Lancashire & South Cumbria Medicines Management Group

NHS Midlands and Lancashire Commissioning Support Unit

Minutes of the Lancashire and South Cumbria Medicines Management Group Meeting

Thursday 12th December 2024 (via Microsoft Teams)

Name	Role and organisation	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25
Andy White (AW)	ICB Chief Pharmacist (Chair)	✓	✓				
Trust senior medical representation from the following trusts							
Dr Hanadi Sari-Kouzel (DHSK)	Blackpool Teaching Hospitals	✓	✓				
	University Hospitals of Morecambe Bay						
	Lancashire Teaching Hospitals						
Dr Shenaz Ramtoola (DSR)	East Lancashire Teaching Hospitals	Deputy	✓				
	Lancashire and South Cumbria Foundation Trust						
Trust senior pharmacist representation from the following trusts							
James Baker (JB)	Blackpool Teaching Hospitals	✓	✓				
Andrea Scott (AS) (Nima Herlekar (NH) or Jenny Oakley temporarily attending (JO))	University Hospitals of Morecambe Bay	✓	NH				
David Jones (DJ)	Lancashire Teaching Hospitals	✓	✓				
Ana Batista (AB)	East Lancashire Teaching Hospitals	✓	✓				
Sonia Ramdour (SR)	Lancashire and South Cumbria Foundation Trust	✓	✓				
Primary care Integrated Care Partnership senior medical representation							
To be recruited	Fylde Coast						
To be recruited	Central						
To be recruited	Morecambe Bay						
To be recruited	Pennine Lancashire						
Primary care Integrated Care Partnership senior pharmacist representation							
Melanie Preston (MP)	Fylde Coast	✓	✓				
Clare Moss (CM)	Central	Apol	Apol				
Lisa Rogan (LR)	Pennine Lancashire	Apol	Apol				
Faye Prescott (FP)	Morecambe Bay	✓	✓				
Other roles							
Nicola Baxter (NB)	ICB Lead for Medicines Governance and Medicines Safety	✓	✓				
	ICB Senior Commissioning Manager						

Lucy Dickinson (LD)	ICB Finance Representative	✓	✓				
	Provider finance representative						
Roger Scott (RS)	Local Medical Committee Representation	✓	✓				
Mubasher Ali (MA)	Community Pharmacy LSC	✓	✓				
Emma Coupe (EC)	Assistant Director of Pharmacy Clinical Services EHTL		✓				
IN ATTENDANCE:							
Brent Horrell (BH)	CSU Head of Meds Commissioning	✓	✓				
Daivd Prayle (DP)	CSU Senior Meds Commissioning Pharmacist	✓	✓				
Adam Grainger (AGR)	CSU Senior Meds Performance Pharmacist	Apol	Apol				
Jill Gray (JG)	CSU Meds Commissioning Pharmacist	✓					
Rebecca Greenwood (RG)	Senior Meds Commissioning Technician (minutes)	✓	✓				

Key

Present	✓
Apologies received	Apol
Apologies received / Deputy Attended	Deputy
Absent	Absent

	SUMMARY OF DISCUSSION	ACTION
2024/236	**Welcome & apologies for absence** Received from Clare Moss. To note, other apologies may have been emailed to Emily who is on leave.	
2024/237	**Declaration of any other urgent business** Nothing raised.	
2024/238	**Declarations of interest (DOI)** No new declarations of interest pertinent to the agenda were made.	
	Minutes and action sheet from the last meeting 14th November 2024 BH explained front sheet of minutes has been updated to show a rolling 6	

2024/239	months of attendance. TOR still being ratified, updated roles as agreed in the draft ToR have been added to attendance list. BH proposed for members to review and check if there is anyone in their organisations to fill the roles, also looking to update distribution list once this is complete. To note LR and FP have roles listed the wrong way around on attendance sheet. BH clarified if NH should be added to attendance list whilst AS on leave, NH added JO will also be attending. The minutes were approved and will be added to the LSCMMG website. **Actions:** Amend LR/FP roles. Include NH and JO on front sheet.	**BH**
2024/240	**Matters arising (not on the agenda):** Prophylactic use of Senna and Docusate to prevent Clozapine Induced Gastrointestinal Hypomotility (CIGH) RS provided background info and data. The trust have had a number of incidents due to gastro effects of clozapine. The proposal is that the trust initiates prescribing of prophylactic treatments then hands over to primary care as green RAG. AW – given we have had incidents in the past and we want to prevent future issues, and it is evidence based it should be supported. BH asked RS if we need specific wording in formulary or given its green RAG will GPs be happy to prescribe. RS confirmed he couldn't see a problem in GPs taking over prescribing. AW asked SR to include wording to GPs/ standard letter explaining. SR added they are including training for their teams. FP has a presentation pack that could be used to support. Agreed. **Actions:** It was noted that LSCMMG support LSCFT prescribing prophylactic Senna and Docusate in this indication. No information will be added to the Formulary at this stage, this will be reviewed should LSCFT encounter any issues when requests for GPs to prescribe are made. SR to develop a standardised letter that will be used when requests for ongoing prescribing are send to primary care.	
NEW MEDICINES REVIEWS		
2024/241	**Azelastine hydrochloride and fluticasone propionate 137microgram / 50 microgram per actuation nasal spray (Dymista®) for relief of symptoms of moderate to severe seasonal and perennial allergic rhinitis if monotherapy with either intranasal antihistamine or glucocorticoid is not considered sufficient Major change:** DP explained the background and the proposed Amber0 RAG rating. There is wide support amongst consultants and the use is supported by national guidance and is evidence based. AW – missing sentence in final figures box, DP to update. AW – questions if this is a major change as supported by National guidance. BH expanded the reason for it being classed as a major is because of the current RAG being Do Not Prescribe and this was a	

	change in RAG. LSCMMG supported the Amber0 RAG rating. **Actions:** DP to add sentence into final figures box. The recommended RAG rating of Amber 0 to be taken to CRG/CEG for support and ratification through ICB Execs.	**DP**
2024/242	**Vedolizumab and infliximab for the treatment of immuno-oncology induced colitis/diarrhoea Moderate change:** DP reviewed the evidence in support of the application and proposed a Red RAG rating. BH highlighted that cost savings in other parts of the system due to impact on bed days means that it is likely that this is cost neutral or cost saving which was agreed by LSCMMG members. AW – if we reference cancer alliance document we need to be able to link to the document. Discuss with Cancer Alliance if we should be approving their documents or involved in them. It was queried if there will be Blueteq for this. BH - yes forms will go live once it has CRG approval for both. **Actions:** Add in extra detail around being cost neutral. The recommended RAG rating of Red to be taken to CRG/CEG for support and ratification through ICB Execs.	**PT/DP**
2024/243	**New Medicines Review Workplan:** DP propose we add drospirenone to workplan as it is in template SPS PDG's. AW agrees to add. **Actions:** Add drospirenone to workplan.	**DP**
2024/244	**New NICE Technology Appraisal Guidance for Medicines November 2024** BH – TA1016 had interim funding through the Innovative Medicines Fund so already added to the formulary. TA1013 and TA1019 will go on once NHSE notifies via circular. AW noted expecting TA on Tirzepatide for weight loss later this month. **Action:** None.	
FORMULARY UPDATES		
2024/245	**Formulary update:** DP explained we achieved end of November timeline, formulary all published, still under constant development. Thanked those involved. AW – big thanks for the team. From the start of January old Optimize profiles will be turned off and the messages in line with the LSC formulary will be switched on in all places, this was agreed by LSCMMG members. FP asked NH to close down Morecambe Bay profile as that is still live. AW – all trusts make sure all links pointing to the LSC NetFormulary site. **Action:**	

	None.	
2024/246	**Paediatric formulary update:** DP summarised the work that has already been completed and that early next year the working group will continue to take this forward. It was highlighted that there will be a need to work through Mersey and Manchester differences. AW – do we need to escalate to region if differences between the 2 hospitals? BH gave example of melatonin liquid - does put us in difficult position. Not sure what best approach is. BH suggests let the process run and if there are significant number of differences then go to NW region. AW agreed. BH noted as per the action log once we receive updated Pennine document we can upload to the place specific area in interim. **Action:** None.	
2024/247	**Palliative care formulary updates:** DP highlighted an error in the paper– Alfentanil should be Amber0 as it is listed in the community pharmacy drug holding list, not Red. AW asked about esomeprazole injection (powder for reconstitution) and the comment can community pharmacy access stocks? might have to be Red instead of Amber0 if it becomes clear that community pharmacy acquisition is difficult. Also raised Octreotide – in the attachment it mentions both green restricted and Amber1 RAG. DP clarified it will be Green restricted. AW – do we need to update stock holding service list? DP to check current list. All agree. **Action:** Update the areas highlighted above then upload to formulary and LSCMMG website. Check the current community pharmacy stock holding to ensure that no amendments are required.	**DP**
2024/248	**Formulary Changes since last LSCMMG:** BH reiterated the change log is updated twice a month and is circulated with LSCMMG papers, with the minutes, and available on LSCMMG and NetFormulary news sections. AW noted the importance of transparency. **Action:** None	
GUIDELINES and INFORMATION LEAFLETS		
	Ophthalmology Macular Pathway: Noted Jenny Oakley (JO) joined the meeting to discuss this item. BH talked to the paper highlighting the issues.	

2024/249	DSR asked do the changes we've seen in uptake of new agents in the ICB match nationally or are we an outlier? BH – varies nationally. Significant differences between places that have ranibizumab mandated as first line within their pathways and those that don't. Doesn't appear to be a middle ground. DSR – what are expert tertiary centres doing to tell us what we should be doing? BH – attended a meeting and some specialist tertiary centres were on the call, and they are using ranibizumab first line. We have seen data from Liverpool using Faricimab showing at 1 year they have been able to treat and extend slightly more than aflibercept, but this is less than 1 injection per year per patient on average. AW – wanted it brought here because of the change with patent expiry, in summer asked for audits from local trusts which we couldn't get so the Liverpool audit came to light. Not much clinical benefits shown in real life compared to what the company were saying. Overall, the treat and extend benefits are small compared to aflibercept. DSR – where are we compared to international practice? BH unsure. DSR – do we hold off until national guidance have made a decision or go with the pathway brought here for 3 months? JO – the company emphasise reducing number of injections but when you look at it, it isn't very significant. From local trust perspective Faricimab is getting away from us and if we don't put something in place we won't get the savings we'd like from aflibercept. MP – Once patients are on them trying to pull is back difficult so even though it could be 3 months, given the financial position is it the right thing to do with such a small benefit? DSR – can we impose new pathways, or do we say we have a temporary restriction for 6 months with new patients. SR agrees with DSR, is there a way we can monitor no new patients? AW – LTH do have Blueteq and low figures of Faricimab. Other trusts stock is supplied to departments rather than prospectively approving. DJ asked why his trust was such big users of ranibizumab and added their ophthalmologists weren't involved in the discussions relating to the pathway. BH – given financial climate and in line with DSRs suggestion, we'd probably need a letter from ICB medical director to go out to trusts re waiting for national guidance so paused new first line initiations of Faricimab. JO – informed DJ there were ophthalmologists from LTH involved and they didn't have an issue with the proposed pathway. AW – is there a second and third line? BH – 8mg aflibercept and Faricimab same place in pathway, as there aren't aflibercept biosimilar 8mg on horizon that we are aware of. EC gave example of another region moving from 2mg to 8mg aflibercept and now struggling to switch back. JO – hold on aflibercept 8mg until biosimilar comes out? AW – suggested aflibercept 2mg and ranibizumab first line. No first line Faricimab or 8mg aflibercept (holding line). JO – agreed that a letter from medical director would be helpful. AW - letter to be sent out ASAP. AW confirmed no new initiations of Faricimab unless second line. aflibercept 8mg holding position of DNP RAG until we receive NHSE commissioning position.	

	Agreed. **Action:** BH to draft a letter and send to AW for consideration and circulation to Medical Directors. Update formulary and Blueteq with holding position once the position has been considered by CRG/CEG and ratified by ICB Execs.	**BH / AW**
2024/250	**Neuropathic pain guideline update and capsaicin cream:** AW - Box 4 the patch is scored out; it is available so needs updating. DHSK asked for clarity around 'removing' the capsaicin cream from the formulary, DP explained it will be a temporary DNP RAG for the 0.025 and 0.075% creams because of lack of availability, so its DNP rather than remove. Approved. **Action:** Update box 4 so the patches aren't scored out in neuropathic pain guideline. Update capsaicin entry on NetFormulary to do not prescribe, this will revert to its previous RAG rating once the product is back in stock.	**DP**
2024/251	**Pathways and Guidance workplan:** BH discussed the 2nd line on the workplan - DMARD shared care, we are working with Rheumatology alliance. Proposal from Lizzie MacPhie we don't move to new format until British Society of Rheumatology guidance is updated. This would mean extending expiry dates of the existing shared care documents by another 6 months, were not aware of anything in them being out of date at present. It was noted that specialists are getting a lot of push back from GPs in relation to shared care, for now hold onto existing shared care format and content. FP/ NH have shared a paper with trust issues and still some grey areas with where responsibility lies, a discussion would be helpful. RS – DMARD shared care has worked well traditionally and funded as a local enhanced service, other new drugs have been slotted in. Lancaster area problems tie in with the GP action. DHSK – as far as their department is aware they haven't asked GPs to initiate. Wanted to make it clear patients are never discharged. NH – clarified what was meant by discharged. Morecambe Bay has historical agreement that might not be across the ICB so discussions would be useful. BH – prudent to be working through the issues whilst wating for the national guidance, better for us to sort funding element then have the process over a few months to unpick local issues and we can agree what drugs to be included. **Action:** To extend expiry of DMARD shared care documents by 6 months. To pull together a group to work through the issues in the new year. AW asked MP to check new NICE asthma guidance matched our guidance we recently approved.	**BH** **MP**

2024/252	**Good prescribing guideline:** Noted Paul Tyldesley (PT) joined the meeting to discuss this item. AW – need to make sure ADHD commissioners and clinical leads see this and check it works with local commissioning services. We need to make sure were not using passive language. Some of the terminology needs explaining (certain tests). MP – relating to the private prescribing section we've experienced problems with private bariatric surgery abroad, need more wording suited to abroad procedures (not CQC how do we understand their credentials). FP – will liaise with PT after meeting. BH – aim was to get the document streamlined and now connect with people to make sure consulted on. Suggests bringing to Feb meeting following meeting with individuals and consulting. AW – could we upload the document on LSCMMG as a consultation document and clearly watermarked– circulate to wider than usual distribution list. Comms to get out to primary care and members on the meeting to circulate around their trusts. DHSK – is there a reason to not send consultation to private institutions? AW – no reason, so we should include. AW – cross reference evidence-based interventions with document. Also confirmed what is meant by 'private'; privately initiated by patients. DSR – a workstream that focuses on biosimilars given the cost pressures currently. Instead of saying no to new treatments we need to look at positively saving money as a workstream and look at various areas biosimilars have been put into availability and work out how to get them properly used. AW agrees. We have a proposal for a HCD work stream within the trusts as part of a funding proposal. AW – is it worth having a value element to the agenda? Value can be an element of reviewing formulary now live. **Action:** BH link in with FP/MP re wording for comms. Upload as a consultation document to LSCMMG. Bring back to future meeting following consultation.	**BH/FP/MP**
NATIONAL DECISIONS FOR IMPLEMENTATION		
2024/253	**New NHS England Medicines Commissioning Policies November 2024** Nothing to discuss.	
2024/254	**Regional Medicines Optimisation Committees – Outputs November 2024** Nothing to discuss.	
2024/255	**Evidence Reviews Published by SMC or AWMSG November 2024** AW raised the 'bismuth subcitrate potassium/metronidazole/tetracycline hydrochloride (Pylera)' from the paper and suggested adding onto the new drugs workplan. Agreed.	**DP**

	Action: Add bismuth subcitrate potassium/metronidazole/tetracycline hydrochloride (Pylera) to new meds workplan.	
ITEMS FOR INFORMATION		
2024/256	**LSCMMG Cost Pressures Log** This will be circulated with the minutes from today's meeting.	
2024/257a	**AOB/ Items for escalation** **Interim chair:** AW - until TOR is agreed AW remains as chair as he is a budget holder within the ICB. Happy to take requests for deputy chair. Add to actions to circulate ask. **Action:** BH to circulate request for deputy chair to members.	**BH**
2024/257b	**Ivermectin for scabies:** MP – outbreak in care home last week, in guidance that is being updated it says ivermectin would be considered. In formulary currently lists as amber0 RAG. In national guidance it says cases in care homes where it's not appropriate to apply topical treatments ivermectin is recommended. GPs not sure where they stand to prescribe in purpose of this outbreak, propose a green RAG. BH asked about timescale and how urgent this is - do we bring proposal to next meeting or try to get done by chairs action? FP – decision ASAP. MP - some practices did prescribe and others still unsure, so we need what is appropriate criteria for prescribing. SR – if there is guidance on it then it's a straightforward position. AW agrees. AW – happy to make decision here, move from amber0 to green and follow national guideline. MP – needs clarifying re wording around care home. AW – FP and MP agree wording around care homes then AW will take as chairs action to agree and upload to formulary. SR – agree with changing to green. Agreed. **Action:** MP/FP agree wording around care homes then share with AW and agree updated RAG and wording via chairs action, then update formulary.	**FP/MP/ AW**
2024/257c	**Next meeting date:** DSR – should we cancel or move Jan meeting? BH suggests cancel Jan meeting due to short timeframe for consultations. AW suggests bringing Feb meeting forward by a week to 6th Feb.	**BH**

2024/257d	Agreed. **Action:** Cancel Jan meeting invite and resend February invite for 6th February. **Cost decisions:** AW emphasised even more so costs need to be considered with all decisions made here. Taken alongside use and benefit for patients. **Action:** None.	
DATE AND TIME OF NEXT MEETING **The next meeting will take place on** **Thursday 6th Feburary2025** **9.30 – 11.30** **Microsoft Teams**		