BEDFORDSHIRE, LUTON AND MILTON KEYNES AREA PRESCRIBING COMMITTEE

Meeting Notes

Date: 04 December 2024
Time: 12.30- 3.00pm
Venue: Microsoft Teams

Attendees:

Name	Initials	Role
Dr Muhammad Nisar	MN	Chair (Medical Representative, Bedfordshire Hospitals NHS Trust)
Pritesh Bodalia	PB	Bedfordshire Hospitals Trust Pharmacy Representative (Chief Pharmacist, Bedfordshire Hospitals Trust)
Dr Marian Chan	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)
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
Emma Hooton	EH	Practice Pharmacist Representative (Independent Prescriber)
Amjid Hussain (until 13:14)	AH	ELFT Pharmacy Representative – Community Services (Beds)/Mental Health Services (Beds and Luton)
Dr Kate Randall (from 12:51)	KR	Place Based Lead GP – Central Bedfordshire
Dr Mitan Sarkar	MS	Place Based Lead GP - Luton
Dr Jenny Wilson	JW	Place Based Lead GP - Bedford
Dona Wingfield (from 12:38-13:38)	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

In attendance:		
Rafal Ali	RA	Commissioning Pharmacist, BLMK ICB
Kelly Pritchard (until 13:24)	KP	ELFT Pharmacy Representative – Community Services (Beds)/Mental Health Services (Beds and Luton)
Samina Hassanali	SH	Formulary & Medicines Safety Pharmacist, BLMK ICB
Sandra McGroarty	SMcG	Commissioning Pharmacist, BLMK ICB
Dr Joy Mutitika	JM	Medical Representative, Keech Hospice
Takudzwa Shumba	TS	CNWL Pharmacy Representative (Prison Services - HMP Bedford and YarlsWood IRC)
Nikki Woodhall	NW	Lead Medicines Optimisation Technician, BLMK ICB
Lauren Ramm (in attendance for agenda item 5.1)	LR	Antimicrobial Pharmacist, MKUH
Dr Prithwiraj Chakrabarti (in attendance for agenda item 5.1)	PC	Consultant microbiologist, MKUH
Dr Rabinder Randhawa (in attendance for agenda item 5.1)	RR	Respiratory consultant, MKUH
Iffah Salim (in attendance for agenda item 5.2)	IS	Advanced clinical practice CAMHS Pharmacist, ELFT
Aberdeen Young (in attendance for agenda item 5.4)	AY	Paediatric Pharmacist, BHFT
Katy Savage (in attendance for agenda item 5.5)	KS	Lead Dietitian for Food First & Prescribing Support, CNWL
Lisa De'Ath (in attendance for agenda item 5.6)	LDA	Highly Specialist Dietitian - Paediatric Team Lead, CCS

Apologies:		
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)
Dorothy Aladejobi	DA	Pharmacist Representative, NHS Northampton Hospital Foundation Trust Secure Services
Dr Dush Mital	DM	Medical Representative, Milton Keynes Hospital

Helen Smith	HS	Milton Keynes Hospital Pharmacy Representative (Chief Pharmacist, Milton Keynes Hospital)
Dr Jonathon Walter	JWa	Place Based Lead GP – Milton Keynes

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. All members confirmed they have no declarations in relation to matters on the agenda.	
3.	**Minutes of 25 September 2024 APC meeting** The minutes of the meeting held on 25 September 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 06/11/24** - this has been delayed due to other priorities. This is an ongoing action and is planned for consideration at the February 2025 meeting.	SMcG
4.1.2	**Daridorexant prescribing support information** Signposting information to the nationally commissioned digital CBTi offering to be added once available. **Update 02/12/24** – a decision has recently been reached by NHS England that they will not fund national access to digitally delivered CBTi in England at this time. Access to locally commissioned CBTi services, via Talking Therapies, remains unchanged. It was proposed and agreed that this action could be closed.	Close
4.1.3	**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).	Close

No	Agenda Item	Action
	Update 06/11/24 – all formulary updates have been actioned. It was proposed and agreed that this action could be closed.	
4.1.4	**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
4.1.5	**Bimekizumab first line for Ankylosing Spondylitis and non-radiographic axial spondyloarthritis** - further work to be undertaken to develop the case to support these requests. **Update 19/11/24** – this is an ongoing action with further assessment being undertaken at BHFT. Further analysis of the data is being undertaken to determine whether the information on Ankylosing Spondylitis and non-radiographic axial spondyloarthritis can be split.	MC/MN
4.1.6	**Azathioprine Rheumatology fact sheet** - fact sheet to be updated to amend the wording in relation to Macrophage activation syndrome (MAS), to remove the requirement to monitor ESR/CRP and the statement that a maximum of 4 weeks' supply should be issued (quantity of supply to be determined by individual practice policy; wording to be amended in each fact sheet / SCG when next updated). **Update 06/11/24** – the document has been updated and uploaded to the Medicines website. It was proposed and agreed that this action could be closed.	Close
4.1.7	**NICE guidance update / formulary status of medicines** - the following NICE approved medicines to be added to both formularies, with agreed traffic light status: linzagolix (SpA; NICE TA996), relugolix (SpA; NICE TA995) and vibegron (green; NICE TA999). Update 06/11/24 – the formulary updates have been actioned. It was proposed and agreed that this action could be closed.	Close
5.	**Items for consideration at meeting**	
5.1	**Nebulised antibiotics for non-CF bronchiectasis / nebulised gentamicin SCG** <u>Nebulised gentamicin shared care guideline</u> The Committee considered a request for the introduction of a shared care guideline for nebulised gentamicin for long-term prophylaxis of chronic lung infection in non-Cystic Fibrosis (CF) bronchiectasis. Targeted nebulised delivery of gentamicin using the injection solution is an option for patients with non-CF bronchiectasis. Currently the formulary lists the injection solution as Red. However, this can be long-term therapy and therefore the proposal was brought to APC for consideration to allow patients to have the gentamicin prescribed in primary care. There are shared care protocols in use elsewhere, including Cambridgeshire and Peterborough ICS. Treatment with nebulised antibiotics has been shown to reduce the number of admissions to hospital and reduce the sputum bacterial density with 30.8% eradication of Pseudomonas aeruginosa. It is anticipated that	

No	Agenda Item	Action
	initiating nebulised gentamicin will result in a cost saving across the ICS due to less frequent hospital admissions and potential reduction of systemic antimicrobial treatment in the community or via the outpatient parenteral antibiotic treatment (OPAT) service at MKUH. The following key points were noted: • Gentamicin is nebulised at a dose of 80mg bd or 160mg once or twice daily using the 80mg/2ml injection solution. This is an off-label use of the product. • Nebulised gentamicin is a recommended treatment option specified in the British Thoracic Society Non-CF bronchiectasis guidelines. • Gentamicin was chosen specifically due to low resistance rates of Pseudomonas aeruginosa in the local area. • The first dose would be administered within secondary care, and pre and post lung function tests performed to ensure the patient experienced no adverse effects. The patient would also be educated by secondary care staff on the use of the nebuliser machine and supplied with the patient information leaflet outlining maintenance and care of the nebuliser. • Secondary care to provide the first month's supply including needles and syringes. • Secondary care to determine the need for, and dose of, salbutamol nebules and communicate this to primary care. • Bloods are required at baseline and as guided by the patient's renal function, usually every 3 months. • Patients with impaired renal function (GFR <45 ml/min/1.73m2) to remain under the care of the specialists. • Patients require a review of benefit at 3 months and then at least every 6-12 months whilst receiving treatment. • All efficacy monitoring to be carried out by secondary care, usually every 6 months. • Renal function and routine U&Es to be carried usually every 3 months. There was further discussion at the meeting regarding whether this should be carried out in primary or secondary care. Secondary care representatives indicated this could be carried out in secondary care when the patient attends to review ongoing treatment benefits. The shared care document currently states that this would be carried out in primary care. • There is limited systemic absorption therefore no anticipated interactions or side effects of systemic absorption expected. A gentamicin level will be taken in secondary care following the test dose to confirm this. • Cost per patient per year, 80mg bd dose = £1004.48 (+£240 per year for sodium chloride 0.9%); Cost per patient per year, 160mg bd dose = £2008.96. It is estimated that 4-5 patients per month would be initiated on nebulised gentamicin by the respiratory team, leading to an annual cost of approximately	

No	Agenda Item	Action
	(for 40 patients, assuming not all patients are on treatment for the full year): 80mg bd dose - £49,779.20; up to £80,358.40 for the 160mg bd dose. Additional considerations which were discussed at the meeting: • Concerns have been raised by primary care clinicians within MK regarding the SCG and members of the Primary Care Prescribing Committee have stated that they do not support the SCG as it involves the off-label use of a medicine in a specialist area. • Delays in hospital correspondence may result in the GP not having received relevant information from the hospital when a new prescription is required. It was discussed that there can be delays in the communication, but that the hospital would retain prescribing until they have received confirmation that the GP practice is willing to take on prescribing. • Although the request for shared care is new, this is not a new treatment – it has been used within Beds/Luton (NB: hospital retain prescribing) for a number of years, and the respiratory team at MKUH have seen no safety issues or concerns when using the treatment in the past. There is currently a cohort of patients under the care of MKUH, most of whom were commenced at the Royal Brompton Hospital. • There is a significantly lower likelihood of the patient experiencing adverse effects when using nebulised gentamicin (in comparison with IV gentamicin). • The secondary care team monitor the patient, including spirometry to monitor lung function. • The secondary care team educate the patient on the use of the nebuliser machine and how to care for it. • The recommended 3-monthly monitoring of renal function is primarily for assurance that the patient's renal function is not deteriorating. Adverse effects, including ototoxicity, are not anticipated due to minimal systemic absorption. • Responsibility for 3-monthly monitoring of U&Es to be confirmed – likely need to alter SCG wording to indicate that this will be carried out within secondary care. • If the request to monitor remains with primary care, this would need to be considered for inclusion in the Primary Care Framework to provide funding for practices for the work being undertaken. • A query was raised around the timing of commencement of shared care – does it need to be at one month if the patient will be seen at the hospital at 3 months. Asking for commencement of shared care after 3 months may be more appropriate. • Purchase and servicing of nebuliser equipment – patients are asked to purchase their own equipment and arrange servicing. A potential equity issue was highlighted if a patient could not afford to do so, and it was confirmed that there are charitable options which could be pursued in this scenario. • Supply of needles/syringes – it is not possible to supply needles and syringes on FP10 prescription (they are not in	LR MD LR

No	Agenda Item	Action
	the drug tariff) and practices are unlikely to be willing to provide these from their own stock. Communication with Cambridge & Peterborough ICB confirmed that the hospital supplies them in their area (gentamicin SCG already approved for use within the ICS). This issue will need to be resolved before approval of the SCG could be considered. • Work done within the Sheffield area in the past was shared with the Committee. This used 120mg bd dosing of gentamicin and avoided the need for needles and syringes to be provided as the gentamicin liquid could then just be poured into the nebuliser chamber. Sharps boxes would still be required for the disposal of the gentamicin ampoules. **Decision**: the shared care guideline was not approved. Further discussion is required to address the issues raised and to allow more time for engagement with primary care. <u>Nebulised antibiotics for non-CF bronchiectasis guidance</u> In September 2020, the Bedfordshire & Luton Joint Prescribing Committee (JPC) approved a commissioning agreement for the use of nebulised antibiotics as prophylaxis to prevent acute exacerbations in patients with non-cystic fibrosis bronchiectasis. Clinicians at MKUH were also consulted during the development of the recommendations in 2020, but it is unclear if they were ratified for use. The guidance agreed was based upon the BTS guidelines for the management of non-CF bronchiectasis, NICE NG117: Bronchiectasis (non-cystic fibrosis), acute exacerbation: antimicrobial prescribing, and input from local specialists. Following the receipt of the above request from MKUH to introduce a shared care guideline for nebulised gentamicin in this patient cohort, the recommendations have been reviewed and updated. The primary changes in the recommendations are: • Nebulised gentamicin moved from a second line to joint first line, with the decision on which treatment to be used to be made by the specialist. The BTS guidelines recommend use of nebulised gentamicin as a second line choice after colistimethate sodium, however local specialists (MKUH) have highlighted the following: ○ *"We (and most other microbiology lab) don't have facility to test colistin sensitivity routinely on pseudomonas isolates. However aminoglycoside sensitivity is 95% in our pseudomonas isolates at MKUH. The choice of nebulised antibiotics at the starting point (colistin vs Gent) lies on respiratory physicians."* • Respiratory specialists at BHFT have confirmed that they are happy to have colistimethate and gentamicin as joint first line options in the guidance but have indicated that in their practice colistimethate is likely to remain first line. • Change of formulary status for colistimethate and gentamicin:	LR/AG/ MD

No	Agenda Item	Action
	○ Nebulised Colistimethate: Amber SpIS (it is noted that there is no dose adjustment/ titration is required; however the test dose and initial supply must be made by the specialist) – proposal to add additional explanatory text to the formularies and to OptimiseRx to state "No dose titration necessary. The specialists will undertake the test dose and provide first month supply". ○ Nebulised gentamicin: Amber SCG – this is dependent on the proposed SCG approved and the publication of the updated document will be held until this has been confirmed. • Rearranging and updating of the document layout. • Addition of references. **Decision**: The updated nebulised antibiotics guidance document was approved, with the exception of the information in relation to gentamicin formulary status. This is subject to amendment depending on the outcome of the discussions around the gentamicin shared care guideline. **EQIA Assessment:** Nebulised gentamicin SCG: No impact on patients with protected characteristics vs whole population. Already in use for the appropriate patient group via secondary care. However, a positive impact would be expected for all patients – it will increase access to the treatment within the community under the shared care protocol so aims to reduce potential health inequalities. Nebulised antibiotics in non-CF bronchiectasis guidance: Positive impact if the shared care guidelines are approved – allowing care closer to home for those being treated with gentamicin. **BLMK ICB E and D Lead comment:** Nebulised gentamicin SCG Suggestion from my understanding if you agree: Positive impact – it will increase access to the treatment within the community under the shared care protocol so aims to reduce potential health inequalities. As per nebulised antibiotics assessment. (NB: this has been addressed above). Nebulised antibiotics in non-CF bronchiectasis guidance: No further comments from an equality perspective.	AG
5.2	**Melatonin Prescribing Support Information – Children & Young People** At the November 2024 Formulary Subgroup meeting, it was discussed and agreed that the existing Bedfordshire/Luton melatonin shared care guideline for use in children and young people could be retired. The formulary status discussed and agreed at the Formulary Subgroup is Amber SpIS. This will ensure that the patient has been initiated and stabilised on melatonin prior to prescribing being transferred to primary care.	

No	Agenda Item	Action
	When the melatonin SCG was originally agreed, all products in use were off-label or unlicensed. With recent licensing of a range of melatonin products, any risks for the patient and prescriber have been reduced. Additionally, there is no specific monitoring that is required for patients on melatonin by primary care other than checking continued benefit (usually via a sleep diary). A prescribing support document has therefore been produced to provide additional information for practices when prescribing melatonin for children and young people. This will replace the existing shared care guideline. Specialists are also requesting confirmation that care can be transferred to the GP once the patient is stable or after review at 6-months or after 12-months – the preference from the specialists is for discharge after 6-months. This would apply only if the patient was remaining under the specialist service solely because of the melatonin and not if there are other clinical reasons why the patient needs the care and support of the specialist team. At any point, practices may refer back to the specialist service for additional support and advice. The Committee agreed that discharge of stable patients after 6-months is acceptable, and the document should be updated accordingly. **Decision**: The melatonin prescribing support document was approved, with the period prior to discharge to be amended to 6-months, as agreed at the meeting. **EQIA Assessment:** No impact on patients / families anticipated as the care pathway will be similar. **BLMK ICB E and D Lead comment:** No further comments from an equality perspective.	AG
5.3	**Proton pump inhibitors – use in children & young people** The item was deferred to a future meeting.	
5.4	**Potassium liquid formulary choices** Kay-Cee-L syrup is currently the only licensed potassium chloride oral solution available. It is licensed and routinely used for the treatment of hypokalaemia and potassium deficiency of renal or extrarenal origin. Local trusts have indicated that it is used in paediatrics more than adult patients. An NPSA safety alert was issued on 26th July 2024 to highlight a shortage of Kay-Cee-L syrup and changes were implemented to reduce use of potassium chloride oral solution, which included the use Sando-K tablets. A further NPSA safety alert was issued on 28th October 2024 highlighting the discontinuation of Kay-Cee-L Syrup. As there are no remaining licensed oral liquid potassium chloride products, and with a continued need for oral liquid potassium, an unlicensed product is required for use in place of Kay-Cee-L syrup.	

No	Agenda Item	Action

	The current BLMK formulary states Kay-Cee-L syrup as the product of choice. This Committee considered an amendment to the formulary to include unlicensed potassium chloride 1 mmol/mL oral solution.
	
	In line with a memo produced by BHFT on 28th October, the APC was asked to consider the restrictions for potassium chloride oral solution as follows:
	
	• Do not initiate new patients on Kay Cee L® Syrup.
	• Review all patients currently prescribed Kay Cee L® Syrup to establish if potassium supplementation is still required and switch to an alternative treatment, if considered necessary, ensuring no intolerance of excipients.
	• For patients requiring doses LESS THAN 12 mmol per dose:
	  ○ Use the remaining supplies of Kay Cee L® Syrup. Once Kay Cee L syrup stocks are depleted, use the unlicensed potassium 1 mmol/mL oral solution.
	• For patients requiring doses equal to or greater than 12 mmol, and where the dose can be rounded to a whole Sando K® tablet, use Sando K® tablets. Each Sando K® tablet contains 12 mmol of potassium.
	• Unlicensed potassium chloride solution to be used for neonatal and paediatric patients requiring doses less than 12 mmol, or where the dose cannot be rounded to a whole Sando K® tablet. The unlicensed preparation should only be used in adult patients where Sando-K is not clinically appropriate or tolerated.
	
	Specialist paediatric pharmacists have reviewed the unlicensed potassium 1 mmol/mL oral solutions currently available for excipients, their suitability for use in neonatal and paediatric patients, shelf life and cost. This identified the Mandeville Medicines product as the most appropriate for the following reasons:
	• Contains only potassium chloride and water for injection BP.
	  ○ Appropriate for paediatric and neonatal patients in terms of excipients.
	• Shelf-life of 48 months.
	• 100mL bottle expires 7 days after opening.
	• Cost effective option compared to other products.
	
	Within the hospital environment it is possible to select a single supplier, however challenges are present within primary care:
	• SystmOne does not show any specific manufacturers, therefore it would be necessary to free type the supplier in either the dosage instruction or as a script note.
	• Community pharmacies do not have the same access to procurement that hospitals have.
	• Every pharmacy has different wholesalers/specials suppliers they purchase from and are unlikely to open accounts with other specials suppliers for one item.	

No	Agenda Item	Action
	It was therefore proposed that potassium chloride oral solution 1mmol/ml should become Red on the formularies, restricted to use for neonatal and paediatric patients (0-17 years) on a dose <12 mmol or doses that cannot be rounded up to a full Sando-K tablet (containing 12 mmol potassium). Patients on Kay Cee L syrup/unlicensed potassium oral solution should be reviewed, and switches initiated to Sando-K tablets where appropriate to reduce the cost pressures and governance issues associated with unlicensed products. There is a cost pressure associated with use of the unlicensed liquid solution: Based on the current primary care usage of Kay Cee L syrup bottles per financial year, the cost for unlicensed potassium liquid in primary care could be: £4380 per financial year (increased from £907) if volumes of use remain unchanged. **Decision**: The Committee approved the addition of unlicensed potassium chloride 1mmol/ml oral solution to the formularies with Red formulary status. Use to be restricted to prescribing in neonates and children aged 0-17 years on a dose <12 mmol or doses that cannot be rounded up to a full Sando-K tablet (containing 12 mmol potassium). **EQIA Assessment:** No impact anticipated as suitable patients will still have access to treatment. Use of unlicensed solution applies to neonatal and paediatric patients only as first line when doses <12 mmol or doses that cannot be rounded up to a full Sando-K tablet (containing 12 mmol potassium). Adult patient's first line product is Sando-K tablets. Where these are not clinically appropriate or not tolerated, then adult patients can use the unlicensed preparation. To remain non-formulary for adults as patient numbers are likely to be low. **BLMK ICB E and D Lead comment:** N/A	SH/JC
5.5	**BLMK Adult Oral Nutritional Supplement Prescribing Guidelines** The Committee considered a review and update of the existing BLMK Adult Oral Nutritional Supplement (ONS) Prescribing Guidelines, which were approved in September 2022. Dietitians have undertaken a comprehensive review of the guidance, and the products recommended. This considered issues such as nutritional content, cost-effectiveness, availability of products and flavours, patient feedback and sustainability. In addition, the following have also been updated: • Food First service provision information has been updated to reflect that this is now available in Milton Keynes, and the areas covered by each team in Luton and Bedfordshire. • Prescribing 'Top Tips' updated to include information on how frequently ONS prescriptions should be reviewed (every 3-6 months, in accordance with NICE guidelines), and to encourage care when selecting products for prescribing as several products have similar sounding names.	

No	Agenda Item	Action
	Work is being undertaken between the ICB Medicines Optimisation team and the dietitians to ensure that appropriate OptimiseRx messages will pop up when prescribing, which will support the implementation of the updated recommendations. The Committee discussed the duration of treatment with ONS, and a request was made that this is clearly communicated on discharge from hospital. It was advised that there is a field on TTAs where dietitians can add their contribution and recommendations and duration of treatment can be included there. The ONS available via the hospital contract are not the most cost effective in the community and therefore switches are required on discharge. A query was raised regarding placing powdered ONS as the first line choice above ready made ONS. It was clarified that the powdered ONS products are more nutritionally complete than their ready made counterparts, as well as being more cost-effective, and therefore the preferred choice. **Decision**: The Committee approved the updated Adult Oral Nutritional Supplement guidelines. **EQIA Assessment:** Options available for all people no matter their physiological or belief requirements. Accessibility to ONS has not changed since the last recommendations. We have improved access to milk-free/vegan options though by the introduction of Fortisip PlantBased. **BLMK ICB E and D Lead comment:** As the recommendations from this guideline will be used in people who may amongst be the most vulnerable in our community (as outlined in section 3), I would suggest including whether access to ONS has been improved or reduced just to clarify. (NB: additional information has been added to the assessment – see above).	
5.6	**BLMK Infant formulae prescribing guidelines** The Committee considered a review and update of the existing BLMK Specialist Infant Formula Prescribing Guidelines, which were approved in September 2022. Specialist paediatric dietitians have undertaken a comprehensive review of the guidance, and the products recommended. This considered issues such as constituent make up of the different formulae, clinical considerations, cost and availability of products. The updates included the following aspects: • Available formulae for first line extensively hydrolysed formula updated. Separated whey based and casein based to emphasise whey based used first line due to cost. • Created a 'first line; amino acid-based formula to reflect significant price difference. • Section on gastro-oesophageal reflux reduced to emphasise the stepped care approach. • Lactose intolerance section updated.	

No	Agenda Item	Action
	• Information included regarding the availability of soya formula over the counter – this is completely unavailable, and signposting has been included to additional information and support. **Decision**: the updated specialist infant formula guidelines were approved. **EQIA Assessment:** Positive impact: • Families eligible for income support - Products recommended for use over the counter can be purchased using the Healthy Start Scheme card if the formula is 'suitable from birth'. All of the over-the-counter products listed are suitable from birth. • Products have been denoted halal approved or suitable for vegetarians. No formula is suitable for vegans. • Children suffering with galactosemia (a rare metabolic condition where you cannot breakdown galactose) will require a lactose-free formula. They cannot breastfeed as an alternative. Families who do not qualify for the Healthy Start scheme and are on a low income may find paying for formula difficult. Some local communities are more at risk of this condition i.e. Traveller community. **BLMK ICB E and D Lead comment:** No further comments from an equality perspective.	
6.0	**NICE Guidance – from 12 September until 20 November 2024** **The following NICE Technology Appraisal Guidance (ICB Commissioned) have been published:** • **Empagliflozin for treating type 2 diabetes in people 10 to 17 years (terminated appraisal)** Technology appraisal Reference number: TA1006 Published: 12 September 2024 https://www.nice.org.uk/guidance/ta1006 **Resource impact:** N/A **APC actions:** link added to formularies (TERMINATED APPRAISAL) • **Latanoprost–netarsudil for previously treated primary open-angle glaucoma or ocular hypertension** Technology appraisal guidance Reference number: TA1009 Published: 02 October 2024 https://www.nice.org.uk/guidance/ta1009 **Resource impact:** NICE expect the resource 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 there are a number of options available. **APC actions:** formulary entries to be updated (SpA traffic light)	

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

Acute kidney injury: prevention, detection and management NICE guideline [NG148] Published: 18 December 2019 Last updated: 16 October 2024 https://www.nice.org.uk/guidance/ng148
This guideline covers preventing, detecting and managing acute kidney injury in children, young people and adults. It aims to improve assessment and detection by non-specialists, and specifies when people should be referred to specialist services. This will improve early recognition and treatment, and reduce the risk of complications in people with acute kidney injury.
APC actions: none required.

Menopause: identification and management NICE guideline [NG23] Published: 12 November 2015 Last updated: 07 November 2024 https://www.nice.org.uk/guidance/ng23
This guideline covers identifying and managing menopause, including in people with premature ovarian insufficiency. It aims to improve the consistency of support and information provided to people experiencing menopause. **Last reviewed:** 7 November 2024
APC actions: none at present. Medicines' recommendations in the update are already reflected in the BLMK formularies.

It was noted that, alongside the updated menopause guideline, NICE has published a useful discussion aid for healthcare professionals and patients (see https://www.nice.org.uk/guidance/ng23/resources/incidence-of-medical-conditions-with-and-without-hrt-a-discussion-aid-pdf-13553199901).

Endometriosis: diagnosis and management NICE guideline [NG73] Published: 06 September 2017 Last updated: 11 November 2024 https://www.nice.org.uk/guidance/ng73
This guideline covers diagnosing and managing endometriosis, including where fertility is a priority. It aims to raise awareness of endometriosis symptoms, and to provide clear advice on referral, diagnosis and the range of treatments available. **Last reviewed:** 11 November 2024
APC actions: none required.

The following NICE TAs are the commissioning responsibility of NHSE and are listed for information only:

Rucaparib for maintenance treatment of relapsed platinum-sensitive ovarian, fallopian tube or peritoneal cancer Technology appraisal guidance Reference number: TA1007 Published: 17 September 2024 https://www.nice.org.uk/guidance/ta1007
APC actions: link added to formularies (NB: replaces TA611)

Burosumab for treating X-linked hypophosphataemia in children and young people Highly specialised technologies

	guidance Reference number: HST8 Published: 10 October 2018 Last updated: 20 September 2024 https://www.nice.org.uk/guidance/hst8 **APC actions:** none required. **Trifluridine–tipiracil with bevacizumab for treating metastatic colorectal cancer after 2 systemic treatments** Technology appraisal guidance Reference number: TA1008 Published: 25 September 2024 https://www.nice.org.uk/guidance/ta1008 **APC actions:** links added to formularies **Belzutifan for treating tumours associated with von Hippel-Lindau disease** Technology appraisal guidance Reference number: TA1011 Published: 16 October 2024 https://www.nice.org.uk/guidance/ta1011 **APC actions:** created and link added to formularies (RED traffic light) **Quizartinib for induction, consolidation and maintenance treatment of newly diagnosed FLT3-ITD-positive acute myeloid leukaemia** Technology appraisal guidance Reference number: TA1013 Published: 23 October 2024 https://www.nice.org.uk/guidance/ta1013 **APC actions:** created and link added to formularies (RED traffic light) **Danicopan with ravulizumab or eculizumab for treating paroxysmal nocturnal haemoglobinuria** Technology appraisal guidance Reference number: TA1010 Published: 23 October 2024 https://www.nice.org.uk/guidance/ta1010 **APC actions:** created and link added to formularies (RED traffic light) **Avapritinib for treating advanced systemic mastocytosis** Technology appraisal guidance Reference number: TA1012 Published: 06 November 2024 https://www.nice.org.uk/guidance/ta1012 **APC actions:** created and link added to formularies (RED traffic light) **Teclistamab for treating relapsed and refractory multiple myeloma after 3 or more treatments** Technology appraisal guidance Reference number: TA1015 Published: 13 November 2024 https://www.nice.org.uk/guidance/ta1015 **APC actions:** created and link added to formularies (RED traffic light) **Alectinib for adjuvant treatment of ALK-positive non-small-cell lung cancer** Technology appraisal guidance Reference number: TA1014 Published: 13 November 2024 https://www.nice.org.uk/guidance/ta1014 **APC actions:** links added to formularies	

No	Agenda Item	Action
	Elafibranor for previously treated primary biliary cholangitis Technology appraisal guidance Reference number: TA1016 Published: 14 November 2024 https://www.nice.org.uk/guidance/ta1016 **APC actions:** created and link added to formularies (RED traffic light) **Pembrolizumab with chemotherapy before surgery (neoadjuvant) then alone after surgery (adjuvant) for treating resectable non-small-cell lung cancer** Technology appraisal guidance Reference number: TA1017 Published: 20 November 2024 https://www.nice.org.uk/guidance/ta1017 **APC actions:** links added to formularies **Fedratinib for treating disease-related splenomegaly or symptoms in myelofibrosis** Technology appraisal guidance Reference number: TA1018 Published: 20 November 2024 https://www.nice.org.uk/guidance/ta1018 **APC actions:** links added to formularies **Crovalimab for treating paroxysmal nocturnal haemoglobinuria in people 12 years and over** Technology appraisal guidance Reference number: TA1019 Published: 20 November 2024 https://www.nice.org.uk/guidance/ta1019 **APC actions:** created and link added to formularies (RED traffic light)	
7.	**Virtual Recommendations/Documents for discussion/ratification**	
7.1	**Ophthalmology Intravitreal Injections algorithm update** In September 2024, NICE issued new technology appraisal guidance on the use of faricimab for treating visual impairment caused by macular oedema after retinal vein occlusion – NICE TA1004. The existing BLMK pathway for intravitreal injections has been updated to include faricimab as an additional option for treating visual impairment caused by macular oedema after central or branch retinal vein occlusion in adults. Local specialists were consulted on the update and are in agreement with it. **Decision**: the updated pathway was approved. **EQIA Assessment:** N/A – update in accordance with NICE guidance only.	
7.2	**Contraception guidance (minor update)** Following recent license extensions. the available brands of 52mg LNG-IUDs (Mirena, Benilexa one handed and Levosert) are all now licensed for use for 8 years for the purposes of contraception. The contraception guidelines IUD section has been updated to reflect this change. In addition, Benilexa brand has been updated to include its full brand name of Benilexa one handed.	

No	Agenda Item	Action
	It was noted that the version circulated to the Committee did not include the update, agreed at September 2024 APC, to include a link to the MHRA 'aide-memoire table' on "Pregnancy testing and contraception for pregnancy prevention during treatment with medicines of teratogenic potential". The final version will include both updates (link to MHRA table and IUD licensing changes). **Decision**: the updated contraception guidance was approved. **EQIA Assessment:** N/A – minor update to reflect license changes only.	
7.3	**Paediatric asthma guideline update** The BLMK paediatric asthma guidelines were reviewed and updated, and approved, at the September 2024 APC meeting. Subsequent to this approval, it was identified that licensing changes have resulted in additional inhalers being suitable treatment options within the guideline. A minor update to the guidance was therefore made to add DuoResp Spiromax and Fobumix Easyhaler as additional AIR/MART options for 12-16 year olds. **Decision**: The Committee approved the updated paediatric asthma guidance. **EQIA Assessment:** N/A – minor update to include additional inhaler choices.	
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 (October and November 2024) and CAS alerts (September and October 2024). In particular: **GLP-1 receptor agonists: reminder of the potential side effects and to be aware of the potential for misuse (DSU, October 2024)** **Action(s) taken:** linked to formulary for information. **Insulin pumps and continuous glucose monitoring (CGM) equipment: guidance for users on reporting suspected adverse incidents and safety concerns to the MHRA's Yellow Card scheme (DSU, October 2024)** **Action(s) taken:** linked to formulary for information. This has also been shared with practices via the primary care bulletin to raise awareness. **Bromocriptine: monitor blood pressure when prescribing bromocriptine for prevention or inhibition of post-partum physiological lactation (DSU, October 2024)** **Action(s) taken:** Linked to formulary for information. Bromocriptine is non-formulary in Bedfordshire and Luton for suppression of	

No	Agenda Item	Action
	lactation due to potential adverse reactions and currently SpA in Milton Keynes, however it has been confirmed that bromocriptine is no longer used at MKUH for this indication and therefore it will be moved to non-formulary. **MedSafetyWeek November 2024: your Yellow Card report helps prevent future harm to others and improves patient safety. The ninth annual #MedSafetyWeek social media campaign took place between 4th to 10th November 2024 (DSU, November 2024)** **Actions(s) taken:** A medicines safety newsletter is planned to feature a compilation of activity for Med Safety Week by different organisations across the ICS. An entry was also included in the primary care bulletin during MedSafetyWeek to highlight the campaign and the resources available to support healthcare professionals in raising the awareness of the importance of using medicines in the right way to prevent side effects, and to report adverse effects when they do occur. **Risk of oxytocin overdose during labour and childbirth (CAS alert, September 2024)** **Action(s) taken:** Relevant to secondary care. There is an SPS article to support with this alert. Non-formulary Carbetocin is being considered locally. BHFT are looking at feasibility and querying improved outcomes when this alert is around the handling of medicines. This will be taken through MI service for reconciliation and is planned to be brought to DTC as a hospital only medicine. BHFT have just updated and aligned their labour augmentation guideline, however, the NPSA alert can be built into the guideline going forward. **Discontinuation of Kay-Cee-L ® (potassium chloride 375mg/5ml) (potassium chloride 5mmol/5ml) syrup (CAS alert, October 2024)** **Action(s) taken:** Unlicensed preparations have been available at trusts as a response to the shortages. BHFT are prioritising paediatric patients, and a list of unlicensed products has been produced by the NPPG (see also agenda item 5.4). **Shortage of Molybdenum-99/Technetium99m generators (CAS alert, October 2024)** **Action(s) taken:** For noting only – used for diagnosis, outside the scope of medication safety. Further guidance/details can be found in the SPS article in managing the shortage. **<u>Medicines Safety Group (MSG) Update</u>** <u>Valproate – system response update (see also agenda item 14.2)</u> Guidance/consensus for patients who decline contraception after a RAF has been signed has been discussed and raised for a national response.	

No	Agenda Item	Action
	Topiramate: A local audit is planned, and providers encouraged to identify patients on topiramate and check adherence to RAF and counselling. Forms are required for each condition, which is adding to the complexity in actioning the safety alert actions. Supply of diluents (e.g. WFI) for patients not on a syringe driver The routine supply of water for injection (WFI) on discharge was queried. There may be a piece of work around promoting the existing list of community pharmacies across BLMK providing end of life medicines including WFI, expanding provision as well as looking at the provision of supply via the provider. In the meantime, it has been confirmed that WFI will continue to be provided on discharge. Clozapine incidents Several recent local incidents involving clozapine were brought to the group for discussion. Issues identified include the recording of clozapine in a patient's SCR for sharing across the system, management of patients on clozapine that are admitted to hospital including the provision of supply out of hours. Actions identified from these discussions include updating a legacy Luton and Dunstable Pathway for patients admitted to hospital and using it across the BHFT sites. CNWL are in the process of reviewing and approving their own policy. The group are investigating the process of adding clozapine to the GP record and if it can be improved. Colchicine toxicity - possible drug related death There has been a recent patient death locally potentially linked to colchicine toxicity. The formularies have been updated to include the MHRA alert and an ORx message fires when prescribed or reauthorised. The SystmOne formulary includes the dose for acute gout and a quantity of twelve tablets to support prescribers. A memo will be sent to practices to raise awareness, and an application has been made to SystmOne to have the quantity of 100 tablets for the colchicine 'multlilex' default prescribing option changed. 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 November 2024 meeting: • **Apomorphine shared care guideline (SCG)**: two separate SCGs are currently available for Bedfordshire / Luton and Milton Keynes which were due for review in 2021. An alignment and update of the guidance for use across BLMK has been undertaken in consultation with stakeholders across the ICS. Agreement was reached amongst stakeholders, although it was identified that the service is not provided in the same way across BLMK. Prescribing of domperidone is required for at least 2 days prior to starting apomorphine and it has been agreed that the specialists will retain the	

No	Agenda Item	Action
	responsibility for prescribing domperidone (usually required only in the short term). The SCG was approved. *Cost impact of decision:* Payment for SCG currently under review under the primary care framework. No anticipated increase in medicines costs as this is a review and update of existing shared care guidelines. • **Review of formulary choice of standard disposable pen needles:** This review has provided an opportunity to align choice across the ICS as there is a wide variation in prescribing from our legacy CCGs and an opportunity to realise cost savings. The Forum for Injection Technique advises use of a shorter length, highest gauge needle to minimise pain on injection. NHSE guidance from 2019 recommends using needles costing less than £5/100 needles. A range of 5 different needles have been selected to mitigate against supply disruptions, all of which cost <£3/100 (GlucoRx CarePoint, GlucoRx CarePoint Ultra, GreenFine, Insupen Original, Microdot Max). They have a universal fit and compatibility with all major pens including insulin and GLP-1 analogues. Stakeholders, including DSN within the different areas of BLMK ICS, were consulted and are supportive of the choices. The recommended choices were approved by the group. *Cost impact of decision:* Cost saving • **Temazepam and nitrazepam formulary status:** the Bedfordshire/Luton (BL) and Milton Keynes (MK) formularies currently designates temazepam as green. BL designates nitrazepam as green restricted, no new initiations in Primary or Secondary care, exemption to exceptional use by Mental Health Trust. In MK, nitrazepam is green. Risks with benzodiazepines, as stated in the NICE CKS for insomnia include, falls and injury in older people due to a greater risk of becoming ataxic and confused. The longer the prescription is continued, the greater the risk of tolerance (within 3 to 14 days of continuous use) which progressively reduces their effectiveness. Dependence may develop, and treatment may serve only to prevent withdrawal symptoms. Preventing long term use avoids experiencing adverse effects (e.g. depression and increased anxiety), risk of a road traffic accidents, as benzodiazepines can impair driving performance and minimises the risk of drug interactions (e.g. with alcohol or other drugs with sedative actions). The group agreed to a change in status of temazepam and nitrazepam from green to 'do not prescribe' with existing patients to be reviewed with a discontinuation plan. *Cost impact of decision:* Cost saving, if deprescribing achieved. • **Alternative guide to prescribing 'specials' update:** Approval was sought for an update of this support tool created for practices which are prescribing specials. Recommendations are based on cost, licensing, and local formularies. This document supports the cost saving element of the PIS 24/25 and future PIS. The Formulary subgroup	

No	Agenda Item	Action
	agreed to the changes to the updated BLMK specials guidance. *Cost impact of decision:* Cost saving. • **Varenicline:** First marketed in the UK by Pfizer in 2006, varenicline (Champix) was an important stop smoking aid until 2021 when it was withdrawn after it was found to contain nitrosamine contaminants above the acceptable level. There is a NICE TA123 for varenicline. NICE has indicated that it should be a first line treatment and smokers should be routinely offered it as one of the options available to them. It should not be necessary for people to have failed to stop smoking with other medication before using varenicline. The NCSCT (National Centre for Smoking Cessation and Training) are supportive of its use. The Formulary subgroup agreed to reinstate varenicline to the formulary as green and review after NICE publishes its updated guidance (NB: an update to NG209 (Tobacco: preventing uptake, promoting quitting and treating dependence) is anticipated. *Cost impact of decision:* Comparisons of cost-effectiveness have found varenicline to be at least as cost-effective as NRT or bupropion. • **Glaucoma eye drops review:** Approval of the rationalisation of the formulary options across MK and BL has been considered with colleagues at both trusts and agreed by Mr Lobo at Bedford (Moorfields) Hospital. The recommendations from NICE Clinical Knowledge Summaries for Glaucoma were revised in February 2023 and formed the basis for the recommendations along with cost and prescribing data. The proposal was for the formulary drops to be designated as SpA. Combination drops should only be recommended if patients are unable to manage individual preparations. Levobunolol (Betagan) is recommended as non-formulary due to not being issued by MKUH in the last year (already NF on the BL formulary). The group approved the recommendations. *Cost impact of decision:* Cost saving. • **BHFT JAC merger and formulary alignment** – the Formulary subgroup approved the recommendations from a piece of work being undertaken at BHFT to merge their pharmacy (JAC) systems and ensure these are in line with the formulary where possible. The recommendations from the review were approved by the group. *Cost impact of decision:* Little if any significant impact. • **Retirement of the melatonin shared care guideline:** A shared care guideline for melatonin is in place for the treatment of Insomnia and Sleep Disorders in Children and Adolescents which is applicable for patients within the Bedfordshire & Luton area under the care of a Specialist at East of London NHS Foundation Trust (ELFT). MK formulary designation for melatonin is SpA, specialist to advise medicine prior to initiation in Primary Care. There are now several licensed melatonin products available as tablets, dispersible tablets, and a liquid formulation with licensing in	

No	Agenda Item	Action
	children and adolescents. This reduces the risk for the patient and primary care prescriber. In addition, there is no specific monitoring that is required for patients on melatonin by primary care other than checking continued benefit (usually via a sleep diary and drug holiday) at the 6-month point between the specialist annual review. The group approved the retirement of the SCG and SpIS formulary designation for melatonin prescribing in children and young people (NB: see also agenda item 5.2). *Cost impact of decision:* No impact. • The subgroup noted and approved the log of minor amendments made to the formularies in between meetings. • Items raised under 'any other business': ○ Colchicine serious incident – see Medicines Safety Group report (agenda item 8.0) ○ NovoNordisk is discontinuing Victoza brand of liraglutide. Biosimilar versions of liraglutide are becoming available and a formulary amendment request is planned for February 2025 FSG to reflect this. ○ Generic prescribing of methylphenidate: to be used in times of shortage for modified release tablet formulations only. The formularies have been updated with information around the bioequivalence of available products. ○ Access to medications for patients not registered with a GP practice: an issue was raised regarding the provision of non-HIV related medications from the sexual health clinic at MKUH for HIV positive patients, particularly for patients who do not wish to disclose their HIV status to general practice – it was confirmed that in order to access care and ongoing medications, patients must register with a GP practice. The sexual health clinic is not commissioned and funded to provide such medications and patients should be advised accordingly. **Decision:** The committee ratified the recommendations of the Formulary Subgroup.	
9.2	**Wound Management Formulary Steering Subgroup Recommendations** A report from the wound management subgroup meeting held in November 2024 was presented to the Committee: • **Formulary Alignment & Development:** ○ Proposal for UrgoK2 reduced compression bandages was approved at last APC but will not go on the Community Wound Management Formularies until training has been rolled out across the BLMK ICS. ○ The foam dressings section is under review by a working group of Tissue Viability Nurses (TVNs), aiming for alignment across BLMK formularies whilst reducing spend.	

No	Agenda Item	Action
	• **Financial:** No concerns. Spend reporting is now extended across all of Primary Care (to include GP practices) with bimonthly review. Practices with high FP10 spend are being approached to move to direct procurement. • **Online formulary:** Adoption of the Eolas Medical site (transferred from Microguide) has been successful. • **Procurement of dressings:** All practices and nursing homes across BLMK are now procuring from the NHS Supply Chain (NHSSC). There is a current project to transfer B&L ordering of dressings to ONPOS (in line with MK) – an online ordering platform for procurement of dressings. Fulfilment of orders will continue to be provided by NHSSC. This is on target to be completed by March 2025. • **Waste reduction in Wound care:** Poster produced by CCS around waste reduction using ReadyWrap is undergoing extensive editing and should be available for next APC. **Decision:** The Committee ratified the recommendations of the Wound Management Steering group.	
10.	**Patient Group Direction Subgroup Recommendations** The following recommendations were made by the Patient Group Direction (PGD) subgroup:	
10.1	**Milton Keynes Urgent Care Service PGDs** The following PGD was presented for approval with clinical changes: • **Metronidazole** as an alternative treatment of human and animal bites where co-amoxiclav is contraindicated, in line with BLMK Primary Care Antibiotic Guidance: addition of a caution for patients with Cockayne Syndrome as per the updated SPC. The following PGDs were presented for approval with no clinical changes: • **Amoxicillin** for acute otitis media in adults and children, in line with BLMK Primary Care Antibiotic Guidance (NB: national template not used as it does not cover whole cohort of patients seen at MKUCS). • **Sodium cromoglicate 2% eye drops** for the treatment of perennial allergic conjunctivitis in adults and children and seasonal allergic conjunctivitis in children aged under 6. • **Senna:** a stimulant laxative for the treatment of constipation. • **Doxycycline** given in conjunction with metronidazole for the treatment of human and animal bites in those allergic to penicillin, in line with BLMK Primary Care Antibiotic Guidance. **Decision:** The Committee ratified the PGDs, as recommended by the PGD subgroup.	

No	Agenda Item	Action
11.	**Antimicrobial Resistance (AMR) Update** A report was presented to the Committee including some key metrics from primary and secondary care: • The BLMK AMR/IPC group plans to meet in December. Following the ICB AMR system maturity matrix mapping with NHSE, the need for a local AMR strategy and workplan has been identified but requires discussion and completion. • Overall antibacterial usage in primary care is above the national target (1.03 items per STAR-PU versus NHSE target of 0.875 items per STAR-PU), however, this is equivalent to other ICB areas. • Prescribing of co-amoxiclav, cefalosporins and quinolones (as a % of total antibiotics) is meeting the national target of <10%. • East of England (EoE) priority to address region wide high prescribing of antibacterials in children – BLMK remains above average for antibacterial prescribing in 0-9 year olds, in comparison to both national and EoE prescribing rates. • Within secondary care, reducing the use of broad spectrum antibiotics has been included in the standard contract. Broad spectrum is denoted by antibiotics which fall into 'watch and reserve' categories. BHFT were trending amongst the highest users of broad spectrum antibiotics in the first quarter of 24/25. • IV to oral switch was included in the AMR CQUIN last year and has been included as a non-mandatory CQUIN this year. The CQUIN was achieved by both Trusts last year. 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/approval**	
12.1	EoEPAC Meeting Notes – 01 July 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) – April, June & July 2024	
13.2	Minutes of the Milton Keynes Hospital Prescribing & Medicines Governance Committee (PMGC) – *none available*	
13.3	Minutes of the BLMK Formulary Subgroup – September 2024	
13.4	Minutes of the BLMK Wound Management Formulary Steering Group – July 2024	

No	Agenda Item	Action
13.5	Minutes of the BLMK Medicines Safety Group – July 2024	
13.6	Minutes of the ELFT Medicines Management Committee – September 2024	
13.7	Minutes of the Cambridgeshire Community Services Medication Safety and Governance Group – October 2024	
13.8	Minutes of the CNWL Trustwide Medicines Optimisation Group (MOG) – September 2024	
13.9	Minutes of Circle/MSK Medicines Management Committee – July 2024	
14.	**Papers for information / ratification**	
14.1	**High Flow Oxygen Policy (myAirvo) update** The Committee considered an update and extension of the existing high flow oxygen policy, which was approved by the legacy Bedfordshire & Luton Joint Prescribing Committee in July 2020. Since then, there has been agreement with the ICB Commissioning team that this policy would also be applicable to MK. The policy has therefore been reviewed & updated and formalised to be a BLMK wide document. The commissioning position and funding criteria remain unchanged. The following minor amendments have been made: • BCCG and LCCG logos replaced with the BLMK ICB logo. • Minor formatting changes such as addition of page numbers and tick boxes to the form for ease of completion. • Additional wording to provide clarity around contacting the Individual Funding Request (IFR) Service for any requests that would fall outside of this policy and so would be an IFR – the contact email for the IFR Service and the IFR website link are both provided on page 3. • Updated contact email for return of completed forms. • Date of review/update of the document and author information added. The Committee noted that the policy allows the use and funding of high flow oxygen therapy with the myAIRVO2 device in the community if patient meets the standard criteria as set out in the policy. It does not include high flow therapy without oxygen (e.g. with air). The myAIRVO2 system delivers warmed and humidified respiratory gases, including at high-flow rates, and can be used in the home or other domiciliary care environment only. myAIRVO2 is currently the only available device for delivering high flow oxygen therapy in the community. The cost impact of the update is expected to be negligible as patient numbers are very low – only one request has been received for myAIRVO2 in the last 4 years. The Committee also noted that the original policy was produced as a collaborative piece of work for the whole of the East of England	

No	Agenda Item	Action
	(EoE) and put in place for provision by the provider (BOC) who supplied the oxygen contract for the whole of the EoE. Milton Keynes wasn't originally included as they had a different oxygen supplier. **Decision**: The Committee approved the updated high flow oxygen policy. **EQIA Assessment:** Positive impact – as patients in Milton Keynes can now access this device in the same way as patients in Bedfordshire and Luton where they meet the criteria as outlined in the policy. **BLMK ICB E and D Lead comment:** N/A	
14.2	**Sodium Valproate – system update** The Committee received an update on the work done to date in response to the NPSA alert on the safter prescribing of valproate. To support the work of the Valproate Prescribing Safety group and ensure safe implementation of the NPSA alert practices were asked to nominate a named individual within the practice. The valproate champion is expected: 1. To be the named point of contact for the valproate group sharing relevant information. 2. To oversee primary care aspects being implemented at a practice level e.g. appropriate referral of patients to specialists or annual review and read coding of annual risk acknowledgement forms (ARAF). In July 2024 practice champions were invited to attend a virtual meeting on valproate prescribing and were asked to undertake an audit and share the anonymised data with the ICB to help inform the work programme. The audit was undertaken in September 24. The audit data collected includes 80% of women of childbearing potential in BLMK. Summary of data available (female patients), via ePACT, SystmOne reporting and audit data: • 64 out of 85 practices completed the audit and shared the results with the ICB, the audit data accounts for 317 patients aged from 8 – 55 years. 21 practices chose not to submit data. • Current female patient number in the practices who submitted audit data, November 2024 = 308. • Patients range in age from <10 years to 90+ years, with the highest numbers in the 50-59 and 60-69 age groups. • 47.6% were not known to a specialist service and may require referral. Pathways have been put in place to enable clinicians in primary care to refer to the relevant secondary care service for the review, and clinical teams are reviewing patients, and referring into the pregnancy advisory services as required.	

No	Agenda Item	Action
	• 23.7% (75) were exempt from the Pregnancy Prevention Programme, the main reasons were post menopause, female sterilisation and hysterectomy. These have been coded by the GP practices and excluded from referral. • Of the remaining 242 patients, 2 were no longer on valproate (removed from repeat), 64 of the remaining patients, 26.7% were on highly effective contraception (LARC). • A range of diagnoses were recorded, with the most common being epilepsy (73%), followed by bipolar disorder (14.5%). • The available data shows that the number of females of childbearing potential has reduced as they have been reviewed and changed to alternate medicines, and the number with an ARAF form or exemption has increased. Currently there are no benchmarks available to compare BLMK ICS to other regions, but indications are that other areas have similar, or slightly lower, ARAF completion rates compared to those in BLMK. The Committee noted the valproate system update.	
15.	**Any other business** The following items were raised: • Update of BHFT contact details in the overarching Rheumatology shared care guideline (Beds/Luton areas only) is required as the details are out of date. No other changes to be made at this time. • The guidance for switching from injectable GLP1-RAs to oral semaglutide requires a minor update – liraglutide (Victoza brand) has been discontinued, and biosimilars are now available. In addition, exenatide (Byetta brand) has been discontinued. The guidance requires an update to reflect these changes in product availability. • The "Guidance for Prescribing Glucagon-like peptide 1 (GLP 1) agonists for adults with Type 2 Diabetes (T2DM)", approved by the APC in December 2022, also requires updated to reflect current product availability as outlined above. • The ABCD-PCDS recommendations, which were ratified for local use alongside NICE NG28 by the APC in July 2023, regarding the GLP1-RA shortages were updated April 2024 and now include tirzepatide. An update is therefore required to the "GLP -1 Receptor Agonists – National Shortage: Frequently Asked Questions (FAQs)" document to reflect this. The Committee approved the proposed amendments and noted that the prescribing guidance for GLP1-RAs and tirzepatide is applicable to use for diabetes only, not for weight management.	
16.	**Future Dates for BLMK APC 2024 Meetings (all to be held from 12:30-15:00 via Microsoft Teams):** Wednesday 26th February 2025 Wednesday 7th May 2025 Wednesday 2nd July 2025	

No	Agenda Item	Action
	Wednesday 24th September 2025 Wednesday 3rd December 2025	

Approval of minutes:

Chair: Dr Muhammad Nisar

Signed: 

Date: 06 Mar 2025

Appendix 1 – Approved 12 November Formulary Subgroup Minutes:

BLMK FSG Minutes
Final November 2024