Minutes of the Lancashire and South Cumbria Medicines Management Group Meeting

Thursday 8th February 2024(via Microsoft Teams)

PRESENT:

Andy White (AW)	Chief Pharmacist (Acting Chair)	Lancashire and South Cumbria ICB
Ana Batista (AB)	Medicines Information Pharmacist	East Lancashire Hospitals NHS Trust
Andrea Scott (AS)	Medicines Management Pharmacist	University Hospitals of Morecambe Bay NHS Foundation Trust
Clare Moss (CM)	Head of Medicines Optimisation	Greater Preston, NHS Chorley, and South Ribble locality
David Jones (DJ)	Assistant director of pharmacy Lancashire teaching hospitals	NHS Lancashire Teaching Hospitals
Faye Prescott (FP)	Senior Medicines Optimisation Pharmacist	NHS North of England Commissioning Support Unit
Dr H Sari-Kouzel (HSK)	Rheumatology Consultant	Blackpool Teaching Hospitals NHS Trust
John Vaughan (JV)	Senior Pharmacist	NHS Lancashire and South Cumbria ICB (Pennine Lancashire locality)
Judith Williams (JW)	Head of ICB Primary Care Finance	Lancashire and South Cumbria ICB
Lucy Dickinson (LD)	Finance Manager for Primary Care	Lancashire and South Cumbria ICB
Mohammed Ahmad (MA)	Assistant Director of Pharmacy	Blackpool Teaching Hospitals NHS Trust
Mubasher Ali (MAL)	Chief Executive	Community Pharmacy Lancashire & South Cumbria
Nicola Baxter (NB)	Head of Medicines Management	NHS Lancashire and South Cumbria ICB (West Lancashire locality)
Rukaiya Chand (RC)	Prescribing Project Manager	NHS Lancashire and South Cumbria ICB (Fylde Coast)
Sonia Ramdour (SR)	Chief Pharmacist/Controlled Drugs Accountable Officer	Lancashire and South Cumbria NHS Foundation Trust

IN ATTENDANCE:

Jenny Oakley (JO)	Lead Pharmacist - Surgery, Critical Care and WACS	University Hospitals of Morecambe Bay NHS Foundation Trust
Adam Grainger (AGR)	Senior Medicines Commissioning Pharmacist	NHS Midlands and Lancashire CSU
Brent Horrell (BH)	Head of Medicines Commissioning	NHS Midlands and Lancashire CSU
David Prayle (DP)	Senior Medicines Commissioning Pharmacist	NHS Midlands and Lancashire CSU

Emily Broadhurst (EB) (Minutes)	Medicines Optimisation Administrator	NHS Midlands and Lancashire CSU

	SUMMARY OF DISCUSSION	ACTION
2024/014	**Welcome & apologies for absence** Apologies were received from Ashley Marsden, Lisa Rogan, Melanie Preston, Dr Ramtoola and Steven Simpson. John Vaughan was in attendance on behalf of Lisa Rogan and Rukaiya Chand was in attendance for Melanie Preston. Nicola Baxter joined the meeting from 10am, Andrea Scott had some issues joining but was able to join just before 10am.	
2024/015	**Declaration of any other urgent business** Tirzepatide was sent out as an additional item. There were two position statements shared, one for Diabetes and one for Weight loss. The diabetes position was shared on screen first for the group. AW gave some context to this; he had received a message from a rep who then met with AW and BH and told them they had acquired a very large amount of stock and that it would be in warehouses from Monday 12th February 2024. So there has been less than a weeks' notice to get this sorted, although it has been discussed previously. The same brand (Monjaro®) is licensed for both indications. The company confirmed that they are bringing multiple more times the current GLP-1 market. The fear is that patient demand could be huge, and although most of it will possibly go to private providers, there is also a real chance that diabetic clinicians and GPs will get requests for this item. The intention is to get the documents to the ICB executives on Tuesday for them to put an organisational stamp of approval on it and for that to go out not long after the drug is released. There is a slight problem as EMIS doesn't currently have the Tirzepatide 'Quick-Pen' (as it has been licensed as) on its drug dictionary, however this should be resolved by the end of the month. AW asked the group for their opinions on the documents. It was highlighted that the diabetes indication has a NICE TA behind it, and that as there is a shortage of GLP-1s and the advice is to use tablets instead of the injection. BH added that PT and LR had linked in with specialists so the wording in the documents is from those discussions that were had in January. FP raised that Paul had mentioned the use of patient contracts if they are initiated, and asked if that is within the document? AW responded that it was in the last line of the document, and it states that patient contracts may support healthcare professionals to undertake the review process and audit with the remainder of the necessary reductions. AW added that he felt it was optional. FP responded that they want this to be reviewed and asked if the wording could be changed to 'must' in terms of making sure it is cost effective. AW highlighted Dr Lindsey Dickinson's comments from a previous meeting where she said they had taken a large	

	number of patients off GLP-1s by just reviewing them against the NICE guidance and found a large number not actually benefiting being on them. However, he added that if there is a product that could potentially take a lot of weight off people they may be reluctant to stop patients and the longevity of weight loss after the drug is stopped is unclear. CM commented that she agreed with FP and asked if there is a prepared patient contract and could that be linked into this document ready. She also added that with regards to the review, there are parameters from NICE around criteria for continuation and asked for them to be included. AW supported both of CM's comments and for them to be included in the document. DJ asked if it would be useful to have obesity related complications specified included or if it is in another document could that sit alongside this one. BH said he would look into this and see if they could add them in succinctly. AW added that the patient contact doesn't need to be ready to go to executives on Tuesday as this is a very tight turn around but could be produced very soon after. AW asked if there were any current patient contracts that could be adjusted to fit this document. CM said she may have one that could possibly be adjusted. DP added that there is currently one for GLP-1s that uses the NICE stopping criteria, however those contracts are there because NICE have criteria on the amount of weight needed to be lost in order to continue on the therapy. This new guidance doesn't have any criteria for discontinuation, so there is a risk of being challenged if this is mandated. AW added while he acknowledged this risk, there is a need to ensure resources are being used wisely. MA asked if the proportion of patients waiting for this were mainly diabetes patients, as if there is going to be around five times the current market is it largely for weight loss or will they be seeing a large uptake from diabetes. AW responded that he felt the majority would be from weight loss and private clinics, but added as a lot of people have not been started on GLP-1s due to stock issues and asked if it was known what the possible update for diabetes could be. BH responded that he felt it is around one thousand items a month lower than where it is expected to be with no stock issues, so felt that a large number of people waiting would be diabetic patients who have either been stopped on GLP-1s or waiting to start due to the stock issues. AW added it is roughly £100 a month with around 830 people the spend will be around £1 million a year. HSK asked if there were any GPs in attendance at the meeting as it is going to be them that will have to deal with this. AW added that unfortunately today there was no GP representatives on the call. But added that Dr Lindsey Dickinson had previously said that she was in the opinion of reviewing them and if they haven't met the criteria they come off it. However it was felt that while this was the right thing to do, it is unusual to actually see this in practice. Dr Ramtoola who is a diabetologist was also not in attendance at this meeting but had previously said that there were patients that she would have started them but hadn't due to stock issues. He also said that the question isn't necessarily if this is good drug but rather that it could move very quickly and uncontrolled if this isn't handled correctly. FP highlighted DP's earlier comments and added that if the manufacturer doesn't have a cut off point for reviewing and/ or stopping treatment and	

	should this be explored with a specialist. AW responded that he didn't feel it goes against NICE guidance as with any drug there would be a stopping criteria if something isn't working. FP said this is what she was eluding to and asked if they should use the same review criteria as Semaglutide and asked if this point should go out to consultation on if this should be followed or if people have something else they think should be implemented. AW replied that while he would really like to have a further debate this needs to go out quickly due to the time scales. BH agreed that while FP raised a responsible principle, they would need to consult with diabetologists and that it isn't something they could do alongside doing the position statement. He said they could draft something in the next few weeks and then consult with the diabetologists to see if they supported this, but it would be difficult to be done quickly as well as approving the position statement. AW added that he had spoken to Lisa previously and she felt that diabetologists felt the large amount of want for this will come from weight loss not diabetes. He said he felt this local guidance reflected what Paul and Lisa discussed with the specialists that it should be respected and put out and then maybe look back later to ask that group if there should be stopping criteria. The group agreed to this. He then asked if 'must' or 'may' should be in the last line of the document. BH said that he was conscious the contract would need to reflect the wording that is agreed with the specialists, so he would be inclined to keep the document in its current draft until that is discussed later on. But that it will be updated when the contract is release. AW asked if this could be revisited once the NICE guidance on the weight loss element is released at the end of March so to revisit it in April or May. The group moved on to the weight loss document. AW commented that this needed to be succinct. SR said that is it difficult as the position statement has always been 'do not prescribe' instead of 'must not prescribe', so suggested either changing the sentence or monitoring it and going back to GP's who are initiating. But added this second option might not be affective if its already being prescribed. CM commented that she felt it was worded fine and that people would understand and added to brief people as there is going to be a lot of push back from patients, their representatives, and media once this is published. JV added it may be useful to include when the NICE update is expected, and this was agreed by the group. AW if anyone knew when it would realistically come through, SR suggested the wording that the document will be reviewed within a month or two months after publication. AW agreed with this. AW asked BH if he was happy with what was needed to get done from this, he said he was and said they will update the diabetes document with the obesity related complications and look into the continuation criteria to be then firmed up with the specialists but to leave the wording as is for now and they will update the weight loss document with the NICE expected update wording. <u>Actions</u> BH and team to update the diabetes document with obesity related complications. BH and team to look into the continuation criteria and look to discuss this with the specialists. BH and team to update the weight loss document with the expected review	**BH** **BH**

	information following the update from NICE.	**BH**
2024/016	**Declarations of interest** None for this meeting.	
2024/017	**Minutes and action sheet from the last meeting 11th January 2024** The minutes were approved and will be uploaded onto the LSCMMG website.	
2024/018	**Matters arising (not on the agenda)** None to discuss.	
	ABBREVIATED LSCMMG ITEMS	
20234/019	**Formulary Update** JO attended the meeting today to give an update on the formulary. The formulary oversite group had met with additional people over the last few weeks to attempt to do an initial amalgamation of the formularies across the ICB. They have aligned formulary positions where this was straight forward and ensured that the decisions made were safe, then highlighted any areas that need further consideration. DP added that the CSU team were meeting on Friday 9th February to go through the list the formulary group have agreed and make amendments to the formulary and then sort out moderate and larger problems that need further discussion. The CSU team will also look at what needs to be done to update the site and then look to have that ready for consultation to start on Friday 16th February and continue through to the 15th of March. LSCMMG members were asked for any representatives to be put forward for the consultation. He added that there will be a form on the website which should be very easy to use for people to send suggestions to the team for them to review. JO added that when the formulary group met they were able to smooth out a lot more things than initially thought. She added that she was aware that there was some worry and concern that the formularies wouldn't be very easy to align but with having a representative from each place and acute trusts for most areas it was more straight forward than expected. She said she felt that the ones that have been brought up were not largely contentious, but items that the formulary group didn't feel it appropriate for them to make the decisions on. They mainly focused on things that were oversights or that should have been changed in practice but haven't changed on individual formularies. She added that she was hopeful that the process wouldn't be too difficult and that obviously there is the need to consult but that hopefully there shouldn't be too many anomalies and disagreements. AW added that he had sat in on a few of the meetings and praised the pragmatism of the group and the way people were working together. He said he is keen for the wording that goes out to be just right so that is currently being reviewed as it isn't quite right yet. But reminded the group that this is not consultation for a brand new formulary, that this is a merging and taking the best form the current formularies out there and that for the moment it will be as best as it could possibly be. He also said that it is important for there to be an ongoing maintenance process with this to look at how new drugs are considered and also how things are removed.	

	So that could be a subgroup of LSCMMG meeting or something else, it needs to be clarified how much work is going to come out of it. But he was hopeful that by the second half of March after the closing date for consultations, all the feedback will be reviewed by the formulary group and then either come to LSCMMG or the formulary group for approval. AW reiterated that new drugs will not be considered during this process, nor will old issues be discussed, as this is to amalgamate what is already there and also making sure that any local information that is useful locally is linked in where appropriate. AB raised a concern she had previously raised with DP in that when they met the ELHT formulary wasn't included on the spreadsheet. She said that DP had said he would look into this as it was too many lines for AB to look into herself, and that they are still concerned and that their position locally is the same. They are still using their EHLT formulary, which is updated every month, and that they are happy to support the development of the new formulary but were still concerned that there may be more discrepancies than originally noted in the first two meetings. DP commented that he agreed with what AB had said and explained that initially they had managed to get good downloads of data from Morecambe Bay and Central Lancashire's formularies in the same format to enable BH to put the information into an excel spreadsheet and create codes which showed up any anomalies between the two. But added that did create a 'blind spot' with East Lancashire formulary information which they have tried to address by having meetings with groups, but again acknowledged that it wasn't a perfect process and that unfortunately it was very difficult to find an easy way to combine the formularies within the timescale. For this process to work the CSU team are relying heavily on the consultations so DP asked again, especially from East Lancashire for feedback and if they have anyone who knows the patch very well to take a look at what they have put together and let him know if they see anything that urgently needs looking at. DP also said that the CSU team has received data from East Lancashire, and they will continue to work through this as the formulary process moves along. AW added that it must be safe to go out and will not be shared out if it is not safe, and that it will go out with a continuous improvement process alongside it. JO added that this doesn't include the four previously harmonised chapters which went through the clinical specialist groups. There should be less anomalies within those four and should be rationalised. The other additional issue JO raised was the inclusion of supporting information in the chapters, as there had been some concerns raised around this. Jill from the CSU team has taken an in-depth look at the cardiovascular chapter and matched what was on other people's websites with what was proposed for the ICB website. Although some places had individual documents, the majority were taken from either NICE guidance or TA's. For this reason JO felt that they wouldn't be able to support some of the individual place guidelines but added that no information would be lost it would just be presented in a different way. She asked the group for agreement with this and stated that they can't have four different treatment pathways from places and then four others from acute trusts as this would be too much information. AW added that this may result in some work after as if there are several different pathways for something there should only be one as the treatment should be the same regardless of where the	

	patient lives. JV asked if the four chapters previously completed were still being maintained and asked what the mechanism for altering people going forward for things such as updates and changes to the website. AW responded that even though those chapters had been agreed by specialists they are still going around for consultation as only a small amount of people have seen them. He added that the consultation will be for NHS staff as this will sit on a public facing website but won't be advertised as such. And that any response form the pharma industry will be for correction only not for discussing which drugs are better. Any clinicians wanting any new drugs will need to go through the appropriate process not bringing it through formulary discussions. AW thanked JO for coming to the meeting and for her and the teams work going into the formulary.	
2024/020	**Endocrine Formulary LSCMMG Updates** DP brought this item; he didn't have anything to verbally update the group with apart from the Tirzepatide item which was discussed earlier in the meeting. AGR had something to highlight for the group. He said that there had been some discussions around Somatropin both in and out of the endocrine meetings. There has been an ask to move it to Amber 1 with a shared care protocol. It was discussed in the endocrine formulary meetings and there was no consensus for either changing it or keeping as it is, AGR suggested bringing a paper back next month to LSCMMG for further discussion. AW asked if there is clear criteria for if something being a certain level of a RAG for example what makes something Green Restricted as opposed to just Green. BH responded that there is criteria for if something should be shared care, it normally relates to monitoring requirements. When this was looked at previously, it was felt it didn't quite reach the criteria for shared care. As highlighted by AGR, there is a difference of opinion as to whether this should be share care or Amber 0 with a prescribing information sheet. AGR added that Paul from the CSU team had meet with Dr Howell, an Endocrinologist from LTH who felt it was Amber 0, but again when it went to the formulary meeting opinion it was still split. AW asked when AGR brings a paper back if he could look and see what other areas of the country are doing with this to help the group make a decision. FP commented that the Morecambe Bay LMC chair Micheal Price had raised that it says shared care in the NICE guidance, but she was happy to have conversations with them if it does stay as Amber 0. She also mentioned taking it to region if it goes to shared care. AW added that the meaning of shared care may now look different to what it did when the guidance was wrote in 2003. **Action** AGR to bring a paper back to March meeting for discussions on making Somatropin Amber shared care or leaving it as it is at Amber 0.	**AGR**

2024/021	**Ceyesto – Melatonin** AW commented on this item, saying it would make sense as it is cheaper than the drug tariff price with the correct price as there is an error in one section of the paper, the price is actually £25.65. CM commented that the paper refers to the liquid for this brand, but there is also a tablet which is very cost effective and that she would like to discuss switching to the tablet so asked if the tablets could be included in this decision as well. She also asked in terms of process, brands wouldn't normally come through LSCMMG, has this been brought here due to it being Melatonin and that there is specific brands that are used or is there another reason/ way for this to be done as she is conscious if another brand comes along in the future that is more cost effective it could mean multiple switches. AW responded that it is testing the principle of the formulary, and in his opinion if this is the cheaper then it should be stated. But recognised CM's comments and added that if it was just a small difference it wouldn't really be noted but as this is a significant difference it needs to be identified. He added that not knowing the patient numbers can make things difficult and asked if there was any way of finding out the amount of patients this would effect and therefore giving an indication of how much money this will cost. CM added that Paul had done some figures, but they were based on the tablets not the liquid. AW asked if this was urgent and if not should it come back next month with both the tablets and the liquids with patient numbers on which will then also give the potential cost/ savings or did the group want to approve now? DP added one further point which is that it isn't just a cost issue as this liquid has significantly less propylene glycol in it than the competitor. This means it is also another good reason to differentiate from just the simple brand change. CM asked if the request had come from the paediatric group to which DP responded that he didn't think it was the paediatric group, but that Jill was already working on the melatonin guidelines with the melatonin guidelines group. CM added she was happy with this and just asked what will be done with the tablets, do they need to be added on or do people just go and use the most cost effective item. AB added into the chat that this item is already mentioned in the melatonin guideline and the formulary when it is done. AW added that housekeeping may need to be done as things may need to be reviewed and make sure that guidelines and sections in the formulary are done in line with the consultation process to make sure it is aligned correctly. **Actions** Ceyesto liquid to be added to the melatonin guideline Melatonin tablets to be brought for discussion at March LSCMMG meeting	 **DP** **DP**
2024/022	**New Medicines Review Workplan** There was nothing to discuss other than DP had not received any feedback on how items should be prioritised. Members are asked people to think on this and send any feedback to DP.	

GUIDELINES and INFORMATION LEAFLETS		
2024/023	**Atrial fibrillation guideline update** AW introduced this item by highlighting to members that the cost of Apixaban has dropped dramatically to less than £5 per box compared to £50-£60 per box of other DOACs, but there is also a national procurement for Edoxaban. EB shared the document shared to members on screen and AW explained that it is what has gone out nationally. It detailed that generic Apixaban is best value twice daily and Edoxaban is best value once daily. The guidance that has been put forward was also shown which showed the amendment to the title which now reads: *Generic Apixaban or Edoxaban to be used first line.* AW commented that he was unsure if this statement was strongly worded enough given the large cost difference and asked if it should read Apixaban is first line and Edoxaban as second line and so on. RC commented that this had been previously discussed outside of the meeting while doing the AF template EMIS web update and said that AW had said unless there is a clinical reason not to use a particular one and they were just listed in alphabetical order, which meant that Apixaban was at the top already. AW responded that yes from an ordering point of view that's right and added the other issue is that Rivaroxaban has a patent challenge and will be off patent within 18months. He asked the group their views on putting Apixaban on with Edoxaban as second line given the big difference in cost. SR asked about frequency of dosing and asked if it should be included in the guidance which AW agreed that it should be included. He also added about possibly putting the drug tariff cost as of February 2024 to make the cost difference clear. RC asked if it would be better than committing to first and second line, would it be better to use the wording of the most cost effective drug should be considered and then adding the price or a link to the drug tariffs. She also highlighted that the ICB are still tied in with the national rebate and wanting to use wording to avoid comeback for promoting another DOAC. AW responded that the ICB have stepped away from the national rebate and said to go with first line with Apixaban because it is such a big cost difference. HSK asked if it was known what people were prescribing the most currently. AW responded that is mostly Apixaban and always has been particularly from stroke physicians and cardiologists. But added that Blackpool has the highest use of Edoxaban in the patch as it has been the preferred DOAC for some time as clinicians were slower to adopt. HSK then added that it is likely if someone has to take the two doses in the day they are likely to forget one dose. So yes it may be cheaper but they both need to be on the same level. AW said the table that this is national guidance could be added. JV commented he agreed with RC's comments and that they had used a patient decision making aids but as a group they would support getting the best value and the most cost effective products and that this is what the statement should include. RC added that they are not promoting a wholesale switch, this is for new	

	prescribing. AW added that it is about keeping it simple. He then asked DP if he was clear on what needed to be done. DP asked as this needed to be done quickly should he make the changes and then send it round to the group for approval. **Action** DP to make the changes detailed above and send it round to the group for approval.	**DP**
2024/024	**Rimegepant interim position statement** AGR brought this item; it was requested by Dr Chhetri at LTH. They are in the process of developing / updating the headache pathway. He was concerned about the number of referrals he is getting for Rimegepant for the prevention and treatment of migraines. He asked if a position statement could be put out in the interim of the headache pathway being completed about appropriate referral criteria according to NICE for referral into secondary care, with the guideline being due at April's meeting. AW mentioned that although this is an interim position statement the front sheet of the document had just none identified for all the options, and he felt it needed to be clearer. And that as it is going to stop people being referred potentially, it needs to be mindful of the possible impact and financial implications. AGR said he would rewrite the front sheet to show the relevant information. **Action** The interim position statement was approved, but to be reviewed once the headache guideline is completed.	
2024/025	**Testosterone shared care – update** AGR brought this item, it is a small update, and he has received some feedback. Paul Tyldesley from the CSU team has worked with Dr Howell the endocrinologist at LTH. Dr Howell has said he would not routinely recommended the monitoring of Lipids, LFTs and oestradiol. AW asked the group for any comments and asked DJ if he was comfortable with this, to which he agreed he was happy with it. AW asked if this directly contradicts the SPC. AGR responded that the SPC has some ambiguities so when it was initially drafted there was some debate as to if it should have been included or not. But having reviewed it and reviewing the guidelines that Dr Howel has sent through, it does seem sensible in that it's not routine monitoring in practice, and it doesn't seem sensible to expect GPs to continue monitoring them. AW highlighted in the document it references a new document about hypogonadism and COVID-19 but it's not referenced. AGR said he would investigate this and add in the extra reference supporting this if there is one. **Action** AGR to look at reference to hypogonadism and add in relevant reference if there is one.	**AGR**
2024/026	**Hybrid closed-loop interim position statement** AW introduced this item, stating it is going to be a high-cost item and it will be the first ever NICE TA to have a five year implementation period from	

	NICE. The commercial agreement has not yet been published so the cost is not yet clear. This position statement is until there is an agreed roll out plan for across the patch, and that he had received some feedback from Dr Ramtoola who stated that clinicians won't be happy with this. AW has spoken to Sarah O'Brian who is the director of Nursing for the ICB and formerly a diabetes specialist nurse, and she said that while it is a NICE appraisal, the affordability needs to be looked at. Which means there needs to be a planned role out route. AW asked the group for their views to get this out into the system. CM asked if there were time scales for the plan, to which AW said the commercial arrangement is due out in April, he then asked BH where the team were up to this. BH responded that they are just waiting on the commercial arrangement to be released and added that NHS England advises that it is rolled out to children in the first stage then a staggered roll out, but he hasn't heard anything else. JV raised comments fed back to him by Dr Ramtoola in that these are already being initiated and that the document won't stop diabetologists initiating something they are already using. AW said that the phased plan and costs need to go along side this to support to which JV agreed it would help. BH commented that there is a prevailing policy on the use of CGMs of which this is one which says that if they meet previous NICE criteria then patients can be initiated. And added that a change to this document would mean a recommended change to that policy position. AW agreed this and said that that was under the support of CPDIG which has not yet restarted. AW asked if Paul from the CSU team could liaise with the public health consultants in Debbie's' team to see if the two could be aligned and for now this will need to be taken to CRG at the end of February. The other option which AW was happy with was to have this document out there and to take the plan once the commercial agreement has been released to CRG at a later date. He added if there needs to be a date added to this document as well such as 'refrain until after April 2024' to which the group agreed. BH asked if the position statement needed to go to CRG or CEG or both. AW responded that it would need to go with both. BH then added the concerns raised by the clinicians needs to also be highlighted as part of that process, and with time scales informed the group they would bring an update on this to the next meeting. AW also added that as agreed previously this will be reviewed from a cost point of view, but that Paul had tried to come up with a creditable figure but has not been able to, and that the number will be quite large on this item. **Actions** Paul from the CSU team to link in with public health consultants in Debbie's team to try and align the two documents. Wording to be added to include 'refrain from prescribing until after April 2024' once the information is clear. Documents to go to CPDIG, CRG and CEG, highlighting the clinician concerns. Follow up to come to the next LSCMMG meeting in March.	**BH** **BH** **AW/BH** **BH**

2024/027	**Dosulepin review guidance for primary care** SR brought this item. She has worked with four associate medical directors for older adults to produce the guideline. This was created following a recent incident where a patient unfortunately died, there was a history of cardiac disease and opportunities to intervene at various stages, but the patient took an overdose following a family bereavement. On further inspection they found over 1,000 patients currently receiving Dosulepin in primary care networks with the 88th centile for prescribing Dosulepin nationally. The spend on this antidepressant is around £177,000, which is part of the guidance for do not prescribe medicines in primary care. In this guideline they have included the rational needed for the review and also included guidance around off label prescribing along with potential principles for discontinuing or switching, including some exemplar regimes. At the end of the document they have also included some guidance from the GMC, for if patients do not want to switch or stop treatment as well as information on how to access further support on LSCFT including phone numbers for referrals. SR also highlighted the choice and medication patient information leaflets located in the useful resources section at the bottom, with one specifically about coming off antidepressants. SR brought it to the group for approval and adoption. AW thanked SR and added that it was a very good and really comprehensive document and was shocked to see how much Dosulepin was being used in community. SR added that she felt these patients were more likely older adults who may now also have some cardiac history and may well have been initiated on this before alternative antidepressants were available. FP added she felt the document was very good and thanked SR for taking her comments on board. She asked if it may be worth putting the bit at the end about accessing support at the top of the document as she felt when she was reading it that was the thing she was looking for but felt the document was very good all round. SR said she could put a statement at the top of the document directing people to the contact details and further support. AW asked if SR wanted this joint branded and on the LSCMMG website or if she wanted to keep it under LSCFT, to which SR said if it was adopted to have it jointly branded. She added she would make sure it is circulated and it is flagged to their IRS teams that potentially people may be referred into and will also circulate it through the older adult teams. AW added that not only is it a cost saving it is also potentially life saving and this is important to be noted. Approved following addition of LSCMMG and LSCFT logos **Action** Guideline to be uploaded once LSCFT and LSCMMG logos have been added	**SR/DP**
2024/028	**Guidelines workplan** There was nothing to mention on this item.	
NATIONAL DECISIONS FOR IMPLEMENTATION		

2024/029	**New NICE Technology Appraisal Guidance for Medicines January 2024** Nothing for discussion this month, all are either NHSE or discontinued.	
2024/030	**New NHS England Medicines Commissioning Policies January 2024** Nothing to discuss.	
2024/031	**Regional Medicines Optimisation Committees – Outputs January 2024** Nothing to discuss.	
2024/032	**Evidence Reviews Published by SMC or AWMSG January 2024** Nothing to discuss.	
ITEMS FOR INFORMATION		
2024/033	**Horizon Scanning 2024/25** DP took this item for BH as he had to leave the meeting. DP felt this was an update for items that may affect the system in the future. A lot of it may have already been discussed and the document has been sent out for the annual process, which should help influence decisions. But the idea is that organisations will already know what they should have additionally planned for in terms of the drugs, except the general inflationary uplift. AW added that this will be looked at from the perspective of things that the ICB should be looking at specifically and focusing their efforts and time on. He went through the document with the group with the document being sent out to members before the meeting. The two items discussed during the meeting were Tirzepatide which was discussed earlier in the meeting and then Lecanemab treatment for early Alzheimer's disease in adults. This one could have a substantial change to pathways and also is a massive cost as well as service implications, as this type of drug needs to be administered in the very early stages of Alzheimer's and the system is not yet equipped to detect these patients. AW added this is yet to be launched but it needs to be noted earlier. SR added this is already licensed by the FDA and the results look encouraging so she felt that NICE will take a position on it, and the capacity for scanning also needs to be thought about as this one used PET scanners which are expensive. And with the future testing that could be developed for early detection could create a large demand for this. AW asked if SR has people already on the pathway with this, to which she responded that they were involved in clinical trials and scanning was considered as part of the resource cost. AW added it needs to be looked at as he isn't aware of anyone else picking this up. SR said she could pick it up with the North England Mental Health Chiefs and see if any other organisations are doing things around this already or if they are waiting for the NICE TA to land. She added that there may be a prolonged implementation process for this as well. AW asked if there was a known estimate for capacity on this, SR responded that they didn't, and she wasn't sure if it had been mapped yet.	

	AW added that he felt this needs to go to CRG as a specific item and use it to highlight up to commissioners. BH agreed and asked if they draft a paper if SR could provide any clarity or further information that she felt would be helpful. To which SR agreed. **Action** BH to draft a paper to take to CRG for highlighting Lecanemab treatment with assistance from SR.	**BH/SR**
2024/034	**LSCMMG Cost Pressures Log** BH didn't have anything to highlight anything mentioned at this meeting had a significant cost impact apart from those items already discussed. Tirzepatide is going to executive this month, the team will work on the numbers for the Melatonin drug and add some figures for the AF switch. AW added possibly mentioning the AF changes and the possible cost saving there, and also including the Dosulepin as even though it is mostly safety there is also a cost saving/ service impact and potential cost pressure. AW added the possibility of adding a quality collum to the cost pressures log to include the life saving impact of some of these drugs. AW asked CM to take the Dosulepin to the QUIPP group. DP added that the Symbicort inhaler should be removed from the log as it was agreed nothing would be done with this until the national guidance came out, this was agreed to be removed. **Action** BH to make chances to the cost pressures log.	**BH**
2024/035	**AOB** During the action table discussions points were raised in relation to the ratification process. BH asked AW to confirm if an item is agreed at LSCMMG and they are cost neutral, that they then need to go to CEG to be approved, and if they have a cost or commissioning impact they also need to go through another mechanism such as CRG or similar for approval. After they have been approved at one or both of these groups will they then go onto the website. AW confirmed this, and both added the ratification process will be discussed when items are approved at LSCMMG. AW asked that going forward that all papers front page is fully filled in to help the group make a decision on the ratification process for each item. Items approved at the last CEG will go onto the website the week beginning 12th February. AW added this is an on going process while they finalise how things will be approved due to the financial implications of the ICB. During another action table item, SR highlighted when documents are given chairs approval they still need to make sure they come back to the group for information only. It has been recorded here for future reference that all items given chairs approval still come back to the group for information. RC raised the outcome with the PGD where the national authorisation on behalf of an ICB, she asked AGR if they were adopting GMMMGs one. AGR said he thought that was the case and AW asked him to bring	

	something back to the next meeting to adopt it. **Action** AGR to bring back a proposal to adopt GMMMG PGD authorisation.	

DATE AND TIME OF NEXT MEETING

The next meeting will take place on

Thursday 14th March 2024

9.30 – 11.30

Microsoft Teams

ACTION SHEET FROM THE

LANCASHIRE AND SOUTH CUMBRIA MEDICINES MANAGEMENT GROUP 08.2.2024

ACTION SHEET FROM THE MEETING 12th October 2023				
2023/421	**Sodium Zirconium Cyclosilicate - Update** AGR to put the GMMMG shared care guidance for this item into LSCMMG formatting and send out for consultation. **November 2023 update:** Will be sent out at the end of November for consultation. **December 2023 update:** Will be sent out this month. **January 2024 update:** AGR was not in attendance today, however BH updated that it needs to go out to consultation before publishing. AGR commented outside of the meeting that there had been a slight delay, and he would be sending out this month. **February 2024 update:** This will now come in April due to the formulary work being prioritised.	**AGR** **AGR** **AGR** **AGR** **AGR**	**Open** **Open** **Open** **Open** **Open**	**12.10.2023** **09.11.2023** **21.12.2023** **11.01.2024** **08.02.2024**
ACTION SHEET FROM THE MEETING 9th November 2023				
2023/438	**Ranolazine MR tablets for adjunctive therapy in the treatment of stable angina, RAG rating change**			

	Ranolazine for adjunctive therapy in the treatment of stable angina, to be presented at the next Commissioning Resource Group with a recommended RAG rating of Green Restricted for approval. **December 2023 update:** Approval acknowledgement has not be received by the organisation. It was taking to CEG, but final approval was still being sought. NB and AW to look into the decision as the CEG meeting for January has been cancelled. **January 2024 update:** Discussions earlier in the meeting highlighted that AW and NB still need to meet and that outstanding outputs will now be published. **February 2024 update:** Went to CEG and was approved.	**DP** **AW/NB** **AW/NB** **AW/NB**	**Open** **Open** **Open** **Closed**	**09.11.2023** **21.12.2023** **11.01.2024** **08.02.2024**
2023/441	**Requests from private prescribers to transfer or share prescribing with an NHS GP** AGR to take the position statement to LMC for their comments. AGR/BH to look at how this would move from a position statement to a policy statement and what that would entail. AGR/BH look to possibly take the statement to the Clinical Effectiveness Group. **December 2023 update:** Ongoing. **January 2024 update:** Still waiting to go to LMC. **February 2024 update:** Is with LMC, AGR is waiting comments.	**AGR** **AGR/BH** **AGR/BH** **AGR/BH** **AGR/BH**	**Open** **Open** **Open** **Open** **Open**	**09.11.2023** **09.11.2023** **09.11.2023** **21.12.2023** **08.02.2024**
2023/442	**Azithromycin RAG and prescriber information sheet consultation** AGR to speak to local AMR leads and Jill Demont regarding treatment holidays. AS to send AGR the summary sheet and the patient leaflet. AGR to make any amendments once the above has been done and bring back to the next meeting if possible. **December 2023 update:** Ongoing. **January 2024 update:** Ongoing. **February 2024 update:** AGR has made contact with AMR group, waiting for feedback from a respiratory	**AGR** **AS** **AGR** **AGR** **AGR**	**Open** **Open** **Open** **Open** **Open**	**09.11.2023** **09.11.2023** **09.11.2023** **21.12.2023** **08.02.2024**

	consultant. AGR will then amend the document and the AMR group will review. Due for completion March 2024.			
2023/444	**Isotretinoin in the community** FP and RS to update the document to include the new MRHA advice. FP and RS to meet with WP and the local pharmaceutical committee to discuss prescribing within the community on FP10s for the service. FP and RS to update the document to show that under 18s will not be included in the initial prescribing cohort. **December 2023 update:** PE responded on behalf of FP. There has been no response from providers or draft document and asked to defer to January/ February meeting. **January 2024 update:** FP updated, is still being worked on and she is hoping to bring something to the next meeting. **February 2024 update:** A draft has come back, a specialist pharmacist from one of the trusts has commented that it doesn't meet the latest MHRA guidance. FP will be looking at this once she is back from leave.	**FP/RS** **FP/RS** **FP/RS** **FP/RS/PE** **FP/RS/PE** **FP/RS/PE**	**Open** **Open** **Open** **Open** **Open** **Open**	**09.11.2023** **09.11.2023** **09.11.2023** **21.12.2023** **11.01.2024** **08.02.2024**
ACTION SHEET FROM THE MEETING 21st December 2023				
2023/455	**Declarations of interest** EB to send out declaration of interest forms. **January 2024 update:** EB and BH to meet to ensure the forms are up to date inline with the ICB's process. They will then be sent out to members. **February 2024 update:** BH has been in contact with IG at the ICB to try and link in with their annual declaration process so they can be pulled in this meeting. The aim for this to be completed is at the beginning of the new financial year.	**EB** **EB/BH** **EB/BH**	**Open** **Open** **Open**	**21.12.2023** **11.01.2024** **08.02.2024**
2023/461	**Anticoagulants RAG change review** Members to send any shared care or other related documents they have for low molecular weight heparins to DP for inclusion. If there are any gaps in the guidance/ shared care documents DP will look to be filled.	**All Members** **DP**	**Open** **Open**	**21.12.2023** **21.12.2023**

	DP to add onto the work plan to try and align either the low molecular weight heparins or the processes relating to choosing them across all trusts.	**DP**	**Open**	**21.12.2023**
	DP to add looking at DOACs during the malignant chapter within the formulary working to the work plan.	**DP**	**Open**	**21.12.2023**
	January 2024 update: AW added that Apixaban has come off patent and is now the cheapest. It has been proposed taking the position statement to Februarys meeting to discuss amendments.	**DP**	**Open**	**11.01.2024**
	February 2024 update: AF is on the agenda, closed here.	**DP**	**Closed**	**08.02.2024**
2023/463	**GnRH analogues in adults – update** By the second week in January 2024 could all members feedback to AGR their views on this item, which will then be fed back to the endocrine discussions before coming back to this group for approval.	**All Members**	**Open**	**21.12.2023**
	January 2024 update: AGR not in attendance, remain open.	**AGR**	**Open**	**11.01.2024**
	February 2024 update: AGR received no feedback, closed.	**AGR**	**Closed**	**08.02.2024**
2023/464	**Actimorph in palliative care** AGR to link in with Kate Stewart and his contacts in NHS England about adding this to the Palliative Care Guideline.	**AGR**	**Open**	**21.12.2023**
	AGR to link in with SR regarding wording to be added about diversion of liquid and switching to Actimorph.	**AGR/SR**	**Open**	**21.12.2023**
	January 2024 update: Wording received from SR, AGR needs to link in with palliative care.	**AGR**	**Open**	**11.01.2024**
	February 2024 update: AGR linked in with palliative care, they are undergoing some changes to the guideline so AGR will reach out to the clinical lead to get it finalized. As the drug is approved the wording can be added to the LSCMMG website in the interim while waiting on the finalised document.	**AGR**	**Open**	**08.02.2024**
	FP asked if AGR could ask for levetiracetam infusion prescribing in primary care on the advice of palliative care to be added when he meets with the palliative care group.	**AGR**	**Open**	**08.02.2024**
2023/466	**Triptorelin for precocious puberty**	**DP**	**Open**	**21.12.2023**

	DP to take this back and look at the prevalence and patient numbers, then bring back something to the meeting in February. **January 2024 update:** To be discussed at February's meeting. **February 2024 update:** DP has done a baseline of around 37 boys and 161 girls who might need treatment. Chairs action for approval.	**DP** **DP/AW**	**Open** **Open**	**11.01.2024** **08.02.2024**
2023/467	**Anastrozole for primary prevention for breast cancer** DP to take this to the appropriate group with the new Amber 0 RAG position for approval. **January 2024 update:** To be discussed at February's meeting. **February 2024 update:** One of the items that went to the last CEG meeting for discussions around the approval process for medicines in the ICB, approved and closed.	**DP** **DP** **DP**	**Open** **Open** **Closed**	**21.12.2023** **11.01.2024** **08.02.2024**
2023/468	**New Medicines Review Workplan** All members to take this back to their teams and send comments back on items for prioritisation and deprioritisation to DP within the next two weeks. **January 2024 update:** To be discussed at February's meeting. **February 2024 update:** On the agenda, closed.	**All Members** **All Members** **All Members**	**Open** **Open** **Closed**	**21.12.2023** **11.01.2024** **08.02.2024**
2023/471	**Apomorphine shared care – update** Members to forward any specialist Parkinson's nurses they would like to be included int the document to AGR. **January 2024 update:** To be discussed at February's meeting. **February 2024 update:** This has been competed, closed.	**All Members** **All Members** **All Members**	**Open** **Open** **Closed**	**21.12.2023** **11.01.2024** **08.02.2024**
2023/472	**Out of area prescribing position statement – update** AGR to link with MP around alternative wording. AW to sign off via Chairs approval once alternative wording has been added. **January 2024 update:** To be discussed at February's meeting. **February 2024 update:** AGR has spoken with MP and wording has been agreed to amend. Once complete AW will give chairs approval and take to CEG for approval. Once AW has give chairs approval,	**AGR/MP** **AW** **AW** **AGR/AW**	**Open** **Open** **Open** **Open**	**21.12.2023** **21.12.2023** **11.01.2024** **08.02.2024**

	AGR to bring it back to the group for information only.			
2023/475	**Denosumab shared care – update** The document was agreed by the group and the RAG change to go to the next ICB ratification meeting. **January 2024 update:** To be discussed at February's meeting. **February 2024 update:** One of the items that went to the last CEG meeting, has been approved and will be uploaded to the website.	**AGR** **AGR** **AGR**	**Open** **Open** **Closed**	**21.12.2023** **11.01.2024** **08.02.2024**
2023/476	**L&SC ICB recommended diabetes meters, strips, and devices** LR to add in wording as to why four options have been included to help with diversity of supply. **January 2024 update:** To be discussed at February's meeting. **February 2024 update:** Actioned, Closed.	**LR** **LR** **LR**	**Open** **Open** **Closed**	**21.12.2023** **11.01.2024** **08.02.2024**
2023/478	**Guidelines workplan** BH to send the item on Daridorexant to Monica for support from the North West MOG. **January 2024 update:** To be discussed at February's meeting. **February 2024 update:** Daridorexant was discussed outside of the meeting, but nothing has been agreed. The CSU team are to bring a paper back to March for discussion. Once approved by LSCMMG the team will look to take this item to CEG due to the nature of complicated place in therapy and the current position of CBTI.	**BH** **BH** **BH** **BH**	**Open** **Open** **Open** **Open**	**21.12.2023** **11.01.2024** **08.02.2024** **08.02.2024**
2023/484	**LSCMMG cost pressures log** BH to look at adding the potential saving from the blood glucose meters and strips. **January 2024 update:** To be discussed at February's meeting. **February 2024 update:** Actioned and closed.	**BH** **BH** **BH**	**Open** **Open** **Closed**	**21.12.2023** **11.01.2024** **08.02.2024**
2023/485	**AOB – LSC ICB Branded Generic Prescribing Criteria – Draft for discussion** CM to make amendments as detailed in the discussions above and AW to approve via Chairs action once they have been made.	**CM/AW**	**Open**	**21.12.2023**

	January 2024 update: To be discussed at February's meeting. **February 2024 update:** CM sent the amended document out to the group in December, this item needs approval.	**CM/AW**	**Open**	**11.01.2024**
ACTION SHEET FROM THE MEETING 11th JANUARY 2024				
2024/003	**Declarations of Interest** EB and BH to meet to go over declaration forms and send out. February 2024 update: Was discussed earlier on in the action log, on going but close here.	**EB/BH** **EB/BH**	**Open** **Closed**	**11.01.2024** **08.02.2024**
2024/004	**Minutes and Action sheet** EB will amend the minutes to reflect the above comments before they are added to the website. **February 2024 update:** Completed, closed.	**EB** **EB**	**Open** **Closed**	**11.01.2024** **08.02.2024**
2024/006	**New NICE Technology Appraisal Guidance for Medicines December 2023** PT to bring back TA943 to a meeting in a few months' time once he has had chance to have further discussions and get a clearer picture on outcomes. **February 2024 update:** On the agenda, closed here.	**PT** **PT**	**Open** **Closed**	**11.01.2024** **08.02.2024**
2024/008	**High strength Fluorides** Wording to clarify the two indications and their respective RAG positions to be updated on the LSCMMG alongside the updated position statement. **February 2024 update:** On the website, there are now two entries which cross reference each other, Closed.	**DP** **DP**	**Open** **Closed**	**11.01.2024** **08.02.2024**
2024/009	**National Patient Safety Alert: Shortage of GLP-1 receptor agonists (GLP-1RA) update** DP and PT to review and bring back to the meeting in March if there are any implications or other things affected with this alert. **February 2024 update:** Coming back to March meeting.	**DP/PT** **DP/PT**	**Open** **Open**	**11.01.2024** **08.02.2024**
2024/012	**Discussion of development of terms of reference for LSCMMG** Members asked to send back any further comments not already discussed today to the team by the end of the month. BH and AW to meet to discuss the update of the LSCMMG and IMOC Terms of Reference. **February 2024 update:** Ongoing, keep open.	**All Members** **BH/AW** **BH/AW**	**Open** **Open** **Open**	**11.01.2024** **11.01.2024** **08.02.2024**

ACTION SHEET FROM THE MEETING 8th February 2024				
2024/015	**Declaration of any other urgent business** BH and team to update the diabetes document with obesity related complications. BH and team to look into the continuation criteria and look to discuss this with the specialists. BH and team to update the weight loss document with the expected review information following the update from NICE.	**BH** **BH** **BH**	**Open** **Open** **Open**	**08.02.2024** **08.02.2024** **08.02.2024**
2024/020	**Endocrine Formulary LSCMMG Updates** AGR to bring a paper back to March 2024 meeting for discussions on making Somatropin Amber shared care or leaving it as it is at Amber 0.	**AGR**	**Open**	**08.02.2024**
2024/021	**Ceyesto – Melatonin** Ceyesto liquid to be added to the melatonin guideline Melatonin tablets to be brought for discussion at March LSCMMG meeting	**DP** **DP**	**Open** **Open**	**08.02.2024** **08.02.2024**
2024/023	**Atrial fibrillation guideline update** DP to make the changes detailed above and send it round to the group for approval.	**DP**	**Open**	**08.02.2024**
2024/025	**Testosterone shared care – update** AGR to look at reference to hypogonadism and add in relevant reference if there is one.	**AGR**	**Open**	**08.02.2024**
2024/026	**Hybrid closed-loop interim position statement** Paul from the CSU team to link in with public health consultants in Debbie's team to try and align the two documents. Wording to be added to include 'refrain from prescribing until after April 2024' once the information is clear. Documents to go to CPDIG, CRG and CEG, highlighting the clinician concerns. Follow up to come to the next LSCMMG meeting in March.	**BH** **BH** **BH/AW** **BH**	**Open** **Open** **Open** **Open**	**08.02.2024** **08.02.2024** **08.02.2024** **08.02.2024**
2024/033	**Horizon Scanning 2024/25** BH to draft a paper to take to CRG for highlighting Lecanemab treatment with assistance from SR.	**BH/SR**	**Open**	**08.02.2024**
2024/034	**LSCMMG Cost Pressures Log**	**BH**	**Open**	**08.02.2024**

	BH to make chances to the cost pressures log.			
2024/035	**AOB** AGR to bring back a proposal to adopt GMMMG PGD authorisation.	**AGR**	**Open**	**08.02.2024**
2024/027	**Dosulepin review guidance for primary care** Guideline to be uploaded once LSCFT and LSCMMG logos have been added	**DP/SR**	**Open**	**08.02.2024**