Minutes of the Lancashire and South Cumbria Medicines Management Group Meeting

Thursday 11th January 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
Faye Prescott (FP)	Senior Medicines Optimisation Pharmacist	NHS North of England Commissioning Support Unit
Dr. H Sari-Kouzel (HSK)	Rheumatology Consultant	Blackpool Teaching Hospitals NHS Trust
Lindsey Dickinson (LiD)	Finance Manager for Primary Care	Lancashire and South Cumbria ICB
Lisa Rogan (LR)	Strategic Director for Medicines Research and Clinical Effectiveness	NHS Lancashire and South Cumbria ICB (Pennine Lancashire locality)
Lucy Dickinson (LD)	Finance Manager for Primary Care	Lancashire and South Cumbria ICB
Melanie Preston (MP)	Head of Medicines Optimisation	NHS Lancashire and South Cumbria ICB (Fylde Coast)
Mohammed Ahmad (MA)	Assistant Director of Pharmacy	Blackpool Teaching Hospitals NHS Trust
Nicola Baxter (NB)	Head of Medicines Management	NHS Lancashire and South Cumbria ICB (West Lancashire locality)
Dr. S Ramtoola (ShR)	Diabetes Consultant	East Lancashire Teaching Hospitals NHS Trust
Sonia Ramdour (SR)	Chief Pharmacist/Controlled Drugs Accountable Officer	Lancashire and South Cumbria NHS Foundation Trust
Steve Simpson (SS)	Chief Pharmacist	NHS East Lancashire Teaching Hospitals

IN ATTENDANCE:

David Prayle (DP)	Senior Medicines Commissioning Pharmacist	NHS Midlands and Lancashire CSU
Brent Horrell (BH)	Head of Medicines Commissioning	NHS Midlands and Lancashire CSU

Paul Tyldesley (PT)	Medicines Commissioning Pharmacist	NHS Midlands and Lancashire CSU
Jill Grey (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
2024/001	**Welcome & apologies for absence** Apologies were received from Ashley Marsden and Adam Grainger.	
2024/002	**Declaration of any other urgent business** AW raised an item that was raised outside of this meeting. The outputs from the October and November meetings haven't been added to the website yet. This relates to confirmation from ICB decision making groups that the recommendations have been ratified and is an administrative error and will be corrected.	
2024/003	**Declarations of interest** There were no declarations of interest. EB and BH are going to meet and check the declaration forms are up to date and will then send them out. **Action** EB and BH to meet to go over declaration forms and send out.	**EB/BH**
2024/004	**Minutes and action sheet from the last meeting 21st December 2023** There were two amendments to the minutes. Lucy Dickinson was not in attendance at the last meeting but was recorded as present. This is the same for Steve Simpson. EB will amend the members present before the document is added to the website. **Action** EB will amend the minutes to reflect the above comments before they are added to the website.	**EB**
2024/005	**Matters arising (not on the agenda)** None to discuss.	
	ABBREVIATED LSCMMG ITEMS	
20234/006	**New NICE Technology Appraisal Guidance for Medicines December 2023** There are two NICE TA's for noting at this meeting, they are:	

	TA943 Hybrid closed loop systems - for managing blood glucose levels in type 1 diabetes. PT commented on this item as he has been linking in with LR in relation to this, this has also been discussed at the diabetes improvement board. Alongside the NICE TA is an implementation letter which was sent out to the medical directors and AW, the letter includes important information which will affect the cost impact. Firstly it is a five year roll out not the usual three month roll out which will change when the costs impact the system. There is wording in the document which states that if there are capacity issues to use the phased roll out which starts with children, then young people, then pregnant patients and finally adults who are already on pumps and then adults who have never had a pump. If the implementation recommendations are followed, the cost implications are more likely to show up further down the time line than around the next twelve months to two years. PT also added that the NICE template was quite complex and difficult to use so he has had to make some assumptions from consultants in this field and other NICE TAs to get the figures. Worse case scenario is that it will cost around £20 million incrementally, however 75% of the costs should be covered by NHS England. Majority of the cost will come early on from implementing it with children and approximately an eighth of the spend will be spent here. AW commented that from April of this year there is a commercial agreement coming into force so these costs may change substantially. PT agreed with this and added that the true cost implications are unknown currently due to this, and that additional framework is due to also come out which could help clinicians decide on if to start a patient with this intervention but until that comes out it is unclear how they will decide to start or not. AW added that he has spoken with Vicky Webster who is the lead for children and asked for support. He questioned if this item should be brought back to this meeting in March once more discussions have been had to provide a clearer picture. PT agreed and said that it has already been started in the area and around 7%-8% children are currently using it. ShR commented that she is aware that it is already happening and that she feels patients will really want this item as she has already been asked for it. She added she didn't feel adult clinicians would deny their patients who meet criteria for this product and make them wait five years to start it. She also added there will be a huge cost saving to be had with this system due to the reduction in need for nursing intervention and also will reduce patients down to an HBA 1C which will also save money. AW asked to remind people that the system is currently £200 million overspent and so it is important to not be adding any additional costs where possible. However items like this do need to be considered. LR commented that the presentation at health improvement board has shown excellent outcome data in children and the impact the system has on children in longer term outcomes and control is significant. Also that it is important to balance the long term clinical outcomes against short term financial deficit. AW agreed with this and added it is important to have an implementation plan and have as much information on impact as well as benefits before it is rolled out.	

	TA942 Empagliflozin – For treating chronic kidney disease. This looks like it will have quite a large cost impact in year five, but the team estimate it to be £86,000 by year two locally. The recommendation of RAG status is Green Restricted. The group discussed this and it was agreed for a Green RAG status. **Action** The concerns relating to the possible cost impact and the need for an implementation plan for the roll out of Hybrid closed loop systems to be raised into the ICB. PT to bring back TA943 to a meeting in a few months' time once he has had chance to have further discussions and get a clearer picture on outcomes.	**AW** **PT**
2024/007	**Guidelines Workplan** BH talked to this agenda item, members were asked if they have any queries or issues relating to the work plan. AW commented that there was a lot to be confirmed on the paper and asked if it could be firmed up more. BH responded that a lot of the items waiting to be confirmed are waiting on formulary discussions which will be had later on in the agenda. No issues were raised by the group.	
2024/008	**High strength Fluorides** DP brought this item. It is an update as there were some queries relating to the position for high strength fluorides for dental caries. There are currently two positions relating to High Strength Fluorides, the first relates to an historic position on LSCMMG was based on the dental document from several years ago and relates the use of High Strength Fluorides for the prophylaxis of dental caries. The recommendation is to keep this position as a Red RAG status as it was felt that prescribing of High Strength Fluorides for the prophylaxis of dental caries should be retained by dentists. Additional wording has been recommended to be added to reference the cancer position as well as over the counter guidance. All responses were in support except for Lancashire Teaching Hospital who wanted further clarification and added the need for further clarification on GPDs as well as GMPs. LR commented that a Maxfac surgeon had presented to ELMMB a request to change the RAG position as they felt a number of patients really required this and didn't feel it was appropriate to prescribe from the hospital and should be done by the patient's dentist. It has been supported at ELMMB to have it as Amber for this indication as not all patients have easy access to a dentist and that the dentists are under direction from the hospital. She felt it was agreed for Amber but as it was due to come here they may not have given a final decision. AB also commented that the position statement links to Duraphat which is Green Restricted RAG so GPs could continue prescribing. SR commented that under their Secure Services site they have a dentist recommending it (high strength one) and have patients prescribed it long term as they may not have access to it in the community. So they are	

	using it outside of the terms of guidance in their secure services. It was highlighted that these discussions relate to the second RAG position for the treatment of head and neck cancer patients who have had surgery, radiotherapy and/or chemotherapy which was approved as a Green Restricted RAG position in 2023. The position statement was agreed, in addition it was agreed to update the wording on LSCMMG website to make it clear that there are two RAG positions for different indications. **Action** Wording to clarify the two indications and their respective RAG positions to be updated on the LSCMMG alongside the updated position statement.	
2024/009	**National Patient Safety Alert: Shortage of GLP-1 receptor agonists (GLP-1RA) update** There are now tablets available and a shortage of the injections. AW asked what impact this has and does it change any guidance already in place in relation to this. ShR commented that the tablets mentioned in the alert (Rybelsus) are in the National NICE guidance for Type 2 diabetes. She felt that the tablets would be cheaper than the injections and that the leaflet has already been shared out to practitioners, so everyone is aware and has agreed to work to this. AW added that he felt step 5 should be completed first but asked the group if they wanted to add any further comments and asked if it also changes any guidance already published. DP said that it could affect the diabetes guidance and what is on the LSCMMG website for other GLP-1s. So there needs to be consideration if action is needed for the alert via the guidance. AW suggested bringing this back to the meeting in March if it has any implications to the diabetes guidance as it gives the CSU team to review and see if it affects things. This was agreed. **Action** 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.	**DP/PT**
2024/010	**New NHS England medicines commissioning policies December 2023** Nothing to consider.	
FORMULARY DEVELOPMENT SESSION		
2024/011	**Next steps for the Lancashire and South Cumbria Formulary – discussion of options** This has been brought to this group for discussions due to old formularies becoming unpublished or not meeting current certification standards. This has caused some confusion, so the CSU team have brough it here for discussions on how to move forward while the new Lancashire and South Cumbria Formulary is being developed. The proposal was for a single published formulary by April to reduce confusion and improve safety. This can only be done by fast tracking the process, DP presented the proposed compromise to be robust in this but	

	to also expedient getting things done. This was a draft paper brought to the group so AW advised the group there may be some things missing but this is due to the very short time scale the CSU team had to present something to the group to resolve current confusion. DP presented to the group and again highlighted this was a suggestion on the steps which would need to be taken to be able to make a formulary available by April 24 and views and opinions were welcomed. This item has been brought for further discussion and agreement from the group as how to best move forward. The aim is to get a formulary in place for April, this is on track to happen due to having three comprehensive formularies, only one was up to date which is UHMB's formulary. The ELMMB site has been archived so can no longer able to be updated which can cause risks, there is the East Lancashire Hospital Trust formulary which is only available to clinicians within the trust. The Central Lancashire Trust Formulary is no longer available due to an issue with Net Formulary and Blackpool has a list of drugs but no RAG ratings and no associated prescribing support documents. DP's first proposal was to take the East Lancashire formulary offline and no longer available to prescribers for risk reduction and accuracy. He felt it still needs to be accessible for developing the formulary but only for this reason. Proposal two involves East Lancashire also, they have their hospital trust formulary on their intranet which is only available to use in trust, DP felt it is important it stays only usable for trust issues and not general practice. Proposal three involves removing public access to the Blackpool drug list but could still be used internally if required. UHMB has the only complete accessible formulary within Lancashire and South Cumbria. DP said prescribers from other regions could be signposted to UHMB, this would allow access to an agreed formulary produced by clinicians within Lancashire and South Cumbria within an accepted governance framework. This option would mean losing the identity of the ICS and could create issues with trying to develop two formulary sites at the same time. Proposal four was to move all UHMB chapters excluding Cardiovascular, Gastrointestinal (which have already been completed under the formulary working group), Respiratory and Endocrinology (which will be completed before April 2024) to the new Lancashire and South Cumbria formulary site and add notification sections under development to make it clear that the sections not yet reviewed will potentially change. LR commented that she would not want to retire the ELMMB archived formulary at this time until the new formulary is completed in full. This is because it is relied on by clinicians and GPs are still accessing it and using it also. She added there are a lot of resources on there not available on LSCMMG that are also in use and removing access to them could create a high number of queries for clinicians. There is also a financial risk to them as well. SS also agreed with LRs comments, he added there has been a lot of work gone into the site including managing in the interim while waiting for the new full formulary. He added that using the UHMB formulary would create confusion. He commented that ELMMB has been looking at their intranet based formulary which has effectively been updated and lunched for trust staff and felt there are ways for LR to cascade it to	

	primary care colleagues for them to have an updated formulary on ELMMB pages. AB also commented that work is currently underway to allow primary care to have an exact copy for them to use so DP's paper is incorrect when it reads that people have no access to the intranet based formulary. AB also said she could give access to Lancashire and South Cumbria staff to see their formulary statutes. Other than a few accuracy and wording issues with the proposals there was no further discussion at this point. DP moved on to the proposed plan going forward. Before going into the plan MP asked if the plan going forward was for the LSCMMG website and all its information and associated documents would remain up and accessible. AW responded that the website and documents would remain but the formulary section would be hidden, and link to the Lancashire formulary would be added, which would be made up of finalised chapters and updated UHMB donor chapters which are currently under review. DP gave a brief overview of the plan which is as follows: • Agreement to move the UHMB on to the Lancashire and South Cumbria formulary today. • The sections could be copied over by the 18th of January 2024. There will be one website which will not be considered live but will have it there all except for the previously mentioned chapters. • Around the 25th/26th of January to arrange a workshop whereas to discuss the remaining steps for the next sections. The workshop would consist of groups working through existing chapters from legacy formularies and highlight any major differences or items that need further discussion. Urgent things will be discussed first, and any non-urgent items will be brought back for discussion at the formulary group later. • Alongside this, documents and information from places should also be highlighted and can be added into the draft formulary chapters. • The agreed provisional chapters will be uploaded onto the new formulary website by the first of February, however highlighting that they are not published just live for people to refer to in the interim. • Consultees will then be contacted to provide additional feedback by the 29th of February. • Any additional changes highlighted by feedback will be actioned by the 14th of March. • The formulary oversite group will then discuss and action anything that required further discussion and those changes will be uploaded to the website by the 28th of March. • Once all changes are complete by the 28th of March, the website will go fully live. AW asked DP to pause for comments from the group. FP mentioned with relation to the additional information and documents, she felt that only items not already on LSCMMG should be included as to not duplicate work already done at LSCMMG. AW agreed and added this would potentially need to be added to the work plan as it is a lot of work to complete in a very small time frame.	

	SR added the importance of acute trusts sharing any internal processes they have for Red or Restricted drugs to allow for signposting to the new formulary from trusts websites. AW agreed with this. SS commented that while he agrees with the ambition and moving towards a single LSCMMG formulary, he said he can't support standing down their internal formulary and they will not direct people to a formulary which they feel doesn't add any additional value to what they already have in place. He added their internal formulary will be as up to date as it can be as they have someone updating it regularly which they feel is possibly more responsive compared to where the joint formulary will be over the coming months. AW responded that while it their internal formulary is theirs deal with as they see fit, this process is about reducing confusion in the system and that any internal processes don't contradict the joint formulary processes. ShR added that she felt that in the interim of the completed LSCMMG formulary each trust should be free to decided what formulary they use, and it should be clear on the plan that they can access the interim formulary should they wish to or continue using their own formulary for a clear agreed timeframe until the joint formulary is ready for adoption across the areas. AW responded that the main thing needs to be what has the least amount of risk relating to patient care. DP then moved on to how this will be maintained on an ongoing basis moving forward. He said it has not been worked out exactly yet on how things will be maintained going forward. He asked members for any SOPs and terms of references and any further documentation people may have to support this as he is aware there are some good documents out there. He added things such as safety committees, medical management boards and other groups like this if they can share any information to help produce a robust process for April would be helpful. SR commented that the document DP shared refers to existing formulary specialists within trusts, that they don't have that resource at LSCFT. She added that she is unsure what it would be like within the acute trusts, but for LSCFT they don't have people to release to support. DP acknowledged her response and moved onto the development of LSCMMG terms of reference as it linked in with her comment. DP has put together a paper for how to develop the LSCMMG terms of reference and how to maintain it. It is felt there will be a need for additional support needed to do this especially in the beginning as this will be done alongside the formulary work. He added he is aware ICS regions have good people within them that already do this and asked if people can draw on the members in their teams that they already do. He also asked if there is anyway their expertise can be shared and everyone work together as although there is the CSU team, they do not want to take anything away from the other organizations who have their expertise own to get the formulary to work the best way possible. AW added the ask is to create a bigger virtual or integrated team so that items are not just gong to one place but have a collective way of looking at things. CM commented that she was very supportive of the approach as the aim is to get one document that is fit for purpose and meets everyone's needs. She added she is happy to help support members within the team who have clinical specialities to take on whatever work to support this.	

	SS asked to clarify as he thought the idea was to get the formulary moving at pace with a quick merging which didn't require the need for specialists. He added recognising the time and effort it takes to get specialist engagement off what was required for the cardiovascular chapter, as it will be difficult to get specialists to attend workshops the clinical input may be missed. And he thought the ask was for a quick merging of formularies but felt like the pervious ask of specialist chapter reviews. AW answered that the ask was more for formulary specialist to help support rather than clinical specialists, and that it will be a quicker review but not perfect with the hope to move a single approach to the formulary. FP asked in the chat if she was right that her assumption of proposal 9 in the paper was getting a workforce together to update post LSCMMG updates post ratification on a timetable basis, which creates continuity for updating. AW confirmed that she was correct. BH offered some clarification on discussions. Firstly there is the discussion on the plan between now and April 1st as to how that is achieved. Then secondly there is the place for discussions with specialists is to how its moved forward, for example if one trust wants to use a hospital only drug how does that then make its way onto the formulary, how is the team working going to be achieved. As community drugs already come through LSCMMG but hospital only PBR excluded drugs currently do not. AW commented his feelings from discussions, which was for a quick job move over to be done by April, but existing place information won't be shut down due to safety concerns. He asked if the group could feedback on thoughts of a realistic timescale for a comprehensive system wide approach after that, as it could take a few years if done slowly but he felt it doesn't need to take that long. ShR commented that she felt the timescale depends on the ambition to get it done, which partly links into the discussions on the terms of reference for LSCMMG, and that there is no real need to be discussing guidelines in this piece of work which is what has been done so far. She added she felt this committee and the formulary needs to stick to medicines, and if medical devices should be a separate thing due to the growing complexity of them. And that work should be streamlined to position statements, traffic lighting and the use of financial resources along with prioritizing and referring people to guidelines that already exist with NICE or specialist societies. AW responded that this would be covered in the terms of reference work for LSCMMG which is on the agenda. DP thanked the group for their input to discussions as he and the team now know what people want to happen and that he would discuss the outcome with the formulary working group later the same day. AW asked if he needed volunteers for the work at the end of January and DP asked if people could look to see who could attend a workshop at the end of the month, with more input from primary care, but nothing has been decided on relating to this yet. HSK asked about medications used only in tertiary centres and if she was right in thinking it just needs to go to the ICS board to notify them. AW responded that this discussion was probably needed in the future but for now his understanding was that if it was a medication to be used across different hospital sites it would need to come here but for the moment if it is only to be used at a tertiary site then it doesn't need to come here. AW	

	asked DP to have a discussion relating to this and acute trusts specialist reviews in May, DP agreed to this.	
LSCMMG TERMS OF REFERENCE REVIEW		
2024/012	**Discussion of development of terms of reference for LSCMMG** DP brought this item; he highlighted that this is a quick first attempt at the terms of reference (ToR) so there will be some changes needed. The first point he raised was that there is no mention of the formulary or its processes in the ToR, and along this the philosophy of LSCMMG changes. Previously LSCMMG has only looked at new drugs, however with the joint formulary there may be a need for LSCMMG to look at any issues that arise. The first point therefore reads 'to receive and consider or approve monthly reports from the formulary oversight group for significant changes to formulary. This means that LSCMMG will only need to consider anything that costs over £100,000 per year for the ICB or any significant changes to guidelines. Any other smaller minor changes LSCMMG would be informed but not required to make decisions. The second point is to receive and consider outputs from provider medicines management or equivalent committees. This has been to try and split the work load but could include things such as specialist hospital only medicines or low molecular weight heparins. This is to also help keep a form of the LSCMMG process but to also recognise other groups work, for example if one trust decides on a process they can bring it to LSCMMG and make a recommendation to other trusts, then to have a system of recognition and review and approval or position. This will also prevent solo working and align the region. The third point is to receive and consider outputs from neighbouring ICB regions. These are usually quite specialist treatments such as having a specialist psychiatric unit where patents could go to outside of Lancashire and South Cumbria. There would to be representation and a decision making member of the group to bring it to LSCMMG and it should be added to the work plan so nothing just springs up on people. The rest of the document has been checked over and updated where needed. DP asked the group for comments. AW highlighted that essentially subgroups will take away the majority of the workload from this group to release LSCMMG to make decisions and look at the higher importance items. LR commented that she fully supports the adoption of national and other guidance from societies for the group. She added the need for timescales to be added into the document, as she highlighted that she has had a consultant waiting on a decision for months and it isn't good when they have to keep telling the consultant is hasn't been done so this needs to be looked at and a process implemented for timescale expectations. AW added hat he felt the subsidiarity links in with the mutual recognition as previously mentioned and that could mean where a trust puts forward the proposal for adoption as opposed to all being done in one central hub. DP agreed this, however for a high cost impact drug there would need to be a level of ICB agreement. ShR had a few comments, firstly she asked for a shorter more concise document as it is quite lengthy. Secondly she added having the secondary	

	advisory group would be helpful, and lastly she added the point of having a medical chair but needs to be someone who has sufficient time to take on the role. AW agreed with having the medical chair and the need to for more members to be included in the group. SR commented an admin error in the document referencing 'CCG' which needs to be amended. She also highlighted with the scheme of delegation of voting, she felt anything that can be done to make it so that is a decision making committee would be appreciated as it creates a lot of unnecessary work. AW confirmed this is no longer the case as the ICB is the sovereign body and decisions go there, but the is still work to be done to streamline the process. He agreed this would be hugely beneficial to be approve items up to a certain value or having an agreed budget to work to. SR also mentioned the appeals process title needed to be reworded. BH commented that some of the points already raised are on his and AW's list of items that needed to be reviewed. He added the ToR for IMOC needs to be reviewed also in terms of reference of what is happening at the ICB relating to process. He added that while they want to nail down the formulary discussions, he is also keen to hear anything else the people need to be picked up. MP asked if environmental impact and sustainability could be added as it was raised and discussed around 12 months ago when AGR was doing a document relating to this, but she was happy to discuss this outside of this meeting. AW added there is a move to have an integrated impact assessment document which looks at quality, equality, and environmental impacts. SS commented in support of ShR's comments on having more clinical representatives at this group, and he also highlighted to monitor the equity of then voting members. He added that it is important to do a review of that clinical membership across the system, as to think about if GPs should be at this group as well. But again highlighted the need to monitor the equity of voting rights. AW responded that is has never been 'us and them' its us and us, and agreed the need to be more robust about the paperwork that comes through this group. Also making sure the finer details of things have been sorted out before coming here to fuller, better structured conversations and decisions can be had. Members in the group again the importance of having primary care representation at the meeting and that they are properly compensated for their time, and that all clinicians in the group need to be 'job in' clinicians with a wide range of specialties. It was also raised around the issue of resistance of secondary care clinicians doing work outside of clinical activities. ShR also mentioned the ToR mentioned consultation with patient groups and she couldn't see a mechanism for this to happen. AW said this has been done in the past however sometimes the patients brings their own issues instead of the collective so is not always appropriate. But he added if anyone knew of someone who would be a good patient representative to let him know. BH commented that historically under the CCG LSCMMG was informative so required no patient engagement, however as things are going to be changing it does need to be considered if this is still appropriate and if so how to link in with patient groups about specific	

	issues or the patient voice. AW summarized comments from the group including the need for members from finance, nursing, and medical back grounds. LR also highlighted that something needs to be in there about co opt people in depending on what specialist areas are being looked at. **Actions** 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.	**All Members** **BH/AW**
2024/013	**AOB** AB/BH had highlighted the missed discussion and decision on Wegovy being prescribed for weight loss. ELHT want to prescribe Wegovy for weight loss for some time, it was raised at ELMMB due to unclear commissioning pathways and there was a drug shortage at the time also. Patients who meet NICE criteria are felt to benefit from the use of Wegovy for weight loss. ELHT ask if they can prescribe it as it has been decided it would be managed with the Dietetic support in East Lancashire. BH commented that while it was a supported NICE TA there was no service available to prescribe it. There is a weight loss clinic in Blackpool that were not starting patients on Wegovy due to a financial commissioning arrangement and being unable to support the cost impact. BH asked if the group needed to agree on if the service can absorb the cost would they be happy for patients to be initiated on it. AW asked if this is for private patients or would the trust be absorbing the costs. BH responded that it is not PRB excluded patients weren't initiated on it at the weight loss service as it was felt the cost of the drug would use a lot of the budget for the service. MP commented that it has been pushed back to the service as it mentions prescribing in the specifications and is not specific. They have had further discussions with them on different interventions and that it is for the clinician to decide but there has been no further movement on this and has been left with commissioners. MA also commented that with Saxenda initially raised the issue, he echoed MP's comments that there is funding for staffing but not for uptake of prescribing. AW added that Wegovy is only available through acute providers and shouldn't be available through community pharmacy. He asked MA if he was aware of how many patients would be suitable for this and MA said he would need to look into it but would assume it is a large number of people. LR commented that she had recently looked into the supply issues and there is stock available in hospitals. She added it is important to look at how to implement the pathway but also that the supply is still not there for community so possibly wouldn't be advisable to start patients on them. She also added that once the supply issues are rectified, these products should be prioritized for Diabetic patients as they are the ones who are more at risk for not having the medication. ShR commented that there is certainly a high patient demand for this and also a large clinical need. But agreed that the diabetic patients need to be	

	prioritized over weight loss patients. LiD added she is having a meeting next week to discuss with colleagues about deprescribing of these GLP1 drugs within primary care in general practice as it is something that needs to be done in conjunction. There are a very large number of patients on these drugs that are inappropriate and this needs to be looked at, as this will help free up medication for those patients that need it. AW thanked LiD for her support on this issue as he felt it hadn't been widely recognized. LiD added they have reduced around 26% of patients on GLP1s in the piece of work she has done in six months. ShR added to keep in mind that it takes a few months to see if the medication will help a patient with weight loss as its not immediate. AW responded that there was a report published that states that GLP1 weight loss is mostly muscle loss not fat, so it is important to remember this also. **<u>RDTC Website Access</u>** AW told members that the RDTC who supports the Regional Medicines Optimisation Committee has granted free access to their website for medicines optimisation members as part of their support. AW just needed to sign off on the document and it means anyone at the ICB in medicines related posts will have access to this until at least the end of March when the contract ends.	

DATE AND TIME OF NEXT MEETING

The next meeting will take place on

Thursday 8th February 2024

9.30 – 11.30

Microsoft Teams

ACTION SHEET FROM THE

LANCASHIRE AND SOUTH CUMBRIA MEDICINES MANAGEMENT GROUP 11.1.2024

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 2025 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.	**AGR** **AGR** **AGR** **AGR**	**Open** **Open** **Open** **Open**	**12.10.2023** **09.11.2023** **21.12.2023** **11.01.2024**
ACTION SHEET FROM THE MEETING 9th November 2023				
2023/438	**Ranolazine MR tablets for adjunctive therapy in the treatment of stable angina, RAG rating change** Ranolazine for adjunctive therapy in the treatment of stable angina, to be presented at the next Commissioning Resource Group with a recommended RAG rating of Green Restricted for approval. **December 2023 update:** Approval acknowledgement has not be received by the organisation. It was taking to CEG, but final approval was still being sought. NB and AW to look into the decision as the CEG meeting for January has been cancelled. **January 2024 update:** Discussions earlier in the meeting highlighted that AW and NB still need to meet and that outstanding outputs will now be published.	**DP** **AW/NB** **AW/NB**	**Open** **Open** **Open**	**09.11.2023** **21.12.2023** **11.01.2024**
	Tirzepatide for treating type 2 diabetes –			

2023/440	**NICE TA924** AGR and PT to bring back proposed statuses for both diabetes and weight management. PT to put together a model for all products based on five times the current market with costing. **December 2023 update:** On the agenda, closed. **January 2024 update:** BH highlighted an email from AB outside the meeting regarding Wegovy and weight management which was not fully discussed under this agenda item. The discussion is under AOB for today's meeting.	**AGR/PT** **PT** **AGR** **BH/AB**	**Open** **Open** **Closed** **Closed**	**09.11.2023** **09.11.2023** **21.12.2023** **11.01.2024**
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	**AGR** **AGR/BH** **AGR/BH** **AGR/BH**	**Open** **Open** **Open** **Open**	**09.11.2023** **09.11.2023** **09.11.2023** **21.12.2023**
2023/442	**Azithromycin RAG and prescriber information sheet consultation** AGR to speak to local AMR leads and Jill Demont regarding treatment holidays. AS to send AGR the summary sheet and the patient leaflet. AGR to make any amendments once the above has been done and bring back to the next meeting if possible. **December 2023 update:** Ongoing. **January 2024 update:** Ongoing.	**AGR** **AS** **AGR** **AGR**	**Open** **Open** **Open** **Open**	**09.11.2023** **09.11.2023** **09.11.2023** **21.12.2023**
2023/444	**Isotretinoin in the community** FP and RS to update the document to include the new MRHA advice. FP and RS to meet with WP and the local pharmaceutical committee to discuss prescribing within the community on FP10s for the service.	**FP/RS** **FP/RS**	**Open** **Open**	**09.11.2023** **09.11.2023**

	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.	**FP/RS** **FP/RS/PE** **FP/RS/PE**	**Open** **Open** **Open**	**09.11.2023** **21.12.2023** **11.01.2024**
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.	**EB** **EB/BH**	**Open** **Open**	**21.12.2023** **11.01.2024**
2023/459	**Formulary Oversight Group update** All members to consider having UHMB formulary live/ available to all for the time being to ensure there is a formulary available ready to discuss at the meeting in January. **January 2024 update:** On the agenda, closed here.	**All Members** **All Members**	**Open** **Closed**	**21.12.2023** **11.01.2024**
2023/461	**Anticoagulants RAG change review** Members to send any shared care or other related documents they have for low molecular weight heparins to DP for inclusion. If there are any gaps in the guidance/ shared care documents DP will look to be filled. DP to add onto the work plan to try and align either the low molecular weight heparins or the processes relating to choosing them across all trusts. DP to add looking at DOACs during the malignant chapter within the formulary working to the work plan. **January 2024 update:** AW added that Apixaban has come off patent and is now the cheapest. It has been proposed taking the position statement to Februarys meeting to discuss amendments.	**All Members** **DP** **DP** **DP** **DP**	**Open** **Open** **Open** **Open** **Open**	**21.12.2023** **21.12.2023** **21.12.2023** **21.12.2023** **11.01.2024**
	Tirzepatide pathway for type 2 DM			

2023/462	LR to take this item to the Diabetes Health Improvement Board to discuss. **January 2024 update:** Closed.	**LR** **LR**	**Open** **Closed**	**21.12.2023** **11.01.2024**
2023/463	**GnRH analogues in adults – update** By the second week in January 2024 could all members feedback to AGR their views on this item, which will then be fed back to the endocrine discussions before coming back to this group for approval. **January 2024 update:** AGR not in attendance, remain open.	**All Members** **AGR**	**Open** **Open**	**21.12.2023** **11.01.2024**
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.	**AGR** **AGR/SR** **AGR**	**Open** **Open** **Open**	**21.12.2023** **21.12.2023** **11.01.2024**
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.	**DP** **DP**	**Open** **Open**	**21.12.2023** **11.01.2024**
2023/467	**Anastrozole for primary prevention for breast cancer** DP to take this to the appropriate group with the new Amber 0 RAG position for approval. **January 2024 update:** To be discussed at February's meeting.	**DP** **DP**	**Open** **Open**	**21.12.2023** **11.01.2024**
2023/468	**New Medicines Review Workplan** All members to take this back to their teams and send comments back on items for prioritization and deprioritization to DP within the next two weeks. **January 2024 update:** To be discussed at February's meeting.	**All Members** **All Members**	**Open** **Open**	**21.12.2023** **11.01.2024**
2023/471	**Apomorphine shared care – update** Members to forward any specialist Parkinson's nurses they would like to be included int the document to AGR. **January 2024 update:** To be discussed at February's meeting.	**All Members** **All Members**	**Open** **Open**	**21.12.2023** **11.01.2024**

	Out of area prescribing position statement – update			
2023/472	AGR to link with MP around alternative wording.	**AGR/MP**	**Open**	**21.12.2023**
	AW to sign off via Chairs approval once alternative wording has been added.	**AW**	**Open**	**21.12.2023**
	January 2024 update: To be discussed at February's meeting.	**AW**	**Open**	**11.01.2024**
2023/473	**Gender dysphoria prescribing information sheets – update**			
	AGR to add NHS to the document so the statement read NHS GIC.	**AGR**	**Open**	**21.12.2023**
	January 2024 update: AGR updated outside of the meeting that this has been completed, closed.	**AGR**	**Closed**	**11.01.2024**
2023/475	**Denosumab shared care – update**			
	The document was agreed by the group and the RAG change to go to the next ICB ratification meeting.	**AGR**	**Open**	**21.12.2023**
	January 2024 update: To be discussed at February's meeting.	**AGR**	**Open**	**11.01.2024**
2023/476	**L&SC ICB recommended diabetes meters, strips, and devices**			
	LR to add in wording as to why four options have been included to help with diversity of supply.	**LR**	**Open**	**21.12.2023**
	January 2024 update: To be discussed at February's meeting.	**LR**	**Open**	**11.01.2024**
2023/478	**Guidelines workplan**			
	BH to send the item on Daridorexant to Monica for support from the North West MOG.	**BH**	**Open**	**21.12.2023**
	January 2024 update: To be discussed at February's meeting.	**BH**	**Open**	**11.01.2024**
2023/484	**LSCMMG cost pressures log**			
	BH to look at adding the potential saving from the blood glucose meters and strips.	**BH**	**Open**	**21.12.2023**
	January 2024 update: To be discussed at February's meeting.	**BH**	**Open**	**11.01.2024**
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.	**CM/AW**	**Open**	**21.12.2023**
	January 2024 update: To be discussed at February's meeting.	**CM/AW**	**Open**	**11.01.2024**

ACTION SHEET FROM THE MEETING 11th JANUARY 2024				
2024/003	**Declarations of Interest** EB and BH to meet to go over declaration forms and send out.	**EB/BH**	**Open**	**11.01.2024**
2024/004	**Minutes and Action sheet** EB will amend the minutes to reflect the above comments before they are added to the website.	**EB**	**Open**	**11.01.2024**
2024/006	**New NICE Technology Appraisal Guidance for Medicines December 2023** PT to bring back TA943 to a meeting in a few months' time once he has had chance to have further discussions and get a clearer picture on outcomes.	**PT**	**Open**	**11.01.2024**
2024/008	**High strength Fluorides** Wording to clarify the two indications and their respective RAG positions to be updated on the LSCMMG alongside the updated position statement.	**DP**	**Open**	**11.01.2024**
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.	**DP/PT**	**Open**	**11.01.2024**
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.	**All Members** **BH/AW**	**Open** **Open**	**11.01.2024** **11.01.2024**