published: 28 March	

No	Agenda Item	Action
	2024 https://www.nice.org.uk/guidance/ta962 **APC actions:** link added to formularies. **Dostarlimab with platinum-based chemotherapy for treating advanced or recurrent endometrial cancer with high microsatellite instability or mismatch repair deficiency** Technology appraisal guidance Reference number: TA963 Published: 03 April 2024 https://www.nice.org.uk/guidance/ta963 **APC actions:** link added to formularies. **Human alpha1-proteinase inhibitor for treating emphysema (terminated appraisal)** Technology appraisal Reference number: TA965 Published: 28 March 2024 https://www.nice.org.uk/guidance/ta965 **APC actions:** none – terminated appraisal. **Cabozantinib with nivolumab for untreated advanced renal cell carcinoma** Technology appraisal guidance Reference number: TA964 Published: 10 April 2024 https://www.nice.org.uk/guidance/ta964 **APC actions:** links added to formularies.	
7.	**Medicines Safety update** A Primary Care Medicines Safety Update and a Medicines Safety Group Update was presented to the committee. **Primary Care Medicines Safety Update** This update focussed on the primary care response to the MHRA Drug Safety Updates (January and February 2024) and National Patient Safety Alerts (NPSAs, January, February and April 2024)). In particular: **Omega-3-acid ethyl ester medicines (Omacor/Teromeg 1000mg capsules): dose-dependent increased risk of atrial fibrillation in patients with established cardiovascular diseases or cardiovascular risk factors (DSU, January 2024)** Link added to formularies. There is low local use of these medicines, as they are medicines of low clinical value (NB: local exception is approved use for the treatment of severe hypertriglyceridaemia, for the prevention of acute pancreatitis). **Fluoroquinolone antibiotics: must now only be prescribed when other commonly recommended antibiotics are inappropriate (DSU, January 2024)** Link added to formularies. Actions being undertaken via the Antimicrobial Stewardship group and also within providers. Providers have reviewed their guidance and moved fluoroquinolones to second line within their antimicrobial guidelines where possible. Use for urological indications remains first line. **Valproate (Belvo, Convulex, Depakote, Dyzantil, Epilim, Epilim Chrono or Chronosphere, Episenta, Epival, and Syonell▼): new safety and educational materials to support regulatory**	

No	Agenda Item	Action
	measures in men and women under 55 years of age (DSU, January 2024) Link added to formularies. The BLMK valproate subgroup is reviewing this in detail. Good progress is being made within primary care and providers on producing governance policies. **Pseudoephedrine: very rare risk of posterior reversible encephalopathy syndrome (PRES) and reversible cerebral vasoconstriction syndrome (RCVS) (DSU, February 2024)** Link added to formularies. Rarely used and DNP on formularies. **Codeine linctus (codeine oral solutions): reclassification to prescription-only medicine (DSU, February 2024)** Link added to formularies. Usage has been decreasing locally and anticipated to reduce further with the change to a prescription only medicine. **National Patient Safety Alert – Transition to NRFit™ connectors for intrathecal and epidural procedures, and delivery of regional blocks (January 2024)** Discussed at the Medicines Safety Group and reviewed within trusts. This has been partially implemented within BLMK and continues to be reviewed. **NPSA Alert – Shortage of salbutamol 2.5mg/2.5ml and 5mg/2.5ml nebuliser liquid unit dose vials (February 2024)** There is widespread use of salbutamol nebules, particularly in the acute trusts and community providers. Use is being restricted and use of unlicensed imports, as advised in the alert, has not yet been necessary. Clinicians are on board with this approach. **Letter from Chief Medical Officers across the UK regarding the recently announced sodium valproate safety measures. Valproate: important new regulatory measures for oversight of prescribing to new patients and existing female patients (February 2024)** Being actioned via the valproate subgroup of the MSG (see also January 2024 DSU above). **NPSA Alert – Reducing risks for transfusion-associated circulatory overload (April 2024)** To be reviewed and actioned via the MSG and reported back to APC at a future meeting. **Potential contamination of some carbomer-containing lubricating eye products with Burkholderia cenocepacia - measures to reduce patient risk (updated April 2024)** The recommendations issued in December 2023 to 'avoid the use of all carbomer-containing eye products in individuals with cystic fibrosis, patients being cared for in critical care settings, the severely immunocompromised and patients awaiting lung transplantation' is no longer required and has been stepped down. There is no longer	

No	Agenda Item	Action
	an indication to avoid use of these products (aside from those that have been previously recalled). **Regional update – MSO EoE Network** Learning from the MSO EoE Network, which is attended by some MSG members: • There has been an update to the learning from patient safety events (LFPSE) primary care reporting system – this is with a view to widening access and increasing reporting. • Reports of increased incidence of propranolol overdoses (intentional) – review by Toxbase and possible national response to follow (possibly in the form of a NPSA alert). • Freedom of Information requests (FOIs) governance (GDPR) – process and governance around FOIs is being reviewed by MSG members. • Consultations are open on Never Events Process and also on Sodium Valproate (key stakeholder responsibilities). **National update – new RPS standards** New standards have been produced by the Royal Pharmaceutical Society (RPS) Patient safety professional standards responding to patient safety incidents 2024-270324-B.pdf (rpharms.com). Each member of the MSG is reviewing/discussing this within their respective area. The Committee noted the medicines safety update.	
8.	**Formulary Update**	
8.1	**Formulary Subgroup Recommendations** The following recommendations were made by the Formulary subgroup (FSG) at the 16 April 2024 meeting: • **Cytisinicline (cytisine) 1.5mg tablets for smoking cessation.** This is a new medicine to the UK market - the use of cytisinicline allows for a gradual reduction of nicotine dependence by relieving withdrawal symptoms. Cytisinicline competes with nicotine for the same receptors and gradually displaces nicotine due to its stronger binding. It is a fixed 25-day treatment course (acute issue only). Proposal: to add as GREEN to both joint formularies, as a second line treatment option after NRT. Smoking cessation teams will assess patients for suitability, fill in the agreed proforma and then write to the GP with a request to prescribe. Primary care prescribers may also initiate if confident to do so. *Cost impact of decision*: None for the ICB. 100% of costs will be re-charged to Public Health in line with other smoking cessation therapies. • **Tadalafil once daily preparations (2.5mg and 5mg) for erectile dysfunction (ED).** Currently 10mg and 20mg are green on both formularies for ED, with the stipulation that	

No	Agenda Item	Action
	they are prescribed on the NHS only where a patient meets the NHS SLS criteria. The 2.5mg and 5mg strengths are licensed for once daily, rather than prn, use and are currently non-formulary as they were previously listed as a low value medicine by NHS England. In August 2023, NHSE updated their recommendations on low value medicines and removed tadalafil 2.5mg and 5mg from these recommendations. The addition of tadalafil 2.5mg and 5mg tablets to the formularies was approved as follows: GREEN traffic light, second line to sildenafil, and only in line with the licensed indication. Tadalafil 2.5mg tablets are restricted for use only when the 5mg dose is not tolerated. *Cost impact of decision:* no significant impact anticipated. • **Melatonin for REM sleep disorder in Parkinson's disease**. Proposed to be added to the Beds & Luton Formulary to align with the MK Formulary and in line with recommendations in NICE NG71 (Parkinson's disease in adults). The proposal to add melatonin to the Beds/Luton Formulary, with SpIS traffic light designation, was approved. *Cost impact of decision:* there may be a shift of prescribing costs from secondary to primary care of approximately £2,600 for this patient cohort. • **Bimi (Bimatoprost 300mcg/mL) eye drops.** Request for addition of Bimatoprost 300mcg/mL preservative free multi-dose eye drop bottles as alternative to single-use eye drops (Unit Dose Vials, UDVs), and to align both joint formularies. Agreed to be added to both formularies with SpA traffic light designation. Additional points/considerations: 1. Supports the NHS green agenda with significant reduction in CO2 emissions (reduced plastic / packaging). 2. Consider keeping UDVs for patients unable to switch / use multi-dose bottles. 3. Engagement with hospital specialists is required to ensure that UDVs are not initiated in the future. 4. Bimi brand is a sterile solution with no preservative. The solution from the multi-dose container can be used for up to 90 days after opening. 5. The predominant name on the formulary will need to be generic (due to frequent changes in the most cost-effective branded generics). Optimise to be used to drive the brand choice in primary care. *Cost impact of decision:* Potential for >£10K annualised cost savings in BLMK from using multi-dose bottles rather than UDVs. • **Dimaz (Dorzolamide 2%) eye drops.** Request for addition of Dorzolamide 2% Preservative free multi-dose eye drop bottles as alternative to single-use eye drops, and to align both joint formularies. Agreed to be added to both formularies with SpA traffic light designation. Additional points/considerations (as 1, 2, 3 and 5 above and): 1. Dimaz (Scope) is a sterile solution with no preservatives. The solution from the multi-dose bottle	

No	Agenda Item	Action
	can be used for up to 28 days after first opening for administration to the affected eye(s). 2. Bausch + Lomb – Vizidor (Dorzolamide 2% in a preservative free, multi-dose bottle) may be a more cost-effective option – being investigated for savings opportunities across BLMK. *Cost impact of decision:* Potential for >£50K annualised cost savings in BLMK from using multi-dose bottles rather than UDVs. • **Codimaz (Dorzolamide 20mg/ml & Timolol 5mg/ml (2%/0.5%)) eye drops.** Request for addition of Dorzolamide 20mg/ml & Timolol 5mg/ml (2%/0.5%) Preservative free multi-dose eye drop bottles as alternative to single-use eye drops, and to align both joint formularies. Agreed to be added to both formularies with SpA traffic light designation. Additional points/considerations (as 1, 2, 3 and 5 above (Bimi) and): 1. Codimaz (Scope) is a sterile solution with no preservatives. The solution from the multi-dose bottle can be used for up to 28 days after first opening for administration to the affected eye(s). 2. Bausch + Lomb – Vizidor Duo (Dorzolamide 2% / Timolol 0.5% in a preservative free, multi-dose bottle) may be a more cost-effective option – being investigated for savings opportunities across BLMK. *Cost impact of decision:* >£40K annualised cost savings to BLMK for using multi-dose bottles rather than UDVs. • **Ivermectin cream (Soolantra) and Azelaic acid 15% gel for inflammatory papules and pustules of rosacea.** Ivermectin 10mg/g cream is recommended as first line treatment for the management of mild to moderate papules and pustules associated with Rosacea by the Primary Care Dermatology Society (PCDS) and within the NICE CKS. Azelaic acid 15% gel is recommended as an alternative topical first line treatment option. Both are non-antibiotic options for the management of mild to moderate rosacea – reducing the impact on antimicrobial resistance (currently the only topical option on Beds and Luton formulary is metronidazole gel). The addition of both products was approved, with GREEN traffic light status. *Cost impact of decision:* no significant cost impact as there is already extensive prescribing occurring across BLMK. • **Alternative guide to prescribing specials.** The formulary subgroup approved a new support tool which has been created to assist practices when prescribing specials – this includes recommendations for alternatives based on cost, licensing, and local formularies. The guidance also supports the cost saving element of the Prescribing Incentive Scheme (PIS) for 2024/25. *Cost impact of decision*: cost saving when recommended products selected.	

No	Agenda Item	Action
	• **Freestyle Libre 2 Plus and standalone CGM guidance update.** The FSG approved the following formulary amendment and associated guidance update: 1. Addition of Freestyle Libre 2 Plus (FSL2 Plus) to the Formularies (GREEN). The upgraded sensor is more accurate, carries an additional day of life in the sensor (15 vs 14 days) and is compatible with the same apps e.g. Libreview as FSL2. The rebate price is also applicable and is therefore the same cost as FSL2 sensors. The intention is to bulk switch patients from FSL2 to FSL2 Plus with notification via letter. 2. The standalone CGM guidance has been updated to reflect the decision at the previous meeting regarding FSL3, and the above proposal regarding FSL2 Plus. The document has also been simplified and summarised on to one page. *Cost impact of decision:* no cost impact anticipated. • **Aflibercept (Eylea) 8mg injection.** Requested for addition of a new product to the formularies: aflibercept (Eylea) 114.3 mg/ml solution for injection (8mg dose). Aflibercept 2mg injection is already on both formularies, and NICE approved for a range of indications. Aflibercept 8mg is licensed for the treatment of AMD and DMO. NICE do not intend to consider aflibercept 8mg separately, as it is too similar (in terms of product and price) to the existing 2mg product. NICE has already issued positive recommendations for AMD and DMO for aflibercept 2mg. The product offers benefits in terms of increased interval between injections resulting in fewer patient visits and increased clinic capacity, and the manufacturer has confirmed that the cost will be the same for both aflibercept (Eylea) products. Aflibercept (Eylea) 8mg injection was approved for addition to the formularies as a RED (specialist only) medicine. The intravitreal injections pathway has been updated accordingly (see agenda item 5.2). *Cost impact of decision:* cost neutral to cost saving. • **Tocilizumab biosimilar (for noting).** Addition of the newly licensed and available tocilizumab biosimilar (Tyenne) to both formularies. This will be used in the same place in existing treatment pathways as the originator product (RoActemra). The biosimilar is available in the following formulations: SC 162mg/0.9mL, IV 200mg in 10mL, IV 400mg in 20mL and 80mg in 4mL. Added to the formularies as a RED (specialist only) medicine. *Cost impact of decision:* cost saving – approx. £11k per annum. • **Minor amendments log** – the minor amendments made to the formulary since the last meeting were noted. • The **Metoject (methotrexate) pen** device has recently been changed by the manufacturer and a link to the information has been added to the formulary. The new pen is simple to use, but patients should be made aware of, and counselled on, the change.	

No	Agenda Item	Action
	• **Tirzepatide for T2DM (GLP1 shortage)** – tirzepatide may be considered as a second line option (after oral semaglutide) as an alternative to GLP1 receptor agonists, during the period of supply shortages. Note: the recommendation for the use of tirzepatide currently only applies to T2DM. • **Gonadotrophin Releasing Hormone Analogues (GnRHa) for paediatric use** (see also agenda item 13.2)**.** In March 2024, NHSE published a clinical policy on the use of puberty blockers in children and young people (CYP) with gender dysphoria. Use of Puberty suppressing hormones (PSH) are not available as a routine commissioning treatment option in this context and is not recommended. Formulary entries have been reviewed and the link to the NHSE guidance has been added. A new entry has been added for other use of GnRHa in paediatrics to confirm this is RED, specialist only. A local review has been undertaking of GnRHa use in CYP. **Decision:** The committee ratified the recommendations of the Formulary Subgroup.	
8.2	**Wound Management Formulary Steering Subgroup Recommendations** A report from the wound management subgroup meeting held in March 2024 was presented to the Committee: **Formulary Alignment & Development:** • MKUH Trust wound management formulary to be added to Microguide (online formulary platform). Beds formularies are already on there. • MK Practice Nurses formulary on there as draft currently – being reviewed by TVNs from CNWL. • The ICB's contract with Horizon, who supply Microguide has been renewed for 3 more years (includes a saving on the cost of annual renewal). **Financial:** • Increase in spend is in line with general cost of living. • ELFT spending being reviewed – issue with some colleagues using incorrect account for ordering via NHSSC. Measures have been put in place to prevent this happening. **Waste Reduction in Wound Care** • Greener products being considered for inclusion in the Wound Formularies, e.g. a range of debridement pads which offer the "lolly" equivalent products but without the plastic handle, these also offer cost savings when compared with similar formulary products. • A poster has been produced to help educate on dressings waste – this will be added to the online formularies. **Decision:** The Committee noted the report from the Wound Management Steering group	

No	Agenda Item	Action
9.	**Patient Group Direction Subgroup Recommendations** The following recommendations were made by the Patient Group Direction (PGD) subgroup – to approve the PGDs submitted for review and approval by the MK Urgent Care Service (MKUCS): The following PGDs were presented for approval with clinical changes: • **Glucagon injection** for the treatment of hypoglycaemia – addition of injection site reactions. The following PGDs were presented for approval with no clinical changes: • **Oral rehydration salts** for the replacement of fluid and electrolyte loss in acute diarrhoea. • **Paracetamol** for the treatment of mild to moderate pain and pyrexia. The Committee noted that the expiry date of Benzylpenicillin PGD has been extended to 31st May 2024, pending the late running publication of the national template. This had been held up waiting for an overdue NICE guideline. The national PGD has now been released and the MKUCS benzylpenicillin PGD is being updated accordingly. The updated PGD will be taken through for virtual approval / Chair's action in advance of the next APC. **Decision:** The Committee ratified the PGDs, as recommended by the PGD subgroup	
10.	**Antimicrobial Resistance Update**. At the February meeting of the antimicrobial resistance (AMR) group, data in relation to both primary and secondary care prescribing was reviewed. The following points were noted: • Primary care: ○ Practices in BLMK are meeting the target for the prescribing of broad spectrum antibiotics. ○ Total antibiotic prescribing remains above target but is consistent with prescribing across the EoE. ○ Amoxycillin 500mg 5-day course prescribing is well below the target of 75% (for BLMK and across EoE). This metric is part of the national medicines optimisation opportunities around reducing course length, with the aim of reducing both adverse effects and the risk of resistance. ○ An antibiotic formulary is being developed for integration within SystmOne to support the appropriate prescribing of antibiotics. ○ There is high prescribing of antibiotics in children and young people within BLMK. A meeting has been arranged with the BLMK Children and Young People Team to discuss the approach to reducing the prescribing rates, in terms of resources and training. • Acute trusts: ○ Acute trusts are monitored in terms of their total antibiotic prescribing and the reduction from a	

No	Agenda Item	Action
	baseline. MKUH is almost achieving this reduction, but BHFT prescribing rates have increased from baseline and there is also comparatively high use of IV antibiotics. ○ Both trusts are achieving the target for switching IV antibiotics to oral. ○ Trusts are also being monitored on the prescribing of quinolones. Both local trusts have reviewed their guidelines for the use of quinolones which should lead to a reduction in prescribing. • Primary care prescribing guidelines which include quinolones will also be reviewed. This is awaiting update from NICE as the primary care antimicrobial prescribing guidelines are based upon NICE recommendations. 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 (EoE PAC) – items for noting/approval**	
11.1	EoE PAC Meeting Notes – November 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 Drug and Therapeutics Committee (DTC) – March 2024	
12.2	Minutes of the Milton Keynes Hospital Prescribing & Medicines Governance Committee (PMGC) – April 2024	
12.3	Minutes of the BLMK Formulary Subgroup – February 2024	
12.4	Minutes of the BLMK Wound Management Formulary Steering Group – January 2024	
12.5	Minutes of the BLMK Medicines Safety Group – *none approved since last APC meeting*	
12.6	Minutes of the ELFT Medicines Management Committee – March 2024	
12.7	Minutes of the Cambridgeshire Community Services Medication Safety and Governance Group – January and March 2024	
12.8	Minutes of the CNWL Trustwide Medicines Optimisation Group (MOG) – February 2024	
12.9	Minutes of Circle/MSK Medicines Management Committee – January 2024	
13.	**Papers for information / ratification**	
13.1	**Covid treatments**	

No	Agenda Item	Action

	The Committee heard an update on the NICE recommendations for covid treatments (specifically, the update of TA878 recommendations for Paxlovid (nirmatrelvir plus ritonavir)) and the implementation of this within BLMK.
	
	The updated guidance, in NICE TA878, includes access to treatment for people who are aged 70 years and over, or who have a body mass index (BMI) of 35 kg/m2 or more, diabetes or heart failure, however a funding variation has been applied so this doesn't come into practice in 01 June 2025 to allow adequate time to plan for the change.
	
	The normal 3-month implementation period applies to the following new cohorts:
	
	• people aged 85 years and over.
	• people with end-stage heart failure who have a long-term ventricular assistance device.
	• people on the organ transplant waiting list.
	• people aged 70 years and over, or who have a BMI of 35 kg/m2 or more, diabetes or heart failure, and:
	  ○ are resident in a care home, or
	  ○ are already hospitalised.
	
	BLMK ICB has commissioned Milton Keynes Urgent Care to provide the Covid Medicines triage and prescribing service for the 24/25 financial year. There is no expectation that GP practices, NHS 111 or secondary care should prescribe for non-hospitalised patients testing positive for Covid 19. The service commissioned for 24/25 includes the cohorts in the normal 3-month implementation period, which is an estimated 23,000 additional patients. Lateral flow devices will be available for eligible patients free of charge from participating community pharmacies.
	
	The BLMK ICB Ardens template on SystmOne has been updated to include the new cohorts from June 24. A system has been put into place to allow patients to self-refer into the Covid Medicines triage and prescribing service, and a pathway has also been developed to allow direct referral from care homes.
	
	It was noted that additional work will need to be undertaken in 24/25 to implement the changes due in June 2025 for a larger cohort estimated to be an additional 200,000 patients in BLMK. The extended timeframe for implementation / funding variation for TA878 was noted to be in place to allow adequate time for the guidance to be implemented safely, including providing appropriate training for general practice.
	
	The Committee noted the update on Covid-19 treatments.	

13.2	**Gender dysphoria** NHS England has recently published two clinical policies in relation to gender incongruence/gender dysphoria in children and young people:	

No	Agenda Item	Action
	• Clinical policy: puberty suppressing hormones (PSH) for children and young people who have gender incongruence/gender dysphoria, published 12th March 2024. • Clinical commissioning policy: prescribing of gender affirming hormones (masculinising or feminising hormones) as part of the children and young people's gender service, published 21st March 2024. The clinical policies provide guidance on the use of puberty suppressing hormones and gender affirming hormones, respectively, as follows: • Puberty suppressing hormones (PSH): PSH are not available as a routine commissioning treatment option for treatment of children and young people who have gender incongruence / gender dysphoria. • Gender affirming hormones (GAH): GAH (masculinising or feminising hormones) are available as a routine commissioning treatment option for young people with continuing gender incongruence / gender dysphoria from around their 16th birthday subject to individuals meeting the eligibility and readiness criteria. The formularies have been updated to include a link to the PSH policy. The existing guidance that primary care clinicians should not prescribe GAH in children and young people remains in place. The Committee noted the NHS England policies on gender dysphoria.	
14.	**Any other business** None raised	
15.	**Future Dates for BLMK APC 2024 Meetings (all to be held from 12:30-15:00 via Microsoft Teams):** Wednesday 3rd July 2024 Wednesday 25th September 2024 Wednesday 4th December 2024	

Approval of minutes:

Chair: Dr Muhammad Nisar

Signed: 

Date: 10/07/2024

Appendix 1 – Approved 16 April 2024 Formulary Subgroup Minutes:

FSG Minutes April 2024 Final.pdf