Minutes of the Lancashire and South Cumbria Medicines Management Group Meeting

Thursday 18th April 2024(via Microsoft Teams)

PRESENT:

Andy White (AW)	Chief Pharmacist (Acting Chair)	Lancashire and South Cumbria ICB
Ana Batista (AB)	Medicines Information Pharmacist	East Lancashire Hospitals NHS Trust
Andrea Scott (AS)	Medicines Management Pharmacist	University Hospitals of Morecambe Bay NHS Foundation Trust
Clare Moss (CM)	Head of Medicines Optimisation	Greater Preston, NHS Chorley and South Ribble Locality
David Jones (DJ)	Assistant director of pharmacy Lancashire teaching hospitals	NHS Lancashire Teaching Hospitals
Emma Coupe (EC)	Assistant Directory of Pharmacy	East Lancashire Hospitals NHS Trust
Dr H. Sari-Kouzel (HS-K)	Rheumatology Consultant	Blackpool Teaching Hospitals Foundation Trust
Jenny Oakley (JO)	Lead Pharmacist - Surgery, Critical Care and WACS	University Hospitals of Morecambe Bay NHS Foundation Trust
Jenny Walters (JW)	Lead Pharmacist for Surgery	Blackpool Teaching Hospitals NHS Foundation Trust
Lucy Dickinson (LD)	Finance Manager for Primary Care	Lancashire and South Cumbria ICB
Paul Elwood (PE)	Senior Medicines Optimisation Pharmacist	NHS North of England Commissioning Support Unit
Nicola Baxter (NB)	Head of Medicines Management	NHS Lancashire and South Cumbria ICB (West Lancashire locality)
Dr Shenaz Ramtoola (DSR)	Consultant Physician	East Lancashire Hospitals NHS Trust
William Price (WP)	Dermatology Clinician Pharmacist	East Lancashire Hospitals NHS Trust

IN ATTENDANCE:

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

	SUMMARY OF DISCUSSION	ACTION
2024/059	**Welcome & apologies for absence** Apologies were received from Lisa Rogan, John Vaughn, Mohammad Ahmad, Kam Mom, Faye Prescott with Paul Elwood attending on her behalf, Melanie Preston, Rukaiya Chand, Sonia Ramdour, Ashley Marsden, Jennifer Graham, and Clare Moss joined later on in the meeting due to a clash.	
2024/060	**Declaration of any other urgent business** None for this meeting.	
2024/061	**Declarations of interest** None for this meeting.	
2024/062	**Minutes and action sheet from the last meeting 21st March 2024** With one amendment to show Dr Ramtoola's apologies, the minutes were approved and will be uploaded onto the LSCMMG website.	
2024/063	**Matters arising (not on the agenda)** None to discuss.	
	NEW MEDICINES REVIEWS	
2024/064	**Formulary update – Flow chart and change classification rules** DP brought this item and shared the updated flow charts on the screen for the group. This was originally one large document, but it has now been split into two separate flow charts for clarity. The first one is named Flow chart inputs and the second is named Flow chart outputs. DP went through the first document, highlighting the different parts of the flow chart with existing process. He started off at the top where new drug applications go through trusts or medicines optimisation in primary care. The next part highlights what will happen when the new formulary is live, which will need monitoring when the new formulary process goes live so that things are not missed, and the system is responsive. The CSU team will meet twice weekly to keep on top of this and everything will be recorded onto a large spreadsheet. At the meetings the team will also classify any changes into the three classification categories. With minor updates they shouldn't require approval so there won't be a consultation and can go straight onto the formulary and it will go onto the spreadsheet and LSCMMG informed of the change. Moderate updates will come with a very small review so there will also be no consultation but will be brought to the group with an expectation of no objections to be made. Major changes fall into two classes, class A is the standard new medicine review, a new expensive drug comes out or new NICE guidance comes out. A class B is slightly different in that it wouldn't go directly through LSCMMG for the consultation process it would go to the specialist clinical groups for the consultation. For a class A the first step would be to copy in the clinical	

	groups so they have chance to comment, then it would come to LSCMMG for review and onto the action spreadsheet along with the various comments, so everyone is in view of everything raised. DP next brought up the page with the class definitions on for the group. Major class A are items with more than a 10% price increase compared to the current formulary option or impacting more than £30,000 by 100,000 population or a new NICE TA. Class B would be a significant formulation change of a formulary drug, this could be a cream that has been suddenly made into tablet form, a new RAG rating for a current formulary item to bring alignment with neighbours so cross boarder working or a new indication for a current formulary drug. Moderate update may need to have some flexibility used as most things will go through as this classification such as drugs used as accepted practice from a trust that will have low cost implications and usually will have a Red RAG rating. DP added at this point he was unsure about the low clinical implications as it sounds dismissive and with the Red RAG rating this could be where trusts work together to use their own processes and come together with an agreed RAG rating. This would mean a decision could be made quickly without having to go through a large consultation and approval process and implemented swiftly. Moderate updates also include current formulary drug and dose/ regime that is included in an accepted LSCMMG, ICB, NHSE or NICE guideline. The minor updates are things such as there's a new strength, a deletion or new warning, and these have a cost impact of below £8,800 per 100,000 population. Class B and moderate updates would be between £8,800 and £30,000 per 100,000 population. AW came in at this point and asked where the numbers had come from, BH responded that these are the NICE threshold where they say something isn't a significant or is a significant cost pressure. He added the only challenge with this is shown in the NICE paper where AGR will put £158,000 so technically this is above AWs delegated financial limit that can be approved here. So its up to the group if the NICE definition is used or if things are kept below the limit on which can be approved. AW asked how this will work with new drug forms and asked how trusts would input into this. DSR added her comment that she was very happy with this and said it will do a lot towards streamlining the processes here. She also added that when the diagram suggests the consultation will go to specialist groups she feels it should also go to the LMC where items to be consulted on relate to things prescribed in primary care. BH responded that the LMC are already part of LSCMMG's consultation process so they would automatically receive these but added that could be made explicit. DSR responded that she was referring to a class B where it states it would go to the specialist groups for consultation. AW added if there was an assumption that it would go to both specialist groups and the previous consultation groups to which DP said yes. DP added that with the clinical speciality groups they are hoping to have GP representation, not necessarily the LMC but GP representation in some form, and the dotted line on the flow chart between specialist groups and LSCMMG means that all will have a chance to see it, but the main driving force for the consultation will be the specialist's groups. AW asked if this has been anywhere else, and DP said that it had been to the formulary oversight group. AW then asked what the feedback was from them and DP responded that they were positive about the process and asked JO who is	

	the chair of that group to comment. JO said they wanted to take it to the chiefs meeting for the acute trusts to discuss how Red drugs could be managed and to do more collaborative working and do things once instead of several different times. AW asked the group for thoughts on the document. DJ asked what the role of the trust committee is in this process as it takes time to get things onto agendas. He asked if there was a form that would go to the trust committee for an expectation of things being approved, but then it's going to the ICB process. Should it be filtered out from trust committees and then go onto the ICB process. AW added this was the bit he wasn't clear on particularly since JO had been asked to look at the consolidated new drugs form to bring things though and how that process fit with this and what filtering process there was. DP responded that this is why JO wanted the take this to the chiefs and felt it would be a mutual recognition procedure where one trust makes a decision and if the others don't object this process could then be used to officially approve. AW agreed on taking this to chiefs and was aware that decisions should not just be made at LSCMMG. He added there needs to be a decision log each month detailing any minor, moderate or major changes and in turn any that need formal sign off. DP responded that the action spreadsheet and the input spreadsheet are the same one so there will be a report each month on everything that has happened. AW asked when the meeting with the chiefs was happening, and DP responded that it hasn't been arranged yet but was hopeful it would happen before the LSCMMG meeting in May as it needs to coincide with the formulary sign off. AW agreed it needs to coincide with the formulary sign off but added this shouldn't be rushed it needs to be agreed and the processes agreed like the new drugs form and understanding where it will all fit in. JO added her agreement of adding in the chairs of local D&T groups as previously mentioned as they are part of the process as well. She added if they should meet the chiefs initially and ask them to feedback to their D&T groups and send back comments as it will be quite difficult to get everyone together at once. AW added that if people can try to meet in May and bring something back to the June LSCMMG meeting, and added if there is a combined new drug form to consult on that would be helpful. JO responded that she had looked at the four separate forms and they are all very similar to LSCMMG's form, and that central and Preston's form was more simplified and user friendly, so she was going to try and mould something on that form if DJ was happy with this. DP said he was happy for this as long as there is a minimum data set that is common to all, and AW added that he was happy to use links instead of repeating long paragraphs form national guidance or other evidence source to keep things light. **<u>Actions</u>** JO and DP to take this to the chiefs meeting and ask them to feedback to their D&T committees and then send their feedback to JO and DP. JO to look at creating the merged new drug form for the acute trusts to consult on. DP to bring this back with the feedback to June's meeting.	**JO/DP** **JO** **DP**

2024/065	**GI Formulary Subchapter: Prokinetics** DP presented this item; it was a brief update on how Prokinetics will be presented on the formulary. AW asked if this would be a minor, moderate or major change under the new classifications. DP responded he felt it would be a moderate change. AW then asked the group if this was the type of format they would be happy with relating to the moderate change as its only come to the meeting for attention and approval not out for a consultation. BH added that the next agenda item is a moderate change and may be more helpful in understanding the classification system for the group. AW asked the group if they were happy with this item, there was no disagreement, this item is approved. **Action** The recommendations for domperidone, metoclopramide and erythromycin for addition to the formulary were agreed as written.	**DP**
2024/066	**Carbetocin for the Prevention of Postpartum Haemorrhage** DP presented this item; it was a request from a consultant from ELTH. DP has looked at this with the new forms and new classification system and taken this as a moderate application. This is because the drug is now included in a NICE guideline which it wasn't previously, and DP felt it should be adopted due to the good evidence. He has provided a bit of background in the paper as to why the recommendation to include it was made. He asked the group if they agreed with the change and also asked the group if this is what they would like to see in terms of a moderate update, being an acceptance of a national guideline update. AW commented with things like equality and inclusion it is presumably done by NICE so instead of putting none in the document, put in that it is covered in the NICE guidance. The other point he made was if there is a different population number would be the only other possible amendment needed. AW asked the group if they were happy to approve this item and if people were happy with the process of a moderate update. The item was approved. **Action** Carbetocin for the Prevention of Postpartum Haemorrhage was approved to be added to the formulary following approval at CRG / CEG.	**DP**
2024/067	**Melatonin – Adults** DP presented this item; this is to get clear RAG ratings for melatonin. After consultations with specialists which the review and conditions are listed in the document such as sleep disturbances in patients, the paper has been sent out for consultation. The feedback was people agreed on the proposed RAG statuses, so the ones listed in the paper the specialists are happy to adopt. The hope is to produce a guideline with the regulations included in the future. AW commented that under equality and inclusion it has none and he felt	

	there are some fairly special groups of patients so there could be some inclusion issues with ADHD patients, Autistic spectrum patients and others. He asked if the ask is to adopt what is in the national guidance and the inclusion issues have been covered off, but added again putting none identified could be seen as dismissive. DP wasn't sure if he agreed on this as the patients are being treated for a disorder but not being treated any differently because of this, so it isn't saying everyone can have it except people with ADHD for example. AW responded that its important that when recommending treatments for some groups not to exclude any, and there is something about any legal issues identified around the legal status of some of these products and how they are recommended. DP responded that if licensing is a legal issue they can be added on, it hasn't previously but it could be added. AW added he was thinking of the audit trail because if they are recommending unlicensed treatment or licensed for an off label indication it needs to be done knowingly instead of saying none identified. He added this isn't specifically to this item, just in terms of the template waving things through in the future, the group needs to ensure these things are covered off adequately. AW asked the group if they were happy with the content of the document. DJ commented that some concerns were raised about the new drug Daridorexant and the use of it. Also that melatonin is not being recommended in the over 55 category yet there's a new drug that's available that is potentially more costly of which there is NICE guidance for, would a short course of Melatonin not be useful. He added he is aware about the amount of CBT that is commissioned and where the commissioning is coming from etc but is known that Melatonin is not harmful. AW added that melatonin isn't beneficial in some patients either so could this be harmful. DJ responded that in the paper there is some evidence for use in that age group. AW added that if there is a higher bar for Daridorexant to go through, should CBTIs be used before any other treatment is offered full stop? DJ agreed he felt that CBT is the way forward but potentially there is going to be hundreds of thousands of patients on Daridorexant, which has a pharmacological action of possible side effects which is going to be costly for long term use when there is step before that which could be Melatonin. AW added it could be better sleep hygiene, which is non drug at all. DP commented that when a decision was made previously on Daridorexant, there already had a Do Not Prescribe RAG rating for Melatonin so that was probably the time to consider Daridorexant. However it has been reconsidered with this. AW asked what the feedback from the partners on this was, are they happy to go ahead with what has been recommended. DP responded that there was general support, and AW asked the group if they were happy to go ahead with these recommendations. The recommendations were approved as written. **Action** The following RAG ratings were agreed following approval at CRG / CEG: Sleep disturbance in adults with ADHD – Agreed as an Amber 0 RAG rating. Sleep problems in patients with dementia associated with Alzheimer's – Agreed as a Do Not Prescribe RAG rating. Older adults with sleep disturbances – Agreed as a Do Not Prescribe RAG	

	rating (This is an existing RAG rating so no further action required). Sleep disorders in the blind – Agreed as an Amber 0 RAG rating, for totally blind patients when started by a specialist and with clear review guidance.	
2024/068	**Melatonin – Products** DP presented this item, a few meetings back the children's pathway for Melatonin for children recommended the Ceyesto brand of liquid which is relatively inexpensive at £17.10 for 100mls. The drug tariff price for Melatonin is £82.73. Ceyesto is licenced for children between the ages of 6 and 17 years old, so is off label for under 6 years. This drug was chosen partially due to the price and partially due to the excipient component. This component is better than some others, but it does still have the excipients of propylene glycol and benzyl alcohol. DP explored the dosage range of the two excipients that are ideal, and the new version doesn't have those excipients so could be seen as being more favourable. The main point is both are licensed for children and adolescents but Ceyesto only being licensed from 6 years old. Possibly if treating those under 6, Ceyesto isn't licensed and if something isn't licensed the risk should be assessed based on things that can be quantified, so it may be beneficial to use the new brand for those patients. AW asked what DP's recommendation is. DP said he recommends to use the new brand of Melatonin for people up to the age of 6 and to continue using the Ceyesto brand for those over the age of 6 as its licensed for this age group, it has been tested and should be safe. AW asked how this fits in with what is stocked at trusts at the moment. JO responded that they have switched to Ceyesto and asked what Alder Hay were doing as she felt they had switched completely to Ceyesto and to maybe have the children who are under 6 on Melatonin. She felt they should be aligned with what Alder Hay are doing as they are the tertiary paediatric centre. AW agreed and asked DP if he had looked into what Alder Hay were doing. DP responded that he hadn't yet, and the next step included the Paediatric group they had started and were due to explore this, he added this paper maybe a bit premature. AW added that this drug is a first line generic being recommended in the guideline. DS-K added with this being primarily prescribed in the community, she felt it didn't really matter what the trusts hold. She added when coming to limiting formulations this could be a good example as if it is being used for the right patient, they might be a reason why they need to use a specific product, while she understood why there is a want to generalize the majority of use if something is allowed to be prescribed there should be caveats for prescribing. Such as a clinical need or need for certain formulations, so in other words not restricting which drug can be prescribed in terms of brands. AW added he felt there is a reason sometimes to specify a brand for continuity of care. DS-K agreed this but added to clarify that they are not saying they can't prescribe the other brands but that this is the preferred drug. AW responded that with the formulary this is the recommended drug for most of the people most of the time but there may also be exceptions. CM commented that in the main points for discussion about branded generics, this isn't normally a function of LSCMMG and asked if this process has been pinned down as to not make lots of additional work for this group. There may be other routes that can look at making these decisions and having some of these discussions as it is well known the	

	world of branded generics its vast and there is a lot of products. With the need to review these things quite regularly, is that going to become part of this group or is there another process that needs to be considered. AW asked DP the reason this had come back to LSCMMG as he felt it was due to the large cost difference. DP agreed it is the excipient issue, as well as a big conversation about should branded generics be discussed within the LSCMMG recommendations of the formulary. AW said there isn't a recommendation paper, so it is hard to see what is actually being agreed. JG added that it was East Lancashire that have asked for the Consilient brand based on a comparative review done in London vs the Ceyesto brand. So the paper has been done on that request from East Lancashire's Paediatric department, so they want to adopt the Consilient brand and Ceyesto for the older age group. AW asked if this should be deferred to next month in order to contact Alder Hay and see what they are using. He added having Consilient for under 6 and Ceyesto for over 6 makes sense to him. He asked the group if they wanted this check or to go ahead based on the information in the paper. DJ responded to defer with the request to check with Alder Hay. This was agreed by the group. **Action** DP to check with Manchester and Alder Hey to see what they are doing with this and bring it back next month.	**DP**
2024/069	**New Medicines Review Workplan** AW asked if DP had anything to raise for the work plan. DP responded that he has still not received any feedback in relation to the work plan which hasn't changed for a few months. He added this is needed in order to prioritise what needs to be done. He also raised a few items that were assigned RAG ratings at the last meeting, it was decided these items couldn't be just pushed through and he has added what classifications he felt they would be under the new system and brought these to the group. Tadalafil 5mg daily has been rated a moderate update as it is from a NHSE change to guidance so recommendations should be able to be made so a short paper can be done for this. Ivermectin has been rated a major change at a class B as it's a significant formulary change as the cream is already available, but the tablets aren't. AW commented that Lisa Rogan raised this as there is new BAD guidance for Ivermectin and scabies which is why it was suggested to adopt to help as there is now a licenced product so this could be more of a minor change rather than a major change. This could also help with the IPC teams and requested this goes high up on the list due to the large number of care home outbreaks currently been seen. DP agreed this could go to a moderate change. AW suggested DP contact Lisa to discuss this further. Liothyronine oral preparations was initially rated as a major change at a class A, however looking at his own mini review, DP discovered it is included in the NICE guideline for treating depression. He now felt it could be classed as a moderate review have it would mean listing the NICE guidance in the review, which could also be done quite quickly. AW suggested having a meeting with DP before the next LSCMMG meeting to discuss this and decide on what format to bring it back to the group so that everyone is comfortable with it. DP agreed with this.	

	AW again asked members to look at the list and let DP know of anything that they felt needs doing quickly or prioritising as it is now 14 pages long and it needs to be slimmed down where possible. SRA commented that the 5mg Tadalafil has already been approved in East Lancashire as they had become aware that NHSE had unblack listed it. She added in terms of equality could this be pushed through and said that there is hardly any cost implication. She also added that there are two indications for this drug which is benign prostatic hypertrophy and that isn't included in the paper. AW asked to test the process should he pick up the ELMMB paperwork and use this next time. DP responded that going with the process, ideally it would be taken as accepted use within a trust therefore making it a moderate change and use their paperwork to save writing it up again. AW agreed and suggested using this as a trial of the process, DP agreed. **Actions** DP to discuss the Ivermectin change with Lisa Rogan. Items agreed to be brought back and used to test the new process. All members asked again to go through the paper and see if there is anything they feel needs prioritising.	**DP/LR** **DP** **All Members**
GUIDELINES and INFORMATION LEAFLETS		
2024/070	**Sodium Zirconium Cyclosilicate prescriber information – Consultation** AGR presented this item, this has gone out for consultation and was originally based on the GMMMG's shared care. It was put in the LSCMMG format then sent for consultation with responses to be received by the 27th of March 2024. There were three responses received by UHMB, Central Lancashire which includes Chorley and South Ribble, and then by Lancashire Teaching Hospital. Two responses said they may agree if additional information was added, and Lancashire Teaching hospital did agree with the content. A comment from UHMB was they disagree with the comment in the document that dose changes should only be made by the specialist team. They felt it actually should be suitable to be changed in primary care, but then there was a comment about the monitoring management and it looking very involved, and they would rather defer to an LMC perspective. In conclusion there wasn't any changes made to the consultation document and AGR asked if the group were happy to approve the document or did they want to defer and get LMC feedback as he was unaware of any being received from them at this point. AW asked if AGR had any recommendation on this, and AGR responded that if they are going to meet with the LMC to discuss other options then it would be sensible if requested to that this along to the discussions. However, looking at the options that were sent to the last meeting, it was discussed possibly to consider Amber 0 and if it should have an information sheet so there has been quite a lot of discussion on this, and it may be sensible to take a bit of extra time to take it to the LMC. AW asked the group if they were happy with this in principle and then for it	

	to go to the LMC for approval or did anyone have any other comments. There were no further comments, so this document is approved in its current form pending agreement from the LMC. **Action** AGR to take this document along to discussions with the LMC for their approval.	**AGR**
2024/071	**Somatropin RAG status and PIL – Update – Deferred to May Meeting**	
2024/072	**Out of Area Prescribing Position Statement – Update** AGR presented this item; it has been an ongoing piece of work between himself, Melanie Preston, and Rukaiya Chand. They decided to refer people to the generic MLCSU inbox for further information instead of referring to local medicine optimisation teams as its likely the CSU team would become involved in the application process if they are to consider LSCMMG applications as well. AGR was having technical issues during the meeting, so BH assisted with this item and asked the group if they were happy with the changes made to the document. AW asked what was definition of NHS specialist, if it meant NHS employed or NHS commissioned care, to which AGR responded that it referred to both. AW asked if that was clear in the document and AGR responded that he could make it clearer. AW also added that specialist refers to not only consultants but also nurse specialists and GPSI's. AGR added he was happy to make this clearer also. AW asked the group if they were happy with the document, there were no objections from the group. The document is approved pending the amendments to be made by AGR. **Action** The document was approved and will be added to the LSCMMG website following the addition of the meaning of NHS specialist and who the term specialist relates to.	**AGR**
2024/073	**Headache Management Guideline for Adults – Consultation** AGR brought this item; this update was a collaboration between AGR and Professor Chhetri at LTH along with one of his registrars. The consultation was sent out and there were a few responses back, Central Lancashire suggested they may support the original document if additional information was added. UHMB and LTH agreed with the guideline in its current format. AGR had made a few changes to the previously approved document prior to the consultation which are highlighted in red within the document and has subsequently made changes following the consultation which are highlighted in green. All the changes that LTH wanted along with changes made by Professor Chhetri were made. Comments from Central Lancashire included a comment around oxygen in cluster headache which has been mentioned in the past. AGR asked Prof Chhetri about this, and he wanted to retain the existing information in the guideline, however if Primary care colleagues would prefer this changed this can be revisited. It was also requested for a Do Not Prescribe RAG for Valproate in primary	

	care for Migraines to be considered for inclusion in the guideline. It didn't mention Valproate in the guideline originally, but this could be added should LSCMMG feel it would be beneficial for this to be included. AW started with the recommendations in the paper, firstly oxygen for cluster headaches. He added he didn't think primary care could prescribe oxygen any longer and that it has to come from a secondary care specialist and that GPs couldn't or wouldn't order oxygen. He added he agreed that Valproate should be Do Not Prescribe particularly with the patient safety alerts this would make sense. HS-K added a comment about consultations in general. She said there are no responses from different trusts and asked if there should be an option for No comments to ensure that consultation has taken place as she felt the consultations are not going to relevant clinicians. AW asked if this only happened through LTH or would this be for any other trust, and HS-K added that it would be a ICB wide guideline so it would affect all trusts. She added the reason she picked up on this one as it does affect Rheumatology and in the general principle of consultations there are a few no comments, and asked if this means that the trusts put no comment or that there is no response at all. AW added this should be made clearer in future documents as to if there is no comment or no response from places and trusts. He added it is difficult to get people to respond and say no response at times as people tend to not respond if they are happy, but he agreed with HS-K's comment. HS-K added that historically there was a phase all feedback wasn't directed or was missed, so setting up this new way of working it might be good to set it up how it will be done and to add in the requirement to say no comment. She also added historically there was a simple link to put no comments and said she didn't see why this can't be done again. AW asked AGR and DP for comments on this. AGR said that his perception was that they send the consultation out to members of LSCMMG and its for those that represent the trusts ideally to liaise within the trusts to collate comments which is how it has worked in the past but was unsure if this was problematic. HS-K added that she felt it was about processes for each trust needs to ensure that the process is occurring and as everyone is working across the ICB for everyone to making sure that the feedback is being collected in these consultations. AB added that from and ELHT perspective she will get the consultations and circulate them to the relevant people, and they are also discussed at ELMMB. In this particular case she had no reply which is why it says no response from them in this. HS-K asked if this meant there was no comments made? AB responded that in this case yes as there was no response. HS-K said this is what needs to be addressed going forward in her view. AW asked BH if this should be picked up under the terms and reference of LSCMMG on how consultations are done so the process is very clear and to include time scales. HS-K agreed with this so that within the trusts it can be pinned down and include how important it is to collect the feedback on these consultations. BH added the process for the CSU team is that if something comes back that says no comment from trusts it means that they have received something back from the trust saying no comments. If they don't receive anything back from a trust there is no mention of that, so if its blank it means they haven't received anything back. He added they could add something to the document which shows for reviewed and no comments back if people would find that helpful. AW agreed this would be	

	helpful and added the purpose of having a wide mix of people at LSCMMG allows for further comments and discussions should anything be missed during the consultation phase. He also added there will be a formal voting process added into the terms of reference for LSCMMG. AW asked the group if they were happy with the pathway. BH added that although there weren't many consultation comments back this time, the pathway has been previously discussed several times at LSCMMG. AW that effectively this was an adoption of the North West pathway, to which BH responded that it's an update of an existing North West document. AW said he was happy for this to go ahead unless anyone else in the group had any objections. DSR said that maybe the group should consider if specialty groups should be actively consulted before documents come to LSCMMG. As it has been demonstrated with other agenda items there are some very specialised items that come to this group where people with generic skills may find difficult to make decisions on. She felt that things should go to the specialist groups before coming to LSCMMG and this should be a part of the formal process. AW commented that the eye care items had gone through specialists' groups over several months, so it might be more around articulating this and the items process on the documents coming to this group. BH added with this document it was developed by the North West group, then this update occurred to the document that was previously approved years ago and the update has been done with the specialist who leads the specialist service. AW asked if Dr Chhetri was happy for the document to go ahead, and AGR confirmed that he had approved it. AW added that Dr Chhetri if the clinical director of the Neurology team at Lancashire Teaching Hospital who are the only Neurology service in the North West but acknowledged that headaches are dealt with in many places. DSR added she felt one of the reasons that consultation responses aren't received is the length of the documents. She said that no practicing medic is going to have time to read them, and it really needs to be streamlined down to 2 sides of A4 maximum. She added there are lots of guidelines everywhere from numerus organisations and that LSCMMG should spend their time making decisions on medications instead of reading lots of long documents which are being view by specialists. AW acknowledged DSR's comments about keeping things simple and asked the group if they were happy to approve the document. There was no disagreement, and this document was approved with the amendments highlighted in discussions. **Action** AGR to add amendments relating to Valproate being Do Not Prescribe in primary care and around Oxygen prescribing in primary care. Following these amendments the document will be uploaded to the LSCMMG website. An additional option to be added to consultation documents for consultees to be able to provide a no comments option.	**AGR** **AGR / DP**
2024/074	**Gender Dysphoria Guidance – NHS England policy update** AGR presented this item, however, was still experiencing technical	

	difficulties so BH supported during the discussions. There are two new NHS England policy documents that have been published. One informs clinicians that puberty suppressing hormones for children and young people who have gender incongruence/ gender dysphoria should not be routinely prescribed. The second one covers prescribing of gender affirming hormones. There is prescribing information sheets on LSCMMG for trans male and trans female prescribing which were developed in order to ensure this is well supported in the community when they got the GIC request to prescribe. The ask is for the prescribing information sheets to be updated with the new information on the NHS England documents. AGR added he felt they could be clearer, and it does refer to adults in the second document. It also states that the ICB is responsible for prescribing gender affirming hormones, but this hasn't been clarified previously. AGR also pointed out that as well as updating the information sheets it needs to include the initiation age of 16 which is one of the new recommendations from NHS England. AW asked if this should be done locally or should it be a move to adopt the national policy and any information sheets associated with this as there is no local services and there is a lot of noise in the system relating to this. AGR responded that this was generally the ask, to update the local documents to reflect the national policy. AW responded with the question of waiting on the local provider which he thought was Leeds say what they are doing then for us to adopt that. He added if the group agree to have puberty suppressing agents to be do not prescribe in line with the national guidance, then if there is an information sheet that comes to adopt that or if not to update the local information sheets in line with the main provider. **Action** It was agreed for AGR to update the information sheets to be in line with the new NHS England policy.	**AGR**
2024/075	**Testosterone Shared Care – Update** AGR presented this item as a point of inclusion. The shared care hasn't been changed yet but it has been asked to consider adding GPs with specialist interests currently working within PCN's and running HRT clinics to the shared care. This again comes back to how the LSCMMG defines a specialist, and these GP's have been asked to be included as there isn't a lot of provision elsewhere in the trusts. NB had requested this come today and AGR has a definition from the British Menopausal Society accreditation including what the different qualifications are. The ask is to consider the shared care to include these GPs with specialist interests so they would initiate prescribing and then the patient's usual GP could continue prescribing alongside the specialist with the shared care agreement. AGR acknowledged this hasn't been done for other shared care agreements but added this is something where there isn't a lot of cover to treat. He added there is a lot of movement across to Greater Manchester and Mersey for patients that to see a specialist in Menopause. AW added that there is a lot of waiting list for treatments. As discussed in other agenda items there is a request consult during May and to bring back to the June meeting of LSCMMG's definition of a	

	specialist to help with items like this. DSR asked for the title of the agenda item to be changed as there are two shared care documents for Testosterone, and it would help to avoid confusion as the one being discussed today is specifically for postmenopausal women not male hypogonadism. AW acknowledged DSR's comment about amending the title. AW asked NB if she would like to add further comment as she wanted this to come today, and NB said she had nothing to add other than it was to cover the governance element to include the GPs as the way it was previously worded said secondary care specialist which technically doesn't cover GPs. BH added the challenge of going wider than secondary care specialist is the question of what training people have had, which will link in with the discussions to take place around what 'is' a specialist. **Action** It was agreed that the document would be amended to include BMS accredited GPs and present it at the May meeting.	**AGR**
2024/076	**Ophthalmology Macular Pathways Summary Guideline** It is noted at the start of this item that two Ophthalmologist consultants from East Lancs were unable to attend discussions today, however there were members who were able to assist in discussions, so the item went ahead. DP presented this item; this guideline has been updated after lots of discussions with Ophthalmology groups within the ICB and trusts. It has been updated to include the new Biosimilar Anti-VEGF and Corticosteroid drugs. The recommendation is that when a patient is newly initiated on an Anti-VEGF drug that the clinician should use a Biosimilar rather than an originator product. The only Biosimilar available is Ranibizumab, and it is also recommended that if the patient is currently on the originator Ranibizumab they should be swapped to the Biosimilar. The clinicians were happy to switch from the branded drug to the Biosimilar drug. However, in the consultation there were a lot of comments asking not to use the Biosimilar as first line in treatment naïve patients as if this is done, the patient is locked in to monthly injections. Whereas the newer drugs allow the treatments to be spaced out to two-three months or longer in some cases. The comments state that if it is mandated the use of the current Biosimilar this could cause issues in the clinics, and this comment was received in the majority of responses. Sharon from the CSU team has looked into what this could mean as clinicians have voiced capacity issues, but it is unclear what the impact of this would look like. In terms of cost, the drug might be less expensive, but there would also be the cost implication of the patient coming to the hospital to be injected. There is also the impact on the patient coming in monthly to be injected to consider. Sharons findings show that the impact cost wise for the change to be not a as large as previously thought. It is a large amount purely on drug cost but when factoring in clinic time etc by using tariff cost the cost differential is smaller. JO commented that if the pathway is going to be updated it also should look at the new Biosimilar that is coming onto the market next year. She also added that if the Ophthalmologist clinicians are asking for an	

	alternative to Ranibizumab or something to go along side it then possibly it should include Aflibercept as it is known that the Biosimilar is coming and there would be cost savings to be made. Her concern is if this is not done, she has seen in practice a lot of patients going straight onto Faricimab which has a significant cost pressure. She also asked how many patients are actually getting to the full treatment extensions, as she is aware a lot of her patients don't actually get far out in treating extenders as previously thought, so the cost saving might not be as big as expected. AW asked if this was for a specific drug or for all, to which JO responded that it was for all but that it is very patient dependant. She said that there is also the Eylea 8mg to add into context with this as there was some feedback with interest in this, and that colleagues at ELHT especially were interested in this. DP added this is in the next agenda item, and AW added he would like to get this item considered first before looking at the Eylea 8mg. JW commented that really the Eylea needs to be considered at the same time as they will be used at the same place in the pathway, and it has the potential to going to 16 or 20 week intervals. She acknowledged that it would take a year to see the effect of this but added she didn't feel it could be looked at separately to the pathway and it should be considered in these discussions. AW added that JW's comment makes sense and asked if it was known for the branded 8mg, when the 2mg becomes available next year would the be a Biosimilar in the 8mg available or was there a longer patent on it. JW responded that she expected not, and said she felt this is why the 8mg has become available now as it will have a patent extension. And that they are offering the 8mg at the same cost as the 2mg but was unsure what will happen when the 2mg becomes Biosimilar. JW also commented that she knew within their clinics they do not have capacity to convert everyone to the Ranibizumab Biosimilar. They are oversubscribed so they would have to stick with Eylea. AW asked if this was due to the treat and extend benefits or expanding numbers. JW said this was due to both, and to go from 8 weekly to four weekly they wouldn't be able to cope. AW summarised that there were two decisions being discussed, one is what is the drug and what is the cost but secondly what is the pathway cost depending on the element, which includes drug cost, attendance cost and if treat and extend can genuinely be implemented which from discussions may not be as much as initially thought. He added that Faricimab is similar according to the NICE TAs in terms of benefits and they add to use the cheapest one. He added that obviously the system is under a huge pressure to use 90% Biosimilar within 6 months of the launch. He added he felt the implement ability was the most crucial decision here today. DJ added they had a slightly different issue come to light, at LTH they have been using Bevacizumab for a number of indications where there isn't currently NICE guidance and Ranibizumab isn't licensed for those indications. He added he thought there was one indication that Ranibizumab was licensed for but there wasn't a NICE TA and that the document says that Bevacizumab shouldn't be used at all. He felt that maybe there should be a part two to the pathway where it looks at other conditions that they are commissioned to treat and what the preferred option is for those treatments. AW commented that he has been told this	

	also outside of the meeting. Again he summarised that there is a part one which is for licensed drugs and licensed indications and a part two which would be licensed drugs for unlicensed indications and possibly even unlicensed drugs for unlicensed indications, and whether they are commissioned a) at all and b) if so in what circumstances. He added to simplify this discussion that Bevacizumab won't be looked at all at this stage as they need to stick to licensed drugs for licensed indications but the practicality of this needs looking into. AW then asked if there was a need to collect some real world data such as audit data to show the level of treat and extend is actually able to happen in the real world opposed to what was proposed in sales pitches. Or does this question around capacity need to go out to clinicians, as there's the principle of Biosimilars should be used first line unless there is a very good reason not to, and what constitutes as a good reason not to. Is clinical capacity a good reason not to or is treating a bigger population more important or treating the ones that can be treated at a lower cost more important. He added he didn't feel that the suggestion is there is not going to be enough capacity for all that is being asked of. JO responded that she felt that capacity is a problem everywhere, and that she also felt that there is a feeling of being unkeen on the Biosimilar and that people prefer other things. Putting all of that together if Aflibercept is proposed as another first line option there is an opportunity to see savings in around 12 months' time. With moving Faricimab into second line if there are contraindications for the other two or the patient is nonresponsive, JO felt this was the most logical way to move forward but this is a very difficult decision. AW agreed it is a very difficult decision, however a decision needs to be made. DSR commented that what she has taken from discussions is that there isn't much of a difference in terms of costings, the staff who will be administering the injections have a preference and agreed that Ophthalmology is one of the most overbooked services everywhere and that there is a cost to patients coming back to hospital. But it is also important to remember the patients may have a preference and may prefer to have eye injections less frequently. She suggested an amendment to the document that states that a Biosimilar must be used first line but to give the clinicians the choice of which drug to use at this stage. Considering it is unknown if the 8mg drug is coming into the pathway, and to maybe look to do a sooner review of this than would normally be done and seek some real world data from the clinicians who are going to use it. AW said he felt that data on frequency of different treatments was already available, and JO responded that they did but they didn't have data on treat and extend. AW added he felt that data showing patient ID and how many times a year they are going in for treatment depending on which they have would be useful. As this would show the cost of the drug and also the cost of attendance and therefore giving a year of the cost for people depending on what treatment they are having and an average cost for each drug. JW commented that she felt this would be hard to do as it depends on where the patient is in the treatment, as they start on four weekly treatments then after a year it starts to extend out so this would make it hard to show which ones were where in their treatment. She also said that in Blackpool they are treating everyone that is on Ranibizumab is on the Biosimilar and anyone new is started on Aflibercept first line. She asked if the expectation would be to continue those on Aflibercept or is it to change them as she felt there would be a lot of reluctance to change	

	someone from a drug they are stable on to got back to Ranibizumab. To clarify she asked if the expectation is for new patients or current patients. AW responded that not wanting to speak for others but generally speaking if someone is stable and there is no good reason to change them it wouldn't happen as a general principle. Particularly as Aflibercept is coming off patent soon it would be futile to jump from one to another. But with Faricimab has only recently launched it could be another 10 years or so before its off patent. So you would want to make sure as proposed that the two first line recommendations are either Biosimilar or will be very soon, then second and third line would be based on cost and treat and extend considerations. He then reiterated what DSR had mentioned earlier about patient impact and if there are few interventions should be included in the pathway not just the healthcare impact. So patients having less trips would be better for people, but it is important to understand the cost effectiveness given the financial and clinical challenges faced by the system at the moment. DJ asked if there was a form of crude data that could define use across all trusts and do some further calculations to take Aflibercept and the other agents and converted them to the Biosimilar Ranibizumab it would show number of attendances and the cost for those attendances. While yes there is a capacity issue it would show a basic understanding what the cost saving potential would look like for those patients. AW responded that he felt that BH had done this a few months ago. BH responded that he had and that he would agree with what JW had said previously that it is extremely difficult to try to work out what that sort of treat and extend is because different patients are at different parts of their treatment pathway. He added there are also different severities, so someone who is less severe is more likely able to treat and extend than someone who is quite severe. From the data he was able to say with those who could treat and extend that they were able to do so, but the proportion who would get to the longer extension is a limited number. With the Eylea 8mg theoretically they can extend to 20 weeks, realistically it would be more like 12 weeks for most patients but its very difficult to be more definitive than this. AW asked the group of they wanted to make a decision on this or to defer. He agreed with the group consensus to have Ranibizumab and Aflibercept alongside each other as the preferred first line but asked the group for comments. JO agreed this felt like the logical idea and added maybe working with clinicians with what treatment failure would look like so it is very clear when they move to Faricimab it is because they have met certain criteria for treatment failure, she felt this would be useful. AW asked to clarify if this was just for wet AMD or for all indications where Ranibizumab Biosimilars are currently first line. JO responded she felt it should be for all where the two can be put together. AW then asked what else would need to be covered as he was conscious that when it gets down to CNV, the only ones that are licensed are Aflibercept and Ranibizumab so there may need to be some differentiation at that point in the pathway. AW suggested this item comes back next month with the amendment of alongside each other for Ranibizumab and Aflibercept. And also to get some data, which may not be robust, in terms of average how many trips per year depending on the drug to give a rough idea on frequency and to see if this is doable. There was agreement with this suggestion. BH added that they can look, with the health warning mentioned, for the average number of visits. He also asked if Aflibercept	

	alongside Biosimilar Ranibizumab, with the 8mg Aflibercept where does that sit only in treatment failures or alongside the first amount. AW responded that he was discussing the 2mg in the current pathway and if that is agreed in principle, then the group would go on to look at the 8mg Aflibercept next on the agenda to decide how if at all it would affect what has been discussed under this item. AW summarised the decisions of the discussions as the following: **<u>Actions</u>** All areas to ask clinicians on the joint first line of Ranibizumab biosimilar and Aflibercept and get the feedback to the CSU by the middle of May. Data is to be collected on the average usage to see if what if any differences there is to June's meeting.	**Area Leads** **BH/DP**
2024/077	**Eylea 8mg Impact** DP presented this item; it coincides with the discussion had in the last agenda item. The paper shows that the 8mg id the same price of the 2mg currently and the is a much longer extended treatment and it is only licensed in two of the indications. The issue is that the generic is available with the lower strength, but it is unclear if this will be the same for the 8mg. Sharon from the CSU has asked Richard Bateman from procurement, and he is also unsure if there will be an 8mg generic either at the same time or in the near future. A quick overview of the predicted impact, firstly the indication would be that there wouldn't be much of a difference as it is a while into the treatment pathway before it can be extended, but this may have a benefit in the future. The downside is the cost potential of having only the branded 8mg available. AW asked the groups for comments. JW commented that her Ophthalmologists are very enthusiastic for this, but she felt they were unaware of a Biosimilar being imminently available or being too concerned about the cost. If there is the extended treatment then it will show a massive reduction in clinic visits, but asked if there was any guarantee that the company are going to keep the price down once their other one comes off patent. AW commented that unless there is some special formulation he couldn't see how they could keep the 8mg on patent, to which JW responded that she has spoken with a rep a few months back and they said they are using a new formulation to make it stronger in tiny volumes so with these discussions she felt it unlikely that the 8mg would become Biosimilar. AW then added that working off the bases that they are usually half the price as a Biosimilar than the drug would need to do double the time frequency for it to be cost effective, and asked if it was more likely the frequency would go from 4 weeks to 12 not 20 as listed in the promotional information. JW agreed this, to which AW added that the drug would need to potentially go to three times more cost effective. BH added that the 2mg can be treatment extended as well, with AW adding to around 8 weeks. He asked in reality if the 8 weeks is seen with the 2mg, JW said that she didn't truthfully know. JO added she would agree with what's been said but asked if a decision could be deferred as it is hard to make a decision where the price is, and that she was unsure it would fit into the current policy because if the patient failed with the 2mg she didn't see the logic then going onto the 8mg. AW asked if the question is which patients would be most suitable to	

	start on either the 2mg or the 8mg if using Aflibercept or is it that if the 2mg is set first line, most new patients might end up on the 8mg of Aflibercept if clinics were full. Is there a need to go back to the experts and ask how this would affect treatment. JW said she felt it would be either the 2mg or the 8mg as you wouldn't put a patient from 2mg to 8mg and that she felt the license was for either not both. AW clarified that he meant that people would be started on the 8mg as opposed to the 2mg and if that would make a difference as the treatment extend may or may not happen. AW summarised that there is a need to speak to the experts again and ask along with the earlier discussions, about the 2mg vs the 8mg and if there is specific criteria where they would use one over the other. This can then be brought back in June to the group with Ophthalmologists either attending a one off meeting to discuss this or some attending the June LSCMMG meeting. He asked for feedback to come back to the CSU by the middle of May on the above item and what is the place of the 8mg Aflibercept. DSR suggested someone to put a team's meeting together with the Ophthalmologists to discuss this and bring back to this meeting. JO suggested the Medical Retinal Group which BH and DP have attended previously. BH added he felt they may have struggled to run this meeting, but this would be a good option to try. **Actions** BH and JO to see if this can be discussed at the Medical Retinal Group meetings.	**BH/JO**
2024/078	**Guidelines Workplan** AGR didn't have anything for discussion at today's meeting.	
NATIONAL DECISIONS FOR IMPLEMENTATION		
2024/079	**New NICE Technology Appraisal Guidance for Medicines April 2024** There were a few items to note for today's meeting. TA878 - Nirmatrelvir plus ritonavir, sotrovimab and tocilizumab for treating COVID-19. There isn't a cost pressure associated but there is an expanded patient cohort. There has been a query through to the ICB board from a pharmaceutical company querying how will those patients be identified that qualify that get COVID and how will they be notified. BH added this is probably not something for LSCMMG, but it will be put on the paper that goes to CRG to highlight the request. AW added the need to possibly review the commissioning of the CMDU as it may not cover the volume of patients coming through it. BH agreed but added that he felt this was discussed previously when the NICE TA originally came out when they increased the days from 5 to 6. AW responded that he had a meeting later that day to discuss this. TA953 – Fluocinolone acetonide intravitreal implant for treating chronic diabetic macular oedema. This has a 30 day implementation period and was agreed as a Red RAG rating. The team are currently engaging with specialists. in relation to the cost impact, as there are some assumptions that can't be made at the moment relating to the proportion that is one eye or both. Due to this they were unable to come up with a cost impact yet but should be able to provide this once the information has come back from the specialists. AW commented that this would need adding to the pathway discussed earlier in the meeting, to which BH agreed that it would	

	be and felt it already had been added in a draft format pending the information from specialists. This will come back in the draft due back to June's meeting. TA955 – Dupilumab for treating moderate to server prurigo nodularis. The paper states NA however it should be Do Not Prescribe as it is not recommended by NICE in that condition, so it will go onto the website as a Do Not Prescribe for this indication. AW asked should this be agreed as a Do Not Prescribe now and not go through any other process with this. BH responded his query would be does it need to go into the paper to CRG, and added it comes down to what delegated decision making there is at that group. AW responded that it is about saving money. BH agreed and said it comes back to the flow chart shown earlier in discussions that if there is no cost pressure and its within the cost budget is AW allowed to authorize it. AW asked for it to be added to the spreadsheet and discussed next month so it can go through the process but on the basis from NICE to add it as a Do Not Prescribe on the website. TA956 – Etrasimod for treating moderately to severely active ulcerative colitis in people aged 16 and over. This is not expected to have a large cost pressure, it has a 30 day implementation and that will go in the paper to CRG with a recommended Red RAG rating. TA958 – Ritlecitinib for treating severe alopecia areata in people 12 years and over. This is a new treatment for alopecia and has a quite significant cost pressure and has a 90 day implementation. It is the first of its kind and it has been highlighted and will go in the paper to CRG due to the significant cost and service pressures. AW asked WP if he had any comment on this, WP responded that he had been forwarded the email from AGR around the cost. He said given that it is a positive NICE TA would there be any scope of any restrictions on it as it is very vague and seems to say if they have alopecia they can have it. AW responded that with it being vague they need to be clear on the commissioning position and if it isn't currently firm it needs to be as it's a large amount of money. BH agreed with WP's concern that the TA is very vague, and added they would like to have done something similar to what was done with Tirzepatide where there is the NICE position but then there is some local recommendations of place in therapy. He said he felt it would be good for AGR to link in with WP and discuss who else could be engaged in conversations for this to get a more explicit place in therapy as opposed to anyone. WP commented that the problem is that although the TA is vague the state of treatment options for alopecia is not great and people are very excited about this drug. The other things they would be trying are Diphone Cyproterone which is expensive in itself as it's a special and doesn't have a great shelf life and there is only a small amount of people who can administer it. Another problem is that often one of the strengths has run out which isn't helpful so the current treatment offerings for this condition aren't great. AW asked if this could come back and if WP could use his expertise and look for where the place in therapy for this could be to try and help the group understand where it could fit in with the other treatments available. WP agreed and added he would discuss it with the consultant dermatologists at his trust. AW added that while he doesn't underestimate the psychological impact of having alopecia to people, currently the trust is unable to afford some potentially lifesaving treatments currently, so it is about having to prioritise treatments at the moment.	

	Actions Nirmatrelvir plus ritonavir, sotrovimab and tocilizumab – will be updated on the website following ratification at the next Clinical Effectiveness Group (CEG) / Commissioning Resource Group (CRG) Meeting and the expanded patient cohort will be highlighted to CRG / CEG. Fluocinolone will be added to the website with a Red RAG rating following ratification at the next Clinical Effectiveness Group (CEG) / Commissioning Resource Group (CRG) Meeting. Once information is received back from specialists relating to Fluocinolone use, the cost pressure log will be updated. Fluocinolone will be added into the macular pathway which is coming back in June. Etrasimod will be added to the website with a Red RAG rating following ratification at the next Clinical Effectiveness Group (CEG) / Commissioning Resource Group (CRG) Meeting. Dupilumab will be added to the website with a Do Not Prescribe RAG rating following ratification at the next Clinical Effectiveness Group (CEG) / Commissioning Resource Group (CRG) Meeting. AGR and WP to meet and discuss the place in therapy for Ritlecitinib, this will come back to the May LSCMMG.	**AGR** **AGR** **BH** **DP** **AGR** **AGR** **AGR/WP**
2024/080	**New NHS England Medicines Commissioning Policies April 2024** Nothing to discuss.	
2024/081	**Regional Medicines Optimisation Committees – Outputs April 2024** Nothing to discuss.	
2024/082	**Evidence Reviews Published by SMC or AWMSG April 2024** Nothing to discuss.	
ITEMS FOR INFORMATION		
2024/083	**LSCMMG Cost Pressures Log** BH commented that the cost pressure log hasn't been circulated this month as he wanted to propose a change in process to circulating this when the minutes are circulated following meetings. This brings it into line with discussions that have been held during the meetings. AW added something else that will be looked into implementing here is what other committees have called a AAA, which is an alert, advise and assure system as to what has happened at the meetings. He added he is thinking about only doing alerts, for example the macular pathway as an alert in terms of things needing to be raised up given the impact on both patient care and costing. This is to advise colleagues in the system about what is being advised on updating a process. BH added that the Ritlecitinib along with the macular pathway were the most significant items that need raising.	

DATE AND TIME OF NEXT MEETING

The next meeting will take place on

Thursday 9th May 2024

9.30 – 11.30

Microsoft Teams

ACTION SHEET FROM THE

LANCASHIRE AND SOUTH CUMBRIA MEDICINES MANAGEMENT GROUP 21.3.2024

ACTION SHEET FROM THE MEETING 12th October 2023				
2023/421	**Sodium Zirconium Cyclosilicate - Update** AGR to put the GMMMG shared care guidance for this item into LSCMMG formatting and send out for consultation. **November 2023 update:** Will be sent out at the end of November for consultation. **December 2023 update:** Will be sent out this month. **January 2024 update:** AGR was not in attendance today, however BH updated that it needs to go out to consultation before publishing. AGR commented outside of the meeting that there had been a slight delay, and he would be sending out this month. **February 2024 update:** This will now come in April due to the formulary work being prioritised. **March 2024 update:** The document is currently out for consultation – to come back to the April meeting. **April 2024 update:** On the Agenda, close here.	**AGR** **AGR** **AGR** **AGR** **AGR** **AGR**	**Open** **Open** **Open** **Open** **Open** **Closed**	**12.10.2023** **09.11.2023** **21.12.2023** **11.01.2024** **08.02.2024** **21.03.2024** **18.04.2024**
ACTION SHEET FROM THE MEETING 9th November 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. **January 2024 update:** Still waiting to go to LMC. **February 2024 update:** Is with LMC, AGR is waiting comments. **March 2024 update:** Comments received from the LMC, to clarify and present at the April meeting. **April 2024 update:** A meeting is being organised with the LMC to close off items.	**AGR** **AGR/BH** **AGR/BH** **AGR/BH** **AGR/BH** **AGR/BH** **AGR/BH**	**Open** **Open** **Open** **Open** **Open** **Closed**	**09.11.2023** **09.11.2023** **09.11.2023** **21.12.2023** **08.02.2024** **21.03.2024** **18.04.2024**
2023/444	**Isotretinoin in the community** FP and RS to update the document to include the new MRHA advice. FP and RS to meet with WP and the local pharmaceutical committee to discuss prescribing within the community on FP10s for the service. FP and RS to update the document to show that under 18s will not be included in the initial prescribing cohort. **December 2023 update:** PE responded on behalf of FP. There has been no response from providers or draft document and asked to defer to January/ February meeting. **January 2024 update:** FP updated, is still being worked on and she is hoping to bring something to the next meeting. **February 2024 update:** A draft has come back, a specialist pharmacist from one of the trusts has commented that it doesn't meet the latest MHRA guidance. FP will be looking at this once she is back from leave. **March 2024 update:** No update at this meeting. **April 2024 update:**	**FP/RS** **FP/RS** **FP/RS** **FP/RS/PE** **FP/RS/PE** **FP/RS/PE** **FP/RS/PE**	**Open** **Open** **Open** **Open** **Open** **Open** **Open**	**09.11.2023** **09.11.2023** **09.11.2023** **21.12.2023** **11.01.2024** **08.02.2024** **21.03.2024** **18.04.2024**

	FP let AW know outside of the meeting she is still awaiting a response.			
ACTION SHEET FROM THE MEETING 21st December 2023				
2023/455	**Declarations of interest** EB to send out declaration of interest forms. **January 2024 update:** EB and BH to meet to ensure the forms are up to date inline with the ICB's process. They will then be sent out to members. **February 2024 update:** BH has been in contact with IG at the ICB to try and link in with their annual declaration process so they can be pulled in this meeting. The aim for this to be completed is at the beginning of the new financial year. **March 2024 update:** BH is currently on leave but will follow up once he is back. **April 2024 update:** BH has met with IG lead, they are looking at what will work. Currently members outside the ICB attending meetings have their declarations approved by appropriate ICB representative. BH will update further once he has heard back from them.	**EB** **EB/BH** **EB/BH** **BH** **BH**	**Open** **Open** **Open** **Open** **Open**	**21.12.2023** **11.01.2024** **08.02.2024** **21.03.2024** **18.04.2024**
2023/464	**Actimorph in palliative care** AGR to link in with Kate Stewart and his contacts in NHS England about adding this to the Palliative Care Guideline. AGR to link in with SR regarding wording to be added about diversion of liquid and switching to Actimorph. **January 2024 update:** Wording received from SR, AGR needs to link in with palliative care. **February 2024 update:** AGR linked in with palliative care, they are undergoing some changes to the guideline so AGR will reach out to the clinical lead to get it finalized. As the drug is approved the wording can be added to the LSCMMG website in the interim while waiting on the finalised document. FP asked if AGR could ask for levetiracetam infusion prescribing in primary care on the advice of palliative care to be added when he meets with the palliative care group. **March 2024 update:** AGR is arranging meeting with Palliative care to discuss Levetiracetam. **April 2024 update:**	**AGR** **AGR/SR** **AGR** **AGR** **AGR**	**Open** **Open** **Open** **Open** **Open**	**21.12.2023** **21.12.2023** **11.01.2024** **08.02.2024** **08.02.2024** **21.03.2024**

	AGR has a meeting with Palliative care on 7th May to discuss all outstanding palliative care items.	**AGR**	**Closed**	**18.04.2024**
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. **January 2024 update:** To be discussed at February's meeting. **February 2024 update:** DP has done a baseline of around 37 boys and 161 girls who might need treatment. Chairs action for approval. **March 2024 update:** The RAG rating of Amber 0 was clarified, DP will complete this and send out for Chair's approval. **April 2024 update:** The above action was completed, this is now going to CRG for approval.	**DP** **DP** **DP/AW** **DP/AW** **DP/AW**	**Open** **Open** **Open** **Open** **Open**	**21.12.2023** **11.01.2024** **08.02.2024** **21.03.2024** **18.04.2024**
2023/472	**Out of area prescribing position statement – update** AGR to link with MP around alternative wording. AW to sign off via Chairs approval once alternative wording has been added. **January 2024 update:** To be discussed at February's meeting. **February 2024 update:** AGR has spoken with MP and wording has been agreed to amend. Once complete AW will give chairs approval and take to CEG for approval. Once AW has given chairs approval, AGR to bring it back to the group for information only. **March 2024 update:** AGR still working on it and will bring back to April's meeting for information. **April 2024 update:** On the agenda, closed here.	**AGR/MP** **AW** **AW** **AGR/AW** **AGR/AW** **AGR/AW**	**Open** **Open** **Open** **Open** **Open** **Closed**	**21.12.2023** **21.12.2023** **11.01.2024** **08.02.2024** **21.03.2024** **18.04.2024**
2023/485	**AOB – LSC ICB Branded Generic Prescribing Criteria – Draft for discussion** CM to make amendments as detailed in the discussions above and AW to approve via Chairs action once they have been made. **January 2024 update:** To be discussed at February's meeting. **February 2024 update:**	**CM/AW** **CM/AW**	**Open** **Open**	**21.12.2023** **11.01.2024**

	CM sent the amended document out to the group in December, this item needs approval. **March 2024 update:** AW and CM have taken to the QIPP group for clarity, DR added that it is still being worked on, it is due to come back to April's meeting. **April 2024 update:** CM was not at the meeting when this item was discussed, BH will chase CM for this item outside the meeting.	**CM/AW** **CM/AW**	**Open** **Open**	**21.03.2024** **18.04.2024**
ACTION SHEET FROM THE MEETING 11th JANUARY 2024				
2024/009	**National Patient Safety Alert: Shortage of GLP-1 receptor agonists (GLP-1RA) update** DP and PT to review and bring back to the meeting in March if there are any implications or other things affected with this alert. **February 2024 update:** Coming back to March meeting. **March 2024 update:** Guideline is now in line with the statements, the new alert to be added to the website. Update for Tirzepatide to go out, AW to link in with comms to get sent out. **April 2024 update:** Tirzepatide is going to the commissioning resources group next week. AW will feedback discussions at the next meeting.	**DP/PT** **DP/PT** **DP/PT/AW** **AW**	**Open** **Open** **Open** **Open**	**11.01.2024** **08.02.2024** **21.03.2024** **18.04.2024**
2024/012	**Discussion of development of terms of reference for LSCMMG** Members asked to send back any further comments not already discussed today to the team by the end of the month. BH and AW to meet to discuss the update of the LSCMMG and IMOC Terms of Reference. **February 2024 update:** Ongoing, keep open. **March 2024 update:** No update at this meeting. **April 2024 update:** To be brought back at May's meeting. Members are asked to let BH know of any changes they would like prior to this meeting.	**All Members** **BH/AW** **BH/AW** **BH/AW** **BH/AW** **All Members**	**Open** **Open** **Open** **Open** **Open** **Open**	**11.01.2024** **11.01.2024** **08.02.2024** **21.03.2024** **18.04.2024** **18.04.2024**
ACTION SHEET FROM THE MEETING 8th February 2024				
2024/021	**Ceyesto – Melatonin**	**DP**	**Open**	**08.02.2024**

	Ceyesto liquid to be added to the melatonin guideline	**DP**	**Open**	**08.02.2024**
	Melatonin tablets to be brought for discussion at March LSCMMG meeting. **March 2024 update:** It was agreed to bring this next month with the Adult Melatonin guideline. **April 2024 update:** On the agenda, closed here.	**DP** **DP**	**Open** **Closed**	**21.03.2024** **18.04.2024**
2024/026	**Hybrid closed-loop interim position statement** Paul from the CSU team to link in with public health consultants in Debbie's team to try and align the two documents. Wording to be added to include 'refrain from prescribing until after April 2024' once the information is clear. Documents to go to CPDIG, CRG and CEG, highlighting the clinician concerns. Follow up to come to the next LSCMMG meeting in March. **March 2024 update:** Still waiting on the meeting with Sarah O'Brien and the diabetes commissioner to discuss. **April 2024 update:** Still awaiting meeting with Sarah O'Brien and team.	**BH** **BH** **BH/AW** **BH** **BH/AW/PT/LR** **BH/AW/PT/LR**	**Open** **Open** **Open** **Open** **Open** **Open**	**08.02.2024** **08.02.2024** **08.02.2024** **08.02.2024** **21.03.2024** **18.04.2024**
2024/033	**Horizon Scanning 2024/25** BH to draft a paper to take to CRG for highlighting Lecanemab treatment with assistance from SR. **March 2024 update:** No update at this meeting. **April 2024 update:** To be discussed at the next CRG meeting. No update at this meeting.	**BH/SR** **BH/SR** **BH/SR**	**Open** **Open** **Open**	**08.02.2024** **21.03.2024** **18.04.2024**
2024/034	**LSCMMG Cost Pressures Log** BH to make chances to the cost pressures log. **March 2024 update:** No update at this meeting. **April 2024 update:** Updated cost pressure log to be circulated with the minutes.	**BH** **BH** **BH**	**Open** **Open** **Closed**	**08.02.2024** **21.03.2024** **18.04.2024**
ACTION SHEET FROM THE MEETING 21st March 2024				
	Aflibercept (Eylea) 8mg – Line Extension DP to ask Sharon at CSU to do a cost analysis for this item.	**DP**	**Open**	**21.03.2024**

2024/039	DP to contact Richard Bateman and discuss regarding the 8mg coming through licensing. DP to contact Ophthalmology and ask them to put a case forward for this, including where they see it would sit within the pathway and why they want it e.g. reducing clinic attendance. **April 2024 update:** On the agenda, Closed here.	**DP** **DP** **DP**	**Open** **Open** **Closed**	**21.03.2024** **21.03.2024** **18.04.2024**
2024/040	**Sucralfate RAG Rating** DP to add in the additional comments from East Lancashire relating to course length to the formulary as additional information. **April 2024 update:** Actioned and complete	**DP** **DP**	**Open** **Closed**	**21.03.2024** **18.04.2024**
2024/042	**Formulary Update and Process Chart** DP to bring back to next month clear definitions on minor, moderate and major changes that would be made to the spreadsheet. DJ to ask Judith if she could link in with the process of developing the single application form. DP to bring an updated version back to May's meeting. **April 2024 update:** On the agenda, closed here.	**DP** **DJ** **DP** **DP**	**Open** **Open** **Open** **Closed**	**21.03.2024** **21.03.2024** **21.03.2024** **18.04.2024**
2024/043	**New Medicines Work Plan** Members to send in any suggestions to clear the list of drugs on the workplan. Ivermectin to be added to the formulary after no objections to this in the meeting. Tadalafil to be added to the formulary after no objections to this in the meeting. Liothyronine Amber 0 RAG agreed and to be added to the formulary after no objections to this in the meeting. **April 2024 update:** Recommended RAG ratings above were not actioned as being pulled into the formulary processes, refer to item 2024/070.	**All Members** **DP** **DP** **DP** **DP**	**Open** **Open** **Open** **Open** **Closed**	**21.03.2024** **21.03.2024** **21.03.2024** **21.03.2024** **18.04.2024**
2024/044	**Antipsychotic Shared Care NICE Approved Off-label Indications** AGR to add NICE- approved off-label indications to the second-generation antipsychotic shared care guideline.	**AGR**	**Open**	**21.03.2024**

	AGR to use the new North West Template for the updated shared care guides. AGR to send to SR for prior approval before bringing it back to LSCMMG next month. **April 2024 update:** AGR to send to SR in advance of presenting at LSCMMG.	**AGR** **AGR** **AGR**	**Open** **Open** **Open**	**21.03.2024** **21.03.2024** **18.04.2024**
2024/045	**ELHT – Insulin Biosimilar Statement** DP to rebrand the document and generalise it, then bring back to the group for approval before adopting. **April 2024 update:** DP has updated, DSR asked for it not to be uploaded before some documents from East are looked at. Once this has been done to bring back for approval.	**DP** **DP/LR/DSR**	**Open** **Open**	**21.03.2024** **18.04.2024**
2024/046	**Azithromycin Prescriber Information Sheet** AGR to take this back to the LMC to confirm they are happy with GPs performing the ECGs. Once the above is confirmed it will be taken to AW for chairs action on approval. **April 2024 update:** A meeting is being organised with the LMC to close off items.	**AGR** **AGR/AW** **AGR**	**Open** **Open** **Closed**	**21.03.2024** **21.03.2024** **18.04.2024**
2024/047	**Daridorexant RAG Status – Update** Following approval at CRG, this item to be added onto the LSCMMG website with the Green Restricted RAG along with a holding statement that the prescribing guidance will be published as soon as more information is released from NHSE. **April 2024 update:** This is going to the next CRG meeting.	**AGR** **AGR**	**Open** **Closed**	**21.03.2024** **18.04.2024**
2024/048	**Lipid Pathway Update** The approved pathway to be added to the LSCMMG website. **April 2024 update:** Added to the website, closed.	**DP** **DP**	**Open** **Closed**	**21.03.2024** **18.04.2024**
2024/049	**Somatropin RAG Status and PIL – Update** AGR to confirm with the LMC that they are happy with initiation being in primary care based on a specialist recommendation.	**AGR**	**Open**	**21.03.2024** **21.03.2024**

	AGR to produce and bring back the patient information leaflet along with LMC confirmation to the next meeting. **April 2024 update:** A meeting is being organised with the LMC to close off items.	**AGR**	**Closed**	
2024/050	**PGD Authorisation Policy – Scope** AGR to create the policy for organisational authorisation sign-off for PGDs. **April 2024 update:** No update at this meeting.	**AGR** **AGR**	**Open** **Open**	**21.03.2024** **18.04.2024**
2024/051	**Recurrent UTI Guideline – Update** The group approved the updated document. To be uploaded to the LSCMMG website. **April 2024 update:** Uploaded to the website.	**AGR** **AGR**	**Open** **Closed**	**21.03.2024** **18.04.2024**
2024/052	**Care Home Depot Injections** SR to engage with representatives across LSC around this proposal, bring back to LSCMMG when appropriate. **April 2024 update:** SR not in attendance, no update.	**SR** **SR**	**Open** **Open**	**21.03.2024** **18.04.2024**
ACTION SHEET FROM THE MEETING 18th April 2024				
2024/065	**Formulary update – Flow chart and change classification rules** JO and DP to take this to the chiefs meeting and ask them to feedback to their D&T committees and then send their feedback to JO and DP. JO to look at creating the merged new drug form for the acute trusts to consult on. DP to bring this back with the feedback to June's meeting.	**JO/DP** **JO** **DP**	**Open** **Open** **Open**	**18.04.2024** **18.04.2024** **18.04.2024**
2024/066	**GI Formulary Subchapter: Prokinetics** The recommendations for domperidone, metoclopramide and erythromycin for addition to the formulary were agreed as written.	**DP**	**Open**	**18.04.2024**
2024/067	**Carbetocin for the Prevention of Postpartum Haemorrhage** Carbetocin for the Prevention of Postpartum Haemorrhage was approved to be added to the formulary following approval at CRG / CEG.	**DP**	**Open**	**18.04.2024**
2024/068	**Melatonin – Adults** The following RAG ratings were agreed following approval at CRG / CEG: Sleep disturbance in adults with ADHD –			

	Agreed as an Amber 0 RAG rating. Sleep problems in patients with dementia associated with Alzheimer's – Agreed as a Do Not Prescribe RAG rating. Older adults with sleep disturbances – Agreed as a Do Not Prescribe RAG rating (This is an existing RAG rating so no further action required). Sleep disorders in the blind – Agreed as an Amber 0 RAG rating, for totally blind patients when started by a specialist and with clear review guidance.	**DP**	**Open**	**18.04.2024**
2024/069	**Melatonin – Products** DP to check with Manchester and Alder Hay to see what they are doing with this and bring it back next month.	**DP**	**Open**	**18.04.2024**
2024/070	**New Medicines Review Workplan** DP to discuss the Ivermectin change with Lisa Rogan. Items agreed to be brought back and used to test the new process. All members asked again to go through the paper and see if there is anything they feel needs prioritising.	**DP/LR** **DP** **All Members**	**Open** **Open** **Open**	**18.04.2024** **18.04.2024** **18.04.2024**
2024/071	**Sodium Zirconium Cyclosilicate prescriber information – Consultation** AGR to take this document along to discussions with the LMC for their approval.	**AGR**	**Open**	**18.04.2024**
2024/073	**Out of Area Prescribing Position Statement – Update** The document was approved and will be added to the LSCMMG website following the addition of the meaning of NHS specialist and who the term specialist relates to.	**AGR**	**Open**	**18.04.2024**
2024/074	**Headache Management Guideline for Adults – Consultation** AGR to add amendments relating to Valproate being Do Not Prescribe in primary care and around Oxygen prescribing in primary care. Following these amendments the document will be uploaded to LSCMMG. An additional option to be added to consultation documents for consultees to be able to provide a no comments option.	**AGR** **AGR / DP**	**Open** **Open**	**18.04.2024** **18.04.2024**
2024/075	**Gender Dysphoria Guidance – NHS England policy update**			

	It was agreed for AGR to update the information sheets to be in line with the new NHS England policy.	**AGR**	**Open**	**18.04.2024**
2024/076	**Testosterone Shared Care – Update** It was agreed that the document would be amended to include BMS accredited GPs and present it at the May meeting.	**AGR**	**Open**	**18.04.2024**
2024/077	**Ophthalmology Macular Pathways Summary Guideline** All areas to ask clinicians on the joint first line of Ranibizumab biosimilar and Aflibercept and get the feedback to the CSU by the middle of May. Data is to be collected on the average usage to see if what if any differences there is to June's meeting.	**Area Leads** **BH/DP**	**Open** **Open**	**18.04.2024** **18.04.2024**
2024/078	**Eylea 8mg Impact** BH and JO to see if this can be discussed at the Medical Retinal Group meetings.	**BH/JO**	**Open**	**18.04.2024**
2024/080	**New NICE Technology Appraisal Guidance for Medicines April 2024** Nirmatrelvir plus ritonavir, sotrovimab and tocilizumab – will be updated on the website following ratification at the next Clinical Effectiveness Group (CEG) / Commissioning Resource Group (CRG) Meeting and the expanded patient cohort will be highlighted to CRG / CEG. Fluocinolone will be added to the website with a Red RAG rating following ratification at the next Clinical Effectiveness Group (CEG) / Commissioning Resource Group (CRG) Meeting. Once information is received back from specialists relating to Fluocinolone use, the cost pressure log will be updated. Fluocinolone will be added into the macular pathway which is coming back in June. Etrasimod will be added to the website with a Red RAG rating following ratification at the next Clinical Effectiveness Group (CEG) / Commissioning Resource Group (CRG) Meeting. Dupilumab will be added to the website with a Do Not Prescribe RAG rating following ratification at the next Clinical Effectiveness Group (CEG) / Commissioning Resource Group (CRG) Meeting. AGR and WP to meet and discuss the place in therapy for Ritlecitinib, this will come back to the May LSCMMG.	**AGR** **AGR** **BH** **DP** **AGR** **AGR** **AGR/WP**	**Open** **Open** **Open** **Open** **Open** **Open** **Open**	**18.04.2024** **18.04.2024** **18.04.2024** **18.04.2024** **18.04.2024** **18.04.2024** **18.04.2024**