BEDFORDSHIRE, LUTON AND MILTON KEYNES AREA PRESCRIBING COMMITTEE

DRAFT Meeting Notes

Date: 25 September 2024
Time: 12.30- 3.00pm
Venue: Microsoft Teams

Attendees:

Name	Initial	Role
Dr Muhammad Nisar	MN	Chair (Medical Representative, Bedfordshire Hospitals NHS Trust)
Mojisola Adebajo	MA	Place Based Lead Pharmacist – Luton
Nicola Ainsworth (until 13:47)	NA	Consultant in Public Health
Reginald Akaruese	RA	CNWL Pharmacy Representative (Community and Mental Health Services Milton Keynes)
Dr Marian Chan (until 13:00)	MC	Medical Representative, Bedfordshire Hospitals NHS Trust
Candy Chow	CC	Chair of Wound Care Group
Janet Corbett	JC	Milton Keynes Hospital Pharmacy Representative (Pharmacy Programme Manager, Milton Keynes Hospital)
Dr Dush Mital	DM	Medical Representative, Milton Keynes Hospital
Dupe Fagbenro	DF	ELFT Pharmacy Representative (Deputy Chief Pharmacist (Luton and Bedfordshire), ELFT)
Fiona Garnett	FG	Associate Director: Pharmacy and Medicines optimisation, BLMK ICB / Chair of Formulary Subgroup
Anne Graeff	AG	Commissioning Lead Pharmacist, BLMK ICB (Professional Secretary)
Cheryl Green	CG	Patient Representative
Emma Hooton	EH	Practice Pharmacist Representative (Independent Prescriber)
Dr Kate Randall	KR	Place Based Lead GP – Central Bedfordshire
Dr Jenny Wilson	JWi	Place Based Lead GP - Bedford
Dona Wingfield	DW	Chair of Medicines Safety Group /

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

		Bedfordshire Hospitals Trust Pharmacy Representative (Medicines Use and Quality Manager, Bedfordshire Hospitals Trust)
Dr Maggie Winter	MW	Place Based Lead GP – Milton Keynes (deputy)

In attendance:		
Anila Anwar (until 13:06)	AA	Bedfordshire Hospitals Trust Pharmacy Representative
Samina Hassanali	SH	Formulary and Medicines Safety Pharmacist, BLMK ICB
Prabjoth Kaur (until 13:57)	PK	Bedfordshire Hospitals Trust Pharmacy Representative
Qiratulain Khan (until 13:52)	QK	Bedfordshire Hospitals Trust Pharmacy Representative (Formulary Pharmacist)
Folake Kufeji (from 12:40)	FK	Bedfordshire Hospitals Trust Pharmacy Representative
Helen McGowan	HMcG	Medicines Optimisation Pharmacist, BLMK ICB
Sandra McGroarty	SMcG	Commissioning Pharmacist, BLMK ICB
Dr Joy Mutitika	JM	Medical Representative, Keech Hospice
Kike Pinheiro	KP	Representative, Willen Hospice

Apologies:		
Dorothy Aladejobi	DA	Pharmacist Representative, NHS Northampton Hospital Foundation Trust Secure Services
Rafal Ali	RA	Commissioning Pharmacist, BLMK ICB
Dr Mya Aye	MAy	Medical Representative, Milton Keynes Hospital
Pritesh Bodalia	PB	Bedfordshire Hospitals Trust Pharmacy Representative (Chief Pharmacist, Bedfordshire Hospitals Trust)
Sally Cartwright	SC	Consultant in Public Health
Matt Davies	MD	Head of Pharmacy and Medicines Optimisation, BLMK ICB
Dr Mitan Sarkar	MS	Place Based Lead GP - Luton
Helen Smith	HS	Milton Keynes Hospital Pharmacy Representative (Chief Pharmacist, Milton Keynes Hospital)
Dr Jonathon Walter	JWa	Place Based Lead GP – Milton Keynes
Nikki Woodhall	NW	Lead Medicines Optimisation Technician, 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.	
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. The following individuals made declarations in relation to the agenda: the Chair declared that he was involved with the development of the business cases to be considered in agenda item 5.1 and would not be involved in the decision making for this item. All other members confirmed they have no declarations in relation to matters on the agenda.	
3.	**Minutes of 03 July 2024 APC meeting** The minutes of the meeting held on 03 July 2024 were approved.	
4.	**Matters Arising**	
4.1	**Feedback on miscellaneous actions not included on the agenda from APC meetings**	
4.1.1	**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 11/09/24** - this has been delayed due to other priorities. This is an ongoing action.	SMcG
4.1.2	**Daridorexant prescribing support information** Signposting information to the nationally commissioned digital CBTi offering to be added once available. **Update 11/09/24** – announcement of the national commissioning of digital CBTi is still awaited. This is an ongoing action.	AG
4.1.3	**Contraception guidance** To complete the development of the 'pill ladders' with a view to incorporating these into the main contraception guidance. **Update 25/09/24 –** it was agreed that this action could be closed as it was unlikely to be taken forward at this time.	Close

No	Agenda Item	Action
4.1.4	**Contraception guidance** - Formularies to be updated to reflect formulary changes proposed in association with the guidance (progestogen only contraceptives, copper IUDs, vaginal delivery systems, drospirenone). **Update 11/09/24** - this is an ongoing action as some formulary changes are still to be actioned.	JC / SH / SMcG
4.1.5	**BLMK Lipid Guidance** - inclusion of inclisiran as the first line choice for patients with LDL-C≥2. 6mmol/L subject to inclusion of inclisiran in the PCF to help facilitate administration by practices/improve the inclisiran pathway. Inclusion of inclisiran in the Primary Care Framework (PCF) to be confirmed. **Update 11/09/24** – work is ongoing around inclusion of inclisiran in the PCF.	MD
4.1.6	**BLMK Lipid Guidance** - the triple combination of statins/bempedoic acid/ezetimibe to be removed from the pathway. **Update 11/09/24** – the combination has been removed from the pathway.	Close
4.1.7	**Drospirenone prescribing support information** - information to be included to state that all patients should routinely have annual blood pressure checks, and the definition of 'specialist' (with respect to SpIS formulary status) to be amended. **Update 11/09/24** – actions completed and on agenda for consideration (see agenda item 7.3)	Close
4.1.8	**Migraine pathway update** - formulary status of rimegepant and atogepant for the prevention of migraine to be amended to SpIS to facilitate continuation of treatment in primary care (following initiation and 12-week review by the specialist). **Update 26/07/24** – formulary traffic light updated on both formularies and link to migraine prevention pathway added. NB: prior to uploading the pathway onto the Medicines website, an error was spotted with the dose of atogepant stated in the migraine pathway. This was amended in accordance with the SPC prior to uploading to the website.	Close
4.1.9	**Mycophenolate for renal autoimmune disease SCG** - wording to be added to the formulary and Optimise Rx to emphasise that mycophenolic acid is a second line choice for patients who are intolerant of mycophenolate mofetil. **Update 11/09/24** – wording has been added to confirm the second line formulary position for mycophenolic acid.	Close
4.1.10	**Azathioprine Rheumatology factsheet** (sub-document of the overarching Bedfordshire/Luton rheumatology shared care guideline) - to be reviewed and updated in accordance with the clinical information included in the national shared care template for azathioprine. **Update 11/09/24** – on agenda for consideration: see agenda item 5.3.	Close

No	Agenda Item	Action
5.	**Items for consideration at meeting**	

5.1	**Interleukin-17 inhibitors – review of place in Psoriatic Arthritis and Ankylosing Spondylitis pathways**
	The Committee considered proposals to amend the place in therapy of bimekizumab, an interleukin-17 (IL17) inhibitor, in the treatment of psoriatic arthritis (PsA), ankylosing spondylitis (AS) and non-radiographic axial spondyloarthritis (nr-axSpA). The following key points were presented:
	
	<u>Psoriatic arthritis:</u>
	• Request to use bimekizumab as a first line treatment option, in the same position as other IL17 inhibitors (secukinumab & ixekizumab), for the treatment of Psoriatic Arthritis, as per NICE and local treatment pathway.
	• Current place in therapy (as per NICE TA 445 (secukinumab) & TA537(ixekizumab)):
	  ○ Treatment of active psoriatic arthritis if:
	  ▪ the person has peripheral arthritis with 3 or more tender joints and 3 or more swollen joints and
	  ▪ the psoriatic arthritis has not responded to adequate trials of at least 2 standard disease-modifying antirheumatic drugs (DMARDs), administered either individually or in combination.
	• Current recommendation for bimekizumab (TA916) – as above *and*:
	  ○ at least 1 biological DMARD or
	  ○ tumour necrosis factor (TNF)-alpha inhibitors are contraindicated but would otherwise be considered.
	• Review and continuation as recommended by NICE.
	• In a meta-analysis of 41 RCTs, bimekizumab ranked favourably among b/tsDMARDs for efficacy on joint, skin and disease activity outcomes, and showed comparable safety.
	• Bimekizumab would replace use of secukinumab / ixekizumab and not TNF inhibitors (TNFi) – not expected to result in a shift of prescribing away from TNFi.
	• Costs: at standard doses, bimekizumab has lower acquisition cost than secukinumab or ixekizumab. At escalated doses, bimekizumab has significantly higher acquisition cost than the other IL17 inhibitors. Specialists confirmed that it is anticipated that the standard, 160mg, dose would be prescribed.
	• Cost per responder network meta-analysis (NMA) indicated lower costs per responder in all groups analysed*.
	* Limitations of the NMA: list prices utilised, rather than the PAS prices available within the NHS.
	
	<u>Ankylosing Spondylitis (AS)</u>
	• Request to use bimekizumab as a first line treatment option, in the same position as secukinumab, as per NICE and local treatment pathway for AS.
	• Place in therapy (as per NICE TA407 for secukinumab):	

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	○ Recommended as a treatment option in adults whose disease has responded inadequately to conventional therapy (non-steroidal anti-inflammatory drugs *or* TNF-alpha inhibitors). • Current recommendation for bimekizumab (TA918) and ixekizumab (TA718): ○ Recommended as a treatment option when conventional therapy has not worked well enough *only if* tumour necrosis factor (TNF)-alpha inhibitors are not suitable or do not control the condition well enough. • Review and continuation as recommended by NICE. • Bimekizumab would replace use of secukinumab and not TNF inhibitors – not expected to result in a shift of prescribing away from TNFi. <u>Non-radiographic axial spondyloarthritis (nr-axSpA).</u> • Current recommendation for bimekizumab (TA918), secukinumab (TA719) and ixekizumab (TA718): ○ Recommended as a treatment option when conventional therapy has not worked well enough *only if* tumour necrosis factor (TNF)-alpha inhibitors are not suitable or do not control the condition well enough. • No IL17 inhibitors are currently recommended first line for nr-axSpA by NICE or in the local treatment pathway. • Proposal to allow as a first line treatment choice similarly to use in AS. • Review and continuation as recommended by NICE. <u>AS and nr-axSpA</u> • A systematic review and network meta-analysis (NMA) to compare the efficacy and safety of bimekizumab 160 mg every 4 weeks with those of biologic or targeted synthetic disease-modifying anti-rheumatic drugs (DMARDs) for the treatment of patients with axSpA (both AS and nr-axSpA) showed the following: ○ In patients with AS, the ASAS 40a response rate after ≥ 12 weeks of treatment and up to 16 weeks was significantly higher for bimekizumab 160 mg Q4W than for secukinumab 150 mg Q4W without a loading dose. ○ In patients with nr-axSpA, the ASAS 40 response rate with bimekizumab was similar to that with other active treatments. No other significant differences in ASAS 40 response between bimekizumab and active comparators were observed. • A 52-week match adjusted indirect comparison of the IL17 inhibitors, for the treatment of AS, indicated that bimekizumab 160mg may have higher likelihood of key efficacy outcomes than secukinumab 150mg, whereas differences with secukinumab 300mg or ixekizumab 80mg were non-significant.	

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	• Costs: bimekizumab has lower acquisition cost than secukinumab or ixekizumab, unless the 150mg dosing is used for secukinumab (150mg monthly is the starting dose for AS and only licensed dose for nr-axSpA). Additional annual cost of bimekizumab vs secukinumb 150mg for 15 patients = £57,135. • Cost per responder network meta-analysis (NMA) indicated lower costs per responder for bimekizumab in some groups analysed for AS and nr-axSpA (in comparison to secukinumab)*. *Limitations of the NMA: list prices utilised, rather than the PAS prices available within the NHS. The following additional points were discussed: • Patient groups to be considered for bimekizumab would be those with psoriasis, uveitis, predominant entheseal disease, history of Multiple Sclerosis / family history of Multiple Sclerosis, history of malignant melanoma. These are similar indications to secukinumab. • It was confirmed that, for patients with uveitis, adalimumab would also be considered as it is licensed for this indication. • If a patient was prescribed an IL17 inhibitor first line (secukinumab or bimekizumab), a TNF inhibitor may be considered second line (if not contraindicated). • Dosing of secukinumab for AS and nr-axSpa is usually 150mg monthly. • Patient numbers were confirmed as: 15 patients per year for PsA and 15 patients per year for AS/nr-axSpA (30 patient total; Bedfordshire Hospitals only – no patient numbers available from Milton Keynes Hospital, although the business cases have been shared with them and it is anticipated that there would be similar patient numbers at MKUH). • The Committee discussed the amount of evidence available for clinical and cost-effectiveness to support the business cases, within the context of current NICE guidance / local pathways and the evidence presented in the business cases. It was felt that the strongest case was presented for PsA, but it was weaker for AS and nr-axSpA, with nr-axSpA being weakest due to the current NICE / local pathway recommendations which do not recommend any IL17 inhibitors as first line treatment options. • Any recommendations from the Committee will be clinical – if approved clinically, the recommendations are subject to further consideration within local trust processes. **Decision**: The Committee approved clinically the request to allow bimekizumab as an additional first line treatment option for Psoriatic Arthritis, alongside the other IL17 inhibitors (secukinumab and ixekizumab). The requests in relation to Ankylosing Spondylitis and non-radiographic axial spondyloarthritis were not approved and	MC/MN

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	further work will be undertaken to further develop the case to support these requests. **EQIA Assessment:** Positive impact: Access to Bimekizumab will be positive for equity and equality and will bring it in line with other agents in the same class providing better access to patients. **BLMK ICB E and D Lead comment:** Statement in the AxSpa document: *"Access to Bimekizumab will be positive for equity and equality and will bring it in line with other agents in the same class providing better access to patients."* Suggest including in both documents: "this change aims to reduce health inequalities".	
5.2	**Paediatric asthma guideline** The Committee considered an update to the existing BLMK paediatric asthma guidelines (for use in patients ≤16 years). This comprised an update to the current treatment strategy in line with the Global Initiative for Asthma guidelines 2023 to include considering a maintenance and reliever therapy (MART) regime (SABA free) for children aged 12 and over. MART regimens will be the option of choice for children aged 12-16 years, but people can switch between SABA-free and traditional regimens if required – consideration should always be given to whether the person is on the right regimen for them. Pharmacological management for younger children remains with traditional regimens (e.g. step 1: low dose ICS inhaler plus SABA when required). The guideline review has also streamlined the previous version. MART should be considered if there is suboptimal asthma control and frequent need for reliever inhaler or if adherence is a problem. Careful education of people with asthma is required for this treatment strategy. **Decision**: The Paediatric Asthma guideline was approved by the Committee. **EQIA Assessment:** No impact anticipated. The revised asthma guidelines are a reflection of the current GINA guidelines. They are not mandatory, and clinicians should use their clinical discretion when using. The revised asthma guidelines refer to some pMDIs that contain alcohol. These pMDIs have been on formulary for some time. The level of ethanol is very small and less than the amount in a ripe banana. Some religious groups may have concerns about ethanol being present in their medications. A statement within or separate to the guidelines may be necessary to raise awareness of the need to disclose ethanol content to patients where appropriate. Alternative ethanol free pMDIs are available where needed. **BLMK ICB E and D Lead comment:** 'No' has been ticked in terms of impact, but an impact (ethanol content) has been included in the document with mitigation of other devices being available (this is great) – 'Yes' should therefore be ticked.	

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	APC Secretary response: this has been updated in the impact assessment.	
5.3	**Azathioprine fact sheet for GPs** A review and update of the existing Bedfordshire and Luton azathioprine fact sheet (an appendix of the overarching Bedfordshire and Luton Rheumatology shared care guideline) was presented to the Committee. The update utilised the national shared care guidelines (SCGs) as the basis for the review, with the aim of ensuring that all current, relevant information is available to clinicians prescribing azathioprine as part of a shared care arrangement. The Committee noted that, going forward, it is anticipated that a drug-based approach will be taken for shared care guidelines, in line with that used in the national templates, with SCGs being drug specific and covering multiple specialities. This is a large piece of work and therefore the continued use of the overarching Rheumatology shared care guideline, with supporting drug fact sheets covering the commonly used DMARDs including azathioprine, was proposed. It was also noted that Milton Keynes currently has a separate, multi-drug, rheumatology SCG which will continue to be used within Milton Keynes. Additional points discussed: • A proposal to reword the information relating to MAS in the Cautions / Special considerations section was presented at the meeting, to provide more context. Proposed wording as follows: ○ "Macrophage activation syndrome (MAS) – azathioprine could potentially increase susceptibility of developing MAS (a known life-threatening disorder which may develop in patients with autoimmune conditions, in particular with inflammatory bowel disease (IBD). Clinicians should also be attentive for symptoms of EBV and cytomegalovirus (CMV), as these are known triggers for MAS". This wording was agreed. • Frequency of CRP/ESR monitoring – the recommendation to monitor 3-6 monthly came from previous fact sheet. It was discussed that not all primary care clinicians will add the inflammatory markers to blood tests for azathioprine or, for example, methotrexate. In addition, it was discussed that these markers are not so relevant for monitoring the drug (rather they are used to monitor disease activity) and it was agreed that this should be removed from the document. The specialists will continue to monitor the inflammatory markers when blood tests are requested at the hospital. Further discussion will be required for other DMARDs during review of the SCGs as part of the SCG workplan. • Quantity of supply – the Committee discussed that the quantity of medication supplied will be dictated by a practice's own policy and may be dependent on whether the practice puts DMARDs on repeat or prescribe acutely and dispense an appropriate quantity to take them to the next due blood test. It was agreed that the fact sheet doesn't need to specify	SMcG

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	the quantity to be supplied as this will be determined by practices' own policies – this statement is to be removed from the fact sheet. The information that a maximum of 4 weeks should be supplied is also to be removed from all DMARD fact sheets at next review. **Decision**: The azathioprine fact sheet was approved with amendments agreed, as documented above. **EQIA Assessment:** N/A	SMcG
5.4	**ICS Stepdown for COPD patients** A review and update of previous guidance available in Milton Keynes and Bedfordshire & Luton on the use of inhaled corticosteroids (ICS) in patients with COPD was considered by the Committee. The guidelines have been updated to reflect more recent guidance from the European Respiratory Society. The document covers two distinct steps to assess/review the patient and then actions to be taken for patients identified as being suitable to step down. 'Step One: Assessment consultation' (who could step down): this identifies patients who may be receiving ICS without any clinical benefit yet are exposed to potential adverse effects. Step Two (how to step down) has been streamlined and the inhaler table updated to reflect the most common inhalers used in BLMK. No cost impact is expected as this is an update of previous guidance and an ongoing workstream. **Decision**: the document was approved by the Committee. **EQIA Assessment:** No impact anticipated. **BLMK ICB E and D Lead comment:** No further comments	
5.5	**Self-monitoring of blood glucose (SMBG) for adults with diabetes managed in primary care** The legacy Bedfordshire and Luton Joint Prescribing Committee (JPC) guidance on self-monitoring of blood glucose (SMBG) in non-insulin treated type 2 diabetic patients for maintaining glycaemic control is now outdated and needed to be updated in accordance with recent NICE recommendations. In November 2023, the APC Formulary sub-group approved the streamlining of BLMK formulary choice blood glucose and ketone meters and testing strips in line with NHSE Commissioning recommendations for blood glucose and ketone meters, testing strips and lancets. For most people with diabetes needing to monitor only blood glucose, clinicians would choose from one of the cost-effective options with test strips (BGTS) costing <£6/pack. This would reduce unwarranted variations in prescribing of testing strips and provide additional cost savings as previous preferred options were costing >£6/pack.	

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	NICE recommends the specific circumstances when SMBG should be offered to a patient with diabetes to ensure that optimal use is guided by robust evidence and does not result in unnecessary NHS expense or inconvenience for patients and their carers. The clinical appropriateness for a blood glucose meter should be assessed before initiation and continued need should be reviewed annually. The widening of eligibility criteria for continuous glucose monitoring (CGM) should reduce need for blood glucose meters and testing strips as some patients no longer need them. However, where there is no longer a clinical need sometimes these are not removed from prescriptions and people continue to order them. The recommendations included in the guidance are based on NICE guidance (NG28) and locally agreed consensus with the diabetes specialist teams. The aim is that the guidance will support primary care clinicians in determining clinical appropriateness of SMBG and quantities of testing strips required. Expenditure for BGTS has reduced and is predicted to continue to reduce in this current financial year as most patients with T2DM needing to monitor their blood glucose can be provided with BLMK approved BGTS costing <£6. The widening of CGM eligibility reduces the need for BGTS but the cost savings will only be realised if unwarranted variations in quantities prescribed is minimised and prescribing is limited to where it is clinically appropriate. At the current time, BLMK has above average prescribing of test strips in comparison to other ICBs. **Decision**: The updated SMBG guidance was approved. **EQIA Assessment:** No impact expected – update of previous guidance. **BLMK ICB E and D Lead comment:** 'No' has been ticked in terms of impact, but please consider: Does T2DM affect certain communities more and therefore these proposed changes may have a disproportionate impact on them? E.g. Patients understanding of how to use CGM and no longer requiring BGTS as use widens. Ensuring that patients are aware of changes in terms of ordering rather than expecting BGTS in their regular repeats (not running out). If these conversations have happened and there are mitigations, then they should be included in this for audit trail. If the answer is still 'No' then please state rationale. **Author's response:** Yes, t2dm affects those in certain communities disproportionately due to various factors e.g. diet, ethnicity, weight but capillary blood glucose (CBG) monitoring is only required in certain circumstances as per NICE recommendations. Conversations about need and frequency of CBG monitoring even where CGM has been initiated would form part of DM review/consultation. The guide will support our clinicians in managing patient expectations.	

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5.6	**Ulcerative Colitis pathway update** The Committee considered an update to the existing BLMK Ulcerative Colitis pathway. The pathway has been updated in light of publication of NICE TA998, which recommends Risankizumab as an option for treating moderately to severely active UC in adults (subject to criteria as outlined in the TA). Risankizumab has therefore been added to the pathway as a treatment option in accordance with the TA recommendations. Local Gastroenterology teams have been consulted and agree with the proposed pathway update. **Decision**: The update to the ulcerative colitis pathway was approved. **EQIA Assessment:** N/A – update in accordance with NICE TA guidance	
6.0	**NICE Guidance – from 20 June 2024 until 11 September 2024** **The following NICE Technology Appraisal Guidance (ICB Commissioned) have been published:** • **Lebrikizumab for treating moderate to severe atopic dermatitis in people 12 years and over** Technology appraisal guidance Reference number: TA986 Published: 10 July 2024 https://www.nice.org.uk/guidance/ta986 **Resource impact:** NICE expect the cost impact of implementing the guidance to be approximately £8,800 per 100,000 population (approximately £88,000 for BLMK). This is because the technology is a further treatment option, and the overall cost of treatment will be similar for this patient group. **APC actions:** created and link added to formularies. Atopic dermatitis pathway updated (see agenda item 7.2) • **Tenecteplase for treating acute ischaemic stroke** Technology appraisal guidance Reference number: TA990 Published: 24 July 2024 https://www.nice.org.uk/guidance/ta990 **Resource impact:** NICE expect the cost impact of implementing the guidance to be approximately £8,800 per 100,000 population (approximately £88,000 for BLMK). This is because the technology is a further treatment option, and the overall cost of treatment will be similar for this patient group. **APC actions:** formularies updated with NICE TA recommendation (RED traffic light). • **Abaloparatide for treating osteoporosis after menopause** Technology appraisal guidance Reference number: TA991 Published: 07 August 2024 https://www.nice.org.uk/guidance/ta991	

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	Resource impact: NICE expect the resource impact of implementing the recommendations to be approximately £8,800 per 100,000 population (approximately £88,000 for BLMK). This is because the technology is a further treatment option, and the overall cost of treatment will be similar for this patient group. **APC actions:** created and added to formularies (RED traffic light). To be added to osteoporosis guideline when update undertaken. • **Linzagolix for treating moderate to severe symptoms of uterine fibroids** Technology appraisal guidance Reference number: TA996 Published: 14 August 2024 https://www.nice.org.uk/guidance/ta996 **Resource impact:** NICE expect the resource impact of implementing the recommendations, for the BLMK population, to be approximately £63,000 in year 1, rising to £298,000 by year 5. **APC actions:** to be created and added to formularies – Amber SpA agreed in line with the agreed recommendations for relugolix–estradiol–norethisterone acetate. The committee noted that there are currently long waiting lists for gynaecology which are driving some off label use / prescribing e.g. of GnRH agonists beyond the timeframes contained within the product license. This is not within the remit of the committee to resolve but was noted as a challenge within the system. • **Relugolix for treating hormone-sensitive prostate cancer** Technology appraisal guidance Reference number: TA995 Published: 14 August 2024 https://www.nice.org.uk/guidance/ta995 **Resource impact:** NICE expect the resource impact of implementing the recommendations, for the BLMK population, to be approximately £13,000 in year 1, rising to £107,000 by year 5. NB: increases in drug costs may be offset by reductions in capacity related costs e.g. attendance for administration of GnRH agonists. **APC actions:** to be created and link added to formularies – Amber SpA in line with GnRH agonists. • **Risankizumab for treating moderately to severely active ulcerative colitis** Technology appraisal guidance Reference number: TA998 Published: 22 August 2024 https://www.nice.org.uk/guidance/ta998 **Resource impact:** NICE expect the resource impact of implementing the recommendations to be approximately £8,800 per 100,000 population (approximately £88,000 for BLMK). This is because the technology is a further treatment option and the overall cost of treatment for this patient group will be similar.	AG / JC AG / JC

No	Agenda Item	Action
	APC actions: link added to formularies (RED traffic light). Ulcerative colitis pathway updated (see agenda item 5.6). • **Vibegron for treating symptoms of overactive bladder syndrome** Technology appraisal guidance Reference number: TA999 Published: 04 September 2024 https://www.nice.org.uk/guidance/ta999 **Resource impact:** NICE expect the resource impact of implementing the recommendations in BLMK will be around £12,000 per year by year 5. This is due to population growth. The lower price of vibegron than mirabegron means that as people choose vibegron rather than mirabegron, the increasing cost is reduced. There is a net overall cost impact. **APC actions:** to be created and link added to formularies – green, 3rd line (after 1st and 2nd line antimuscarinics) as for mirabegron. • **Faricimab for treating visual impairment caused by macular oedema after retinal vein occlusion** Technology appraisal guidance Reference number: TA1004 Published: 11 September 2024 https://www.nice.org.uk/guidance/ta1004 **Resource impact:** Minimal impact anticipated in the short term as the majority of current prescribing for RVO is currently for aflibercept, however aflibercept biosimilars are expected during the period covered by the NICE resource impact template which could lead to significant financial implications. **APC actions:** link added to formularies (RED traffic light). Ophthalmology Intravitreal Injection Treatment Pathway to be updated. **The following NICE Guidelines (NG) (Medicine related and ICB Commissioned) have been published / updated by NICE:** **Diabetic retinopathy: management and monitoring** NICE guideline [NG242] Published: 13 August 2024 https://www.nice.org.uk/guidance/ng242 This guideline covers managing and monitoring diabetic retinopathy in people under the care of hospital eye services. This includes non-proliferative and proliferative diabetic retinopathy, and diabetic macular oedema. **APC actions:** in consultation with ophthalmologists – to be added to workplan for follow up. **Adrenal insufficiency: identification and management** NICE guideline [NG243] Published: 28 August 2024 https://www.nice.org.uk/guidance/ng243	AG / JC

No	Agenda Item	Action
	This guideline covers identifying and managing adrenal insufficiency (hypoadrenalism) in babies, children, young people and adults. It aims to improve the treatment of primary, secondary and tertiary adrenal insufficiency, and the prevention and management of adrenal crisis. **APC actions:** none required. **The following NICE TAs are the commissioning responsibility of NHSE and are listed for information only:** **Lisocabtagene maraleucel for treating relapsed or refractory aggressive B-cell non-Hodgkin lymphoma (terminated appraisal)** Technology appraisal Reference number: TA987 Published: 10 July 2024 https://www.nice.org.uk/guidance/ta987 **APC actions:** none – terminated appraisal. **Etranacogene dezaparvovec for treating moderately severe or severe haemophilia B** Technology appraisal guidance Reference number: TA989 Published: 24 July 2024 https://www.nice.org.uk/guidance/ta989 **APC actions**: none – no local use expected. **Ivacaftor–tezacaftor–elexacaftor, tezacaftor–ivacaftor and lumacaftor–ivacaftor for treating cystic fibrosis** Technology appraisal guidance Reference number: TA988 Published: 24 July 2024 https://www.nice.org.uk/guidance/ta988 **APC actions:** none – no local use expected. **Trastuzumab deruxtecan for treating HER2-low metastatic or unresectable breast cancer after chemotherapy** Technology appraisal guidance Reference number: TA992 Published: 29 July 2024 https://www.nice.org.uk/guidance/ta992 **APC actions:** link added to formularies (NOT RECOMMENDED) **Burosumab for treating X-linked hypophosphataemia in adults** Technology appraisal guidance Reference number: TA993 Published: 07 August 2024 https://www.nice.org.uk/guidance/ta993 **APC actions:** none – no local use expected. **Enzalutamide for treating non-metastatic prostate cancer after radical prostatectomy or radiotherapy (terminated appraisal)** Technology appraisal Reference number: TA994 Published: 08 August 2024 https://www.nice.org.uk/guidance/ta994 **APC actions:** link added to formularies (TERMINATED APPRAISAL)	

	Pembrolizumab with platinum- and fluoropyrimidine-based chemotherapy for untreated advanced oesophageal and gastro-oesophageal junction cancer Technology appraisal guidance Reference number: TA737 Published: 20 October 2021 Last updated: 29 August 2024 https://www.nice.org.uk/guidance/ta737 In August 2024, this guidance was partially updated by NICE technology appraisal guidance 997 on pembrolizumab with platinum- and fluoropyrimidine-based chemotherapy for untreated advanced HER2-negative gastric or gastro-oesophageal junction adenocarcinoma. **APC actions:** none **Pembrolizumab with platinum- and fluoropyrimidine-based chemotherapy for untreated advanced HER2-negative gastric or gastro-oesophageal junction adenocarcinoma** Technology appraisal guidance Reference number: TA997 Published: 29 August 2024 https://www.nice.org.uk/guidance/ta997 **APC actions:** link added to formularies. **Iptacopan for treating paroxysmal nocturnal haemoglobinuria** Technology appraisal guidance Reference number: TA1000 Published: 04 September 2024 https://www.nice.org.uk/guidance/ta1000 **APC actions**: none – no local use expected (The National PNH Service is funded by NHS England as a highly specialised service to treat PNH. The service consists of 2 centres, with one based at St James' University Hospital in Leeds and the other based in King's College Hospital in London. People with PNH will be cared for and supported by one of these centres). **Zanubrutinib for treating marginal zone lymphoma after anti-CD20-based treatment** Technology appraisal guidance Reference number: TA1001 Published: 04 September 2024 https://www.nice.org.uk/guidance/ta1001 **APC actions:** link added to formularies. **Evinacumab for treating homozygous familial hypercholesterolaemia in people 12 years and over** Technology appraisal guidance Reference number: TA1002 Published: 11 September 2024 https://www.nice.org.uk/guidance/ta1002 **APC actions:** none – no local use expected (providers are NHS tertiary centres where patients have other HoFH treatments). **Exagamglogene autotemcel for treating transfusion-dependent beta-thalassaemia in people 12 years and over** Technology appraisal guidance Reference number: TA1003 Published: 11 September 2024 https://www.nice.org.uk/guidance/ta1003 **APC actions:** none – no local use expected. **Futibatinib for previously treated advanced cholangiocarcinoma with FGFR2 fusion or rearrangement** Technology appraisal guidance Reference number: TA1005 Published: 11 September 2024 https://www.nice.org.uk/guidance/ta1005 **APC actions:** created and link added to formularies.	

No	Agenda Item	Action
7.	**Virtual Recommendations/Documents for discussion/ratification**	
7.1	**BLMK Area Prescribing Committee Terms of Reference update** A review and update of the Area Prescribing Committee terms of reference has been undertaken and the following amendments made: • Minor adjustments to wording in the "Purpose" section. • Removal of reference to Regional Medicines Optimisation Committees (RMOCs), as these have been replaced with new national arrangements for medicines optimisation in England. • Updates to the membership due to organisational changes within the ICB and to include a Practice pharmacist (Independent Prescriber). • Amendments to the section on quoracy to provide additional clarity on actions to be taken if a meeting is not quorate. • "Nature of decisions and reporting mechanisms" section: updates made to reflect changes in reporting and authorisation processes for the ICB and providers. **Decision:** The proposed update to the terms of reference were approved by the Committee.	
7.2	**Atopic dermatitis pathway update** The atopic dermatitis pathway has been updated to include Lebrikizumab in accordance with NICE TA986. Lebrikizumab has been added to the pathway as a treatment option in accordance with the TA recommendations. Local Dermatology teams have been consulted and agree with the proposed pathway update. The Committee noted that Lebrikizumab is recommended by NICE as an option for people aged 12 years and over (with a body weight of 40 kg or more) who meet the criteria as set out in the TA. Confirmation has been provided by NHS England that treatment for people aged under 18 years would be the commissioning responsibility of NHSE (on the proviso that these patients are managed within a specialised approved Dermatology service). The ICB therefore commissions for adults only. **Decision**: The update to the atopic dermatitis pathway was approved. **EQIA Assessment:** N/A – update in accordance with NICE TA guidance.	
7.3	**Drospirenone prescribing support information** The APC considered the drospirenone prescribing support information sheet, for primary care clinicians, at the July 2024 meeting. The guidance was approved with some amendments which were agreed at the meeting. Post meeting, whilst updating the document with the agreed amendments, it was noted that the information relating to the length of time additional contraception is required in certain circumstances	

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	is different from other POPs. A further amendment was therefore made to the information to help illustrate these differences, with links to the relevant pages of the FSRH guidance, detailing this information, included. The Committee therefore reviewed the updated document in light of these changes. **Decision:** The Drospirenone prescribing support information was approved. **EQIA Assessment:** positive impact – this will ensure a consistent approach is adopted across BLMK. **BLMK ICB E and D Lead comment:** N/A – reviewed for the July 2024 meeting.	
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 (June to September 2024) and CAS Alerts (May to July 2024). In particular: **Topiramate (Topamax): introduction of new safety measures, including a Pregnancy Prevention Programme (PPP) (DSU, June 2024)** Linked to Formulary for information. OptimiseRx messaging in place for patients without an annual risk assessment. Bedfordshire hospitals have put warnings on nerve centre, circulated to clinical teams and have encouraged clinicians to use leaflets for the PPP. Whole pack dispensing will ensure patients receive the leaflet. SystmOne has a report to identify patients and there is an Arden's monitoring template. General practice actions were discussed at the valproate champions meeting on the 18th of July. There is potential to address actions via the current valproate working group. **Warfarin: be alert to the risk of drug interactions with tramadol (DSU, June 2024)** Linked to formulary entries. There is a national OptimiseRx message in place that flags that this combination is not recommended whenever these drugs are co-prescribed. Patient counselling on the drug interaction is also strongly advised – patients are advised to inform their GP if considering stopping the tramadol or changing the dosing frequency themselves as this may affect their INR. **Epimax Ointment and Epimax Paraffin-Free Ointment: reports of ocular surface toxicity and ocular chemical injury (DSU, July 2024)** To be discussed at MSG in October. Linked to formulary entries. OptimiseRx messaging in place. Information included in preset directions when selecting from the formulary on SystmOne.	

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	A question was raised regarding whether there is a specific component in Epimax which makes it higher risk than other emollients for causing ocular surface toxicity and ocular chemical injury. This is unclear at the current time and the DSU will be discussed at MSG in October. Post meeting note: information from the DSU, and associated Field Safety Notice, identifies the following points: • Epimax Ointment and Epimax Paraffin-Free Ointment are regulated as medical devices, although some emollients are regulated as medicines. • Epimax Ointment and Epimax Paraffin-Free Ointment product ingredients and consistency are likely to lead to them taking longer to remove/ wash out, if inadvertently introduced into the eye, compared to the rest of the products in the Epimax range. • Amendments have been made to the product labelling to ensure prescribers or patients/ consumers are fully aware of the need to avoid contact of these ointments with the eyes. **Yellow Card Biobank: call to contribute to study of genetic links to side effects (DSU, August 2024)** To be discussed at MSG in October. Contact has been made with Ardens to explore the potential of building a clinical report to cover the range of ADRs and drugs that are currently being studied. As always, Yellow Card reporting of suspected adverse reactions to drugs, particularly those related to the studies, is encouraged. **Valproate use in men: as a precaution, men and their partners should use effective contraception (DSU, September 2024)** Linked to formulary entries. OptimiseRx messaging in place. To be discussed further at the valproate task & finish group. **National Patient Safety Alert – Transition to NRFit™ connectors for intrathecal and epidural procedures, and delivery of regional blocks (CAS alert, updated May 2024)** Ongoing action within the trusts. Led by quality team at BHFT and assessment by each clinical area. Currently being looked at via BHFT pain subgroup and levofentanyl has been transitioned over. **Kay-Cee-L® (potassium chloride 5mmol/5ml) syrup will be out of stock from late September 2024. The resupply date is to be confirmed (CAS alert, July 2024)** Linked to Formulary for information. OptimiseRx messaging in place. Advice on no new initiations and details on review of current prescriptions by NPPG included. **<u>Medicines Safety Group (MSG) Update</u>** <u>Penicillamine / penicillin allergy mis-recording</u> Medicines Safety Officers have raised that digital systems list penicillamine above penicillin when adding an allergy to a patient's record. If penicillamine is incorrectly selected, an alert will not fire	

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	when penicillin is being prescribed and this could put patients at risk, particularly if they have a true severe allergy to penicillin. It has been identified nationally and locally that patients have been inadvertently recorded as having an allergy to penicillamine rather than an allergy to penicillin on the GP clinical system. This item was discussed at AMR group and 375 patients were identified as having a penicillamine allergy recorded via SystmOne across BLMK. For context, only 32 patients have been prescribed penicillamine in primary care in the last 10 years. It is likely that most, if not all, of these patients were incorrectly coded, as an allergy to penicillamine is very rare. Practices will be advised about the need to review these patients and manually update their allergy records on the system as appropriate. Work is being done to investigate this issue further and communication will be sent out to practices with support and guidance. <u>Valproate – System response update</u> The Valproate task & finish group has been looking at the type and numbers of referrals to specialists. Valproate champions provide representation from all the GP practices across BLMK. A webinar was held on the 18th of July to help the champions work through their patient lists to identify actions required e.g. confirmation of indication (i.e. neurology or mental health), whether patients are currently under a specialist, identifying patients requiring referral to the appropriate services, patients that have potentially been lost to follow up. This data will help the group better understand the impact and resources required. The valproate Arden's template will include referral forms for sexual health to clarify that the referral is due to a patient being on a teratogenic medicine. The electronic referral form will require additional information to allow the neurology and mental health specialists to triage appropriately. There has been a longer gap between meetings this time to allow data gathering to take place. Training with primary care in July helped to progress the collation of patient numbers. More information will be presented to the Committee next time with specific numbers following a patient level audit. The audit information is currently still being submitted and collated. A query was raised about whether the data gathered in primary care will be shared with specialists in secondary care. It was confirmed that specialists will not be provided with a list of patients, rather individual referrals will be submitted (for patients who are not currently under the care of the relevant specialist service) and a top-level summary of patient numbers for each speciality will be shared. Referrals to specialists have already started to be submitted by practices, but the top-level summary will only be possible once all practices have submitted their data. It is hoped that this information will be available in the next few weeks.	

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	The publication of the alert regarding use of Valproate in men was noted (see also the information above) and it was clarified that the actions regarding Topiramate will be progressed separately to the Valproate workstream. 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 September 2024 meeting: • **Heylo leak detection stoma product.** This is a newly launched product designed as a leakage notification system, for people with an ileostomy, or colostomy with liquid or mushy outcome. It consists of a sensor layer that that sits between the skin and the stoma or ileostomy bag. It is used with a reusable rechargeable transmitter that connects to a smart phone via Bluetooth® to give an audible alarm. A stakeholder engagement meeting was held In July, and it was felt that it was more important to address the cause of the leaking stoma or ileostomy i.e. review the product being used due to the risk of skin damage rather than managing leaks via an alert. The proposal to designate Heylo leak as a DNP (Do Not Prescribe) product was agreed by the group. *Cost impact of decision:* Cost avoidance of the potential cost pressure estimated to be at least £167k per annum. • **Adult ADHD shared care and transfer of care agreement – ELFT.** This SCG has been updated using the BLMK shared care template. Changes include the addition of the Psychiatry UK details, inclusion of guanfacine, information on CAMHS transition and continuing of medication, contact details for adult ADHD services and additional information about dexamfetamine in contraindications/cautions, pregnancy, and breastfeeding. There is advice on the need to inform the DVLA if a patient's condition/medication could affect their ability to drive. This agreement only covers Luton and Bedfordshire patients under the care of East London Foundation Trust. The updated SCG was approved with some amendments agreed at the meeting. *Cost impact of decision:* N/A. • **Aymes ActaGain Protein Shot.** This is a new high protein product for oral and tube fed patients. It is phosphate free and low in electrolytes, with all the essential amino acids. High protein products are recommended in patients with pressure and surgical wounds that are not healing to improve skin integrity and prevent breakdown. Supplementation can therefore have the potential for reducing appointments required with district nurses/TVNs. Some patients on enteral feeding may require a lower calorie, higher protein product. However, Aymes ActaGain Protein Shot is not nutritionally complete. The most cost-effective protein product (Protifar) is	

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	milk based. ProSource and ActaGain Protein are an alternative being lactose (and gluten) free. The proposal to add Aymes ActaGain Protein to the formularies as SpA was approved as a second line, dietitian only recommended product for patients requiring protein supplementation via oral or enteral routes if Protifar is not appropriate. Dietitians were requested to order in multiples of 15 and Optimise Rx messaging to be used to support prescribers with this. *Cost impact of decision:* The potential saving if all patients were switched from ProSource could be £32,414 per annum. • **Combination antidiabetic tablets.** Fixed-dose combination oral antidiabetic medicines offer a convenient alternative to simplify administration. Reducing pill burden may support adherence to treatment although there is currently no evidence to support this. The combination tablets can be larger and more difficult to swallow. Patients may be confused about which medicine to stop due to sick day rules and two medicines for diabetes would be stopped when only one is required. Increased adverse drug events may be experienced i.e., from the use of standard release metformin instead of modified release. Some doses may be split when used in combination preparations, when the single components could have been prescribed once daily. Medication recognition may be more difficult and there may be a greater risk of picking errors with combination descriptors. Titrating doses is made more difficult when having to account for the two different drugs in the preparation. It was noted that current prescribing was low, and specialists do not use the combination products. The group agreed to designate the combination preparations non-formulary. *Cost impact of decision:* no impact. • **Latanoprost 50mcg/ml preservative free eye drops (multi-dose bottle; Lotacryn®).** Lotacryn, is cheaper than the current brand leader Monopost preservative free formulation and can significantly reduce CO2. It is presented in a multi-dose bottle rather than single use unit dose vials (UDVs). Alignment of the formularies is required as latanoprost 50mcg/ml single-use drops are on MKF (as SpA) but not on the B&LF. Lotacryn is a sterile solution with no preservatives, however the buffering system does contain phosphate-based substances. Patients unsuitable to switch could still access UDVs if clinically appropriate. The proposal to add Lotacryn multi-dose bottles to the formularies as SpA, first line option when a preservative free formulation is required in preference to UDVs was agreed. *Cost impact of decision*: There is a potential annual cost saving of £14,631 and CO2 saving of 823 kg if using Lotacryn instead of Monoprost. • **Biosimilar ustekinumab.** Ustekinumab is on the local formularies and in use in line with NICE TA recommendations (TA180, 340, 456 and 633) and local agreement / pathways.	

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	The originator brand, Stelara®, lost its patent exclusivity on 19th July 2024, after which biosimilar versions of ustekinumab have been marketed in the UK. At launch, ustekinumab biosimilars are not licensed for ulcerative colitis. A national procurement process has been undertaken for the currently available biosimilars and made available for use within the NHS. The framework commenced on 1st September 2024. Local trusts have selected products appropriate for their needs from the national framework and the proposal to add the Pyzchiva and Wezenla biosimilars to the formularies was approved. *Cost impact of decision:* With an estimated 45-50% uptake within the 2024/25 financial year, savings of up to £1.3m would be generated within the ICS. • **Additional recommendations / items noted by the subgroup:** ○ Newly licensed mexiletine 50mg, 100mg and 200mg capsules have been added to the formulary for the treatment of ventricular arrhythmias as Red drugs for specialist prescribing only. ○ Rivaroxaban has moved to category M in the drug tariff, and this may have an impact on the DOAC position. ○ The following medicines have been de-branded and OptimiseRx and formulary messaging has been amended accordingly: alogliptin (Vipidia® name removed – patent still in place), sulfasalazine (Salazopyrin® name has been removed – now generic), lidocaine patches (Ralvo® name removed – now generic). **Decision:** The committee ratified the recommendations of the Formulary Subgroup.	
9.2	**Wound Management Formulary Steering Group Recommendations** A report from the wound management subgroup (WMFSG) meetings held in July and September 2024 was presented to the Committee: • **Financial:** No concerns • **Online formulary:** ○ MK Community/Practice Nurses formulary reviewed by TVNs from CNWL and published to coincide with the changes to the ordering process in MK. ○ The online formulary is being transferred from Microguide to Eolas Medical – more functionality, easier access to local guidelines as well as other resources. A mobile app also available, with offline functionality. Comms will be sent out when the Eolas platform is ready to go live. It will be freely accessible online. • **Procurement of dressings:** ○ Switched to NHSSC from NWOS in MK Practices & Nursing homes in July. ○ The ordering platform for procurement of dressings in B&L will transfer to ONPOS, in line with MK Practice	

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	Nurses & Nursing Homes. Fulfilment of orders will continue to be provided by NHSSC. ○ All BLMK Practice Nurses aware they can have an NHSSC account for direct procurement of formulary dressings. • **Waste reduction in Wound care:** A project to reduce overordering of dressings in patients' homes has been accepted as a QI project and has been started by ELFT. • **Terms of Reference for the Wound Management Formulary Steering Subgroup** updated, amendments made: ○ "Medicines Management" has been amended to "Medicines Optimisation". ○ The note regarding electronic Wound Management Formulary has been amended to include MK as well. The WMFSG also recommended **UrgoK2 reduced compression bandages** for addition to the wound management formulary. Items requested for addition are: • UrgoKTwo Latex Free, 2 layer compression kit Reduced Compression, 18-25cm ankle circumference (10cm bandages). • UrgoKTwo Latex Free, 2 layer compression kit Reduced Compression, 25-32cm ankle circumference (10cm bandages) UrgoK2 is a reduced compression system which is not available with the current system (Actico, currently on the formulary, is a single layer bandage), which offers the following benefits: • A multi-component bandage system shown to be more effective than single component systems. • Ensures safe consistent compression – in line with national wound strategy care programme. • Clinical benefits with UrgoK2: latex free, ease of application, better adherence of the dressing to the wound, lower incidence of dressing failure, improved healing rate, reduced number of dressings needed per patient, and reduced number of clinic visits per patient. • Potential cost impact currently unknown and difficult to quantify, as patient cohort is anticipated to be very small, and savings are not predictable as yet. • Offset costs anticipated: Reduced number of dressings needed and reduced number of clinic visits per patient. It was noted that there are likely to be more proposals coming through for amendments to the wound care formulary which have a focus on reduced numbers of dressings required, and reduced clinic / nursing time. The wound care group are looking closely at sustainability considerations in the management of wounds. **Decision:** The Committee ratified the recommendations of the Wound Management Steering group, including the update to the	

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	Terms of Reference and the addition of UrgoK2 to the wound care formulary.	
10.	**Patient Group Direction Subgroup Recommendations** The following recommendations were made by the Patient Group Direction (PGD) subgroup:	
10.1	**Milton Keynes Urgent Care Patient Group Directions** The following PGDs were presented for approval with clinical changes: • **Dalteparin** for patients weighing <99kg awaiting diagnostic confirmation of DVT – amendments made to the following sections: exclusion criteria; storage; instructions to patients; and Identifying & Managing Potential Adverse Outcomes. • **Salbutamol for children aged 1-2 years** – amendments made to the following sections: dose/administration; discharge / safety netting. The following PGD was presented for approval with no clinical changes: • **Hyoscine Butylbromide** 10mg tablets for relief of GI or GU smooth muscle spasm. The following PGD was presented following an update to adopt the national template: • **Revaxis** (DTP) vaccine. **Decision:** The Committee ratified the PGDs, as recommended by the PGD subgroup.	
10.2	**British Pregnancy Advisory Service (BPAS) Patient Group Directions** BPAS currently holds a commissioning relationship with BLMK ICB (Termination of Pregnancy service: 2022-2025). Following a review of their service a number of their PGDs have been archived leaving the following PGDs requiring authorisation for use at BPAS: • **Lidocaine 1% injection** to facilitate insertion and/or removal of etonorgestrel (e.g. Nexplanon) implant. • **Ceftriaxone** (reconstituted with lidocaine 1% injection) for treatment of uncomplicated Neisseria Gonorrhoeae infection. • **Etonorgestrel** (e.g. Nexplanon) subdermal implant for contraception. • Intramuscular **medroxyprogesterone acetate** injection for contraception. • Insertion of the **Progestogen-Only** Intra-Uterine Device (**levonorgestrel**). • **Azithromycin** for the treatment of uncomplicated Chlamydia trachomatis. • **Combined Hormonal Contraceptive (CHC) Vaginal Ring. Combined Hormonal Contraceptive (CHC) Transdermal Patches.** • **Combined oral hormonal contraceptive** (COC).	

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	• **Doxycycline** for the treatment of uncomplicated Chlamydia trachomatis. • **Progestogen only contraceptive pill** (POP). • **Sodium Chloride injection 0.9%** intravenous flush. All except sodium chloride flush are based on national templates and any variance from these has been accounted for. It was clarified that these PGDs will only be used specifically by BPAS in carrying out the services they are commissioned to provide. Patients are generally advised by GPs to self-refer to BPAS when their services are required. **Decision:** The Committee ratified the PGDs, as recommended by the PGD subgroup.	
11.	**Antimicrobial Resistance Update** The antimicrobial resistance update highlighted the following key points. Primary care: • Work which has been done on the antimicrobial formulary is starting to show some improvement in the prescribing of 5 day courses of amoxicillin, although it remains below the national target of 75%. • There is still work to be done on the prescribing of antimicrobials in children and this will be an area of regional focus in the coming year. Secondary care: • The percentage of antibiotics prescribed as IV remains above the national average in both local trusts, but MKUH is closer to the average than BHFT. • Use of quinolones remains higher than target in both trusts. BHFT have lower usage than MKUH. The Committee noted the antimicrobial stewardship update.	
All other papers (from this point in the agenda) are for noting/information by the Committee		
12.	**East of England Priorities Advisory Committee (EoEPAC) – items for noting**	
12.1	EoEPAC Meeting Notes – May 2024 The committee noted the minutes for information.	
13.	**Bedfordshire, Luton and Milton Keynes Local Prescribing Committee Minutes.** The Committee noted the following minutes for information.	
13.1	Minutes of the Bedfordshire Hospitals Foundation Trust Drug and Therapeutics Committee (DTC) – *none available*	
13.2	Minutes of the Milton Keynes Hospital Prescribing & Medicines Governance Committee (PMGC) – *none available*	

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13.3	Minutes of the BLMK Formulary Subgroup – June 2024	
13.4	Minutes of the BLMK Wound Management Formulary Steering Group – May 2024	
13.5	Minutes of the BLMK Medicines Safety Group – April 2024	
13.6	Minutes of the ELFT Medicines Management Committee – July 2024	
13.7	Minutes of the Cambridgeshire Community Services Medication Safety and Governance Group – July 2024	
13.8	Minutes of the CNWL Trustwide Medicines Optimisation Group (MOG) – *none available*	
13.9	Minutes of Circle/MSK Medicines Management Committee – *none available*	
14.	**Any other business** The MHRA have recently updated their 'aide-memoire table' on "Pregnancy testing and contraception for pregnancy prevention during treatment with medicines of teratogenic potential". It was proposed and agreed that a link to the aide-memoire table would be added to the BLMK contraception guidance, for information.	
15.	**Future Dates for BLMK APC 2024 Meetings (all to be held from 12:30-15:00 via Microsoft Teams):** Wednesday 4th December 2024 Wednesday 26th February 2025 Wednesday 7th May 2025 Wednesday 2nd July 2025 Wednesday 24th September 2025 Wednesday 3rd December 2025	

Approval of minutes:

Chair: Dr Muhammad Nisar

Signed: 

Date: 5 Dec 2024

Appendix 1 – Approved 03 September 2024 Formulary Subgroup Minutes:

BLMK Formulary subgroup Minutes Se|