Minutes of the Lancashire and South Cumbria Medicines Management Group Meeting

Thursday 9th November 2023 (via Microsoft Teams)

PRESENT:

Andy White (AW)	Chief Pharmacist (Acting Chair)	Lancashire and South Cumbria ICB
Ana Batista (AB)	Medicines Information Pharmacist	East Lancashire Hospitals NHS Trust
Andrea Scott (AS)	Medicines Management Pharmacist	University Hospitals of Morecambe Bay NHS Foundation Trust
Clare Moss (CM)	Head of Medicines Optimisation	Greater Preston, NHS Chorley, and South Ribble locality
David Jones (DJ)	Assistant director of pharmacy Lancashire teaching hospitals	NHS Lancashire Teaching Hospitals
Judith Williams (JW)	Head of Primary Care Finance	Lancashire and South Cumbria ICB
Lucy Dickinson (LD)	Finance Manager for Primary Care	Lancashire and South Cumbria ICB
Mohammed Ahmad (MA)	Assistant Director of Pharmacy	Blackpool Teaching Hospitals NHS Trust
Faye Prescott (FP)	Senior Medicines Optimisation Pharmacist	NHS North of England Commissioning Support Unit
Rukaiya Chand (RC)	Medicines Optimisation	NHS Lancashire and South Cumbria ICB (Fylde Coast)
Sonia Ramdour (SR)	Chief Pharmacist/Controlled Drugs Accountable Officer	Lancashire and South Cumbria NHS Foundation Trust
Steve Simpson (SS)	Chief Pharmacist	NHS East Lancashire Teaching Hospitals

IN ATTENDANCE:

William Price (WP)	Dermatology Pharmacist	East Lancashire Hospitals NHS Trust
Richard Sharma (RS)	Medical Director	OMNES
Paul Tyldesley (PT)	Medicines Commissioning Pharmacist	NHS Midlands and Lancashire CSU
Adam Grainger (AGR)	Senior Medicines Performance Pharmacist	NHS Midlands and Lancashire CSU
David Prayle (DP)	Senior Medicines Commissioning Pharmacist	NHS Midlands and Lancashire CSU
Brent Horrell (BH)	Head of Medicines Commissioning	NHS Midlands and Lancashire CSU

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

	SUMMARY OF DISCUSSION	ACTION
2023/432	**Welcome & apologies for absence** Apologies were received from Dr Ramtoola, apologies were also received for Melanie Preston and Rukaiya is deputizing for her.	
2023/433	**Declaration of any other urgent business** None.	
	SUMMARY OF DISCUSSION	**ACTION**
2023/434	**Declarations of interest** There were no declarations of interest, EB/DP to send the declaration form out to new members.	**EB/DP**
2023/435	**Minutes and action sheet from the last meeting 12th October 2023** AW raised a few typing errors in the document which he will send over to EB for her to amend before it is added to the website but other than this they are approved.	**AW/EB**
2023/436	**Matters arising (not on the agenda)** Sucralfate – RC asked for this to be discussed however there was not enough time during the meeting, so this is deferred until next month,	
2023/437	**Governance Update** There was nothing discussed under this agenda item.	
2023/438	**Ranolazine MR tablets for adjunctive therapy in the treatment of stable angina, RAG rating change** DP brought this item; it has been reviewed following prioritisation by the formulary group. There were differing RAG statuses across the area with most having Amber 0 and the rest having a Green status. The clinical specialist group couldn't come to a decision, so it was taken for a review and the proposed RAG rating is for a Green Restricted to bring it in line with NICE CG 126. It was sent out for consultation and there were two responses received, the first supported a Green RAG and the other agreed with the Green Restricted status. Since the production of today's papers DP received further comments from the LMC who agreed with the Green Restricted RAG rating. DP attached a guideline that East Lancashire forwarded for consideration, which DP suggested was for information as the guideline has effectively been superseded by the NICE TA which updates automatically as the evidence changes. AB commented that they responded with the Green Restricted rating as that was what was on the paper and was surprised that others were saying Green with no restrictions. AW asked what the restriction would be. DP responded that it would be in line with the NICE guidance 126, which contains a specific plan for treating patients along with the MRHA warnings and that it is used later on in the treatment pathway not at the	

	beginning. AW asked if DP felt this would be unlikely to be primary care initiated and more likely on advice from a specialist to which DP agreed but added that he didn't feel that is why it is advised as restricted. He said that primary care could initiate it and the guidance gives that extra guidance on how the drug should be used. AW asked for a show of hands in the group each for Green and Green Restricted RAG status. There was an even three votes for each status. SR commented that as the LMC agreed with the Green Restricted to follow them. DJ added in terms of options if this was still priced slightly higher than some of the other options, and that given the current financial elements asked if there is something further that can be done within NICE guidance to help where it will sit. RC highlighted that if this being restricted it is similar to Inclisiran. In that it is accessible and can be prescribed by primary care clinicians, but that use is in line with clinical criteria, so it is only used in a defined patient cohort. So, she agreed with the Green Restricted position. It was agreed by the group for a Green Restricted RAG status. **Action** Ranolazine for adjunctive therapy in the treatment of stable angina, to be presented at the next Commissioning Resource Group with a recommended RAG rating of Green Restricted for approval.	**DP**
2023/439	**New Medicines Review Workplan** The drugs listed for consideration for prioritization are: Infliximab for treatment of chemotherapy induced colitis. This came from an Oncology pharmacist at UHMB. GoResp digihaler which was requested by Fylde Coast. It is not a new medicine but a new device such as Dexcom, which can link up to an app. A late request for Melatonin in the over 55's. Currently it is Do Not Prescribe, this RAG was adopted in 2013 when LSCMMG was originally formed. There was a detailed request from the GP to request that this decision is reviewed, DP felt it could be time to revisit it and look at the evidence to see if there is anything new there. SR commented that as there is a plan to review the melatonin RAGs for adults as the children's work is complete, would the above request for the melatonin in over 55s be pulled into that and prioritize melatonin in adults and do it all together? DP and AW agreed with this, and DP proposed moving this over into the melatonin work with the adult guideline production and incorporate the review. AW added that due to the financial challenges within the ICB, there is encouragement to look at everything including deferring items where possible and asked if there is anything with cost savings that could be moved up the list or anything with a cost implication that could be deferred as long as there is no risk in doing so. DP went down the list and noted that Acarizax will be expensive, Liothyronine compared to other preparations would be expensive and the others were either cost neutral or not going to cost much but he would need to look into things further before moving anything around but would be happy to do that. AW added that another avenue is to focus all efforts into the formulary and postpone this list for the time being. DJ added that anything listed for insomnia could be covered under the NICE TAs, and added with the melatonin position statement it may	

	influence who may get it and look at the use. AW also added that there is a risk of being non-compliant with NICE guidance to reach financial balance, so those risks need to be looked at.	
2023/440	**Tirzepatide for treating type 2 diabetes – NICE TA924** PT was invited to the meeting to discuss this item. This is a new drug and has been marked as a novel agent, so it acts on both glucose dependant insulinotropic polypeptide and GLP-1, but effectively by NICE is has been treated like the other GLP-1 agents. It has been placed in a similar position in the pathway as other GLP-1 agents where you would expect that patients have tried triple therapy with metformin and two other agents, and they still require treatment escalation. NICE published their TA guidance in October, it most likely Tirzepatide would be used extensively as it is supported by a NICE TA appraisal and there is also the supply issues with other GLP-1 agents. PT added that in trials Tirzepatide had been compared to Semaglutide, which is currently the most used GLP1. The improvements in glycaemic control of Tirzepatide versus Semaglutide were of a similar magnitude of the differences between Semaglutide and the other GLP1s. In addition, there was also an improvement on weight loss with Tirzepatide which will possibly be a large element viewed when making decisions as to who receives this agent. When Semaglutide came onto the market it was the same price as other GLP-1 agents, which allowed for improved treatment outcomes without an increase in price. However, with Tirzepatide there is a cost implication of around £250 more a year for a patient on the lower dose right up to £550 more per year for higher doses. PT concluded that the decision wouldn't necessarily be which was the most effective more of how much is willing to be invested in the improvements. He included in the paper more of a breakdown of the costing which also showed based on clinical trials in the UK, that around 60% of people being on the lower end of the dose range, around 30% in the middle range and 10% being on high doses. Comparing that to Semaglutide, which is currently around half the market there would be around £2 million cost difference compared to other GLP ones. If this takes around ¾ of the market it would be up to £3 million. When looking at the market to see how quickly Semaglutide took to reach current levels, PT found that it took around 4 and a half years, however this doesn't account for issues with GLP-1 availability and that it didn't have a NICE TA either. Based on this, his assumption was that this would be quicker to take up than Semaglutide, this assumption includes a discussion with a specialist where they want primary care to be able to initiate treatment in line with the other GLP-1 agents, so it doesn't create a backlog within outpatients. The current launch is predicted around January-March 2024, which means the cost rise is looking to hit the same levels of Semaglutide would be between January 2026-January 2027. He asked the group to think about how this could be looked at, as it is as TA it needs to be available but would that mean assigning a normal RAG status or that Semaglutide should be first line, and this could follow. AW commented that he, PT and a few others met with the manufactures and the European UK managing director and conversation included the manufacturers asking units to provide five times the current GLP-1 market for the UK as he felt it would have such a large impact. He highlighted that the shortage issue at the moment is with delivery devices not the molecules, and if this was rectified this product could really take off. It has a licence for weight management which is due around January	

	2024 which means it will have indications for both weight management and diabetes management. He also added the manufacturers had said they would not be launching in the UK until they had sufficient stock to meet demand. AW also commented that there are thousands of people on waiting lists for Wegovy and Semaglutide, on top of the issues of not having a commissioned weight management service except for in Liverpool, Blackpool and Salford which are either closed to new patients or near closing to new patients. AW has raised the issue up to commissioning; however, this requires spending which is not currently happening. BH highlighted the issue around demand, where Semaglutide took around a year to get to 1000 items due to availability. He felt that if there was product and devices available this could reach thousands of items within months. CM commented that they do have a GLP-1 review worked into the QIPP plan for quarter four. She added that there is a feeling that a lot of patients on products are not reaching targets, and lots of patients been initiated too early onto these products and general poor management which adds the need for education in practice nurses. She also added that she wanted to discuss with LR around diabetes enhances services for general practice, as there is a feel that there is a need to work with primary care colleagues to improve general management. CM felt that inappropriate use and use without outcomes is what concerns her and agreed with earlier suggestions to try get ahead of this before it becomes a real issue. SR thanked CM for her information and comments and added the need to look at the long-term benefits and costs that would be offset by this being prescribed. AW asked PT if there was a calculator within the NICE information. PT said that there wasn't, but that NICE had said that this drug is cost effective and that it was less than £20,000 per QALY. AW agreed with SR's comments on focusing on outcomes not inputs, and that this could potentially transform care, but it was important to look at how to prevent GPs from prescribing inappropriately. BH added that in PT's paper it states that the outcome of the trials is not yet published. He said that this would possibly be in around 12 months' time before trials conclude. AW asked what outcomes were being measured in the trials. PT said that there is a measure looking at different types of cardiovascular outcomes such as deaths, strokes and heart attacks. AW summarised for the group and added that he felt the estimate of £3 million and due to the supply issues of other GLP-1 agents that it was a conservative estimate and only applied to the diabetes indication. But added there is not a need for a fast decision on this as stock won't be available until at least January. However, said that he did feel this needed to be escalated up into the system as a major pressure, which also links into the non-compliance of the Wegovy guidance. He requested a pathway be looked at to where this would sit and if there is a preference for this over other GLP-1 agents to state this and where specifically it would sit. The effect on diabetes and then weight management also needs to be included into this. He also asked if there is a tool available to identify which patients would best benefit from this and also CM's point about taking people off the drug that are not meeting criteria.	

	AGR added that if there was a bariatric service and this drug is approved for weight loss then the costs may be offset against the reductions in bariatric surgery. AW asked for this to be brought back with a proposed RAG status on this, which could mean differing status for diabetes and weight loss. He added he would anticipate large numbers of patients being swapped from GLP1s, and he felt the estimated cost pressure was possibly close for diabetes but could be much higher for weight loss. He also asked for a model to be put together for what would be the costs for all products at five times the current market as this would be worse case scenario. Then it can be looked at to see if there needs to be any restrictions put in place. **<u>Actions</u>** AGR and PT to bring back proposed statuses for both diabetes and weight management. PT to put together a model for all products based on five times the current market with costing.	**AGR/PT** **PT**
GUIDELINES and INFORMATION LEAFLETS		
	Requests from private prescribers to transfer or share prescribing with an NHS GP AGR brought this item, this was drafted and brought to a previous meeting, and it was agreed to send out for consultation. One response was received from East Lancashire Medicines Management Board who said they may support the position statement and take into account further comments. They did mention if a patient has been receiving equivalent care from private specialists and would a GP consider prescribing, and that there needs to be care with having the separation between NHS and private. He added that this is what the position statement was also trying to reflect. He asked the group if they felt it had been fed back on enough or if they wanted it to go out for another consultation. AW asked AGR if he had managed to look at the RDTC guidance and compared it to this document. AGR responded that the RDTC guidance was used as a basis for the position statement. AW then asked if there was a need to define the root to the private care as some will be GP recommended and some won't be. AGR said that as they are still accessing private care, he didn't think that the route in needed to be defined if they are still paying for their care. AW raised the issue with ADHD and gender identity services where there are high numbers of people seeking private care without GP knowledge then trying to come back and asking for shared care. SR raised a comment that was in the personal feedback on the statement from Tara Gallagher at LSCFT where if there is a traditional NHS specialist service, there may be a delay in getting an appointment. However there then wouldn't be any prioritising for patients just because they are on medication. Then there is a query as to what happens in the interim as potentially a GP is prescribing until the patient is seen by a specialist which could have long waiting lists, or the treatment is stopped while waiting a review from a specialist which could create tension. There is also a possible cross over if the specialist service is also providing the NHS service.	

	AGR said that the department of health's policy states that the treatment must remain separate otherwise patients could go private for treatment then jump the queue in the NHS and get treatment. He also added the importance of not inadvertently offering an advantage to those who can afford to pay for private care over those who can't. AW added the need to be clear on what is meant by private care as there may be private services commissioned by the NHS to provide NHS services. AGR said that this could be done and made clear it means patients who are paying for their care. CM commented that there is a lot of noise about this in the media and added it would be good to get the view of the LMC for this position statement. She felt they would find it very helpful and added that the RDTC element was also very useful in terms of some of the nuances of this and asked if the guidance could be reference just to help people think through the information. She added she agreed that there was an issue with ADHD and waiting lists and said that she felt some of the processes are not being done as they should be. She also discussed the recent national discussion around it but said she was not clear what that had recommended as it was issues specific with ADHD and independent providers for ADHD care, and that there were cases of patients' queue jumping by going privately then doing a self-referral under the NHS under choice and being placed on the pathway. She asked to look to link the two discussions together as she was unsure on the most recent guidance. AW added this is a complex issue, and that right to choose is what the NHS thinks it is however private providers are sometimes doing is quite different. RC came in as their comments had not made it through to AGR during the consultation. She said they had gone along similar lines and had had discussions on managing patient expectations. During this they had discussed explaining to the patient that if they were referred it wouldn't be immediate, they would have to join the queue and that there may very well be a delay in that. AW summarised that a decision wouldn't be made today but look for LMC to review. There needs to be some clarity on what is meant by private and maybe include right to choose and other routes. Also, whether to append the RDTC guidance or make sure its fully embedded in this and something needs to be included around managing patients' expectations. He then asked if the group felt rather than a position statement should this be a policy statement as it states what should and shouldn't be done in cases, and to include stronger yes/no language. BH responded that it would need to be looked at the route into a policy position from a position statement and if it would need to go into the ICB. AW suggested testing it at the Clinical Effectiveness Group. He asked for this to be brought back either next month or January's meeting depending on how long it takes for responses. **<u>Actions</u>** AGR to take the position statement to LMC for their comments. AGR/BH to look at how this would move from a position statement to a policy statement and what that would entail. AGR/BH look to possibly take the statement to the Clinical Effectiveness Group.	**AGR** **AGR/BH** **AGR/BH**

2023/442	**Azithromycin RAG and prescriber information sheet consultation** AGR brought this item, it was sent for consultation with a proposed RAG status of Amber 0. It is for long term Azithromycin use in adults for prevention of respiratory infections, asthma, and Bronchiectasis. It was a dual format consultation and members were asked to consult on both the RAG status and the prescribing information sheet. It received two responses from UHMB and East Lancashire, both agreed with the Amber 0, UHMB agreed with the information sheet and East Lancashire MMB gave a maybe around the review period. The document has not yet been amended in line with comments received and they also received some comments from Blackpool which were largely supportive but also raised the review period. AGR said to the group in the review period could be revisited but that broadly the content was supported. FP said that if it was going to be recommended, she felt that the acute trusts recommending treatment to GPs should include what baseline tests and reviews have been done prior to initiation, as from her experience it had involved having to find the different teams to ask these questions before prescribing to patients for this indication. She also said she felt that the first review should be done around 3 months with the consultant before it is handed over to GPs to continue prescribing. She added when looking at other guidance there was questions such as had the patient taken a medication holiday in the summer when the risk of chest infection was lower, who educates the patient about what to do if they experience any of the side effects and to go to the GP for an ECG before it is due if they experience any problems. AGR asked if the group felt it should be more of an Amber 1 RAG status instead of the Amber 0? AW suggested consulting antimicrobial pharmacists as they are the experts and the points FP raised are valid and the risks need to be looked at. AGR said he felt the points raised were covered in the document but was happy to go to the antimicrobial pharmacists for their opinion. RC added that the comment made in the consultation regarding removing the 12-month review, and when this happens it creates issues in primary care and that some patients are left on antibiotics long term without a review. She added from an AMR perspective it needs to be clear who holds the responsibility of the reviews. AS commented that this was developed by a pharmacist at UHMB who is an antimicrobial pharmacist and it is only initiated on the advice of a respiratory consultant and this includes the patient also having baseline reviews such as X-rays, ECG and hearing tests. There are also lots of medication reviews done prior to this being initiated and the respiratory consultant advises on a review at three months, then six and then 12 months and then an annual review with the GP. She added that there is a summary sheet but was unsure if AGR had received the summary sheet at the same time as the other information sent to him. AW asked if there was a patient summary sheet, to which she replied that there isn't but there is a patient information leaflet. SR commented that the element of a medication holiday was interesting and to maybe ask the view of Gill Damant as the consultant regional AMR pharmacist. And she added that a patient information leaflet would also be useful. AW asked for this to be brought back to the next meeting after having spoken with local AMR leads and Gill Damant to see if the holiday is	

	necessary or appropriate, and also if someone is severe, he would expect them to be having a 12-month review with a consultant so asked for that to be clarified. He asked when it comes back if the whole package including the summary sheet and the patient leaflet could come back so people have a view of everything. **Actions** AGR to speak to local AMR leads and Gill Damant regarding treatment holidays. AS to send AGR the summary sheet and the patient leaflet. AGR to make any amendments once the above has been done and bring back to the next meeting if possible.	**AGR** **AS** **AGR**
2023/443	**Denosumab RAG change** AGR brought this item, this has been out for consultation. The ask was for a shared care for the 120mg dose of Denosumab for the prevention skeletal related events in patient bone metastases from solid tumours. AGR highlighted this is separate to the 60mg and shared care that is already in place as this is for a different dose and indication. The consultation received a maybe from East Lancashire Medicines Management Board and a yes from East Lancashire Hospitals Trust. They did receive some comments from the East Lancashire Medicines Management Board stating that the impact on primary care needs to be looked at. There were also comments from East Lancashire Hospital Trust's Oncology lead pharmacist who supported the shared care but did also have a few questions, however, were broadly supportive of the adoption of a shared care. The document hasn't been developed yet so the consultation was more for the RAG status. AGR then asked the group if they were happy this had received enough engagement to carry on with the change of RAG. MA added the consultants at Blackpool were very supportive of it also and felt this could relieve some pressure at the day clinics as well. AS added that the comments that were made around frequency of monitoring calcium and renal function, the actual guidance has been revised and now the monitoring is only required for patients prone to renal problems. This means generally there is no monitoring required in primary care except for exceptional patients. She also added that when they had set up their shared care there was a discount available for Denosumab 120mg in community through the company, but she was unsure if it was still available. DJ commented that this was similar to Ibandronic acid that was approved last month. The feedback from one of his lead consultants was that it was amazing so any pressures to relieve from the Oncology Chemo units would be greatly appreciated. AW added that there needs to be some movement on the cost tracker and asked BH if this could be done to move costs from one side to the other and to show what the benefits are. CM asked if there would be any knock-on cost in terms of commissioned services from GP to shared care? AW asked if that would be expected and asked FP and AS if this is a commissioned service or if it is just done by the GPs. FP answered that they are paid for this within the service spec. AW summarised that before any changes could be made there needs to be a revised and updated shared care protocol and for this to be brought back. He added that Amber 1 seemed to be right but to be mindful that this	

	may or may not be a commissioned service in all areas and the impacts of this need to be understood. He also asked for primary care colleagues to be asked if there are services for this or similar drugs that it could be added to the list for the enhanced services. **Actions** AGR to bring back a revised shared care protocol to the next meeting. Members to speak to primary care and see if they have any specialist services for this or similar that it could be added to.	**AGR** **All Members**
2023/444	**Isotretinoin in the community** FP brought this item along with RS who is the medical director for Omnes. FP gave a brief overview to the group. The ICB has commissioned a community dermatology service which RS is one of the clinical leads, and there is an ask for Omnes to review and commence treatment for severe acne which would include prescribing Isotretinoin. This currently has a Red RAG status on LSCMMG and currently locally only a specialist or consultant can prescribe this, and it has to be issued from the acute trusts. Locally within Morecambe Bay they previously had a community service for this on two sites, one has since closed, and the other is still operating and is proactively prescribing Roaccutane. The consultant has been asked that since the closure of the CCGs and the Red RAG status to refrain from prescribing Roaccutane to which they have agreed for the current month while this is looked at. FP spoke with the Omnes team and asked them how they envisage prescribing to look like in the community and the response was for an expectation for Roaccutane to be supplied by community pharmacists on FP10s. But with the current RAG status this is not possible, and RS was asked to draft up something to provide a robust system for how this could be done within the community. This service is run by Omnes in another area, and they prescribe these items via FP10s, and FP has liaised with Maria Martin who is aware of other services like this throughout the country who are prescribing Roaccutane via FP10s. Maria also told FP that there is a Primary care dermatology society and they have written guidance for dermatologists working in the community. FP's ask for today was if there were any questions to either RS or regarding the document and to discuss the possibility for dispensing of Roaccutane via FP10s. RS spoke to the group and gave some more background information on prescribing in community. This included the implementation of the recent MRHA guidance around prescribing for under 18s. WP came in and introduced himself more to the group and RS and asked what the plan would be for the entire cohort of patients, would the under 18s be included and was there sufficient capacity within Omnes to have the second prescriber as detailed in the report. RS responded by firstly stating he was not a dermatologist by specialty but that a dermatology medical director would be leading the change. He added that currently they have sufficient capacity within Omnes to have the second prescriber and that they are looking to do this remotely as they believe this is the way several other services are looking to implement the guidance. Currently they have capacity for under 18s, and added if the committee would prefer, they could look to exclude under 18s from the cohort for now but said that they do have a contractual agreement with the ICB to implement this. RS also highlighted that there is a 6-month implementation period, and he would be happy to share the protocol for	

	this and the plan to implement it with the group. WP added he was going to ask about this as there was no implementation period mentioned in the report and during his time with working with the Human Medicines group this was something that was requested. He also added things may be a bit difficult if things were to change immediately with the existing protocol and to keep changing things unless there are some logistical reasons for doing so. AW asked as this is a new service was there any patients currently receiving this and RS answered that no patients are receiving Isotretinoin within this service, however FP did mention to him that there was some previous prescribing of this at the James Cochran centre that they weren't aware of. AW agreed with WP's comments about starting as they are meaning to go on and to have a protocol which is clear. CM asked what exactly was the ask for this group, were they being asked to look at the pathway or the RAG rating? AW answered and said it would be two-fold. That firstly this drug is currently under a Red RAG status which is for specialist/ hospital only and does this service meet the criteria for a specialist service and then does the protocol safeguard patients including the information that has just come through on the MRHA alerts. AW asked FP if this was correct to which she agreed that it is. FP also added that it is currently still RAG rated as Red in one ICB, however they accept it is more cost effective having the service in community and have added a comment to their formulary that they recognize the community dermatology team are specialists and that the service is consultant lead so they grant permission for them to prescribe this in community and that community pharmacies can issue the prescriptions. They also acknowledge a comment RS made earlier regarding having a negative pregnancy test and the validity for the prescription is 7 days after issue. CM commented that she was sure it was defined somewhere that a Red RAG doesn't mean secondary care but specialists and that they could sit anywhere within prescribing. WP added a comment around the pregnancy prevention program that recent changes have been made and now there are also different levels of prescriptions depending on sexual activity status of patients and felt it is important that community pharmacists are aware of these changes and levels before engaging them to provide these prescriptions. AW asked if RS knew the number of patients this would be as it may mean that some pharmacies only see this kind of prescription every now and again. RS responded that he wasn't sure at present but felt it would be hundreds of prescriptions a year across the geography and size of the service. AW added that this could mean that some pharmacists never see this, and others would see lots. So, the possibility would be to look at nominated pharmacies, and if the service could contact the pharmacy before they issue the prescription to make sure they are aware of this protocol and for them to follow it through. RS said this would be possible. AGR asked how the validity of 7 days of the prescription be enforced and what is in place to stop a patient requesting the prescription to go to a pharmacy that doesn't provide the service as patients can choose which pharmacy they go to. How would they guarantee this wouldn't happen. RS responded that the 7 days validity could be put on the notes, and they could communicate that to the pharmacy. AW added that with EPS it is possible to withdraw the prescription or make it invalid, to which RS added that it can be done but in his experience it doesn't always work.	

	AGR then raised that in the report it is mentioned about the history if psychiatric side effects, and asked what has been put in place to monitor these effects after initiation. RS responded that with each prescription, clinicians follow a computer template which includes a reminder to ask about mood and symptoms as part of the review. AGR asked how often the reviews are done, RS said that for female patients it is every month and for males it is every one-two months depending on the patient. ARG asked who conducts the reviews and RS said that they are done by either a consultant dermatologist and associates specialists who are GPSI or occasionally they will be done by dermatology nurses who have experience with doing them. AGR then stated that he was aware of a change but previously the MRHA guidance stated that they should be initiated by consultant dermatologists, he asked if this is what happens or if this is delegated to another member of the team. RS said that it is delegated to another member of the team. AGR then asked how often patients see the consultant dermatologists, to which RS answered that they may never see the consultant, but it is a consultant led service. SR commented with the RAG issue and asked if there could be a tweak to the wording to say prescribed by a specialist service. She added this is going to be a reoccurring issue where it is not necessarily trust prescribing especially with services within the community. AW agreed this would be sensible. CM then asked if this is run as an enhanced service in other areas of the country as she wondered what the response from community pharmacy would be around the additional work required. RS said that he didn't believe it was run as an enhanced service elsewhere. CM said that maybe this question could be anticipated but it may not come. RS added there has not been any pushback form other areas so far. RC asked if this means for this to be allowed at a few pharmacies or all across the geography, and RS said ideally it would be allowed at all pharmacies due to the size of the area. He added it could be limited but certain ones would need to be identified to cover all areas and the group agreed it should be all and ensure the communications are sent out to each pharmacy. FP agreed with SR's earlier comment around the RAG definition and added that there is a possible need for a pathway of a safe dispensing process which RS has written and if that could be brought back to this meeting for members to see to ensure everyone is working together and in agreement of what is to happen in terms of the process. She also said prior coming back here for herself and RS to meet with WP and the local pharmaceutical committee. AGR asked for it to be recorded that he didn't feel this should become an Amber 0 drug as he doesn't think this is something that would be considered if not for this newly commissioned service. AW responded that he didn't think that was the ask, and that it is being looked at as a Red RAG but with a possible change to the wording and prescribing so it is from a community specialist service rather than a hospital specialist service. SS commented that he echo's the majority of the comments and raised his biggest concern for him is the safety concerns and the dispensing and how to get a robust process. He added for LPC colleagues, that the worst thing that could happen is if they are talking about hundreds spread across hundreds of pharmacies what can be done about the detail for this as it's the detail that is important. He also added that talking about the	

	geography being large, what happens with people potentially sitting on boarders and potentially some have not even been reached on the boarders. It has the potential to go very wrong and added that he agreed the need for a pathway and that it needs to be down to the level of detail that ensures that any risks are covered. DJ added that there is a potential cost pressure, which may not be very big but that the BNF prices are around 5 times the amount trusts potentially pay. So, while he is not against relieving pressures in secondary care and there may be other benefits of the pathway, but it is important to include the finances in the equation. AW summarised that as a system there is a need to look at the RAG statuses to include community specialises services, but then also how does that relate to pharmacy dispensing. He asked FP and RS to take this away and update it given the comments received today and to liaise with relevant people such as WP and the local pharmaceutical committee. The feeling from the group is that the group doesn't want prescribing for under 18s in the short term, probably for adults first once there is a robust system in place. He asked if there were any restrictions for handling this and FP added that the Royal Pharmaceutical Society have produced guidance for pharmacies, but she was unsure if this was just for hospital pharmacies or for community pharmacies as well as she has not had chance to read it fully yet. AW said that this would need looking at as well as it also needs to be considered about storage of the drug as well. He also added GP communication, particularly the psychological symptoms that they need to be aware of. AW asked for a time frame for this, FP and RS said they would aim for December but if that was not possible as there is a lot of liaising to be done then it will come back as soon as it is done. WP agreed that December was tight and within the hospital dermatology systems are aiming for the new year. AW added another action for there to be an alignment with comms with the hospital dermatology services and this new one to ensure everything is lined up correctly. **Actions** FP and RS to update the document to include the new MRHA advice. FP and RS to meet with WP and the local pharmaceutical committee to discuss prescribing within the community on FP10s for the service. FP and RS to update the document to show that under 18s will not be included in the initial prescribing cohort.	**FP/RS** **FP/RS** **FP/RS**
2023/445	**Lipid management pathway updates** DP brought this item; it was a simple change where Bempedoic acid monotherapy has been added to the primary and secondary prevention document and shared with the Lipid group. They have indicated acceptability; however, this was just from one email. DP ask RC if she felt this needed to go to the Lipid group next Tuesday or if they were happy with the response. RC added that it was raised that there is a gap in the guideline. DP agreed that there is a gap however this consultation was for just the Bempedoic acid element which was agreed. The gap in the guideline was briefly shown to the group, and DP explained that there is a gap within secondary prevention as to what to give people between certain steps. He acknowledged this is needed to be discussed with the consultants to get the gap filled and felt this could be done relatively simply and taken to the Lipid group next week. RC advised DP to take to the Lipid group and discuss both elements with them and if everyone is happy as far as the Bempedoic acid element.	

	AW asked for it to be looked at to see if there is a service or financial impact and asked if it was a substantial patient group. DP responded that he was unsure and needed to find out more. It was agreed by the group that if the Lipid group were happy, it could be approved, but if they wanted something substantial changed it needed to come back to this group next month. **Action** DP to take to the Lipid group and discuss elements on Bempedoic acid and the gap in the document as well as if there will be any service or financial impact. Dependent on the outcome at the Lipid group it is either agreed or will need to come back to this group if there are substantial changes needed.	**DP** **DP**
2023/446	**Guidelines workplan** AGR commented that it is quite a lot on there. He added that DJ had asked for a Benzodiazepine withdrawal guideline which AGR has drafted but still needs to liaise with the people DJ highlighted to him. The other item AGR wanted to highlight was that he has been making sure prior to this meeting all NICE TA's that require a Blueteq form are added onto the Blueteq system in advance of the 30- or 90-day implementation expiry. Normally they are added on once agreed at LSCMMG to ensure they are available before the deadline. Due to recent conversations around finance, he asked the group if they would like him to continue to do this or if they would like him to wait until the items have been to CRG to be approved then be put on the system. He asked as once they are on the Blueteq system they are allowing use which trusts will take as confirmation that funding is available, and he doesn't want mixed messages going out to the trusts. AW commented that he felt it would be ok to draft them but not making it live until it has gone through the correct governing processes and been ratified by the ICB. SR added that the Maudsley write the prescribing guidelines for mental health, and they are currently working on a specific resource for deprescribing antidepressants, benzodiazepines and there will be three different regimes for each drug. AGR asked if she knew when this was due to be published, and SR said she felt it was fairly soon. She added that the benzodiazepines guidelines were fairly straight forward and that it is more so the antidepressants that are becoming increasingly difficult with the updated guidance. AW added that if there is a national guidance maybe this should just be adopted instead of rewriting here. AGR responded that this one was already done but would be mindful of other items coming out.	
NATIONAL DECISIONS FOR IMPLEMENTATION		
2023/447	**New NICE Technology Appraisal Guidance for Medicines October 2023** **TA916 Bimekizumab for treating active psoriatic arthritis** – This is a Red and will need a TA form. The cost pressure expected with this is £158,000 which is the NICE estimate, and it is supposed to be as effective as Ixekizumab which is an established therapy. This is to be used as well as/ another option for treatment. AGR added that the Psoriatic arthritis guideline also needs to be updated.	

	TA918 Bimekizumab for treating axial spondyloarthritis – This also has a cost pressure of £158,000 and NICE state that this is because it is just another option and is as effective as the current options. **TA919 Rimegepant for treating migraine** – TA 906 for the prevention of migraine was considered at the September meeting. TA 919 covers the acute treatment of migraines. This has an estimated cost pressure of £158,000. **TA920 Tofacitinib for treating active ankylosing spondylitis** – This also has a cost impact of £158,000 and there was a meta-analysis in the NICE TA evidence pack which didn't find any differences between the injectables biologics and the oral option. This one has been recommended a Red RAG status and will require a Blueteq form. **TA922 Daridorexant for treating long-term insomnia** – This was also mentioned previously and has another large cost impact of between £165,000 in year one to £960,000 by year five, but this estimate does not include the effect on GP capacity. This has modest gains, similar to melatonin but it did say in the evidence summary this was more for the maintenance of sleep rather than the amount of sleep. This is also recommended for long term therapy, but the RAG position needs to be considered as there is a current status of Green for Benzos, but this may need to differ so to not end up with lots of patients on long term use. SR added that daytime function needs to be assessed, but she was unsure if there was cognitive behavioural therapy for insomnia. And if there wasn't there was more likely to be a rise in prescribing as that option isn't available. BH asked SR where they could look to check for this, and she said to look at online packages for some kind of resource and added that she could speak to their psychologists at her trust. SR added that LSCFT can't take on lots of referrals for insomnia due to resources so would look for this to be maybe Green Restricted. The team will work on this and bring something back to the next meeting for this once they have more information and a better understanding of it. A decision was not made on the RAG position for this drug. AGR will bring something back to a future meeting to help the group with deciding on a RAG position. After the meeting SR sent the following statement to EB for the group: 'Talking Therapies offer CBT, and sleep problems are often a part of anxiety and depression. Therapists do support with sleep psychoeducation and to some extent address sleep difficulties as part of therapy. They occasionally have sleep groups which are psychoeducational in nature. They don't offer full CBT for insomnia as a standalone intervention currently. They are due to engage with a new digital CBT offer (Wysa) in the springtime, but don't think CBT for Insomnia will be part of that. They will update me when they know more.' **TA924 Tirzepatide for treating type 2 diabetes** – This was discussed under agenda item 2023/440.	
	New NHS England medicines commissioning policies October 2023 Nothing urgent to consider	
	Regional Medicines Optimisation Committees - Outputs October 2023 Nothing to consider	

	Evidence reviews published by SMC or AWMSG October 2023 There was one item DP raised for the members. Atogepant (Aquipta) – This is for prophylaxis of migraine in adults who have at least four migraine per month. NICE are due to review it next year, he raised it but asked members to be mindful that they will be doing headaches/migraine guideline so this may need to be considered.	
ITEMS FOR INFORMATION		
	Lancashire and South Cumbria NHSFT Drug and Therapeutic Committee October 2023 Minutes attached just for information.	
	LSCMMG cost pressures log Currently around £7.7 million, possibly higher with the change to the cost prediction for Tirzepatide. BH asked AW if he wanted the team to increase the cost pressure from £3 million, AW responded that he felt that was quite low and BH agreed. He asked if he wanted him to put another line on it for diabetes at £3 million and then the weight management add another £3 million AW said he felt this would make sense. AW asked the group what items they felt needed to be prioritised. Tirzepatide was one, possibly to be done this month to highlight the possible cost and service impact that availability may cause the system.	

DATE AND TIME OF NEXT MEETING

The next meeting will take place on

TBC

Microsoft Teams

ACTION SHEET FROM THE

LANCASHIRE AND SOUTH CUMBRIA MEDICINES MANAGEMENT GROUP 14.09.2023

ACTION SHEET FROM THE MEETING 9th March 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®. **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. **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. Wegovy EIRA and paper produced and presented to the Commissioning Resource Group to escalate to the ICB to consider further action. 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. **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	**AGR** **AGR** **BH** **BH** **AGR** **AGR** **AGR/JO** **BH/PT** **BH/NB** **BH**	**Closed** **Open** **Closed** **Closed** **Closed** **Closed** **Closed** **Closed** **Open** **Open**	**09.03.2023** **20.04.2023** **20.04.2023** **11.05.2023** **11.05.2023** **11.05.2023** **13.07.2023** **13.07.2023** **13.07.2023** **14.09.2023**

	clinics. A paper summarizing this item will be taken to the Commissioning Resource Group. **October 2023 update:** This item was not discussed in the actions. **November 2023 update:** AW asked for this item to be grouped up in with the GLP ones as Tirzepatide was on the agenda for discussion at this meeting. Closed.	**BH** **AW**	**Open** **Closed**	**12.10.2023** **09.11.2023**
ACTION SHEET FROM THE MEETING 13th July 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. **October 2023 update:** Will be ready for December's meeting. **November 2023 update:** On target to come to December's meeting.	**AGR** **AGR** **AGR** **AGR**	**Open** **Open** **Open** **Open**	**13.07.2023** **14.09.2023** **12.10.2023** **09.11.2023**
ACTION SHEET FROM THE MEETING 14th September 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. **October 2023 update:** EB shared it out for MP. Members are asked to respond by 18.10.2023. **November 2023 update:** MP was not in attendance today, DP fed back that she has sent to AW for comments, once agreed it will go onto the website, closed.	**DP/MP** **MP** **MP** **DP/MP**	**Open** **Open** **Open** **Closed**	**14.09.2023** **14.09.2023** **12.10.2023** **09.11.2023**
2023/402	**Blood glucose and ketone device monitoring recommendations** LR to take the document to the health improvement board and feedback comments to BH. **October 2023 update:** AW commented that there should be feedback for this next month. The document to be sent out for consultation to all trusts and localities once comments from the Health Improvement Board are received. **November 2023 update:** BH waiting on feedback from the Health Improvement Board.	**LR** **LR** **DP/BH** **DP/BH**	**Open** **Open** **Open** **Open**	**14.09.2023** **12.10.2023** **12.10.2023** **09.11.2023**
	Guidelines workplan BH to check he has the correct document via Sharon to send around in relation to clarity on	**BH**	**Open**	**14.09.2023**

	molecular drug preferences. LR to forward email from Donna Parker in relation to commissioning and the biosimilar pathway. BH 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. **October 2023 update:** Neither BH/ LR are in attendance, defer. **November 2023 update:** DP fed back from the meeting; the ophthalmologists haven't discussed the guideline in full. This will be done in December. An update will be brought to the next LSCMMG. BH to have a meeting with SS regarding the methodology for the gain share.	**LR** **BH** **BH** **LR/BH** **DP** **BH/SS**	**Open** **Open** **Open** **Open** **Open** **Open**	**14.09.2023** **14.09.2023** **14.09.2023** **12.10.2023** **09.11.2023** **09.11.2023**
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. **October 2023 update:** AGR still needs to speak to counterpart from Cheshire and Mersey. **November 2023 update:** Mersey have an Amber retained which is similar to Amber 0 here due to their specialists' maintaining patients until they are stable around the 12-week mark. Agreement for Amber 0 with the note that there is due to be a Northwest Headache pathway being developed.	**AGR** **AGR** **AGR** **AGR**	**Open** **Open** **Open** **Closed**	**14.09.2023** **14.09.2023** **12.10.2023** **09.11.2023**
ACTION SHEET FROM THE MEETING 12th October 2023				
2023/413	**Declarations of interest** DP to send DR the declaration of interest form. **November 2023 update:** Done, closed.	**DP** **DP**	**Open** **Closed**	**12.10.2023** **09.11.2023**
2023/415	**Minutes and action sheet from the last meeting 14th September 2023** EB to go through the last recording and make recommended changes for clarity. **November 2023 update:** The minutes were amended and added to the website.	**EB** **EB**	**Open** **Closed**	**12.10.2023** **09.11.2023**
2023/415	**Matters arising (not on the agenda)** Any members interested in chairing the meeting to come forward and let AW know.	**All Members** **EB**	**Open**	**12.10.2023**

	EB to write out to members regarding change of day/time of LSCMMG meetings from the new year. DP to add Tamoxifen and Dapsone to the workplan. **November 2023 update:** No one has come forward yet regarding being chair, if anyone is interested, please let AW know. EB didn't have any responses for changing of day/time of LSCMMG meetings in the new year. EB to email out to members regarding a change to Decembers meeting.	**DP** **All Members** **All Members** **EB**	**Open** **Open** **Open** **Open** **Open**	**12.10.2023** **12.10.2023** **09.11.2023** **09.11.2023** **09.11.2023**
2023/416	**Dailiport Position Statement** Dailiport to be added to the formulary with a Red RAG status. **November 2023 update:** Actioned and closed.	**DP** **DP**	**Open** **Closed**	**12.10.2023** **09.11.2023**
2023/417	**Bempedoic Acid Monotherapy update** DP to add in the reasoning for a Green RAG for Bempedoic acid monotherapy to the lipid pathway and send to the lipid group. Once it has been to the lipid group it is to be brought back to this group for approval. Bempedoic acid monotherapy to be added to the formulary with Green RAG rating, following CRG approval. **November 2023 update:** On the agenda, closed here.	**DP** **DP** **DP** **DP**	**Open** **Open** **Open** **Closed**	**12.10.2023** **12.10.2023** **12.10.2023** **09.11.2023**
2023/418	**New Medicines Workplan** Ivabradine for treatment of POTS, Colesevelam for CVD prevention, Nefopam for treatment of pain and Liothyronine for treatment of resistant depression to be added to the workplan. **November 2023 update:** Have all been added to the work plan, closed.	**DP** **DP**	**Open** **Closed**	**12.10.2023** **09.11.2023**
2023/420	**Restless Legs Guidance – Update** AGR to make the recommended changes and put the guidance onto the website. **November 2023 update:** Added to the website, closed.	**AGR** **AGR**	**Open** **Closed**	**12.10.2023** **09.11.2023**
2023/421	**Sodium Zirconium Cyclosilicate - Update** AGR to put the GMMMG shared care guidance for this item into LSCMMG formatting and send out for consultation. **November 2023 update:** Will be sent out at the end of November for consultation.	**AGR** **AGR**	**Open** **Open**	**12.10.2023** **09.11.2023**

2023/422	**Melatonin Pathway (Children) – LSCMMG Website Amendments** DP to make necessary changes to the LSCMMG website as listed in the paper. **November 2023 update:** This has been changed and all the previous positions have been removed.	**DP** **DP**	**Open** **Closed**	**12.10.2023** **09.11.2023**
2023/423	**NHSE Free of Charge (FOC) Medicines Schemes – National Policy Recommendations for Local Systems** SPS guidance on Free of Charge medicines schemes to be removed from LSCMMG website. Link to NHSE guidance "NHSE Free of Charge (FOC) Medicines Schemes – National Policy Recommendations for Local Systems" to be added to LSCMMG website. **November 2023 update:** These have all been completed, closed.	**DP** **DP** **DP**	**Open** **Open** **Closed**	**12.10.2023** **12.10.2023** **09.11.2023**
2023/424	**Omega 3-Acid-Ethyl Esters (Omacor) Proposal** DP to get the updated version for the website/ find an externally facing website which is hosting it so LSCMMG can direct people to the most updated version. **November 2023 update:** This has been completed, closed.	**DP** **DP**	**Open** **Closed**	**12.10.2023** **09.11.2023**
2023/425	**Guidelines workplan** Vaginal dilators, Edoxaban and the regional headache pathway to be added to the workplan. **November 2023 update:** These items were added, closed.	**AGR** **AGR**	**Open** **Closed**	**12.10.2023** **09.11.2023**
2023/430	**Lancashire and South Cumbria NHSFT Drug and Therapeutic Committee September 2023** SR to share them out to the group. **November 2023 update:** These were sent out, closed.	**SR** **SR**	**Open** **Closed**	**12.10.2023** **09.11.2023**
2023/432	**AOB** DP, AGR and AW to meet to discuss getting information from CRG out to the system. **November 2023 update:** CRG did meet and all items were agreed and uploaded, closed.	**DP/AGR/AW** **DP/AGR/AW**	**Open** **Closed**	**12.10.2023** **09.11.2023**
ACTION SHEET FROM THE MEETING 9th November 2023				
2023/434	**Declarations of interest** There were no new declarations of interest,	**DP/EB**	**Open**	**09.11.2023**

	EB/DP to send the declaration form out to new members.			
2023/435	**Minutes and action sheet from the last meeting 12th October 2023** AW raised a few typing errors in the document which he will send over to EB for her to amend before it is added to the website but other than this they are approved.	**AW/EB**	**Open**	**09.11.2023**
2023/438	**Ranolazine MR tablets for adjunctive therapy in the treatment of stable angina, RAG rating change** Ranolazine for adjunctive therapy in the treatment of stable angina, will be presented at the next Commissioning Resource Group with a recommended RAG rating of Green Restricted for approval.	**DP**	**Open**	**09.11.2023**
2023/440	**Tirzepatide for treating type 2 diabetes – NICE TA924** AGR and PT to bring back proposed statuses for both diabetes and weight management. PT to put together a model for all products based on five times the current market with costing.	**AGR/PT** **PT**	**Open** **Open**	**09.11.2023** **09.11.2023**
2023/441	**Requests from private prescribers to transfer or share prescribing with an NHS GP** AGR to take the position statement to LCM for their comments. AGR/BH to look at how this would move from a position statement to a policy statement and what that would entail. AGR/BH look to possibly take the statement to the Clinical Effectiveness Group.	**AGR** **AGR/BH** **AGR/BH**	**Open** **Open** **Open**	**09.11.2023** **09.11.2023** **09.11.2023**
2023/442	**Azithromycin RAG and prescriber information sheet consultation** AGR to speak to local AMR leads and Gill Damant regarding treatment holidays. AS to send AGR the summary sheet and the patient leaflet. AGR to make an amendments once the above has been done and bring back to the next meeting if possible.	**AGR** **AS** **AGR**	**Open** **Open** **Open**	**09.11.2023** **09.11.2023** **09.11.2023**
2023/443	**Denosumab RAG change** AGR to bring back a revised shared care protocol to the next meeting. Members to speak to primary care and see if they have any specialist services for this or similar that it could be added to.	**AGR** **All Members**	**Open** **Open**	**09.11.2023** **09.11.2023**

2023/444	**Isotretinoin in the community** FP and RS to update the document to include the new MRHA advice. FP and RS to meet with WP and the local pharmaceutical committee to discuss prescribing within the community on FP10s for the service. FP and RS to update the document to show that under 18s will not be included in the initial prescribing cohort.	**FP/RS** **FP/RS** **FP/RS**	**Open** **Open** **Open**	**09.11.2023** **09.11.2023** **09.11.2023**
2023/445	**Lipid management pathway updates** DP to take to the Lipid group and discuss elements on Bempedoic acid and the gap in the document as well as if there will be any service or financial impact. Dependent on the outcome at the Lipid group it is either agreed or will need to come back to this group if there are substantial changes needed.	**DP** **DP**	**Open** **Open**	**09.11.2023** **09.11.2023**