Minutes of the Lancashire and South Cumbria Medicines Management Group Meeting

Thursday 21st December 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
Lindsey Dickinson (LD)	Finance Manager for Primary Care	Lancashire and South Cumbria ICB
Mohammed Ahmad (MA)	Assistant Director of Pharmacy	Blackpool Teaching Hospitals NHS Trust
Paul Elwood (PE)	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

IN ATTENDANCE:

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
2023/453	**Welcome & apologies for absence** Apologies were received from Judith Argall, Dr Sari-Kouzel and Ashley Marsden.	
2023/454	**Declaration of any other urgent business** None.	
	SUMMARY OF DISCUSSION	**ACTION**
2023/455	**Declarations of interest** There were no declarations of interest. AW asked for the declarations to be checked to ensure all who attend have a declaration. **Action** EB to check all members have a declaration of interest and if not send the form out for them to complete.	**EB**
2023/456	**Minutes and action sheet from the last meeting 11th November 2023** There were three amendments to be made to the minutes. The first was to amend the minutes regarding Rimegepant for treating migraine to make it clear that this related to NICE TA 919 and that NICE TA 909 has been considered at a previous meeting. The second related to a misspelling of the regional antimicrobial lead's name, this is to be amended to Gill Damant and the third amendment was to make it clear that a RAG position for Daridorexant had not been agreed and needed to come back to a future LSCMMG for approval. **Action** EB will amend the minutes to reflect the above comments before they are added to the website.	**EB**
2023/457	**Matters arising (not on the agenda)** None to discuss.	
2023/458	**Governance Update** AW commented that there is some confusion as to where things go from this meeting for ratification within the ICB. Currently there is the Clinical Effectiveness Group but it is unclear where they will go in the future. AW will be working on getting this rectified in the new year but added there are still some governance changes due within the organisation.	
	NEW MEDICINES REVIEWS	
2023/459	**Formulary Oversight Group update** DP highlighted that the Formulary Oversight Group have approved the Gastro chapter for the updated formulary, but it has been noted that the East Lancashire formulary website hasn't been fully archived and online but no longer being updated which is a risk. The proposal is to bring a	

	paper back to January's LSMMG meeting that has two possible options which are using the UHMB website or taking everything in house onto the LSCMMG website. This will however involve a lot of different processes and that as the team have not managed a full formulary before there is uncertainty around every place's needs and what procedures they currently have in place. AW commented that from Chiefs they are unhappy with having a mixed economy so they want to try and accelerate the formulary process so that by the end of April at the latest the majority of the formulary will be done. Which means a pretty intense few months, which it has been suggested to help support this that this group largely spending time in the meetings approving items from the formulary group including any tidying up and that only exceptional or high impact items come back here for further discussion. He added that with the work plan (which is discussed later on the agenda) to look to deprioritising items that won't have a material impact on the formulary, he then asked the group for their opinions on the suggestion. BH added that the proposal from the formulary group was to have the UHMB formulary live or available to all but to highlight legacy chapters that have been adopted by LSCMMG. He asked members to take the suggestion for this away and look to discuss this in the January meeting. **Action** All members to consider having UHMB formulary live/ available to all for the time being to ensure there is a formulary available ready to discuss at the meeting in January.	**All Members**
2023/460	**Endocrine Formulary LSCMMG Updates** AW commented that as this was a tidy up of the formulary item, to save on time if members was unhappy with any items in the paper that was sent out for this agenda could voice what that is now, and once those items were all agreed to take this as accepted. SR requested the decision that was required for Quinagolide for hyperprolactinemia and if it was being prioritised for review or to be removed. DP added that it is on the website as Grey for review but there is no detail as to where the request came from. SR confirmed that LSCFT don't prescribe this for this indication. It was agreed to remove as no one had requested it and to look at it in the future if it was requested. There were no further comments from the group, all requested amendments were approved.	
2023/461	**Anticoagulants RAG change review** DP brought this item. It is proposed as a Green RAG status for Warfarin as there is a mixture of RAG statuses. It has also been highlighted what the different regions have for DOACs and suggested RAG statuses which are outlined in the paper. He added that there was an additional paper sent after the first set which highlighted that East Lancashire have a Low Molecular Weight Heparin (LMWH) guideline which it has been suggested to preserve for just East Lancashire. He acknowledged that this suggestion could be seen as against the formulary however most trusts tend to follow their own guidance on LMWH and to try and align all of them would be a very big job. So the proposal is to keep for now and to find a mechanism to	

	have this separate and specific for each of the hospitals but to align the DOACs and Warfarin. AW asked if trusts are still using different low molecular weight heparins due to supply diversity. BH responded that the last time it was looked into there were differences and a lot of that was due to there being different specialities in different trusts. As it would be difficult and undesirable to try and align this it would be OK to keep them as is. AW asked the group if they were all happy with the proposed RAG statuses for the Anticoagulants which were: Warfarin Green or Green Restricted, and Amber 0 for Warfarin for the treatment of Thromboembolism. He asked if it should be Green for all indications. LR commented that it depends on what services are commissioned as in her area they have a local enhanced service for DVT but this was not available in all areas so this could be why there are different proposed RAG statuses. DP agreed this was the reason for different statuses. MP added they also have a service for this and the ADAS service and that her GPs understand they wouldn't initiate the treatment for DVT. The proposed status of Amber 0 for DVT was agreed by the group. DP moved on with the DOACs, in the document it is illustrated the RAG positions for the different indications in the paper. He added there are some exceptions for East Lancashire with a slight difference but felt it was the best outcome. This was accepted by the group. AW asked the group if anyone else had any published guidance for low molecular weight heparins that need to be looked at and kept. MP added that they did have a BTH shared care document which had a few slight differences to East Lancashire's document. AW asked for members from other areas if they have any documents relating to low molecular weight heparins to send to DP for them to all be included. He also added if there were any gaps if DP could look to see if they could be filled. AW added to put on the work plan for around April time to try and align either the drugs or at least the methods used to try and create consistency across all the trusts. JD added that they are seeing more use of DOACs within oncology and added this may need looking at down the line and to have a position on them. BH asked DP if this could be looked at during the malignant chapter within the formulary. DP said this could be done and it was agreed to add this to the work plan. **Actions** Members to send any shared care or other related documents they have for low molecular weight heparins to DP for inclusion. If there are any gaps in the guidance/ shared care documents DP will look to be filled. DP to add onto the work plan to try and align either the low molecular weight heparins or the processes relating to choosing them across all trusts. DP to add looking at DOACs during the malignant chapter within the formulary working to the work plan.	**All Members** **DP** **DP** **DP**

2023/462	**Tirzepatide pathway for type 2 DM** DP brought this item; Paul from the CSU team has put together the paper due to the NICE TA that has come out regarding this. He spoke with diabetic consultants and had a lot of replies which are listed below in the paper. It is summarized into bullets which show that they would like to reserve this for certain types of patients. This has all been discussed via email contact so far but there is meeting booked for January, however as there is a NICE TA something needs to be done regarding this. AW asked if a decision needs to be made right now as this drug hasn't been launched. BH added that feedback seems pretty balanced from specialists in terms of using it where the likes of Semaglutide are not appropriate or in high risk patients. He added he felt it does need to be recognised that, due to stock shortages involving GLP1s and that these are likely to continue, if supplies of tirzepatide are secured, it is possible that tirzepatide will become the default GLP1. He recommended having a place for it in therapy but to be aware that there is a large cohort of patients waiting for treatment due to the stock shortages. LR added from her discussions it seems people want to use it in both primary and secondary care, and the stock issues are causing issues as well as moving a large amount of patients that may need to be changed over to Tirzepatide is worrying. She also mentioned the use of patient contracts which she has some experience with and that this may be an option in terms seeing the adding the value of the drugs. There is evidence to show that a lot of patients prescribed these drugs haven't achieved the outcome data as highlighted by NICE and making sure that if the outcomes aren't met then it stops otherwise the cost could be huge. LD asked if there are actual stock issues which is effecting patients getting the drugs as she hasn't had any issues in her practice. She added they have stopped 30% of their patients on these medications following audits and reviews and looking at the outcomes. But again, that she isn't aware of any stock issues affecting patients getting the drugs, and that the piece of work they have done has been really effective and that she would also not want to be starting patients on a drug just because something else is unavailable. AW commented that it was a national supply shortage. LD commented that she was aware of the national shortage but that it didn't seem to be an actual problem, as she has not had one diabetic patient come back and say they can't get hold of this or that drug as she is the diabetic specialist in her practice so they would be going to her. CM added it was interesting to hear LD's experience with this and that she would need to speak to staff who are closer to this to get a better picture but added that in relation to the audit LD mentioned the QIPP group and they had done a pilot in a few areas. They wondered if there was some guidance from this group to back up all of the points raised by LR and LD and to reinforce the messages about titrating patient doses and assessment to see if the drug is working. Also that there may be some patients who have had to stop this treatment due to stock issues and that nobody would want to just put them back on something that may not have been affective anyway. LR went back to the topic of patient contacts and added that she felt it was very successful approach. She asked if the group felt it would be a good	

	idea to take this to the Diabetes Health Improvement board or something similar. AW commented that he felt that the patient contract sounded like an approach to support the development of a shared decision and that the shared decision making is important, and that the trials show this drug could be more effective than the existing GLP1s, but it will be interesting to see what happens in the real world. He agreed that LR taking this to the Diabetes Health Improvement Board would be helpful. He also added maybe having a template for GPs and for the diabetic reviews having specific points that need to happen along with codifying the NICE guidance and ensuring the patients are meeting those requirements. He also added in the added benefit of activity levels regardless of drug choice. This was not agreed today but AW added that it will be looking towards having a best practice for these items. And that this could have a large financial impact, so it is important this is well managed. **Action** LR to take this item to the Diabetes Health Improvement Board to discuss.	**LR**
2023/463	**GnRH analogues in adults – update** AGR brought this item, this is a consideration for a shared care for GnRH analogues in adults. This was looked at in 2018 and it was proposed as an Amber 0 RAG status at that time with an information sheet, but it was decided to not progress further. Currently LSCMMG doesn't have a position on this apart from in gender dysphoria. Paul Tyldesley (PT) from the CSU has put the paper together while he has been looking at the endocrine chapter for the formulary. There are a few positions across the patch, Morecambe Bay have an Amber 0, there is also a shared care in East Lancashire for some indications but is a Red for Triptorelin. For the second part of the paper there are some cross boarder issues, Pan Mersey currently have GnRH analogues as Amber retained which is similar to our Amber 0 jus no shared care. GMMMG have a shared care approach for GnRH analogues in breast cancer, gender dysphoria services and prostate cancer and for everything else they have it as Red. The proposal is that the group could either adopt the shared care protocol from GMMMG for the cancer indications only and produce an additional shared care guidance for other indications which includes the gynaecology indications for all GnRH analogues which ae currently Amber 0 which means a RAG change there. Or to progress with the Amber 0 RAG status and produce supporting prescribing information sheets, however this wouldn't match up with what East Lancashire has which is shared care. AGR added that there will need to be further work on this and has raised it as work is currently ongoing for the endocrine chapter under the formulary. He suggested taking it back for further discussion and consultation with specialists, or if the group wanted to, to move forward with Paul's proposed options. AW asked AGR to clarify if the ask is for a decision or a consider, and AGR confirmed it is a consider to give more of a directional steer for decision later on. He again added his suggestion of having more discussion with the specialists. After a short discussion AW asked if the group could take away and discuss, then to feedback to AGR if people have a preference if which route to go down. BH added that he felt it would be useful to get initial thoughts from the group to inform the endocrine discussions so when it	

	comes back to this group they have been considered. AW added he felt a single approach would be preferred instead of a mixed approach. AW asked if this would include the use in endometriosis as that is neither cancer nor transgender indications, AGR responded that is does include this. **Action** By the second week in January 2024 could all members feedback to AGR their views on this item, which will then be fed back to the endocrine discussions before coming back to this group for approval.	**All Members**
2023/464	**Actimorph in palliative care** DP brought this item. This would be for a very small group of patients who would normally use Oramorph, but this is a tablet presentation. It was asked if it can be used, and the team propose a Green restricted as second line with the conditions listed in the paper. The consultation comments received were quite mixed, some said Do no prescribe and some said Amber 0. There is a palliative formulary which doesn't have RAG statuses but is a recommendation list and DP asked if the group felt it would be suitable for that also. The other point to highlight is that Oramorph 10mg/5ml is not a controlled drug whereas Actimorph is, and that if this is agreed to be used it would bring it into alignment with other areas in the region. AW asked LD for her view as she has a background in palliative care. LD commented that the palliative care group have been keen to have this but that there, but noted this group is predominantly specialists not GPs. She added this is not a huge costing for the drug in comparison to Oramorph so there isn't a concern from a costing perspective. She added this is also going to be used short term in palliative care so it is unlikely this will be used daily for months at a time. CM added that her team had discussed and agreed with having it and that she had spoken to the consultant at LTH who had originally requested it and that the Green restricted seemed like a suitable RAG. But added it would be good to pin down exactly what the restrictions are. AW added that on page 3 of the document it says 'For treating severe pain and breathlessness and for patients with symptoms due to palliative (life limiting) illness' so felt that this restricts it to palliative care as opposed to chronic pain. CM responded that she felt it was more restricted to an even smaller group of patients within palliative care such as those who don't get on with Oramorph or who were maybe not preparing and consuming the correct doses or that they couldn't tolerate liquids but asked DJ to confirm. DJ agreed with CM's statement and added that he felt the risks associated with patients who couldn't manage the liquid effectively would be one of the focuses. BH commented that the wording currently says: second line treatment option for patients when morphine is not suitable as the small volume patient or carer has difficulty measuring doses or they have difficulty understanding the difference between milligrams and mls or is not tolerated. He asked CM if she felt this would be clear enough or if she felt it needed more clarity. She said her team didn't feel it was clear enough but agreed it could be quite difficult to pin down. SR also added as a controlled drug accountable officer she added it was important to reference there may need to be a conscious decision to	

	switch to this from another drug where there is diversion suspected with the liquid alternatives, as it is quite easy to divert liquid and add water back in so they may have to make the switch decision as a secondary care trust. MP added that their decision for Do not prescribe was brought about by the feeling that the benefits weren't great to making the switch and agreed with CM's earlier comments on it being hard to pin down and these things do tend to move across into other prescribing not just palliative care. And that it could also end up being using in addition too rather than instead of regardless of how the restrictions are worded. LR commented that their discussions concluded in them being comfortable either way in the Green Restricted or Amber 0. But added the rational for the Amber 0 from the palliative care consultants at LTH was they felt it may be able to be prescribed and restricted for more select group of patients. They also added the need for it to be clearly explained that Actimorph is an immediate release drug as sometimes people get mixed up between immediate and slow realise drugs. She also asked if this was agreed for use would it need to be added to the end of life medicines count for community pharmacies. AW summarized that the preference seems to be Green Restricted, but that it would be good to include some words from SR regarding the risk of diversion. He said it would make sense to add this to the palliative care guidance as an alternative to Oramorph liquid and to be more expansive about the restrictions. He added as it is felt it would be a small number of patients it wouldn't need to be added to the end of life medicines in community pharmacies. LD added her agreement with the last statement as it wouldn't be considered as a mainstream medication so it wouldn't be expected to be used routinely by practitioners. AW asked AGR if he would be the person who would update the palliative guideline and he responded that it would be the North West SCN as its their guideline. AW added that they are no longer meeting and AGR said he still had contacts with NHS England who he could contact. LD asked AGR to include Kate Stewart from LTH who is a consultant doing some clinical leadership work for LD around palliative care and end of life care. It was agreed by the group for Green Restricted and for it to be added to the palliative care guideline. **Action** AGR to link in with Kate Stewart and his contacts in NHS England about adding this to the Palliative Care Guideline. AGR to link in with SR regarding wording to be added about diversion of liquid and switching to Actimorph.	**AGR** **AGR/SR**
2023/465	**Symbicort for asthma** DP brought this agenda item. Symbicort has a new license for use, not within the MART regimen, but when using separate steroid and reliever inhalers. The one to be used with other inhalers is a lower strength and the idea is that when using this the patient would have some of the steroid and it helps to control symptoms in the long term. The cost impact in the paper is quite high as DP did an estimate based of converting every single Salbutamol inhaler given out in the region and replacing it with this lower dose Symbicort inhaler. However, this wouldn't realistically happen, he	

	predicted actually only around 10% of that number would switch as most patients won't cease using their Salbutamol inhalers. This will be an option and there could be a change over, but this is what the new guidance says should be done. AW asked when BTS guidance would be updating as that would be the bigger change. DP responded that he wasn't sure but that it could be next year at some point. MP commented that when they first spoke with the Symbicort rep it was clear this is a step in the direction it was moving in. However, one of the consultants Catherine Pryor flagged it up and it was agreed that at that time it wasn't going to be a priority. MP added that the work has been done and it has been brought here but felt it doesn't need to be rushed through, and that there will possibly be competitors coming into the market which could then affect the pricing and cost impact. She felt while this is moving in the right direction the guidance isn't there yet so was happy for this to be put onto the sideline for the time being as there are other items that need prioritising at the moment. AW added as he can't see a 'must do' in the paper, would the group agree to not allow this as it was brought here for consideration not approval. MP commented that she felt it could be deferred as it is the right thing to do but with lots of other things going on in the background there is no rush for this right now. And added there are other things such as MART which are more important. CM added she would be guided by MP and that they had received similar feedback from the respiratory group and similar concerns. If approved they wanted to know where it would fit within the guidelines and a slight concern with if this starts to be used in the same way as Salbutamol and is used every day by asthmatics with several inhalers it could have quite a bit cost impact. MP added that the response could be that the group wish to await updated guidance. DJ commented that the respiratory consultants agreed the trial data is good and that it should be being used, but also had another viewpoint of there maybe use of Salbutamol inhalers in primary care without diagnosis and if they are using this in the same way there is potentially unnecessary overuse of the inhaled corticosteroids so there was a mixed review. MP commented that she felt it was unlikely that there would be overuse of it and she felt they had looked into that possible issue. AW put it to the group that due to that this is emerging evidence which is not yet in the UK or national guidance at this stage and there are other items that need to be prioritized would they be happy to agree on at this time it is not approved, but that when there is more clear evidence based direction of travel it will be brought back to the group for further discussion. This was agreed by the group.	
2023/466	**Triptorelin for precocious puberty** DP brought this item. It is already used but the ask is for a shared care or even a Green RAG (which was from Manchester Foundation Trust so is out of region). DP added that there needs to be a shared care if the proposed RAG rating of Amber 1 is approved. It's a change that would make things more convenient for patients and GPs would have to be happy to support. AW asked the group for opinions on the Amber 1 shared care.	

	MP added this came from one of her practices and they get asked about it. She added it seems sensible and an option, but she added she felt it was more about the RAG rating but felt the Amber 0 ensures that specialist oversight. AW asked if the product was licensed for this indication and DP responded that it was. LR commented that as there are only two of the licensed drugs for this indication something needs to be done but felt it may need to be consulted on with primary care if it goes down the shared care route as there is more and more pushback from primary care. LR added her team were not decided on either an Amber 0 or Amber 1. AW responded that there are some views that this should remain specialist controlled in some of the feedback received and the comments leaned more towards a Red over an Amber rating. He added if there is a 3-6 month review with the paediatrician so why would they not just give the drug at the review appointment. LD added that she agreed with AW's comments and said that her GPs would not be happy prescribing this and that she couldn't imagine the requirement in the change with patient numbers coming through either. She also added that shared care would be a push getting people to sign up to it and prescribe something that is probably not being used that often, so they are therefore not too familiar with it. AW suggested deferring this and finding out the prevalence of precocious puberty and how many patients this this affect. He added due to the possible low patient numbers it didn't feel like it should be shared care but kept under the specialists. BH agreed with AW's suggestion to defer and added it should be looked at but will go onto the list of items for after the formulary is complete. After some further discussion it was agreed for the CSU team to take this away and look at the prevalence of this and how many patients it would affect and bring something back to the meeting scheduled for February. **Action** DP to take this back and look at the prevalence and patient numbers, then bring back something to the meeting in February.	**DP**
2023/467	**Anastrozole for primary prevention for breast cancer** DP brought this item, Anastrozole has been part of the repurposing scheme that the NHSE has been doing with NICE. It has now been given a license for a specific treatment of prevention of breast cancer in postmenopausal women at high risk and this has been asked to be supported nationally by the director of specialist commissioning. DP worked out the national figures that it would cost £28,488 but that comes with a treatment cost saving of £46,656 so the cost implication would sit with primary care. It didn't go out for consultation as the drug it is a widely used and this is just a new licensed use for it and it is in NICE guidance. AW added this should be approved as its national guidance and it is a good option. BH asked the group on which RAG status they agreed on, Morecambe Bay and East Lancashire have it as Amber and asked the group if they were happy with this and as it would be recommended by a specialist it would be Amber 0. The group agreed this item and agreed the Amber 0 RAG status.	

	Action DP to take this to the appropriate group with the new Amber 0 RAG position for approval.	**DP**
2023/468	**New Medicines Review Workplan** DP has split the workplan into two sections, one section with already prioritized items and the second section with drugs that have been requested to be reviewed but have not yet been prioritized. This is to enable to the work to be spread out, provide an impact on formulary innovation and better value. DP added that a full review has not been completed on a lot of the items yet for speed so this means the group can discuss if the focus is to be on formulary which of the drugs that have already been prioritized or have been requested for prioritization and if they are needed to be done now or if they can wait a while. For the items already prioritized there is a small amount of information for the group on each one. For the ones not yet decided on DP has gone into a little more information to such as evidence background, cost, if there has been a Cochran review or a NICE review or anything from national to help give the group some direction in the decision making. DP asked the group if they wanted to go through each item during the meeting but added that it is a long list. AW added that previously the was a low, medium, and high category but with no definition on what that meant in terms of prioritization, so it has been done on how it meets the threshold. DP confirmed this was correct. AW then asked if this could also be used as a deprioritisation list due to the financial situation. He added there are items that if it could be added that something isn't recommended it would help take away the indecision. Due to the size of the list, AW asked members to take this away and over the next few weeks to feedback to DP on which items they feel should be put on for prioritization and which items that shouldn't be prioritized at all. The new medicine reviews will be slowed down for now to allow for the formulary to get completed so unless there is something that needs looking at before April it will have to wait until then. **Action** All members to take this back to their teams and send comments back on items for prioritisation and deprioritisation to DP within the next two weeks.	**All Members**
GUIDELINES and INFORMATION LEAFLETS		
2023/469	**Overactive bladder in female patients – update** AGR brought this item. As it was a basic update, to save time for needed discussions the group agreed the updates without further discussion.	
2023/470	**Recurrent UTI prophylactic antibiotic pathway – update** AGR brought this item. As it was a basic update, to save time for needed discussions the group agreed the updates without further discussion.	
2023/471	**Apomorphine shared care – update** AGR brought this item. AS had a comment on this document. She highlighted that there are listed specialist Parkinson's disease nurses, but they are all Preston based and there are specialist Parkinson's nurses in other areas. AGR responded that this was done as historically this was	

	developed with them but added if members have these specialist nurses if they want to forward their details to AGR he will add them in as well. As it was a basic update, to save time for needed discussions the group agreed the updates without further discussion. **Action** Members to forward any specialist Parkinson's nurses they would like to be included int the document to AGR.	**All Members**
2023/472	**Out of area prescribing position statement – update** AGR brought this item. He had made it clearer that it refers to NHS specialists but other than this there were no other major updates. MP also asked as it stated in a previous version about referring back to local medicines optimisation teams but is it right to refer if they have a position statement and so does our area. She also said about it saying refer back to tertiary specialist until we have a position on it. AW asked if there could be alternative wording such as refer to secondary specialist, MP agreed if there was a service then yes. AW asked AGR to create some alternative wording and then it will be approved via Chairs action. This was agreed by the group. **Action** AGR to link with MP around alternative wording. AW to sign off via Chairs approval once alternative wording has been added.	**AGR/MP** **AW**
2023/473	**Gender dysphoria prescribing information sheets – update** AGR brought this item. MP had a comment on this document. In relation to Gender Identity Clinics, it references Leeds GIC, but she asked for NHS to be added in, so it reads NHS GIC.BH added discussions by the group around the use of a new medicine and the process to decide if to agree to use it needs to be further discussed in the formulary work outside of this meeting. As it was a basic update, to save time for needed discussions the group agreed the updates without further discussion. **Action** AGR to add NHS to the document so the statement read NHS GIC.	**AGR**
2023/474	**NICE approved off-label indications included to be included in shared care agreements – consultation** AGR brought this item, the request came from LSCFT on the back of the antipsychotic guideline. The request was to not consider for psychotics but whether the group agrees in principle to include non NICE approved off label indications in LSCMMG shared care documents. The consultation went out and there was approval from ELMMB, LSCFT and Fylde Coast. There were some comments from Central Lancashire and Morecambe Bay and some additional comments from East Lancashire mostly referring to antipsychotics, however this request was to not include antipsychotics but were included in the document. It was noted in the comments that it	

	would be useful to have a separate section within the document which highlights that the drugs are NICE approved but that it is an unlicensed indication. AGR highlighted within the document that if the direction of movement is towards shared care templates, the North West templates that are currently been implemented contain this separate section. AGR asked the group that if they were happy to approve this inclusion then it may be worth waiting for the North West approach and the national shared care documents to be fully implemented as this section is already included within their templates. SR commented that there is no national shared care document for antipsychotics so that would need to be done first as a priority. AGR clarified this is for the template. SR then added there is a debate about if the form is at the back relating to the approval of accepting it or can it be the wording included but added that this should be discussed at another meeting due to time limits on today's meeting. BH added that there has been four shared care documents that have been reviewed and updated on behalf of the Noth West MOG, and that the intention is to bring them through this group to then make the decision on if to adopt or not. AW asked if the documents would be approved here first, BH clarified that they had already been to the North West MOG and that they have been updated by RDTC but they currently have no local information on them so the plan is to bring them here for approval and then the local information will be added. AW added this work with the North West is being split three ways between Greater Manchester, Cheshire and Mersey and Lancashire and South Cumbria. With the first three coming from Greater Manchester there will need to also be some coming from Lancashire and South Cumbria soon. It was agreed that NICE approved off-label indications could be included in shared care agreements as long as the indications are clearly stipulated as off-label.	
2023/475	**Denosumab shared care – update** AGR brought this item, it is a RAG change from Red to Amber one and this was raised at the previous meeting. The ask was to bring an updated shared care document to the meeting to aid with decision making. This is for the 120mg dose, the oncology indications and AGR added there is already a shared care for the 60 mg dose so this would be a separate shared care than the existing one. AW if there was a need for two separate shared care for the two different strengths. AGR commented that they for different indications so there is a need for both, however if the group would like them to be combined he could change this. AW suggested adding some wording referencing the other shared care in each document. AGR agreed this could be added. **Action** The document was agreed by the group and the RAG change to go to the next ICB ratification meeting.	
	L&SC ICB recommended diabetes meters, strips, and devices AW commented on this item that it seems to be a quick turnaround item which is waiting on this group's decision for implementation in the new	

2023/476	year. DP brought this item, LR feedback on this item to the diabetes group previously. The top part of the document has been split and one section includes comments back from the diabetes group with various actions highlighted. The main 'quick win' which AW raised is to have a document with two sections that includes brief details on the meters and test strips that have been approved in our region which are aligned with the national effort. The second part has more detail including things such as protocols for switches and switch support contact details. DP asked the group if they would approve the document. LR commented that this is a more succinct version than what may have previously been viewed. She gave a brief overview of the documents, with the first one containing a summary of the recommended meters and test strips in line with national publication. She added she has removed a section that was originally included and replaced it with a link to the national documents as it was for a very small patient cohort with specialist requirements such as paediatrics, gestational diabetes etc. However most patients will fall into the categories listed within the document. The health improvement board brought some comments which required some changes, with the first one being some adjustments being made to for first and second line for Glucofix tech sensor test strips as they were slightly more cost effective than others. The second line has been left in case of supply issues. LR highlighted there is no mass switch for patients which should help with supply issues. The other included paper shows where conversations have been had with the different companies and includes contact information for the companies for use relating to the different strips and meters and switch support. While a mass switch is not recommended however they are there to support if places have capacity issues to support switches. LR then shared current position and costing for these. The current costing relates to the most used across the different areas which showed to be Freestyle libre optium strips which is showing a cost of around £316,000. The next on is ContourNext which is around £223,000 and mobile cassette which is around £204,000 and Aviva testing strips which are almost £187,000. These are the four biggest which are the main focus for the switching program to the more budget friendly options mentioned in the paper. AW added this helps with the prioritisation plan and also added that it may be worth adding into the document why four have been chosen as even though it has been verbal discussed that is it to create diversity of supply within the budget options it isn't included within the document. LR agreed to add this in. AW also highlighted that embedded documents don't work in PDF so this needs to be considered. This was approved by the group to go out. **Action** LR to add in wording as to why four options have been included to help with diversity of supply.	**LR**
2023/477	**Valproate safety alert NPSA/2023/013/MHRA** DP brought this item to the group, and there were several members on the meeting that involved in looking into this.	

	This is another alert for Valproate but is quite strict in that it states it must not be initiated in female patients under 55 unless two specialists independently consider and document there is no other effective or tolerated treatment. It also states that patients should be enrolled in the pregnancy prevention program, which already exists but has a new requirement, and also at the next review there should be a second signature. This has all been dealt with by the Valproate group, but it is relevant for LSCMMG to have website entries that support this. DP suggested adding the new NPSA safety alert. There are currently two entries numbered one and two and entry two actually supersedes entry one so that can now be removed, and the new entry could be updated and be up to date with the NPSA alerts. AW asked if this new alert supersedes the previous two, to which DP responded that the alert labelled two gives details about the pregnancy prevention program and all the additional materials. SR commented that while this covers women under 55 there also needs to be some wording around men under 55 also as the alert is for everyone now. AW added that he co-authored a letter with David Levy which went to all areas for knowledge and encouraging people to make representatives available got the Valproate group. He added there are substantial concerns that particularly in neurology they won't have capacity to either engage in the group or to do these checks which puts them at odds with this context. They are planning on taking feedback to the valproate group as a plan has to be in place by the end of January 2024, so the intention is to take it to the ICB Quality committee in January to look at what the plans are to have a system wide approach and to also highlight any gaps that need to be filled. AW added that the outcomes from the valproate group needs to come here to ensure information is put on the website. SR added that she was aware that neurology are engaging in the meeting, not a neurologist but a specialist nurse or pharmacist. She added this maybe more difficult for areas such as neurology as it is still first line for many indications. AW agreed this may have to be continued in some indications and that this new alert means there will be more input to ensure that valproate is the best treatment for the patient. LD commented the need to think about the resources required for this ongoing management and the difficulty in primary care with making sure that forms are completed in a timely manner and highlighting that the time and effort that is going into chasing those forms down is significant, along with patients that have been discharged and still having to chase down the forms every year. AW agreed and added this is why it is important to get this robust process in place. SR commented that the valproate group are aware of this, and they are looking at it and that they are trialling getting the annual form on LPRES (Lancashire Patient Record Exchange Service) and as far as she was aware this was successful so if this can get up and working it would make a big difference in getting the yearly reviews completed. AW added that the epilepsy consultants were also keen to have an online epilepsy record as well.	
	Guidelines workplan AGR brought the workplan for the group. He had three items that needed to be highlighted. The team have been asked to look at the cannabis based medicinal products position statement as there have been an increase of private providers prescribing buds. This request was from SR,	

2023/478	but AGR has heard about this in other areas also, he asked the group if they were happy to be reopened and looked at. AW commented that there are a lot of TBC items on the list and also asked if the January deadline listed was realistic. AGR agreed it probably wasn't and he would review them. AW added he was giving AGR permission to prioritise the formulary work for now. AGR responded that he had looked through the items and highlighted in blue on the document items he felt could be paused to support the formulary work. He added he had tried to prioritise updating current work that has already started, and that while he had a concern about UHMBs shared care documents he acknowledged that there is an interim arrangement so they can still be used. AW added this was agreed but asked the group if they could think of anything else that could be delayed to let AGR know. AGR added he has been given a query on PGDs and how a practice would now access IMS and VACs PGDs. He said he was aware of a google drive that was previously hosted on EMMB so he asked if they could replicate that page and put on LSCMMG so people can be signposted to view those documents there. This was agreed. The last item was Daridorexant which was the sleep NICE TA which came out last month, the team are still unsure where it will sit as it was mentioned it would be primary and secondary care. The advised RAG is Amber 0, GMMMG are considering a Green Restricted and Pan Mersey still have it listed as Grey so it still isn't clear what service it will sit in. SR commented that the management of insomnia is primarily in primary care so Amber 0 would be difficult. AW commented that there are some specialist sleep services available. SR responded that she has also sent out information about the availability of CBT for insomnia, so this is something that needs to be looked at and decided if it needs to be more readily available, to which AW agreed. BH added that all ICBs are struggling on what to do with this drug as lots of services aren't equipped to deal with it and there were some concerns about making it Green. So he didn't feel this would be a quick fix. AW suggested taking a recommendation to the North West MOG or ask them for a recommendation, he asked BH to send it to Monica to ask them if they could pick this up. **Action** BH to send the item on Daridorexant to Monica for support from the North West MOG.	**BH**
NATIONAL DECISIONS FOR IMPLEMENTATION		
2023/479	**New NICE Technology Appraisal guidance for Medicines November 2023** **TA929 Empagliflozin** - for treating chronic heart failure with preserved or mildly reduced ejection fraction. There is no cost impact as it's the same price as Dapagliflozin and the cobalt.	
2023/480	**New NHS England medicines commissioning policies October 2023** Nothing urgent to consider	

2023/481	**Regional Medicines Optimisation Committees - Outputs October 2023** Nothing to consider	
2023/482	**Evidence reviews published by SMC or AWMSG October 2023** DP brought this item, the only one of interest was Degarelix which is still under review by NICE. There may be some pressure to prescribe but for now DP is raising it just for awareness. He also highlighted a few items on the paper for interest only at this time.	
ITEMS FOR INFORMATION		
2023/483	**Lancashire and South Cumbria NHSFT Drug and Therapeutic Committee October 2023** The minutes were sent out for information. SR asked if there was a need for this to still come here due to the length of the agenda and that no other D&T minutes are sent to this group so she asked if this could be reviewed to see if it is still needed. AW suggested if the D&T suggests a system wide change that could come here as a specific thing rather than the D&T minutes. SR agreed to this so actions will come here from the D&T.	
2023/484	**LSCMMG cost pressures log** BH brought this item, it was updated on the Tirzepatide from discussions at the last meeting. A speculative cost pressure of £2 million against the weight management indication which is based on information from what is in the SPS horizon scanning document. From today's discussion there is no additional cost pressure as it was agreed to pause Symbicort. AW asked if Actimorph was really as small as £864. BH responded that in theory if it is really short term at 100 patients a year then yes, it could be bigger, but it wouldn't be a very big impact. SR asked if the blood glucose meters and strips as a potential saving to which AW and BH agreed, BH said he would look into adding it to the log. **Action** BH to look at adding the potential saving from the blood glucose meters and strips.	**BH**
2023/485	**AOB – LSC ICB Branded Generic Prescribing Criteria – Draft for discussion** CM brought this item; local pharmacy committee members were also invited but none were in attendance when this was discussed. This paper was circulated to members in the additional papers pack. CM highlighted is the title of the paper which she said AW had a preference to change it to Branded Prescribing Criteria which AW confirmed. This change was agreed by the group. CM explained to the group that this document had already been to various internal groups including QIPP and they have also met with the LPC for input as well as the IMOC. She went on to explain there were two statements highlighted in blue within the document that had caused the most discussions and one further statement she would like some discussion on also. The first highlighted statement was bullet two and it read: *branded generic*	

	manufacturers sometimes reduce the price of their products to one that is cheaper than the equivalent generic product listed in the drug tariff. CM added her own view from primary care which was that this is a factual statement, and it does present a saving to the primary care prescribing budget, and that the feedback she had received from the LPC was that they didn't want this highlighting. CM added she was unsure if this statement should be included or not. AW asked if it was statement or fact to which CM responded that it is a statement of fact. AW replied that it may be inconvenient however it's a statement of fact. The second statement was the first statement and it read: t*he branded generic product is not in category M of the NHS drug tariff.* CM explained for members outside of primary care that the way community pharmacy colleagues are paid, there are a variety of categories within the drug tariff which lists the way that those contractors are paid. Category M is the category of products that are used by the NHS to balance profit on purchase as a contractual payment to the community pharmacy contractors. This comes around once or twice a year, it fluctuates up and down so it recognised that pharmacy colleagues receive a balance sum from profit on purchase and that is monitored and adjusted throughout the year. She added that this can be quite difficult to balance. She continued that there are two main ways that they would work with GP colleagues in promoting the use of these particular products. One is Optimize which is the decision support software on GP systems, which will give them a prompt message and promote cost effective prescribing. The second method is Switch programs. This may mean using staff from leads teams or practice staff to suggest particular products when they have become more cost effective, and the cost switch program should be actioned. This second option can be more disruptive to pharmacy colleagues. CM added her concern for this statement which was that there are messages on Optimize for category M products which present particular savings to primary care for the primary care prescribing budget, and this is important it is kept and not be in a position where there isn't a mechanism to recommend the most cost effective product at the point of prescribing. She advised to rework the statement to clarify either through weakening the category M statement and stating generally there won't be a use of category M and there will not be a switch done at that point but that there will be a recommendation for a cost effective product. AW asked the group for any comments at this point to which there was one from BH. He added he felt that this seemed like a sensible approach to include CM's recommendation to reworking the statement and that so long as it isn't a mass switch the impact on community pharmacy shouldn't be too significant. CM moved onto her next point. The last statement reads: *any change programs to be completed by PCN/ GP Practices should be made in line with the ICB agreed list now and we have different models of medicines optimization input across the ICB.* There are different models of medicines optimization input across the ICB, there are some employed teams and some contracted teams and in some localities there are some directly employed by practices through contract arrangements with the ICB meaning some PCNs will do cost saving projects themselves. What has been asked is for them to do this in line with this statement and in reference to any guidance that comes out. The QIPP group have particular brands that should be used but practices can prescribe as they would like to. Currently in the statement there is a should	

	rather than a must and CM has received support for both strengthening and weakening the statement so at the moment CM feels this is a middle ground. She asked the group for opinions on this. AW asked PE if he had any comments as he has been involved with the value group and some of the other discussions. PE agreed with CM and felt the statement was fine as is. AW asked if anyone from trusts had any issues with it as the aim is to align products across the patch. SR commented that she would add about not exceeding ten per annum, and that there is some consistency across the ICB on what the ten are and not having ten per locality. Another thing she added was a need to be minded of commercial medicines unit contracts that secondary care access. She added there is some monitoring of off contract purchases so this needs to be included. AW asked if the ten is 'tying hands.' SR responded that she felt is has been put in for balance as there is some drawbacks from branded generics, she was in agreement with it but that it needs to be consistent. AW responded with adding 'would not normally exceed ten per annum' as there may be good reason for this fluctuating from year to year depending on what is in contract. SR responded that its an agreement process and its important to analyse the benefits and having a clear process for that. AW commented that this is linked with how, actively or otherwise, this is implemented as there are different processes across the patch from legacy CCGs and trust approaches. It is important to note that people should automatically do a switch but that it would be done at the point of review not making mass switches. He added there may be a need to be explicit on this as that is where some of his concerns had come from. CM agreed with SR's comments to get consistency across the patch and there is a group that has memberships from each locality that will look at this. CM added she had made a change to the document since coming from IMOC which was in relation to when products are being considered that there will be a discussion with the whole system including community pharmacy and secondary care colleagues. She agreed it needs finalising and the process needs to be further explored and that the statement around the ten per year refers to active switching versus recommendations versus recommendations and Optimize. AW thanked CM and the value team for going though this, and asked the group if they were happy to approve via chairs action once the little changes have been made. He added the need to ask the value group to list the ten items to be put on the website which can then be approved at a future meeting. This was agreed by the group. **Action** CM to make amendments as detailed in the discussions above and AW to approve via Chairs action once they have been made.	**CM/AW**

DATE AND TIME OF NEXT MEETING

The next meeting will take place on

11th January 2024

9.30 – 11.30

Microsoft Teams

ACTION SHEET FROM THE

LANCASHIRE AND SOUTH CUMBRIA MEDICINES MANAGEMENT GROUP 21.12.2023

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. **December 2023 update:** On the agenda, closed.	**AGR** **AGR** **AGR** **AGR** **AGR**	**Open** **Open** **Open** **Open** **Closed**	**13.07.2023** **14.09.2023** **12.10.2023** **09.11.2023** **21.12.2023**
ACTION SHEET FROM THE MEETING 14th September 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. **December 2023 update:** On the agenda, closed.	**LR** **LR** **DP/BH** **DP/BH** **DP/BH**	**Open** **Open** **Open** **Open** **Closed**	**14.09.2023** **12.10.2023** **12.10.2023** **09.11.2023** **21.12.2023**

2023/403	**Guidelines workplan** BH to check he has the correct document via Sharon to send around in relation to clarity on 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. **December 2023 update:** To be discussed today, closed.	**BH** **LR** **BH** **BH** **LR/BH** **DP** **BH/SS** **BH/SS**	**Open** **Open** **Open** **Open** **Open** **Open** **Open** **Closed**	**14.09.2023** **14.09.2023** **14.09.2023** **14.09.2023** **12.10.2023** **09.11.2023** **09.11.2023** **21.12.2023**
ACTION SHEET FROM THE MEETING 12th October 2023				
2023/415	**Matters arising (not on the agenda)** Any members interested in chairing the meeting to come forward and let AW know. 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. **December 2023 update:** Actioned, closed.	**All Members** **EB** **DP** **All Members** **All Members** **EB** **EB**	**Open** **Open** **Open** **Open** **Open** **Open** **Closed**	**12.10.2023** **12.10.2023** **12.10.2023** **09.11.2023** **09.11.2023** **09.11.2023** **21.12.2023**
2023/421	**Sodium Zirconium Cyclosilicate - Update**			

	AGR to put the GMMMG shared care guidance for this item into LSCMMG formatting and send out for consultation. **November 2023 update:** Will be sent out at the end of November for consultation. **December 2023 update:** Will be sent out this month.	**AGR** **AGR** **AGR**	**Open** **Open** **Open**	**12.10.2023** **09.11.2023** **21.12.2023**
ACTION SHEET FROM THE MEETING 9th November 2023				
2023/434	**Declarations of interest** There were no new declarations of interest, EB/DP to send the declaration form out to new members. **December 2023 update:** Actioned, Closed.	**DP/EB** **DP/EB**	**Open** **Closed**	**09.11.2023** **21.12.2023**
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. **December 2023 update:** Actioned, Closed.	**AW/EB** **AW/EB**	**Open** **Closed**	**09.11.2023** **21.12.2023**
2023/438	**Ranolazine MR tablets for adjunctive therapy in the treatment of stable angina, RAG rating change** Ranolazine for adjunctive therapy in the treatment of stable angina, to be presented at the next Commissioning Resource Group with a recommended RAG rating of Green Restricted for approval. **December 2023 update:** Approval acknowledgement has not be received by the organisation. It was taking to CEG but final approval was still being sought. NB and AW to look into the decision as the CEG meeting for January has been cancelled.	**DP** **AW/NB**	**Open** **Open**	**09.11.2023** **21.12.2023**
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. **December 2023 update:** On the agenda, closed.	**AGR/PT** **PT** **AGR**	**Open** **Open** **Closed**	**09.11.2023** **09.11.2023** **21.12.2023**

2023/441	**Requests from private prescribers to transfer or share prescribing with an NHS GP** AGR to take the position statement to LMC for their comments. AGR/BH to look at how this would move from a position statement to a policy statement and what that would entail. AGR/BH look to possibly take the statement to the Clinical Effectiveness Group. **December 2023 update:** Ongoing.	**AGR** **AGR/BH** **AGR/BH** **AGR/BH**	**Open** **Open** **Open** **Open**	**09.11.2023** **09.11.2023** **09.11.2023** **21.12.2023**
2023/442	**Azithromycin RAG and prescriber information sheet consultation** AGR to speak to local AMR leads and Jill Demont regarding treatment holidays. AS to send AGR the summary sheet and the patient leaflet. AGR to make any amendments once the above has been done and bring back to the next meeting if possible. **December 2023 update:** Ongoing.	**AGR** **AS** **AGR** **AGR**	**Open** **Open** **Open** **Open**	**09.11.2023** **09.11.2023** **09.11.2023** **21.12.2023**
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. **December 2023 update:** On the agenda, closed.	**AGR** **All Members** **AGR**	**Open** **Open** **Closed**	**09.11.2023** **09.11.2023** **21.12.2023**
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. **December 2023 update:** PE responded on behalf of FP. There has been no response from providers or draft document and asked to defer to January/ February meeting.	**FP/RS** **FP/RS** **FP/RS** **FP/RS/PE**	**Open** **Open** **Open** **Open**	**09.11.2023** **09.11.2023** **09.11.2023** **21.12.2023**

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. **December 2023 update:** DP has contacted the Lipid group, and a meeting is planned for some point in the new year. This has been moved to the work plan and removed from the action log. Closed.	**DP** **DP** **DP**	**Open** **Open** **Closed**	**09.11.2023** **09.11.2023** **21.12.2023**
ACTION SHEET FROM THE MEETING 21st December 2023				
2023/455	**Declarations of interest** EB will amend the minutes to reflect the agreed amendments before they are added to the website.	**EB**	**Open**	**21.12.2023**
2023/459	**Formulary Oversight Group update** All members to consider having UHMB formulary live/ available to all for the time being to ensure there is a formulary available ready to discuss at the meeting in January.	**All Members**	**Open**	**21.12.2023**
2023/461	**Anticoagulants RAG change review** Members to send any shared care or other related documents they have for low molecular weight heparins to DP for inclusion. If there are any gaps in the guidance/ shared care documents DP will look to be filled. DP to add onto the work plan to try and align either the low molecular weight heparins or the processes relating to choosing them across all trusts. DP to add looking at DOACs during the malignant chapter within the formulary working to the work plan.	**All Members** **DP** **DP** **DP**	**Open** **Open** **Open** **Open**	**21.12.2023** **21.12.2023** **21.12.2023** **21.12.2023**
2023/462	**Tirzepatide pathway for type 2 DM** LR to take this item to the Diabetes Health Improvement Board to discuss.	**LR**	**Open**	**21.12.2023**
2023/463	**GnRH analogues in adults – update** By the second week in January 2024 could all members feedback to AGR their views on this item, which will then be fed back to the	**All Members**	**Open**	**21.12.2023**

	endocrine discussions before coming back to this group for approval.			
2023/464	**Actimorph in palliative care** AGR to link in with Kate Stewart and his contacts in NHS England about adding this to the Palliative Care Guideline. AGR to link in with SR regarding wording to be added about diversion of liquid and switching to Actimorph.	**AGR** **AGR/SR**	**Open** **Open**	**21.12.2023** **21.12.2023**
2023/466	**Triptorelin for precocious puberty** DP to take this back and look at the prevalence and patient numbers, then bring back something to the meeting in February.	**DP**	**Open**	**21.12.2023**
2023/467	**Anastrozole for primary prevention for breast cancer** DP to take this to the appropriate group with the new Amber 0 RAG position for approval.	**DP**	**Open**	**21.12.2023**
2023/468	**New Medicines Review Workplan** All members to take this back to their teams and send comments back on items for prioritization and deprioritization to DP within the next two weeks.	**All Members**	**Open**	**21.12.2023**
2023/471	**Apomorphine shared care – update** Members to forward any specialist Parkinson's nurses they would like to be included int the document to AGR.	**All Members**	**Open**	**21.12.2023**
2023/472	**Out of area prescribing position statement – update** AGR to link with MP around alternative wording. AW to sign off via Chairs approval once alternative wording has been added.	**AGR/MP** **AW**	**Open** **Open**	**21.12.2023** **21.12.2023**
2023/473	**Gender dysphoria prescribing information sheets – update** AGR to add NHS to the document so the statement read NHS GIC.	**AGR**	**Open**	**21.12.2023**
2023/475	**Denosumab shared care – update** The document was agreed by the group and the RAG change to go to the next ICB ratification meeting.	**AGR**	**Open**	**21.12.2023**
2023/476	**L&SC ICB recommended diabetes meters, strips, and devices**	**LR**	**Open**	**21.12.2023**

	LR to add in wording as to why four options have been included to help with diversity of supply.			
2023/478	**Guidelines workplan** BH to send the item on Daridorexant to Monica for support from the North West MOG.	**BH**	**Open**	**21.12.2023**
2023/484	**LSCMMG cost pressures log** BH to look at adding the potential saving from the blood glucose meters and strips.	**BH**	**Open**	**21.12.2023**
2023/485	**AOB – LSC ICB Branded Generic Prescribing Criteria – Draft for discussion** CM to make amendments as detailed in the discussions above and AW to approve via Chairs action once they have been made.	**CM/AW**	**Open**	**21.12.2023**