Minutes of the Lancashire and South Cumbria Medicines Management Group Meeting

Thursday 8th June 2023 (via Microsoft Teams)

PRESENT:

Andy Curran (AC)	Chair of LSCMMG	Lancashire and South Cumbria ICS
Andy White (AW)	Chief Pharmacist	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
Lisa Rogan (LR)	Strategic Director for Medicines Research and Clinical Effectiveness	Lancashire and Blackburn with Darwin locality
Nicola Baxter (NB)	Head of Medicines Management	West Lancashire locality
Rukaiya Chand (RC)	Prescribing Project Manager- Medicines Optimisation Pharmacist	NHS Lancashire and South Cumbria ICB
DR Shenaz Ramtoola (SHR)	Consultant Physician	East Lancashire Hospitals NHS Trust
Sonia Ramdour (SR)	Chief Pharmacist/Controlled Drugs Accountable Officer	Lancashire and South Cumbria NHS Foundation Trust

IN ATTENDANCE:

Brent Horrell (BH)	Head of Medicines Commissioning	NHS Midlands and Lancashire CSU
Adam Grainger (AGR)	Senior Medicines Commissioning Pharmacist	NHS Midlands and Lancashire CSU
David Prayle (DP)	Senior Medicines Commissioning Pharmacist	NHS Midlands and Lancashire CSU
Emily Broadhurst (EB)	Administrator	NHS Midlands and Lancashire CSU

	SUMMARY OF DISCUSSION	ACTION
2023/334	**Welcome & apologies for absence** Apologies were received from Lindsey Dickinson, Vince Goodey, Melanie Preston with Rukaiya Chand attending on her behalf and Rebecca Bond.	
2023/335	**Declaration of any other urgent business** None.	

	SUMMARY OF DISCUSSION	ACTION
2023/336	**Declarations of interest** None.	
2023/337	**Minutes and action sheet from the last meeting 11th May 2023** The minutes from the last meeting were accepted and will be uploaded onto the LSCMMG website.	
2023/338	**Matters arising (not on the agenda)** DJ raised that there is a supply issue with Glucagon as they are having manufacturing problems. This may cause an increase in the use of Ogluo which was reviewed last month.	
NEW MEDICINES REVIEWS		
	SUMMARY OF DISCUSSION	**ACTION**
2023/339	**Formulary Update** DP gave this update; the formulary group are due to meet later on today. The remit of the group is to harmonize formularies, not to make new decisions or to solve issues that have been problematic previously. The group will work towards getting formulary positions in one place, being correct and up to date and sorting out any inconsistencies along the way. The principles of going through each step are as follows, drug positions with minor formulary discrepancies will usually be adopted, for moderate discrepancies, consultation would usually be via MS Forms. Major discrepancies will be discussed at a series of newly formed clinical expert groups. A list of aligned drugs will be taken to the formulary group to be approved. DP added that at the last meeting membership was agreed but he is yet to have a final list of members which he was hoping to get completed today. AW will be chairing the meeting and there are some volunteers, but DP felt that getting GPs to the group would be the most challenging and may result in changing the meeting timing. The first chapter the group went through was Cardiovascular. It was a big piece of work with members from the CSU team meeting in person and	

	going through each line of the different formularies including local formularies, trust formularies, formularies from primary care and also from Greater Manchester and Liverpool. They managed to align 89 drugs, there were 30 minor discrepancies. Consultation type forms were sent out with consultees being given 2 weeks to respond. The group feel it will take around three months to complete each chapter, but they will run several (three different chapters ideally) different chapters at one time. Each month a new chapter will be started so there is a constant overlap of chapters to get the harmonization done as quickly as possible. The next chapter will most likely be Gastro as the clinical group are most established for Gastro and it is a large chapter. LR asked if there was just one standard clinical group for all chapters or would there be different specialists for each chapter included. DP shared the current membership plan for the different clinical groups and confirmed that there would be separate groups for each chapter. AC raised the importance of ensuring primary care representation at the formulary group. He also added this is a precursor to set up subgroups where there will be a group of clinicians with expertise in cardiovascular who understand about medicines and how they work rather than each time having to explain about the process of commissioning medicines and bringing in new ones. LR reiterated the need for primary care representation at the formulary meetings to ensure the process doesn't become too secondary care focused. DJ then asked for clarity on compliance with the formulary and what the direction of travel will be. He asked this as at the moment patients are being admitted on items that his trust would consider non-formulary, but they would continue to supply them unless it was something very unreasonable. He asked if there was going to be an ask in both secondary and primary care to switch programs to move towards the single formulary. AW responded that currently there isn't an answer for this, but the group would need to look at this. However, he suggested that new initiation should be from the new formulary, and then move towards monitoring the formulary usage over time. SR then asked DP to ensure LSCFT are included in the members list for the relevant groups, but also raised the issue of shared care as Mersey and GM were being looked at. AC added that he recently attended the first North West Regional Medicines Oversight Group and shared care was one of the things that was discussed BH came in on a few points, with SR's point they looked at aligning the definitions of the three ICB RAG statuses, but they felt it was unnecessary to deal with issues raised by SR where there are different RAG positions or different shared care agreements. They are going to meet quarterly across the three ICBs with a view to understand some of the larger differences or issues with RAG positions with an aim to unpick why there are differences and to look at what the issue could be. He asked if members have any particular issues for any services to feed them back to him then the CSU team will ensure they get followed up into the ICB group to review. LR then raised the issue around contracts as some trusts have contracts in place for good deals on drugs but then when they make their way into primary care the cost drastically increases. And as this is where most repeat prescribing this means cost could go up significantly for primary	

	care if they have to prescribe medication on the formulary if it is mainly put together by secondary care colleagues. AW added any areas that were not alignment of existing formulary positions would need to go through LSCMMG to ensure system wide agreement and be ratified following the same process as existing new formulary positions.	
2023/340	**Keppra Position Statement and SOP** DP brought a position statement and a switch SOP for Keppra to levetiracetam. It is a position statement which is still in draft form and the SOP will go along side it. The primary care SOP was developed by the Operational Medicines Management teams. AC commented that Neurology colleagues from LTHTR had some concerns around the impact of the switch on workload and Walton have agreed for it to go through. It was felt it would be useful to have the positions statement and SOP for members here to have sight of them together. BH asked the group if they would be comfortable approving the position statement here being conscious of the discussions that have taken place with the Neurologists. SR had some questions about the SOP. She said she would presume it would be either a pharmacy technician, nurse or GP doing the switch so was unsure why there is information relating to governance as it is being undertaken by registered healthcare professionals. She also asked if the excipients between Keppra and the generic were different, and if they are the same why is there an exclusion criteria. She presumed it states for patients under 18 due to licensing, but for her reading the information that's going to patients, she is concerned that patients may not realize that Levetiracetam is the active ingredient in Keppra. BH thanked SR for her comments and CM commented that they would take the comments back and agreed with them to be added. CM also said that it will be approached differently in areas depending on the model of medicines optimisation, but it would be a registered professional, but they may need some support from someone such as a medicines coordinator in conducting the searches. CM added she will make sure that is clear on the SOP, and she added that the SOP is here for supporting the discussion about what is being done rather than here for approval. RC added that recent data shows around 80% of prescribing is already using the generic, and she felt there doesn't need to be concern about a mass switch as it is a small number of patients. BH confirmed that around 86% of prescribing across the ICB is generic, but the 14% is around £700,000 extra which is a significant cost. He also added that it is around £60 a month for Keppra where as the generic is around £3 a month so again it is a large cost differential between the two. He asked the group if they were happy to ratify the position statement in support of the SOP work that will be going in in Primary care, and he asked DJ especially if he had any queries or concerns regarding this. DJ responded that neurologists have raised their concerns and he felt this would be as good as it could get for the position and moving this forward. He added that last month they discussed potential risk and concerns around the possible impact on referrals back into neurologists. These were noted and it will be part of the EQIAA around it. BH added about having in an early warning system so that if neurologists are getting referrals back in due to the	

	review it comes back to this group as quickly as possible to try and mitigate risk. DJ agreed to take the discussion on referrals back to neurologists and for them to log an incident into the system if this happens so the group could be made aware of it. The group agreed to ratify the position statement and note the comments on the SOP and that the SOP is a piece of work that will be done in primary care. <u>Actions</u> CM to take comments from SR and add the information raised to the letter and SOP. DJ to feed back to neurologist's discussions on reporting an incident if referrals start going back to them due to the switched drug.	**CM** **DJ**
2023/341	**New Medicines Review workplan** DP brought this item, he explained that it looks slightly different as he agreed to add dates for when the team estimate medicines will be reviewed. On page 4 he said that Avanafil listed for Erectile Dysfunction, is listed for review in October 2023, but he has put in brackets July 2023. He did this as he felt it may not need a full review or a consultation, as its more a concept of to try another PD5 if they have tried the formulary type drugs first. He asked if the group were happy with this, and he would put it further up the list as they have had a fair amount of pressure to update it. He added he was unsure if they will have a statement primarily but that will need to be done. There are three medicines for prioritisation, the first one is Fluorides. There is already a position for this which is RED, but this is a refresh of it as it is an old review which was based on an old dental document. The next one is Bempedoic Acid for Monotherapy, and it will be a big one due to the focus on lipid control currently. He added there have been questions on whether they can use this drug for monotherapy when NICE have said it is only cost effective when used with ezetimibe. The third one is Qutenza cutaneous patch, the request has come from a pain management consultant in Blackpool for neuropathic pain. BH added for Avanafil the team will bring a paper to the next meeting with the intention that people will have had enough information. If not, it will go out for consultation. This drug is a slightly different situation as it was mentioned in a guideline implying it can be used however there is a Do Not Prescribe position on the medicine. RC added they have had some pressure to prescribe in the Fylde Coast region. RC had a question around Bempedoic acid. She asked when the monotherapy position is considered, how will it align with the AAC pathway as that is being worked on currently. DP responded that the AAC pathway only allows combination therapy as the pathway is in line with NICE, so it would mean moving away from a NICE position. BH added for clarity that they have the primary prevention pathway here today and the secondary prevention will be coming next month. DP confirmed that they are not changing the AAC pathway, but they are producing an easier to read version. SHR asked if as principle, would they going with NICE for what that covers	

	and not consider any other requests and only look at requests that fall outside of NICE, as it can't be allowed for one thing and not considered for others. AC responded that the group has gone outside of NICE before when a collective decision has been made. This decision would be escalated up now to ICB board and executives to say this is what we recommend and that is to not follow NICE on this particular issue. He added that this is why he feels the prescribing guidance and SOPs are so useful as it's for the prescriber to actually use not for a national group like NICE to make a recommendation on. BH added that in a situation like this they would expect the specialist to give a clear indication of the cohort of patients they want to use it in, and the group would go back and look at if NICE to consider if that cohort was specifically considered in their decision making or not. Then bring it back here to make it clear on what information did they make their decision and is there any information out there that wasn't considered, and if there is a case for using it. DJ asked for some clarity on Actimorph which went through their medicines governance committee back in April. They were almost happy that they have a cohort of patients where they felt it would be useful, but he is aware it is on the workplan but not coming until November. He asked if they should put a hold on any use of Actimorph, but he said was sure when he first brought it here for discussion that some trusts were already using it. AC as there is currently governance process in place that entitles trusts to look at what they are going to prescribe for their patients. In the future with the single formulary there may be a difference but that is not currently where things are. So, for the time being to follow current processes.	
GUIDELINES and INFORMATION LEAFLETS		
2023/342	**Antihistamines & nasal sprays for mild to moderate hay fever and allergic rhinitis Position statement – ELMMB document – LSCMMG review and adoption** AGR brought this item, he has been liaising with East Lancashire health economy and primarily with John Vaughan. They have put together a plan to review the current ELMMB website content and what will go onto LSCMMG. The first thing for priority was the antihistamine position statement. The current one was developed by ELMMB, AGR reviewed it and compared it to what is currently held on LSCMMG. There isn't currently any substantive LSCMMG guideline that covers the same content as the one produced by ELMMB. However, LSCMMG did produce a template policy previously for "Items that should not be routinely prescribed in Primary Care" which included antihistamines. The template policy was designed to be adopted by CCGs, however it wasn't formally ratified as an LSCMMG policy. AGR proposed that, as the template policy was approved by LSCMMG and was subsequently adopted by all legacy CCGs, for the ICB to adopt the OTC policy as a system, making it a substantive LSCMMG guideline, for use across the ICB. The RAG rating of the antihistamines could be formalized as part of the formulary work. AGR's other recommendation was to have LSCMMG approve the position statement presented, in the interim for the Pennine Lancashire footprint only until the piece of work has been completed so to not disadvantage	

	East Lancashire prescribers. John Vaughn was keen for this to be one of the policies that was incorporated into the LSCMMG website and one that they needed to see some progress on. LR added they are keen to keep it for their practices and highlighted that the policy highlights what NHS England self-care policy states around over the counter medications. She also suggested maybe adopting the NHS England policy that was published and put it on the website for people to see. BH added this is a slightly different situation where most CCGs adopted a policy, but the ask is more for policy positions as opposed to clinical guidance on the LSCMMG website. He added there is also something to think about in terms of is there going to be formalizing some of these things as ICB policy positions and if so, what process do they need to go through. Does it need to go out for a full public consultation such as when in policy development for interventions through the clinical policy group. RC echoed what LR had said and added that this time of year tends to have a surge of requests for items on prescription as the high pollen levels patients feel warrants a prescription so having an individual position on antihistamines would be helpful. She also said they had received a query only yesterday and as there is only a template it didn't give them much to go back on other than to say its in the national NHS England policy not to prescribe. CM commented that she agreed with BH's comments on policy and that it would be interesting outside of this group. In terms of other policies that existed at CCG level it needs to have a similar process for medicines policies as is happening for other policies within the ICB and added it would be good to prioritize existing ones which is not a large number. She said that self-care and a gluten free policy which she felt would be the most important but that there probably isn't many others, but there may be a need to work on some more. AC said he was unsure why the document was needed and that he felt there shouldn't be different documents for East Lancashire and if there is a need for that it should be for no more than three months as the across the ICB everyone is working to move away from that. This is because it would be unfavored within the wider ICB that one area gets something separate without a clear justification as to why, and that he didn't feel this was a big enough issue for this but was happy for discussions. BH said the case for this could be that is its just giving clarity and somewhere for primary care clinicians to point to. But it is clarifying a position that historically all the CCGs had adopted. He said there are two ways of doing this, either putting the document on and give it a very limited time period but not making it explicit to East Lancashire and say it is confirming the policy position that was in place for all legacy CCGs and that the policy is being reviewed through the ICB with a view to adopting it. Secondly, it doesn't go on at all. BH felt comfortable with the first option as the CCGs adopted the policy previously and the position can be given a very limited time frame of either three or six months while they go through the process of considering the policies through the ICB. But making it explicit on the website that it was pre ICB CCGs had adopted the self-care policy. Both AC and LR were happy with this approach with it being explicit that	

	the ICB has not adopted the policy but that it is going through the process for the ICB to consider it. Action AGR to put the document on the website with explicit wording that this is in line with legacy CCG positions and that a policy position is being considered for adoption by the ICB but is currently going through that process with a three-month time limit.	**AGR**
2023/343	**Gluten Free Commissioning Statement for NHS EL/BwD – LSCMMG review and adoption** This is very similar, but AGR is recommending that this policy goes out for consultation. This is because there is a 2018 NHS England policy which does allow some for some bread mixes and breads to be prescribed but the position statement is a complete do not prescribe for gluten free. LR commented that she felt most places had agreed on the Gluten free policy before the NHS England changed direction and that East Lancashire had an established policy and felt this may be the same across the whole patch. She added that East Lancashire received a lot of complaints initially, but they have been worked through and essentially calmed down. She is concerned that if changes are made after people have accepted most of the products are available in supermarkets it may create some of the same issues, they had in the beginning with lots of challenges and complaints. Others agreed with this and BH added that all legacy Lancashire CCGs had adopted a Do Not Prescribe position for gluten free preparations as there were now a large number of gluten free products available in the supermarkets. There is next to no prescribing across Lancashire and South Cumbria, but BH felt it does need to go into the group of what process is going to be used to ratify this into the ICB and it may need to go through a public consultation or something similar as it probably does need discussion outside of the meeting. CM agreed with BHs comments about having discussions outside this meeting around adopting policy positions and agreed that all legacy CCGs had approved policies, but they were on their own CCG websites that have now been archived. She added she would be apprehensive of going out for a consultation when this was done previously as if the same question is asked again we are likely to get similar responses. It was agreed to undertake a similar process as with the antihistamines discussed under item 2023/342, and include a position statement on the LSCMMG website. Action AGR to put the document on the website with explicit wording that this is in line with legacy CCG positions, and that a policy position is being considered for adoption by the ICB but is currently going through that process with a three-month time limit.	**AGR**

2023/344	**UHMB local shared care documents – review** AS sent the local Morecambe Bay shared care documents over to AGR. This showed arrangements in place and UHMB did mention having some pushback within the local area as they were not substantive ICB wide documents. Which meant there was some reluctance locally to engage with these documents but as UHMB have raised they are important documents in terms with their locality and they wanted a LSCMMG review. There are local shared care documents developed for Dapsone, Denosumab, Enoxaparin and Hydroxycarbamide, and ARG had each had slightly different recommendations for each. Firstly, with Dapsone, the actual document was in appendix one and the indication was on the UHMB shared care is for dermatitis herpetiformis and other dermatoses along with an unlicensed indication for vasculitis. Currently LSCMMG doesn't have a RAG position on Dapsone and there isn't a national Dapsone shared care either. AGR said they would try to review this and the others as part of the formulary work as it will undoubtably come up as part of that as the UHMB formulary is on the list. So, with that the formulary group will consider the RAG as part of that work and if they feel the shared care is relevant then the ICB can adopt the shared care. This route seemed the best fit for this drug. Members agreed with this approach for Dapsone. Secondly Denosumab is in appendix 2 and the UHMB indication in their shared care was the prevention of skeletal related event in patients with bone metastases from solid tumors and other than prostate tumors. LSCMMG RAG position on this is Red for the 120-milligram preparation so for shared care to apply this would require a change in RAG position Amber 1 in Morecambe Bay. This is for the 60-milligram preparation and there is no national shared care for Denosumab. AGR recommends a consultation on the 120-milligram from Red RAG to Amber 1, which seemed the fairest way to proceed. If LSCMMG agreed to this there would need to be an LSCMMG shared care developed for the 120-milligram preparation. Also, they have different preparations and different brands also but from the same manufacturer so AGR felt this would be the safest way to proceed with this. FP commented at this point that they couldn't endorse it locally as they are looking a whole system approach. DJ added that they would endorse Amber 1 as that is what they are doing in their trust. LR commented her concern at this going out to consultation due to the impact on GPs and primary care as asking them to pick this up may result in pushback. BH commented that as it is a substantial change he would also advise going out for consultation and AC agreed. It was agreed for the change in RAG for Denosumab to go out for consultation. Next AGR brought his recommendations for Enoxaparin. This one was more difficult than the others, the indication in the UHMB shared care was for extended treatment of prophylaxis of VTE in patients whom oral anticoagulation is contra-indicated or not recommended. They gave a list of examples which is listed in the document in appendix 3. The position LSCMMG has is in the LSCMMG guideline for lower molecular weight	

	heparins. The indications listed in the UHMB document, although not worded exactly the same, fall under the indicators defined for a having a Amber 1 RAG status in the LSCMMG LMWH guideline. However, even though the lower molecular weight heparins as listed as Amber 1 in the policy, there is no current shared cared guidelines. AGR felt it may have been discussed at some time but was unable to find anything relating to discussions, so this showed a discrepancy. The only difference between the two policies would be that patients with solid tumors standard treatment in symptomatic VTE and prevention, of which occurrence is RAG rated as Amber 1 but prophylaxis in VTE and oncology patients is Red RAG rated. I In summary AGR has recommended to develop a shared care for all Amber 1 RAG rating for lower molecular weight heparins but was happy to be challenged on this. The only addition to this would be a consultation with Morecambe Bay to see if a Red RAG rating for Enoxaparin in VTE inducing therapy in oncology patients would be workable. CM commented that she thought that shared care wasn't developed as there was a difference in commissioning of across CCGs historically, Central Lancashire CCG area did have a local shared care that was tweaked when the statement from LSCMMG came out. LR added that there are different local molecular weight heparins in use in different hospitals and they change quite often with supply issues. This means it may be quite complex trying to capture all indications, doses, preventative treatments, cancer and VTE into one. DJ commented that they are now starting to see some oncology patients on DOACs so this might be an area worth reviewing specifically around VTE in oncology patients. RC agreed this would be quite complex to do as they also get some unusual requests for lower molecular weight heparins for indications that aren't covered. AC said that currently this may be something that needs to be looked at individually. In the future looking at a single formulary it may need to be consider what happens elsewhere but agreed this is a high-risk area. And it maybe also that will have to be accepted due to the acute trust differences, and there will also be differences within primary care prescribing linking into the acute trusts as well. BH agreed with AC's comments and asked if there are any other local shared care relating to this and it may be worth going through the process of reviewing any with a view to adopting them through LSCMMG but making it clear what geographical footprints are utilizing the shared care. LR added that they don't have a shared care but a comprehensive trust guideline. AC summarized that things should continue as they are in relation to this, but then collate what there is and look for uniformity in what is currently there as it could be vastly different or very similar. AC asked for trusts to send AGR what they have in place for lower molecular weight heparins or specifically for Enoxaparin. BH added they will bring a proposal to a future meeting for Morecambe Bay depending on what they get from other trusts as it may be an isolated thing with Enoxaparin, or it could be quite different.	

	Lastly AGR brought up Hydroxycarbamide. UHMB have a shared care, LSCMMG do not but have considered this previously. AGR confirmed there is a national shared care for hydroxycarbamide. LSCMMG previously decided against shared care and retained a Red RAG status as at the time the group felt the intensity of monitoring required in primary care was too high, although it was also raised at the time that Cumbria had it as Amber 1. AGR added that the majority of prescribing was in the Morecambe Bay area. He recommended either to review as part of the formulary work and consider the RAG at the specialist formulary working group then adopt a shared care if applicable. Or the RAG change could go out for consultation from Red to Amber 1 or 2, but added he felt that the formulary work would make more sense as it will undoubtably would come up there anyway. AC agreed with the formulary approach and added that the evidence was looked at a long time ago. SR asked if there is a national shared care document is that an indication that the Red RAG status really does need a review. She also asked if there was an option to just adopt the shared care document across the ICB. AGR agreed that these needs looking at. It was agreed for it to go through the formulary group for consideration and to also look at the national shared care document. BH added that Manchester had adopted the national shared care document and there are some issues with clinical content so there are ongoing discussions with the national team around this so it maybe wouldn't be wise to just adopt the shared care at this time. LR added that is there a population side to this as there maybe a bigger need for this in Morecambe Bay area than in others due to them being rural and the size of the geography. AC added that he has seen similar issues but there is the need to be uniform across the whole trust. Maybe it may be useful of using caveats in the documents as to not disadvantage patients in more rural communities. FP agreed with this and added that it may mean looking at commissioning issues if drugs are rated Red rather than just making it more convenient having it as an Amber medication because of geographical issues. FP commented that there is one other shared care that they were not aware of and wanted to confirm with AS what was happening with that one. AS confirmed the shared care is domperidone. She added she had forgotten about it as it doesn't go through pharmacy just through pediatrics. She has queries with it as there are lots of issues with it but said she would sent it through to AGR. FP asked for clarity if it had gone through local D&T groups as it had gone through pediatrics and asked if there was reassurance that other care groups have not got any shared care going on. AS responded as far as she was aware domperidone was the only other one. AC added that for the moment Morecambe Bay are ok to continue to use the shared care guidelines such as agreed earlier in discussions for East Lancashire.	

	Actions The formulary group will consider Dapsone in their work and look at the RAG position and if appropriate adopt the shared care. The change of RAG position for Denosumab to go out for consultation. Trusts to send AGR their current shared care for Enoxaparin and other low molecular weight heparins. The CSU team to bring a proposal for UHMB shared care for Enoxaparin after receiving information from other trusts. The formulary group will consider Hydroxycarbamide in their work and look at the RAG position and if appropriate adopt the shared care. AGR to review the national shared care document for Hydroxycarbamide. AS to send the shared care for Domperidone to AGR.	**Formulary Group** **AGR** **Acute Trusts** **AGR** **Formulary Group** **AGR** **AS**
2023/345	**Lipid pathway – primary prevention** DP brought this item. This was discussed what pathway the team have linked to the LSCMMG website which is the AAC pathway. There has been some discussion about how others may be developing pathways that could eclipse what is on LSCMMG. It was felt the reason this could happen was that the AAC pathway is really complicated as it is a dense single page document that has everything on it. But the team want to make it as simple as possible for people to follow the pathway. They also want to make sure the pathway was asserted on LSCMMG, so this exercise split the pathway into primary and secondary prevention and make the pathway as straightforward as possible. DP also linked in the AAC pathway and added a slightly briefer version with the LSCMMG logo on it. Hopefully this should clarify that there is a pathway and what should be followed in the region. AC asked RC how this would fit in with all the work she has been doing with lipids. She said it was good and it was an ask from her cardiovascular group for this and to prioritize secondary prevention. As she has mentioned earlier in the meeting the lead has an issue with Bempedoic acid which he would like to discuss here but for now they understand they will continue with what is there. RC also said she has asked the cardiovascular group to look at the number of patients they currently see in clinics that they think would be suitable for monotherapy or whatever changes that they would like to deviate from the AAC pathway. The lead will bring this to discussions here as part of the evidence. She added that there is currently a lot of work with familial hyperlipidemia as well, but she will keep this group updated on this. LR added that it may be worth moving the green box with lifestyle changes near the top of the document instead of jumping straight to the drugs as it is constantly being said about focusing on lifestyle interventions. AC	

	responded that it does mention about lifestyle modification being effective but that it could be highlighted more. DP will move the box. AC continued that the paper states it is going to recommendations to the ICB so asked where it was going. DP said that normally LSMMG would approve this, but he had put ICB as it is like a drug review but felt it could stay with LSCMMG at this stage. BH added that guidelines are usually agreed with LSCMMG, and it is only commissioning positions that would go to the medicines group. AC agreed that while this may change, currently this is still the case. The document was approved. **Action** DP to move the green box with lifestyle change information towards the top of the document to highlight it at the beginning.	**DP**
2023/346	**Menopause – Product Price List** AGR brought this item. The Menopause product price list is finished, it has been brought here to ensure the group were happy for both items to be uploaded. BH added that they have set up a process to update pricing from drug tariff prices with the intention of updating that quarterly as the new tariff prices come in quarterly. LR asked if the reference at the bottom of the document around testosterone and shared care had been agreed and if so, could it be linked in the document. AGR agreed this had been agreed and could be added to the document. <u>Action</u> AGR to link in the shared care document with testosterone and the documents can be added to the website.	**AGR**
2023/347	**Guidelines workplan** There was nothing to mention for this other than the dates have been added such as the medicines workplan.	
NATIONAL DECISIONS FOR IMPLEMENTATION		
2023/348	**New NICE Technology Appraisal Guidance for Medicines May 2023** There was one highlighted for discussion, which didn't have a template associated with it. NICE TA 888 – Risankizumab for previously treated moderately to severely active Crohn's disease. Nice estimate about £8800 per 100,000 population so would be around £158,000 per annum. It has a Red RAG status, is PDR excluded and the guidance doesn't need to be changed yet and a Blueteq form is required.	
2023/349	**New NHS England medicines commissioning policies May 2023** N/A	
2023/350	**Regional Medicines Optimisation Committees - Outputs May 2023**	

	N/A	
2023/351	**Evidence reviews published by SMC or AWMSG May 2023** There is no action needed but DP felt it was to be aware of the differences between NICE and Scotland noted in the paper.	
ITEMS FOR INFORMATION		
2023/352	**Lancashire and South Cumbria NHSFT Drug and Therapeutic Committee 25th May 2023 – TO FOLLOW** The minutes were finalized yesterday so they will be ready for the next LSCMMG meeting.	
2023/353	**LSCMMG cost pressures log** The was one drug on the cost pressures log this month which is Risankizumab NICE TA 888 mentioned above which is around £158,000 but no other pressures this month.	

DATE AND TIME OF NEXT MEETING

The next meeting will take place on

Thursday 13th July 2023

9.30am – 11.30am

Microsoft Teams

ACTION SHEET FROM THE
LANCASHIRE AND SOUTH CUMBRIA MEDICINES
MANAGEMENT GROUP 08.06.2023

ACTION SHEET FROM THE MEETING 13th October 2022				
2022/164	**Nutritional Supplements Post Bariatric Surgery – Post Private Surgery** **March 2023 update:** AGR is struggling to engage. AGR to link in with LD for her to support. **April 2023 update:** AGR still progressing **May 2023 update:** Still on going. **June 2023 update:** AGR has made contact and they are arranging a meeting to discuss issues.	**ARG/LD** **AGR/LD** **ARG/LD** **AGR/LD**	**Open** **Open** **Open** **Open**	**09.03.2023** **20.04.2023** **11.05.2023** **08.06.2023**
ACTION SHEET FROM THE MEETING 10th November 2022				
2022/180	**Keppra Position Statement** **May 2023 update:** Further conversations have been had, it was decided to move ahead with this and if neurology needs additional support to do this then there may need to be a look to see where the funding could come from. It is noted that their nervousness around having more work to do, and that it is not necessarily that the increased resource is in the neurology specialist service but maybe more in primary care for people doing the switch. It may have to go out without the full support of the neurology team. AW agreed this needs doing sooner due to being a QIPP win. AC asked for it to be brought back to the next meeting with the idea of closing it at that meeting. DJ requested it be added to a risk register if not already done, DP said it hadn't been done one a quality/ equality impact assessment report.	**AC/DJ**	**Open**	**11.05.2023**

	A new action here for AW to complete and share the QIA and EIA with members for comments. **June 2023 update:** Is on the agenda, closed.	**AW** **DP**	**Open** **Closed**	**11.05.2023** **08.06.2023**
ACTION SHEET FROM THE MEETING 12TH January 2023				
2023/226	**Menopause guidance – Update** AGR to change patches to the first choice in the document instead of oral. **February 2023 update:** AGR has made the amendments and is waiting for BH to look over the document to send over to Kath Gulson. Once ready, AGR to include Kath Gulson and community pharmacy in the circulation of the document. Still awaiting final checks before send out. **March 2023 update:** BH and AGR to meet to finalize before sending Kath Gulson. LD to also support bringing someone from primary care to this group. **April 2023 update:** Work ongoing, this will be prioritised over the coming weeks. **May 2023 update:** It was more difficult to set up the automated updates, but the draft is done and is awaiting to be QA'd. Will bring the final draft version to the next meeting. **June 2023 update:** On the agenda, closed.	**AGR** **AGR** **AGR** **AGR/BH** **AGR/BH** **AGR/BH**	**Closed** **Closed** **Closed** **Open** **Open** **Closed**	**12.01.2023** **09.02.2023** **09.03.2023** **20.04.2023** **11.05.2023** **08.06.2023**
ACTION SHEET FROM THE MEETING 9th March 2023				
2023/271	**COPD guideline – update** DP and team to revisit the document and create a simplified version like done previously with the asthma inhaler guideline and bring back to the group. **April 2023 update:** Has been reviewed by the project group, work ongoing. To remain on the action log until complete, aim to come to the May LSCMMG.	**DP** **DP**	**Open** **Open**	**09.03.2023** **20.04.2023**

	May 2023 update: Comments proposed by respiratory group, to be incorporated and further discussion with respiratory group. **June 2023 update:** There has been a lot more comments come back, DP will bring an update to the next meeting.	**DP** **DP**	**Open** **Open**	**11.05.2023** **08.06.2023**
2023/286	**Developing a single joint formulary for Lancashire and South Cumbria** EB/BH to send an email detailing the ask for volunteers for the single formulary working group. **April 2023 update:** A few names have been provided. AW / BH to meet to agree the oversight group membership. Members to contact BH with any nominations. **May 2023 update:** There is the first meeting of the Formulary oversight group this afternoon. **June 2023 update:** This item was discussed under agenda item 2023/339.	**EB/BH** **AW/BH** **AW/BH** **AW/BH**	**Open** **Closed** **Open** **Closed**	**09.03.2023** **20.04.2023** **11.05.2023** **08.06.2023**
	New NICE Technology Appraisal Guidance for Medicines March 2023 AGR to review the cost template and RAG status for Finerenone. **April 2023 update:** There is not costing template, so AGR is unable to be more specific with costing. The proposed RAG status is Green as the renal cut off is around the same as Dapagliflozin. There was some reservation in primary care as clinicians are not familiar with it. MLCSU to draft information sheet with a recommendation of Green to the next meeting. MLCSU to liaise with AW and MP to draft a risk register entry and liaise with colleagues to produce an EIRA in relation to Saxenda® and Wegovy®.	**AGR** **AGR** **BH**	**Open** **Open** **Open**	**09.03.2023** **20.04.2023** **20.04.2023**

	May 2023 update: Paul is working on the new Equality and Health Inequality impact and risk assessment which is the new EIRA. Would be helpful to take to a commissioner and wider than medicines, Jane Miller or Steve Flynn would be good to link into. MLCSU to contact Jenny Oakley to ascertain which drugs are being requested by clinicians in intensive care to manage COVID. AGR has some other people to contact which he will do after this meeting.	**BH** **AGR** **AGR**	**Open** **Open** **Open**	**11.05.2023** **11.05.2023** **11.05.2023**
ACTION SHEET FROM THE MEETING 20th April 2023				
2023/291	**Ogluo (glucagon solution for injection in pre-filled pen, 0.5mg and 1.0mg)** Ogluo to be given a Green RAG rating with the development of prescribing guidance to support the identification of appropriate patients in whom Ogluo should be initiated. **May 2023 update:** DP still to do prescribing guidance then will send to the Medicines Policy Subgroup for ratification, can be closed once it goes to the Medicines Policy Subgroup. **June 2023 update**: Awaiting for it to go the next Medicines Policy Subgroup, which is due to be held on 16th June 2023.	**DP** **DP** **DP**	**Open** **Open** **Open**	**20.04.2023** **11.05.2023** **08.06.2023**
2023/292	**IQoro for treatment of hiatus hernia and for treatment of stroke related dysphagia.** IQoro to be given a Red RAG DP to recalculate the cost pressure and update the cost pressure log **May 2023 update:** Log has been updated, will now go to the quality meeting. BH added there needs to be another Medicines Policy's task and finish group to ratify the outputs from the last few meetings.	**DP** **DP**	**Open** **Open**	**20.04.2023** **11.05.2023**

	June 2023 update: Awaiting for it to go the next Medicines Policy Subgroup, which is due to be held on 16th June 2023.	**DP**	**Open**	**08.06.2023**
2023/294	**Baricitinib in the Treatment of Patients Hospitalised Due to COVID-19** DP to contact Jenny Oakley to gain feedback from the Chief Pharmacists and the policy will be considered at the next meeting. **May 2023 update:** Jenny Oakley (JO) presented the feedback to the group. Most trust critical care and respiratory consultants would like continued access to Baricitinib. There is a request for further clarity and consistency across the patch. Small numbers have been recorded so now the estimated cost needs to be checked. BH to work with JO to reword the NHSE Blueteq form for adoption across LSC and look at creating guidance to go on LSCMMG. JO to collate data for it to go onto the LSCMMG website. **June 2023 update:** Ongoing, JO will bring an update to the next meeting.	**DP** **BH/JO** **JO** **JO**	**Open** **Open** **Open** **Open**	**20.04.2023** **11.05.2023** **11.05.2023** **08.06.2023**
ACTION SHEET FROM THE MEETING 11th May 2023				
2023/315	**Minutes and action sheet from the last meeting 20th April 2023** EB to amend the minutes before uploading them to the website. **June 2023 update:** This was completed and the minutes have been uploaded to the LSCMMG website.	**EB** **EB**	**Open** **Closed**	**11.05.2023** **08.06.2023**
	Trifarotene (Aklief®) 50 microgram/g cream for the cutaneous treatment of acne vulgaris of the face and/or the trunk in patients from 12 years of age and older, when many			

2023/317	**comedones, papules and pustules are present** Trifarotene (Aklief®) 50 microgram/g cream for the cutaneous treatment of acne vulgaris, a Green RAG rating will be considered for ratification at the next Medicines Policy Subgroup. **June 2023 update:** Will go to the next Medicines Policy Subgroup on 16th June 2023.	**DP** **DP**	**Open** **Open**	**11.05.2023** **08.06.2023**
2023/318	**TheraBite® Jaw Rehabilitation Device for the treatment of trismus and mandibular hypomobility** TheraBite® Jaw Rehabilitation Device for the treatment of trismus and mandibular hypomobility, a Red RAG rating will be considered for ratification at the next Medicines Policy Subgroup. **June 2023 update:** Will go to the next Medicines Policy Subgroup on 16th June 2023. AS to feedback discussion on the Red RAG decision to MaxFax specialists. **June 2023 update:** AS fed back to specialists and they have started prescribing the product.	**DP** **DP** **AS** **AS**	**Open** **Open** **Open** **Closed**	**11.05.2023** **08.06.2023** **11.05.2023** **08.06.2023**
2023/319	**Budesonide M/R 9mg tablets (Cortiment MMX) For induction of remission in adults with mild to moderate active ulcerative colitis where 5-ASA (aminosalicylate) treatment is not sufficient - RAG status change proposal** Budesonide M/R 9mg tablets (Cortiment MMX) to be recommended for a change in RAG position from Red to Amber 0, highlighting the requirement to prescribe by brand, at the next Medicines Policy Subgroup.	**DP**	**Open**	**11.05.2023**

	June 2023 update: Will go to the next Medicines Policy Subgroup on 16th June 2023	**DP**	**Open**	**08.06.2023**
2023/320	**Estradiol (as estradiol hemihydrate) and progesterone 1mg/100mg Soft Capsules (Bijuve®) For continuous combined hormone replacement therapy (HRT) for oestrogen deficiency symptoms in postmenopausal women with intact uterus and with at least 12 months since last menses** Estradiol (as estradiol hemihydrate) and progesterone 1mg/100mg Soft Capsules (Bijuve®) for continuous combined hormone replacement therapy (HRT) to be considered for ratification at the next Medicines Policy Subgroup. **June 2023 update:** Will go to the next Medicines Policy Subgroup on 16th June 2023.	**DP** **DP**	**Open** **Open**	**11.05.2023** **08.06.2023**
2023/321	**MHRA Alert: JAK inhibitors – actions to update web site** DP to send the link to relevant specialists, in addition the link with be added onto the LSCMMG website in each of the relevant guidelines and each JAK inhibitor drug entry. **June 2023 update:** On the website, closed.	**DP** **DP**	**Open** **Closed**	**11.05.2023** **08.06.2023**
2023/322	**New Medicines Review Workplan** Actimorph to be added to the work plan. Ibandronic Acid to be added to the work plan and prioritised. DJ to find out the request RAG status for Ibandronic Acid. DP to add proposed time frames for items on the Work plan.	**DP** **DP** **DJ** **DP**	**Open** **Open** **Open** **Open**	**11.05.2023** **11.05.2023** **11.05.2023** **11.05.2023**

	June 2023 update: All above items have been added to the work plane. Closed.	**DP**	**Closed**	**08.06.2023**
2023/323	**Sodium Zirconium Cyclosilicate – Evidence Review** AC and AW to consider the best avenue for work relating to Heart Failure to be progressed. **June 2023 update:** On going, AC and AW to meet to discuss.	**AC/AW** **AC/AW**	**Open** **Open**	**11.05.2023** **08.06.2023**
2023/324	**Gout Guidance – Update** AGR will look into the dosing for Febuxostat to change from 300 to 360. AGR to make the style of the document consistent with other documents on the website. AGR to add in cardiovascular risk assessments to be completed annually for patients on Febuxostat. **June 2023 update:** Ongoing as it is a large project to change format. AGR will bring an update to the next meeting.	**AGR** **AGR** **AGR** **AGR**	**Open** **Open** **Open** **Open**	**11.05.2023** **11.05.2023** **11.05.2023** **08.06.2023**
2023/325	**Camouflaging Products – Update** AGR to add link into the service to the document if available, the final document to be uploaded to the LSCMMG website. **June 2023 update:** On the website, closed.	**AGR** **AGR**	**Open** **Closed**	**11.05.2023** **08.06.2023**
2023/333	**AGR to look at the documents from AS for review with Denosumab being a priority with a view to bring an update to the next meeting.** AGR to look at the documents from AS for review with Denosumab being a priority with a view to bring an update to the next meeting. **June 2023 update:** On the agenda, closed.	**AGR** **AGR**	**Open** **Closed**	**11.05.2023** **08.06.2023**
ACTION SHEET FROM THE MEETING 8th June 2023				

2023/340	**Keppra Position Statement and SOP** CM to take comments from SR and add the information raised to the letter and SOP. DJ to feed back to neurologist's discussions on reporting an incident if referrals start going back to them due to the switched drug.	**CM** **DJ**	**Open** **Open**	**08.06.2023** **08.06.2023**
2023/342	**Antihistamines & nasal sprays for mild to moderate hay fever and allergic rhinitis Position statement – ELMMB document – LSCMMG review and adoption** AGR to put the document on the website with explicit wording that this is in line with legacy CCG positions and that a policy position is being considered for adoption by the ICB but is currently going through that process with a three-month time limit.	**AGR**	**Open**	**08.06.2023**
2023/343	**Gluten Free Commissioning Statement for NHS EL/BwD – LSCMMG review and adoption** AGR to put the document on the website with explicit wording that this is in line with legacy CCG positions, and that a policy position is being considered for adoption by the ICB but is currently going through that process with a three-month time limit.	**AGR**	**Open**	**08.06.2023**
2023/344	**UHMB local shared care documents – review** The formulary group will consider Dapsone in their work and look at the RAG position and if appropriate adopt the shared care.	**FWG**	**Open**	**08.06.2023**

	The change of RAG position for Denosumab to go out for consultation.	**AGR**	**Open**	**08.06.2023**
	Trusts to send AGR their current shared care for Enoxaparin and other low molecular weight heparins.	**Acute Trusts**	**Open**	**08.06.2023**
	The CSU team to bring a proposal for UHMB shared care for Enoxaparin after receiving information from other trusts.	**AGR**	**Open**	**08.06.2023**
	The formulary group will consider Hydroxycarbamide in their work and look at the RAG position and if appropriate adopt the shared care.	**FWG**	**Open**	**08.06.2023**
	AGR to review the national shared care document for Hydroxycarbamide.	**AGR**	**Open**	**08.06.2023**
	AS to send the shared care for Domperidone to AGR.	**AS**	**Open**	**08.06.2023**
2023/345	**Lipid pathway – primary prevention** DP to move the green box with lifestyle change information towards the top of the document to highlight it at the beginning.	**DP**	**Open**	**08.06.2023**
2023/346	**Menopause – Product Price List** AGR to link in the shared care document with testosterone and the documents can be added to the website.	**AGR**	**Open**	**08.06.2023**