BEDFORDSHIRE, LUTON AND MILTON KEYNES AREA PRESCRIBING COMMITTEE

DRAFT Meeting Notes

Date: 26 February 2025
Time: 12.30- 14.10
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 13:45)	NA	Consultant in Public Health
Dr Marian Chan	MC	Medical Representative, Bedfordshire Hospitals NHS Trust
Candy Chow	CC	Chair of Wound Care Group
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)
Emma Hooton	EH	Practice Pharmacist Representative (Independent Prescriber)
Saema Arain	SA	ELFT Pharmacy Representative – Community Services (Beds)/Mental Health Services (Beds and Luton)
Jill McDonald	JM	Milton Keynes Hospital Pharmacy Representative (Associate Director of Pharmacy, Milton Keynes Hospital)
Dr Kate Randall	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 12:41)	DW	Chair of Medicines Safety Group / Bedfordshire Hospitals Trust Pharmacy Representative (Medicines Use and Quality Manager, Bedfordshire Hospitals Trust)
Dr Maggie Winter	MW	Place Based Lead GP – Milton Keynes

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

In attendance:		
Samina Hassanali	SH	Formulary and Medicines Safety Pharmacist, BLMK ICB
Sandra McGroarty	SMcG	Commissioning Pharmacist, BLMK ICB
Helen McGowan	HMcG	Medicines Optimisation Pharmacist, BLMK ICB
Dr Joy Mutitika	JM	Medical Representative, Keech Hospice
Kelly Pritchard (until 1.20pm)	KP	ELFT Pharmacy Representative – Community Services (Beds)/Mental Health Services (Beds and Luton)
Takudzwa Shumba	TS	CNWL Pharmacy Representative (Prison Services - HMP Bedford and YarlsWood IRC)
Nikki Woodhall	NW	Lead Medicines Optimisation Technician, BLMK ICB
Clare Morlidge (in attendance for agenda item 5.1)	CM	Consultant renal pharmacist, East & North Hertfordshire NHS Trust
Aarti Shah (in attendance for agenda items 5.3 and 5.4)	AS	Medicines Optimisation Pharmacist, BLMK ICB

Apologies:		
Reginald Akaruese	RA	CNWL Pharmacy Representative (Community and Mental Health Services Milton Keynes)
Rafal Ali	RA	Commissioning Pharmacist, BLMK ICB
Dr Mya Aye	MAy	Medical Representative, Milton Keynes Hospital
Janet Corbett	JCo	Milton Keynes Hospital Pharmacy Representative (Pharmacy Programme Manager, Milton Keynes Hospital)
Dupe Fagbenro	DF	ELFT Pharmacy Representative (Deputy Chief Pharmacist (Luton and Bedfordshire), ELFT)
Cheryl Green	CG	Patient Representative
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 make 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 04 December 2024 APC meeting** The minutes of the meeting held on 04 December 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 10/02/25** – update underway. This is an ongoing action and is planned for consideration at the May 2025 meeting.	SMcG
4.1.2	**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 10/02/2025** – agreement has been reached on payments for inclisiran which will be in place until 31st March 2025. There is also agreement that payments will continue for the next financial year via the Primary Care Framework. Lipid pathway documents are being finalised and will be uploaded onto the Medicines website soon. It was proposed and agreed that the action could be closed.	Close

No	Agenda Item	Action
4.1.3	**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 04/12/2024** – 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
4.1.4	**Nebulised gentamicin shared care guideline** - responsibility for 3-monthly monitoring of U&Es to be confirmed - to be undertaken in primary or secondary care? Timing of commencement of shared care to be confirmed (1 month vs 3 months). **Update 22/01/2025** – guideline presented at MK interface meeting on 22/01/2025 where it was agreed that further discussion was required outside of the meeting. No further action until further feedback received regarding MK place discussions.	LR
4.1.5	**Nebulised gentamicin shared care guideline** - if monitoring to be undertaken in primary care, to be considered for inclusion in the Primary Care Framework for 2025/26. **Update 22/01/2025** – see above: on hold pending further discussions within MK place.	MD
4.1.6	**Nebulised gentamicin shared care guideline** - provision of needles and syringes to be resolved - how will supply be arranged on an ongoing basis as they cannot be prescribed on FP10 prescriptions. **Update 22/01/2025** – see above: on hold pending further discussions within MK place.	LR / AG / MD
4.1.7	**Nebulised antibiotics in non-CF bronchiectasis guidance** - to be updated to reflect agreed formulary status for nebulised gentamicin once the issues around the proposed gentamicin SCG have been resolved. **Update 22/01/2025** – see above: on hold pending further discussions within MK place regarding the gentamicin shared care guideline.	AG
4.1.8	**Melatonin prescribing support information (children & young people)** - document to be updated to reflect the agreement that patients who are solely under the care of children's services for melatonin (i.e. require no other support or medications via children's services) may be discharged after 6 months. **Update 05/12/24** – the document has been updated and uploaded onto the Medicines website. It was proposed and agreed that the action could be closed.	Close
4.1.9	**Potassium chloride oral solution** - formularies to be updated to include unlicensed potassium chloride oral solution, following the discontinuation of Kay Cee L syrup. **Update 17/12/24** – both formularies have been updated accordingly. It was proposed and agreed that the action could be closed.	Close

No	Agenda Item	Action
4.1.10	**Overarching Rheumatology DMARD shared care guideline** (Beds/Luton) - contact details to be updated to reflect current information. No other changes at this time. **Update 05/12/24** – the changes have been actioned and the amended document uploaded to the Medicines website. It was proposed and agreed that the action could be closed.	Close
4.1.11	**Switching from injectable GLP1-RAs to oral semaglutide guidance** - to be updated to reflect product availability for liraglutide and exenatide. **Update 26/02/25** – Victoza® discontinued in December 2024 and biosimilar liraglutide entering into the UK market. Liraglutide biosimilar agreed at formulary subgroup on 04/02/2025 but product not yet available. Update in progress to reflect biosimilar liraglutide. Exenatide discontinued and there should be no prescribing, including for existing patients. Document to be a support resource for clinicians if switching from oral to injectable GLP 1 RA.	MA
4.1.12	**Guidance for Prescribing Glucagon-like peptide 1 (GLP 1) agonists for adults with Type 2 Diabetes (T2DM)** - to be updated to reflect product availability of liraglutide and exenatide. **Update 26/02/25** - the continued need for prescribing guidance for GLP1 RA was discussed as they are now widely prescribed in primary care and GREEN on both formularies. It was proposed and agreed that the prescribing guidance for GLP1 receptor agonists could be retired.	MA / SMcG
4.1.13	**GLP -1 Receptor Agonists – National Shortage: Frequently Asked Questions (FAQs)** – to be updated to include information on tirzepatide (as per ABCD-PCDS guidance). **Update 26/02/25** – National shortage of GLP-1 RAs now largely resolved therefore it was proposed that the FAQ document is retired, and links removed from website. It was also proposed that the GLP-1 RA formulary entries should be amended and tidied up to remove previous links to shortage information and guidance. Formulary designation of GLP-1 RAs to be updated, to reflect equal first line status for oral and injectable choices. NICE place in therapy for Tirzepatide in t2dm is an alternative to GLP1 RAs but due to better outcomes likely to be prescribed more and continued if patients tolerate. Prescribing guidance already available: Tirzepatide-prescribing-support-information.pdf.	MA / SH / JC / SMcG
5.	**Items for consideration at meeting**	
5.1	**Finerenone Formulary Status Change & Prescribing Support** Finerenone is indicated for the management of chronic kidney disease (CKD) in patients with type 2 diabetes (T2DM), and is recommended for this patient cohort, with restrictions, in NICE TA877. There is a context of increasing incidence of CKD, both nationally and for the local BLMK ICS. The importance of global management of cardiovascular and renal risks in patients with T2DM was highlighted, including early identification of disease (case finding / standard care); treatment (initiate medications e.g. ACEI/ARB. SGLT2i, finerenone; BP and glycaemic control); and reduction of	

No	Agenda Item	Action
	cardiovascular risk (lipid management, lifestyle changes, smoking cessation, regular aerobic exercise, weight and BMI reduction). The Committee considered a change in formulary designation for finerenone, like other neighbouring ICBs, i.e. change from **SpA** to **Green** for the treatment of patients with T2DM and stage 3 and 4 CKD with albuminuria (with albuminuria defined as a minimum urine albumin to creatinine (UACR) ratio of 3 mg/mmol). There is an unmet clinical need for patients with T2DM and CKD in BLMK, with around 27% not on ACEi/ARB and 55% not on a SGLT2 inhibitor. Approximately 80% of people with CKD are managed in primary care To support the proposal for a change to formulary status, two documents have been produced: • Prescribing Guidance for Finerenone for treating chronic kidney disease (CKD) with type 2 diabetes (T2DM). • Finerenone Prescribing/ Monitoring Checklist for Diabetic Kidney Disease. The documents are based upon resources previously developed by the Buckinghamshire, Oxfordshire and Berkshire (BOB) ICB medicines optimisation team, in collaboration with Oxford renal consultants. The adoption and adaptation of the documents has been supported by the renal team at East & North Hertfordshire (ENH) Trust. Renal patients from BLMK are usually under the care of the ENH or Oxford trusts. The diabetes team at ENHT are also keen to support the initiation of finerenone in primary care as a 'Green' medicine. These documents provide key information details to support the prescribing of finerenone in primary care, including: • Responsibilities • Cautions and contraindications • Initiation and maintenance dosing regimens, including guidance on appropriate dosing / actions according to potassium levels • Significant interactions • Monitoring requirements • Use in pregnancy and breast feeding • Advice to patients • Contact details for specialist teams The resources will not replace individual clinical judgement, and support is available via advice & guidance from both renal centres at Oxford and ENHT. The Committee discussed the need for monitoring of potassium levels two weeks after initiation of therapy. There are useful tables in the prescribing resources to guide clinicians on dosing / actions to be	

No	Agenda Item	Action
	taken depending on the potassium level. Once on a stable dose, routine monitoring will be alongside that undertaken for ACEI/ARB. **Decision**: the prescribing support documents, and change to Green formulary status, were approved. **EQIA Assessment:** The guidance will have a positive impact. Access to finerenone will support slowing CKD disease progression and reduce number of end-stage renal events in adults with T2DM with stage 3 and 4 CKD (with albuminuria), many of whom will be from lower socio-economic groups and minority BAME populations as they have a higher risk of disease progression. Patients suitable for finerenone will not usually be under the care of the specialist teams and would be managed in primary care. The prescribing resources will support safe prescribing, monitoring and counselling thereby potentially helping with reducing health inequalities. **BLMK ICB E and D Lead comment:** No additional comments from the equality perspective.	
5.2	**Antimicrobial guideline update** A full review and update of the BLMK primary care antimicrobial prescribing guidelines has been undertaken. This has taken into account UKHSA and NICE recommendations on antimicrobial prescribing and managing common infections, with any amendments due to local resistance patterns. Products have been selected according to current NICE guidance. Amendments have been made throughout the document, including the updating of reference links and revision dates. More significant changes have been made in some sections: • Scarlet fever – update to treatment choices • Acute otitis externa – expanded range of products included, as per NICE CKS update. • Community acquired pneumonia – addition of oral choice for high severity pneumonia in adults (CRB 3-4 & 2nd line). • Recurrent UTI – addition of methenamine as a primary option and inclusion of a flow chart to guide treatment choices; addition of vaginal estradiol (off label use in peri-menopausal and post-menopausal women). • Chlamydia – updates to 2nd line choices (addition of ofloxacin). Update to wording around chlamydia screening programme. • Trichomoniasis – metronidazole duration amended to 7 days. Removal of clotrimazole pessary as an option for symptom relief in pregnant women – refer to sexual health clinic if metronidazole declined / unsuitable. • Vaginal candidiasis – update to recommendation in pregnancy: clotrimazole 500mg PV for 7 days (unlicensed duration – recommended by BASHH and NICE CKS). • Epididymitis – update to the treatment choices for infection caused by enteric pathogen. Ofloxacin or levofloxacin or co-amoxiclav.	

No	Agenda Item	Action

	• Mastitis – update to treatment recommendations: split into lactational and non-lactational.
	• Scabies – inclusion of ivermectin for treatment failure and for crusted (Norwegian) scabies.
	• Dermatophyte infections (body) – updated text and additional choice of miconazole cream for mild infections. Recommendation to use topical steroid if associated inflammation.
	• Blepharitis – removed antibiotics, and more information included on conservative measures.
	
	Most changes are expected to have minimal financial impact, however the introduction of methenamine for recurrent UTIs represents a cost pressure of approximately £14k – £34.6k, depending on percentage increase in usage versus traditional antimicrobial options.
	
	The Committee discussed the following additional points:
	• Recurrent UTI:
	  ○ Clearer stopping criteria for methenamine (at 6 months) to be included to prevent prescribing continuing on an ongoing basis without review. It was noted that approximately 50% of patients won't return to a recurrent UTI after a six month period.
	  ○ Information to be added to the guidance to highlight the possibility of pulmonary fibrosis with nitrofurantoin.
	• Scabies:
	  ○ Use of ivermectin for patients who have had treatment failure with 2 topical treatments recommended to be Green on the formularies
	  ○ Use of ivermectin for crusted (Norwegian): SpA: Restricted. Seek dermatology advice.
	
	Decision: the updated BLMK primary care antimicrobial guidelines were approved, with the amendments to the recurrent UTI section as agreed at the meeting.
	
	EQIA Assessment: N/A – as per national guidance
		HMcG

5.3	**Bempedoic acid prescribing support information** Prescribing support information has been produced to assist primary care clinicians with the implementation of NICE TA694: Bempedoic acid with ezetimibe for treating primary hypercholesterolaemia or mixed dyslipidaemia, and the BLMK Lipid Pathway. The guidance was developed due to the number of queries the Medicines Optimisation team have been receiving, and also the low prescribing rates of bempedoic acid. The Committee considered the document and noted: • Bempedoic acid is an adenosine triphosphate citrate lyase (ACL) inhibitor that inhibits cholesterol synthesis in the liver, thereby lowering LDL cholesterol. • Bempedoic acid is recommended by NICE in TA694 (April 2021) in combination with ezetimibe as an option for treating	

No	Agenda Item	Action
	primary hypercholesterolaemia (heterozygous familial and non-familial) or mixed dyslipidaemia as an adjunct to diet in adults. It is recommended only if: ○ statins are contraindicated or not tolerated. ○ ezetimibe alone does not control low-density lipoprotein cholesterol well enough. • The prescribing support document includes information on: ○ Therapeutic indications, NICE approved criteria for use, and place in BLMK Lipid Management Pathway. ○ Dosage, including special patient populations (e.g. renal/hepatic impairment, pregnancy/breast feeding). ○ Contraindications and cautions. ○ Drug interactions. ○ Counselling points. The following changes were discussed and agreed at the meeting: • To add clarification on when bempedoic acid can be used as monotherapy. • To add clarification on whether bempedoic acid should be started if Hb is out of target. • To clarify that interaction with simvastatin has been added for information only as may be initiated by lipid specialist. • To add what the next steps are if non-HDL-C has not decreased by 40%. • To amend lipid monitoring to non-fasting full lipid panel. • Request for prescribing check list – if this is deemed appropriate this will be brought back to APC at next meeting. A query was raised regarding whether bempedoic acid is suitable for patients with lactose intolerance. It was confirmed that the tablets do contain lactose and therefore they are not suitable for use in patients with genuine lactose intolerance. **Decision**: the prescribing guidance was approved subject to the proposed amendments as documented above. **EQIA Assessment:** Positive impact. Bempedoic acid and bempedoic acid with ezetimibe for treating primary hypercholesterolaemia or mixed dyslipidaemia - Prescribing Support Information for Primary Care will have a positive impact as it will support the initiation and continuation of the treatment in primary care to allow access to all patient groups who fall under the indications for use. The support document will increase access to patients in inclusion health groups so aims to reduce health inequalities. **BLMK ICB E and D Lead comment:** Rationale for impact assessment includes the following wording: "….continuation of inclusion in primary care allow access to all patient groups who fall under the indications for use". Should the word 'inclusion' read 'treatment'? *Author's response:* wording reviewed and updated in response to these comments.	AS

No	Agenda Item	Action
5.4	**Inclisiran prescribing support information** Prescribing support information has been produced to support primary care clinicians with the implementation of NICE TA733: Inclisiran for treating primary hypercholesterolaemia or mixed dyslipidaemia, and the BLMK Lipid Pathway. The guidance was developed due to the number of queries the Medicines Optimisation team have been receiving, and also the low prescribing rates of inclisiran. The Committee considered the document and noted the following points: • Inclisiran is a small interfering RNA (siRNA) that works by inhibiting the production of PCSK9 in the liver. This increases the number of LDL-C receptors able to clear LDL-C from the bloodstream and reduces the level of LDL-C in the blood. • Inclisiran is recommended NICE in TA733 as an option for treating primary hypercholesterolaemia (heterozygous familial and non-familial) or mixed dyslipidaemia as an adjunct to diet in adults. It is recommended only if: ○ there is a history of any of the following cardiovascular events: ▪ acute coronary syndrome (such as myocardial infarction or unstable angina needing hospitalisation) ▪ coronary or other arterial revascularisation procedures ▪ coronary heart disease ▪ ischaemic stroke or ▪ peripheral arterial disease, and ○ low-density lipoprotein cholesterol (LDL-C) concentrations are persistently 2.6 mmol/l or more, despite maximum tolerated lipid-lowering therapy, that is: ▪ maximum tolerated statins with or without other lipid-lowering therapies or, ▪ other lipid-lowering therapies when statins are not tolerated or are contraindicated, and ○ the company provides inclisiran according to the commercial arrangement. • Inclisiran is recommended only in research for treating primary hypercholesterolaemia (heterozygous familial and non-familial) or mixed dyslipidaemia in adults who have no history of cardiovascular events. This research is in the form of a clinical trial currently in development. The prescribing support document includes information on: • Therapeutic indications, NICE approved criteria for use, and place in BLMK Lipid Management Pathway. • Dosage, including special patient populations (e.g. renal/hepatic impairment, pregnancy/breast feeding). • Missed doses. • Monitoring and continuation criteria. • Contraindications and cautions.	

No	Agenda Item	Action
	• Drug interactions. The following changes were discussed and agreed at the meeting: • To amend lipid monitoring to non-fasting full lipid panel. • To amend "Guidelines recommend that Inclisiran initiation is intended to be carried out within the primary care setting in patients with *ASCVD*" to "Guidelines recommend that Inclisiran initiation is intended to be carried out within the primary care setting in patients with *cardiovascular disease"*. The Committee discussed the payment arrangements for the administration of inclisiran within primary care (see also agenda item 4.1.2). It is anticipated that the payment arrangements (in place for the rest of this financial year (2024-25) and next financial year (2025-26)) will improve the prescribing and administration rates of inclisiran within primary care and work continues to raise awareness of the funding arrangements available. If it becomes evident that there are some practices which are not comfortable administering inclisiran, the ICB will look at alternative arrangements for patients at those practices. **Decision**: the prescribing guidance for inclisiran was approved, with the amendments agreed at the meeting (see above). **EQIA Assessment:** Inclisiran for treating primary hypercholesterolaemia or mixed dyslipidaemia Prescribing Support Information for Primary Care will have a positive impact as it will support the initiation and continuation of treatment in primary care to allow access to all patient groups who fall under the indications for use. The support document will increase access to patients in inclusion health groups so aims to reduce health inequalities. **BLMK ICB E and D Lead comment:** Rationale for impact assessment includes the following wording: "….continuation of inclusion in primary care allow access to all patient groups who fall under the indications for use". Should the word 'inclusion' read 'treatment'? *Author's response:* wording reviewed and updated in response to these comments.	AS
5.5	**Epilepsy formulary section review** A review and update of the oral antiepileptics section on the formularies has been undertaken to achieve alignment across BLMK and take into account the recent update to NICE Guideline NG217: Epilepsies in children, young people and adults. The review has taken into consideration prescribing data, neurology workload and waiting times, practicalities for the patient, and patients under tertiary centres being safely managed in primary care. Recommendations include: • Amber SpA formulary designation when included in NG217 and there is current prescribing. • Amber SpIS when the treatment is more specialised, and the patient is likely to be under a tertiary provider.	

No	Agenda Item	Action
	• Red where the medicine has an associated patient access scheme / commercial arrangement. The majority of medicines are proposed to have Amber SpA formulary status, with the following exceptions: • Amber SpIS: cenobamate, stiripentol, felbamate. • Red: cannabidiol, fenfluramine. • Retigabine to be moved to non-formulary as it has been discontinued. It was noted that information on disease prevalence in Bedfordshire is now available via the population health intelligence unit. The health intelligence unit can be contacted for data/information to support the writing and development of papers. **Decision**: the Committee approved the formulary recommendations for oral epilepsy medications. **EQIA Assessment:** Positive impact, ensuring equity of access across BLMK. **BLMK ICB E and D Lead comment:** N/A	
5.6	**East of England Hypertension Protocols** In 2023 BLMK ICB developed new local guidelines for the management of hypertension in people aged 80 years and over and people aged under 80 years which were approved by the BLMK APC. To support hypertension management across the region clinical leads, commissioners and medicines optimisation teams from ICBs across the East of England, with the support of the NHS England regional team, Health Innovation East and PrescQIPP have developed a regional protocol for the management of hypertension. The EoE guidelines/protocols are based on the Hypertension guidelines originally produced by BLMK ICB. The committee considered the EoE Regional Hypertension Pathway for adoption in BLMK. The guidelines are based on the BLMK hypertension guidelines and there are only minor changes from the current agreed pathways, with no changes in the BP treatment thresholds and targets, class of medications used at each step of the pathway, medication choice in class or recommended dosages. Changes to the guideline include: • Front page introduced to explain the principles of the guidelines. • Additional information added into the BP > 180/120 box to clarify who should be referred as emergency to A&E. • Information added on further investigation / referral if secondary hypertension suspected. • Reference that those with stage 2/3 hypertension are likely to need two medications. • Reference to use of ARNI and ACEI in preference for HFrEF added.	

No	Agenda Item	Action
	• Reference added to considering last BP when considering titrating ARB and CCB or starting a third agent at step 3 of pharmacological management. • "Add indapamide" changed to "add thiazide-like diuretic (e.g. indapamide 2.5mg daily)". **Decision**: the East of England hypertension protocols were approved. **EQIA Assessment:** N/A as no significant difference from previously agreed guidelines	
6.0	**NICE Guidance – from 21 November 2024 until 12 February 2025** **The following NICE Technology Appraisal Guidance (ICB Commissioned) have been published:** • **Bevacizumab gamma for treating wet age-related macular degeneration** Technology appraisal guidance Reference number: TA1022 Published: 04 December 2024 https://www.nice.org.uk/guidance/ta1022 **Resource impact:** expected to be minimal as bevacizumab gamma will be an additional treatment option in the existing pathway. • **Tirzepatide for managing overweight and obesity** Technology appraisal guidance Reference number: TA1026 Published: 23 December 2024 https://www.nice.org.uk/guidance/ta1026 **Resource impact:** the resource impact of implementing TA1026 is expected to be up to approximately £50m over time (note: extended implementation period of up to 12 years due to significant effect on NHS resources (availability of services, capacity and monetary). See also agenda item 14.1. • **Andexanet alfa for reversing anticoagulation from apixaban or rivaroxaban** Technology appraisal guidance Reference number: TA697 Published: 12 May 2021 Last updated: 15 January 2025 https://www.nice.org.uk/guidance/ta697 **Resource impact:** nil additional resource – no change to substantive recommendations. • **Andexanet alfa for reversing anticoagulation in people with intracranial haemorrhage (terminated appraisal)** Technology appraisal Reference number: TA1029. Published: 15 January 2025 https://www.nice.org.uk/guidance/ta1029 **Resource impact:** N/A terminated appraisal.	

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

Asthma: diagnosis, monitoring and chronic asthma management (BTS, NICE, SIGN) NICE guideline [NG245]
Published: 27 November 2024
https://www.nice.org.uk/guidance/ng245
This guideline covers diagnosing, monitoring and managing asthma in adults, young people and children. It aims to improve the accuracy of diagnosis, help people to control their asthma and reduce the risk of asthma attacks. It does not cover managing severe asthma or acute asthma attacks.
APC action(s): none required, as recent BLMK asthma guideline updates already reflect the updated recommendations.

Urinary tract infection (recurrent): antimicrobial prescribing NICE guideline [NG112] Published: 31 October 2018 Last updated: 12 December 2024
https://www.nice.org.uk/guidance/ng112
This guideline sets out an antimicrobial prescribing strategy for preventing recurrent urinary tract infections in children, young people and adults who do not have a catheter. It aims to optimise antibiotic use and reduce antibiotic resistance.
APC action(s): included in the update of the BLMK antimicrobial guidelines (see agenda item 5.2)

Overweight and obesity management NICE guideline [NG246]
Published: 14 January 2025 https://www.nice.org.uk/guidance/ng246
This guideline covers the prevention and management of overweight, obesity and central adiposity in children, young people and adults. It brings together and updates all NICE's previous guidelines on overweight and obesity. It does not cover pregnancy.
APC actions: nil at present. Recommended medicines already included in the formularies (see also agenda item 14.1: Tirzepatide for managing overweight and obesity).

Maternal and child nutrition: nutrition and weight management in pregnancy, and nutrition in children up to 5 years NICE guideline [NG247] Published: 15 January 2025
https://www.nice.org.uk/guidance/ng247
This guideline covers nutrition and weight management in pregnancy for anyone who may become pregnant, is planning to become pregnant or is already pregnant, and nutrition in children up to 5 years. Care of babies and children born preterm or with low birth weight is not covered. The guideline does not give detailed advice on what constitutes a healthy diet.
APC actions: none at present – medicines recommendations relate to vitamins only – already on formularies/in guidance.

Epilepsies in children, young people and adults NICE guideline [NG217] Published: 27 April 2022 Last updated: 30 January 2025
https://www.nice.org.uk/guidance/ng217

No	Agenda Item	Action
	This guideline covers diagnosing and managing epilepsy in children, young people and adults in primary and secondary care, and referral to tertiary services. It aims to improve diagnosis and treatment for different seizure types and epilepsy syndromes, and reduce the risks for people with epilepsy. Recommendations have been updated following publication of the latest Medicines and Healthcare products Regulatory Agency (MHRA) guidance on the use of valproate, valproate use in people younger than 55 years, valproate use in men, and the use of topiramate. **APC actions:** implementation of the MHRA recommendations on valproate and topiramate are being actioned via the BLMK ICS Medicines Safety Group, and updates provided regularly to the APC. Epilepsy (oral medications) formulary section reviewed (see agenda item 5.5). **Tobacco: preventing uptake, promoting quitting and treating dependence** NICE guideline [NG209] Published: 30 November 2021 Last updated: 04 February 2025 https://www.nice.org.uk/guidance/ng209 This guideline covers support to stop smoking for everyone aged 12 and over, and help to reduce people's harm from smoking if they are not ready to stop in one go. It also covers ways to prevent children, young people and young adults aged 24 and under from taking up smoking. NICE reviewed the evidence for cytisinicline (sometimes referred to as cytisine) and have made new and updated recommendations in the section on stop-smoking interventions. **APC actions:** cytisinicline already on formulary and NICE guideline update information communicated to the local smoking cessation services (cytisinicline (cytisine) recommended as an option which is *more likely* to result in successfully stopping smoking. NB: only recommended for people aged 18-65 years). **The following NICE TAs are the commissioning responsibility of NHSE and are listed for information only:** **Eplontersen for treating hereditary transthyretin-related amyloidosis** Technology appraisal guidance Reference number: TA1020 Published: 27 November 2024 https://www.nice.org.uk/guidance/ta1020 **APC actions:** none required (provider is the National Amyloidosis Centre) **Crizotinib for treating ROS1-positive advanced non-small-cell lung cancer** Technology appraisal guidance Reference number: TA1021 Published: 04 December 2024 https://www.nice.org.uk/guidance/ta1021 **APC actions:** link added to formularies (RED traffic light)	

	Toripalimab with chemotherapy for untreated advanced oesophageal squamous cell cancer (terminated appraisal) Technology appraisal Reference number: TA1024 Published: 11 December 2024 https://www.nice.org.uk/guidance/ta1024 **APC actions:** none required (terminated appraisal) **Elranatamab for treating relapsed and refractory multiple myeloma after 3 or more treatments** Technology appraisal guidance Reference number: TA1023 Published: 11 December 2024 https://www.nice.org.uk/guidance/ta1023 **APC actions:** created and link added to formularies (RED traffic light). **Ublituximab for treating relapsing multiple sclerosis** Technology appraisal guidance Reference number: TA1025 Published: 18 December 2024 https://www.nice.org.uk/guidance/ta1025 **APC actions:** created and link added to formularies (RED traffic light). **Tebentafusp for treating advanced uveal melanoma** Technology appraisal guidance Reference number: TA1027 Published: 09 January 2025 https://www.nice.org.uk/guidance/ta1027 **APC actions:** created and link added to formularies (RED traffic light). **Elacestrant for treating oestrogen receptor-positive HER2-negative advanced breast cancer with an ESR1 mutation after endocrine treatment** Technology appraisal guidance Reference number: TA1036 Published: 05 February 2025 https://www.nice.org.uk/guidance/ta1036 **APC actions:** created and link added to formularies (RED traffic light). **Pembrolizumab for adjuvant treatment of resected non-small-cell lung cancer** Technology appraisal guidance Reference number: TA1037 Published: 05 February 2025 https://www.nice.org.uk/guidance/ta1037 **APC actions:** link added to formularies (RED traffic light) **Bimekizumab for treating moderate to severe hidradenitis suppurativa (terminated appraisal)** Technology appraisal Reference number: TA1028 Published: 15 January 2025 https://www.nice.org.uk/guidance/ta1028 **APC actions:** link added to formularies (TERMINATED APPRAISAL) **Durvalumab with chemotherapy before surgery (neoadjuvant) then alone after surgery (adjuvant) for treating resectable non-small-cell lung cancer** Technology appraisal guidance Reference number: TA1030 Published: 15 January 2025 https://www.nice.org.uk/guidance/ta1030 **APC actions:** link added to formularies.	

No	Agenda Item	Action
	Vamorolone for treating Duchenne muscular dystrophy in people 4 years and over Technology appraisal guidance Reference number: TA1031 Published: 16 January 2025 https://www.nice.org.uk/guidance/ta1031 **APC actions:** none – no local use anticipated. **Niraparib with abiraterone acetate and prednisone for untreated hormone-relapsed metastatic prostate cancer (terminated appraisal)** Technology appraisal Reference number: TA1032 Published: 22 January 2025 https://www.nice.org.uk/guidance/ta1032 **APC actions:** links added to formularies (TERMINATED APPRAISAL) **Anhydrous sodium thiosulfate for preventing hearing loss caused by cisplatin chemotherapy in people 1 month to 17 years with localised solid tumours** Technology appraisal guidance Reference number: TA1034 Published: 22 January 2025 https://www.nice.org.uk/guidance/ta1034 **APC actions:** created and link added to formularies. **Vadadustat for treating symptomatic anaemia in adults having dialysis for chronic kidney disease** Technology appraisal guidance Reference number: TA1035 Published: 23 January 2025 https://www.nice.org.uk/guidance/ta1035 **APC actions:** created and link added to formularies. **Ganaxolone for treating seizures caused by CDKL5 deficiency disorder in people 2 years and over** Technology appraisal guidance Reference number: TA1033 Published: 12 February 2025 https://www.nice.org.uk/guidance/ta1033 **APC actions:** none – not recommended **Selpercatinib for advanced thyroid cancer with RET alterations after treatment with a targeted cancer drug in people 12 years and over** Technology appraisal guidance Reference number: TA1038 Published: 12 February 2025 https://www.nice.org.uk/guidance/ta1038 **APC actions:** link added to formularies (RED traffic light). **Selpercatinib for advanced thyroid cancer with RET alterations untreated with a targeted cancer drug in people 12 years and over** Technology appraisal guidance Reference number: TA1039 Published: 12 February 2025 https://www.nice.org.uk/guidance/ta1039 **APC actions:** link added to formularies (RED traffic light). **Olaparib for treating BRCA mutation-positive HER2-negative advanced breast cancer after chemotherapy** Technology appraisal guidance Reference number: TA1040 Published: 12 February 2025 https://www.nice.org.uk/guidance/ta1040 **APC actions:** link added to formularies (RED traffic light).	

No	Agenda Item	Action
7.	**Virtual Recommendations/Documents for discussion/ratification**	
7.1	**BLMK Ophthalmology Intravitreal Injections algorithm update** In December 2024, NICE issued new technology appraisal guidance on the use of bevacizumab gamma for treating wet age-related macular degeneration – NICE TA1022. The existing BLMK pathway for intravitreal injections has been updated to include bevacizumab gamma as an additional option for treating wet age-related macular degeneration (wAMD) in adults. Local specialists were consulted on the update and are in agreement with it. It was noted that, at the current time, bevacizumab gamma is not included in the national High Cost Drugs list (unlike all other medicines included in the algorithm), although it is anticipated this will be added to the High Cost Drugs list for 2025/26. It was also noted that the introduction of bevacizumab gamma may result in a cost pressure for BHFT. Feedback from the lead clinician at the trust to the pathway update indicated that its place in therapy is likely to be for patients with wet age-related macular degeneration (wAMD) who require frequent intravitreal injections, however biosimilar ranibizumab would be a suitable alternative (the latter being the more cost effective option). **Decision**: the updated pathway was approved. **EQIA Assessment:** N/A – update in line with NICE guidance only	
7.2	**BLMK Treatment Pathway for Moderate to Severe Ulcerative Colitis pathway update** The pathway has been updated to include clarification around treatment with mirikizumab. Previously, only the term 're-induction' of mirikizumab was included in the pathway under the 'General Prescribing Notes' section on page 1, but not 'extended induction therapy'. Queries from a provider Trust have highlighted that clarification was needed to differentiate between the terms 're-induction' and 'extended induction therapy'. As a result of a review of the NICE committee papers for NICE TA925 (mirikizumab for treating moderately to severely active ulcerative colitis) and the SPC for mirikizumab, it has been confirmed that 'extended induction therapy' and 're-induction' are separate aspects of mirikizumab therapy. These terms are now included and clearly defined in the pathway on the front cover (page 1), which will help to support clinicians in the prescribing of mirikizumab from a commissioning perspective. In addition, the following minor updates have also been made: • The wording 'TNF inhibitors are the preferred 1st line choice and are most cost effective' has been added to the pathway in the first line treatment options box.	

No	Agenda Item	Action
	• The biosimilars symbol # has been added to ustekinumab as there are now ustekinumab biosimilars available. Biosimilars are cost-effective treatment options. **Decision**: the updated pathway was approved. **EQIA Assessment:** N/A – update in line with NICE guidance only	
8.	**Medicines Safety update** A Primary Care Medicines Safety Update and a Medicines Safety Group Update were 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 (DSUs, October 2024 to January 2025) and CAS alerts (October and December 2024). In particular: **Medroxyprogesterone acetate: Risk of meningioma and measures to minimise this risk (DSU, October 2024)** **Action(s) taken:** This alert will be discussed at the March MSG. Linked to formulary for information. Information on this DSU is available SystmOne (OptimiseRx message not required). **Welireg ® (belzutifan) Patient alert cards (DSU, November 2024)** Risk minimisation materials are available to minimise the risk of hypoxia related adverse reactions. **Action(s) taken:** Linked to formulary for information. For noting/action by acute providers. **Hydroxocobalamin - Cyanokit® 5 g powder for solution for infusion: Important information regarding batch 2404 in a product shortage context (DSU, December 2024)** **Action(s) taken:** This alert will be discussed at the March MSG. For noting/action by acute providers. **GLP-1 and dual GIP/GLP-1 receptor agonists: potential risk of pulmonary aspiration during general anaesthesia or deep sedation (DSU, January 2025)** Healthcare professionals should be aware of the potential risk in patients who undergo surgery or procedures with general anaesthesia or deep sedation. **Action(s) taken:** This alert will be discussed at the March MSG. For noting/action by acute providers. **Discontinuation of Kay-Cee-L ® (potassium chloride 375mg/5ml) (potassium chloride 5mmol/5ml) syrup (CAS alert, October 2024)** **Action(s) taken:** Preferentially selected unlicensed preparations have been available at the trusts in response to the shortages. The formularies have been reviewed and updated to include unlicensed 1mmol/ml potassium chloride oral solution (RED formulary status), for use in paediatric patients (0-17 years) on a dose of <12 mmol only.	

No	Agenda Item	Action
	Influenza season 2024/25: Use of antiviral medicines (CAS alert, December 2024) **Action(s) taken:** For noting. Local supply issues with Tamiflu and Relenza are necessitating the production of local guidance on how to prioritise patients. **Shortage of Pancreatic enzyme replacement therapy (PERT) - Additional actions (CAS alert, December 2024)** This alert contains actions which are in addition to those outlined in the National Patient Safety Alert (NatPSA/2024/007/DHSC) issued on 24th May 2024. This is an updated alert requiring ICB action to formulate a local management plan and communicate that with GP practices, community pharmacies and acute providers. **Action(s) taken:** A management plan for BLMK has been developed and was approved at the January 2025 MSG meeting. This has been shared with stakeholders. GP practices are asked to prescribe a maximum of one month's supply of PERT, as per the serious shortage protocols, and arrangements are in place to support community pharmacies with accessing stock of PERT. The process is supported by the Medicines Optimisation team. Use of the unlicensed, imported alternative to Creon (Pangrol) is available if all routes of supply for licensed PERT products have been exhausted. It was noted that, as of 1st March 2025, the manufacturer of Creon is moving to Alliance Healthcare as their sole distributor, with the aim of aggregating stock in one place and making it easier to manage the PERT shortages. **Medicines Safety Group (MSG) Update** Females of childbearing age on warfarin / contraindication in pregnancy There was a recent significant event when a female on warfarin became pregnant. Neither the patient nor the GP practice appeared to be aware that the use of warfarin is contraindicated in pregnancy. The incident triggered a review of female patients of childbearing age, and whether they were on effective contraception. Key themes discussed at MSG included: patient education and pre-pregnancy planning, referral for a long-acting reversible contraception (LARC), and what steps can be taken to prevent a similar incident happening in the future. **Action(s):** The OptimiseRx team will investigate the potential for any messaging to help support prescribers in primary care. Ardens will add a prompt to their warfarin template on SystmOne to discuss contraception (as there are for other teratogenic medicines). Any gaps in the current process will be looked at and addressed and patients will be reaudited once measures are in place. Further discussion around the use of warfarin in females of child-bearing age highlighted: • Primary care/GPs do not initiate warfarin therefore need to ensure that secondary care anticoagulant services are also	

No	Agenda Item	Action
	made aware of the incident. NB: conversations with secondary care have been instigated and assurance provided that the contraindication of use in pregnancy is covered during initial patient counselling, including the need for effective contraception (including pregnancy testing and referral for LARC by some services). • The reduction in the use of warfarin is likely contributing to the de-skilling of staff members. • The numbers of females of child-bearing age identified to be on warfarin seems unexpectedly high – is there a need for a review / audit of the requirement for these patients to remain on warfarin? • There is another meeting of MSG next week when the issues around use of warfarin in females of child-bearing age will be discussed further. • The use of DOACs in pregnancy will also be discussed at the next MSG and has been taken to the regional and national MSO networks for discussion. <u>Non-registered HCPs administering medication</u> Routine administration of medicines by non-registered healthcare professionals (HCPs) was identified by BHFT in designated areas. As a result, a Trust-wide principles policy for medicine administration by non-registered HCPs was developed. Site-specific SOPs were created with designated leads for oversight, competency validation, and management. Registered staff provide legal and professional accountability and are responsible for safe delegation. Non-registered staff can administer medicines with validated training and competency validation. This guidance development aligns with the expanding roles of registered HCPs. 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 04 February 2025 meeting: • **BLMK ADHD children and young people shared care guideline (SCG):** This guidance has been updated using the BLMK SCG template for use across the ICS in collaboration with ELFT, CNWL and CCS providers. Contact information for specialist services has been updated. It includes information on treatment breaks to consider individual circumstances and preferences. Support with generic prescribing and selection of bioequivalent alternatives during shortages has been provided. Dexamfetamine has been included as it was an alternative during the shortages but is not a common treatment option due to the three times a day dosing. The SCG now includes information on driving (as provided by the DVLA), pregnancy and breast feeding. The updated shared are guideline was approved. *Cost impact of decision:* Payment for SCG (3 and 6- monthly monitoring requirements in younger children) referred for	

No	Agenda Item	Action
	review under the primary care framework. No anticipated increase in medicines costs as this is a review and update of existing shared care guidelines. • **Nephrotrans for chronic kidney disease:** The addition of Nephrotrans (sodium hydrogen carbonate 500mg gastro-resistant capsules) to the formularies was approved as Amber SpIS, on recommendation of the renal specialists only, as a second line treatment option if patients cannot tolerate sodium bicarbonate capsules. Nephrotrans is used for adults with chronic kidney disease (eGFR <30ml/min/1.73^2 and a serum bicarbonate <20mmol/litre). Nephrotrans is more cost effective than the alternative, non-formulary option, sodium bicarbonate 600mg tablets and there is the potential to create savings by switching patients from the tablets to Nephrotrans. Optimise messaging will be used to support appropriate prescribing in primary care and potential switching of patients from sodium bicarbonate 600mg tablets to Nephrotrans when sodium bicarbonate 500mg capsules have already been tried. *Cost impact of decision:* cost is £694/patient/year if taking 10 capsules per day compared with £222/patient/year for sodium bicarbonate 500mg capsules or £990/patient/year for sodium bicarbonate tablets. There is therefore expected to be a cost saving in comparison with sodium bicarbonate tablets. • **Liraglutide biosimilar:** liraglutide is a GLP-1 receptor agonist and the originator product (Victoza®) is licensed for managing type 2 diabetes mellitus in adults, adolescents and children over 10 years old. The patent for Victoza® has expired and the first biosimilar products have been approved for use in the UK. The Liraglutide biosimilar Zegluxen® represents a cost saving (35%) over the discontinued originator product and a 19% cost saving over the alternative licensed liraglutide biosimilar product. The proposal to add the liraglutide biosimilar product Zegluxen® to the formularies as Green was approved. *Cost impact of decision:* Total spend on liraglutide is approximately £25k, so with 100% switch savings of £8750 should be realised. • **Xonvea® (doxylamine 10mg / pyridoxine 10mg)** is the only UK licensed product for treating nausea and vomiting in pregnancy (NVP). It is currently on the formularies as red, for hospital issue only. NICE CKS for nausea and vomiting in pregnancy was updated in February 2024 to include recommendations from the Royal College of Obstetricians and Gynaecologists (RCOG) update to their Green-top Guideline No.69, Management of Nausea and Vomiting in Pregnancy and Hyperemesis Gravidarum. This states that there are safety and efficacy data for first line antiemetics such as anti (H1) histamines, phenothiazines and doxylamine/pyridoxine (Xonvea®) and they should be prescribed initially when required for NVP and Hyperemesis Gravidarum. However, Xonvea® is a cost pressure, and it is estimated that if 661 women (half the number of women	

No	Agenda Item	Action

	predicted to experience severe nausea and vomiting in pregnancy annually in BLMK) were treated for 12 weeks this would be a potential local cost of over £300,000. BHFT have approved the use of Xonvea® on the proviso of completion of an audit. There would be value in understanding local experience and outcome from this audit. Therefore, a decision to review the formulary status has been postponed until BHFT have reviewed the audit results, and it was requested that they consider the formulary designation and present their review at FSG.
	Cost impact of decision: no impact at the current time.
	• **Progesterone pessaries for HRT:** Endometrial protection in the form of progesterone is required for women with a womb/endometriosis who are on HRT and can be obtained via a variety of licensed options such as oral body identical (micronised progesterone), oral synthetic, transdermal synthetic and IUS (Mirena coil). However, a minority of women experience "progesterone intolerance". For these women the remaining option is vaginal administration of prpgesterone, as recommended by the British Menopause Society. The group approved intravaginal use of oral micronised progesterone 100mg capsules (off label use) with a second line option of Cyclogest® (progesterone) 200mg pessaries (off label use). Formulary status: Amber SpIS (restricted to initiation by a specialist (defined as a Consultant Endocrinologist/Gynaecologist or a primary care clinician who has relevant experience and is clinically competent to prescribe)).
	Cost impact of decision: minimal impact due to low patient numbers.
	• **Omalizumab biosimilar:** request to add an omalizumab biosimilar (Omlyclo®) to the formularies (Red traffic light). The originator brand (Xolair®) is indicated for severe persistent allergic asthma, NICE TA278 (NHSE commissioned) and previously treated chronic spontaneous urticaria, NICE TA339 (ICB commissioned). A national procurement process has been undertaken to make Omlyclo available for use in the NHS. The framework start date was September 2024 and availability is anticipated by Q1 2025.
	Cost impact of decision: Approximate 42% price reduction per dose, with possible savings of £117k for the ICB if all patients were swapped to the biosimilar.
	• **Calcium and Vitamin D formulary alignment:** alignment of choices across the formularies to steer prescribers to the more cost-effective options that are likely to be better tolerated to aid compliance.
	  ○ First line options: once daily preparations that should aid compliance including Calci-D, Accrete D3 One a day and TheiCal-D3. These products are suitable for vegetarians and those with allergies to peanuts, soya or soya bean.
	  ○ Second line options (if a patient prefers a non-chewable tablet) include Accrete D3 and Adcal D3.	

No	Agenda Item	Action
	○ Effervescent options include ColeKal-D3 Dissolve and Cacit D3 Dissolve (recommended by NEWT for those patients being tube fed). Accrete D3 non-chewable and Cacit D3 effervescent are the only products not suitable for vegetarians or patients with an allergy to peanuts, soya or soya bean. ○ Formulary entries for the effervescent preparations will state the quantity of sodium. ○ No active bulk switching of products is being recommended, but these are the preferred options for new initiations. ○ Retain information on formularies stating: “hospital contract brands will be supplied in secondary care”. *Cost impact of decision*: cost saving due to utilising more cost-effective products first line. • **Budesonide (Budenofalk®) suppositories:** approved for addition to the formularies as Amber SpA for mild to moderate ulcerative proctitis (affecting 30-50% of ulcerative colitis patients). Early initiation can prevent deterioration and the risk of disease progression. Budesonide suppositories topically target rectal inflammation and are better tolerated by patients with low systemic absorption. Studies show that those patients not responding to mesalazine have a mucosal and symptomatic response to budesonide. The current option available on the formulary is prednisolone 5mg suppositories. There are no comparison studies, but prednisolone suppositories cost significantly more. *Cost impact of decision*: Cost saving, if 20% of patients currently on prednisolone were initiated on budesonide, this could save over £28,000 annually. • The subgroup noted and approved the log of minor amendments made to the formularies in between meetings, and the work / amendments made as part of the BHFT JAC alignment project. • Items raised under ‘any other business’: ○ Blood glucose and ketone testing: the table for the preferred blood glucose and ketone meters has been updated on the formularies with the corresponding test strips. ○ Fluoride toothpaste on prescription: the Subgroup agreed to designate high fluoride toothpaste as red and for the other fluoride products, that are available OTC, non-formulary. BMA recommendations for GP dental prescribing will be linked to the formulary entry. **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 in January 2025 was presented to the Committee:	

No	Agenda Item	Action

	• **Formulary Alignment and Development:**
	  ○ Biatain Silicone has been moved to a new formulary sub-section within Foam dressings to highlight that this should only be used where 3D fit is considered necessary by TVNs.
	  ○ A proposal for addition of **UrgoStart Plus Pad** (6x6cm and 10x10cm) to the Bedfordshire & Luton Community Wound Management Formulary has been agreed virtually by the Wound Care Group. This would bring it in line with the Milton Keynes Community Wound Management Formulary. Experience and data from an in use trial has shown positive results; the product is found to be efficacious, safe and effective for complex leg ulcer wounds, which helps to prevent hospital admissions. The product is for TVN specialist use only, or on their advice. TVNs will monitor usage and spend data via ONPOS to ensure TVN only prescription.
	• **Online formulary**: the Foam dressings section continues to be reviewed by a Working Group of TVNs. Suprasorb P, which is already on the Milton Keynes formulary has been trialled across Bedfordshire and Luton with promising results. A decision is expected at the next meeting in March. This product is currently being trialled across Bedfordshire and Luton community and hospital Trusts.
	• **Financial:** Spend on FP10 for dressings compared with direct procurement for the year to end November 2024 was in the region of 49:51 (ideal 20:80). A reminder will be sent to Practice Nurses across BLMK addressing high FP10 spend on dressings and reminding them of the direct procurement process.
	• **Waste reduction in wound care:** no updates.
	• **Matters arising**: The project to transfer Bedfordshire and Luton ordering of procurement of dressings to ONPOS is still on target to be completed by March 2025. Current requisition points for Community bases will be moved to ONPOS by the beginning of March 2025, with practices that are currently using NHSSC being transferred by the end of March, and practices that are new to NHSSC being moved by 28th April. Only one practice has not engaged with signing up – however their spend on FP10 is minimal (c. £1200 pa).
	
	Decision: The Committee ratified the recommendations of the Wound Management Steering group, including the addition of UrgoStart Plus Pad to the Bedfordshire / Luton wound management formulary.	

10.	**Patient Group Direction Subgroup Recommendations** The following recommendations were made by the Patient Group Direction (PGD) subgroup:	

No	Agenda Item	Action
10.1	**Milton Keynes Urgent Care Service PGDs** The following PGDs were presented for approval with clinical changes: • **Co-amoxiclav**: first line treatment of human and animal bites – allopurinol added to exclusions as may increase incidence of skin rash. • **Clarithromycin** for treatment of lower respiratory tract infection in children allergic to penicillin: addition of exclusion criteria for patients on ivabradine, terfenadine, domperidone, ticagrelor, ranolazine; interaction with edoxaban. • **Clarithromycin** for treatment of cellulitis, suspected bacterial tonsillitis & pharyngitis in those allergic to penicillin: addition of exclusion criteria for patients receiving ivabradine, terfenadine, domperidone, ticagrelor, ranolazine; interaction with edoxaban. • **Miconazole oral gel** for oral candidiasis in adults, children and infants aged 2 and above – information added as per SPC: This medicinal product contains orange flavour (containing: citral, citronellol, linalool, geraniol, d-limonene) and cocoa flavour (containing: benzyl alcohol, benzyl benzoate) that may cause allergic reactions. This medicinal product contains 0.000000017 mg of benzyl benzoate in each single maximum dose for an adult (10 ml of oral gel). Benzyl benzoate may cause mild local irritation. Contains 0.0000000285 mg of benzyl alcohol in each single maximum dose for an adult (10 ml of oral gel). Benzyl alcohol may cause allergic reactions. Administration of benzyl alcohol is associated with the risk of severe side effects including breathing problems (called “gasping syndrome”) in young children. Can also cause metabolic acidosis. The following PGDs were presented for approval with no clinical changes: • **Prednisolone 5mg tablets and oral solution** STAT dose prior to transfer to hospital for children aged 1-18 with acute exacerbation of wheeze/asthma. • **Ipratropium bromide** for children aged 2-16 years for the relief of acute exacerbations and severe attacks of asthma unresponsive to salbutamol. The national template was adopted for the following PGD: • **Buccal midazolam** for the management of seizures. **Decision:** The Committee ratified the PGDs, as recommended by the PGD subgroup.	
10.2	**British Pregnancy Advisory Service (BPAS) PGDs** BPAS has developed two new PGDs for the provision of emergency hormonal contraception. They are being implemented to meet an unmet demand to allow the supply or administration of levonorgestrel or ulipristal to patients attending a Nurse or Midwife led clinic appointment meeting the criteria for emergency hormonal contraception.	

No	Agenda Item	Action
	• PGD for supply and administration of levonorgestrel • PGD for supply and administration of ulipristal They have been developed using the SPS templates with the following localisations: - The training requirements for both have been localised to be consistent with other organisational documents - As per the decision at the Drugs and Therapeutics committee meeting where the PGDs were approved, as an organisation BPAS have opted to not use the off-license high dose of levonogestrel for those taking enzyme inducing medicines or herbal products or those with a BMI over 26 or who weigh more than 70kg and these have been moved to the exclusion criteria. This is to allow the supply of original packs as per the SPS guidance for supply of contraception under PGD. Patients will have the option of ulipristal if eligible or the copper coil. **Decision:** The Committee ratified the PGDs, as recommended by the PGD subgroup.	
11.	**Antimicrobial Resistance Update**. The Committee was presented with a summary of discussions held at the BLMK antimicrobial resistance (AMR) / infection prevention and control (IPC) meeting held in December 2024. The following key themes were discussed: • **C. Difficile infection:** there has been a national upward trend in C. Difficile infections which has also been observed at local trusts. Root cause analyses have been undertaken of hospital acquired cases within BLMK, but no particular patterns/trends have been noted amongst affected patients and there haven't been any outbreaks. Patients often have a lot of co-morbidities but may not be particularly unwell with the C Diff infection. • **Antimicrobial stewardship (AMS) ICB governance**: an AMR ICB system maturity matrix discussion took place with NHSE in September 2024, and an AMS self-assessment tool for ICBs has recently been published (January 2025). Work is underway to complete the toolkit and to try and improve AMR visibility within the organisation. • **Paediatric antimicrobial prescribing** (regional priority): BLMK is now the highest prescribing area in England for antibiotics in children. There is a recognised need for: ○ Public health messaging, collaborative work: Local Authority / public health / communications teams. ○ Clinician education sessions. ○ Engagement with other areas, e.g. Out of Hours services / walk-in centres. The Committee noted the antimicrobial stewardship update.	
All other papers (from this point in the agenda) are for noting/information by the Committee		

No	Agenda Item	Action
12.	**East of England Priorities Advisory Committee (EoEPAC) – items for noting**	
12.1	EoEPAC Meeting Notes – September 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.	
13.3	Minutes of the BLMK Formulary Subgroup – November 2024	
13.4	Minutes of the BLMK Wound Management Formulary Steering Group – September & November 2024	
13.5	Minutes of the BLMK Medicines Safety Group – October & November 2024	
13.6	Minutes of the ELFT Medicines Management Committee – November 2024	
13.7	Minutes of the Cambridgeshire Community Services Medication Safety and Governance Group – January 2025	
13.8	Minutes of the CNWL Trustwide Medicines Optimisation Group (MOG) – November 2024	
13.9	Minutes of Circle/MSK Medicines Management Committee – October 2024	
14.	**Papers for information**	
14.1	**Tirzepatide for managing overweight and obesity** NICE published TA1026: Tirzepatide for managing overweight and obesity on 23rd December 2024. NHS England applied for a funding variation for TA1026 due to concerns regarding availability of services, clinical capacity, inequity of access and the budget impact of implementing the TA recommendations. The funding variation was granted by NICE and extends the implementation period up to 12 years to enable patients with the greatest clinical need to be prioritised. Prioritisation is by BMI and weight-related medical conditions, including hypertension, dyslipidaemia, obstructive sleep apnoea, cardiovascular disease, prediabetes and type 2 diabetes. NHS England has not yet published the eligible cohorts for the first 3 years: tirzepatide will remain RED on the formulary until a pathway is in place. Going forward: • It is anticipated it will move to a commissioned service in Primary Care (not routine GP prescribing) with wrap around care. • A short life working group has been established to support local implementation once the financial allocation, initial	

No	Agenda Item	Action
	eligibility criteria and wrap around care package have been shared by NHS England An ICS partnership position statement has been published to assist patients and local clinicians https://blmkhealthandcarepartnership.org/an-update-on-weight-loss-medication-tirzepatide/	
15.	**Any other business** None raised	
16.	**Future Dates for BLMK APC 2025 Meetings (all to be held from 12:30-15:00 via Microsoft Teams):** 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: 14/5/2025

Appendix 1 – Approved 04 February 2025 Formulary Subgroup Minutes:

BLMK FSG Minutes February 2025 Final.d