BEDFORDSHIRE, LUTON AND MILTON KEYNES AREA PRESCRIBING COMMITTEE

Meeting Notes

Date: 03 December 2025
Time: 12.30- 3.00pm
Venue: Microsoft Teams

Attendees:

Name	Initial	Role
Dr Muhammad Nisar	MN	Chair (Medical Representative, Bedfordshire Hospitals NHS Trust)
Nicola Ainsworth	NA	Consultant in Public Health
Reginald Akaruese	RA	CNWL Pharmacy Representative (Community and Mental Health Services Milton Keynes)
Pritesh Bodalia	PB	Bedfordshire Hospitals Trust Pharmacy Representative (Chief Pharmacist, Bedfordshire Hospitals Trust)
Dr Marian Chan	MC	Medical Representative, Bedfordshire Hospitals NHS Trust
Matt Davies	MD	Head of Medicines Optimisation, BLMK ICB (deputising for 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	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)
Dr Kate Randall	KR	Place Based Lead GP – Central Bedfordshire
Dr Mitan Sarkar	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 12:46)	DW	Chair of Medicines Safety Group / Bedfordshire Hospitals Trust Pharmacy Representative (Medicines Use and Quality Manager, Bedfordshire Hospitals Trust)

In attendance:		
Lisa Bond (in attendance for agenda item 8.2)	LB	Tissue Viability Nurse, Cambridge Community Services
Samina Hassanali	SH	Medicines Optimisation Pharmacist, BLMK ICB
Taiya Large	TL	Formulary and Medicines Safety Pharmacist, BLMK ICB
Sandra McGroarty	SM	Commissioning Pharmacist, BLMK ICB
Helen McGowan	HM	Medicines Optimisation Pharmacist, BLMK ICB
Carly Morrison (in attendance for agenda item 8.2)	CM	Tissue Viability Nurse, Cambridge Community Services
Dr Joy Mutitika	JM	Medical Representative, Keech Hospice
Kike Pinheiro	KP	Representative, Willen Hospice
Takudzwa Shumba (until 14:00)	TS	CNWL Pharmacy Representative (Prison Services - HMP Bedford and YarlsWood IRC)
Nikki Woodhall	NW	Lead Medicines Optimisation Technician, BLMK ICB

Apologies:		
Mojisola Adebajo	MA	Medicines Optimisation Lead Pharmacist
Dorothy Aladejobi	DA	Pharmacist Representative, NHS Northampton Hospital Foundation Trust Secure Services
Rafal Ali	RA	Commissioning Pharmacist, BLMK ICB
Dupe Fagbenro	DF	ELFT Pharmacy Representative (Deputy Chief Pharmacist (Luton and Bedfordshire), ELFT)
Fiona Garnett	FG	Associate Director: Pharmacy and Medicines optimisation, BLMK ICB
Qiratulain Khan	QK	Bedfordshire Hospitals Trust Pharmacy Representative
Dr Dush Mital	DM	Medical Representative, Milton Keynes Hospital
Helen Smith	HS	Milton Keynes Hospital Pharmacy Representative (Chief Pharmacist, 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 meeting was confirmed as quorate.	
2.	**Declarations of Interest** The Chair invited the members to reconfirm their current declarations on the Register of Interests and advise of any new declarations. All members confirmed their declarations were accurate and up-to-date. The Chair invited members to declare any declarations relating to matters on the agenda. All members confirmed they have no declarations in relation to matters on the agenda.	
3.	**Minutes of 24 September 2025 APC meeting** The minutes of the meeting held on 24 September 2025 were approved.	
4.	**Matters Arising**	
	The Committee was provided with a brief update on the merger of BLMK ICB with Cambridge & Peterborough ICB and the Hertfordshire part of Hertfordshire and West Essex ICB, to form Central East ICB. It is anticipated that Central East ICB will form from April 2026 and the existing ICBs are currently working to achieve this. The chief executive, Chair, and other executives for Central East ICB have already been appointed. The new ICB will be a more strategic commissioner and ICB staff are currently going through a consultation process on proposed new structures and roles for Central East ICB. Alongside this, work has commenced on creating a new Area Prescribing Committee for Central East ICB, looking at existing APCs, subgroups and processes. This is in its early stages, but March 2026 BLMK APC will be the final meeting of the BLMK committee. Committee members will be updated in due course, including expressions of interest for membership of the new Central East ICB Area Prescribing Committee.	
4.1	**Feedback on miscellaneous actions not included on the agenda from APC meetings**	
4.1.1	**Relugolix–estradiol–norethisterone for endometriosis (TA1057)** – prescribing support document to provide additional information for primary care prescribers to be produced. **Update 19/11/25** – a draft document has been produced and has been circulated to stakeholders for comment. This is an ongoing action.	AG
4.1.2	**Adult asthma guidelines** - to confirm that local specialists are in agreement with the proposal to place montelukast as the first choice	Close

No	Agenda Item	Action
	additional add-on therapy (before tiotropium - Spiriva Respimat) for primary care clinicians, on cost-effectiveness rationale. **Update 16/10/2025** – following discussion with local specialists there was divided opinion on the appropriate first choice add-on therapy. Both have therefore been left as equal options in the guideline. It was proposed and agreed that the action could be closed.	
4.1.3	**Feedback to NICE regarding challenges of implementing TAs with a 30-day implementation period –** with input from acute trusts, from a secondary care perspective. **Update 19/11/2025** – feedback on 30-day implementation given during a NICE associates face to face day. It was proposed and agreed that the action could be closed.	Close
4.1.4	**Betula verrucosa (Itulazax 12 SQ Bet)** for treating moderate to severe allergic rhinitis or conjunctivitis caused by tree pollen to be added to formularies with RED traffic light status. **Update 24/11/2025** – Itulazax has been added to both formularies with Red traffic light status. It was proposed and agreed that the action could be closed.	Close
4.2	**Pylera for the treatment of H. Pylori** (action transferred from the Formulary Subgroup action log) At the Formulary Subgroup (FSG) meeting in June 2025, an application was considered for the addition of Pylera® (140mg bismuth subcitrate potassium (equivalent to 40mg bismuth oxide), 125mg metronidazole and 125mg tetracycline hydrochloride). The FSG agreed to add Pylera to the formularies as a green first line option for patients allergic to penicillin and second line for patients without a penicillin allergy, with the following provisos: • A local support document to be produced for guidance. • Clinician agreed to support with a short GP education session regarding this change to practice. Requests are also being received in primary care, from the gastro teams, to prescribe Pylera. Whilst the above guidance is awaited, an interim SpA traffic light has been implemented on the formularies. BHFT committee members were requested to support with achieving the above actions.	SH/DW/ QK
5.	**Items for consideration at meeting**	
5.1	**Dry Eye guideline update** A review and update of the BLMK prescribing guidelines for dry eye syndrome has been undertaken. Changes to the previous document include: • Addition of wording in the introduction: “When a recommendation is made to purchase a treatment over the counter, community pharmacists can advise on appropriate product options.” • Reference to brand names removed and replaced with generic product names. • Replacement of information on “what is dry eye syndrome”, “ways of helping patients with dry eye disease” and “when to	

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	refer" with information from the NICE CKS on Dry Eye Disease, or reference to it.
	• Preservative toxicity.
	  ○ Specific information on benzalkonium chloride removed.
	  ○ Included specifics on "patients with true preservative allergy, soft or hybrid contact lens wearers." in the preservative toxicity section instead of after "If corneal staining occurs" box.
	  ○ "In a patient with mild dry eye, preserved drops are often well tolerated when used 4 times a day or less; replaced "4-6 times a day".
	  ○ Addition of: "Whenever a PF preparation is needed, consider the 10ml PF bottles, which are more cost-effective to the NHS than unit dose vials (UDVs) and reduce the environmental impact of plastic waste."
	• Add on (all stages).
	  ○ Removed reference to light liquid paraffin and vitamin A ointment (Hylonight®) and replaced with "Light liquid paraffin with white soft paraffin and wool alcohols"
	  ○ Addition: "This can be added to other options as a nighttime treatment. Especially in cases of recurrent corneal epithelial erosion. Can cause blurred vision after administration. Do not use with contact lenses in place."
	  ○ Removed: Not suitable for use with VisuXL products
	• Replacement of "green" traffic light status with "self".
	• Amber/Amber 1/Amber 2/Amber 3 replaced with SpA.
	• Self-care column removed.
	• Prescribing notes under Hypromellose 0.3% drops: It may need to be instilled frequently (e.g. hourly) for adequate symptom relief, then at a reduced frequency.
	• Prescribing notes under Meibomian Gland Disease: Encourage adherence to eye drops and the use of warm compresses if there is evidence of meibomian gland dysfunction. Be aware that adherence to the use of warm compresses is thought to be poor.
	• Removed reference to:
	  ○ Hyaluronate 0.2%/carbomer/glycerol drops (Evolve Revive).
	  ○ Thealoz Duo. Replaced with "Hyaluronate/trehalose +/-d-penthenol".
	
	The following points were discussed:
	• Hyaluronate to be amended to sodium hyaluronate, as this is how the products are listed on SystmOne.
	• It was confirmed the meibomian gland disease (MGD) is a different condition from blepharitis; GPs would not be able to diagnose MGD in primary care.
	• It was highlighted that for this, and other APC papers, the local health intelligence unit can be approached for up-to-date population data.
		SH

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	• There are some formatting issues in the document which will be addressed before it is finalised and published. • Work will need to be done, by the Medicines Optimisation team, to identify the preferred products to be prescribed in primary care – this will then be used to update OptimiseRx and inform primary care prescribing. • The document has been circulated to specialists and input sought on its contents. An initial response was received from BHFT, but further feedback is awaited. **Decision**: The Committee approved the dry eye guidance, pending receipt of any further comments from the specialists. **EQIA Assessment:** Positive impact anticipated, by reducing health inequalities: DES is more prevalent in older adults and women. Ensuring consistent access to effective treatments across BLMK (updated following receipt of ED comments) **BLMK ICB E and D Lead comment:** Under the section on 'rationale for impact assessment", is it necessary to explain that the decision is about "reducing health inequalities" through ensuring improved or equitable access to effective DES treatments across BLMK particularly for the groups (older adults and women) with high prevalence of DES.	SH SH
5.2	**Acamprosate prescribing support document** At the September 2025 Formulary Subgroup, it was agreed that the existing Beds/Luton shared care guideline for acamprosate could be stepped down and replaced with a prescribing support document. The Committee is asked to review the proposed document, noting that this will be applicable in Bedfordshire and Luton only. A different situation exists in Milton Keynes and the specialist drug and alcohol service (CNWL) retain the prescribing. Changes from the information contained within the existing SCG: • Removal of the requirement for primary care to review the patient at 6 months – this review is carried out by the specialist team. • Removal of the requirement to carry out 3-monthly blood tests as this is not required for patients on acamprosate. • Removal of appendix 1 (Clinical indicators of relapse to excessive alcohol use) as feedback from specialists indicated that the majority of the information was too subjective to be helpful / supportive. • Updating of contact details for the specialist providers. • Updating of references. The Committee discussed the difference in formulary status between Bedfordshire & Luton and Milton Keynes. It was confirmed that this is largely historical and based on the set up within the different drug & alcohol providers. There are three different providers for BLMK, covering Bedfordshire, Luton and Milton Keynes respectively. Primary care prescribing is fairly rare in Bedfordshire and Luton and	

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	any differences in patient experience would be highlighted via contractual discussions. **Decision**: The prescribing support document was approved. **EQIA Assessment:** No impact anticipated, as the proposed document does not change the current care pathways or method of supply for acamprosate.	

5.3	**Paediatric Asthma Guidelines (for children ≤16 years)**
	The Committee was presented with an update to the current BLMK paediatric asthma guidelines following publication of the NICE/ BTS / SIGN guideline update. This includes:
	• Changes to diagnostics – aligned for GP contract 25/26.
	• Pharmacological management for under 5s – layout updated, and minor tweaks to wording.
	• Pharmacological Management 5-11yrs
	  ○ Conventional pathway – addition of Fobumix 80/4.5 (included to reflect license as a choice for this age group; Fobumix is already on formulary and a cheaper choice than Symbicort or Duoresp).
	  ○ Addition of a MART pathway for select patients.
	• Pharmacological management 12-16yrs
	  ○ For MART – addition of an MDI choice. Symbicort 100/3 is the first licensed MDI available in this age group. It was noted that this inhaler has a high carbon footprint, but it is currently the only licensed MDI option in this age group; it is anticipated that usage will be low as most people in this age group will be able to use a DPI.
	  ○ Addition of Fobumix 160/4.5 for AIR (new license)
	  ○ Update to positioning of montelukast & LAMA trial, as per adult asthma guidelines (see also agenda item 4.1.2).
	  ○ The conventional pathway identifies a clear path to switch to MART when appropriate.
	• Updates to acute asthma management pathways as per BLMK ICS CYP group.
	
	Decision: The Committee approved the updated paediatric asthma guidelines.
	
	EQIA Assessment: no impact anticipated. The revised asthma guidelines reflect the current NICE / BTS / SIGN guidelines. They are not mandatory, and clinicians should use their clinical discretion when using.	

5.4	**Stoma Accessories Formulary and Agreed Fair usage Guideline update** Minor amendments have been made to the stoma accessories formulary, following further product evaluation by the stoma nurses. Changes made are product rationalisation / amendments in the following sections: • Adhesive Removers Sprays • Adhesive Remover Wipes	

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	• Barrier Wipes (films, foams) • Other Barriers e.g. creams (for mucocutaneous hypersensitivity, cancer patients & complex dermatological conditions) • Discharge Solidifying gels **Decision**: The updates to the stoma accessories formulary and agreed fair usage guideline were approved. **EQIA Assessment:** No issues with equality, inclusion and human rights have been identified.	

5.5	**Chronic Heart Failure NICE guideline NG106**
	The Committee considered updates to NICE NG106 Chronic heart failure in adults: diagnosis and management, with a focus on the pharmacological management. The updates to NG106 incorporate TA902 and TA929 (dapagliflozin and empagliflozin for heart failure with preserved or mildly reduced ejection fraction). The following aspects of NG106 were discussed alongside proposed formulary changes to help implement the guideline recommendations:
	
	• Dapagliflozin and empagliflozin for treating chronic heart failure with reduced ejection fraction; proposed change of formulary status from SpA to Green.
	  ○ Adding SGLT2i reduces mortality and hospitalisation without increased adverse events.
	  ○ Early use of and MRA and SGLT2i in combination with ACEi and beta-blocker is cost-effective.
	  ○ Correct sequencing varies from person to person.
	• Move eplerenone (MRA (mineralocorticoid receptor antagonist) from SpA to Green:
	  ○ HF (heart failure) with reduced ejection fraction (EF) (HFrEF):
	  ▪ (Offer) Early use of and MRA and SGLT2i in combination with ACEi and beta-blocker is cost-effective.
	  ○ HF with preserved EF:
	  ▪ (Consider)Treatment with MRA reduces hospitalisation for heart failure and may also improve all cause and cardiovascular mortality.
	• Sacubitril and valsartan (Entresto®) (angiotensin receptor-neprilysin inhibitor (ARNI)) from SpIS to SpA.
	  ○ HFrEF:
	  ▪ (Offer) ARNI, beta-blocker and MRA reduced all-cause and cardiovascular mortality compared with ACEi, beta-blocker and MRA.
	  ▪ Primary care prescribers should consider seeking advice from a heart failure specialist before starting someone on an ARNI.
	• Digoxin from Green to SpA for heart failure:
	  ○ Offer digoxin to people with worsening or severe heart failure with reduced ejection fraction despite optimised	

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	treatment combinations. Seek specialist advice before starting treatment.
	• Hydralazine from Green to SpA:
	  ○ If ACE inhibitors, ARNIs and ARBs are not tolerated, seek specialist advice and consider hydralazine in combination with nitrate.
	
	The Committee noted the following key changes to the medicines' recommendations in NG106:
	
	• 4 medicines to be started for HF with reduced ejection fraction: ACEi (angiotensin-converting enzyme inhibitor), beta-blocker, MRA (mineralocorticoid receptor antagonist) and SGLT2i (sodium-glucose cotransporter 2 inhibitor).
	• New recommendations for heart failure with preserved and mildly reduced ejection fraction.
	• New recommendations on IV iron. Note: it has been confirmed by pathology at BHFT that transferrin saturation can be measured, but the test is only available in presence of anaemia, and if the ferritin is between the lower limit of normal and 100.
	• Some TAs are incorporated in the guideline, but some TAs are based on a previously recommended pathway and therefore the NG106 recommendations differ from the TAs.
	
	Comparing the guideline and the unreferenced TAs:
	▪ TA388: sacubitril valsartan for HF with reduced EF
	  ○ Guideline covers symptomatic HF (class II or greater in the TA).
	  ○ Guideline defines reduced EF as 40% or less (LVEF 35% or less in TA)
	  ○ ARNI option instead of ACEi for
	  ▪ Symptomatic on max dose ACEi, beta-blocker, MRA and SGLT2i or
	  ▪ People who cannot tolerate ACEi (other than angioedema)
	▪ TA679 and TA773: dapagliflozin and empagliflozin for HF with reduced EF
	  ○ Alongside ACEi, beta-blocker and MRA (TA states add-on to optimised care with ACEi or ARB plus beta-blocker, and MRA if tolerated or ARNI plus beta-blocker, and MRA if tolerated).
	  ○ Order of introduction based on medical history, prognosis and preferences.
	  ○ Not necessary to optimise dose of each medicine before introducing another.
	
	Other TAs incorporated into, and directly referenced in, the guideline:
	▪ Potassium binder for hyperkalaemia
	  ○ Patriomer (TA623, 2020)
	  ○ Sodium zirconium cyclosilicate (TA599, 2022)
	▪ Implantable cardioverter defibrillators and cardiac resynchronisation therapy (TA314, 2014)	

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	▪ Ivabradine for treating chronic heart failure (TA267, 2012) ▪ Dapagliflozin for treating chronic heart failure with preserved or mildly reduced ejection fraction (TA902, 2023) ▪ Empagliflozin for treating chronic heart failure with preserved or mildly reduced ejection fraction (TA929, 2023) The change in drug cost to current practice is estimated to be £101,000 in year 1 rising to £580,000 by year 5. It was noted that, due to the size of the potential financial impact, additional oversight / approval is required from the ICB. The Committee discussed the following additional points: • Heart failure is diagnoses by the specialists following blood tests and echocardiogram. It is expected that medication would be initiated within 5-7 days of diagnosis. • Community heart failure teams will conduct follow-up reviews of patients. • Digoxin is not normally initiated in primary care, therefore a change in formulary status to SpA is not expected to have an impact on secondary care specialists. • BHFT has recently updated their IV iron guidelines which may need to be cross referenced against this updated NICE guidance. • Prescribing guidance will be produced to aid primary care teams prescribing for heart failure patients. **Decision**: The Committee supported the implementation of NICE NG106, and the proposed formulary amendments, but noted the need for further financial scrutiny within the ICB. Prescribing guidance to be produced to support implementation. **EQIA Assessment:** Implementation of the guidance improves access to therapies and patient's preferences when deciding when and how to optimise medicine doses. People with chronic heart failure could be considered disabled under the Equality Act 2010. Adoption of the NICE guidance recommendations is anticipated to have a positive impact on the population of patients with chronic heart failure as it will optimise the treatment choices for this patient cohort. (note: wording updated following receipt of ED comments). **BLMK ICB E and D Lead comment:** Under the section on 'rationale for impact assessment", is there a need to explain that the decision is about "improving access to therapies and patient's preferences when deciding when and how to optimise medicine doses.	MD/SH
5.6	**Baloxavir formulary application** Its single-dose oral regimen and distinct mechanism of action provide clinical and operational advantages where neuraminidase inhibitors (NAIs) are unsuitable or ineffective. The 2025 UKHSA guidance recognises baloxavir marboxil as a valid alternative class of direct-acting antiviral.	

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	Benefits: • Provides a single-dose oral treatment option. • Offers mechanistic diversity (cap-dependent endonuclease inhibitor). • Useful where NAIs are contraindicated or impractical. • May improve adherence and early initiation of treatment. • Supports pandemic and seasonal influenza preparedness. Single-dose oral baloxavir shortens time to symptom alleviation versus placebo, reduces viral load rapidly, prevents influenza in household contacts (post-exposure prophylaxis), is generally well tolerated — but treatment-emergent resistance (PA-I38 substitutions) occurs relatively frequently (especially in children) and may prolong shedding or blunt clinical benefit in some cases. Cost of single dose treatment: £100 (dm+d). Numbers difficult to quantify but are expected to be relatively low as baloxavir sits as third line therapy. It was proposed to add as Green restricted to microbiologist advice in line with other similar therapies on the Formularies. Interest has been expressed by microbiologists at both trusts. The following points were discussed: • It may be more appropriate to utilise a SpA traffic light; this would align with the formulary entries for fidaxomicin and similar wording could be used (NB: the fidaxomicin formulary entries state “On recommendation of a Consultant Microbiologist only, or prescribed in accordance with the BLMK Antimicrobial Prescribing Guidelines”). • Prescribing of antivirals is very low in primary care and it is difficult to gauge whether a patient will progress to serious illness. Prescribing in primary care would normally take place without swabbing. • If there is a suspected outbreak in a care home, this would be reported to UKHSA who would conduct swabbing. Appropriate treatment would be recommended by the UKHSA in this scenario. **Decision**: The Committee agreed that baloxavir should be added to the formularies as Amber SpA, on the advice of a microbiologist or UKHSA (may be prescribed/ initiated in primary care following specialist advice) Post meeting note: baloxavir is not currently available via wholesalers for community pharmacists to order; hospital pharmacies have a process by which they can order. A note will be added to the formularies to indicate the lack of availability in primary care at the current time, which will be updated as/when this changes. **EQIA Assessment:** Positive impact as additional option will become available for patients to treat influenza. There are no restrictions to	TL/FK TL/FK

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	patient groups that would negatively impact any protected characteristics.	
6.0	**NICE Guidance – from 11 September to 19 November 2025** **The following NICE Technology Appraisal Guidance (ICB Commissioned) have been published:** • **Mirabegron for treating neurogenic detrusor overactivity in people 3 to 17 years (terminated appraisal)** Technology appraisal Reference number: TA1100 Published: 01 October 2025 https://www.nice.org.uk/guidance/ta1100 **Resource impact:** none – terminated appraisal **APC actions:** link added to formularies for information • **Targeted-release budesonide for treating primary IgA nephropathy** Technology appraisal guidance Reference number: TA937 Published: 20 December 2023 Last updated: 09 October 2025 https://www.nice.org.uk/guidance/ta937 **Resource impact:** no additional resource impact. Change of units in recommendation 1.1 only. **APC actions:** None • **Sparsentan for treating primary IgA nephropathy** Technology appraisal guidance Reference number: TA1074 Published: 25 June 2025 Last updated: 09 October 2025 https://www.nice.org.uk/guidance/ta1074 **Resource impact:** no additional resource impact. Change of units in recommendation 1.1 and 1.2 only. **APC actions:** None • **Clascoterone for treating acne vulgaris in people 12 years and over (terminated appraisal)** Technology appraisal Reference number: TA1105 Published: 22 October 2025 https://www.nice.org.uk/guidance/ta1105 **Resource impact:** none – terminated appraisal **APC actions:** formulary entries updated to add DNP traffic light and link to TA1105. • **Delgocitinib for treating moderate to severe chronic hand eczema** Technology appraisal guidance Reference number: TA1107 Published: 05 November 2025 https://www.nice.org.uk/guidance/ta1107	

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	Resource impact: NICE estimates that the resource impact will be approximately £18k in year 1, rising to £110k by year 3. **APC actions:** created and link added to formularies (RED traffic light) **The following NICE Guidelines (NG) (Medicine related and ICB Commissioned) have been published / updated by NICE:** **Atopic eczema in under 12s: diagnosis and management** Clinical guideline Reference number: CG57 Published: 12 December 2007 Last updated: 22 September 2025 https://www.nice.org.uk/guidance/cg57 This guideline covers diagnosing and managing atopic eczema in children under 12. It aims to improve care for children with atopic eczema by making detailed recommendations on treatment and specialist referral. The guideline also explains how healthcare professionals should assess the effect eczema has on quality of life, in addition to its physical severity. **Last reviewed:** 22 September 2025 NICE reviewed the evidence and amended the section on complementary therapies, washing and clothing. NICE also added a link to an education resource to the section on education and adherence to therapy. See the September 2025 surveillance decision for details. **APC actions**: none required. No changes to medicines recommendations; a statement has been added that "there is no evidence of any benefit in taking fewer baths or showers, or in using ion exchange water softeners or silk clothing". Silk garments are DNP on the BLMK formularies. **Suspected sepsis in people aged 16 or over: recognition, assessment and early management** NICE guideline Reference number: NG253 Published: 19 November 2025 https://www.nice.org.uk/guidance/ng253 This guideline covers the recognition, diagnosis and early management of suspected sepsis in people aged 16 or over who are not and have not recently been pregnant. It includes recommendations on recognition and early assessment, initial treatment, escalating care, finding and controlling the source of infection, early monitoring, information and support, and training and education. **Last reviewed:** 19 November 2025 NICE has split the sepsis guideline, that covered all age groups, into 3 guidelines (including this one). The most important changes to practice in the 2024 and 2025 updates are: • new recommendations on the volume and type of intravenous fluid (2025) • recommendations on the use of NEWS2 in acute mental health, ambulance and acute hospital settings (2024).	

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	APC actions: a full review of the BLMK antimicrobial guidance is being undertaken and will be considered at March 2026 APC. Guideline changes will be taken into account as part of this review. **Suspected sepsis in under 16s: recognition, diagnosis and early management** NICE guideline Reference number: NG254 Published: 19 November 2025 https://www.nice.org.uk/guidance/ng254 This guideline covers the recognition, diagnosis and early management of suspected sepsis in under 16s (not pregnant or recently pregnant). It includes recommendations on recognition and early assessment, initial treatment, escalating care, finding and controlling the source of infection, early monitoring, information and support, and training and education. **Last reviewed:** 19 November 2025 NICE has split the original sepsis guideline, that covered all age groups, into 3 guidelines (including this one). **Next review:** NICE plans to review the use of the national paediatric early warning score (PEWS) and consider making recommendations on it in this guideline. **APC actions:** a full review of the BLMK antimicrobial guidance is being undertaken and will be considered at March 2026 APC. Guideline changes will be taken into account as part of this review. **Suspected sepsis in pregnant or recently pregnant people: recognition, diagnosis and early management** NICE guideline Reference number: NG255 Published: 19 November 2025 https://www.nice.org.uk/guidance/ng255 This guideline covers the recognition, diagnosis and early management of suspected sepsis in pregnant or recently pregnant people. It includes recommendations on recognition and early assessment, initial treatment, escalating care, finding and controlling the source of infection, early monitoring, information and support, and training and education. **Last reviewed:** 19 November 2025 NICE has split the sepsis guideline, that covered all age groups, into 3 guidelines (including this one). **Next review:** NICE plans to review the use of the modified early obstetric warning score (MEOWS) and consider making recommendations on it in this guideline. **APC actions:** a full review of the BLMK antimicrobial guidance is being undertaken and will be considered at March 2026 APC. Guideline changes will be taken into account as part of this review. **The following NICE TAs are the commissioning responsibility of NHSE and are listed for information only:**	

	Enfortumab vedotin with pembrolizumab for untreated unresectable or metastatic urothelial cancer when platinum-based chemotherapy is suitable Technology appraisal guidance Reference number: TA1097 Published: 11 September 2025 https://www.nice.org.uk/guidance/ta1097 **APC action:** created and link added to formularies (RED traffic light) **Isatuximab in combination for untreated multiple myeloma when a stem cell transplant is unsuitable** Technology appraisal guidance Reference number: TA1098 Published: 24 September 2025 https://www.nice.org.uk/guidance/ta1098 **APC action:** links added to formularies (RED traffic light) **Durvalumab for treating limited-stage small-cell lung cancer after platinum-based chemoradiotherapy** Technology appraisal guidance Reference number: TA1099 Published: 01 October 2025 https://www.nice.org.uk/guidance/ta1099 **APC action:** link added to formularies (RED traffic light) **Garadacimab for preventing recurrent attacks of hereditary angioedema in people 12 years and over** Technology appraisal guidance Reference number: TA1101 Published: 08 October 2025 https://www.nice.org.uk/guidance/ta1101 **APC action:** created and link added to formularies (RED traffic light) **Lorlatinib for ALK-positive advanced non-small-cell lung cancer that has not been treated with an ALK inhibitor** Technology appraisal guidance Reference number: TA1103 Published: 21 October 2025 https://www.nice.org.uk/guidance/ta1103 **APC action:** link added to formularies (RED traffic light) **Sarilumab for treating polyarticular or oligoarticular juvenile idiopathic arthritis in people 2 to 17 years (terminated appraisal)** Technology appraisal Reference number: TA1104 Published: 22 October 2025 https://www.nice.org.uk/guidance/ta1104 **APC action:** link added to formularies (TERMINATED APPRAISAL) **Iptacopan for treating complement 3 glomerulopathy (terminated appraisal)** Technology appraisal Reference number: TA1102 Published: 29 October 2025 https://www.nice.org.uk/guidance/ta1102 **APC action:** none – terminated appraisal **Cabotegravir for preventing HIV-1 in adults and young people** Technology appraisal guidance Reference number: TA1106 Published: 05 November 2025 https://www.nice.org.uk/guidance/ta1106 **APC actions:** created and link added to formularies (RED traffic light) **Cemiplimab with platinum-based chemotherapy for untreated advanced non-small-cell lung cancer** Technology appraisal guidance Reference number: TA1108 Published: 05 November 2025 https://www.nice.org.uk/guidance/ta1108 **APC actions:** none – not recommended	

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	Darolutamide with androgen deprivation therapy for treating hormone-sensitive metastatic prostate cancer Technology appraisal guidance Reference number: TA1109 Published: 12 November 2025 https://www.nice.org.uk/guidance/ta1109 **APC action:** link added to formularies (RED traffic light) **Abiraterone (originator and generics) for treating newly diagnosed high-risk hormone-sensitive metastatic prostate cancer** Technology appraisal guidance Reference number: TA1110 Published: 19 November 2025 https://www.nice.org.uk/guidance/ta1110 **APC action:** link added to formularies (RED traffic light) **Nintedanib for treating fibrosing interstitial lung disease in people 6 to 17 years (terminated appraisal)** Technology appraisal Reference number: TA1111 Published: 19 November 2025 https://www.nice.org.uk/guidance/ta1111 **APC action:** link added to formularies (TERMINATED APPRAISAL) **Trastuzumab deruxtecan for treating hormone receptor-positive HER2-low metastatic breast cancer after 2 or more endocrine treatments (terminated appraisal)** Technology appraisal Reference number: TA1112 Published: 19 November 2025 https://www.nice.org.uk/guidance/ta1112 **APC action:** link added to formularies (TERMINATED APPRAISAL)	
7.	**Medicines Safety update** A Primary Care Medicines Safety Update and a Medicines Safety Group (MSG) 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 (September and October 2025) and CAS alerts (November 2025). In particular: **Paracetamol and pregnancy - reminder that taking paracetamol during pregnancy remains safe (DSU, September 2025)** Patients should be reminded and reassured that there is no evidence that taking paracetamol during pregnancy causes autism in children. Paracetamol is recommended as the first-choice pain reliever for pregnant women, used at the lowest dose and for the shortest duration. It also acts as an antipyretic and is therefore used to treat fever. **Actions taken:** Discussed at MSG in October and linked to formularies. **#MedSafetyWeek (3-9 November 2025): A call to action to improve patient safety (DSU, October 2025)** The annual #MedSafetyWeek campaign took place from 3 to 9 November 2025. This year's campaign theme is 'we can all help make medicines safer.'	

No	Agenda Item	Action
	In the UK, we are focusing on highlighting the importance of reporting suspected problems from all healthcare products to the Yellow Card scheme, no matter who you are. The MHRA was seeking support to raise awareness of the scheme to increase awareness and reporting from the general public. **Actions taken:** This DSU will be discussed at the January MSG and activity shared. Information has been shared at place meetings. **Isotretinoin – updates to prescribing guidance and survey of services (DSU, October 2025)** The MHRA seeks to undertake a baseline survey of services by 16 November 2025 where isotretinoin is prescribed. The aim is to support the development of a new approach to monitor adherence to risk minimisation measures, whilst supporting patient access to treatment across all age groups. Changes to isotretinoin prescribing advice: • Follow-up consultations do not necessarily need to be in person (face to face) and could be remote if appropriate, however the first appointment should be in person. • Medically supervised pregnancy testing may be performed remotely with appropriate oversight to ensure tests are performed correctly and safely. • Patients should be asked about sexual function at follow up appointments, although by the third appointment, this may be brief. **Actions taken:** Risk minimisation materials are linked to the formulary. This alert will be discussed at the January MSG. **Influenza season 2025/26: early season activity and implications for clinical practice (CAS alert, November 2025)** UKHSA surveillance data indicates that influenza is circulating in the community earlier than usual this season with a drifted strain of Influenza A(H3N2) predominating. Clinicians should continue to promote and deliver influenza vaccination for eligible patients and for healthcare workers. Clinicians are also reminded that early antiviral treatment reduces the risk of complications and improves clinical outcomes. **Actions taken:** Local health systems, including ICBs, should ensure plans are in place to optimise vaccination coverage and ensure timely access to antivirals in community and care home settings. **Rybelsus® (oral semaglutide): risk of medication error due to introduction of new formulation with increased bioavailability (Direct Healthcare Professional Communication, August 2025)** Rybelsus tablets will be replaced with a new formulation with increased bioavailability, which is bioequivalent to the initial formulation. **Actions taken:** Discussed at the October MSG. Formulary pages and ORx messaging will support prescribers with the change. The ICB have sent out communications to primary care (including a switch letter), community pharmacies and the LPC.	

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	The Committee also noted the following **MHRA press releases**: • MHRA crackdown on illegal 'Botox' after victims left seriously ill – people hospitalised following suspected use of unlicensed botulinum toxin products. • Parents and caregivers advised to stop all use of specific brand of kids' magnesium gummies due to the presence of an undeclared prescription-only medicine **Medicines Safety Group (MSG) Update** Management of Safety Alerts and MSNs A procedure is in place within the Medicines Optimisation Team for management of shortages which includes an MSN (medicines supply notification) log. It was noted that the responsibility for logging and acting on alerts lies with the practices, which is audited by the CQC. Pharmacy WhatsApp groups are used locally to source stocks of medicines in the system. The CQC Live module on Eclipse contains pre-built searches for all these alerts. An article will be added to the Primary Care Bulletin to raise awareness and engagement. Clozapine Incident Following an incident where clozapine was administered to a patient in supported living, after missing 4 doses, without undergoing blood test and re-titration, the group noted the need for more education. PrescQIPP have been approached to include information in their e-learning packages for managing medicines for adults receiving social care in the community and care homes, and a CQC article on clozapine will be shared via the Primary Care Bulletin. ELFT will arrange a mental health training session for primary care staff on clozapine and high-risk psychiatric medication. MSOs will be invited to cascade the session to junior doctors. Insulin prescribing error and look alike sound alike medicines The group shared information relating to an incident in Primary Care involving selection error of an insulin at the point of prescribing. Instructions on enabling Tall Man lettering on SystmOne has been shared with practices at last year's Place Prescribing Meetings to minimise the likelihood of these errors. PrescQIPP have recently released an e-learning package on look-alike sound alike errors. This course is designed for any healthcare professional, in primary and secondary care, involved in the medicine prescribing, optimisation, supply, administration or monitoring. System update on Levemir discontinuation The discontinuation of this product requires careful management of patients and poses several possible safety risks, as a significant number of patients are required to switch to alternative products. A well-defined process for this, clear counselling where devices and alternative insulins are chosen, and appropriate monitoring are all key in ensuring a safe system response to the discontinuation. A working group has formed with key stakeholders from primary and secondary care.	

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	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 November 2025 meeting: • **Compleat 1.1 enteral nutrition:** New to market, nutritionally complete tube-feeding formula made with real food ingredients, proposed for patients requiring a fibre feed or as an intermediate option when standard feeds are intolerable. It is a more cost-effective option than peptide regimens like Peptamen and a reduction in prescribing of these is expected to realise cost-savings. It was proposed to add to Formularies as Specialist-initiated and Primary Care Prescribed (SpA). *Outcome:* The committee was happy to approve a decision outside of the group, pending discussion with procurement leads to ensure it does not upset existing contracts. It has been confirmed that there is no problem anticipated in terms of existing contracts, as this is a unique product. *Cost impact:* Cost saving through reduction in the use of Peptamen (difficult to quantify, however assuming 100% switch - Potential one-year saving if all patients switched to Compleat 1.1 (using average percentage saving/1000ml bottle) = £47,614.43). • **Compleat 1.5 HP enteral nutrition**: A similar product to Compleat 1.1 (see above), however it has a higher calorie density per mL and a higher amount of protein. *Outcome:* The decision was as per item 5.1. (SpA, pending contract investigation). *Cost impact:* Potential one-year cost implication if all patients on standard fibre feeds were switched to Compleat 1.5 HN = £2969.41. • **Dydrogesterone-only (Nalvee®)**, oral hormone replacement therapy (HRT) formulation as an option for non-hysterectomised women receiving oestrogen therapy: *Outcome:* Nalvee® was assessed and not added to Formulary at this time due to licensing status that limits usefulness of the product. NB: Nalvee is only licensed for cyclical not continuous use, therefore the cohort expected to benefit is very niche, as most patients with problems controlling bleeding would require continuous progesterone therapy. *Cost impact:* none, as not added to formularies. • **Dexamethasone Formulary choices for croup** (GREEN): Dexamethasone 2mg and 10mg soluble tablets have been added for children who require oral steroid therapy for acute management of croup. For children unable to tolerate tablets or require a dose that cannot be made from the above strengths of tablets, 2mg/5mL oral solution is also available on Formulary, noting that the "off the shelf" availability of the liquid in community pharmacies is likely to be limited. The	

No	Agenda Item	Action
	liquid is higher cost and subject to broken bulk/wastage therefore many pharmacies do not stock it. *Outcome*: added to formularies as GREEN. *Cost impact*: Likely cost saving overall as Formulary now steers to cost-effective, clinically appropriate choices. Reduction in wastage from broken bulk also expected. • **Reusable insulin pens device guide**: reference guide for available re-useable pens and compatible insulin cartridges. Increasing the use of reusable pens represents an opportunity to reduce plastic waste vs disposable pens. *Outcome*: the guide was approved. Alongside the document, FSG recommend that two pens are issued in case of loss or failure of a pen, and that pens should be issued as acutes to prevent oversupply as many pens have a 2+ year lifespan. *Cost impact*: N/A • **Amiodarone Shared Care Guidance:** The Shared Care Guidance for amiodarone has undergone a full update and has also been rolled out across BLMK (formerly only Beds/Luton were under SCG arrangement). Clarification of responsibilities and monitoring arrangements are now detailed in an easy-to-read table. Previously, Milton Keynes was not under Shared Care, however the document is a welcome step in improving safety for patients and a clear framework for monitoring responsibilities between Primary and Secondary Care. *Outcome:* approved, pending clarification around magnesium monitoring and subsequent management. *Cost impact:* cost neutral. • **Estring® vaginal ring** for atrophic vaginitis in postmenopausal women (GREEN, third line): the FSG reconsidered the formulary status of Estring® following feedback from primary care clinicians. Estring® brings the benefit of less frequent administration (3 monthly vs twice a week with pessaries/cream) and reduces plastic waste as applicators are not required. *Outcome*: traffic light status changed from SpA third line to Green third line, for patients with dexterity issues and/or are unable to administer themselves, to improve ease of access to treatment. *Cost impact*: cost neutral – product is already on the formularies. • **Aflibercept biosimilars**: Following loss of Eylea® patent, a national procurement process has taken place for the available / soon to be available biosimilars and awarded on a regional basis for use within the NHS. The framework will commence on 1st December 2025. At launch, aflibercept biosimilars available on the NHS framework are anticipated to be approved for all reference product (Eylea®) indications except retinopathy of prematurity. Retinopathy of prematurity is not a locally approved use for aflibercept. Note: this does not apply to the aflibercept (Eylea®) 8mg product, which maintains its product exclusivity.	

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	Outcome: added to the formularies as RED; brands in accordance with national framework allocations. *Cost impact:* Large cost saving vs originator (prices are commercially sensitive). • The formulary **minor amendments log** was noted. • **Sildenafil Oral Spray (Hezkue®)** for Erectile Dysfunction Hezkue® was assessed and rejected for use as the reported benefits were considered to be cosmetic not clinical. The benefits did not justify the large cost differential vs the tablets. *Outcome*: added to formularies with DNP status *Cost impact:* N/A (cost avoidance from increased use of spray vs tablets). • **Bupropion for treatment resistant depression**: Pending development of guidance to support Primary Care, bupropion remains Red on the Formularies until publication of the document. • **Xonvea** (doxylamine/pyridoxine) remains SpIS on the formularies; discussions are ongoing with the trust regarding the pathway for patient access. • **Denosumab biosimilar**: Following patent expiry of Prolia – several biosimilars are expected to launch in the UK. Hospitals will get a regional allocation, with associated contract prices, but these prices probably won't be available in the community. Additionally, MKUH and BHFT are in different contracting regions and have been allocated a different product. Framework 'go live' is from January. It is planned to add the biosimilar brands as they are assessed in line with implementation plans and updates will be brought to FSG, likely February 2026. **Decision:** The committee ratified the recommendations of the Formulary Subgroup.	
8.2a	**Wound Management Formulary Steering Subgroup Recommendations** A report from the wound management subgroup meeting in November 2025 was presented to the Committee: • **Formulary changes, alignment and development:** ○ Cutimed Sorbion Sachet is to be replaced DRYMAX Super Absorbent, which is on the Milton Keynes Practice Nurse and Nursing Homes formulary. This represents a cost saving and aligns the formularies. ○ The group considered formulary applications for: ▪ Readywrap® Compression system (adjustable compression wraps) ▪ Geko® neuromuscular electrostimulation technology (see also item 8.2b) ▪ Both were support by the group as restricted (TVN only) items. • **Financial**: Spend is within expected limits. High FP10 prescribing of formulary items is being examined, with support from Practice Nurses and TVNs to engage with practices where necessary.	

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	• **Additional matters discussed:**
	  ○ The project to onboard nursing homes in Bedfordshire and Luton onto ONPOS so that they can order dressings via the direct procurement is now underway. This brings the process in line with nursing homes in Milton Keynes. It is expected nursing homes will begin to have access to ONPOS in the new year.
	  ○ The TVNs in Bedfordshire led a successful Stop the Pressure information day at the Rufus Centre this month, which attracted around 80 practitioners from the BLMK ICB footprint who learnt about avoidance and treatment of pressure ulcers.
	
	Decision: The Committee ratified the recommendations of the Wound Management Steering group	

8.2b	**Geko® neuromuscular electrostimulation device** The Committee considered the addition of Geko® to the wound care formulary for TVN/specialist use only, as recommended by the wound management formulary steering group. This is being presented to the Committee as a substantive agenda item because Accel-Heal® electrical stimulating device is DNP on the formularies, following consideration as part of the medical devices' guidance review. The following points were noted: • There are significant differences between Geko and Accel-Heal, including: patient/carer application vs healthcare professional application; method of electrostimulation; overall benefits in terms of patient experience and wound healing. • Geko is suitable for most patients without active DVT. • The Luton TVN team have identified that the best outcomes are achieved for patients with low BMI and minimal oedema. • In a local trial, patients with complex co-morbidities showed slower or limited progress. However, the device may be used in both mobile and less mobile patients. • The ability to self-manage (or have support from a carer/ family) is essential. • Depending on the patient's presentation, a course of treatment would run from a minimum of 6 weeks to 18 weeks plus. The device costs £230.79 for 7 devices (2 weeks treatment) £692.37 for 6 weeks treatment. This would be monitored by the specialist prescribing the treatment to ensure it remains suitable. • The device is available on FP10 and via the NHS Supply Chain. • Experience from a London trust, which has already adopted Geko onto the formulary, has demonstrated cost and efficiency savings including reduced time to wound healing, reduced total visits and nursing time to heal wounds. Geko is therefore expected to be cost saving overall. • There is no NICE guidance for Geko in this patient cohort; NICE HTG344 (June 2014) supports use in people who have a high risk of VTE and for whom other mechanical and	

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	pharmacological methods of prophylaxis are impractical or contraindicated. **Decision:** The Committee approved the addition of Geko to the formularies, in accordance with the recommendations from the wound management steering group, as a TVN specialist product.	
9.	**Patient Group Direction Subgroup Recommendations** None submitted for consideration	

10.	**Antimicrobial Resistance (AMR) Update**
	The Committee was presented with an AMR update which included review of the following metrics:
	• Children's antibiotic prescribing, in the age group 0-9 years, remains well above the national target in the last 12 months. Work is ongoing to address this, including education, sharing of resources, and linking in with public health colleagues.
	• A new metric has been introduced which reviews the proportion of antibiotic DDDs from AWaRe categories. The use of AWaRe categories has been in place in secondary care for some time but is new in primary care.
	• A national medicines' optimisation opportunity reviewing the percentage of amoxicillin 500mg items prescribed as a 5 day course has been identified – this is reviewed on a 12 month rolling basis. BLMK is currently below the national target of 60% for this metric.
	
	Additionally, information was shared on the following AMR projects targeting prescribing in children and young people:
	• An AMR Leadership bid has been made, to work on specific projects:
	  ○ Herts and West Essex led with paediatric focus.
	  ○ Expressions of interest for secondary and primary care clinician to work up and provide training on paediatric antibiotic prescribing to high prescribing practices.
	• Point Of Care Testing pilot project (MK Urgent Treatment Centre):
	  ○ Due to commence January 2026.
	  ○ Use of Febri-DX (MXA/ CRP) in 1-9yr olds presenting with acute respiratory tract infection.
	  ○ Supports more accurate identification of viral vs bacterial infections, reducing diagnostic uncertainty and enabling more targeted management.
	  ○ Looking at antibiotic prescription rate, infection prevalence, clinician and patient survey and cost analysis.
	
	World Antimicrobial Awareness Week (WAAW) took place from 18th - 25th November, with the slogan "Act Now: Protect our Present, Secure our Future." NHS England hosted an East of England launch event with diverse stakeholders. Comms were shared with primary care teams, and widely across social media to promote antimicrobial	

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	awareness. With the support of Public Health teams, materials were shared with schools, early years settings, and community groups. 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 – July 2025 The committee noted the minutes for information.	
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) – none available	
12.2	Minutes of the Milton Keynes Hospital Prescribing & Medicines Governance Committee (PMGC) – August, September & October 2025	
12.3	Minutes of the BLMK Formulary Subgroup – June 2025	
12.4	Minutes of the BLMK Wound Management Formulary Steering Group – September 2025	
12.5	Minutes of the BLMK Medicines Safety Group – August 2025	
12.6	Minutes of the ELFT Medicines Management Committee – November 2025	
12.7	Minutes of the Cambridgeshire Community Services Medication Safety and Governance Group – October 2025	
12.8	Minutes of the CNWL Trustwide Medicines Optimisation Group (MOG) – June 2025	
12.9	Minutes of Circle/MSK Medicines Management Committee – September 2025	
13.	**Any other business** For information: there is a project underway via a joint working agreement with industry (the Oasis project) which will utilise specialist nurses to review children and young people between the ages of 12 and 25 who have poorly controlled asthma (links to agenda item 5.3) and concentrating specifically on those practises that are struggling with their metrics. This is a 12-month project, and the nurses will also support with staff training and mentoring.	
14.	**Future Dates for BLMK APC 2026 Meetings (all to be held from 12:30-15:00 via Microsoft Teams; note any dates after March 2026 are subject to change):** Wednesday 4th March 2026 Wednesday 6th May 2026 Wednesday 1st July 2026	

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	Wednesday 23rd September 2026 Wednesday 2nd December 2026	

Approval of minutes:

Chair: Dr Muhammad Nisar

Signed: 

Date: 24/Mar/26

Appendix 1 – Approved 11 November 2025 Formulary Subgroup Minutes:

BLMK ICB FSG
Minutes November 2(