BEDFORDSHIRE, LUTON AND MILTON KEYNES AREA PRESCRIBING COMMITTEE

Final Meeting Notes

Date: 02 July 2025
Time: 12.30- 2.30pm
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 (from 13:05)	RA	CNWL Pharmacy Representative (Community and Mental Health Services Milton Keynes)
Dr Marian Chan	MC	Medical Representative, Bedfordshire Hospitals NHS Trust
Dr Mya Aye	MAy	Medical Representative, Milton Keynes Hospital
Matt Davies	MD	Head of Medicines Optimisation, BLMK ICB
Dupe Fagbenro (from 12:45)	DF	ELFT Pharmacy Representative (Deputy Chief Pharmacist (Luton and Bedfordshire), ELFT)
Fiona Garnett	FG	Associate Director: Pharmacy and Medicines optimisation, BLMK ICB
Anne Graeff	AG	Commissioning Lead Pharmacist, BLMK ICB (Professional Secretary) / Chair of Wound Care Group
Cheryl Green (until 14:00)	CG	Patient Representative
Emma Hooton	EH	Practice Pharmacist Representative (Independent Prescriber)
Faisal Khan	FK	Milton Keynes Hospital Pharmacy Representative (Medicines Use & Quality Manager, Milton Keynes Hospital)
Dr Kate Randall	KR	Place Based Lead GP – Central Bedfordshire
Dr Mitan Sarkar (from 12:37)	MS	Place Based Lead GP - Luton
Dr Maggie Winter	MW	Place Based Lead GP – Milton Keynes
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 (Medicines Use and Quality Manager, Bedfordshire Hospitals Trust)

In attendance:		
Rafal Ali	RA	Commissioning Pharmacist, BLMK ICB
Qiratulain Khan	QK	Bedfordshire Hospitals Trust Pharmacy Representative (Lead Pharmacist Medicines Information and Formulary, BHFT)
Helen McGowan	HM	Medicines Optimisation Pharmacist, BLMK ICB
Sandra McGroarty	SMcG	Commissioning Pharmacist, BLMK ICB
Dr Dush Mital (from 13:37)	DM	Medical Representative, Milton Keynes Hospital
Dr Joy Mutitika	JM	Medical Representative, Keech Hospice
Kike Pinheiro	KP	Representative, Willen Hospice
Takudzwa Shumba	TS	CNWL Pharmacy Representative (Prison Services - HMP Bedford and Yarls Wood IRC)
Nikki Woodhall	NW	Lead Medicines Optimisation Technician, BLMK ICB
Dr Fatima Mohri (in attendance for agenda item 5.5)	FM	GP, Milton Keynes Place

Apologies:		
Nicola Ainsworth	NA	Consultant in Public Health
Dorothy Aladejobi	DA	Pharmacist Representative, NHS Northampton Hospital Foundation Trust Secure Services
Samina Hassanali	SH	Formulary and Medicines Safety Pharmacist, BLMK ICB
Dr Jonathon Walter	JWa	Place Based Lead GP – Milton Keynes

No	Agenda Item	Action
1.	**Welcome, Introductions and Apologies** The Chair welcomed everyone to the meeting. Apologies were received and noted as above. The meeting was confirmed as quorate.	12.30pm
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.	12.35pm

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	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 07 May 2025 APC meeting** The minutes of the meeting held on 07 May 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	**Osteoporosis guidelines** – amendments and updates to be made as discussed and agreed at the May APC meeting. **Update 19/6/25** – the guideline has been updated and finalised, in accordance with the discussions at the May meeting, and has been uploaded to the Medicines website. It was proposed and agreed that the action could be closed.	Close
4.1.3	**Ibandronic (oral and IV) to be added to both formularies** in line with the osteoporosis guidelines. **Update 17/6/25** – both formularies have been updated. It was proposed and agreed that the action could be closed.	Close
4.1.4	**Buccal midazolam prescribing guidance** – text in the flow chart for review of patients prescribed a product other than Buccolam to be revised to remove reference to GPs conducting the review to determine suitability to switch. **Update 15/5/25** – the text has been amended and the updated document uploaded onto the Medicines website. It was proposed and agreed that the action could be closed.	Close
4.1.5	**Formulary amendments / additions to be made for ICB commissioned NICE TAs** (12 SQ-HDM SLIT (Acarizax), molnupiravir, relugolix CT). **Update 12/6/25** – all actions have been completed on both formularies. It was proposed and agreed that the action could be closed.	Close
4.1.6	**Relugolix–estradiol–norethisterone for endometriosis (TA1057)** – prescribing support document to provide additional information for primary care prescribers to be produced.	AG

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	Update 30/6/25 – a draft document has been produced and has been circulated to stakeholders for comment. This is an ongoing action.	
5.	**Items for consideration at meeting**	
5.1	**Chronic Kidney Disease pathway** The Committee considered an adapted version of the Cambridgeshire University Hospital (CUH) team's chronic kidney disease (CKD) management pathway. The pathway is an example of the "do once and share" approach, and the document has been approved through the East of England Renal Network and the Cambridgeshire and Peterborough ICB. The CKD pathway is similar to the East and North Herts Trust (ENHT) CKD pathway and fully supported by the ENHT consultant renal pharmacist. In addition, the pathway signposts to the London Kidney Network (LKN) resources which are predominantly for use in primary care. The resources were developed by the LKN CKD Prevention Workstream, in partnership with patients, clinicians, Kidney Care UK and/or other relevant stakeholders. The resources can support primary care with identification and management of CKD thereby reducing risks of disease progression and CVD complications, and are included with the kind permission of the LKN to support improvements. The Committee noted the following additional points: • The economic burden of kidney disease in the UK reported (2023) as £7.0 billion, with £6.4 billion attributable to direct costs to the NHS – about 3.2% of NHS budget which could rise to £13.9 billion by 2033. • Interventions such as early detection and appropriate management in primary care can support delay of CKD progression, reduce risk of complications and CVD, and reduce economic burden of the disease. • Transformation of CKD diagnosis and management needed to improve patient outcomes/experience and reduce unwarranted variations (e.g. uACR checks – 17.7% - 74.5% variation amongst BLMK practices). • BLMK CKD (G3a to G5) prevalence is low at 2.92% vs regional average (4.56%) and national average (4.36%). • Prescribing of evidence-based treatments like SGLT2i is still variable (8.5% - 33.5%). • NICE published updated TA recommendations for dapagliflozin for managing chronic kidney disease on 2nd July 2025 – this recommends the same prescribing criteria for dapagliflozin as for empagliflozin. • Primary Care can benefit from access to tools / resources and support with clinic capacity / upskilling e.g. Pharma Industry offers. • Variation from the C&P guidance includes, for example: hypertension management reflects the agreed BLMK guidelines for the management of hypertension.	

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	• A minor amendment to the pathway was proposed and agreed for the uACR thresholds. For patients without type 2 diabetes (T2DM), if the uACR is <22.6 then lifestyle advice should be given, whereas if uACR is ≥22.6 the CKD treatment pathway should be followed (≤22.6 and >22.6 respectively on the circulated document). For patients with T2DM, the thresholds are <3 and ≥3 respectively (≤3 and >3 on the circulated document). • It is hoped that a dedicated CKD page will be created on the Medicines website, to support clinicians and signpost to resources. The Committee discussed the possibility that dapagliflozin may be available as generic soon, and whether it should be placed as a first line choice in the pathway to futureproof and ensure best use is made of NHS resources. It was confirmed that the majority of SGLT2i prescribing in BLMK is already dapagliflozin, with empagliflozin used to a much lesser extent, and only a very small amount of canagliflozin prescribing. Dapagliflozin is listed first in the pathway, as written, but additional clarification will be added to indicate the dapagliflozin should be the first choice SGLT2i (where suitable) following availability of generics. **Decision**: The Committee approved the chronic kidney disease pathway with the amendments to the uACR thresholds as documented above. **EQIA Assessment:** The pathway is anticipated to have a positive impact through improved care of patients with CKD. **BLMK ICB E and D Lead comment:** N/A	MA
5.2	**Stoma Accessories Formulary and Agreed Fair usage Guideline** A stoma prescribing service was launched in June 2023 across BLMK ICB. Following a procurement the contract for delivering the service was awarded to Bullen Healthcare. The service was developed with the intention of: • Providing easy-to-access, immediate clinical support for patients in primary care with a stoma. • Reducing waste in the prescribing of stoma appliances. • Stoma Nurse Specialists having the responsibility of undertaking the prescribing for patients, thereby improving patient care, reducing GP workload, and ensuring that the patient receives the most appropriate appliance. The stoma prescribing service is used by 2350 people registered with a GP practice in BLMK ICB. To ensure consistency of prescribing between Bullen Healthcare and the stoma nurses across BLMK ICB a stoma accessories formulary and agreed fair usage guideline for stoma bags has been developed. The focus of the document is around ensuring the use of the most cost-effective products and that ancillaries which are cosmetic	

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	should not be prescribed. From an environmental perspective, flushable bags have been removed. **Decision**: The Stoma Accessories Formulary and Agreed Fair usage Guideline was approved. **EQIA Assessment:** No issues with equality, inclusion and human rights have been identified. **BLMK ICB E and D Lead comment:** N/A	
5.3	**Relugolix–estradiol–norethisterone (Ryeqo) prescribing support document** This item was deferred for consideration at a future meeting.	
5.4	**Glucocorticoid-induced Osteoporosis guidelines** The guidance on the management of glucocorticoid-induced osteoporosis has been separated out from the main osteoporosis guidelines into a standalone document. The Committee considered this redesign of the existing glucocorticoid induced osteoporosis management guideline (for use in Primary Care), and discussed the following points: • The existing glucocorticoid induced osteoporosis guideline was initially written in 2011 and last updated in June 2022. The National osteoporosis guideline group (NOGG) refers to glucocorticoid induced osteoporosis in patients treated with oral glucocorticoids ≥7.5 mg prednisolone/day or equivalent. The BLMK existing guideline states patients taking ≥ 5mg for a period of longer than 3 months. Following discussions with local specialist, it was proposed that the previous advice is retained as it's based on Royal College of Physicians guidance, and the latest data suggests that 5-7.5mg can be hazardous for the local population. • Calcifediol 266 microgram capsules (Domnisol®) has been added as an option for patients who require vitamin D monotherapy (in accordance with the agreed formulary status). It was proposed and agreed that this should also be added as a treatment option in the main osteoporosis guideline. • To align with the newly formatted osteoporosis guideline, the formatting of the guideline has been updated and a link to the main guideline has been added to enable clinicians to access the supporting information. The Committee discussed the timing of relevant investigations (blood tests and DXA scans) for patients on steroids. As the biggest risk for bone loss is in the first 3 months after starting steroids, it is key that treatment with bone protective agents should not be delayed whilst awaiting the results of investigations. Text will be added to the guideline to clarify this. In addition, the Committee discussed the timing of repeat DXA scans for patients still being treated with steroids, and those who have stopped treatment. It was clarified that the timing contained within the document is correct for patients still being treated with steroids (repeat every 1-3 years, with exact	SMcG SMcG

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	frequency depending on present dose, duration of steroid treatment, and other risk factors), and that any patients who have stopped steroid treatment should revert back to the recommendations in the main osteoporosis guideline. Additional text to be added to clarify this in the guideline. **Decision**: The glucocorticoid-induced osteoporosis guidance was approved with the amendments agreed at the meeting. **EQIA Assessment:** the guidance is not anticipated to have an equality impact, as it is a reformatted version of existing guidance with few changes. **BLMK ICB E and D Lead comment:** N/A	SMcG
5.5	**Shared care guideline principles and updated template** The Committee considered proposed new documents to support the management of patients under shared care prescribing arrangements. The documents were circulated for wider consultation in advance of the meeting. <u>Revised shared care guideline template</u> With a view to improving the layout and readability of the BLMK shared care guideline template, a revised template has been developed. This is based upon the national shared care guidelines (SCGs) which have been developed to encourage consistency across the country for SCGs. The previous BLMK SCG template was based upon the proposed design of the national template, but the design was altered prior to the final publication of the national SCGs. The existing, national SCG templates are available via the NHS England website (NB: there is no plan to update the national templates at the current time). As per the national template, additional information (over the current template) is included to clarify that "Transfer of monitoring and prescribing to Primary Care is normally after the patient's dose has been optimised and with satisfactory investigation results for at least 4 weeks" is usually a period of 3 months for the specialist to prescribe, monitor and maintain care of the patient. It is also clarified that, once the patient is stabilised and initiation of shared care has been requested, that a minimum of 28 days' supply should be given by the specialist to enable transfer of prescribing to primary care. An additional, minor, amendment was proposed at the meeting following feedback received – amendment to section 7 regarding ongoing monitoring (specialists): current wording "This should usually be undertaken annually" – proposed change to "This should be undertaken on at least an annual basis". <u>Shared care principles</u> The shared care principles document is designed to summarise the purpose and main responsibilities for shared care arrangements. This is based upon information which was previously at the start of the BLMK template, and incorporates the appendix providing further	AG

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	information on circumstances where shared care may be refused by primary care. In addition, the following changes have been made: • Link added to the BLMK position statement on shared care with private providers. • Following feedback from primary care, reference to discussing / making arrangements within the PCN has been removed as this is not reflective of the workings of a PCN. • As in the template, clarification has been added regarding the typical time period for stabilisation of a patient, and supply to be provided by the specialist to facilitate the smooth transfer of prescribing to primary care / initiation of shared care, including time taken to answer practice/GP enquiries. • Clarification has been added to confirm that practices need to respond within 14-21 *calendar* days, if refusing the request to undertake shared care. • An additional sentence has been added to clarify that primary care prescribers should inform the specialist if any changes to dosage are made. • Additional bullet point added to link to BMA Principles for Shared Care. • Minor changes to the wording have been made to simplify / clarify the text without changing the meaning. • Additional information has been added the patient responsibilities to state that they must inform health care professionals of any medications they are taking (including herbal, OTC, medications obtained from private providers etc), and they must keep their contact details up to date with the specialist and primary care provider. The Committee discussed the following additional points in relation to the updated template and shared care principles: • The specialist should be informing primary care when a shared care medicine is started (even if not yet requesting the sharing of care), to ensure the GP/primary care clinician is aware that the patient is on the medicine. • Stabilisation period may vary between patients and specialities. For example, the Rheumatology team at Bedfordshire Hospitals Trust is now starting people on 20mg methotrexate and therefore patients are stable very quickly. • A 12-week stabilisation period is likely to be appropriate for the majority of patients to ensure that it is safe to commence the sharing of care between the specialist and primary care. • From the patient perspective, it is vital that all the information regarding shared care is clearly provided at the start of treatment. It is also important the patient understands their responsibilities under shared care. • Communication is key to the success of shared care. The responsiveness by specialists to queries raised in primary care is variable, and a quick response to any queries (e.g. requested via advice and guidance) is important. It can take a	

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	prolonged period of time for letters from outpatient appointments to reach the GP practice, meaning that patients may be advising that their dose has been changed, but there is no record of this in the patient's primary care record. • Lack of integration of IT systems was noted to be an ongoing problem. For example, specialists are not able to access SystmOne, which would allow the use of the 'task' function to communicate between parties and ensure this is immediately documented in the patient's records. Access to blood results via ICE in primary care is also still not universal e.g. practices in Bedford can access results from Bedford Hospital, but not the Luton & Dunstable Hospital. These issues are outwith the remit of the Committee to resolve but were noted to be a factor influencing the management of patients on shared care medicines. • There may be an issue, within a GP practice, if the prescriber who agreed to take on the shared care leaves and the relevant skills and knowledge are not available in the practice. • It was discussed and agreed that the proposed addition of text stating that "primary care prescribers should inform the specialist if any changes to dosage are made" is not required. In practice this would not happen, and primary care prescribers would always contact the specialist team for advice before making any changes. Text to be removed. • Following a suggestion received from a BLMK GP, text to be added to the patient responsibilities signposting them to accessing blood test results via the NHS app (to both the principles and the template). <u>Individual drug vs therapy area shared care guidelines?</u> In addition to the above, the Committee was asked for an opinion on the preferred format of SCGs going forward. In BLMK there is currently a mixture of drug specific and therapy area shared care guidelines. For example, Rheumatology DMARD SCGs for Beds/Luton and Milton Keynes cover multiple drugs e.g. methotrexate, sulfasalazine, azathioprine. Many other SCGs are drug/therapy area specific e.g. Azathioprine and Mercaptopurine in Inflammatory Bowel Disease (IBD) and Autoimmune Hepatitis; Azathioprine / Mercaptopurine for Renal Autoimmune Disease. The national templates, (and those from other areas such as Cambridge & Peterborough and Herts & West Essex) are drug specific and often cover multiple therapy areas e.g.: • The national methotrexate SCG covers use in rheumatology, gastroenterology, dermatology, neurology, ophthalmology and respiratory disease. • The national azathioprine/mercaptopurine SCG covers use in dermatology, neurology, ophthalmology, rheumatology, renal and respiratory disease. It was noted that it is hoped that the national templates will be able to be used as a starting point when developing / updating SCGs. Many existing Beds/Luton and Milton Keynes shared care guidelines are	AG AG

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	out of date, and overdue for review and update. Potential priority SCGs for review include: medicines covered by existing DMARD SCGs, riluzole, cinacalcet for primary hyperparathyroidism, acamprosate, amiodarone, and denosumab.
	
	The Committee discussed and agreed that the single drug, multiple therapy area approach would be best in most circumstances, although it was acknowledged that there may be challenges with this approach in reaching agreement between specialities and across the ICS.
	
	Within mental health, for example ADHD and dementia medicines, a preference was expressed for the multi-drug format to continue. In this therapy area, there is only a single speciality which uses the medicines and patients may be on multiple medicines. It was therefore agreed that 'multi-drug' shared care guidelines will continue to be used in these therapy areas, and reassurance given that relevant details of the individual medicines will be available within the SCGs when this approach is used (NB: this is the case currently for the BLMK ADHD and dementia medicine SCGs).
	
	The Committee reviewed a list of shared care documents which are currently overdue for review and discussed potential priority areas for review / current SCGs which are overdue for review:
	
	• Rheumatology. The majority of the medicines contained in the current Rheumatology SCGs for Beds/Luton and Milton Keynes are the same. The exceptions to this are: ciclosporin, mepacrine, minocycline and sodium aurothiomalate (gold), which are only in the Milton Keynes SCG. The Committee discussed ongoing need for SCGs for these 4 medicines:
	  ○ Ciclosporin – use likely to be short term therefore SCG may not be required going forward (for further discussion / consultation with Milton Keynes rheumatologists).
	  ○ Mepacrine – pre-meeting input from MK rheumatologists indicated that mepacrine is still rarely used for patients with SLE/SCLE. It was noted that patient numbers would be very small and that mepacrine has not been issued from MK hospital pharmacy since approximately 2016. Shared care therefore not needed going forward.
	  ○ Minocycline and sodium aurothiomalate (gold) – pre-meeting input from MK Rheumatologists indicated these are no longer used. Shared care therefore not needed going forward.
	  ○ **Post-meeting note:** mepacrine and sodium aurothiomalate (gold) are both currently non-formulary on the Beds/Luton and Milton Keynes joint formularies (status quo to be maintained).
	• Acamprosate – this was introduced at the request of a particular consultant (who has now retired) who worked for ELFT. It was felt by the Committee that prescribing has	

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	reduced and that the specialist service is likely retaining prescribing, although there is still some prescribing in primary care (from ePACT data). To link in with providers (drug and alcohol services) for further discussion and to seek their input. • Denosumab – proposal to retire the shared care guideline and replace this with a prescribing support document. Payments in primary care would be unaffected as they are not for shared care, but for the blood tests required and the administration of the treatment. This was broadly supported, with a caveat that it should not be retired until biosimilar(s) have been implemented (expected late 2025 / early 2026). • Amiodarone – retain and expand across BLMK (currently Beds/Luton only). • Cinacalcet for primary hyperparathyroidism – likely retain and expand across BLMK (currently Beds/Luton only). • Riluzole – national template available, but likely small patient numbers. To consider local need. The Committee discussed the suitability of medicines for shared care if there are very low patient numbers, as primary care prescribers will struggle to gain sufficient knowledge and experience in prescribing the medicine(s). Anticipated patient numbers will need to be considered when writing and / or renewing shared care guidelines. The exception to this may be for medicines where there is a national template available, as the assessment on suitability for shared care has already been done via wider consultation. **Decision**: The principles for shared care, and the updated shared care template, were approved with the changes agreed at the meeting (as documented above). **EQIA Assessment:** N/A	AG
6.0	**NICE Guidance – from 24th April to 18th June 2025** **The following NICE Technology Appraisal Guidance (ICB Commissioned) have been published:** • **Nirmatrelvir plus ritonavir, sotrovimab and tocilizumab for treating COVID-19** Technology appraisal guidance Reference number: TA878 Published: 29 March 2023 Last updated: 01 May 2025 https://www.nice.org.uk/guidance/ta878 **May 2025**: In section 1, NICE updated the recommendation on nirmatrelvir plus ritonavir to remove groups eligible for treatment. Based on changes to the company's list price, nirmatrelvir plus ritonavir is no longer cost effective for these groups. For full details see update information.	

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	Resource impact: Medicine costs move to ICBs from 1st June 2025. Based on current usage (guidance for these cohorts remains unchanged), expected annual costs for nirmatrelvir plus ritonavir expected to be approximately £137,600. **APC actions:** none. Formulary traffic light for nirmatrelvir plus ritonavir (Paxlovid) changed to RED following discussion and agreement at May APC. • **Cenobamate for treating focal onset seizures in epilepsy** Technology appraisal guidance Reference number: TA753 Published: 15 December 2021 Last updated: 06 May 2025 https://www.nice.org.uk/guidance/ta753 **May 2025:** The wording in recommendation 1.1 has been updated to address concerns raised by the clinical community that restricting starting treatment in a tertiary care setting has resulted in inequitable access to the treatment. **Resource impact:** NICE does not anticipate a significant resource impact. The overall resource impact for BLMK is expected to be less than £90,000 per annum. **APC actions**: Cenobamate is already on the formularies with Amber SpIS traffic light. Formularies amended to remove the statement that it must be initiated in a tertiary epilepsy service. • **Somapacitan for treating growth hormone deficiency in people 3 to 17 years** Technology appraisal guidance Reference number: TA1066 Published: 03 June 2025 https://www.nice.org.uk/guidance/ta1066 **Resource impact:** it is not anticipated that somapacitan will have a significant resource impact, as it is another treatment option in an existing pathway. **APC actions**: added to formularies with RED traffic light • **Linzagolix for treating symptoms of endometriosis** Technology appraisal guidance Reference number: TA1067 Published: 04 June 2025 https://www.nice.org.uk/guidance/ta1067 **Resource impact:** NICE estimates the resource impact of implementing TA1067 (linzagolix) and TA1057 (relugolix CT) to be £110,000 in year 1, rising to £560,000 by year 5. The Committee discussed the appropriate formulary status for linzagolix for treating symptoms of endometriosis. The following points were noted: • Relugolix CT for treating symptoms of endometriosis (NICE TA1057) discussed at the May meeting – SpIS traffic light agreed.	

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	• The use of relugolix CT and linzagolix is expected to displace some usage of GnRH agonists, reducing administration appointments and some environmental impact (waste). • Linzagolix requires separate add-back therapy. • Linzagolix and relugolix CT have the same eligible treatment population. Relugolix CT is cheaper and contains add-back therapy with estradiol and noritheristerone in the combination tablet. • NICE assumes initiation by specialists with continuation in primary care. The Committee discussed that use of relugolix CT first line is likely to be sensible as it is the more cost-effective option, which includes the add-back therapy in a single combination tablet. Linzagolix is more expensive and add-back therapy must be given separately. There may be potential advantages to giving the add-back therapy separately, as it may allow flexibility in the add-back regimen used (note: in the clinical trials, add-back therapy with estradiol 1 mg and norethisterone acetate 0.5 mg was given (same as relugolix) but the dosing information in the SPC for linzagolix simply states "200mg once daily with concomitant hormonal add-back therapy"). It was queried whether there is a suitable available product to give norethisterone at a dose of 0.5mg, and identified that Kliovance® contains estradiol 1mg / norethisterone acetate 0.5mg. The Committee agreed that an Amber SpIS formulary status was appropriate for linzagolix for the treatment of endometriosis. • **Spesolimab for treating generalised pustular psoriasis flares** Technology appraisal guidance Reference number: TA1070 Published: 18 June 2025 https://www.nice.org.uk/guidance/ta1070 **Resource impact:** NICE estimates the resource impact of implementing TA1070 to be £66,000 in year 1, rising to £227,000 by year 5. **APC actions:** added to formularies with RED traffic light **The following NICE Guidelines (NG) (Medicine related and ICB Commissioned) have been published / updated by NICE:** **COVID-19 rapid guideline: managing COVID-19** NICE guideline Reference number: NG191 Published: 23 March 2021 Last updated: 01 May 2025 https://www.nice.org.uk/guidance/ng191 This guideline covers managing COVID-19 in babies, children, young people and adults in community and hospital settings. It includes recommendations on communication, assessment, therapeutics for COVID-19, non-invasive respiratory support, preventing and managing acute complications, and identifying and managing co-infections.	AG/FK

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	NICE updated the recommendation on nirmatrelvir plus ritonavir in line with NICE's technology appraisal guidance on nirmatrelvir plus ritonavir, sotrovimab and tocilizumab for treating COVID-19. Because of a change to the company's list price, this treatment combination is now only recommended for people at increased risk of progression to severe COVID-19. **APC actions:** change in formulary status to RED for nirmatrelvir + ritonavir agreed at May APC to reflect provision via CMDU and acute trusts only. **Headaches in over 12s: diagnosis and management** Clinical guideline Reference number: CG150 Published: 19 September 2012 Last updated: 03 June 2025 https://www.nice.org.uk/guidance/cg150 This guideline covers the diagnosis and management of tension-type headache, migraine (including migraine with aura and menstrual-related migraine), cluster headache and medication overuse headache in young people (aged 12 years and older) and adults. It aims to improve the recognition and management of headaches, with more targeted treatment to improve the quality of life for people with headaches, and to reduce unnecessary investigations. **Last reviewed:** 3 June 2025 NICE changed the strength of recommendations on migraine prevention to make the use of topiramate or propranolol a 'consider' recommendation alongside amitriptyline, to better reflect the balance between the benefits and harms associated with the 3 medicines. We also added links to relevant technology appraisal guidance in the section on treating and preventing migraine with or without aura. This is to provide easy access to relevant guidance at the right point in the guideline only and is not a change in practice. **APC actions:** none required – changes are already reflected in local guidance and formularies. **Intrapartum care** NICE guideline Reference number: NG235 Published: 29 September 2023 Last updated: 18 June 2025 https://www.nice.org.uk/guidance/ng235 This guideline covers the care of women and their babies during labour and immediately after birth. It focuses on women who give birth between 37 and 42 weeks of pregnancy ('term'). The guideline helps women to make informed choices about where to have their baby and about their care in labour. It also aims to reduce variation in aspects of care. **Last reviewed:** 18 June 2025 We have updated and made new recommendations on fluid balance, bladder care and hyponatraemia during labour. See update information for further details. **APC actions:** none required **The following NICE TAs are the commissioning responsibility of NHSE and are listed for information only:**	

	Omaveloxolone for treating Friedreich's ataxia in people 16 years and over (terminated appraisal) Technology appraisal Reference number: TA1061 Published: 06 May 2025 https://www.nice.org.uk/guidance/ta1061 **APC actions:** none – terminated appraisal. **Brentuximab vedotin in combination for untreated stage 3 or 4 CD30-positive Hodgkin lymphoma** Technology appraisal guidance Reference number: TA1059 Published: 07 May 2025 https://www.nice.org.uk/guidance/ta1059 **APC actions**: link added to formularies **Osimertinib with pemetrexed and platinum-based chemotherapy for untreated EGFR mutation-positive advanced non-small-cell lung cancer** Technology appraisal guidance Reference number: TA1060 Published: 08 May 2025 https://www.nice.org.uk/guidance/ta1060 **APC actions:** links added to formularies **Erdafitinib for treating unresectable or metastatic urothelial cancer with FGFR3 alterations after a PD-1 or PD-L1 inhibitor** Technology appraisal guidance Reference number: TA1062 Published: 12 May 2025 https://www.nice.org.uk/guidance/ta1062 **APC actions:** created and link added to formularies (RED traffic light) **Capivasertib with fulvestrant for treating hormone receptor-positive HER2-negative advanced breast cancer after endocrine treatment** Technology appraisal guidance Reference number: TA1063 Published: 15 May 2025 https://www.nice.org.uk/guidance/ta1063 **APC actions:** created and link added to formularies (RED traffic light) **Dostarlimab with platinum-based chemotherapy for treating primary advanced or recurrent endometrial cancer with high microsatellite instability or mismatch repair deficiency** Technology appraisal guidance Reference number: TA1064 Published: 22 May 2025 https://www.nice.org.uk/guidance/ta1064 **APC actions:** link added to formularies **Nivolumab plus ipilimumab for untreated unresectable or metastatic colorectal cancer with high microsatellite instability or mismatch repair deficiency** Technology appraisal guidance Reference number: TA1065 Published: 28 May 2025 https://www.nice.org.uk/guidance/ta1065 **APC actions:** links added to formularies **Tislelizumab for treating unresectable advanced oesophageal squamous cell cancer after platinum-based chemotherapy (terminated appraisal)** Technology appraisal Reference number: TA1068 Published: 29 May 2025 https://www.nice.org.uk/guidance/ta1068 **APC actions:** none – terminated appraisal	

No	Agenda Item	Action
	Efgartigimod for treating antibody-positive generalised myasthenia gravis Technology appraisal guidance Reference number: TA1069 Published: 04 June 2025 https://www.nice.org.uk/guidance/ta1069 **APC actions**: none – not recommended	

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 (March to June 2025) and CAS alerts (April 2025). In particular:
	
	Prolonged-release opioids: Removal of indication for relief of post-operative pain (DSU, March 2025)
	Increased risk of persistent post-operative opioid use (PPOU) and opioid-induced ventilatory impairment (OIVI).
	Actions taken: Linked to formulary for information.
	
	BHFT:
	• Discussed at Medicines Safety Committee, with anaesthetists; a lead has been appointed.
	• A position statement supporting the alert and discouraging supply on discharge will be released.
	• Phased approach as prolonged release opioids are included within Enhanced Recovery After Surgery (ERAS) protocols.
	
	MKUH:
	• Incorporated the DSU recommendations within:
	  • ERAS pathway
	  • Chronic pain management guidelines
	  • Raised and accepted by
	  • opioid stewardship group
	  • prescribing medicines and governance committee
	  • clinical improvement group.
	• With governance in place, plan to audit implementation of the change via the surgical special interest group which has pharmacist representation.
	• The outcomes will be shared along with any documents and communication to primary care.
	
	The MSG members were encouraged to discuss this alert at their opioid stewardship committees.
	
	Fezolinetant▼(Veoza): risk of liver injury; new recommendations to minimise risk (DSU, April 2025)
	Liver function should be monitored before and during treatment in all patients. Avoid in patients with known liver disease or at a higher risk of liver disease.	

No	Agenda Item	Action
	Actions taken: Linked to non-formulary entry for information (pending NICE appraisal: TBC. Draft TA recommendations are negative). **Kaftrio▼ (Ivacaftor, tezacaftor, elexacaftor): risk of psychological side effects (DSU, May 2025)** Psychological side effects such as anxiety, low mood, sleep disturbance, poor concentration, and forgetfulness have been infrequently reported in people with cystic fibrosis treated with Kaftrio. Healthcare professionals should advise patients and their caregivers that, while the risk is small, they should be alert to changes in mood and behaviour and, if they occur, to seek medical advice as soon as possible. **Actions taken:** Linked to formulary for information. This alert will be discussed at the September MSG. **Thiopurines and intrahepatic cholestasis of pregnancy (DSU, May 2025)** Intrahepatic cholestasis of pregnancy (ICP) has been rarely reported in patients treated with azathioprine products and is believed to be a risk applicable to all drugs in the thiopurine class (azathioprine, mercaptopurine and tioguanine). Cholestasis of pregnancy associated with thiopurines tends to occur earlier in pregnancy than non-drug-induced cholestasis of pregnancy, and elevated bile acid levels may not reduce with ursodeoxycholic acid. **Actions taken:** Linked to formulary for information. This alert will be discussed at the September MSG. **Valproate (Belvo, Convulex, Depakote, Dyzantil, Epilim, Epilim Chrono or Chronosphere, Episenta, Epival, and Syonell▼): updated safety and educational materials to support patient discussion on reproductive risks (DSU, June 2025)** Updated safety and educational materials are now available to support the implementation of the regulatory measures announced in the November 2023 National Patient Safety Alert and the September 2024 Drug Safety Update. They also include previous updates to product information on the risk of low birth weight in children exposed to valproate during pregnancy. **Actions taken:** Linked to formulary for information. This alert will be discussed at the September MSG. **IXCHIQ Chikungunya vaccine: temporary suspension in people aged 65 years or older (DSU, June 2025)** The Commission on Human Medicines (CHM) has temporarily restricted use of the IXCHIQ Chikungunya vaccine in people aged 65 years and over following very rare fatal reactions reported globally. This is a precautionary measure while the MHRA conducts a safety review. The IXCHIQ vaccine will be available on the UK market from 18 June 2025. **Actions taken:** This alert will be discussed at the September MSG. **Short-acting beta 2 agonists (SABA) (salbutamol and terbutaline): reminder of the risks from overuse in asthma and**	

No	Agenda Item	Action
	to be aware of changes in the SABA prescribing guidelines (CAS alert, April 2025) **Actions taken:** Overuse of SABAs has been reviewed by practices as part of the incentive scheme last year with the potential to switch patients to MART (Maintenance and Reliever Therapy) or AIR (anti-inflammatory reliever) and this work in ongoing. ELFT review ePACT data for trends in SABA prescribing and nothing has been flagged recently. Incidents identified relate to poor discharges and lack of clarity on inhaler regimens. **<u>Medicines Safety Group (MSG) Update</u>** <u>NHSE identified Medicines Safety Priorities for 2024-2027</u> A survey will be sent out to help the group prioritise the eight workstreams for local action. The aim of the medicines' safety priorities is to reduce avoidable medication-related harm by 1/3 by 2027. The priorities are split into 3 areas: • Medication safety leadership approach (incorporating empowering the Medication Safety Officer workforce and increasing the reliable administration of time critical medicines). • Whole system approach (incorporating reducing harm in the following areas: opioid use in chronic pain, psychotropics in learning disability, falls-risk inducing drugs in frailty, and valproate taken in pregnancy). • Targeted approach (primary care) (incorporating reduced acute kidney injury induced polypharmacy, and optimising dosing of direct oral anticoagulants). <u>Females of childbearing age on anticoagulation / contraindication in pregnancy</u> Primary care data for DOACs prescribed to women in the 8–54-year age range will be broken down and shared at the next meeting. <u>Valproate</u> All providers are looking at producing a valproate policy. A referral process is in place for primary care into secondary care when it is identified that an annual review is required. Bedfordshire are working on their policy and a mapping exercise will be completed to ensure all components are addressed. <u>Topiramate</u> Patient numbers in primary care by condition and age group have been obtained for baseline data. BHFT were planning to check issuing of ARAF forms at the end of June. This work will be shared with MKUH and a systemwide approach taken involving mental health providers and health and justice.	

No	Agenda Item	Action
	The audit in primary care will be rerun to determine the number of women of childbearing age on the pregnancy prevention programme and patients requiring referral, with percentage compliance. <u>Timely administration of time critical medicines (TCM)</u> Providers have been asked to report back on how patients can be supported in the timely administration of time critical medicines, for mapping. The Royal College of Emergency Medicine (RCEM) produced an advisory statement entitled "Time critical medication self-administration in emergency departments" in March 2025. The RCEM defined time critical medication (TCM) as: scheduled medication that the patient is already on when they present to the Emergency Department (ED). These medications are time-critical because a delayed or missed dose can result in harm with exacerbation of symptoms and the development of complications leading to an increased mortality if it continues. The RCEM identified important TCM in the ED: **M** Movement disorders – Parkinson's / Myasthenia medication **I** Immunomodulators including HIV medication **S** Sugar (Insulin) **S** Steroids – Addison's and adrenal insufficiency **E** Epilepsy – anticonvulsants **D** DOACs and warfarin TCM lists and self-administration policies to be collated for wider sharing. BHFT will feedback post implementation of SAMI (Self-administration of Insulin) boxes. The Committee noted the medicines safety update.	
8.	**Formulary Update**	
8.1	**Formulary Subgroup Recommendations** The following recommendations were made by the Formulary subgroup (FSG) at the 10 June 2025 meeting: • **Pylera®.** In combination with omeprazole, Pylera® (bismuth subcitrate potassium 140 mg, metronidazole 125 mg, tetracycline hydrochloride 125 mg) is indicated for the eradication of Helicobacter pylori (H. Pylori). The treatment regimen is 3 capsules 4 times a day for 10 days. PHE (Public Health England) guidance on H. Pylori has not been updated since 2019, however resistance patterns have changed, and new medication is available. H. Pylori resistance is a significant global problem. There is more than 40% resistance to clarithromycin and 78% to metronidazole in the UK. Clarithromycin resistance of more than 15% significantly impacts on eradication. Resistance to amoxicillin and tetracycline is low at 2% and less than 1% respectively. Levofloxacin resistance is low at 4%, but recent studies suggest it is increasing to 15-20%. A 10-day course of Pylera	

No	Agenda Item	Action
	costs £40.14 compared to standard triple therapy which costs £2.91 for a 7-day course. The FSG agreed to add Pylera to the formulary as a green first line option for patients allergic to penicillin and second line for patients without a penicillin allergy. *Cost impact of decision:* Approx. 855 patients across BLMK have required H. Pylori eradication over the last year. For 100 patients prescribed Pylera across the ICB, this would cost £3,223/annum. • **Paediatric Oral Nutritional Supplements (ONS).** The addition of paediatric ONS products contained within a toolkit to support prescribing/product selection decisions was agreed as Amber SpA, following recommendation by a paediatric dietitian and trialled via a taste test. The toolkit guidance considers cost and patient acceptability, as well as the nutritional needs of different age groups. The recommendation from the dietitian will come with a plan which would include information on discontinuation. *Cost impact of decision:* A more cost-effective product such as Nestle Resource Junior, generates a potential saving of £133,739 per annum when switched from Abbot Paediasure Plus or Nutricia Fortini. • **Cyclogest to help maintain a pregnancy.** The FSG discussed a proposal that Cyclogest (progesterone pessaries) formulary status for threatened miscarriage / preventing pre-term labour should be changed from the current status of Red to Amber SpIS. It was felt that it was not clinically appropriate for GPs to take on the responsibility of prescribing for high-risk patients under the specialist for an unlicensed indication. In addition, there is a single point of access for midwives when a patient falls pregnant, and prescribing can be taken up immediately. Cyclogest is therefore to remain Red on the BLMK formularies for preventing pre-term labour. *Cost impact of decision*: n/a. • **Safinamide** as an add-on therapy to a stable dose of levodopa, an addition to a combination of other PD (Parkinson's Disease) medication in mid-to-late-stage PD patients with motor fluctuations or dyskinesia and/or a second line monoamine oxidase B inhibitor (MAOB) where first line MAOB are ineffective or are not tolerated. Safinamide reduces dopamine agonist dose better than rasagiline, with significant reduction in daily "off" time and UPDRS (Unified Parkinson's Disease Rating Scale) motor scores compared to rasagiline. No serotonin syndrome or hypertensive crises have been reported. Patients would be under the care of the PD nursing teams and the consultant will prescribe if the PD nurse is unable to. Patient numbers are expected to be low at less than 10 per year across the ICB as this is an option after rasagiline and selegiline have been tried. It was agreed for safinamide to be added to the formularies with Amber SpIS traffic light.	

No	Agenda Item	Action
	Cost impact of decision: 10 patients/year would be a cost pressure of £8,970. • **Ketamine oral solution.** The FSG discussed a request for the formulary status of ketamine oral solution to be changed to Amber SpIS. Ketamine has been shown to be effective in the treatment of opiate-resistant pain syndromes of different aetiologies and is being increasingly used in the palliative care setting due to its opiate-sparing effects. It is used for managing pain that is neuropathic, inflammatory, ischaemic limb-related, or procedure-related when other treatments have failed. It was agreed that ketamine oral solution should remain Red on the formularies, but support for the hospices in the prescribing and issuing of this prescription needs to be put in place to avoid patient supply being delayed. *Cost impact of decision:* n/a • **Tavistock SCGs for transmen and transwomen.** The Tavistock shared care guidelines have been ratified for local use since 2018. The SCGs have been updated in 2025 and include several changes, including: ○ Enhanced clarification of the roles of the gender specialists and the role of the GP, with details of who is responsible for blood tests etc. ○ Inclusion of non-binary clients (as they may elect to take lower doses of hormones, and this will be clarified in communication with the GP) ○ Inclusion of a shared care agreement letter (to be completed by the GP) (NB This is different to normal BLMK shared care practice). Ratification of the updated SCGs was agreed. *Cost impact of decision:* n/a • **Shampoos and scalp preparations.** Shampoos and treatments for psoriasis of the scalp and seborrhoeic dermatitis reviewed and rationalised with recommendations on appropriate treatment choices, effective use of products, timely review and the promotion of self-care. It was noted that there are no single topical vitamin D preparations currently available, and that a specialist should be involved in the care of all children and young people with psoriasis and their guidance on treatment should be followed. The recommendations made from the shampoos and scalp preparations review of the formulary were approved. *Cost impact of decision:* Deprescribing of 30% of shampoos and treatments for psoriasis of the scalp and seborrhoeic dermatitis could release savings of almost £54,000. • **Ferric maltol** is the first oral formulation of a ferric salt licensed in the UK. It is currently not on the B&LF but in MK it is Red, second line for iron deficiency anaemia in adults with mild to moderate IBD (inflammatory bowel disease), who have failed 2 oral ferrous products, for consideration prior to administration of IV options. There could be the potential for primary care to prescribe this treatment for patients and avoid the need for IV iron administration via the hospital. The therapeutic indication of ferric maltol has been extended to	

No	Agenda Item	Action
	adults for the treatment of iron deficiency of any cause. Ferric maltol does present a cost pressure, at £285.60 for a 24-week course compared with £3.56 for ferrous sulphate. The group agreed to align the Beds/Luton formulary with the MK formulary and include ferric maltol as Red, second line for iron deficiency anaemia in adults with IBD who have failed two iron products, with the potential to revisit in approximately a year's time (depending on the volume of usage) when the trusts have more experience. *Cost impact of decision:* n/a in primary care. • **Enolio (liothyronine 10mcg/ml oral solution)** was presented as a potential cost-effective liothyronine option for new and existing patients (in line with BLMK agreed formulary status only). Issues in relation to using a liquid, as opposed to a solid dosage form, were discussed. The group agreed that switching patients from the solid dosage form would be difficult but, as it offered the benefits of savings, it should be added to the formulary as Amber SpA even if uptake is likely to be low. *Cost impact of decision:* A 50% switch from the 20microgram liothyronine tablets to Enolio, would realise savings of almost £12,000 per annum. A 50% switch from 10microgram tablets and capsules to Enolio would make an almost £13,000 per annum saving. • **Adcal D3 dissolve** was agreed to be added to the formularies as a replacement calcium & vitamin D preparation for ColeKal-D3 Dissolve 400unit/1500mg effervescent tablet. It has been identified that ColeKal-D3 Dissolve is classed as a food supplement and contains 161.19mg sodium per tablet. Adcal D3 dissolve is a licensed product suitable for vegetarians and patients with soya or peanut allergy and contains only 42.03 mg sodium per tablet. • It was noted that in mid-April 2025, Pfizer Ltd introduced medroxyprogesterone acetate tablets, the new generic alternative to Provera® tablets. For a limited transition period, both branded and generic versions will be available. After this phase, the branded product will be phased out from routine availability. It was shared with the Committee that there is anticipated to be a proposal for a single national formulary to be developed, as part of the government reforms and 10-year health plan, with a view to having this in place by 2028. Additionally, NICE recommendations which are no longer current / relevant will be archived. This would end the NHS's statutory mandate to supply the retired medicines, treatments, medical devices and procedures. **Post meeting note:** the 10-year health plan was published on 3rd July 2025. **Decision:** The committee ratified the recommendations of the Formulary Subgroup.	

No	Agenda Item	Action

8.2	**Wound Management Formulary Steering Subgroup Recommendations**
	A report from the wound management subgroup meeting in May 2025 was presented to the Committee:
	
	• **Financial:** No concerns. Spend for practices who are newer to direct procurement is increasing well. For the new financial year there will be more spend through ONPOS and less through NHSSC directly. A comparison with FP10 spend will be conducted as soon as the corresponding FP10 data is available for the period to year end.
	• **Online formulary:**
	  ○ The Group is working on a new Burns section with information around referral to Stoke Mandeville Hospital.
	  ○ The Diabetic Foot section is being updated, with dressings and referral guidance for District Nurses. There will also be a corresponding update for the restrictions around the use of Inadine dressings in the community.
	• **Waste Reduction in Wound Care**:
	  ○ A pilot initiative to reduce dressings use and waste by District Nurses (DNs) in patients' homes has been concluded. Data is being collected to review the impact and is expected to be available in July.
	  ○ Results of the ReadyWrap trial are expected imminently. Anecdotally the TVNs report excellent compliance and a large impact in reduction of waste through using these reusable wraps that replace bandaging and can be managed by the patient themselves once initiated.
	• **Additional matters discussed:**
	  ○ It was agreed that Inadine dressings should be removed from general procurement and placed on the restricted list which can only be accessed by TVNs. The wording on the Formulary will be updated to make this change clear.
	  ○ There has been ongoing collaboration with the BLMK ICB Care Homes Pharmacy team on guidance for use of dressings by staff in residential and nursing homes.
	
	Decision: The Committee noted the report from the Wound Management Steering group	

9.	**Patient Group Direction Subgroup Recommendations** The following recommendations were made by the Patient Group Direction (PGD) subgroup:	
9.1	**Update to BLMK Patient Group Directions Policy** The Committee discussed a routine review and update of the BLMK ICB Patient Group Direction Policy and terms of reference for the PGD subgroup. There were no material changes to either document, with updates made to job titles, dates, version control, checking / updating of weblinks (policy only), and minor amendments to	

No	Agenda Item	Action
	wording to improve clarity. In addition, in the policy, the EQIA and DPIA screening has been reviewed, and email addresses updated. **Decision:** The Committee approved the updated PGD policy and PGD subgroup terms of reference.	
9.2	**MK Urgent Care Service PGDs** The following PGDs were presented for approval with limited clinical changes: • **Diclofenac IM injection for the treatment of renal colic** Additional exclusions: ○ Patients who have already taken 150mg diclofenac in the previous 24 hrs. ○ Patients who have taken naproxen within the previous 12 hours or ibuprofen in the last 8 hours • **Dexamethasone Oral Solution for croup:** Slight rewording to make patient inclusions and exclusions clearer i.e. to explicitly exclude patients classified as severe and transfer them to the ED. **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, with focus on primary care metrics: • NHS Performance and Assessment framework 25/26 – percentage of children (0-9 yrs) prescribed antibiotics in primary care in the last 12 months (rolling 12m data to Apr 25): BLMK 43.9% versus target of ≤27%. • Actions on children's antibiotic prescribing: ○ Practice staff training: ▪ Undertaken at B&L PLT May 25. Requested for MK PLT Oct 25. ▪ Planned training Luton SpRs & NHSE TARGET funding requested for staff training. ○ Public Health Engagement ▪ Initial discussions and utilisation of resources discussed. ○ Out of Hours engagement ▪ Initial discussion around educational sessions for ICB commissioned services. Some services are commissioned directly from Acute Trusts. • Proportion antibiotic DDDs from "Access" from AWaRe categories. DDDs 12m rolling to April 25: 66.2% vs target of ≥70% The Committee noted the antimicrobial stewardship update.	

<table>
<tr><th>No</th><th>Agenda Item</th><th>Action</th></tr>
<tr><td>10.1</td><td>BLMK Antimicrobial Resistance (AMR) and Healthcare Associated Infection (HCAI) Steering Group Terms of Reference
The Committee noted a review and update to the Antimicrobial Resistance (AMR) and Healthcare Associated Infection (HCAI) Steering Group terms of reference. The updated terms of reference were discussed and agreed at the last AMR/Infection prevention and control (IPC) meeting.

The terms of reference have been updated to reflect the new National Action Plan on AMR 2024-2029 as below:

<table>
<tr><td>Target 1a</td><td>by 2029, we aim to prevent any increase in a specified set of drug-resistant infections in humans from the 2019 to 2020 financial year baseline – specified in ESPAUR report 22-23.</td></tr>
<tr><td>Target 1b</td><td>by 2029, we aim to prevent any increase in Gram-negative bloodstream infections in humans from the 2019 to 2020 financial year baseline</td></tr>
<tr><td>Target 4a</td><td>by 2029, we aim to reduce total antibiotic use in human populations by 5% from the 2019 baseline</td></tr>
<tr><td>Target 4b</td><td>by 2029, we aim to achieve 70% of total use of antibiotics from the Access category (new UK category) across the human healthcare system</td></tr>
</table>

Additional National Action Plan points:
• Raising public awareness and understanding of AMR & IPC.
• Utilisation of digital & new diagnostics</td><td></td></tr>
<tr><td>11.</td><td>East of England Priorities Advisory Committee (EoEPAC) – items for noting/approval</td><td></td></tr>
<tr><td>11.1</td><td>EoEPAC Meeting Notes – January 2025
The Committee noted the minutes for information.</td><td></td></tr>
<tr><td>12.</td><td>Bedfordshire, Luton and Milton Keynes Local Prescribing Committee Minutes.
The Committee noted the following minutes for information.</td><td></td></tr>
<tr><td>12.1</td><td>Minutes of the Bedfordshire Hospitals Foundation Trust Drug and Therapeutics Committee (DTC) – April 2025</td><td></td></tr>
<tr><td>12.2</td><td>Minutes of the Milton Keynes Hospital Prescribing & Medicines Governance Committee (PMGC) – March 2025</td><td></td></tr>
<tr><td>12.3</td><td>Minutes of the BLMK Formulary Subgroup – April 2025</td><td></td></tr>
<tr><td>12.4</td><td>Minutes of the BLMK Wound Management Formulary Steering Group – March 2025</td><td></td></tr>
<tr><td>12.5</td><td>Minutes of the BLMK Medicines Safety Group – March 2025</td><td></td></tr>
</table>

No	Agenda Item	Action
12.6	Minutes of the ELFT Medicines Management Committee – March 2025	
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) – none available	
12.9	Minutes of Circle/MSK Medicines Management Committee – March 2025	
13.	**Papers for information / ratification**	
13.1	**BLMK Area Prescribing Committee Annual Report 2024/25** The committee considered the fourth Annual Report of the BLMK APC, the contents of which reflect the output from the committee meetings on 1st May 2024, 3rd July 2024, 25th September 2024, 4th December 2024 and 26th February 2025. The report summarises the participating organisations, meeting attendance figures, the Committee's activities and achievements and the future work programme. The Chair and Professional Secretary thanked the Committee for all their hard work and commitment to the APC. **Decision:** The Committee ratified the BLMK Area Prescribing Committee 2024/25 annual report.	
13.2	**Tirzepatide for the management of overweight and obesity – implementation update** Tirzepatide for the management of overweight and obesity is being made available in England in accordance with NICE TA1026 recommendations. The TA is subject to a 12-year funding variation due to availability of services, clinical capacity, potential inequity of access, and the budgetary impact. A limited cohort of patients is eligible for treatment in the first year: People with BMI ≥ 40kg/m2 (37.5 kg/m2 for people from South Asian, Chinese, other Asian, Middle Eastern, Black African or African-Caribbean ethnic backgrounds), with 4 or more of the specified comorbidities: • Hypertension • Dyslipidaemia • Obstructive sleep apnoea • Cardiovascular disease • Type 2 diabetes mellitus Low patient numbers are expected in year one due to the restricted eligible population and funding available. Within BLMK this will be provided as a community outreach service, led by the specialist weight management team from the Luton & Dunstable Hospital. There will be outreach into all 4 places, but clinics have commenced initially at the hub in Dunstable. No GP prescribing in year one. An	

No	Agenda Item	Action
	Ardens template has been developed and is available on SystmOne for GP referrals. Wraparound care, to encompass appropriate nutritional and dietetic advice, physical activity guidance and behavioural change components, is nationally commissioned. This is the NHS Behavioural Support for Obesity Prescribing Programme (BSOP), which is provided in BLMK by Xyla. The BSOP mirrors the NHS. Diabetes Prevention Programme (NDPP). Patients on the existing waiting list for tier 3 and 4 weight management services have been triaged and appropriate, eligible patients given an option to be seen in the community weight management service instead. This is to reduce the burden on GP practice referrals for patients eligible for tirzepatide treatment. The first community weight management service clinic took place on 23rd June. Those patients seen in the clinic who are clinically appropriate were initiated on tirzepatide and referred to the BSOP programme. The Committee noted the updated on the implementation of the NICE TA recommendations for tirzepatide for the management of overweight and obesity.	
14.	**Any other business** None raised	
15.	**Future Dates for BLMK APC 2025/26 Meetings (all to be held from 12:30-15:00 via Microsoft Teams):** Wednesday 24th September 2025 Wednesday 3rd December 2025 Wednesday 4th March 2026 Wednesday 6th May 2026 Wednesday 1st July 2026 Wednesday 23rd September 2026 Wednesday 2nd December 2026	

Approval of minutes:

Chair: Dr Muhammad Nisar

Signed: 

Date: 30 Sep 2025

Appendix 1 – Approved 10 June 2025 Formulary Subgroup Minutes:

BLMK FSG Minutes June 2025 Final.pdf