# BEDFORDSHIRE, LUTON AND MILTON KEYNES AREA PRESCRIBING COMMITTEE

## Meeting Notes

Date: 03 July 2024
Time: 12.30- 3.00pm
Venue: Microsoft Teams

**Attendees:**

| Name | Initial | Role |
|---|---|---|
| Dr Muhammad Nisar | MN | Chair (Medical Representative, Bedfordshire Hospitals NHS Trust) |
| Yolanda Abunga (until 13:35) | YA | CCS Pharmacy Representative (Community Services Pharmacist, Beds and Luton) |
| Mojisola Adebajo | MA | Place Based Lead Pharmacist – Luton |
| Pritesh Bodalia (from 12:43 – 14:15) | PB | Bedfordshire Hospitals Trust Pharmacy Representative (Chief Pharmacist, Bedfordshire Hospitals Trust) |
| Sally Cartwright (from 12:40 – 14:00) | SC | Consultant in Public Health |
| Dr Marian Chan (from 12:50) | 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) |
| Naomi Currie | NC | Place Based Lead Pharmacist - Bedford |
| Matt Davies | MD | Head of Medicines Optimisation, BLMK ICB (deputised for FG until 13:25) |
| Fiona Garnett (from 13:25) | FG | Associate Director: Pharmacy and Medicines optimisation, BLMK ICB |
| Anne Graeff | AG | Commissioning Lead Pharmacist, BLMK ICB (Professional Secretary) |
| Cheryl Green | CG | Patient Representative |
| Grace Khoo | GK | CNWL Pharmacy Representative (Community and Mental Health Services 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**

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| Natasha Patel | NP | ELFT Pharmacy Representative – Community Services (Beds)/Mental Health Services (Beds and Luton) |
| Dr Kate Randall | KR | Place Based Lead GP – Central Bedfordshire |
| Dr Jenny Wilson | JWi | Place Based Lead GP - Bedford |
| Dona Wingfield (from 13:47) | DW | Chair of Medicines Safety Group / Bedfordshire Hospitals Trust Pharmacy Representative (Medicines Use and Quality Manager, Bedfordshire Hospitals Trust) |

| **In attendance:** | | |
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| Rafal Ali | RA | Commissioning Pharmacist, BLMK ICB |
| Alicia Gandhi (until 13:18) | AGa | Medicines Optimisation Lead Pharmacist, BLMK ICB |
| Samina Hassanali | SH | Place Based Lead Pharmacist, BLMK ICB |
| Taiya Large | TL | Formulary and Medicines Safety Pharmacist, BLMK ICB |
| Sandra McGroarty | SMcG | Commissioning Pharmacist, BLMK ICB |
| Dr Joy Mutitika | JM | Medical Representative, Keech Hospice |
| Nikki Woodhall | NW | Lead Medicines Optimisation Technician, BLMK ICB |
| Qiratulain Khan (in attendance for agenda items 5.6 & 5.7) (from 13:00 – 13:55) | QK | Pharmacist, Bedfordshire Hospitals Trust |
| Dr Hijaza Razzaq (observer) (from 13:00) | HR | GP Trainee |

| **Apologies:** | | |
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| Nicola Ainsworth | NA | Consultant in Public Health |
| Carole Jellicoe | CJ | Nurse Representative (Independent Prescriber) |
| Dr Dush Mital | DM | Medical Representative, Milton Keynes Hospital |
| Dr Mitan Sarkar | MS | Place Based Lead GP - Luton |
| Helen Smith | HS | Milton Keynes Hospital Pharmacy Representative (Chief Pharmacist, Milton Keynes Hospital) |
| Dr Jonathon Walter | JWa | Place Based Lead GP – Milton Keynes |

| No | Agenda Item | Action |
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| **1.** | **Welcome, Introductions and Apologies**<br><br>The Chair welcomed everyone to the meeting.<br>Apologies were received and noted as above.<br>The meeting was confirmed as quorate.<br><br>The Chair welcomed Qiratulain Khan to the meeting (in attendance for agenda items 5.6 and 5.7). | |

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| | The Chair thanked Naomi Currie for her valuable input and service to the Committee and wished her all the best in her new role. The Chair also extended best wishes to Taiya Large, who is going on maternity leave, and welcomed Samina Hassanali who will be covering the role of Formulary Pharmacist in Taiya's absence. | |
| **2.** | **Declarations of Interest**<br><br>The Chair invited the members to reconfirm their current declarations on the Register of Interests and advise of any new declarations.<br><br>All members confirmed their declarations were accurate and up to date.<br>The Chair invited members to declare any declarations relating to matters on the agenda.<br><br>All members confirmed they have no declarations in relation to matters on the agenda. | |
| **3.** | **Minutes of 01 May 2024 APC meeting**<br><br>The minutes of the meeting held on 01 May 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**<br>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)<br>**Update 18/06/24** - this has been delayed due to other priorities. This is an ongoing action. | SMcG |
| **4.1.2** | **Daridorexant prescribing support information**<br>Signposting information to the nationally commissioned digital CBTi offering to be added once available.<br>**Update 18/06/24** – announcement of the national commissioning of digital CBTi is still awaited. This is an ongoing action. | AG |
| **4.1.3** | **Contraception guidance: emergency contraception (EC)**<br>To ensure that it is clear that clinicians have free choice of oral EC, guided by patient/clinical factors - individuals not involved with developing the guidance to be consulted.<br>**Update 11/06/24** - emergency contraception guidance updated and on agenda for approval (see agenda item 7.1). It was proposed and agreed that the action could be closed. | Close |
| **4.1.4** | **Contraception guidance**<br>To complete the development of the 'pill ladders' with a view to incorporating these into the main contraception guidance.<br>**Update 18/06/24 -** this is an ongoing action. | SMcG / JWi |
| **4.1.5** | **Contraception guidance** - Formularies to be updated to reflect formulary changes proposed in association with the guidance | JCo / TL / SMcG |

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| | (progestogen only contraceptives, copper IUDs, vaginal delivery systems, drospirenone).<br>**Update 18/06/24** - this is an ongoing action as some formulary changes are still to be actioned. | |
| **4.1.6** | **Contraception guidance**<br>Drospirenone prescribing guidance/support document to be developed and brought to July APC.<br>**Update 11/06/24** - on agenda for consideration (see agenda item 5.4). It was proposed and agreed that the action could be closed. | Close |
| **4.1.7** | **Continence guidelines**<br>Guidelines to be updated to include the 3 intermittent self-catheterisation products, as tabled at the meeting.<br>**Update 17/06/24** - intermittent self-catheters added as agreed at the meeting. In addition, some changes have been made (post meeting) to the anal incontinence section as it was noted that it contained a discontinued product (BBraun S set), that some products had been inadvertently omitted (not all relevant Aquaflush products included), Qufora toilet systems updated with current information, and that some had mistakenly placed in the incorrect subsection of the document (Aquaflush toilet system listed under mini systems). It was proposed and agreed that the action could be closed. | Close |
| **5.** | **Items for consideration at meeting** | |
| **5.1** | **Iron chelators for myelodysplastic syndrome**<br>The Committee considered new BLMK commissioning policy recommendations on the use of iron chelation agents (deferasirox and desferrioxamine) for the management of iron overload in transfusion dependent low to intermediate 1 risk myelodysplastic syndrome (MDS). MDS is a group of haematological medical conditions characterised by ineffective and dysplastic haematopoiesis resulting in one or more cytopenias, predominantly anaemia. There is an increased risk of acute myeloid leukaemia (AML). The anaemia associated with MDS is usually initially treated with erythropeotins e.g. epoetin alfa but many patients will eventually require repeated blood transfusions. The repeated transfusions lead to the risk of iron overload and associated complications.<br><br>The proposed recommendations aim to align practice across BLMK with regard to use of iron chelation agents in MDS, as these are currently in use at Milton Keynes University Hospital (MKUH) due to their historic arrangements and adoption of the Thames Valley Priorities Committee Commissioning Policy prior to their transfer to the East of England regional commissioning network. Bedfordshire and Luton historically did not support routine commissioning of the use of iron chelators in MDS, in line with the EoE Priorities Advisory Committee recommendations.<br><br>In addition, the recommendations aim to optimise choice of the available iron chelating drugs based on available evidence for clinical effectiveness, safety and cost effectiveness/impact. | |

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| | There is no NICE guidance available regarding the management of myelodysplastic syndromes including the place in therapy of iron chelation agents. Guidance published by the British Society of Haematology (BSH) in 2021 recommends that all suitable lower risk patients should be considered for iron chelation around the time they have received 20 units of red cells, or when serum ferritin is more than 1000ug/l. Patients should have ferritin levels measured every 12 weeks.<br><br>These proposed recommendations are:<br><br>• Iron chelation agents, deferasirox and desferrioxamine, will be routinely commissioned for the management of iron overload due to blood transfusions on a restricted basis when the following conditions are met:<br>• Patient has been reviewed by a multidisciplinary team (MDT) decision and either:<br>  ○ Low risk MDS patients with a very good prognosis (greater than 2 years with an IPSS-R score of 3.0 or less), who have received at least 20 units of red blood cells or when the ferritin is 1000ug/l.<br>  ○ Patients who are transplant (allogeneic stem cell transplantation) eligible with high risk forms of MDS as defined by the MDT.<br>• Patients should have ferritin levels measured every 12 weeks. Ophthalmological and auditory examinations are required at baseline and then annually.<br>• Iron chelation with desferrioxamine should be stopped if the ferritin falls below 1000ug/l, or 500ug/l with deferasirox.<br>• Deferiprone is **not** recommended for iron chelation in MDS patients.<br><br>As this intervention is already in use at MKUH, additional patient numbers are anticipated to come primarily from Bedfordshire Hospitals Trust. It is estimated that 5 – 8 patients per year may require treatment with iron chelators for MDS. The cost impact of this ranges from approximately £84,000 for 5 patients at average body weight of 70kg at the lower end of the dose range, up to approximately £269,000 for 8 patients at average body weight of 70kg at the upper end of the dose range. These costs are indicative and affected by a number of factors including patient's body weight, choice and dose of iron chelator, and duration of treatment. It was noted that it would be very unlikely that the cost impact would reach this upper end, as patients would usually be initiated on the lowest dose and, depending on the serum ferritin levels and if a dose increase is required, it would not occur until after 3 to 6 months post initiation. It was also noted that the likely duration of treatment would be in the range of 12 to 19 months. The costs of treatment with iron chelation agents may be offset by a reduction in secondary care activity costs for associated iron related co-morbidities, such as treatment for cardiac, liver and kidney co-morbidities.<br><br>The Committee discussed the following additional points: | |

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| | • BHFT does not routinely commission at the current time, although some individual patients have had funding approved.<br>• Cost effectiveness falls outside (borderline) the standard NICE cost-effectiveness QALY threshold of £20k and it is difficult to quantify the offsetting of the costs of the treatment.<br>• Currently there is a 'post code lottery' within the patch and equity of access is required within BLMK.<br>• Clinical recommendations proposed are reasonable and in line with BSH guidance.<br>• Block funding arrangements are in place which means the guidance is subject to local trust financial approval. This is only relevant to BHFT as MKUH has already been treating patients with iron chelators for MDS for many years.<br><br>**Decision**: The Committee approved the recommendations clinically, but this is subject to local trust financial approval.<br><br>**EQIA Assessment:** If approved, the recommendations will have a positive impact on patients with transfusion dependent low to intermediate-1 risk MDS.<br><br>**BLMK ICB E and D Lead comment:** Currently states: If approved, the recommendations will have a positive impact on patients with transfusion dependent low to intermediate-1 risk MDS.<br>Please clarify - Is it a case that there is a positive impact on all patients regardless of their protected characteristics?<br>This policy/recommendation will provide clarity and a consistent approach across BLMK to reduce health inequalities?<br>**Author's response** – the EQIA assessment has been updated accordingly | |
| **5.2** | **BLMK local lipid guidance**<br>A proposal to introduce a local pathway for lipid management in adults for the secondary prevention of Cardiovascular (CVD) events was presented to the Committee. This includes secondary prevention of lipid management for people with established CVD, including those with statin intolerance. There have been significant changes in pathways for the management of hypercholesteremia and raised triglycerides in the last few years, including the publication of new NICE technology appraisals and clinical guidelines.<br><br>The introduction of new NICE approved lipid-lowering medications and the introduction of new lipid lowering targets for people with CVD has given BLMK ICS a significant opportunity to reduce future CVD events in people with existing CVD or with high CVD risk. Despite significant improvements being made in the lipid management of our population, there is still significant work to be done to optimise lipid management for our population and reduce variation between practice and inequalities within our system.<br><br>The proposed pathway is based upon published NICE TA and NG guidance and the AAC Lipid Lowering Pathway for Secondary prevention of CVD events, alongside additional clinical trial information and local agreements. The pathway aims to rationalise the available | |

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| | guidance and make it simpler for primary care clinicians to follow, giving clear indications of the treatment choice(s) at each step.<br><br>The Committee discussed the following additional points:<br>• Target of LDL-C ≤2.0 and non-HDL≤ 2.6mmol/L to be included in the local pathway, as per NICE guidance.<br>• The guidance recommends the use of inclisiran as the first line choice for patients with LDL-C≥2. 6mmol/L, as inclisiran produces greater lipid lowering effects in comparison with ezetimibe. The Committee discussed the lack of a robust inclisiran pathway and that this is a barrier for receiving any treatment (inclisiran or ezetimibe, if inclisiran is offered first). It was agreed that inclusion of inclisiran as the first choice option for this patient cohort would be subject to the agreement to include inclisiran in the local Primary Care Framework to facilitate administration of inclisiran by practices.<br>• Daily rosuvastatin or non-daily rosuvastatin titrated to maximum dose as option for those with previous statin intolerance – agreed for inclusion in the pathway.<br>• The pathway includes a recommendation that bempedoic acid (BA) and ezetimibe should be started at the same time, rather than initiating ezetimibe first then adding in BA. This is included due to the modest lipid lowering effect seen with ezetimibe and reluctance seen in practice from patients not wishing to start a second medication. Concerns were raised regarding starting two medicines at the same time, as it is then difficult to determine which one is causing any adverse effects, however the recommendation was agreed.<br>• The proposed pathway also includes the triple combination of BA, ezetimibe and low intensity statin. The Committee considered the guidance and discussion included in TA694 (Bempedoic acid with ezetimibe for treating primary hypercholesterolaemia or mixed dyslipidaemia) and noted that the triple combination was not considered by NICE as "*During the appraisal, the company decided that it was no longer seeking a recommendation in the maximally tolerated statin population (populations 4a and 4b), because the incremental cost-effectiveness ratio (ICER) estimates were too high to be recommended for routine use in the NHS*". This indicates that this combination is not a cost effective use of NHS resources, and the APC also discussed that the conflicting guidance could be confusing in practice. It was therefore agreed that the use of BA/ezetimibe in combination with low intensity statins should be removed from the pathway.<br>• Isosapent ethyl – use of non-fasting triglycerides (TG) ≥ 2.0mmol/L for initiation of icosapent ethyl in addition to fasting TG ≥ 1.7mmol/L – this was agreed by the APC at the May 2024 meeting.<br><br>**Decision**: The Committee approved the pathway with the amendment agreed in point 5 above, and the agreement to include inclisiran administration in the Primary Care Framework. | MD<br><br>MD |

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| | **EQIA Assessment:** None anticipated.<br><br>**BLMK ICB E and D Lead comment:** Ticked 'no' box.<br>I would suggest that this would give clinicians a consistent approach to ensure all patients have access to the correct treatment and aim to reduce health inequalities.<br><br>Note: From my recollection, there was evidence of more resistance to statins in people from a BME background? Does this guidance take account of and consider this? Please include if it does or if there may be a disproportionate impact.<br>**Author's response:** The guidance has been streamlined to reduce the contacts required with a clinician and the need for repeat phlebotomy so we are expecting that this will support those in our more deprived communities who often struggle with access to surgeries and phlebotomy appointments. Our BME population does have lower treatment to lipid targets although we do sit higher than the national average in this. We don't foresee that guidance would worsen inequalities and should hopefully reduce them by standardising the pathway and reducing the need for repeat pathway. We will ensure that we try to reduce inequalities within the BME group through targeted inequality work. | |
| **5.3** | **BLMK Primary Care Antimicrobial Prescribing Guideline update**<br>An update has been made to the 'suspected meningococcal disease' section of the prescribing guidelines following the publication of NICE guidelines (NG240) Meningitis (bacterial) and meningococcal disease: recognition, diagnosis and management.<br><br>NG240 makes recommendations regarding the use of pre-hospital antibiotics for management of strongly suspected cases of meningitis. The guideline recommends that either benzylpenicillin or ceftriaxone can be used prior to hospital admission (previously ceftriaxone had not been recommended) and this has been included in the proposed update.<br><br>**Decision**: the APC approved the proposed updates to the Primary Care Antimicrobial Prescribing Guideline.<br><br>**EQIA Assessment:** Not assessed as the update is to include updated NICE guidance only.<br><br>**BLMK ICB E and D Lead comment:** N/A | |
| **5.4** | **Drospirenone Prescribing Support Information**<br>Following the addition of drospirenone 4mg tablets (Slynd®) in May 2024 to the BLMK formularies, prescribing support information has been developed to support primary care clinicians prescribing the medication. It was approved for addition to the formularies as follows:<br><br>• Second line progestogen only pill (POP) that can be considered if desogestrel is not appropriate after a suitable trial (minimum 3 months) and where other methods of contraception including long-acting reversible methods are contraindicated, have been declined or are not suitable. | |

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| | • **AMBER SpIS** formulary status, requiring initiation and stabilisation by a specialist*, prior to continuation in primary care.<br>*in this context, a specialist is defined as a "Sexual Health Specialist or a Primary care clinician who has relevant expertise and is clinically competent to prescribe (holds the FSRH Diploma (DFSRH)".<br><br>The Committee reviewed the prescribing support information and considered the proposed monitoring parameters for drospirenone. The FSRH (Faculty of Sexual and Reproductive Healthcare) state that U&Es and blood pressure should be monitored in specific patient groups however no specific details have been recommended.<br><br>The suggested monitoring schedule, as proposed in the document, was (for specific patient groups): Frequency of monitoring will need to be made on a case-by-case basis. Suggested monitoring schedule: baseline and 6 weeks after initiation and then 3-12 monthly depending on the condition and results. The patient's renal physician/ endocrinologist can be consulted for advice. Integrated sexual health services can also offer support where required.<br><br>The Committee noted and discussed the following key points:<br>• The document is not designed to replace the SmPC or BNF, rather to be an easy access guide which links users to other key sources of information.<br>• Patients on a POP would routinely have their blood pressure monitored as part of standard care. Information to reflect this is to be included in the document.<br>• It is unlikely patients with renal impairment will be started on drospirenone.<br>• The definition of specialist agreed at the last meeting, requiring primary care prescribers to hold the DFSRH diploma, was discussed and agreed to be too narrow. It is therefore to be adjusted so that a specialist prescriber is defined as: "Sexual Health Specialist or a primary care clinician who has relevant experience and is clinically competent to prescribe".<br>• The monitoring schedule as proposed above was agreed to be appropriate for patients in the specific patient groups defined within the fact sheet.<br><br>**Decision**: The fact sheet was approved with the amendments agreed (see above).<br><br>**EQIA Assessment:** Positive impact - If approved, this will ensure a consistent approach is adopted across BLMK.<br><br>**BLMK ICB E and D Lead comment:** N/A | SMcG<br><br>SMcG |
| **5.5** | **Migraine pathway update**<br>Following the publication of new NICE TA guidance recommending the use of atogepant for the prevention of migraine (NICE TA973, published May 2024), the BLMK migraine prevention pathway has been updated to incorporate atogepant. Minimal cost impact is expected from this | |

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| | additional treatment option within the pathway as the cost is comparable to other treatment options, and it will be used as an alternative within the existing pathway.<br><br>The Committee discussed a proposal to amend the formulary status of rimegepant (for the prevention of migraine) from RED (specialist only) traffic light status to AMBER SpIS (specialist initiation and stabilisation, followed by continuation in primary care). Similarly, an AMBER SpIS formulary status was proposed for atogepant. Rimegepant is already on the formularies with a GREEN traffic light for the treatment of acute migraine, and therefore there is currently recognition that the 'gepants (rimegepant and atogepant) are suitable for prescribing in primary care. AMBER SpIS traffic light designation for prevention of migraine will ensure that patients are assessed by a specialist, with consideration of all available treatments at this stage in the treatment pathway (some of which are only available via hospitals and will remain RED on the formularies), prior to the commencement of treatment. Specialists will initiate, provide the first 12 weeks treatment, and assess the patient for efficacy/response at 12 weeks to ensure patients meet the NICE criteria for continuation of treatment. Following a successful initial trial, specialist would then request ongoing prescribing in primary care.<br><br>In line with the above consideration for AMBER SpIS traffic light designation, a minor amendment was also proposed for the "*Rimegepant for acute treatment of migraine with or without aura in adults. Prescribing Support Information for primary care"* document. This is to remove a sentence which states "Rimegepant should not be prescribed for prevention or prophylaxis in primary care".<br><br>**Decision**: The pathway update, amendment of formulary status, and the minor amendment to the prescribing support document for rimegepant for acute migraine were approved.<br><br>**EQIA Assessment:** Yes, a positive impact– the addition of a new oral drug will benefit patients. The other drugs in this pathway are mostly injections, therefore this addition to the pathway will increase treatment options and improve access and patient care.<br><br>Changing the formulary status of oral treatment options for migraine prevention from RED to AMBER SpIS will increase access and improve care for patients and will alleviate waiting times for specialist services.<br><br>**BLMK ICB E and D Lead comment:** No further comments in relation to EIHR. | SH/AG/ JCo |
| **5.6** | **Azathioprine and Mercaptopurine Shared Care Guideline for treatment of Autoimmune Renal Disease**<br>Due to changes in the setup and responsibilities in the renal clinic at the Luton & Dunstable Hospital, it has been necessary to develop a new shared care guideline (SCG) for patients being treated at the trust with azathioprine or mercaptopurine for the management of autoimmune renal disease. Note: renal services at the trust are primarily managed by the renal specialists from East & North Hertfordshire Trust (ENHT). | |

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| | Azathioprine is currently approved on the Bedfordshire and Luton Formulary as Amber with a Shared Care Guidance for use in inflammatory bowel disease, autoimmune hepatitis and rheumatology. It is also approved on the Milton Keynes Formulary as amber with shared care guidance for the indications of autoimmune hepatitis, gastroenterology and rheumatology.<br><br>Mercaptopurine is currently approved on the Bedfordshire and Luton Formulary and the Milton Keynes Formulary as Amber with a Shared Care Guidance for use in inflammatory bowel disease and autoimmune hepatitis.<br><br>Within the new SCG, azathioprine is used both with a licensed indication (SLE) and also off-label indications; mercaptopurine is used off label.<br><br>The SCG has been developed with reference to the Hertfordshire & West Essex SCG (East & North Herts trusts falls under this ICB area) and the national template for the medicines.<br><br>The Committee noted that:<br>• The SCG would not be relevant to MKUH, as renal services there are provided by Oxford. No change to formulary status is therefore required on the MK formulary.<br>• The longer term plan is to formulate overarching SCGs for all specialities who use azathioprine/mercaptopurine.<br>• Patient numbers – approximately 15-20 patients in the renal service are on azathioprine/mercaptopurine, but the majority of patients are already having their medication provided via their GP. No significant impact is therefore expected on the budget allocated for the monitoring of medicines used under shared care by practices within BLMK.<br>• Patients were already in the service but managed by ENHT, but they will be managed by BHFT staff going forward.<br><br>**Decision**: The shared care guideline was approved.<br><br>**EQIA Assessment:** N/A | |
| **5.7** | **Mycophenolate Mofetil and Mycophenolic Acid Shared Care Guideline for treatment of Autoimmune Renal Disease**<br>As above, changes in the setup and responsibilities in the renal clinic at the Luton & Dunstable Hospital, have necessitated the development of a new shared care guideline (SCG) for patients being treated at the trust with mycophenolate mofetil and mycophenolic acid for the management of autoimmune renal disease.<br><br>Mycophenolate Mofetil is approved on Bedfordshire and Luton Formulary as Amber with a Shared Care Guidance for use in rheumatology, as well as RED Restricted for Transplant indications. Mycophenolate Mofetil is approved on Milton Keynes Formulary for use in renal patients as RED for new patients and amber for existing | |

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| | patients. It is also approved as AMBER with a Shared Care Guidance for use in rheumatology.<br><br>Mycophenolic acid is non-formulary for Milton Keynes and not listed on the Bedfordshire and Luton Formulary. Addition of mycophenolic acid as a second line option for use in patients intolerant of mycophenolate mofetil was therefore proposed. Mycophenolic acid is indicated as second line treatment in patients who are unable to tolerate mycophenolate mofetil due to its side effects, but still have disease response. Expected patient numbers are very small – prescribing data over the months of January to April for BLMK show 540 patients on mycophenolate mofetil and 11 patients on mycophenolic acid (all indications) – this number is not expected to increase significantly therefore there should be little financial impact.<br><br>The SCG has been developed with reference to the Hertfordshire & West Essex SCG (East & North Herts trusts falls under this ICB area) and the national template for the medicines. Mycophenolate is used off label within this SCG.<br><br>Other considerations were noted as above (agenda item 5.6).<br><br>**Decision**: The shared care guideline was approved.<br>The addition of mycophenolic acid to the formulary was agreed.<br>Wording is to be added to the formulary and Oprimise Rx to emphasise that it is a second line choice for patients who are intolerant of mycophenolate mofetil.<br><br>**EQIA Assessment:** N/A | SH/JCo |
| **6.0** | **NICE Guidance – from 18 April 2024 to 19 June 2024**<br><br>**The following NICE Technology Appraisal Guidance (ICB Commissioned) have been published:**<br><br>• **Gefapixant for treating refractory or unexplained chronic cough (terminated appraisal)** Technology appraisal Reference number: TA969 Published: 30 April 2024 https://www.nice.org.uk/guidance/ta969<br><br>**Resource impact:** N/A – terminated appraisal<br><br>**APC actions:** added to formularies with non-formulary status (DNP – terminated appraisal)<br><br>• **Remdesivir and tixagevimab plus cilgavimab for treating COVID-19** Technology appraisal guidance Reference number: TA971 Published: 08 May 2024 https://www.nice.org.uk/guidance/ta971<br><br>**Resource impact:** minimal use at local trusts but may increase following publication of the TA. Estimate 2 patients/month – likely maximum cost impact of approximately £90,000 per year. | |

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| | **APC actions:** remdesivir formulary entries updated (RED traffic light); NB: 30 day implementation. New entries created for tixagevimab plus cilgavimab (non-formulary, DNP – NOT RECOMMENDED).<br><br>• **Atogepant for preventing migraine** Technology appraisal guidance Reference number: TA973 Published: 15 May 2024 https://www.nice.org.uk/guidance/ta973<br><br>**Resource impact:** NICE expect the cost impact of implementing the guidance to be approximately £8,800 per 100,000 population (approximately £88,000 for BLMK). This is because atogepant is a further treatment option. Uptake of atogepant would displace other calcitonin gene-related peptide (CGRP) receptor antagonists, and the overall cost of treatment for this patient group will be similar.<br><br>**APC actions:** to be added to formularies (AMBER SpIS traffic light) and chronic/episodic migraine pathway updated (see agenda item 5.5).<br><br>• **Ranibizumab for treating choroidal neovascularisation associated with pathological myopia** Technology appraisal guidance Reference number: TA298 Published: 27 November 2013 Last updated: 20 May 2024 https://www.nice.org.uk/guidance/ta298<br><br>**Resource impact:** N/A – no material changes to the recommendations<br><br>**APC actions:** none<br><br>• **Ranibizumab and pegaptanib for the treatment of age-related macular degeneration** Technology appraisal guidance Reference number: TA155 Published: 27 August 2008 Last updated: 20 May 2024 https://www.nice.org.uk/guidance/ta155<br><br>**Resource impact:** N/A – no material changes to the recommendations<br><br>**APC actions:** none<br><br>• **Ranibizumab for treating visual impairment caused by macular oedema secondary to retinal vein occlusion** Technology appraisal guidance Reference number: TA283 Published: 22 May 2013 Last updated: 20 May 2024 https://www.nice.org.uk/guidance/ta283<br><br>**Resource impact:** N/A – no material changes to the recommendations<br><br>**APC actions:** none<br><br>**The following NICE Guidelines (NG) (Medicine related and ICB Commissioned) have been published / updated by NICE:**<br><br>None | AG/JCo |

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| | **The following COVID 19 related information has been produced/updated by NICE:**<br><br>**COVID-19 rapid guideline: managing COVID-19** NICE guideline [NG191] Published: 23 March 2021 Last updated: 08 May 2024 https://www.nice.org.uk/guidance/ng191<br>**APC actions**: as per TA971 above<br><br>**The following NICE TAs are the commissioning responsibility of NHSE and are listed for information only:**<br><br>**Pembrolizumab with gemcitabine and cisplatin for untreated advanced biliary tract cancer (terminated appraisal)** Technology appraisal Reference number: TA966 Published: 24 April 2024 https://www.nice.org.uk/guidance/ta966<br>**APC actions:** links added to formularies (terminated appraisal)<br><br>**Melphalan flufenamide with dexamethasone for treating relapsed or refractory multiple myeloma (terminated appraisal)** Technology appraisal Reference number: TA968 Published: 25 April 2024 https://www.nice.org.uk/guidance/ta968<br>**APC actions:** created (DNP) and link added to formularies (terminated appraisal) (NB: TA968 relates to Pepaxti 20 mg powder for concentrate for solution for infusion; formulary entries created for this new product).<br><br>**Pembrolizumab for treating relapsed or refractory classical Hodgkin lymphoma in people 3 years and over** Technology appraisal guidance Reference number: TA967 Published: 01 May 2024 https://www.nice.org.uk/guidance/ta967<br>**APC actions:** link added to formularies.<br><br>**Pembrolizumab for treating relapsed or refractory classical Hodgkin lymphoma** Technology appraisal guidance Reference number: TA540 Published: 03 September 2018 Last updated: 01 May 2024 https://www.nice.org.uk/guidance/ta540<br>**APC actions:** none (see also above)<br><br>**Selinexor with dexamethasone for treating relapsed or refractory multiple myeloma after 4 or more treatments** Technology appraisal guidance Reference number: TA970 Published: 08 May 2024 https://www.nice.org.uk/guidance/ta970<br>**APC actions:** created and link added to formularies (RED traffic light).<br><br>**Selinexor with bortezomib and dexamethasone for previously treated multiple myeloma** Technology appraisal guidance Reference number: TA974 Published: 15 May 2024 https://www.nice.org.uk/guidance/ta974<br>**APC actions**: link added to formularies. | |

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| | **Tisagenlecleucel for treating relapsed or refractory B-cell acute lymphoblastic leukaemia in people 25 years and under** Technology appraisal guidance Reference number: TA975 Published: 15 May 2024 https://www.nice.org.uk/guidance/ta975<br>**APC actions**: link added to formularies.<br><br>**Cladribine for treating relapsing–remitting multiple sclerosis** Technology appraisal guidance Reference number: TA616 Published: 19 December 2019 Last updated: 21 May 2024 https://www.nice.org.uk/guidance/ta616<br>**APC actions:** none<br><br>**Alemtuzumab for treating highly active relapsing–remitting multiple sclerosis** Technology appraisal guidance Reference number: TA312 Published: 28 May 2014 Last updated: 21 May 2024 https://www.nice.org.uk/guidance/ta312<br>**APC actions:** none<br><br>**Natalizumab for the treatment of adults with highly active relapsing–remitting multiple sclerosis** Technology appraisal guidance Reference number: TA127 Published: 22 August 2007 Last updated: 21 May 2024 https://www.nice.org.uk/guidance/ta127<br>**APC actions:** none<br><br>**Sirolimus for treating facial angiofibroma caused by tuberous sclerosis complex in people 6 years and over (terminated appraisal)**<br>Technology appraisal Reference number: TA972 Published: 22 May 2024 https://www.nice.org.uk/guidance/ta972<br>**APC actions:** none – terminated appraisal<br><br>**Setmelanotide for treating obesity and hyperphagia in Bardet-Biedl syndrome** Highly specialised technologies guidance Reference number: HST31 Published: 22 May 2024 https://www.nice.org.uk/guidance/hst31<br>**APC actions**: none – no local use expected (highly specialised technology)<br><br>**Trastuzumab deruxtecan for treating HER2-mutated advanced non-small-cell lung cancer after platinum-based chemotherapy (terminated appraisal)** Technology appraisal Reference number: TA976 Published: 29 May 2024 https://www.nice.org.uk/guidance/ta976<br>**APC actions:** link added to formularies (terminated appraisal)<br><br>**Dabrafenib with trametinib for treating BRAF V600E mutation-positive glioma in children and young people aged 1 year and over** Technology appraisal guidance Reference number: TA977 Published: 29 May 2024 https://www.nice.org.uk/guidance/ta977<br>**APC actions:** links added to formularies<br><br>**Zanubrutinib with obinutuzumab for treating relapsed or refractory B-cell follicular lymphoma after 2 or more treatments (terminated appraisal)** Technology appraisal Reference number: TA978 Published: 29 May 2024 https://www.nice.org.uk/guidance/ta978<br>**APC actions:** links added to formularies (terminated appraisal) | |

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| | **Ivosidenib with azacitidine for untreated acute myeloid leukaemia with an IDH1 R132 mutation** Technology appraisal guidance Reference number: TA979 Published: 05 June 2024 https://www.nice.org.uk/guidance/ta979<br>**APC actions:** links added to formularies<br><br>**Nivolumab for adjuvant treatment of completely resected melanoma at high risk of recurrence in people 12 years and over (terminated appraisal)** Technology appraisal Reference number: TA980 Published: 05 June 2024 https://www.nice.org.uk/guidance/ta980<br>**APC actions:** link added to formularies (terminated appraisal)<br><br>**Voxelotor for treating haemolytic anaemia caused by sickle cell disease** Technology appraisal guidance Reference number: TA981 Published: 12 June 2024 https://www.nice.org.uk/guidance/ta981<br>**APC actions:** created and link added to formularies<br><br>**Pembrolizumab with trastuzumab and chemotherapy for untreated locally advanced unresectable or metastatic HER2-positive gastric or gastro-oesophageal junction adenocarcinoma** Technology appraisal guidance Reference number: TA983 Published: 12 June 2024 https://www.nice.org.uk/guidance/ta983<br>**APC actions:** link added to formularies (NOT RECOMMENDED)<br><br>**Baricitinib for treating juvenile idiopathic arthritis in people 2 years and over (terminated appraisal)** Technology appraisal Reference number: TA982 Published: 13 June 2024 https://www.nice.org.uk/guidance/ta982<br>**APC actions:** link added to formularies (terminated appraisal)<br><br>**Tafamidis for treating transthyretin amyloidosis with cardiomyopathy** Technology appraisal guidance Reference number: TA984 Published: 19 June 2024 https://www.nice.org.uk/guidance/ta984<br>**APC actions:** none – no local use expected. | |
| **7.** | **Virtual Recommendations/Documents for discussion/ratification** | |
| **7.1** | **Emergency contraception guidance**<br>A draft version of the Emergency Contraception (EC) guidance was discussed at the May 2024 APC. During the discussion, a query was raised regarding whether the message that prescribers had a free choice, dependent on individual patient factors, of which oral agent (ulipristal or levonorgestrel) to prescribe was clear enough and it was agreed that the wording would be reviewed and amended if necessary.<br><br>The guideline was originally written to act as a resource for GPs however it was acknowledged at the meeting that community pharmacists can issue EC via PGDs and also that some community pharmacists have the ability to issue oral EC over the counter. | |

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| | As the guidance, once published, will be shared to both GPs and community pharmacists, some additional text has been added in order to highlight the importance of referring to the FSRH and / or CKS guidance to aid decision making, and to consider individual factors when deciding which EC to offer a woman.<br><br>The Committee discussed the suggested addition of text to ensure that, if operating under a PGD, people also ensure that the patient meets the criteria within the PGD (as there may be additional conditions to be considered). This information was agreed to be added to the 'initial assessment' box on page 1.<br><br>**Decision**: The emergency contraception guidance was approved.<br><br>**EQIA Assessment:** Positive impact: to standardise treatment protocols to ensure that patients who present requesting EC receive the same approach and options offered from ICaSH and sexual health clinics.<br><br>**BLMK ICB E and D Lead comment:** Suggest adding: this document is based on national guidance and will provide clarity and consistent approach to access to emergency contraception aiming to reduce potential inequalities. | |
| **7.2** | **Risk Sharing / Patient Access Schemes Medicines policy update**<br>The Risk Sharing and Patient Access Schemes for Medicines Policy has previously been approved by both of the legacy APCs. Version 1.0, aside from some minor updating (to reflect changes to organisations), was unchanged and went through the BLMK ICB ratification process. The document therefore came to the September 2022 APC for information only.<br><br>The policy was subsequently updated in September 2023 to include the newly published NHS England policy on Free of Charge medicines and also to clarify that Early Access to Medicines schemes and 'European Medicines Agency (EMA) access for compassionate use in certain scenarios' are out of scope.<br><br>The Risk Sharing/Patient Access Schemes for Medicines policy has reached its routine review date and has therefore been reviewed and updated accordingly. Changes are minor and include updating of job title of document owner, minor formatting and wording changes, and change of date the Associated Document was updated.<br><br>The Committee noted that compassionate use schemes and Individual Funding Requests are outside of the scope of the policy.<br><br>**Decision:** The updated Risk Sharing / Patient Access Schemes Medicines policy was approved. | |
| **8.** | **Medicines Safety update**<br>A Primary Care Medicines Safety Update and a Medicines Safety Group Update was presented to the committee. | |

**Primary Care Medicines Safety Update**

This update focussed on the primary care response to the MHRA Drug Safety Updates (February to May 2024) and CAS Alerts (February to May 2024). In particular:

**Pseudoephedrine: very rare risk of posterior reversible encephalopathy syndrome (PRES) and reversible cerebral vasoconstriction syndrome (RCVS) (DSU, February 2024)**
Linked to Formularies entry for information. Pseudoephedrine is not a prescribable medicine in BLMK (self-care). Community pharmacy to advise on side-effects upon purchase.

**Codeine linctus (codeine oral solutions): reclassification to prescription-only medicine (DSU, February 2024)**
Linked to Formularies for information. Potential need to monitor usage as patients seek prescriptions. A message had been sent via the primary care bulletin to raise awareness in the community.

**Montelukast: reminder of the risk of neuropsychiatric reactions (DSU, April 2024)**
Linked to Formularies for information.

**Finasteride: reminder of the risk psychiatric side effects and of sexual side effects (which may persist after discontinuation of treatment) (DSU, April 2024)**
Linked to Formularies for information.

**Topical steroids: introduction of new labelling and a reminder of the possibility of severe side effects, including Topical Steroid Withdrawal Reactions (DSU, May 2024)**
Linked to Formularies for information. Potency of topical steroids already noted on Formulary monographs.

**Shortage of salbutamol 2.5mg/2.5ml and 5mg/2.5ml nebuliser liquid unit dose vials (CAS Alert, February 2024)**
Linked to Formularies for information. Sourcing of unlicensed imports to support shortage is underway. Use is generally restricted to complex patients only and these patients would usually have specialist input for review. The shortage has not significantly impacted primary care; secondary care are optimising use of available stock and looking into the use of unlicensed imports should it be necessary.

**Potential contamination of some carbomer-containing lubricating eye products with Burkholderia cenocepacia - measures to reduce patient risk – updated 2nd April, recommendations stepped down (CAS Alert, April 2024)**
OptimiseRx messaging in primary care has been updated accordingly.

**Shortage of Erelzi (etanercept) (CAS Alert, May 2024)**
RED on Formularies. Erelzi not currently a preferred brand in BLMK (using Benepali). Benepali can support full uplift in demand.

**Shortage of Orencia Clickject (abatacept) (CAS Alert, May 2024)**
RED on Formularies. NPSA alert linked to Formularies.

**Shortage of pancreatic enzyme replacement therapy (PERT) (CAS Alert, May 2024)**
Action plans/memos have been circulated at both Trusts. The system is intending to source unlicensed pancreatin to support the shortage as other options cannot support uplift in demand (Nutrizyme 22 – out of stock until Aug 2024 and Pancrex V – insufficient stocks to support demand). NPSA alert linked to Formularies. An active monitoring process is in place to assess impact on an ongoing basis.

**Medicines Safety Group (MSG) Update**

**Actimorph – engagement to use project**
Milton Keynes has set up an opioid stewardship group with representation from different sectors managing patients with chronic and acute pain such as a GP, specialist pain teams, addiction and recovery specialists, pharmacists and social prescribers. Workstreams including medicines safety around opioids are being looked at. Bedfordshire Hospitals Trust is in the process of converting its pain management group into an opioid stewardship group.

Actimorph is listed on the BLMK SystmOne formulary, and an Optimise Rx message will fire when Oramorph is prescribed for the first time and when it has not been issued in the preceding 18 months suggesting Actimorph is prescribed.

Actions following the meeting are discussing the potential uses of Actimorph, as an alternative to Oramorph, at the pharmacy educational and place meetings and reviewing the formulary webpages with information on the use of Actimorph.

**Valproate task and finish group**

- BLMK Valproate group continues to meet monthly.
- Providers to supply ICB with referral contact details to support with primary care referring patients back in by 18th July.
- Second authorisation process to be determined at provider level.
- Valproate Primary Care Champions' Day - PCN engagement event - audit for females under 55 years.
- Specialist review referral and sexual health referral form in progress.
- The Valproate Prescribing NPSA alert was presented to the ICB Quality and Performance committee in June 24.
- The risk has been added to the risk register. The Medical Director is aware of the issue.

The Committee noted the recent publication of a Drug Safety Alert announcing a pregnancy prevention programme (PPP) for topiramate. The focus in the system will remain on sodium valproate in the short term to ensure that this workstream can be completed. Work can then commence on the topiramate PPP and reviewing patients on topiramate.

The Committee noted the medicines safety update.

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| **9.** | **Formulary Update** | |
| **9.1** | **Formulary Subgroup Recommendations**<br>The following recommendations were made by the Formulary subgroup at the 11 June 2024 meeting:<br><br>• **Domnisol (calcifediol monohydrate) 266 micrograms capsule for vitamin D deficiencies.** Domnisol has a number of advantages in comparison with colecalciferol, for example it does not require hepatic metabolism, has better intestinal absorption and is less lipophilic than colecalciferol. The proposal to add Domnisol to the formularies as GREEN was approved. Optimise Rx and formulary messaging to be used to support appropriate use (second line but may be suitable as first line in certain patient groups).<br>*Cost impact of decision:* Likely cost saving as we move away from expensive colecalciferol products and define cohorts for inclusion.<br>• **Dexcom One+ sensor.** This is a second-generation product which offers more features and accuracy for patients and clinicians at cost parity to Dexcom One. It is smaller, more accurate, has a reduced warm up period of 30 minutes, requires no separate transmitter, is compatible with share and follow app for up to 10 people and utilises the same Clarity app for healthcare providers. Dexcom One is expected to be discontinued within the next 12 months, therefore the intention is to bulk switch patients from Dexcom One to Dexcom One+ via notification message. The addition of Dexcom One + to the formularies (AMBER SpA designation) was approved. Optimise messaging to be used to support appropriate selection with an explanation that it is due to discontinuation of Dexcom One and with a summary of the benefits.<br>*Cost impact of decision:* minimal – the new sensor has cost parity with the original Dexcom One sensor system,<br>• **Fluticasone nasal drops for nasal polyps.** Newly launched product on the market which replaces the previously discontinued, but widely used product, Flixonase nasules for nasal polyps. Specialist opinion is that fluticasone nasal drops are more effective compared with the alternative, Betnesol nasal drops, and there is less systemic absorption. Request to re-add this similar alternative product back on to the Formularies was approved as GREEN, for use when nasal sprays and other first line formulary options are not effective.<br>*Cost impact of decision:* Approx £45k per annum based on usage habits of the predecessor product.<br>• **Review of oral triptans for migraine.** Review and alignment of triptan lineage of choice and addition of missing cost-effective products to Formulary. Key changes include: All triptan to be given GREEN Formulary status (some previously SpA). Restrictions added to dispersible products (i.e. for use in those unable to swallow). Frovatriptan restricted to use for menstrual migraine. Remove rizatriptan 5mg from Formulary – starting dose is 10mg and product is high cost. Remove zolmitriptan | |

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| | 5mg tablet from Formulary – high cost product, more cost-effective to prescribe dispersible 5mg tablet (£6 per tablet vs £3.18 per tablet). It was also agreed that the 3mg injection should be added alongside the 6mg injection as the lower strength is equally efficacious with fewer side effects.<br>*Cost impact of decision:* Cost saving overall from rationalisation of choices, however difficult to quantify.<br>• **Hertfordshire renal shared care guidelines: phosphate binders and cinacalcet.** Previously, the Bedfordshire and Luton Joint Prescribing Committee (JPC) ratified the Hertfordshire SCGs for lanthanum and sevelamer for local use to facilitate the provision of the medicines via shared care between the renal unit at the East & North Herts Trust (ENHT) and practices in Bedfordshire and Luton. These SCGs have recently been reviewed, updated and moved onto a new HWE shared care template. The renal team have requested ratification and adoption of the updated SCGs for lanthanum and sevelamer and also for 2 additional SCGs:<br>○ Sucroferric oxyhydroxide for hyperphosphatemia in adult patients with end stage renal failure requiring renal replacement therapy.<br>○ Cinacalcet for Use in Secondary Hyperparathyroidism in Adults with End Stage Kidney Disease (ESKD) Requiring Renal Replacement Therapy.<br>The above SCGs have been in used in Hertfordshire for some time, but not ratified and adopted for use within BLMK (not previously forwarded for consideration by the Beds/Luton JPC). The SCGs will be for use for patients under the care of ENHT only. The SCGs were approved.<br>*Cost impact of decision:* NHSE commissioned treatments – no impact.<br>• **Nutricia Human Breast Milk Fortifier for use in preterm infants – Milton Keynes only.** Nutriprem Human Breast Milk Fortifier (BMF) was discussed at the Feb 2024 FSG with subsequent support for use. The pathway for appropriate supply mechanisms was subject to further discussion following the meeting. It was agreed that 2 boxes would be supplied on discharge from the unit, with a further 4 boxes prescribed by GP to complete the course, alongside a supporting letter detailing that this is a “supply only” arrangement. Regarding Bedfordshire and Luton, the Trust has a different set of challenges with regards to the pathway for this product therefore work is ongoing to form a suitable plan for these patients.<br>*Cost impact of decision:* Anticipated annual cost pressure to Primary Care = £4000 per annum.<br>• **Hydrocortisone 10mg/5mL and 5mg/5mL licensed oral suspension.** Review of licensed hydrocortisone 5mg/5ml and 10mg/5ml SF oral solutions which have recently been released. These products are high-cost vs the current preparations already on the Formulary. The propylene glycol content of the licensed oral solutions is unsafe in neonates according to NPPG recommended levels. They were therefore rejected for use and agreed to be designated as DNP. The unlicensed liquid has also | |

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| | been removed as there are other more suitable licensed formulations on Formulary that will meet the needs of paediatric patients. A practice level audit is underway to investigate and where possible switch from liquids to a more appropriate formulation and investigate further any potential niche uses.<br>*Cost impact of decision:* none, not recommended for use (added to formularies as DNP).<br>• **Praziquantel/albendazole for tapeworms.** There was a need for alignment of the products for the treatment of tapeworms across the joint formulary (currently the two medicines are only listed on Bedford/Luton Formulary) and addition of information to clarify situations for use, choice and sourcing of medicine to prevent delay to treatment. There is more evidence for the use of praziquantel, (compared with albendazole) and it has the additional benefit of causing paralysis of the worm (making it fall off the lining of the intestine and allow excretion by the body). However, microbiology prefer to use albendazole first line. It was agreed, due to the specialist nature and infrequent need for the medicines, that albendazole and praziquantel to be assigned a RED formulary status.<br>*Cost impact of decision:* minimal due to low product cost and very small patient numbers (5 in the last 5 years issued with treatment for tapeworms).<br>• **Vizidor and Vizidor Duo eye drops.** These formulations are presented in a multidose preservative free eye drop bottle which provide a greener choice; however, they are slightly more expensive, although Bausch and Lomb are offering a higher rebate. It was therefore decided to go with the Scope Eyecare products, Dimaz and Codimaz, instead (the latter products were agreed for addition to the formularies at the April FSG meeting).<br>• **Daktacort discontinuation – replacement with Nystaform HC.** Daktacort is being discontinued - MK formulary now includes the alternative Nystaform HC which is already on the Beds and Luton formulary.<br>• **Dapagliflozin – removal of first line lineage on Formulary for Type 2 diabetes (T2DM).** NICE NG28 recommended an SGLT2i with proven cardiovascular benefit for Type 2 DM. Initially, Dapagliflozin had wider indication for use in HF (+/- T2DM) and later CKD (+/- T2DM) and was assigned first choice on formulary. Empagliflozin now has a wider indication for use and there is no significant difference in effectiveness between both in T2DM with CVD. The BLMK primary care prescribing guidance in HF and CKD recommends dapagliflozin or empagliflozin and acquisition cost is same for both. Additionally, dapagliflozin is likely to be first off patent. The “first choice” SGLT2i designation for Dapagliflozin on both formularies is to be removed and all SGTL2i are to be options within their licensed indications.<br>• **Sativex** – the wording on the Bedfordshire and Luton formulary has been updated to clarify that specialists within community settings may continue prescribing for patients following consultant/hospital specialist initiation and stabilisation. | |

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| | **Decision:** The committee ratified the recommendations of the Formulary Subgroup. | |
| **9.2** | **Wound Management Formulary Steering Subgroup Recommendations**<br>A report from the wound management subgroup meetings was presented to the Committee:<br><br>**Formulary Alignment and Development:**<br>MKUH wound management formulary has been added and is being edited by MKUH TVNs. This will sit along with the MK Practice nurses and the Bedfordshire Formularies on Microguide and will support alignment across the ICS.<br>Two products are being considered for inclusion in the Wound Management Formulary over the next few months and will be sent to the APC for ratification if appropriate.<br><br>**Financial:**<br>Spending is increasing in line with general cost of living.<br>ELFT spending issues have been resolved.<br><br>**Online formulary:**<br>The draft version of the Milton Keynes Practice Nurses formulary has been reviewed by TVNs from CNWL and is now being edited, with publishing planned to be aligned with changes to the ordering process in MK.<br>A system has been reintroduced within the Group to ensure regular review of dressings sections, so the information provided on the online formulary is kept up to date.<br><br>**Waste Reduction in Wound care**<br>Waste reduction and other sustainability issues is now a standing agenda item, with a lead in the Group who will link in with other ICB programmes and projects. Several suggestions have been made as there is a bit of focus on this subject in Wound Care generally. Going forward, all formulary applications will contain a Green impact section. Ideas & initiatives will be linked into the ICB Green Group and the Medicines Optimisation Green Group.<br><br>**Matters arising**<br>The procurement of dressings in Milton Keynes will be moving to NHS Supply Chain (NHSSC) from NWOS (North West Ostomy Supplies) in the next month or so. This will aid alignment across the ICB. NHSSC already have weekly deliveries in Milton Keynes, rather than couriering orders, and deliver in cages with no extra packaging. Both of these aspects support the NHS Sustainability plan by directly cutting down on carbon emissions. There are also several opportunities for savings with the resulting larger purchasing base. There will be phased implementation to introduce NHSSC in MK which will initially affect the practices, then will be rolled out to other stakeholders and care homes. NHSSC will be the first line option for obtaining dressings, but ONPOS will be available as back up during the transition period. | |

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| | **Decision:** The Committee noted the report from the Wound Management Steering group. | |
| **10.** | **Patient Group Direction Subgroup Recommendations**<br>The following recommendations were made by the Patient Group Direction (PGD) subgroup: | |
| **10.1** | **MK Urgent Care Patient Group Directions**<br>The following PGDs were presented for approval with clinical changes:<br>• **Flucloxacillin** for Impetigo and Cellulitis – doses brought into line with BLMK Guidance<br><br>The following PGDs were presented for approval with no clinical changes:<br>• **Amoxicillin** for the treatment of lower respiratory tract infection in children aged 1 to 16.<br>• **Phenoxymethylpenicillin (penicillin V)** for the treatment of suspected bacterial tonsilitis and pharyngitis.<br><br>In addition, the following PGD was approved via Chair's action, as the update was delayed pending publication of the revised national PGD template:<br>• **Benzylpenicillin** for suspected meningitis.<br><br>The Committee notes that the current UKHSA Revaxis (Td/IVP) PGD is due for review. The national template expires on 4th August 2024 and the new version is not expected to be published until early July which does not give sufficient time to get it to the July APC. It was therefore agreed to extend the use of the current PGD to the end of August (but change over earlier if the new version can be approved sooner by Chair's agreement).<br><br>**Decision:** The Committee ratified the PGDs, as recommended by the PGD subgroup | |
| **10.2** | **HCRG Care Group Patient Group Directions**<br>The following PGD was presented for approval with clinical changes:<br>• **Lidocaine injection:** amended to include 2% strength and maximum injection quantities for this strength. Minor amendment made to clarify the group of physiotherapists using the PGD (and remove podiatrists). No additional changes to clinical content.<br><br>**Decision:** The Committee ratified the PGD, as recommended by the PGD subgroup | |
| **11.** | **Antimicrobial Resistance (AMR) Update**<br>The BLMK AMR group are meeting on 4th July (after the APC meeting), so an update was presented in terms of performance against antimicrobial targets. A new antimicrobial national action plan for 2024-2029 has been published and this is expected to be main agenda item at the meeting AMR group meeting. A paper will be brought to APC in the future to outline the BLMK response to the action plan.<br><br>The Committee noted the following information: | |

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| | • Total antibiotic prescribing for BLMK primary care is still above the national benchmark – this continues to be a target in the primary care prescribing incentive scheme.<br>• The antimicrobial formulary has been embedded into SystmOne to support the appropriate use of antimicrobials, including the use of shorter, 5-day courses of amoxicillin.<br>• Paediatric prescribing – BLMK is a notable outlier in terms of antimicrobial prescribing in children and the ICB has the second highest levels of prescribing in primary care (nationally). This has been escalated to the children and young people's group, will be taken to the AMR group, and regional work on reducing this is planned.<br>• Use of quinolones is steadily decreasing in BLMK following the MHRA alert and provision of education.<br>• Some metrics for secondary care were not able to be presented because of a data/reporting issue.<br>• Both acute trusts are on target to meet CQUIN targets for IV to oral switches.<br><br>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 – January 2024<br>The committee noted the minutes for information. | |
| **13.** | **Bedfordshire, Luton and Milton Keynes Local Prescribing Committee Minutes.**<br>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) – May 2024 | |
| **13.3** | Minutes of the BLMK Formulary Subgroup – April 2024 | |
| **13.4** | Minutes of the BLMK Wound Management Formulary Steering Group – March 2024 | |
| **13.5** | Minutes of the BLMK Medicines Safety Group – January 2024 | |
| **13.6** | Minutes of the ELFT Medicines Management Committee – May 2024 | |
| **13.7** | Minutes of the Cambridgeshire Community Services Medication Safety and Governance Group – May 2024 | |
| **13.8** | Minutes of the CNWL Trustwide Medicines Optimisation Group (MOG) – April 2024 | |
| **13.9** | Minutes of Circle/MSK Medicines Management Committee – March 2024 | |

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| **14.** | **Papers for information / ratification** | |
| **14.1** | **BLMK Area Prescribing Committee Annual Report 2023/24**<br>The committee considered the third Annual Report of the BLMK APC, the contents of which reflect the output from the committee meetings on 3rd May 2023, 5th July 2023, 27th September 2023, 6th December 2023 and 28th February 2024.<br><br>The report summarises the participating organisations, meeting attendance figures, the Committee's activities and achievements and the future work programme.<br><br>The Chair and Professional Secretary thanked the Committee for all their hard work and commitment to the APC.<br><br>**Decision:** The Committee ratified the BLMK Area Prescribing Committee annual report | |
| **15.** | **Any other business**<br>• **Retirement of the "Available gonadorelins and their licensed indications" table.**<br>The table was reviewed and, following consultation, has been retired as the content changes too frequently to maintain accuracy of the document. It is also straightforward to check the latest information via EMC website, so the document is no longer needed.<br><br>• **Amendment of the fact sheet for azathioprine (sub-document of the overarching Bedfordshire/Luton rheumatology shared care guideline)**<br>It was proposed that the azathioprine fact sheet should be updated in line with the information included in the RMOC shared care guideline template, to ensure that the clinical information it contains is in line with more recently updated guidance. The proposal was agreed, and this will be taken forward. | SMcG |
| **16.** | **Future Dates for BLMK APC 2024/2025 Meetings (all to be held from 12:30-15:00 via Microsoft Teams):**<br><br>Wednesday 25th September 2024<br>Wednesday 4th December 2024<br>Wednesday 26th February 2025<br>Wednesday 7th May 2025<br>Wednesday 2nd July 2025<br>Wednesday 24th September 2025<br>Wednesday 3rd December 2025 | |

**Approval of minutes:**

Chair: Dr Muhammad Nisar

Signed: 

Date: 14/10/2024

## Appendix 1 – Approved 11 June 2024 Formulary Subgroup Minutes:

FSG Minutes June 2024 Final.pdf