Minutes of the Lancashire and South Cumbria Medicines Management Group Meeting

Thursday 14th September 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
David Rawlinson (DR)	Locality Medicines Optimisation Pharmacist	NHS North of England Commissioning Support Unit
Lisa Rogan (LR)	Strategic Director for Medicines Research and Clinical Effectiveness	NHS Lancashire and South Cumbria ICB (Pennine Lancashire locality)
Nicola Baxter (NB)	Head of Medicines Management	NHS Lancashire and South Cumbria ICB (West Lancashire locality)
Melanie Preston (MP)	Head of Medicines Optimisation	NHS Lancashire and South Cumbria ICB (Fylde Coast)
Mohammed Ahmad (MA)	Assistant Director of Pharmacy	Blackpool Teaching 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 Performance Pharmacist	NHS Midlands and Lancashire CSU
Jill Gray (JG)	Medicines Performance Pharmacist	NHS Midlands and Lancashire CSU
Emily Broadhurst (EB) (Minutes)	Medicines Optimization Administrator	NHS Midlands and Lancashire CSU

	SUMMARY OF DISCUSSION	ACTION
2023/380	**Welcome & apologies for absence** Apologies were received from David Prayle and Dr Ramtoola. AC made the group aware he would need to leave at 11am for another meeting, AW is to chair the meeting from this point.	

2023/381	**Declaration of any other urgent business** None.	
	SUMMARY OF DISCUSSION	**ACTION**
2023/382	**Declarations of interest** None.	
2023/383	**Minutes and action sheet from the last meeting 13th July 2023** The minutes from the last meeting were accepted and will be uploaded onto the LSCMMG website.	
2023/384	**Matters arising (not on the agenda)** None	
NEW MEDICINES REVIEWS		
	SUMMARY OF DISCUSSION	**ACTION**
2023/385	**Brimonidine gel for the symptomatic treatment of moderate to severe facial erythema of rosacea in adult patients** This item went out for consultation with a proposed RAG rating of Green Restricted, with two responses being received by the closing date, one from Fylde Coast and the other from East Lancashire. Both responses recommended Green. It was noted that the reason for assigning a proposed Green Restricted rating is that licensing for the drug is broader than the proposed position as it is not restricted to moderate to severe rosacea. This item is currently available in Pan Mersey and GMMMG who both have it as a Green RAG rating. There is evidence from two trials of four weeks duration which showed a positive treatment benefit in 25-30% of patients versus 10% patients who received a placebo and a longer-term study showing treatment effect continues up to 12 months. There are some minor skin reactions, but no other notable safety issues were identified. If made available, it would bring the area in line with the rest of the Northwest. There were some discussions around what the cost implications may be, but it was felt by the team with the added restriction as proposed to patients with moderate to severe rosacea it would mean a smaller number of patients receiving the treatment, so it is not expected to have a significant cost pressure. MP added that the response for Fylde Coast should have been Green Restricted not just Green. The group discussed how easily it would be to determine moderate to severe rosacea and AC commented that he didn't feel it required a pathway. AW added he felt it should be kept away from dermatology and kept in primary care in line with the restrictions included in the recommendation. The group agreed for a Green Restricted RAG rating for moderate to severe facial erythema of rosacea in adult patients. <u>Action</u>	

	Brimonidine gel for the symptomatic treatment of moderate to severe facial erythema of rosacea in adult patients, to be presented at the next Commissioning Resource Group with a recommended RAG rating of Green Restricted for approval.	**BH/DP**
2023/386	**Ibandronic Acid 50 mg Tablets (Bondronat®) for the adjuvant treatment of early breast cancer in postmenopausal women with a high risk of recurrence (unlicensed indication)** The request for this item is for the use of Ibandronic acid for patients with early breast cancer in postmenopausal women. The requested position is off label as the licensing supports breast cancer with bone metastases whereas the request here is for early breast cancer. It was highlighted that NICE recommends Bisphosphonates in this patient cohort but doesn't mention Ibandronic acid, the NICE guidance pre-dates the evidence in support of this indication. There is a significant size meta-analysis which shows that *'adjuvant bisphosphonates reduced the risk of breast cancer recurrence'.* There is also a RCT which compares different bisphosphonates and shows that there is no efficacy differences between the different bisphosphonates. Currently patients will be coming in for IV infusions which is causing an impact on cancer services. It is estimated that around 10% of patients could move off the IV infusions onto Ibandronic acid. The cost impact is around £30,000. Pan Mersey and GMMMG do not currently have a position for Ibandronic acid in this cohort so Lancashire & South Cumbria would be the first to make it available in the region. The consultation document recommended it as Amber 1 Shared Care due to the off-label nature, the monitoring requirements are not large. The responses received demonstrated a request for Amber 1 or Amber 0. UHMB requested Amber 2 which was the response from a chemotherapy oncologist, however BH felt they may believe that Amber 2 is shared care. The group discussed the item, It was asked if there had been a cost comparison of this drug to the cost of a patient coming in and having an IV infusion. BH said that a comparison had been undertaken against the tariff cost and it did show as a cost pressure. He added while it does show a cost pressure against the tariff cost, there is also the impact on service which needs to be considered. AC raised the possibility of adding restrictions and have it only for patients who have difficult venous access who aren't able to have the infusion to help with additional costs. SR asked if this would meet the criteria for shared care as the criteria has been previously agreed. LR asked if there was a way to record the reduction in activity within the efficiency savings from a system wide perspective as there would be an additional pressure added to primary care prescribing. AC agreed with her point and said it is important to note the savings will come from the acute sector while recognizing there will be an increase in the prescribing spend. DJ commented that their main priority from his perspective was to release capacity at their chemo units, adding any released time would be utilized by getting more patients in and started on chemotherapy. It was agreed by the group that this would be the right thing to do in relation to quality and patient experience. AC asked if something could be added to the front page highlighting the cost savings to the system, being mindful not to go into too much detail as this could slow the process of getting it approved. CM asked if other areas had been able to get any GP input relating to this as she had not been able to and while she agreed it is a good idea, she wanted to ensure it had been viewed by all the relevant areas. LR added she had received GP input. MP stated that while she	

	didn't specifically have GP input, that upon reflection she felt it could be an Amber 0. She would support Amber 0 due to the minimal monitoring required and that bisphosphonates were extensively prescribed in primary care. AC returned to SR's earlier comment about if this meets the criteria for shared care. BH answered that the difference between Amber 0 and Amber 1 came down to two main points. Amber 0 states little or no specific monitoring required whereas Amber 1 states minimal monitoring required. The second point is how much supporting information is needed, so Amber 0 would be a brief prescribing document whereas Amber 1 would require a full prior agreement detailing how the patients ongoing care must be reached under a shared care agreement. He added the reason for the proposal of an Amber 1 instead of an Amber 0 was due to the off license use as other bisphosphonate indications were rated as a Green. But that the monitoring for this indication would be no different. The group agreed for an Amber 0 RAG rating. ***Please note* -** *Upon reflection of the draft minutes for this meeting it was determined that it was not made clear in discussions the intention for this drug is for all patients which meet the above criteria to help with cancer unit capacity. This was highlighted in the original paper which was sent to the group. It was agreed at the meeting for use for all patients and this was also confirmed at the meeting held on 12.10.2023.* Action Ibandronic Acid 50 mg Tablets (Bondronat®) for the adjuvant treatment of early breast cancer in all eligible postmenopausal women with a high risk of recurrence (unlicensed indication), to be presented to the next Commissioning Resource Group with a recommended RAG rating of Amber 0 for approval.	**BH/DP**
	Flupentixol dihydrochloride tablets for treatment of schizophrenia and other psychoses This request came from SR and LSCFT regarding the RAG position for Flupentixol as it is currently Do Not Prescribe for depressive illness and schizophrenia and other psychoses. The requested change is to Green for schizophrenia and psychosis and 'Do not prescribe' for depressive illness. While there is a general agreement around the drug's use, there has been some debate around the position in the responses with LSCFT wanting the Green, Fylde Coast recommended Amber 0 and East Lancashire ICB have recommended Amber 1. Currently on LSCMMG the other first-generation antipsychotics are Green; however, all second-generation antipsychotics are shared care. With some of the comments for Amber 1 and having a shared care, BH asked if this would fit the criteria for a shared care as it would then make it different to all the other first-generation antipsychotics as they are all Green. BH added that the consensus was people were happy to keep it as 'Do not prescribe' depressive illness. SR added the need for consistency, and this would mean a Green status, and that she didn't want to start doing shared care agreements for first generation antipsychotics. She added doing so would put the area in a different position to the rest of the region and possibly the country. She also said she was aware that Flupentixol would probably be specialist initiation so would be happy to accept Amber 0 but would be reluctant to	

	go down the shared care route for this drug. MP highlighted that that their comments were more around its place in therapy, and when it was explained to them which led them to the Amber rating rather than a Green as it wouldn't be initiated by a GP. CM added that they had similar reasons discussed for their position of Amber 0 as GPs wouldn't be initiating this drug. DR added in the chat from a Morecambe Bay perspective, FP felt the status should be Amber 1 due to the monitoring and ongoing specialist input. LR agreed with the comment from DR and said that they came to the same conclusion which resulted in the Amber 1. She added she felt the need for careful monitoring of these older antipsychotics that don't have shared cared when there are newer drugs with shared care. SR responded that the side effect profiles are different as the first-generation antipsychotics there are more extrapyramidal side effects whereas with the second generation there are more concerns with cardiometabolic disorders. LR highlighted that that there is work ongoing with trying to deprescribe these types of drugs especially in the frail and elderly particularly within care homes. AC asked the group if they agreed that the monitoring seems to be the issue and then asked SR for her to explain the monitoring required. SR responded that the monitoring required is for blood pressure, pulse, BMI, lipid and blood glucose annually which would be done anyway for someone on the SMI register. AC said that it did not sound significant and asked if while doing the monitoring if they would be required to take someone off the medication. SR highlighted that primary care would not be expected to remove a patient from therapy as a result of monitoring and added that if it is noticed that the patients cholesterol has gone up for example then the GP may need to start them on a statin but that this was standard GP practice. AC asked BH if this RAG decision was similar to the last item around the decision for either Amber 0 or Amber 1. BH responded that if there weren't historical RAG positions, looking at the monitoring requirements then it would possibly fall into an Amber 0, however the group need to be aware that we would be giving it a different RAG position from any other antipsychotics. The group agreed on an Amber 0 position for this item. <u>Action</u> Flupentixol dihydrochloride tablets for treatment of schizophrenia and other psychoses, to be presented to the next Commissioning Resource Group with a recommended RAG rating of Amber 0 for approval. It was noted that the Do Not Prescribe position for depressive illness would remain.	**BH/DP**
2023/388	**Sodium fluoride 1.1% toothpaste for treatment of head and neck cancer patients who have had surgery, radiotherapy and/or chemotherapy are often left with severely dry mouths, restricted mouth opening, and reduced access for toothbrushing or professional dental care (abbreviated review)** This request came from a consultant in restorative dentistry at LTH who wanted the review of the RAG position. It is currently Red and recommends that it comes from a specialist or dental services. Across the borders there are different RAG positions, Pan Mersey have it as Amber recommended and GMMG have it as Grey/ Green specialist advice. BH added he felt after looking at the details they were both in line with a Lancashire and South Cumbria RAG rating of Amber 0, but asked AW to	

	clarify. AW responded that the Manchester position effectively means it is restricted. This had previously come to LSCMMG in July and a small review was requested. As this is a high concentration Fluoride toothpaste, there are some risks of over fluoridation of the teeth however BH felt it was generally fairly safe. The aim for today was for discussion on whether based on the information in the paper would the group be comfortable to consider changing the RAG from the current Red to either a Green Restricted or an Amber 0 that would be advised by a specialist. LR commented that they had previously had a similar request and changed from Red to Amber as under the RAG definition the recommendation to prescribe would have to come from a specialist. And that if it was made Green that a GP would be able to initiate treatment, which had become problematic in the past with lots of people getting high fluoride toothpaste on prescription. BH added that by definition all the patients requiring this would be under a specialist anyway. The group agreed for it to move to Amber 0. <u>Action</u> Sodium fluoride 1.1% toothpaste for treatment of head and neck cancer patients who have had surgery, radiotherapy and/or chemotherapy are often left with severely dry mouths, restricted mouth opening, and reduced access for toothbrushing or professional dental care, to be presented to the next Commissioning Resource Group with a recommended RAG rating of Amber 0 for approval.	**BH/DP**
2023/389	**Bempedoic acid review update** BH brought this item. He stated that there is NICE guidance for Bempedoic acid which states that it is recommended by NICE in combination therapy and that it doesn't recommend it for use as monotherapy. There are two requests brought in the paper: The first is to change the existing RAG position from Amber to Green, the second is to consider its use as monotherapy. **Monotherapy** DP has reviewed the NICE guidance to find the basis of their recommendation to not recommend Bempedoic acid as monotherapy and he found the following: it wasn't considered for monotherapy due to the proposed position of Bempedoic acid in the treatment pathway, NICE felt it should be restricted only to patients who had ezetimibe at baseline. The evidence considered by NICE included patients who are on monotherapy or combination with ezetimibe, so there is some evidence of patients just receiving monotherapy. NICE only looked at this and felt that their decision was an appropriate part of the treatment pathway. There is now evidence that shows that Bempedoic acid has a mortality benefit in terms of cardiovascular events. BH added that when NICE considered Bempedoic acid, they estimated that based on its reduction on cholesterol what the mortality impact would be. The new study confirms the estimate made by NICE, so they have proven the estimated mortality impact. BH highlighted that DP hadn't discussed in the paper that Bempedoic acid comes in both a combination product and as a single monotherapy tablet and that they both cost the same. This means that Bempedoic acid as a combination product with ezetimibe is more cost effective.	

	AW shared in the chat the pathway for primary care initiation and asked if this would be a specialist drug or part of primary cares available prescribing. He added that there is the mortality data for this and not yet available for Inclisiran which is not due until 2026. BH highlighted that this related to the second ask of the paper, to change the existing RAG position for use in combination with ezetimibe from Amber to Green. AW stated that if is the same price as enhanced lipid reduction and there is the evidence base unless there was a known intolerance to ezetimibe why would you prescribe monotherapy. LR agreed with AW's comments and also asked if there was any indication on numbers of patients that would be intolerant to ezetimibe. BH responded that he wasn't aware of figures relating to intolerance however didn't feel it would be a large number. LR suggested speaking to cardiologists in terms if they feel there is a place for this and if they knew of any reasons, they would prefer to have their patients on Bempedoic acid. AC responded that the Lipid lead had stepped down so there may be a problem getting that kind of information. Both LR and AC said if it is small numbers there may not be a need to look into this further. DJ joined the discussion and said looking at the statin intolerance pathway patients can end up on this or potentially alirocumab and asked what the price comparison for those and any other costs associated with bringing patients into hospital to receive the drugs. BH responded that from memory Bempedoic acid was around £55 a month vs the alirocumab and others that are pretty expensive and are aligned with other monoclonal antibodies which are in the thousands. AC added that it is important that the cost elements to these decisions. MA said he was happy to go back and ask the questions around intolerance and patient numbers. AC thanked MA and said this would be very helpful to have the input from members in his team. AW asked if the pathway should be changed and that there be a preference instead of several consider medications. He suggested to defer the outcome and further discussions on this until MA has been able to ask the questions around intolerance. BH agreed and added that if it was placed after combination therapy then would feel like an appropriate place for it to go in the pathway. **Amend existing RAG Position** BH asked about the second request in the paper to the existing RAG position for Bempedoic acid in combination with ezetimibe from Amber to Green. Both AC and AW commented that it is in primary care in the pathway so would support it to change to Green. LR commented in the chat she felt it makes sense to have this as an option if cardiology felt it is a priority and also asked if it comes before Inclisiran in the pathway. AC said it isn't currently on the pathway so would suggest it comes after Inclisiran. It was agreed to change to a Green RAG status for combination therapy with the rational that it is already within the primary care prescribing guidance. <u>Actions</u> MA to take questions and discussions had here around patient intolerance numbers and if the specialists are looking to have it in place for patients that are intolerant to ezetimibe, and they are considering this as the next	**MA**

	step in treatment. BH to bring this item back next month for further discussion after MA's feedback. Bempedoic acid with ezetimibe as an option for treating primary hypercholesterolemia (heterozygous familial and non-familial) or mixed dyslipidaemia as an adjunct to diet in adults, to be presented to the next Commissioning Resource Group with a recommended RAG rating of Green for approval.	**BH** **BH**
2023/390	**New Medicines Review Workplan** There are a few items to consider before they go onto the work plan. The first is the transanal irrigation system Nova Smart requested by Fylde Coast. There are position statements for transanal irrigation systems where there was a review done of a device so this would be in line with what has been done previously. This was agreed to go onto the work plan. The second is for Docosahexaenoic acid 380mg, Eicosapentaenoic acid 460mh capsules (Omega 3-acid-ethylesers). This is for treatment of women at risk of preterm birth fitting and would align with the Northwest Regional Guidance. The request has come from LTHT. AW asked if this could be just adopted from the Northwest as it will have been through the correct processes. BH responded that he had not had sight of the document from the Northwest, and he isn't familiar with their processes but was supportive of doing a review of the documents and its processes and bring the findings back to the group to see if this can be just adopted or it needs a further review. AW added his thinking was for all items like this in the future if there is a process from Northwest or Regional that it is just adopted and suggested this discussion could come to the next meeting. DJ commented that he felt the fast-track idea would be good and to just look at any local implications that may need refining. It was agreed that a brief paper will come to the next meeting to give a basis on how this position was reached for people to agree or not agree. This was agreed to go onto the work plan. The third item is Acarizax 12 SQ-HDM oral lyophilisate for the treatment of house dust mite's sensitization and this was requested by ELHT. It was agreed to add this to the work plan. The fourth item is Symbicort which was requested by the ICB respiratory group. This request is due to a change from SPC. AC asked if there would need to be a full review and asked MP for her input. MP said that Symbicort is the first reliever that has gone for an extended license for the first presentation of asthma symptoms, she added that the respiratory group felt it should be a quick process. The final item was that Eluxadoline has been highlighted that is has had its removal of its marketing authorization and it is currently on LSCMMG. BH raised it to the group to inform them that it will be removed off the LSCMMG website. <u>Actions</u> Docosahexaenoic acid 380mg, Eicosapentaenoic acid 460mh capsules (Omega 3-acid-ethylesers) for treatment of women at risk of preterm birth fitting to be brought back to the next LSCMMG for consideration of whether it can be adopted.	**DP**

	AW and BH to consider a process for adopting other Northwest or Regional guidance in the future. Eluxadoline to be removed from the LSCMMG website.	**AW/BH** **AGR**
GUIDELINES and INFORMATION LEAFLETS		
2023/391	**Gout guideline – Update** AGR brought this update, the format has been updated to be in keeping with other LSCMMG guidelines and a few adjustments have been made but nothing material. AGR asked the group if they were happy with the changes and the new format before it goes onto the website. AGR clarified that the context remained the same it was just the format that had been changed. AW highlighted one error in the document with an incorrect title. AGR will amend this, and the group were happy for it to then go onto the website. Action AGR to amend title error and it to be uploaded to the website.	**AGR**
2023/392	**COPD desktop guideline update** BH brought this item. There have been a couple of changes to the desktop guidance to reflect the 2023 version of Gold and the Green agenda. The assessment tool has been revised and some slight changes made to positioning around LABAs, LAMAs and LABAs and ICS's. It went out for consultation and responses were received from Fylde Coast and East Lancashire which were supportive of the guidance. AW asked for the format to be changed to reflect the other guidelines such as the previous item and to just make it a little clearer, but the content was fine. MP acknowledged AW's comments on the format and said this could be looked at and as long as the clinical information was ok this would be done. It was agreed that the clinical information was fine, and it would be revisited for formatting. MP will circulate this to members for approval once it has been changed for approval. Action DP/MP to look at slight changes to the formatting to make it more aligned with other guidelines. MP to circulate the guideline to members once changes have been made for approval.	**DP/MP** **MP**
2023/393	**Requests from private prescribers to transfer or share prescribing with an NHS GP position statement** AGR brought this agenda item. The request came in over the summer, so this has been put together quite quickly. AGR pointed out that this is the draft version of the document, and the aim is to give GPs a good set of guidance and assistance on how to deal with requests from private prescribers to either prescribe or enter into a shared care agreement. The RDTC document was taken into account when developing this position statement and the recently updated good prescribing guidelines were also looked at. AGR asked the group if they were happy to consult on the document in its current format or if members wanted things changing. LR commented and said it was really helpful and thanked AGR for this. She asked how it could be circulated out to private prescribers and to	

	ensure they are clear on what the expectation is and that there will be pushback from GPs if the guidelines are not followed. AC said he felt it needs to be adopted and then spread out as wide as possible and added the longer it is out there for private prescribers to see the more it will become known. He suggested sending to groups such as mental health teams and then on individual basis for GPs to send out to show this is what is being worked towards. LR added she felt it would be good to go out for consultation to ensure all possible experiences are looked. It was agreed to go out for consultation. <u>Action</u> AGR to send out for consultation.	**AGR**
2023/394	**Cenobamate for focal seizure – RAG consultation** AGR brought this item. It was asked at the last meeting to consider a RAG change from Red to Amber 0. When the product was first recommended by NICE, Cenobamate was given a Red RAG status due to the quality of the clinical trials data included in NICE TA 735 and the lack of clinician experience. It was sent for consultation and there has been a few responses back and were broadly supportive of the Amber 0 RAG status. It was agreed to change the RAG position from Red to Amber 0. <u>Action</u> Cenobamate for focal seizure, to be presented to the next Commissioning Resource Group with a recommended RAG rating of Amber 0 for approval.	**AGR**
2023/395	**ELMMB Nefopam position statement - consultation** AGR brought this item. It was asked at the last meeting to consider a RAG change from Red to Amber 0. It was sent for consultation and within the consultation it asked if members were supportive of the intent of the position statement but that the format would be changed to match others. There were some good consultation responses, LSCFT responded with no and there was an additional response from the community pain service. Fylde Coast was a maybe with some queries and both UHMB and East Lancashire. Some of the concerns raised were that the community pain service did use the advantage of that it is a non-opioid analgesic and is easier to monitor in primary care. There was no mention of any circumstances of consideration for appropriate usage. Another point raised that it is sometimes used for inpatients so it was felt it may be more beneficial as a Red rather than 'Do not prescribe'. It was also raised that removing this option even if limited reduces the number of options for specialists to initiate and continue in primary care. To summarize it was broadly supportive with a possible and a no. MA commented on some of the points raised from a Blackpool perspective. He said there was discussion from a variety of specialties within the organisation and all were keen to keep this as an option. One of the points highlighted was around cost implications which MA said he thought it was based on the higher does which is not always the case, and added possibly revisiting this aspect to see where it would then be placed with the cost implication. Blackpool were against making the drug Do not prescribe but were in favor of keeping it as a specialist medication. AW commented his concern for having it as a Red was if when referring to	

	specialist pain clinics for chronic pain there is no repeat prescribing service within the clinics so said he felt it more to be specialist initiation opposed to ongoing care via the Red Status. He added that there is massive use of opioids at present and said he felt other alternatives need to be looked at for some potentially unpleasant things patients are one. SR agreed with AW's comments and added that this isn't something that would want to retain prescribing indefinitely in specialist paint services and that it is an alternative. DJ brought comments from his specialist pain team that isn't something they are recommending. There is a small amount initiated but that it must be under specialist, so he presumed it wouldn't be long term. He added if it was Red then the repeat prescribing shouldn't be an issue as the pain specialists are saying they are not using it. LR said she wasn't convinced with this one as the evidence base is weak, conflicting, or absent as stated in the paper. The adverse effects are very common and toxic in overdose so said she couldn't see a place for it in therapy. She added if approved she would be pushing for a Red or Do not prescribe based on the clinical evidence. AC likened this issue to the issues around Ketamine where the evidence is not there, but a small number of people may be on the drug for a very long period. LR added the drug also has a high abuse potential as well and said overall it doesn't feel like a great drug. AW asked if it was known the number of people using it currently and AC responded that from the responses received it looks to be a small number of patients. MA came in and said he could go back to his consultant community geriatrician and ask how long a patient would be expected to be on the drug, does he feel it would be chronic use or short term and if short term they would probably support the Red RAG status. AC responded that he felt this would be helpful as its not currently entirely clear about what patient population is being discussed. BH added in terms of usage in the last three months there has been 5000 items across Lancashire and South Cumbria, 3800 of those are Blackpool and Fylde and Wyre so significant use there and small usage elsewhere. This item will be brought up at a future meeting after responses are received. <u>Action</u> MA to go back to his consultant community geriatrician to get more information on the specific patient group.	**MA**
2023/396	**Erectile dysfunction guideline – update** Avanafil was approved prior to this meeting and was given a Green Restricted RAG position and added to the pathway. The changes made to the document were highlighted in red for members to see, AGR asked the group if they were happy with the changes and would approve the document before it goes onto the website. DR had a comment from FP who asked for it to be included in the minutes that NHS England had retracted the statement on once daily dosing. This was released on the 3rd of August, and it was retracted later in the month. CM added that there was a change in the guidance, but it was quickly removed, and FP's comments was put it when it was in the guidance and	

	suggested a review of LSCMMG guidance, but this is no longer needed as the added point In the guidance has been removed. This was approved by the group with the change of Black to Do not prescribe wording. <u>Action</u> AGR to amend the wording from Black to Do not prescribe and add it to the website.	**AGR**
	Sodium Zirconium Cyclosilicate – update This item was brought to the meeting in May, and it was agreed that Sodium Zirconium would remain as a Red RAG status. This was because of primarily patient numbers and the ongoing monitoring requirements along with the limited evidence base. However, it was agreed that if the numbers or usage increased then it would be reviewed. Some extra information has come from LTH and on that basis there has been an increase in use. When it was first looked at there was 900 sachets of Sodium Zirconium being used in renal patients, that has now increased, however the figures only cover outpatient and were unable to give figures for other departments which needs to be considered. LTH asked for the group to look at the Amber RAG position in the neighbouring ICBs. GMMMG estimate that there will be 3-5 patients per GP practice on Sodium Zirconium and there was also specialist support for the Amber as well as at the trust. AGR asked the group to consider the additional information and ask if the group wanted to put an extra period of consultation or if they would like to maintain the Red status. DJ commented that it is a 43% increase of patients on Sodium Zirconium longer term but added that not all of these patients would necessarily come under the renal team. There are for example patients with cardiovascular reasons that are trying to maintain on ACE inhibitors which wouldn't come under the renal team, so this is an added pressure to the service. AW asked for clarity if this would hopefully prevent further admissions and keep patients safe in the community, he added this is potentially about the financial impact as well and people not being escalated up. DJ responded there is an element of that and bring able to maintain patients on other treatment such as heart failure treatment so there are longer term health outcomes. He added he felt this isn't necessarily using this that much in the acute hyperkalaemia phase, and that the data excludes any inpatient usage costs which is more often treated. AW then asked if the GMMMG figures are correct in being around 600 to a thousand patients if that number felt realistic. DJ was unsure as the renal consultants operate in clinics on other sites and those prescriptions go through the outpatient pharmacies in that organisation which would show the missing data and that there will be numbers to be added to the figure estimated by GMMMG. AW said this felt like it is moving away from very specialist care and asked the group if they felt it should be shared care or Amber 0 such as LTH has requested. He added the rest North West seem to be going for Amber 1 equivalent. AGR stated there isn't a national shared care for Sodium Zirconium so one would have to be developed if that was what was wanted. DJ commented that there are examples in other organisations that could be used to support the development of a shared care. BH added that there is	

	currently very limited prescribing in primary care as there was 24 prescriptions in the last three months. MP highlighted that when this was first looked at there was an example shared care and it was very complicated and as a clinician picking it up looked very confusing which she felt was one of the problems in the beginning when discussing shared care for this drug. She added she felt there was a lack of confidence with actually dealing with it depending on the numbers, and if shared care was considered it would need to be looked at in detail to make it as clear as possible for prescribers. BH asked with North West working would it be worth picking up an existing shared care document from one of the ICBs and bring it back to the next meeting for discussion about the reality of what it would mean in terms of monitoring and try to pick that up as a North West wise shared care. AW agreed with this idea and said he would support this; he asked the group if they were happy with this approach. LR added she had similar concerns from a GP that MP raised and said she would forward the email to AGR for him to consider with this piece of work. <u>Action</u> LR to forward concerns from GP around monitoring and reducing potassium levels. BH/AGR to look at bringing an adopted shared care agreement from another ICB to the next meeting for the group to discuss.	**LR** **BH/AGR**
2023/398	**Melatonin** BH presented this item. He added that the word document was very lengthy however this was due to it being the third time this has been brought back to the group for discussion. The document has been reviewed and updated following the two previous consultations and the responses received from the last one is on page 17 of the document. The two responses received during August were from Fylde Coast and from East Lancashire. It was noted that they didn't have GP input the responses were largely supportive and there were some comments around the use of Melatonin and ADHD, however BH felt these were issues outside of the pathway. ON page 16 are notes following discussions at July's LSCMMG meeting. BH asked if members were happy with the updated documents following comments. AB commented that comments from her Paediatric Directorate Pharmacist were missing from the paper and that they may have been sent out on the 5th of September. She added it was quite lengthy and put the comments in the chat function. AW asked if it was generally supportive or against to which AB said she was unsure as there are quite a few points. JG who coordinated the responses and the document was present today and said in response to AB that there had been liaised a lot with East Lancashire Pharmacy and their Paediatric department and that she had just skimmed over the comments and that they looked fairy reflective, and she hoped this would be reassuring to her. However, she added she will look over the comments again to check nothing was missed. BH asked the group if they were happy for JG to review the comments from AB to make sure nothing that needs to be changed and that pending	

	this the document is approved. He added that if it is felt that there are things that need to be changed a final version of the document will be brought back to the next meeting for discussion. AW suggested the same but approval via chairs action if needed instead of bringing it back again. The group were happy with this. SR commented that looking through AB's comments they seem to have already been covered by feedback. She added that there was a lot of feedback around commissioning of services and asked if this is something that needs to be escalated or if this is already in process. AW responded that the first thing would be to get the document done and then take to either the new group CEG or the Commissioning Reference Group and state that there is a lack of commitment of consistent services and therefore it has not been able to be implemented and requesting a change. AW asked if JG had a feel for the inconsistencies described and she responded that it was a big thing highlighted in the comments and so the document took the approach of providing information on what is currently there instead of what can and can't be done as there is a lot that can't be done but JG felt this was outside of the scope of the document. She added that the document can be updated to reflect changes made in the future. The document was agreed by the group pending final checks from JG and approval by AW. Following finalising of the document, RAG changes would be agreed and taken to a future meeting of the CRG. <u>Actions</u> JG to review comments put forward by AB and make any material changes if required and forward to AW for final approval. Following finalising of the document, RAG changes would be agreed and taken to a future meeting of the CRG.	**JG** **BH**
2023/399	**Lithium shared care guideline – proposed update by LSCFT** AGR brought this agenda item. The current lithium shared care guideline lists the adverse effects and actions to be taken if the level is of the target range, the wording is from the SPC. LSCFT have recommended a change of wording which they have sent through which is more useful. The ask is if the group are happy to replace the old wording from the SPC with the new wording from LSCFT. AGR added he didn't feel this would require a consultation but if the group felt differently this would be done. AW asked why the national protocol wouldn't be adopted and is this a deviation from that national protocol or why would you retain a local one. SR provided some context to this change; it was reviewed after a serious incident where a patient died and there was a lot going on including acute kidney injury, but lithium toxicity was also implicated. They have been doing some GP training in a particular locality but feedback they received was it would be good to have more helpful guidance for GPs on what to do in response to different levels. SR added she was unsure if the new wording was taken from the national protocol but would check. AW said that it seems sensible in terms of the changes particularly with the background context given. He added that the national ones are due to be updated so this may mean this document is ahead of where national is, but he just wanted to make sure it wasn't working backwards. The wording was approved by the group.	

	Action AGR to put the amended document onto the LSCMMG website.	**AGR**
2023/400	**DMARD shared care guidelines – extension of expiry date** AGR brought this item. The DMARD shared care guidelines expiry date was previously extended by 6 months while it was decided if the national shared care guidelines would be adopted. This however has not yet been decided. There is an ongoing piece collaborative piece of work with other APC areas in the North West such as Pan Mersey and GMMMG and things are moving towards having a North West approach. As this is still ongoing AGR asked the group to again extend the expiry dates of the current DMARD shared care guidelines by 6 months. He added that the clinical information is accurate and up to date it is the pathway that may change. It was agreed by the group to extend the DMARD share care guidelines expiry date by 6 months while collaborative work is ongoing. Action AGR to extend the expiry date on the LSCMMG website by 6 months.	**AGR**
2023/401	**Scabies treatment pathway** LR brought this item. She gave some background, there have been quite a high number of outbreaks of Scabies in care homes particularly in the East Lancashire and Blackburn with Darwen areas. Due to this it was felt that a clinical operation pathway was needed as care homes weren't sure what they needed to be doing in terms of treatment, intervals, contact and contract tracing amongst other things. UKHSA have already put together a pathway which is on the second page of the document, and this has been incorporated into this treatment pathway. The document has had input from dermatology, infection prevention and control, and GPs so has been viewed by a wide range of specialists. LR added that the document it not perfect but has the links to the national document and gives some guidance on what UKHSA and NICE say in relation to this. The document also allows practices to have some sensible advice in terms of practice and care homes and what to do with patients. LR added there is still a supply issue and said that after another outbreak this week they are struggling to replenish stocks of Permethrin. She also stated that there some issues around resistance to Permethrin so there are more and more requests for Ivermectin. But there has been some pushback from GPs for prescribing Ivermectin due to the unlicensed nature and them not being familiar with it. It is also hoped this document will help with quicker diagnosis to help patients get effective treatment sooner. AW commented that the document has been through clinical inputs and was agreed but it was felt it may be good to get approval from this group and add the LSCMMG branding to give it legitimacy across the patch. NB came in and asked how the stock issue is going to be managed and asked if this is detailed in the document. LR responded that what they have had to do is to treat symptomatic patients rather than contacts which she added was not ideal, but that UKSHA were aware. AW asked if it was worth having a sentence put in around treating symptomatic patients only if unable to acquire stock and LR responded that UKSHA were not keen for this as it is against the guideline although they accept this is what is having	

	to be done practically at the moment due to stocking issues across the country. AW also added that the drug is now licensed but not marketed so it is off license rather than unlicensed. CM commented that the document looks good and added that there are some contact information details for Medicines Optimisation teams across the patch and CM wanted to know if rather than having individuals' emails such as hers for central was there a generic email or an alternative phone number that could be put on in case of absence. LR said she wasn't aware of any generic ones but if people had them, she would be happy to add them. LR added about putting any generic contact information also on the LSCMMG website on the local team contact's page. AW concluded to look at alternative contacts as a secondary item and firstly to get this document out as soon as possible for people to have sight of. <u>Action</u> The document to have LSCMMG branding added and can then be circulated out to members to further circulate to relevant prescribers.	**LR**
2023/402	**Blood glucose and Ketone device monitoring recommendations** Before BH presented this item AW commented that there was a national intervention stating there a large overspend and this was one of the four main areas where the ask is to consider adopting it quickly to get the greatest number of savings. BH brought the item and echoed AW's comments that there is a national guidance produced by NHSE and there is some pressure on the ICB to look at adopting, this paper is a summary of the recommended devices. It relates to both Glucose testing strips and lancets. BH added the question he had was how it can be made easy to look at supporting places with any sort of changes. Looking at usage, in the blood glucose testing strips around 50% of all strips are used are the non-recommended ones which is equivalent to 60% of the costs. This is around 20,000 items per quarter of non-recommended testing strips. Lancets are similar trends but in smaller numbers so around 30% of items are non-recommended and that is around 6000 items per quarter. Adding the two together becomes around 27,000 items per quarter. The question for the group is should the NHSE recommended items be adopted, those of which are highlighted in the paper, and how to target when up against such large numbers. He added initially he felt putting something in the value report would be good but then acknowledged that this may dampen down the rest of the report. AW commented that there are some areas that have done this already so they will have some learning on this, and that he has had one company approach him and offer help in rolling it out. He added agreement needs to be made on which items to use as preference rather than do things based on who is willing to support in the roll out. LR commented that they had been approached by a company they have a good working relationship with who's product is one on the recommended list, she would feel more comfortable working with a company like this that they have a good working relationship with. CM commented that there was an ask to trusts about their contracts and mapping them to the national formulary, she asked if there was any feedback received regarding this. BH responded that he was unsure of	

	what came back to DP. SR commented for LSCFT they would always follow the acute trusts so it may differ in different localities for LSCFT. AW suggested clearing the diabetes centres of anything not on the preferred list and ban reps from putting anything in there other than those items on the preferred list. He asked if members could take that back to trusts to try get the principle agreed if possible. BH described the document to the group. It lists the recommended devices for both lancets and test strips. He asked if the group supported these recommendations from the NHSE guideline, and what would need to be considered for implementation. LR suggested in the chat taking it to the Diabetes Health Improvement board to ask for support. AW agreed this would be very helpful. AW asked if the requirement was to adopt the national recommended list or if there was going to be a smaller list containing less than the national one. BH responded that currently it is to adopt the national recommended list and then in have discussions about if there is a need to tighten up the list as some might need to be prioritized. LR said that with slimming the list down to reduce confusion and people get used to what they are given to use. AW agreed this point. The document is to go around for consultation to all trusts and localities around slimming the list down. AW asked who would be able to contact other companies around support for roll out. BH responded that he and the team should be able to try to engage but asked if it would be better coming here or through the health improvement board. AW commented that some of the items were only launched a few months ago so there won't be a lot of existing usage so historic patterns may not be helpful in this situation as they have been in the past. AW also suggested a maximum of two in each category to allow for stock issues. BH asked members to also highlight any first line items that they have utilized or used in the past and how it went so he and the team can try to get some feedback to companies. AW asked to add confidentially how implementation support was. LR commented that she was happy to take the paper through the health improvement board as they have expertise and specialists within the group that may use things every day that others could possibly miss. It was agreed for LR to do this step first to enable a shorter list of companies for BH and the team to engage with based on the health improvement boards feedback. AW added this needs to be done quickly as this will be performance managed so responses need to be returned as soon as possible. <u>Actions</u> LR to take the document to the health improvement board and feedback comments to BH. The document to be sent out for consultation to all trusts and localities once an amended document is agreed by the health improvement board.	**LR** **DP/BH**
	Guidelines workplan Before AGR brought this item, AW raised that DJ had a request for clarity on the macular drug preferences. He added that Sharon from the Hub team had a good pathway drafted and that there is interest for a Northwest approach to adopting a macular pathway. AW asked if the draft could be	

2023/403	shared to the Northwest if possible and others in terms of prioritization. LR commented that it would be helpful and asked if someone could link in with the lead commissioner for the ICB Donna Parker on this if this is happening at ICB level as she has received an email requesting information on alternative biosimilars. She was unsure if it was just for one area or across the patch. AW agreed this would be a good idea and would join up conversations. BH said he would be happy to share the document with the Northwest, he would check with Sharon from his team as she drafted it to ensure the right one is sent out. DJ had an item of AOB which was added here. It is in relation to the Biosimilar statement which refers to compounded biosimilars which currently is Flixabi which is a brand of Infliximab. At the time this was the cheaper however the original item is now cheaper than this, so they are wanting to change. However, the statement talks about agreement at ICB level, financial year and they don't want to hold back and miss out on any savings, but DJ wanted to clarify the process before anything was switched. AW responded by suggesting a Biosimilar statement that says the cheapest acquisition cost biologic or biosimilar is the preferred product. The group discussed this and agreed the wording could be changed and simplified in the statement. DJ asked if they are allowed to make the switch and the savings will be worked through, AW agreed with DJ moving forward with the switch and the paperwork can be worked through after. LR raised an email she had been included in which had discussions for an interim pathway which looks to be based of a NHS West Yorkshire ICB pathway. AW said they had been made aware of two, one from West Yorkshire and another from East Yorkshire and Humber and when they were compared to the local pathway it was felt the local pathway was more comprehensive. AW asked BH to send the local pathway and the other two to the Northwest medicines optimization group as a draft and ask them if they would consider it going forward as a Northwest approach. LR asked for this to be made clear to commissioners and BH responded by asking her to point Donna in his direction. She said she would forward the email to BH. BH also to send it around this group for people to view. There were no other items to discuss for the workplan. <u>Actions</u> BH/AW to check they have the correct document via Sharon Andrew to send around in relation to clarity on macular treatment preferences. LR to forward email from Donna Parker in relation to commissioning and the biosimilar pathway. AW to send all three macular pathways to the Northwest Medicines Optimization group for discussion and the ask of adopting the local pathway as a Northwest approach. BH to also send pathways around this group for members.	**BH/AW** **LR/BH** **AW** **BH**
NATIONAL DECISIONS FOR IMPLEMENTATION		

2023/404	**New NICE Technology Appraisal Guidance for Medicines July/August 2023** There was one NICE TA which was TA906 Rimegepant for preventing migraine. There is a cost pressure of £158,000 per annum and it reduces the frequency of attacks by 50%. GMMMG, Cheshire and Mersy are considering an Amber 0/1 RAG status for this and AGR felt it sits well with an Amber 0 as there is no particular stringent monitoring required. AGR asked the group as the other areas have not decided on a RAG did they want to wait and see what they decide on or make their own decision and added he felt it would sit well within an Amber 0 RAG and it is not PR excluded so there is no need for a Blueteq form. It was agreed to assign an Amber 0 RAG position and to confirm the approach taken by Cheshire and Mersey and GMMMG. AW added that taking into account that its probable that it will be made clear on the non-compliance with Wegovy due to what was discussed in previous conversations around commissioning of services, is there a need for a short statement to be sent up to CRG to say this. As even though there is a cost pressure if it is implemented AW didn't feel that there is any likelihood of being able to implement it. **<u>Action</u>** Rimegepant for preventing migraine, to be presented to the next Commissioning Resource Group with a recommended RAG rating of Amber 0 for approval. To confirm the approach taken by Cheshire and Mersey and GMMMG at the next meeting.	**AGR** **AGR**
2023/405	**New NHS England medicines commissioning policies July/August 2023** N/A	
2023/406	**Regional Medicines Optimisation Committees - Outputs July/August 2023** N/A	
2023/407	**Evidence reviews published by SMC or AWMSG July/August 2023** There is one item on page 7 that has been highlighted for review. This is Apalutamide for non-metastatic carcinoma and cancer. BH was not convinced that the cancer drug fund covers this drug for this indication, however, it was agreed to do nothing at this stage unless a request is received by the group.	
ITEMS FOR INFORMATION		

2023/408	**Lancashire and South Cumbria NHSFT Drug and Therapeutic Committee 20th July 2023 –** The team didn't have the document at the time of circulation. SR will send the document round to members. She asked if they are still wanted as she is minded that other Drugs and Therapeutics (D&T) committees don't bring their information here. AW said he was not sure how this would fit in with the current formulary working group and asked BH to bring this back to the next meeting. BH agreed and said there also needs to be a process on how LSCMMG interacts with other formularies and different places. DP will be contacting people, and this will be ongoing over the next few months. <u>Actions</u> SR to circulate the document to members. BH to bring discussions around D&T group feedback to a future meeting.	**SR** **BH**
2023/409	**LSCMMG cost pressures log** This was circulated with the Scabies document. All cost pressures identified withing the agenda have been added to the log.	
2023/410	**AOB Items** 1) This meeting was AC's last meeting as chair as he has been asked to chair the new Clinical Effectiveness Group that has been formed. Members thanked AC for his input for this meeting and AW added he will be chairing in the interim until hopefully someone from a clinical background will be able to chair. 2) AW highlighted the proposed process for the formulary work. The team plan to use UHMBs net formulary as a donor formulary and have that informed by East and Central formularies. The hope is that this will speed up the process slightly and added if people cannot make the meeting this afternoon to please send any responses back as soon as possible. AW also added in light of AW stepping down as chair of LSCMMG and him taking over in the interim he shouldn't be chairing the formulary meeting so asked for anyone interested in chairing that meeting to come forward and let him know.	

DATE AND TIME OF NEXT MEETING

The next meeting will take place on

Thursday 12th October 2023

9.30am – 11.30am

Microsoft Teams

ACTION SHEET FROM THE
LANCASHIRE AND SOUTH CUMBRIA MEDICINES
MANAGEMENT GROUP 14.09.2023

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. **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. **July 2023 update**: Expected to be on the agenda for the September 2023 meeting. **September 2023 update:** On the agenda, closed.	**DP** **DP** **DP** **DP** **DP** **DP/BH**	**Closed** **Closed** **Closed** **Open** **Open** **Closed**	**09.03.2023** **20.04.2023** **11.05.2023** **08.06.2023** **13.07.2023** **14.09.2023**
	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.	**AGR** **AGR**	**Closed** **Open**	**09.03.2023** **20.04.2023**

	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®. **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.	**BH** **BH**	**Closed** **Closed**	**20.04.2023** **11.05.2023**
	MLCSU to contact Jenny Oakley to ascertain which drugs are being requested by clinicians in intensive care to manage COVID.	**AGR**	**Closed**	**11.05.2023**
	AGR has some other people to contact which he will do after this meeting.	**AGR**	**Closed**	**11.05.2023**
	July 2023 update: AGR has met with Jenny Oakley about drugs used in intensive care for COVID and Jenny is at the meeting to discuss.	**AGR/JO**	**Closed**	**13.07.2023**
	Wegovy EIRA and paper produced and presented to the Commissioning Resource Group to escalate to the ICB to consider further action.	**BH/PT**	**Closed**	**13.07.2023**
	BH to share the CRG paper with the group. NB to contact the chair of the Commissioning Resource Group to discuss the communications around weight loss service provision and liaise with complaints team to ensure that the necessary information is being collated.	**BH/NB**	**Open**	**13.07.2023**
	September 2023 update: There have been some emails earlier this week discussing this discussing Wegovy being made available through their three weight loss clinics but not through Diabetes clinics. A paper summarizing this item will be	**BH**	**Open**	**14.09.2023**

	taken to the Commissioning Resource Group.			
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**: Waiting for it to go the next Medicines Policy Subgroup, which is due to be held on 16th June 2023. **July 2023 update:** David Levy has requested all outputs from the LSCMMG go to the Commissioning Resource Group (next meeting 2nd August 2023) **September 2023 update:** This item went to the Commissioning Resource Group and was approved, closed.	**DP** **DP** **DP** **BH** **BH**	**Closed** **Closed** **Closed** **Open** **Closed**	**20.04.2023** **11.05.2023** **08.06.2023** **13.07.2023** **14.09.2023**
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. **June 2023 update:** Waiting for it to go the next Medicines Policy Subgroup,	**DP** **DP** **DP**	**Closed** **Closed** **Closed**	**20.04.2023** **11.05.2023** **08.06.2023**

	which is due to be held on 16th June 2023. **July 2023 update:** David Levy has requested all outputs from the LSCMMG go to the Commissioning Resource Group (next meeting 2nd August 2023) **September 2023 update:** This item went to the Commissioning Resource Group and was approved, closed.	**BH** **BH**	**Open** **Closed**	**13.07.2023** **14.09.2023**
ACTION SHEET FROM THE MEETING 11th May 2023				
2023/317	**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 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. **July 2023 update:** David Levy has requested all outputs from the LSCMMG go to the Commissioning Resource Group (next meeting 2nd August 2023) **September 2023 update:** This item went to the Commissioning Resource Group and was approved, closed.	**DP** **DP** **BH** **BH**	**Closed** **Closed** **Open** **Closed**	**11.05.2023** **08.06.2023** **13.07.2023** **14.09.2023**
	TheraBite® Jaw Rehabilitation Device for the treatment of trismus and mandibular hypomobility			

2023/318	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.	**DP**	**Closed**	**11.05.2023**
	June 2023 update: Will go to the next Medicines Policy Subgroup on 16th June 2023.	**DP**	**Closed**	**08.06.2023**
	AS to feedback discussion on the Red RAG decision to MaxFax specialists.	**AS**	**Closed**	**11.05.2023**
	June 2023 update: AS fed back to specialists and they have started prescribing the product.	**AS**	**Closed**	**08.06.2023**
	July 2023 update: David Levy has requested all outputs from the LSCMMG go to the Commissioning Resource Group (next meeting 2nd August 2023)	**BH**	**Open**	**13.07.2023**
	September 2023 update: This item went to the Commissioning Resource Group and was approved, closed.	**BH**	**Closed**	**14.09.2023**
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**	**Closed**	**11.05.2023**
	June 2023 update: Will go to the next Medicines Policy Subgroup on 16th June 2023	**DP**	**Closed**	**08.06.2023**

	July 2023 update: David Levy has requested all outputs from the LSCMMG go to the Commissioning Resource Group (next meeting 2nd August 2023) **September 2023 update:** This item went to the Commissioning Resource Group and was approved, closed.	**BH** **BH**	**Open** **Closed**	**13.07.2023** **14.09.2023**
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. **July 2023 update:** David Levy has requested all outputs from the LSCMMG go to the Commissioning Resource Group (next meeting 2nd August 2023) **September 2023 update:** This item went to the Commissioning Resource Group and was approved, closed.	**DP** **DP** **BH** **BH**	**Closed** **Closed** **Open** **Closed**	**11.05.2023** **08.06.2023** **13.07.2023** **14.09.2023**
2023/323	**Sodium Zirconium Cyclosilicate – Evidence Review** AC and AW to consider the best avenue for work relating to Heart Failure to be progressed.	**AC/AW**	**Open**	**11.05.2023**

	June 2023 update: On going, AC and AW to meet to discuss. **July 2023 Update:** Await further updates on Clinical networks. **September 2023 update:** On the agenda, closed.	**AC/AW** **AC/AW**	**Open** **Closed**	**08.06.2023** **14.09.2023**
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 and July 2023 update:** Ongoing as it is a large project to change format. AGR will bring an update to the next meeting. **September 2023 update:** On the agenda, closed.	**AGR** **AGR** **AGR** **AGR** **AGR**	**Open** **Open** **Open** **Open** **Closed**	**11.05.2023** **11.05.2023** **11.05.2023** **08.06.2023** **14.09.2023**
ACTION SHEET FROM THE MEETING 8th June 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. 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.	**FWG** **AGR** **Acute Trusts** **AGR**	**Open** **Open** **Open** **Open**	**08.06.2023** **08.06.2023** **08.06.2023** **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. AGR to review the national shared care document for Hydroxycarbamide. AS to send the shared care for Domperidone to AGR.	**FWG** **AGR** **AS**	**Open** **Open** **Closed**	**08.06.2023** **08.06.2023** **08.06.2023**
ACTION SHEET FROM THE MEETING 13th July 2023				
2023/358	**Fluorouracil 5% Cream for treatment of superficial pre-malignant skin lesions** Fluorouracil 5% Cream for treatment of superficial pre-malignant skin lesions will be taken to the Commissioning Resource Group for ratification (Green RAG rating). **September 2023 update:** This item went to the Commissioning Resource Group and was approved, closed.	**DP** **DP**	**Open** **Closed**	**13.07.2023** **14.09.2023**
2023/359	**Hydrocortisone sodium phosphate (Softacort) eye drops for treatment of mild non-infectious allergic or inflammatory conjunctival diseases** Hydrocortisone sodium phosphate (Softacort) eye drops for treatment of mild non-infectious allergic or inflammatory conjunctival diseases will be taken to the Commissioning Resource Group for ratification (Red RAG rating). **September 2023 update:** This item went to the Commissioning Resource Group and was approved, closed.	**DP** **DP**	**Open** **Closed**	**13.07.2023** **14.09.2023**
2023/360	**Avanafil tablets (Spedra®) for the treatment of erectile dysfunction in adult men**			

	Avanafil tablets (Spedra®) for the treatment of erectile dysfunction in adult men will be taken to the Commissioning Resource Group for ratification (Green (restricted) RAG rating, 3rd line PDE5). **September 2023 update:** This item went to the Commissioning Resource Group and was approved, closed.	**DP** **DP**	**Open** **Closed**	**13.07.2023** **14.09.2023**
2023/361	**New Medicines Review workplan** DP to bring a paper/short review to the September 2023 for sodium fluoride in the treatment of head and neck cancer patients. **September 2023 update:** On the agenda, closed.	**DP** **DP**	**Open** **Closed**	**13.07.2023** **14.09.2023**
2023/362	**Post-bariatric nutrition position statement – update** Update the Post-bariatric nutrition position statement and add it to the website. Add oral vs injectable vitamin B12 to the work plan. **September 2023 update:** On the website and the workplan, closed.	**AGR** **AGR** **AGR**	**Open** **Open** **Closed**	**13.07.2023** **13.07.2023** **14.09.2023**
2023/363	**UHMB domperidone shared care – review** AGR to liaise with AS and consultants at UHMB to review evidence for use and consult on a RAG position for domperidone in the indication. **September 2023 update:** On the workplan, closed.	**AGR** **AGR**	**Open** **Closed**	**13.07.2023** **14.09.2023**
	ELMMB nefopam position statement – review for LSCMMG adoption			

2023/344	AGR to send the nefopam position statement out for consultation. **September 2023 update:** On the agenda, closed.	**AGR** **AGR**	**Open** **Closed**	**13.07.2023** **14.09.2023**
2023/365	**Zoladex shared care** AGR to add a review of Zoladex/GNRH analogues to the workplan. **September 2023 update:** On the workplan, closed.	**AGR** **AGR**	**Open** **Closed**	**13.07.2023** **14.09.2023**
2023/366	**Cenobamate for focal seizures – summary of evidence** AGR to consult on an evidence summary for Cenobamate. **September 2023 update:** On the agenda, closed.	**AGR** **AGR**	**Open** **Closed**	**13.07.2023** **14.09.2023**
2023/367	**Antipsychotic shared care – NICE recommended off-label indications – review** AGR to send out a consultation on the principle of NICE recommended off-label uses being included in shared care guidelines. **September 2023 update:** Will be sent out as soon as it is ready.	**AGR** **AGR**	**Open** **Open**	**13.07.2023** **14.09.2023**
2023/368	**Pain management guidance review – approach and process** FP to forward a list of the sections of the GMMMG resource document that the ICB opioids group consider to be useful additions to the Lancashire and South Cumbria opioid resources for consideration by the pain management working group. **September 2023 update:** FP was not present at today's meeting, however, if it is on the workplan it can be closed.	**FP** **FP/ AGR**	**Open** **Closed**	**13.07.2023** **14.09.2023**

2023/369	**Lipids pathway, secondary prevention** DP to upload the approved Lipid pathway secondary prevention document to the LSCMMG website. **September 2023 update:** On the website, closed.	**DP** **DP**	**Open** **Closed**	**13.07.2023** **14.09.2023**
2023/370	**Diabetes guideline – update** DP to upload the updated diabetes guideline to the LSCMMG website. **September 2023 update:** On the website, closed.	**DP** **DP**	**Open** **Closed**	**13.07.2023** **14.09.2023**
2023/371	**Melatonin Pathway (Children)** DP to bring back a paper to the next meeting with the suggested amendments from today's meeting to enable further discussion. **September 2023 update:** On the agenda, closed.	**DP** **DP**	**Open** **Closed**	**13.07.2023** **14.09.2023**
2023/372	**Guidelines workplan** AGR to produce a shared care agreement form for testosterone and add a link relating to supply shortages on the website. **September 2023 update:** On the website, closed. Review of testosterone shared care to be added to the workplan with consultation beginning after the summer. **September 2023 update:** Testosterone shared care is on the website, closed. AGR was due to speak to the consultants who are prescribing the menopause service in Pan Mersey and GMMMG however	**AGR** **AGR** **AGR** **AGR**	**Open** **Closed** **Open** **Closed** **Open**	**13.07.2023** **14.09.2023** **13.07.2023** **14.09.2023** **14.09.2023**

	the meeting was cancelled so is back on the workplan.			
2023/373	**LSC critical care network vancomycin guideline** AGR to add to the guideline to the LSCMMG website when SM provides the final version which has been adopted by each of the acute trusts in Lancashire. **September 2023 update:** Still going through governance process, once complete will go onto the website.	**AGR** **AGR**	**Open** **Open**	**13.07.2023** **14.09.2023**
2023/374	**New NICE Technology Appraisal Guidance for Medicines June 2023** AGR agreed to check NICE cost estimates prior to submission to the Commissioning Resource Group and add a column on utility/outcomes of the use of medicines to subsequent LSCMMG NICE papers. **September 2023 update:** These items went to the Commissioning Resource Group and were approved. The column was also added, closed.	**AGR** **AGR**	**Open** **Closed**	**13.07.2023** **14.09.2023**
ACTION SHEET FROM THE MEETING 14th September 2023				
2023/385	**Brimonidine gel for rosacea** Brimonidine gel for the symptomatic treatment of moderate to severe facial erythema of rosacea in adult patients, to be presented at the next Commissioning Resource Group with a recommended RAG rating of Green Restricted for approval.	**DP/BH**	**Open**	**14.09.2023**
2023/386	**Ibandronic acid for breast cancer** Ibandronic Acid 50 mg Tablets (Bondronat®) for the adjuvant treatment of early breast cancer in postmenopausal women with a high risk of recurrence (unlicensed indication), to be	**DP/BH**	**Open**	**14.09.2023**

	presented to the next Commissioning Resource Group with a recommended RAG rating of Amber 0 for approval.			
2023/387	**Flupentixol RAG rating** Flupentixol dihydrochloride tablets for treatment of schizophrenia and other psychoses, to be presented to the next Commissioning Resource Group with a recommended RAG rating of Amber 0 for approval. It was noted that the Do Not Prescribe position for depressive illness would remain.	**DP/BH**	**Open**	**14.09.2023**
2023/388	**Sodium fluoride 1.1% toothpaste** Sodium fluoride 1.1% toothpaste for treatment of head and neck cancer patients who have had surgery, radiotherapy and/or chemotherapy are often left with severely dry mouths, restricted mouth opening, and reduced access for toothbrushing or professional dental care, to be presented to the next Commissioning Resource Group with a recommended RAG rating of Amber 0 for approval.	**DP/BH**	**Open**	**14.09.2023**
2023/389	**Bempedoic acid review update** MA to take questions and discussions had here around patient intolerance numbers and if the specialists are looking to have it in place for patients that are intolerant to ezetimibe, and they are considering this as the next step in treatment. BH to bring this item back next month for further discussion after MA's feedback. Bempedoic acid with ezetimibe as an option for treating primary hypercholesterolaemia (heterozygous familial and non-familial) or mixed dyslipidaemia as an adjunct to diet in adults, to be presented to the next	**MA** **BH** **BH**	**Open** **Open** **Open**	**14.09.2023** **14.09.2023** **14.09.2023**

	Commissioning Resource Group with a recommended RAG rating of Green for approval.			
2023/390	**New Medicines Review Workplan** Docosahexaenoic acid 380mg, Eicosapentaenoic acid 460mh capsules (Omega 3-acid-ethylesers) for treatment of women at risk of preterm birth fitting to be brought back to the next LSCMMG for consideration of whether it can be adopted. AW and BH to go through adopting other North West or Regional guidance in the future. Eluxadoline to be removed from the LSCMMG website.	**DP** **AW/BH** **AGR**	**Open** **Open** **Open**	**14.09.2023** **14.09.2023** **14.09.2023**
2023/391	**Gout guideline- Update** AGR to amend title error and it to be uploaded to the website.	**AGR**	**Open**	**14.09.2023**
2023/392	**COPD desktop guideline update** DP/MP to look at slight changes to the formatting to make it more aligned with other guidelines. MP to circulate the guideline to members once changes have been made for approval.	**DP/MP** **MP**	**Open** **Open**	**14.09.2023** **14.09.2023**
2023/393	**Requests form private prescribers to transfer or share prescribing with an NHS GP position statement** AGR to send out for consultation.	**AGR**	**Open**	**14.09.2023**
2023/394	**Cenobamate for focal seizure – RAG consultation** Cenobamate for focal seizure, to be presented to the next Commissioning Resource Group with a recommended RAG rating of Amber 0 for approval.	**AGR**	**Open**	**14.09.2023**
	ELMMB nefopam position statement – consultation			

2023/395	MA to go back to his consultant community geriatrician to get more information on the specific patient group.	**MA**	**Open**	**14.09.2023**
2023/396	**Erectile dysfunction guideline – update** AGR to amend the wording from Black to Do not prescribe and add it to the website.	**AGR**	**Open**	**14.09.2023**
2023/397	**Sodium Zirconium Cyclosilicate – update** LR to forward concerns from GP around monitoring and reducing potassium levels. BH/AGR to look at bringing an adopted shared care agreement from another ICB to the next meeting for the group to discuss.	**LR** **BH/AGR**	**Open** **Open**	**14.09.2023** **14.09.2023**
2023/398	**Melatonin** JG to review comments put forward by AB and make any material changes if required and forward to AW for final approval. Following finalising of the document, RAG changes would be agreed and taken to a future meeting of the CRG.	**JG** **BH**	**Open** **Open**	**14.09.2023** **14.09.2023**
2023/399	**Lithium shared care guideline – proposed update by LSCFT** AGR to put the amended document onto the LSCMMG website.	**AGR**	**Open**	**14.09.2023**
2023/400	**DMARD shared care guidelines – extension of expiry date** AGR to extend the expiry date on the LSCMMG website by 6 months.	**AGR**	**Open**	**14.09.2023**
2023/401	**Scabies treatment pathway** The document to have LSCMMG branding added and can then be circulated out to members to further circulate to relevant prescribers.	**LR**	**Open**	**14.09.2023**
	Blood glucose and ketone device monitoring recommendations			

2023/402	LR to take the document to the health improvement board and feedback comments to BH. The document to be sent out for consultation to all trusts and localities once an amended document is agreed by the health improvement board.	**LR** **DP/BH**	**Open** **Open**	**14.09.2023** **14.09.2023**
2023/403	**Guidelines workplan** BH/AW to check they have the correct document via Sharon Andrew to send around in relation to clarity on macular treatment preferences. LR to forward email from Donna Parker in relation to commissioning and the biosimilar pathway. AW to send all three macular pathways to the Northwest Medicines Optimization group for discussion and the ask of adopting the local pathway as a Northwest approach. BH to also send pathways around this group for members.	**BH/AW** **LR** **AW** **BH**	**Open** **Open** **Open** **Open**	**14.09.2023** **14.09.2023** **14.09.2023** **14.09.2023**
2023/404	**New NICE Technology Appraisal Guidance for Medicines July/August 2023** Rimegepant for preventing migraine, to be presented to the next Commissioning Resource Group with a recommended RAG rating of Amber 0 for approval. To confirm the approach taken by Cheshire and Mersey and GMMMG at the next meeting.	**AGR** **AGR**	**Open** **Open**	**14.09.2023** **14.09.2023**
2023/408	**Lancashire and South Cumbria NHSFT Drug and Therapeutic Committee 20th July 2023** SR to circulate the document to members.	**SR** **BH**	**Open** **Open**	**14.09.2023** **14.09.2023**

	BH to bring discussions around D&T group feedback to a future meeting.			