BEDFORDSHIRE, LUTON AND MILTON KEYNES AREA PRESCRIBING COMMITTEE

Meeting Notes

Date: 07 May 2025
Time: 12.30- 2.25pm
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
Reginald Akaruese	RA	CNWL Pharmacy Representative (Community and Mental Health Services Milton Keynes)
Dr Marian Chan (until 14:03)	MC	Medical Representative, Bedfordshire Hospitals NHS Trust
Matt Davies (deputising for FG until 12:40)	MD	Head of Medicines Optimisation, BLMK ICB
Fiona Garnett (from 12:40)	FG	Associate Director: Pharmacy and Medicines optimisation, BLMK ICB
Anne Graeff	AG	Commissioning Lead Pharmacist, BLMK ICB (Professional Secretary)
Cheryl Green	CG	Patient Representative
Emma Hooton	EH	Practice Pharmacist Representative (Independent Prescriber)
Carole Jellicoe	CJ	Nurse Representative (Independent Prescriber)
Faisal Khan	FK	Milton Keynes Hospital Pharmacy Representative (Medicines Use & Quality Manager, Milton Keynes Hospital)
Natasha Patel	NP	ELFT Pharmacy Representative – Community Services (Beds)/Mental Health Services (Beds and Luton)
Dr Kate Randall (from 12:37)	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

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

Dona Wingfield (from 13:00)	DW	Chair of Medicines Safety Group / Bedfordshire Hospitals Trust Pharmacy Representative (Head of Medicines Governance Safety and Quality, Bedfordshire Hospitals Trust)
Dr Maggie Winter	MW	Place Based Lead GP – Milton Keynes

In attendance:		
Rafal Ali	RA	Commissioning Pharmacist, BLMK ICB
Samina Hassanali	SH	Formulary and Medicines Safety Pharmacist, BLMK ICB
Qiratulain Khan (from 12:37)	QK	Bedfordshire Hospitals Trust Pharmacy Representative (Lead Pharmacist Medicines Information and Formulary, BHFT)
Helen McGowan (from 12:50-14:14)	HMcG	Medicines Optimisation Pharmacist, BLMK ICB
Sandra McGroarty	SMcG	Commissioning Pharmacist, BLMK ICB
Dr Joy Mutitika	JM	Medical Representative, Keech Hospice
Takudzwa Shumba	TS	CNWL Pharmacy Representative (Prison Services - HMP Bedford and YarlsWood IRC)
Nikki Woodhall	NW	Lead Medicines Optimisation Technician, BLMK ICB
Alisha Gandhi (in attendance for agenda item 5.1)	AGa	Medicines Optimisation Pharmacist, BLMK ICB

Apologies:		
Nicola Ainsworth	NA	Consultant in Public Health
Dr Mya Aye	MAy	Medical Representative, Milton Keynes Hospital
Pritesh Bodalia	PB	Bedfordshire Hospitals Trust Pharmacy Representative (Chief Pharmacist, Bedfordshire Hospitals Trust)
Candy Chow	CC	Chair of Wound Care Group
Alice Green-Smith	AGS	Representative, St John's Hospice
Dr Dush Mital	DM	Medical Representative, Milton Keynes Hospital

No	Agenda Item	Action
1.	**Welcome, Introductions and Apologies** The Chair welcomed everyone to the meeting. Apologies were received and noted as above. The Chair extended best wishes to Candy Chow, who has recently started maternity leave. The meeting was confirmed as quorate.	

No	Agenda Item	Action
2.	**Declarations of Interest** The Chair invited the members to reconfirm their current declarations on the Register of Interests and advise of any new declarations. All members confirmed their declarations were accurate and up-to-date. The Chair invited members to declare any declarations relating to matters on the agenda. All members confirmed they have no declarations in relation to matters on the agenda.	
3.	**Minutes of 26 February 2025 APC meeting** The minutes of the meeting held on 26 February 2025 were approved.	
4.	**Matters Arising**	
4.1	**Feedback on miscellaneous actions not included on the agenda from APC meetings**	
4.1.1	**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 23/04/2025** – 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
4.1.2	**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 05/03/2025** – due to the difficulties in prescribing discussed with the GPs, the request for shared care has been withdrawn and the trust will retain prescribing within secondary care. Nebulised gentamicin will remain RED on the BLMK formularies. It was proposed and agreed that the action could be closed.	Close
4.1.3	**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 05/03/2025** – see above: request for shared care withdrawn. It was proposed and agreed that the action could be closed.	Close
4.1.4	**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.	Close

No	Agenda Item	Action
	Update 05/03/2025 – see above: request for shared care withdrawn. It was proposed and agreed that the action could be closed.	
4.1.5	**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 05/03/2025** – see above. Guidance document updated to state that nebulised gentamicin has red formulary status. No other changes required. Document finalised and uploaded onto Medicines website. It was proposed and agreed that the action could be closed.	Close
4.1.6	**Switching from injectable GLP1-RAs to oral semaglutide guidance** - to be updated to reflect product availability for liraglutide and exenatide. **Update 26/02/2025** – 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 16/04/2025** - the update has been completed and the revised version of the guidance is available via the Medicines website. It was proposed and agreed that the action could be closed.	Close
4.1.7	**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. **Update 16/04/2025** – the guidance has been retired and removed from the Medicines website. It was proposed and agreed that the action could be closed.	Close
4.1.8	**GLP -1 Receptor Agonists – National Shortage: Frequently Asked Questions (FAQs)** – to be updated to include information on tirzepatide (as per ABCD-PCDS guidance). Update 16/04/2025 – the national shortage of GLP1 RAs has now resolved and the FAQs are no longer needed. The guidance has been archived. It was therefore proposed and agreed that the action could be closed.	Close
4.1.9	**Bempedoic acid prescribing support document** - document to be updated to clarify details in relation to use as monotherapy, use if Hb is out of range, information in relation to next steps if non-HDL-C has not reduced by 40% and that it is non-fasting lipids which should be checked. **Update 13/03/2025** – the updates have been made, the document finalised and uploaded to the Medicines website. It was proposed and agreed that the action could be closed.	Close
4.1.10	**Inclisiran prescribing support document** - to amend lipid monitoring to non-fasting full lipid profile, and 'ASCVD' to 'cardiovascular disease'.	Close

No	Agenda Item	Action
	Update 13/03/2025 – the updates have been made, the document finalised and uploaded to the Medicines website. It was proposed and agreed that the action could be closed.	
5.	**Items for consideration at meeting**	
5.1	**Medicines in Schools Guidance** A revision and update of the previous guidance from Bedfordshire was presented to the Committee. The updated Medicines in Schools guidance is now for use across the whole of BLMK and has been reviewed by the local councils and community services providers. The following changes / updates have been made from the Bedfordshire document: • Additional sections added to the guidance to support of managing medications which were not previously covered e.g. school trips and sporting activities, cough sweets/lozenges, treating conjunctivitis, and information on Education, Health and Care (EHC) plan for children with special educational needs and disabilities (SEND). • Additional information has been added for those children who may be initiated on MART or AIR therapy for asthma and require emergency treatment. • Information on safe handling and spillages has been added for the rare occasion cytotoxic medications may need to be administered in schools. • Appendices C-G have been removed as the information is covered via links and other information included throughout the document. It was confirmed that there is information contained within the document about management and administration of controlled drugs in schools, including in relation to school trips, and that the document provides guidance in relation to adrenaline autoinjectors. **Decision**: The Committee approved the updated Medicines in Schools guidance. **EQIA Assessment:** No expected impact. The document has been reviewed with regard to Equality, Inclusion and Human Rights and no issues have been identified. **BLMK ICB E and D Lead comment:** Under the equity, equality, diversity and inclusion impact assessment section: I advise that you change “No expected impact” to ‘No negative equality impact is expected on any group of people, and this will be monitored and reviewed on an ongoing basis.’ NB: This section has been updated in accordance with the recommendations of the E and E lead.	
5.2	**Vitamin D in Adults Guideline** The Committee considered a revised and updated guideline for the management of vitamin D deficiency and insufficiency in adults from 18 years of age in primary care. Previously, Bedfordshire & Luton	

No	Agenda Item	Action
	had their own vitamin D guidelines for adults (last updated September 2018) and so did Milton Keynes (April 2019). Milton Keynes also had separate documents for the management of vitamin D deficiency in adults, at-risk groups and pregnancy. This new BLMK version brings together recommendations for adults, at-risk groups and pregnancy in one place taking into account the previous versions and the latest national guidance and evidence available. The key changes/updates that have been made in the guideline include: • Update to the vitamin D thresholds – i.e. vitamin D deficiency = serum vitamin D level < 25 nmol/L (previously < 30 nmol/L). Vitamin D insufficiency = serum vitamin D level between 25 and 50 nmol/L (previously it was between 30 and 50 nmol/L). • When to test for vitamin D deficiency – wording amended, and list of symptoms updated to add clarity. Wording regarding a low serum calcium as a criterion for vitamin D testing from the previous B&L guideline has been removed. • The flow chart diagram (figure 1 in the guideline) summarising the management of vitamin D deficiency and insufficiency (and sufficiency) has been updated according to the latest national guidance and recommendations from relevant professional groups/societies. • The recommended treatment options and formulary choices for colecalciferol have been updated (figure 2 in the guideline). This is based on a review of the drug tariff prices of all available vitamin D products from April 2025 – the most cost effective licensed products have been chosen. • The recommended formulary choices for combined vitamin D/calcium supplements have also been included for completeness (figure 3). These products were agreed at the Formulary Subgroup in February 2025. • Information has been included in the guideline in relation to suitability for vegetarians and those who are allergic to peanuts/soya – this is accurate at the time of writing based on available licensing information and information from the Specialist Pharmacy Service (SPS). As manufacturers may change the formulations of their products, it is recommended to check the most up to date information on excipients and product ingredient origins on any prescribed item for any patient with specific dietary requirements or allergy to peanut, soya or soya bean. • Information and signposting in relation to vitamin D for vegans has been added. • Information on vitamin D during pregnancy and breastfeeding has been added. • Information on safety considerations when using vitamin D has been added/updated. The Committee noted the following additional points: • **SELF-CARE** with vitamin D supplements is advised for those who are vitamin D sufficient (serum vitamin D level >50 nmol/L) and also for those who require maintenance	

No	Agenda Item	Action
	supplementation of 800-2000 units daily. Vitamin D preparations are easily available in supermarkets, pharmacies and health shops, and should **not** be prescribed. • A prescription may be given in exceptional circumstances, i.e. those with osteoporosis, or a chronic condition or surgery that results in vitamin D deficiency or malabsorption. • If a prescription is required for maintenance supplementation, it is recommended to opt for the cost-effective formulary choices as outlined in Figure 2, i.e. Colextra D3® 800 unit capsules first line, Stexerol D3® 1000 unit tablets second line. Domnisol® (calcifediol) 266 microgram capsules is preferred for certain patient groups (see formularies for details). • For the treatment of vitamin D deficiency (serum vitamin D level <25 nmol/L) with a high dose/loading course regime, the following options are recommended: Colextra D3® 20,000 unit capsules (2 capsules once weekly, for 7 weeks) first line; InVita D3® 50,000 units/1ml oral solution unit dose ampoules sugar free (1ml once weekly, for 6 weeks) second line (if patient has swallowing difficulty or is a vegetarian). Domnisol® (calcifediol) 266 microgram capsules is preferred for certain patient groups (see formularies for details). • Full treatment / loading course to be prescribed on an acute prescription. • Where a deficiency is diagnosed in secondary care, the full treatment course should be issued by the hospital when the patient is discharged or on an outpatient prescription if the patient isn't an inpatient. • Products to be prescribed by brand name to ensure a licensed product which is suitable for the patient is dispensed. • All 400 unit colecalciferol preparations are non-formulary as these are self-care products. • On rare occasions higher maintenance doses of 4000 units daily may be required (e.g. for patients for malabsorption), which would be advised by the specialists. Desunin® 4000 unit tablets are advised to be prescribed in this scenario and are proposed to be added to the formulary with SpA formulary status. This product is not specifically included in the guideline as primary care prescribers would not be expected to initiate it. • Formulary changes, to align the formularies and in line with the guideline recommendations, have also been recommended. • There is likely to be high prescribing of vitamin D 800 units in Milton Keynes as, in the previous guidance, it was not stated to be self-care. There was also further discussion around prescribing of maintenance doses of vitamin D across BLMK and that it may be useful to conduct an audit in this area. **Decision**: The BLMK vitamin D prescribing guidance for adults was approved.	

No	Agenda Item	Action
	EQIA Assessment: No impact anticipated. Some people are at a higher risk of vitamin D deficiency, such as people aged 65 years and over, people with darker skin tones, those who cover their skin for cultural or health reasons, those who are housebound/ in care facilities, those who are confined indoors for long periods, pregnant women and breastfeeding women. These patient groups are clearly identified within the guideline, and advice on appropriate management of these patients is outlined. The recommendations are based on national guidance and recommendations from relevant professional groups/committee consensus, all of which acknowledge that these patient groups are at a higher clinical risk of developing vitamin D deficiency. In addition, information and signposting in relation to vitamin D and the choice of products for people on a vegetarian or vegan diet have been provided within the guideline to ensure consideration and inclusion of these patient groups. Similarly, patients with an allergy to peanut, soya or soya bean, and those with swallowing difficulty, have also been accounted for in terms of product choice and availability. **BLMK ICB E and D Lead comment:** Under the equity, equality, diversity and inclusion impact assessment section, I advise that you add: 'the EIA outcome that the implementation of this decision may impact on one or more equality group differently to others will be monitored and reviewed on an ongoing basis.' NB: This section has been updated in accordance with the recommendations of the E and E lead.	
5.3	**Osteoporosis guidelines** The existing osteoporosis guideline was originally written in 2011 for Bedfordshire in Luton. Since then, it has been reviewed and updated to reflect new guidance and incorporate NICE Technology Appraisal (TA) Guidance. In 2021 it was revised and extended to cover the whole of BLMK, with further update in June 2022. In 2024, the National Osteoporosis Guideline Group (NOGG) published an updated guideline and the BLMK guidance has been revised to reflect this, alongside consideration of CKS guidelines and NICE TAs. The Committee noted that a separate update of guidance for patients on corticosteroids is underway and will be presented at the July 2025 APC meeting. The Committee discussed the following specific points: • **Oral bisphosphonates** – weekly versus daily dosing – the wording in the guidance is to be updated to include the weekly dosing as the preferred regimens, with a footnote to say daily options are available if preferred. The Committee discussed the licensed indications for weekly alendronate and risedronate and noted that weekly alendronate is only licensed for use in post-menopausal women, whereas weekly risedronate is also licensed the treatment of osteoporosis in men at high risk of fractures. It was agreed that off-label use	SMcG

No	Agenda Item	Action

	of weekly alendronate in men was common, but that a footnote should be added to note that use in men is off-label.
	• **Hormone Replacement Therapy (HRT)**: NOGG (National Osteoporosis Guideline Group) now includes recommendations for the use of HRT for younger postmenopausal women (age ≤ 60 years) with high fracture risk, and low baseline risk for adverse malignant and thromboembolic events. The Committee agreed that this recommendation should be included, using the wording from NOGG, but that a footnote should be added to say that menopause guidance recommends using HRT only for women with menopausal symptoms and for the shortest possible period. Discussion would take place with the individual to determine the best treatment option for them.
	• Pre-menopausal osteoporosis in women sits outside of the guidance and is more specialist.
	• **Review date** of therapy for bisphosphonates: it was agreed that the review date for bisphosphonates should be 3-5 years +/- DXA.
	• Recalculation of FRAX following DXA report – the Committee discussed whether there is a need for primary care clinicians to recalculate the FRAX score following a DXA scan as it is expected that the clinician writing the DXA report would have taken into account the FRAX score and DXA scan results when making treatment recommendations. On rare occasions when this is not the case, primary care clinicians should consider recalculating the FRAX following the result of a patient's first DXA scan (FRAX is not validated for people who have already commenced treatment). Wording to clarify this is to be added to the guideline document.
	• Medication reviews for bisphosphonates –The Committee agreed that compliance should be checked after one month, 3 months, then annually.
	• It was highlighted that ibandronic acid (oral and IV) is in the guideline but is not listed on the Beds/Luton and MK formularies – this will need to be added.
	• Calcium and vitamin D supplementation – it was proposed and agreed that the wording in this section should be amended as follows:
	  ○ Consider supplementation with vitamin D +/- calcium (if dietary calcium is low and/or vitamin D insufficiency is a risk – calcium should not be prescribed on its own):
	  ▪ If required, prescribe vitamin D 800 IU, or calcium 1-1.2g and Vitamin D 800 IU (combined product).
	  ▪ For frailty / care home residents – prescribe calcium 1-1.2g and Vitamin D 800 IU (combined product).
	• Amendment to title of document. An amendment to the information on the title page, in relation to transpeople, in line with information from the Royal Osteoporosis Society was proposed and agreed: "*Transgender (Transpeople): -
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		SMcG
		SMcG

No	Agenda Item	Action
	Assess fracture risk on an individual basis as it will depend on the particular pattern of hormone replacement being taken, alongside any other general risk factors for osteoporosis (Ref Royal Osteoporosis Society – Transgender people and Osteoporosis fact sheet). Additional text will also be added to state that specialist advise should be sought for transpeople. • It was agreed that having a one page summary of the guidance, similar to the one available in the previous version, would be reintroduced to aid primary care clinicians. **Decision**: The guidance was approved with the amendments outlined above. **EQIA Assessment:** No impact anticipated. The committee have been asked to comment on the title of the document i.e. it refers to postmenopausal women and men > 50 years and the committee have been asked to consider whether a footnote should be added to say that this guideline also applies for transmen, transwomen and non-binary people. **BLMK ICB E and D Lead comment:** N/A	SMcG
5.4	**Atopic dermatitis pathway update** The Committee considered a minor update to the BLMK treatment pathway for moderate to severe atopic dermatitis in adults (after inadequate response to topical treatments and conventional systemic therapies). The update is required as it has recently been identified that there is variation across the East of England (EoE) region of what the minimum Eczema Area and Severity Index (EASI) score should be before starting a high cost drug treatment for moderate to severe Atopic Dermatitis (AD). The BLMK treatment pathway for AD currently says ≥16. This is not in line with most other ICBs in the EoE (Hertfordshire and West Essex being the exception, though they are currently reviewing this), or the existing BLMK Blueteq form for dupilumab for treating moderate to severe atopic dermatitis (NICE TA534), which states “The disease is moderate to severe as defined by a EASI score of 7.1 or more and a DLQI of 6 or more”. The dupilumab TA was the first one to be published for this therapy area and therefore these thresholds have been the ones in use since 2018 when TA534 was published. It was therefore proposed that the EASI score threshold on the atopic dermatitis pathway is amended from 16 to 7.1, in line with the BLMK dupilumab Blueteq proforma and the threshold being used by most other ICBs in the East of England. In addition, it was proposed that the threshold Dermatology Life Quality Index (DLQI) score of ≥6 is added to the pathway and that the other two parameters currently in the pathway – Investigator’s Global Assessment (IGA) score and the affected body surface area (BSA) – are removed. This is because these parameters are not included in the NICE TAs for atopic dermatitis treatments.	

No	Agenda Item	Action
	The Committee noted that the potential addition of another treatment to the pathway (nemolizumab) had been anticipated in addition to the changes outlined above, however the draft TA recommendations are negative and the expected publication date for the technology appraisal delayed to July. **Decision**: The updated atopic dermatitis pathway was approved. **EQIA Assessment:** N/A	
5.5	**BLMK Adult Recurrent UTI guidance** At the last APC, in February 2025, the Committee considered an update to the primary care antimicrobial guidelines. As part of the consideration, the Committee discussed the recommendations on the management of recurrent urinary tract infection (rUTI). The Committee agreed that a 6-month stop date should be included for methenamine, and that information should be included to highlight the risk of pulmonary fibrosis with nitrofurantoin. On further review, it was decided to create a standalone document for the management of rUTI, to provide additional information and support to clinicians managing patients with rUTI. This will be linked to the main primary care antimicrobial prescribing guidelines, and vice versa. The rUTI guidance reflects recent updates to NICE NG112: Urinary tract infection (recurrent): antimicrobial prescribing and the BNF, and includes information on the use of methenamine hippurate and vaginal oestrogen, as well as the use of antimicrobials. The document also provides additional practical detail on stepwise management, patient review and trialling stopping prophylaxis. Information has been included on the risk of pulmonary fibrosis with nitrofurantoin, including a link to the MHRA alert. Patients should be regularly reviewed. The Committee noted that, anecdotally, vaginal oestrogen has been used occasionally in pre-menopausal women with vaginal dryness due to use of progesterone only contraception. This is not to be included in the guidance **Decision**: The recurrent UTI guidance was approved. **EQIA Assessment:** No impact expected. Summary document of national guidance. **BLMK ICB E and D Lead comment:** N/A	
5.6	**Buccal midazolam prescribing guidance** The existing prescribing guidance for buccal midazolam (agreed for use across BLMK in June 2022; previous version approved by the Bedfordshire and Luton Joint Prescribing Committee, Sept 2017) has been reviewed and updated in light of licensing changes to available products. The changes are as follows:	

No	Agenda Item	Action
	• Buccolam is now licensed for use in adults, as well as children. • Epistatus pre-filled syringes (2.5mg, 5mg, 7.5mg and 10mg) are now licensed products and the colour coding of the different strengths is the same as Buccolam (previously only the Epistatus 10mg strength was licensed). • The Epistatus 10mg/ml (5ml) bottle remains an unlicensed product. Buccolam pre-filled syringes are the established, preferred formulary choice within BLMK and remain significantly cheaper per syringe than the Epistatus product for each strength (ref: drug tariff, April 2025). Additional text has been added to clarify that the recommendation to use Buccolam applies for patients of all ages and that, for all patients, an emergency seizure plan should be completed when initiating or reviewing the medication The updated document has been circulated to local clinicians for comment and their comments incorporated as outlined above. The Committee discussed the flowchart for review of patients prescribed a product other than Buccolam, and whether it is appropriate for the GP / primary care clinician to review a patient for suitability to change to Buccolam. It was agreed that primary care clinicians would not do this review and therefore the text should be amended to read "**Relevant Specialist** to review patient for suitability to change to Buccolam® Oromucosal solution pre-filled oral syringes". **Decision**: The buccal midazolam prescribing guidance was approved with the amendment outline above. **EQIA Assessment:** No impact anticipated: material contents of the guidance remain unchanged, with updates relating to the changes in licensing of available products. **BLMK ICB E and D Lead comment:** N/A	AG
6.0	**NICE Guidance – from 13 February until 23 April 2025** **The following NICE Technology Appraisal Guidance (ICB Commissioned) have been published:** • **12 SQ-HDM SLIT for treating allergic rhinitis and allergic asthma caused by house dust mites** Technology appraisal guidance Reference number: TA1045 Published: 05 March 2025 https://www.nice.org.uk/guidance/ta1045 **Resource impact:** the resource impact of implementing TA1045 is expected to be approximately £10,000 in year 1, rising to £20,000 from year 3 onwards. No prescribing at local trusts (no immunotherapy services offered). Patients are likely to be referred to Addenbrooke's, Oxford or Royal Brompton for treatment.	

No	Agenda Item	Action
	The Committee considered the appropriate formulary designation for 12 SQ-HDM SLIT for the BLMK ICS. Current ICS arrangements for tertiary centres: • Addenbrooke's: in use prior to publication of TA1045. Specialist initiation (first month of treatment provided by specialist) without shared care guidance with continuation in Primary Care. • Oxford: APC decision - Red as part of the NICE TA implementation paper, with a note that it will be changed to Amber Initiation if a full formulary application is brought forward by the specialists. • Royal Brompton – currently Red traffic light status. To be discussed at the next APC meeting in May. May change to Amber. NICE assumption: initiation by specialists and continuation in primary care: • "12 SQ-HDM SLIT is a tablet. It is assumed that following initiation of the treatment in secondary care, the treatment will continue to be prescribed and dispensed in primary care". Note: PAC is producing some supporting documents – prescribing support information for primary care prescribers and a commissioning statement to support a potential Amber formulary designation for 12 SQ-HDM SLIT (Acarizax). The Committee discussed the above points and considerations and agreed an Amber formulary status (SpA or SpIS – to be confirmed at a later meeting) once the PAC documents are finalised and available for use. Until such time, 12 SQ-HDM SLIT (Acarizax) will be added to the formularies with RED formulary designation. • **Molnupiravir for treating COVID-19** Technology appraisal guidance Reference number: TA1056 Published: 16 April 2025 https://www.nice.org.uk/guidance/ta1056 **Resource impact:** expected to be very low, as current patient numbers indicate that fewer than 20 patients have been treated with molnupiravir in the last year. Cost impact approx. £11k/year. The Committee discussed the appropriate formulary status for molnupiravir and agreed that it should be RED - restricted to prescribing by specialists in the CMDU service or secondary care only in accordance with NICE TA1056. • **Relugolix–estradiol–norethisterone for treating symptoms of endometriosis** Technology appraisal guidance Reference number: TA1057 Published: 16 April 2025 https://www.nice.org.uk/guidance/ta1057	AG/FK AG/FK

	Resource impact: to be determined following additional conversations with local trusts. The Committee discussed the appropriate formulary status for relugolix–estradiol–norethisterone (relugolix CT) for treating symptoms of endometriosis. It was noted that relugolix CT is already on the formularies, with SpA formulary status, for the management of fibroids. Prescribing numbers are very low, with 115 prescriptions issued in the last year (assumed for fibroids indication). The following points were noted: • NICE assumes initiation by specialists with continuation in primary care. • The use of relugolix CT is expected to displace some usage of GnRH agonists, reducing administration appointments and some environmental impact (waste). • Duration of therapy of relugolix CT – it was confirmed that, for both the fibroids and endometriosis indications, relugolix CT can be taken without interruption. Discontinuation should be considered when the patient enters menopause, as the symptoms of both uterine fibroids and endometriosis are known to regress when menopause begins. The Committee agreed that an Amber SpIS formulary status was appropriate (applicable to fibroids indication also) and that a prescribing support document would be useful to support prescribers. **The following NICE Guidelines (NG) (Medicine related and ICB Commissioned) have been published / updated by NICE:** **Early and locally advanced breast cancer: diagnosis and management** NICE guideline [NG101] Published: 18 July 2018 Last updated: 19 February 2025 https://www.nice.org.uk/guidance/ng101 This guideline covers diagnosing and managing early and locally advanced breast cancer. It aims to help healthcare professionals offer the right treatments to people, taking into account the person's individual preferences. NICE reviewed the evidence and made new or updated recommendations on identifying, managing and reducing risk of lymphoedema. For more details, see update information. **APC actions:** updated recommendations around the management of lymphoedema (use of compression garments (already included in the locally agreed medical devices policy) and kinesiology tape (not available on NHS prescription)) to be discussed at the next Wound Management Steering Group meeting. **Advanced breast cancer: diagnosis and treatment** Clinical guideline [CG81] Published: 23 February 2009 Last updated: 19 February 2025 https://www.nice.org.uk/guidance/cg81 This guideline covers care and support for people with advanced (stage 4) breast cancer. It aims to help them and their healthcare professionals make shared decisions about tests and treatments to improve outcomes and quality of life.	AG/FK AG

No	Agenda Item	Action
	For new and updated guidance on identifying and managing lymphoedema, see recommendations on managing local treatment complications in the NICE guideline on early and locally advanced breast cancer: diagnosis and management, which have updated and replaced the recommendations on lymphoedema in this guideline. **APC actions:** as above **The following NICE TAs are the commissioning responsibility of NHSE and are listed for information only:** **Durvalumab with etoposide and either carboplatin or cisplatin for untreated extensive-stage small-cell lung cancer** Technology appraisal guidance Reference number: TA1041 Published: 19 February 2025 https://www.nice.org.uk/guidance/ta1041 **APC actions:** Link added to formularies (RED traffic light) **Selpercatinib for previously treated RET fusion-positive advanced non-small-cell lung cancer** Technology appraisal guidance Reference number: TA1042 Published: 19 February 2025 https://www.nice.org.uk/guidance/ta1042 **APC actions:** Link added to formularies (RED traffic light) **Osimertinib for adjuvant treatment of EGFR mutation-positive non-small-cell lung cancer after complete tumour resection** Technology appraisal guidance Reference number: TA1043 Published: 26 February 2025 https://www.nice.org.uk/guidance/ta1043 **APC actions:** Link added to formularies (RED traffic light) **Exagamglogene autotemcel for treating severe sickle cell disease in people 12 years and over** Technology appraisal guidance Reference number: TA1044 Published: 26 February 2025 https://www.nice.org.uk/guidance/ta1044 **APC actions**: none required; no local use expected. NB: resource impact statement states providers are “Secondary care - acute. Limited to authorised providers only”. **Zolbetuximab with chemotherapy for untreated claudin-18.2-positive HER2-negative unresectable advanced gastric or gastro-oesophageal junction adenocarcinoma** Technology appraisal guidance Reference number: TA1046 Published: 12 March 2025 https://www.nice.org.uk/guidance/ta1046 **APC actions:** none – not recommended **Atezolizumab for untreated advanced or recurrent non-small-cell lung cancer when platinum-doublet chemotherapy is unsuitable (terminated appraisal)** Technology appraisal Reference number: TA1047 Published: 12 March 2025 https://www.nice.org.uk/guidance/ta1047 **APC actions:** link added to formularies (TERMINATED APPRAISAL)	

	Lisocabtagene maraleucel for treating relapsed or refractory large B-cell lymphoma after first-line chemoimmunotherapy when a stem cell transplant is suitable Technology appraisal guidance Reference number: TA1048 Published: 26 March 2025 https://www.nice.org.uk/guidance/ta1048 **APC actions:** likely none (no local use expected) **Blinatumomab with chemotherapy for consolidation treatment of Philadelphia-chromosome-negative CD19-positive minimal residual disease-negative B-cell precursor acute lymphoblastic leukaemia** Technology appraisal guidance Reference number: TA1049 Published: 26 March 2025 https://www.nice.org.uk/guidance/ta1049 **APC actions:** link added to formularies **Fenfluramine for treating seizures associated with Lennox–Gastaut syndrome in people 2 years and over** Technology appraisal guidance Reference number: TA1050 Published: 26 March 2025 https://www.nice.org.uk/guidance/ta1050 **APC actions:** link added to formularies (NB: providers are tertiary care) **Efanesoctocog alfa for treating and preventing bleeding episodes in haemophilia A in people 2 years and over** Technology appraisal guidance Reference number: TA1051 Published: 02 April 2025 https://www.nice.org.uk/guidance/ta1051 **APC actions:** likely none (no local use expected) **Pegylated liposomal irinotecan in combination for untreated metastatic pancreatic cancer (terminated appraisal)** Technology appraisal Reference number: TA1052 Published: 02 April 2025 https://www.nice.org.uk/guidance/ta1052 **APC actions:** none – terminated appraisal **Olipudase alfa for treating acid sphingomyelinase deficiency (Niemann–Pick disease) type AB and type B** Highly specialised technologies guidance Reference number: HST32 Published: 02 April 2025 https://www.nice.org.uk/guidance/hst32 **APC actions**: none – not recommended **Burosumab for treating X-linked hypophosphataemia in children and young people** Highly specialised technologies guidance Reference number: HST8 Published: 10 October 2018 Last updated: 08 April 2025 https://www.nice.org.uk/guidance/hst8 **APC actions:** none – minor update to wording only (In September 2024, recommendation 1.1 was amended. This change was made in error and, in **April 2025,** it was corrected back to the original wording). **Cladribine for treating active relapsing forms of multiple sclerosis** Technology appraisal guidance Reference number: TA1053 Published: 15 April 2025 https://www.nice.org.uk/guidance/ta1053 **APC actions:** link added to formularies	

No	Agenda Item	Action
	Ruxolitinib for treating acute graft versus host disease that responds inadequately to corticosteroids in people 12 years and over Technology appraisal guidance Reference number: TA1054 Published: 15 April 2025 https://www.nice.org.uk/guidance/ta1054 **APC actions:** likely none (no local use expected) **Rucaparib for maintenance treatment of advanced ovarian, fallopian tube and peritoneal cancer after response to first-line platinum-based chemotherapy** Technology appraisal guidance Reference number: TA1055 Published: 16 April 2025 https://www.nice.org.uk/guidance/ta1055 **APC actions:** link added to formularies **Tislelizumab in combination for untreated advanced non-small-cell lung cancer (terminated appraisal)** Technology appraisal Reference number: TA1058 Published: 23 April 2025 https://www.nice.org.uk/guidance/ta1058 **APC actions:** none: terminated appraisal **Leniolisib for treating activated phosphoinositide 3-kinase delta syndrome in people 12 years and over** Highly specialised technologies guidance Reference number: HST33 Published: 23 April 2025 https://www.nice.org.uk/guidance/hst33 **APC actions:** unlikely to be used local and therefore will not need to be added to the formularies.	
7.	**Medicines Safety update** A Primary Care Medicines Safety Update and a Medicines Safety Group Update was presented to the committee. **Primary Care Medicines Safety Update** This update focussed on the primary care response to the MHRA Drug Safety Updates (DSUs, February to April 2025) and CAS alerts (March 2025). In particular: **Valproate (Belvo, Convulex, Depakote, Dyzantil, Epilim, Epilim Chrono or Chronosphere, Episenta, Epival, and Syonell▼): two specialist review will not be required for male patients already taking valproate (DSU, February 2025)** Review by two specialists remains in place for patients initiating valproate under 55 years of age, but the Commission on Human Medicines (CHM) has advised that it will not be required for men currently taking valproate. Also, 3 infographics have been developed to provide clarity regarding valproate prescribing and which situations would require review by 2 specialists: • for female patients under 55 years old • for male patients under 55 years old • for male and female patients 55 years and older	

No	Agenda Item	Action
	Actions taken: Linked to formulary for information. Shared at place based prescribing meetings. ELFT and other providers will be incorporating these infographics into their policies. **Prolonged-release opioids: Removal of indication for relief of post-operative pain (DSU, March 2025)** The indication for the treatment of post-operative pain has been removed from the licences of all prolonged release opioids due to the increased risk of persistent post-operative opioid use (PPOU) and opioid-induced ventilatory impairment (OIVI). **Actions taken:** Linked to formulary for information. This alert will be discussed at the June MSG. **Fezolinetant▼(Veoza): risk of liver injury; new recommendations to minimise risk (DSU, April 2025)** Fezolinetant treatment is associated with a risk of drug induced liver disease. New recommendations have been introduced to minimise this risk. Liver function should be monitored before and during treatment in all patients taking fezolinetant. Fezolinetant should be avoided in patients with known liver disease or at a higher risk of liver disease. **Actions taken:** linked to formulary for information (NB: fezolinetant is currently non-formulary pending NICE technology appraisal publication. Expected publication date: tbc. Draft recommendations are negative). This alert will be discussed at the June MSG. **CAS Alert-NPSA-Discontinuation of Promixin (colistimethate) 1-million unit powder for nebuliser solution unit dose vials (CAS alert, March 2025)** Promixin® (colistimethate) 1-million-unit powder for nebuliser solution unit dose vials (UDVs) are being discontinued from early May 2025, with stocks anticipated to be exhausted by this date. **Actions taken:** This alert will be discussed at the June MSG. General practices receive NPSA CAS alerts directly and it will be shared via the primary care bulletin. A national Optimise Rx alert has been enabled to fire when Promixin is prescribed. Responses across the ICS to this alert are being collated. BHFT are working on an action plan as there have been referrals back into the hospital when patients have been unable to source supply in the community. A memo has been circulated trust wide to support clinicians in response to the alert, including consideration of alternative treatment choices, appropriate education and training for patients, and communication across the interface. A system wide response has been developed, including looking at prescribing in primary care (via ePACT data). The alert has been circulated to community pharmacies. The NPSA alert signposts prescribers to switch to Colicym brand, as a suitable alternative to Promixin. However, at the current time, trusts are struggling to obtain this brand. This has been fed back to regional procurement. At BHFT, paediatric patients are being prioritised for review and may be switched to tobramycin. Adult patients to be managed in line with the BLMK guidance on nebulised	

No	Agenda Item	Action
	antibiotics for prevention of exacerbations of non-Cystic Fibrosis bronchiectasis. **<u>Medicines Safety Group (MSG) Update</u>** <u>Females of childbearing age on anticoagulation / contraindication in pregnancy</u> Following a recent significant event when a female on warfarin fell pregnant. Awareness around managing anticoagulation in females of childbearing age will be added to the MSG work plan with the support of MKUH and BHFT. <u>Valproate</u> ELFT shared their valproate policy which was produced with the involvement of stakeholders and patients. It includes a definition of the specialist that can complete the ARAF form, a process if there is disagreement between the specialists, provision in an emergency acute patient setting, the consideration of different patient groups and at e.g. pre-menarche, the incorporation of an electronic ARAFs and future developments including mapping of ARAFs to a medicines' dashboard using Power BI. Incorporation of this great work across the ICS is planned. <u>Topiramate</u> BHFT have put together an audit proposal and designed a tool. The results and completed template will be shared with the group for wider use. Patient numbers in primary care will be obtained for baseline data. Generally, primary care is aware and have been proactive in reviewing patients on topiramate for migraine. The Committee noted the medicines safety update.	
8.	**Formulary Update**	
8.1	**Formulary Subgroup Recommendations** The following recommendations were made by the Formulary subgroup at the 22 April 2025 meeting: • **Doxylamine/pyridoxine (Xonvea) for nausea and vomiting in pregnancy (NVP).** The Green-top Guideline No.69 for the Management of Nausea and Vomiting in Pregnancy and Hyperemesis Gravidarum (HG) was published by the Royal College of Obstetricians and Gynaecologists in February 2024. A first line treatment option suggested is Xonvea (the only licensed medicine for this indication). The usual starting dose is one tablet at night or one tablet twice a day with the potential to increase to a maximum of 4 tablets daily. Other first line options include cyclizine, prochlorperazine, promethazine, or chlorpromazine. Clinicians from BHFT presented the results of a audit where the use of Xonvea had been trialled in a small number of patients with NVP. All patients experienced an improvement in their symptoms of NVP, with most patients stopping treatment by 20 weeks, or	

No	Agenda Item	Action
	reducing the dose to one tablet at night and stopping other anti-emetics. The prevention in admissions would provide a significant cost saving. It was agreed for Xonvea to be switched from a Red formulary status to Amber SpIS, for secondary care treatment and initiation to prevent delays in obtaining treatment once the patient has been assessed as requiring treatment by secondary care. *Cost impact of decision: Anticipated annual cost pressure to Primary Care – £11,520 per annum if 24 patients were prescribed the maximum dose for 12 weeks.* • **Bupropion for depression and prescribing guide.** Bupropion is currently being used off-label for TRD (refractory/treatment-resistant depression) in BLMK by the specialists and has been brought to the subgroup following anticipated resolution of supply issues. The addition of bupropion hydrochloride to the BLMK formulary as an Amber SpIS – Specialist Initiation and Stabilisation, unlicenced option for TRD in adults was approved along with the prescribing guide following the suggested amendments. The specialists will initiate and stabilise patients and, only if patients are stable (after a minimum of 6 months), would primary care be asked to take over prescribing. The only specific monitoring required would be blood pressure. Patient numbers are expected to be low with prescribing across BLMK ~3–5/year. *Cost impact of decision:* approximately £2,300 per annum. • **Proxor 100/6 & Proxor 200/6 pMDI.** Proxor is a pMDI containing beclomethasone and formoterol for asthma and COPD which is equivalent to Fostair and Luforbec. Unlike Luforbec, it doesn't cause a cough from the presence of maleic acid, and it is 66% cheaper than Fostair and cheaper than Luforbec, even with the rebate. The FSG agreed to the addition of Proxor to the formulary as the first-choice beclomethasone and formoterol pMDI for new patients (unable to use a dry powder inhaler) with the potential to switch patients from Fostair for a cost saving. *Cost impact of decision:* Proxor is a cost saving. A 25% shift of Fostair to Proxor (both strengths) represents a saving of £413,082 per annum. A 40% shift would represent a saving of £743,549 per annum. • **Felodipine MR.** The addition of felodipine MR to the formulary prescribed as the branded generic, Delofine XL was requested. The first line calcium channel blockers on the formulary are amlodipine and lercanidipine. Even though felodipine MR is not on the formulary, there were 12,000 prescriptions issued in a quarter. The addition of Delofine XL was approved for addition to the formularies as an option after amlodipine and lercanidipine have been considered. Optimise Rx will be utilised to support appropriate initiation and switching. *Cost impact of decision: Cost saving* – A total saving of £65,000 per annum could be made if 100% of current generic felodipine MR tablets were switched to Delofine XL brand.	

No	Agenda Item	Action
	• **Estring**. Estring is a vaginal ring releasing 7.5 micrograms estradiol over 24 hours and is licensed for atrophic vaginitis in post-menopausal women. It is an alternative option to the cream and pessary for patients who struggle with administration due to dexterity issues or conditions such as dementia as it only requires insertion every 3 months. The maximum recommended duration of continuous therapy is two years according to the Summary of Product Characteristics. It would reduce caregiver burden and improve compliance. There is estimated to be an 83% symptom improvement, which is equivalent to vaginal cream, and no endometrial hyperstimulation, which occurs in approx. 11% of patients using the cream. There is improved comfort and ease of use in comparison to the cream. However, it is more costly than the alternative formulations. As the ring does not require an applicator, like the cream, this avoids plastic waste. Estring was approved for addition to the formularies as amber SpA third line option, so it will be recommended/initiated by the specialist, perhaps first insertion by the GP, with continuation in primary care and an annual review. *Cost impact of decision:* Assuming patient numbers could double from current prescribing if added to the formulary for primary care prescribing, the annual cost pressure for 60 patients (including initiation) would be £7,552. • **Aminosalicylates review.** As part of the JAC alignment and formularies review, this therapeutic class, with a £2.27M spend annually in primary care, was reviewed to rationalise product choice. NICE recommends use of once daily maintenance dosing, but patients may experience increased side effects. The high dose formulations can be of value in patients needing to reduce tablet burden. Most products are currently green on the formulary, but as patients are diagnosed, and treatment initiated by the specialist it is recommended that these products are moved to Amber SpA. SpIS status should be retained for the sulfasalazine preparations as there is initial titration and frequent monitoring required. The recommendations support access to different preparations across BLMK. Any switching needs to ensure patients are supported in monitoring for any changes in tolerability and symptom control with specialist review for complex cases. The recommendations were approved. *Cost impact of decision:* The cost saving if 50% of Pentasa suppositories were switched to the Salofalk brand would be £4,427/year. The cost saving if 50% of Asacol tablets were switched to the Octasa brand would be £5,851/year. A potential cost pressure from the recommendations includes an estimated £5,208/year from using Octasa 1600mg MR (offset by reduced pill burden) as opposed to the lower strength formulations. • **Ketamine in palliative care.** A shared care guideline for ketamine has been in place in Bedfordshire and Luton since 2018, but it has a Red formulary status in Milton Keynes.	

No	Agenda Item	Action
	Patient numbers are low with only two patients prescribed ketamine in primary care in the last year. The proposal is to retire this shared care guideline considering it is rarely used. St John's and Keech Hospices (covering Bedfordshire and Luton) have been consulted and agree. Ketamine for use as an analgesic in palliative care to be Red on both formularies. *Cost impact of decision:* minimal, due to extremely low prescribing rates. • **Standalone CGM Guidance Update.** Freestyle Libre (FSL) 3+ has recently been launched by Abbott, an upgrade from Freestyle Libre 3, and available on FP10. FSL2+ is the clear market leader with a lower acquisition cost. As a standalone CGM, the only significant advantage of FSL3+ over FSL2+ is that it is smaller and would be better for children under 12 with a small limb size. However, there is a risk that current patients on FSL2+ (5150 patients) could be switched to FSL3+ with a potential cost pressure of £1.6m without any clinical benefit. Therefore, the proposal is for FSL3+ to be recommended as a standalone CGM for type 1 diabetic patients under 12 years, usually in the first 8-12 weeks post diagnosis, before a pump can be introduced. The diabetes teams have been consulted and are supportive of the proposal. The proposal was approved. A new standalone CGM has been introduced, CareSens Air, which is comparable but slightly more expensive, in our ICB, than the market leader, FSL2+. It is only licensed in patients over 18. The FSG was asked to consider its addition as a second line option alongside Dexcom ONE+. The DSNs feel patient numbers are likely to be small, but it offers an alternative. As the current FSL2+ rebate is also based on prescribing volume, alternatives could reduce the saving. It was agreed that CareSens Air would not be approved but could, if necessary, be reviewed later. *Cost impact of decision*: prevention of a potential cost pressure of £1.6m without any clinical benefit. • The recommendations as a result of the BHFT JAC alignment project, and the minor amendments log, were noted. • A self-care symbol  has been added to both formularies for items that should be purchased over the counter but may be prescribed for chronic long-term conditions or on admission to hospital. **Decision:** The Committee ratified the recommendations of the Formulary Subgroup.	
8.2	**Wound Management Formulary Steering Subgroup Recommendations** A report from the wound management subgroup meetings on 19 March 2025 was presented to the Committee: • **Formulary Alignment and Development:** • Proposals for addition of Urgotul Absorb Border and Flamigel RT – for APC ratification.	

No	Agenda Item	Action
	○ **UrgoTul Absorb Border** is proposed to be added to the formulary as a result of the recent extensive review of the foams dressings chapter. It is to be used joint first line with Suprasorb P sensitive, although it is anticipated that UrgoTul Absorb Border will be used mainly in secondary care whilst Suprasorb P sensitive mainly in the community. Offset costs of using UrgoTul Absorb Border are expected due to reduced number of issues (as the product is expected to adhere better to wounds). This benefit also means further support of the green sustainability agenda. ○ **Flamigel RT** is proposed to be added to both the hospital and community wound care formularies in line with the pathway for use on radiodermatitis. Having it on the wound care formulary means that GPs would not have to prescribe this product once a patient is discharged back into the community. Flamigel RT is intended for a very specialist and small cohort of patients requiring radiotherapy. It is given as a course of treatment. It would be initiated by specialists and unlikely for use in the community, although a supply may be needed for patients to coincide with their radiotherapy treatments. • **Financial:** No concerns. • **Online formulary:** No concerns. Review of formulary sections will resume in the new financial year. • **Waste Reduction in Wound Care**: An initiative to reduce dressings in patients' homes has been introduced for District Nurses and posters have been introduced into dressings bases to guide DNs into making sustainable choices when they take in products to patients' homes. ELFT hope to roll this out to the whole of Bedfordshire and the Wound Care Group is hoping the same will happen across Luton and Milton Keynes. A dressings audit has taken place and any change in the amount and costs of dressings used will be reported back. • **Matters arising:** The project to transfer Bedfordshire and Luton ordering of procurement of dressings to ONPOS is still on target to be completed by end of April 2025. Currently 96% of practices and community bases are onboarded to ONPOS, with positive feedback from users on the ease of ordering, and only one practice challenging the request for dressings to be obtained via direct procurement instead of FP10. Coloplast, who own ONPOS, are collaborating with NHSSC to provide updates of any stock issues. The next stage of this project will be to allow access to direct procurement for Nursing Homes in Bedfordshire and Luton. Milton Keynes Nursing Homes already have access. **Decision:** The Committee ratified the recommendations of the Wound Management Steering group, including the addition of UrgoTul Absorb Border and Flamigel RT to the formularies.	

No	Agenda Item	Action
9.	**Patient Group Direction Subgroup Recommendations** The following recommendations were made by the Patient Group Direction (PGD) subgroup:	
9.1	**Milton Keynes Urgent Care Service PGDs** The following PGDs were presented for approval with clinical changes: • **Macrogol sachets** for the treatment of constipation in children: Reduced expiry of reconstituted mixture from 24 hrs to 6 hrs in line with SmPC. The sachets are unflavoured, but fruit squash may be added if preferred – wording added. • **Nystatin oral suspension** for oral candidiasis in infants aged 1 month to 2 years: The longer the suspension is kept in contact with the affected area before swallowing, the greater the effect will be – wording added. **Decision:** The Committee ratified the PGDs, as recommended by the PGD subgroup.	

10.	**Antimicrobial Resistance Update**
	The Committee was presented with an antimicrobial resistance update:
	
	• Antibacterial items prescribed in primary care per STAR-PU. (rolling 12m, Jan 25) is currently above the NHS England target of 0.875, at 1.02 items per STAR-PU.
	• Paediatric antibacterial prescribing (no of items for 0-9yrs old; rolling 12m) – this is an East of England priority and is still being worked on by the steering group to reduce local usage. BLMK prescribing rates are high and above prescribing rates seen nationally and across the East of England (EoE) region.
	• Secondary care:
	  ○ Proportion of total antibiotic prescribing from 'Watch' and 'Reserve' categories of WHO AWaRe index. (Q2 24/25) – both local trusts are currently above the England average for the use of 'Watch' and 'Reserve' antibiotics.
	  ○ Proportion of all antibiotics prescribed as IV (DDD%) in 12m ending Feb 25 – both local trusts are very slightly above the nationally average, but MKUH is slightly below the EoE average for this metric.
	
	The Committee noted the antimicrobial stewardship update.	

All other papers (from this point in the agenda) are for noting/information by the Committee		
11.	**East of England Priorities Advisory Committee (EoEPAC) – items for noting/approval**	
11.1	EoEPAC Meeting Notes – November 2024 The committee noted the minutes for information.	
11.2	**EoE PAC document for ratification - Ritlecitinib for severe alopecia areata**	

No	Agenda Item	Action
	On 27 March 2025, NICE published recommendations on the use of Ritlecitinib for treating severe alopecia areata in people 12 years and over (NICE TA958). The NICE recommendations are: 1.1 Ritlecitinib is recommended, within its marketing authorisation, as an option for treating severe alopecia areata in people 12 years and over. Ritlecitinib is only recommended if the company provides it according to the commercial arrangement. Ritlecitinib is a high cost drug and the commissioning responsibility of ICBs when used to treat alopecia areata. ICBs are the responsible commissioners for all ages (children aged 12 years and over, and adults). It has RED traffic light status on the local formularies and is restricted to prescribing by dermatology specialists. Due to the lack of specific detail in the NICE TA recommendations regarding the definition of severe alopecia areata, the stopping criteria for non-response, and some supplementary guidance published by the British Association of Dermatologists, it was agreed that an EoE PAC agreement would be reached to ensure consistency of implementation across the East of England. NICE confirmed that the assessment of ritlecitinib carried out for the TA was based on a Severity of Alopecia Tool (SALT) score of 50% or more. The clinical and cost-effectiveness of ritlecitinib in patients with SALT<50% was not considered. During the development of the PAC recommendations document, views were sought from specialists at all 3 hospital sites in BLMK. Clinicians from each site confirmed they agreed with the recommendations. The final document has also been circulated, and no additional comments were received. The aim of the document is to provide clarity around initiation and stopping criteria for ritlecitinib and ensure consistency of implementation across the EoE, as this is not made clear in the TA recommendations. The document provides detail on: • Initiation criteria (classification of severe alopecia areata using the Severity of Alopecia Tool (SALT) score; severe disease = SALT score of ≥50). • Review periods for assessment of efficacy. • Stopping criteria (SALT score ≤20 not achieved). • Risks associated with the use of JAK inhibitors. **Decision**: The PAC recommendations for ritlecitinib were approved and ratified for use within BLMK. **EQIA Assessment:** No impact expected. As per NICE TA958. The PAC guidance provides additional clarification, but does not alter, the guidance from NICE.	

No	Agenda Item	Action
	BLMK ICB E and D Lead comment: N/A	
12.	**Bedfordshire, Luton and Milton Keynes Local Prescribing Committee Minutes.** The Committee noted the following minutes for information.	
12.1	Minutes of the Bedfordshire Hospitals Foundation Trust Drug and Therapeutics Committee (DTC) – January 2025	
12.2	Minutes of the Milton Keynes Hospital Prescribing & Medicines Governance Committee (PMGC) – February 2025	
12.3	Minutes of the BLMK Formulary Subgroup – February 2025	
12.4	Minutes of the BLMK Wound Management Formulary Steering Group – January 2025	
12.5	Minutes of the BLMK Medicines Safety Group – January 2025	
12.6	Minutes of the ELFT Medicines Management Committee – none available	
12.7	Minutes of the Cambridgeshire Community Services Medication Safety and Governance Group – none available	
12.8	Minutes of the CNWL Trustwide Medicines Optimisation Group (MOG) – February 2025	
12.9	Minutes of Circle/MSK Medicines Management Committee – January 2025	
13.	**Papers for information / ratification**	
13.1	**Tirzepatide for the management of overweight and obesity** Funding has now been received for the management of the initial cohort of patients eligible for treatment under NICE TA1026: Tirzepatide for managing overweight and obesity. This cohort includes patients with BMI of 40 or more plus 4 of the 6 defined comorbidities. Due to low numbers (under 300 people), a community outreach model is more likely initially, and a referral template will be made available once this has been commissioned. No GP/primary care prescribing for obesity is anticipated in year one outside of the commissioned service. Once the service has been commissioned, the possibility of a community dietetic led service with independent prescribers is being explored via the community outreach model. It was clarified that something will be in place for the primary care implementation date for the TA (23rd June 2025). For further update at the next APC meeting. The Committee noted the update on the implementation of TA1026.	
13.2	**Treatments for Covid-19 / CMDU update** On 01 May 2025 NICE published an update to TA878 – nirmatrelvir plus ritonavir, sotrovimab and tocilizumab for treating COVID-19. The recommendation for nirmatrelvir plus ritonavir was updated. The recommendation made in March 2024 after a partial review of the guidance was based on a confidential price offered by the company	

No	Agenda Item	Action
	to the NHS. In May 2025, the company withdrew this price and reverted to the list price. Nirmatrelvir plus ritonavir is no longer cost effective for the groups evaluated in the partial review (people with diabetes, obesity or heart failure, or aged 70 years or over). So, these groups were removed from the recommendation. Nirmatrelvir plus ritonavir remains cost effective for the highest-risk group, so this recommendation remains in place. The CMDU triage service provided by Milton Keynes Urgent Care has been extended for the current time whilst alternate options are considered. • The referral template has been updated on Ardens to reflect the updated cohorts in the NICE TA (GP practices) • The Directory of Services has been updated to include the updated cohorts (NHS 111) • The referral pathway remains unchanged • The drug costs associated with the service will move to the ICB for any nirmatrelvir plus ritonavir (Paxlovid) prescribed on FP10 from 01 June 25, Alliance Healthcare will remain the supplier. This is a cost pressure to the ICB and has been flagged within the system. • In the 24/25 financial year 139 people were prescribed Paxlovid by the CMDU service • Formulary status of Paxlovid proposed to be changed to RED – restricted to prescribing by specialists in the CMDU service or secondary care only in accordance with NICE TA878. The Committee noted the Covid/CMDU update and approved the change of formulary status for nirmatrelvir plus ritonavir (Paxlovid) to RED.	
14.	**Any other business** Updating of "Guidance for General Practitioners to support prescribing of Liraglutide for children and young people under 18 years with Type 2 Diabetes (T2DM)" – this document has had a minor update to reflect the available brands of liraglutide, with the originator brand (Victoza) being discontinued and biosimilars now being available. Zegluxen is the preferred brand in BLMK and is licensed for use in children aged 10 years and above (NB: there are other biosimilar brands available, but not all are licensed for use in children). The Committee noted the update of the guidance.	
15.	**Future Dates for BLMK APC 2025 Meetings (all to be held from 12:30-15:00 via Microsoft Teams):** Wednesday 2nd July 2025 Wednesday 24th September 2025 Wednesday 3rd December 2025	

Approval of minutes:

Chair: Dr Muhammad Nisar

Signed: 

Date: 8/7/25

Appendix 1 – Approved 22 April 2025 Formulary Subgroup Minutes:

BLMK FSG Minutes April 2025 Final.docx