Minutes of the Lancashire and South Cumbria Medicines Management Group Meeting

Thursday 21st March 2024(via Microsoft Teams)

PRESENT:

Andy White (AW)	Chief Pharmacist (Acting Chair)	Lancashire and South Cumbria ICB
David Jones (DJ)	Assistant director of pharmacy Lancashire teaching hospitals	NHS Lancashire Teaching Hospitals
Daivd Rawlinson (DR)	Locality Lead Optimisation Pharmacist	NHS North of England Commissioning Support Unit
Jenny Oakley (JO)	Lead Pharmacist - Surgery, Critical Care and WACS	University Hospitals of Morecambe Bay NHS Foundation Trust
John Vaughan (JV)	Senior Pharmacist	NHS Lancashire and South Cumbria ICB (Pennine Lancashire locality)
Judith Williams (JW)	Head of ICB Primary Care Finance	Lancashire and South Cumbria ICB
Hannah Robinson (HR)		East Lancashire Teaching Hospitals Trust
Lucy Dickinson (LD)	Finance Manager for Primary Care	Lancashire and South Cumbria ICB
Mohammed Ahmad (MA)	Assistant Director of Pharmacy	Blackpool Teaching Hospitals NHS Trust
Mubasher Ali (MAL)	Chief Executive	Community Pharmacy Lancashire & South Cumbria
Nicola Baxter (NB)	Head of Medicines Management	NHS Lancashire and South Cumbria ICB (West Lancashire locality)
Nicola Schaffel (NS)	Lead Medicines Optimisation Pharmacist Greater Preston & Chorley/South Ribble	NHS Lancashire and South Cumbria ICB (Greater Preston & Chorley/South Ribble)
Sonia Ramdour (SR)	Chief Pharmacist/Controlled Drugs Accountable Officer	Lancashire and South Cumbria NHS Foundation 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
Emily Broadhurst (EB) (Minutes)	Medicines Optimisation Administrator	NHS Midlands and Lancashire CSU

	SUMMARY OF DISCUSSION	ACTION
2024/034	**Welcome & apologies for absence** Apologies were received from Ana Batista with Hannah Robinson attending on her behalf, Lindsey Dickinson, Lisa Rogan with John Vaugan attending on her behalf, Andrea Scott with Jenny Oakley attending in her behalf, Dr Ramtoola and Dr Sauri-Kouzel.	
2024/035	**Declaration of any other urgent business** None for this meeting.	
2024/036	**Declarations of interest** None for this meeting.	
2024/037	**Minutes and action sheet from the last meeting 8th February 2024** The minutes were approved and will be uploaded onto the LSCMMG website.	
2024/038	**Matters arising (not on the agenda)** None to discuss.	
	NEW MEDICINES REVIEWS	
2024/039	**Aflibercept (Eylea) 8mg – Line Extension** This is a new higher dose of Aflibercept which may allow prescribers to administer less frequently which would help with capacity. The clinical trial data is complex but indicated for two indications to which is showed as non-inferior. The financial impact has been added to the paper which shows no direct drug impact, however there could be a service impact, and people could potentially be persuaded to use Aflibercept rather than Ranibizumab (Biosimilar). NICE won't be reviewing it, as it is a new formulation that is non-inferior to aflibercept 2 mg in terms of efficacy with lower total costs does not warrant assessment. BH highlighted a comment by AW at the beginning of the item that aflibercept is due to come off patent in 2025. And although there aren't currently any cost pressure issues now, there may be delays in the savings that could be released when it does come off patent. He added that it felt like a patent extension and asked if it is non-inferior should something that is going to cause an increase in prices in a few months be used. AW added that members think about Aflibercept's place in therapy. JO agreed with BH and AW's statements and added her concern of patients being moved on to this and then being unable to move them over to the Biosimilar at the end of the year which has a large cost saving. She added her advice on being careful considering this and to use Ranibizumab first line which is out for consultation. AW asked if it was the molecule that is coming off patent and if there would then be the 2mg and the 8mg when the Biosimilar launches. JO responded that she was aware that 2mg biosimilars had been approved by MHRA but was unsure about the 8mg. BH also added he was unsure and that they had looked	

	previously but were unable to find anything relating to this. AW discussed the options with the group, which included doing nothing and saying no to the 8mg strength. The other option was to ask for this to come back once the pathway has been released to then be able to see if it fits in anywhere. He added asking regional procurement about the likelihood of the 8mg coming through the licensing as it may impact both, for example if an 8mg biosimilar comes out this may be an option. DP added he felt the biggest risk with this item was that it gives another reason not to use Ranibizumab biosimilar, to which AW agreed. AW asked the group what they would like to do. DJ asked if the benefits of this freeing up clinical time needed to be explored as this might be a potential gain reducing waiting times in Ophthalmology. AW added he felt this would be part of the consultation for the pathway but agreed it was worth asking the question. BH added his suggestion of speaking with regional procurement lead Richard Bateman and also asking Ophthalmology to make a case for this and ask them where they would want it in the pathway including the possibility of opening up clinical time. JO added she felt it should be delayed until the treatment pathway consultation has been done as the questions being asked may already be included in that consultation. AW asked if Sharon from the CSU team could put together a cost analysis to see if there is a higher drug cost but less frequent admissions to see what that looks like. No decision made today, await the outcome from the pathway and the following actions. <u>Actions</u> DP to ask Sharon at CSU to do a cost analysis for this item. 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.	**DP** **DP** **DP**
2024/040	**Sucralfate RAG Rating** This has been brought here to help with the formulary process. There are varying RAG ratings cross the patch. It went out to specialists who have come back with their recommendations which are shown in the paper. It also notes a supply issue with the drug. The final recommendations are Amber 0 for suspension and tablets with Specialist initiation only, by GI consultants or GI surgeons and Red for suspension when used as an enema for radiation proctitis. AW mentioned an East Lancashire document which clarifies course length, DP commented that this could be added into the formulary easily as an update. HR added that this would be very useful as the consultants use this often. AW asked if they were happy with the RAG rating due to the high usage, to which HR added that if the additional document relating to course length could be added she would be happy with the RAG rating. The proposed RAG ratings were agreed by the group.	

	Actions DP to add in the additional comments from East Lancashire relating to course length to the formulary as additional information.	**DP**
2024/041	**Freestyle Libre 3 – Commissioning Position** This is a new Freestyle Libre device and can be used as part of a closed loop system. Due to this the recommendation is to give it a Red RAG rating along the lines of an insulin pump. The consultation with the specialist group all supported this. DP also added that while this may seem restrictive it will stop any confusion with the other types of Libre. MP asked if this had been fully supported by secondary care to ensure there is no pushback further along. DP responded that they received wide feedback supporting this but nothing formal. But added the rating doesn't force them to use it but gives another option. AW asked if it comes under the procurement for the hybrid closed loop, to which DP was unsure at this stage as procurement costs had not been confirmed. AW advised this comes back in April once the procurement list has been released and it can be compared with the hybrid closed loop devices. He added that he felt the Red RAG was fine but asked if people felt the need for something to be put out with the months delay. BH responded that he didn't feel the delay would be a problem, and that if it is being recommended it would be being recommended by the specialists so it would be sensible to bring it back alongside the paper once the full details are released from procurement. AW also asked if this is being made Red does this mean that GPs cannot prescribe any of the consumables. To which BH agreed that this would be correct, and then added the question would be, are Trusts able to supply the consumables or what is the pathway to get access to them. AW added that this may not be implementable if the Red RAG is approved. MP added that it can start with the position, but the question is are secondary care happy for patients to keep coming to them for their supplies, how much of a supply would they be willing to provide each time and is this convenient for patients. AW commented that this felt like the right pathway for initiation but not for continuation. JO added she was unsure how it would be sustainable as a Red RAG and felt that it wouldn't help patient compliance if it was Red as it requires people to come back to the Trusts and getting scripts to cover repeated dispensing. JO suggested either Amber 1 or Amber 0. AW added that as it doesn't require shared care it wouldn't be Amber 1 but may be Amber 0. He asked the group on their opinions for Amber 0. The group agreed that Amber 0 would be more workable as they felt that while the Red to avoid confusion is positive but long term the Red is not practical. AW asked if they would be withdrawing Libre 2 as they did with Libre 1, to which DP was unsure but said that he assumed there would be confusion between Libre 2 and Libre 3. The group agreed to defer this item until it is known what is going on with the hybrid closed loop from procurement, and that the proposed Red RAG doesn't seem practical, but that Amber 0 could mean a lot of prescribing.	
	Formulary Update and Process Chart DP reminded the group that the end date for the consultation on the quick	

2024/042	version of the formulary ends on the 22nd March 2024. So they will be looked at over the coming week to see what the outcome of the consultation is. In terms of full chapter reviews, Respiratory and Endocrine are being finished off and CNS has been started. The CSU team met to discussed how the working formulary could be maintained such as keeping up to date with NICE and SPC updates. DP has drafted a rough process chart for the group. This was shared onscreen for members as it had not been sent out to the group as it was still being worked on. All requests from trusts and primary care would go into the formulary inbox as would updates from Optimize RX, Product updates, NICE, Pharma, Cross border work, Clinical groups or IFRs. DP created a group based on the formulary working group who would then put everything coming in onto a spreadsheet, then on Mondays and Thursdays the CSU team would categorise the types of changes or requests. Minor updates such as an update from the SPC that don't require approval would then be added to the formulary and added to an action spreadsheet. Moderate updates would be taken to the formulary working group and then updated on the formulary and again added to the action spreadsheet, and with major updates or changes DP suggests taking these to clinical speciality groups which are being developed for each clinical area. The items would then come to LSCMMG for either information or approval along with the main spreadsheet for information. Also comms would go out to Primary Care and Trusts when the spreadsheet is updated. HR commented that she felt the chart looked good but asked for some clarity on how defining if something is a minor, moderate or major change would be done. DP responded this hasn't been agreed on yet and is still being worked on. AW asked for this information to be brought back next month. DR asked if one of the outcomes from the actions to the spreadsheet could be to send into the Optimize group as they don't yet a working formulary across all areas, to which DP agreed this could be done. JO asked if a Red initiation come under a major change, and would it still go through the same process or would it stay Red at the local trust. AW added that if it is Red in one trust, moving towards one formulary it should be Red for all trusts. DP agreed and added that the idea is to try and move away from doing everything at LSCMMG. It would need to still come to LSCMMG in this instance as it is a new drug but there would be a change in the review process. AW reminded the need to be mindful of the governance for new initiations. JO added that from an acute trust side they will need to work in a more joined up way as currently they would just apply for something internally, whereas they will need to link in with other trusts and build these new working relationships. BH agreed with the comments and added that some more work needs to be done in terms of trust processes. JV added into the chat if time scales could be added to the chart and added that it would be useful to help manage expectations on the process. AW asked where new drug requests would come through as the whole point of this process is to help streamline the process instead of having different Trusts working on the same thing. He included the work that JO is doing outside of the meeting to streamline a single application form. JO agreed that it would be good to have a more streamline process and that the chiefs will need to help but each other's contacts together, so people	

	know who to go to with items for discussion. AW brought back the governance issue and that if there is a moderate change the spreadsheet needs to come to LSCMMG to keep things inclusive and that it could just be a small update like at the end of LSCMMG with other meetings outcomes. He then asked JO how things were going with the idea of the single application form. JO responded that Morecambe Bay and East Lancashire Teaching Hospitals forms were the closest in similarity to the LSCMMG form, and instead of doing lots of additional work she felt it would be best to use the LSCMMG form but possibly including the flow chart included in the East Lancashire Teaching Hospitals form and it includes licensed and unlicensed drugs. SR commented on the chart that it would be easier for LSCFT however they would need more support if it was a new drug. But also that they would need more clear guidance to chairs of local D&T committees as things do change and if they are reviewing something that requires a change say from a Red to an Amber 0 there could be challenge at this point. DP agreed with this. AW summarised the discussions in that there needs to be clear definitions on what will be regarded as minor, moderate and major changes and what is decisions making and what are advisories as individual trusts and places are making advisories for adoption to LSCMMG. Then, once they have come through LSCMMG they will then be adopted if agreed by any statutory body that is linked with LSCMMG. He offered his help in working through the points made today with DP and asked if anyone else would like to be involved with working this out to get in touch. JO asked DJ if Judith could be involved with this as their form is the most different to the rest of them with the flow chart and she felt it would be good to get her perspective. DJ responded that he would ask her. AW added the need to include a chart that was taken to IMOC recently around how NICE guidance is adopted or not. AW asked if the new formulary would be coming back in April, DP responded that it would be the end of April so will miss the April meeting but can come back to May's meeting. They also discussed that the May meeting may be formulary items and urgent items. <u>Actions</u> 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.	**DP** **DJ** **DP**
2024/043	**New Medicines Review Workplan** This was mostly the same workplan that was sent around to the group a few months back. DP asked for feedback on what should be prioritised but didn't receive any responses. A new item that has been added was Ivermectin for the treatment of scabies. This was a local issue which was bigger when there was no licensed product available, but this has now been added. Another new item is Bisacodyl rectal solution for the treatment of constipation by specialists only and is used mostly in spinal units. But there is a question it can be used as a shared care arrangement	

	for primary care. Ones that have already been prioritized, Qutenza is almost ready and Liothyronine for depression has been started as it should align nicely with the CNS section of the formulary. DP added that the workplan has been slowed down due to the work with formulary being prioritized, but asked if there is something that members really thing needs looking at urgently to please let him know. AW commented that a lot of the dates are from the past and asked how quickly the backlog can be cleared to allow further prioritization of new items. He added that he found the added comments from innovation, better care and value factors being added very helpful. He reiterated DP's comment about if there is anything people in the group felt needed to be prioritized to speak up. He added that he would include Ivermectin as he believed it was a licenced preparation that has become available this week and that it should be added to the formulary today as it would be helpful. JV agreed that this going on as soon as possible would be very helpful. AW asked if there was any on the list that were just possibly administrative that could just be done here and taken off the list. He asked about Tadalafil as he felt this had already been done. DP responded that it was never actually discussed but added if all agreed to have it included in the formulary it would be good as it is much cheaper than when it was first reviewed. AW said he was inclined to say to add it as it is now only 78p for four tablets. SR commented that Liothyronine probably doesn't need discussion as it is included in the NICE guideline for depression and the numbers are small and the proposal RAG is Amber 1. AW asked the group if they could be pragmatic and asked if anyone objected to this being added onto the formulary as Amber 1. There were no objections from the group to this being added to the formulary. HR brought a comment around Dymista, as their consultants are quite keen to use it and in terms of the price it is actually cheaper for them to prescribe one item instead of two separate ones. She was aware this was a contentious issue but wanted to raise that they would be happy to see it on the formulary as it is either cost neutral or better for them to prescribe. AW commented that the price can vary and that there were some consultants writing contentious letters which wasn't helpful, however with some other consultants involved in this now it could be open for discussion again. DJ commented from an LTH perspective there is now a different consultant who is keen to engage and sighting guidance relating to this, so although this has been reviewed several times it could now be discussed from a different perspective. AW added that now the discussion needs to be its place in therapy. BH added that they are now quite keen to push forward these discussions with the new consultant. AW asked the group if there was anything else that people felt could be taken off this list or that doesn't need to go through a full process. DP added that Methadone, Naltrexone and Naloxone items could just go through the formulary as part of that group. AW agreed with this. DR added that Faye has contacted the council, and they are going to do a new application for the IM injectable form of Buprenorphine for substance misuse as well. AW moved onto Colesevelam and said that it is not included in the lipid	

	guideline so asked would that mean this is a no to this drug. DP responded that this is for patients who can't tolerate the other lipid lowering drugs, so it is very last line usage. AW then asked if this would be Red or Amber 0 RAG rating as to get to this he felt the patient would need to be under a lipid specialist. AW asked for the group to send in pragmatic suggestions to help resolve the list, and that at the next meeting the group works to clear this list by as much as possible as there are items on this list that have been there for months. <u>Actions</u> 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.	**All Members** **DP** **DP** **DP**
GUIDELINES and INFORMATION LEAFLETS		
2024/044	**Antipsychotic Shared Care NICE Approved Off-label Indications** This was a request from LSCFT. The consultation was completed last year on the principle of whether or not NICE approved off label indications should be included in shared care agreements. The consultation result was positive, and the group agreed that it should. LSCFT have sent a list to the CSU team of NICE approved off label indications with second generation antipsychotics are being included in the shared care guideline and they are listed in the paper as there is a large number of them. The ask of the group today is taking into consideration the previous consolation and engagements are the group happy for AGR to include those within the shared care and also are the group happy for it to be transferred over to the North West template format for shared care as this will need to be done eventually to avoid confusion. SR asked if the North West template includes the letter at the back of the document included in the current one where a separate document is sent out to GPs and then they respond back to that. She added GP's felt in some areas that it was creating unnecessary work for them having to respond to the request which then in turn creates more work for them if it is in the letters. She also said she felt that if the position was in the letters that this would be sufficient. AW commented that it had been discussed for LPRES to send this communication out where if people are happy to accept they can tick the box and the record is shared but he didn't think it was quite at this stage yet. SR agreed and added that having it as a current position that its optional as long as the information is sent over to the GP in some format. AGR confirmed this has been changed to optional. AW asked if AGR wanted it to come back to which he said he would like it to come back to ensure the format works. AW agreed and added that he should send it via SR prior to coming back here for their approval also.	

	AGR also asked for it to be minuted that the LMC were happy with the inclusion of the NICE recommended off label indications also. Actions AGR to add NICE- approved off-label indications to the second-generation antipsychotic shared care guideline. AGR to use the new North West Template for the updated antipsychotic shared care guideline AGR to send to SR for review before bringing it back to LSCMMG next month.	**AGR** **AGR** **AGR**
2024/045	**ELHT – Insulin Biosimilar Statement** The statement is good in general; however it is very specific to East Lancashire, DP advises to adopt the statement but to reword it to be more generic before it is adopted. DP also added that this is one of the first examples of how things could be jointly implemented or dealt with and suggested there should be a set of standards on how documents are produced but added this should probably be discussed outside of the meeting. AW said he would be happy for it to be rebranded and generalised, then brought back here for approval before adopting if others were happy to adopt. There were no objections from the group. Actions DP to rebrand the document and generalise it, then bring back to the group for approval before adopting.	**DP**
2024/046	**Azithromycin Prescriber Information Sheet** This was previously brought to the group and agreed to take to the AMR leads for feedback. AGR has received feedback and made some amendments to the document and also added in the patient information sheet. This sheet was developed by UHMB but will be rebranded to include the LSCMMG badge to be used by prescribers at the point of prescribing and the LMC were happy with the document in its current format. AGR asked if the group were happy with the new amended document. DR added a concern from Faye Prescott in relation to the ECGs and added it could be a potential barrier if the prescribers were intended to perform the ECGs. AW asked who was intended to perform the ECGs long term as on page 2 of the document it states a GP review and includes ECGs in that section. AGR confirmed that the paper recommends for GPs to review and perform the ECGs. AW asked that LMC were happy with this to which AGR again confirmed that the LMC were happy with this. AW asked if there is capacity in primary care for this. AGR checked the commented received back by the LMC and discovered they had also suggested a review by the specialist at 12 months and added he would be happy to take this back to the LMC and clarify if they are happy with the ECGs being performed in primary care or if it should be performed by secondary care. AW added that the paper does include discussions on QT levels which cant be accessed unless an ECG has been conducted, with this information the LMC will have read AW added the presumption that this	

	was ok with them, however agreed that AGR should go back and clarify with them. Once this has been done it was agreed by the group to be approved via chairs action unless the LMC do not agree with the original statement around GPs performing the ECGs. Actions Due to conflicting responses received 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.	**AGR** **AGR/AW**
2024/047	**Daridorexant RAG Status – Update** It has been released that there will be a nationally commissioned CBTI service. NICE have reviewed Sleepio and released a NICE Medicines Technology Appraisal and AGR believes this will be the programme commissioned nationally, however acknowledged that he had nothing in writing confirming this. AGR added that once further information has been released the CSU team will be able to recommend a RAG rating and produce a position statement or brief guidance. The LMC would be supportive with a guideline in place and prescribers would be initially directed to CBTI as the NICE guidance suggests and then consider Daridorexant after that step. AGR added that the paper suggests to have some reasonably strict criteria for continuation at 12 months as this is as long as the trials have lasted, which means there isn't any evidence for effectiveness after 12 months of use. He suggested a review at this stage and added this could be included in the guidance given to prescribers. AW asked if this was going to be picked up with the North West Sleep Network, to which AGR said he wasn't aware if it would be. There had been some discussions and the GMMMG had given it a Amber 0 equivalent RAG rating and that Pan Mersey had given it a Green RAG but he hadn't been involved in any further discussions. AW asked if this would be worked towards the national scheme being announced to then publish this document, to which AGR confirmed this. AGR added the proposed RAG rating should be Green Restricted now as this is now passed the implementation date, and suggested this be put on the LSCMMG website as Green Restricted with a placeholder detailing that the prescribing guideline will be in place once more information was available from NHSE. This was agreed by the group. Actions 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.	**AGR**
2024/048	**Lipid Pathway Update** DP highlighted that there are some gaps in the current Lipid pathway which is aligned to national guidance. The CSU team have worked with the Lipids group to fill in the gaps and update the pathway. The main part is within the word document sent around to the group, which was a gap between LDL-C above 2.0mmol/L and below 2.6 mmol/L. There was no recommendation in there so this has been added, the document is now in alignment with the AHC pathway and the Lipid group are also happy with	

	it. AW added that Inclisiran and the PCSK 9 at the end shows above 2.6 and the other one is above 4. He asked if this means that Inclisiran is between 2.6 and 3.9 or is there a cross over. DP responded that he felt it is a cross over as it isn't directive enough to cover everything. He added that there is also Icosapent Ethyl at the top which also crossed over slightly. The work with the Lipid group is going to continue to refine it further but wanted to get it as is now. AW added the feedback received from Rukaiya and Andy Knox in the last 48 hours was the need to focus on the top left hand box which is about how primary care is getting patients onto this and if that is done to optimal effect then the lower half of the page isn't really needed and the Inclisiran and other debates don't come into it. He added that primary care are reluctant due to the lack of payments now to use Inclisiran. AW then asked if the full AC statin and tolerance algorithm is really needed. DP responded that using the algorithm shows it is quite difficult to be truly intolerant. AW asked the group if they were happy to approve this document and its changes to the Lipid pathway. There were no objections from the group so this is approved. <u>Action</u> The approved pathway to be added to the LSCMMG website.	
2024/049	**Somatropin RAG Status and PIL – Update** This has been to the group previously and was taken back after further discussions. The discussions were around the RAG rating and if it should or shouldn't be an Amber 1 as it is currently Amber 0 on all legacy formularies. It was proposed as Amber 0 in the new draft formulary and specialists have advocated for it remain Amber 0. This is due to the lack of monitoring and specialists' willingness to manage dose changes or changes in clinical circumstances for patients. Primary care representation has leaned more to the requirement of a shared care agreement and highlighted that this was listed in the NICE TA, however this was developed in 2003. There were concerns also raised by primary care about the adverse effects of Somatropin and therefore the potential need to refer back to the specialists. There are also some boarder issues, GMMMG does have a shared care in place for Somatropin in Paediatric patients and they used to have a shared care also for adult patients and Pan Mersey have it as a Red RAG. East Lancashire did have a shared care for adults which as based on GMMMG's adult shared care which has now been retired, and there are also other ICBs around the country that do have a shared care such as Glasgow, with some requiring monitoring and some not with the majority not requiring long term monitoring. The LMC agreed on the patient's information leaflet rather than a shared care, however there are other comments relating to ongoing monitoring should remain in secondary care and discusses a shared care so there is a mixed review from them. AGR asked the group if they would want the Amber 1 as per the drive from primary care although specialists would prefer to keep it as Amber 0, there is limited monitoring required and there is some cross boarder issues. AGR's recommendation would be to continue with the patient's information leaflet but ensure the lines of communication between primary care and the specialists is kept open for GP's who feel unsure.	

	MP commented that this has been discussed at the place leads meeting a few times, and they have not had a lot of pushback and it has worked well at Amber 0 with no shared care. JO commented that the specialists are very keen to keep it as Amber 0, and if there is minimal monitoring it doesn't feel like it should be Amber 1. AW asked the group if they were happy to keep at an Amber 0 with a developed patient information leaflet. JV commented they may get push back with regards to the first dose and initiation as being Amber technically GPs can initiate on the recommendation of the specialist. And as East Lancashire were working with a shared care the first dose and initiation would be given in secondary care and they would continue it, he asked for clarity on the expectation of initiation and first dose would be useful. AW asked if there were any risks of the first dose being given in primary care, to which JV responded he felt it would be just push back when asked to give the first dose and is more around facilitating adoption and take up. AW summarised the ask of it being Amber 0 with ideally the first dose being given in secondary care with a patient information leaflet rather than a shared care and asked the group if they were happy to proceed with this recommendation. JO commented that her concern with the first dose to be given in secondary care could delay the initiation while finding somewhere for it to be given and if it is Amber 0 it can be given in primary care on the recommendation of the specialists and there is no risk associated with the first dose and patients are not at a higher risk for this of adverse reactions. AW added with JO's concerns and asked if there were any risk of adverse reactions to which JO said she was unaware of any but would need to look further to be sure. AW re-summarised this as Amber 0 on the recommendation of a specialist and asked JV how he felt this would be received by East Lancashire. JV confirmed he felt there would be pushback with primary care now being asked to initiate on specialist recommendation and added the LMC might get involved again. AW added that the LMC had said they were happy with this, to which JV queried that the LMC were happy with initiation in primary care and asked if the East Lancashire Rep had been included in this and was happy they would be able to go back and tell primary care that the LMC agree with the decision. It was agreed for AGR to confirm with the LMC that they are happy with initiation being in primary care on the recommendation of specialists and bring this confirmation and the patient information leaflet back to the next meeting for the group's approval. <u>Actions</u> AGR to confirm with the LMC that they are happy with initiation being in primary care based on a specialist recommendation. AGR to produce and bring back the patient information leaflet along with LMC confirmation to the next meeting.	**AGR** **AGR**
2024/050	**PGD Authorisation Policy – Scope** AGR has worked through a large amount of guidance for this item and has come up with three options for the group to discuss and agree a way forward. AGR gave an overview of the paper sent around to the group. In summary of the paper, there are two parts to PGD authorisation: clinical	

	and legal sign-off and authorisation by the authorising body. Clinical and legal sign-off can be delegated. MLCSU has a new governance structure in place to carry out this function. It is not clear whether authorisation by the authorising body can be delegated. SPS indicated that it can, but the NHSE document states delegation should not occur if conditions are imposed on the terms of delegation i.e. in statutory guidance. It could be argued that for PGDs this is the case under regulation 229 of the Human Medicines Regulations Act 2012. There are three options available for the authorisation of PGDs by LSC ICB. Firstly, the PGDs can be developed, approved and authorised 'in house' where the ICB will retain flexibility in the development of the PGD, retaining responsiveness to local needs as they arise. Full apparatus of PGD development and governance would be required along with the apparatus to approve national PGDs for local use. The second option would be to delegate PGD development to a third party and retain organisational authorisation in the ICB. A Memorandum Of Understanding (MOU) would be required with the third party covering the development and legal sign-off. Governance arrangements and policies would be required to cover the ICB organisational sign-off process. There would be less flexibility in the PGD development, but the ICB could retain responsiveness to local needs if the MOU is structured appropriately. This option is less resource intensive and apparatus to approve national PGDs for local use would exist. The third option would be to delegate the development and approval (including organisation authorisation) of PGDs for use by providers across Lancashire and South Cumbria. With this option NHSE or legal advice is required before entering into this type of agreement. An MOU would be required with the third party to cover development, legal sign-off and organisational authorisation. The ICB could retain responsiveness to local needs if the MOU is structured appropriately. This option is also less resource intensive long-term, however setting up the MOU initially would be time consuming, and clarity would be required if the apparatus to approve national PGDs for local use is needed separately. AGR's recommendation to the group is option 2. The CSU has a new PGD development process in place, it is structured to be responsive to organisational needs so they can develop the PGDs, but it still needs to be signed off for authorisation within the ICB and the governance on that will need to be clear. He added he didn't feel it would take too long to put together a policy detailing the authorisation as along as they knew where it needs to go for this. He asked the group for their opinions on this. AW added that this is not for any NHS statutory bodies this is purely for third party commissioning care services from the independent sector. If it is under NHS regulations then the statutory body approves it, and it is down to local processes to agree. AGR added that the CSU can do the legal sign-off as they have a GP and would get other specialist as and when required it is the ICB authorisation which can't be delegated out. DJ asked if and how this would affect secondary care, to which AW responded that it wouldn't affect secondary care. SR asked if there would be national PGD templates that could be used for the PGDs likely to be being approved as that would help to determine the likely workload. AW responded that there is, but it is limited, they have around 10-15 nationally where as there were 8 that came in recently for one provider and only one	

	was on the national list. SR also added that it is important to ensure the governance is worked to, ensuring it's the correct version and that any updates are delegated appropriately. AW asked the group to let him know if there are any other providers using PGDs that may not be authorised. AW summarised the feeling from the group was the second option, and asked AGR to create the policy for organisation authorisation sign-off. <u>Action</u> AGR to create the policy for organisational authorisation sign-off for PGDs.	**AGR**
2024/051	**Recurrent UTI Guideline – Update** The guidance has been updated following AGR linking in with the antimicrobial group and the changes are highlighted in red within the document shared to the group. The AMS committee provided feedback around Prophylaxis UTI's having an Amber RAG rating and adding in some additional treatments. BH asked the group if they were happy to approve the update and the document. <u>Action</u> The group approved the updated document. To be uploaded to the LSCMMG website.	
2025/052	**Care Home Depot Injections** AW asked if this item had been approved by LSCFT's medicine management committee, to which SR responded that it hadn't gone there formally however it was proposed by LSCFT and she had written the paper. SR presented the paper to the group. There has been a situation where if a patient who is currently on a depot antipsychotic and is in either a care home or a residential home where there are registered nursing staff, these patients still have to be taken to the depot clinic to receive their medication by LSCFT staff. This proposal supports the efficient use of resource and care closer to home and puts forward a process where if the depot was changed to an Amber 0 RAG, it could be prescribed by the GP, supplied by community pharmacy, and then administered by nursing staff working in the care homes. If it was a RED, then LSCFT staff could prescribe and arrange for the injection to be delivered to the care home for the nursing staff within the care home to administer. There are a small number of patients currently on Olanzapine which is currently Black do not prescribe and is usually a tertiary service recommendation so LSCFT would retain everything for those patients. Similarly this would also be the case for patients on Fluphenazine decanoate and Pipotiazine Palmitate which are now both unlicensed in the UK. AW asked of this is a big change in terms of what happens currently, to which SR responded that it is a big change for care home patients as it would be administered at the home instead of the depot clinic. AW asked if there would be a substantial amount of training required or would the nursing staff already be able to do this. SR responded that for most they should be able to already administer this, however where the need for training is identified then LSCFT would administer the training to support safe administration.	

	AW then asked who would commission the care for these patients, he asked if it would be the ICB and would it need to go into the contact that they should be doing it. SR said she hadn't given it much thought and AW added that if it was in the contract people would be less likely or unable to say no to this. JV agreed this and asked if it had been discussed with the regulated care sector and contracting. While he agreed with the care closer to home he had some concerns knowing the state of some of the nursing homes and the number of agency staff working in them the practicalities of this actually working need to be looked at. And that there may need to be a contractual agreement and he felt that there would be big training education required and extra governance in homes as well as pushback from pushback and safe storage in homes. AW asked JV if he had a contact for SR to contact in relation to the concerns raised and he put the contact of Adel Thornburn at the ICB in the chat of the meeting for SR. NS raised a similar concern on behalf of Clare Moss relating to GP liability, as if they are taking on the responsibility of prescribing but this is then reliant on nursing home staff administering the drug, the GP has no ability to control the performance of the competency. JV added the need for the governance around this to be clear, which includes the training, the authorisation to administer, what forms need to be completed ext. He added it is workable, but there needs to be the assurance that the staff are competent and trained along with having the policies and processes updated in care homes to reflect the administration around it. AW summarised that in principle the group felt this was ok however there needs to be a fair amount of training, governance and contracts required for this to consistently happen. He asked SR if she had patient numbers, to which SR said she will get the data but didn't feel it was big numbers. AW then added an issue of people doing it infrequently. SR added it would more likely be the Red drugs that LSCFT would prescribe, and AW asked if patients are in secure facilities or within nursing homes, to which SR responded with nursing homes. In summary, SR will engage with Adel and JV and asked if anyone else can put forward people for her to raise and discuss this with it would be helpful. AW asked if all the beds are NHS funded or if some are private, to which JV said there is a mix. AW added that if contracts are required, they may be able to get funding for the NHS beds, but he was unsure what would happen to the private ones. Once agreement is obtained and the governance is all arranged it will come back to the group for sign off as the group agree on the RAG statuses for the drugs proposed. <u>Actions</u> SR to engage with representatives across LSC around this proposal, bring back to LSCMMG when appropriate.	**SR**
2024/053	**Guidelines workplan** There was nothing major to note for this section, there are a number of items coming to April's meeting. AW mentioned the Ophthalmology pathway as it showed as TBC, and asked JO if those items would be picked up as part of the consultation she is doing. JO said it would be picked up within this consultation which was due to close soon. AW asked if the ones on hold were on hold forever or are no longer	

	needed and can be removed. As AGR has left the meeting at this point DP advised leaving items in there until it could be checked with him. AW then asked if heart failure and diabetes was a specific guideline or if it was apart of the heart failure guideline with the addition of the diabetes information. DP explained this was from when there was a split of diabetes and heart failure due to the drugs crossing over. DP added his advice to remove this one from the work plan as the majority of the information was in the diabetes guideline. AW asked if the good prescribing in primary care guidance was just an update, to which BH agreed that it was.	
NATIONAL DECISIONS FOR IMPLEMENTATION		
2024/054	**New NICE Technology Appraisal Guidance for Medicines February 2024** Nothing for discussion this month.	
2024/055	**New NHS England Medicines Commissioning Policies February 2024** Nothing to discuss.	
2024/056	**Regional Medicines Optimisation Committees – Outputs February 2024** Nothing to discuss.	
2024/057	**Evidence Reviews Published by SMC or AWMSG February 2024** Nothing to discuss.	
ITEMS FOR INFORMATION		
2024/058	**LSCMMG Cost Pressures Log** There were no cost pressures from decisions this month.	
2024/059	**AOB** During item 2024/041 JO raised a query about Blood Glucose meters and Accu Chek as the ICB's contract is ending. They are struggling to get supplies and as the contract is ending the company are unwilling to get more supply for any new patients. AW responded that the preferred meters have been agreed for the whole system and asked if this query relates to Accu Chek professional or for the ones going out from the DSN's into community and JO said it was a query from Paediatrics. AW continued that Accu Chek is not on the preferred meter list that was agreed for system wide previously which is what the system is moving towards. The feeling on this decision was for uncomplicated patients (who AW was unsure if Paeds fell into this category) there was enough items on the list to chose from. He added that if Paeds could pick one off the preferred list that would be preferable. **<u>CMDU</u>** CMDU is being re-commissioned, it is currently a 5 days a week service currently being subsidised by other services as there was more people coming in than was service available. There have been some breaches at	

	weekends with people not getting antivirals within the time frame. There has been an unfunded increase in the service, and it will now run on a Saturday, and it will be 5 hours daily during the week and 3 hours on a Saturday and it will be run out of FCMS. SR added this month the scope for antivirals as increased and said she would send the information to AW.	

DATE AND TIME OF NEXT MEETING

The next meeting will take place on

Thursday 11th April 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.	**AGR**	**Open**	**12.10.2023**
	November 2023 update: Will be sent out at the end of November for consultation.	**AGR**	**Open**	**09.11.2023**
	December 2023 update: Will be sent out this month.	**AGR**	**Open**	**21.12.2023**
	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.	**AGR**	**Open**	**11.01.2024**
	February 2024 update: This will now come in April due to the formulary work being prioritised.	**AGR**	**Open**	**08.02.2024**
	March 2024 update: The document is currently out for consultation – to come back to the April meeting.	**AGR**	**Open**	**21.03.2024**

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.	**AGR** **AGR/BH** **AGR/BH** **AGR/BH** **AGR/BH**	**Open** **Open** **Open** **Open** **Open**	**09.11.2023** **09.11.2023** **09.11.2023** **21.12.2023** **08.02.2024** **21.03.2024**
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. **February 2024 update:** AGR has made contact with AMR group, waiting for feedback from a respiratory consultant. AGR will then amend the document and the AMR group will review. Due for completion March 2024. **March 2024 update:** On the agenda, closed here.	**AGR** **AS** **AGR** **AGR** **AGR** **AGR**	**Open** **Open** **Open** **Open** **Open** **Closed**	**09.11.2023** **09.11.2023** **09.11.2023** **21.12.2023** **08.02.2024** **21.03.2024**
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/RS** **FP/RS** **FP/RS**	**Open** **Open** **Open**	**09.11.2023** **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. **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.	**FP/RS/PE** **FP/RS/PE** **FP/RS/PE** **FP/RS/PE**	**Open** **Open** **Open** **Open**	**21.12.2023** **11.01.2024** **08.02.2024** **21.03.2024**
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. **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.	**EB** **EB/BH** **EB/BH** **BH**	**Open** **Open** **Open** **Open**	**21.12.2023** **11.01.2024** **08.02.2024** **21.03.2024**
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	**AGR** **AGR/SR** **AGR** **AGR**	**Open** **Open** **Open** **Open**	**21.12.2023** **21.12.2023** **11.01.2024** **08.02.2024**

	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.	**AGR** **AGR**	**Open** **Open**	**08.02.2024** **21.03.2024**
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.	**DP** **DP** **DP/AW** **DP/AW**	**Open** **Open** **Open** **Open**	**21.12.2023** **11.01.2024** **08.02.2024** **21.03.2024**
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 give 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.	**AGR/MP** **AW** **AW** **AGR/AW** **AGR/AW**	**Open** **Open** **Open** **Open** **Open**	**21.12.2023** **21.12.2023** **11.01.2024** **08.02.2024** **21.03.2024**
2023/478	**Guidelines workplan** BH to send the item on Daridorexant to Monica for support from the North West MOG. **January 2024 update:** To be discussed at February's meeting. **February 2024 update:**	**BH** **BH**	**Open** **Open**	**21.12.2023** **11.01.2024**

	Daridorexant was discussed outside of the meeting, but nothing has been agreed. The CSU team are to bring a paper back to March for discussion. Once approved by LSCMMG the team will look to take this item to CEG due to the nature of complicated place in therapy and the current position of CBTI. **March 2024 update:** On the agenda, closed here.	**BH** **BH** **BH**	**Open** **Open** **Closed**	**08.02.2024** **08.02.2024** **21.03.2024**
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 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.	**CM/AW** **CM/AW** **CM/AW**	**Open** **Open** **Open**	**21.12.2023** **11.01.2024** **21.03.2024**
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.	**DP/PT** **DP/PT** **DP/PT/AW**	**Open** **Open** **Open**	**11.01.2024** **08.02.2024** **21.03.2024**
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:**	**All Members** **BH/AW** **BH/AW** **BH/AW**	**Open** **Open** **Open** **Open**	**11.01.2024** **11.01.2024** **08.02.2024** **21.03.2024**

	No update at this meeting.			
ACTION SHEET FROM THE MEETING 8th February 2024				
2024/015	**Declaration of any other urgent business** BH and team to update the diabetes document with obesity related complications. BH and team to look into the continuation criteria and look to discuss this with the specialists. BH and team to update the weight loss document with the expected review information following the update from NICE. **March 2024 update:** Tirzepatide was discussed on agenda, updated position statements approved.	**BH** **BH** **BH** **BH**	**Open** **Open** **Open** **Closed**	**08.02.2024** **08.02.2024** **08.02.2024** **21.03.2024**
2024/020	**Endocrine Formulary LSCMMG Updates** AGR to bring a paper back to March 2024 meeting for discussions on making Somatropin Amber shared care or leaving it as it is at Amber 0. **March 2024 update:** On the agenda, closed here.	**AGR** **AGR**	**Open** **Closed**	**08.02.2024** **21.03.2024**
2024/021	**Ceyesto – Melatonin** Ceyesto liquid to be added to the melatonin guideline 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.	**DP** **DP** **DP**	**Open** **Open** **Open**	**08.02.2024** **08.02.2024** **21.03.2024**
2024/023	**Atrial fibrillation guideline update** DP to make the changes detailed above and send it round to the group for approval. **March 2024 update:** Action complete and the guideline has been added to the website.	**DP** **DP**	**Open** **Closed**	**08.02.2024** **21.03.2024**
2024/025	**Testosterone shared care – update** AGR to look at reference to hypogonadism and add in relevant reference if there is one. **March 2024 update:** Action complete and the guideline has been added to the website.	**AGR** **AGR**	**Open** **Closed**	**08.02.2024** **21.03.2024**
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.	**BH**	**Open**	**08.02.2024**

	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.	**BH** **BH/AW** **BH** **BH/AW/PT/LR**	**Open** **Open** **Open** **Open**	**08.02.2024** **08.02.2024** **08.02.2024** **21.03.2024**
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.	**BH/SR** **BH/SR**	**Open** **Open**	**08.02.2024** **21.03.2024**
2024/034	**LSCMMG Cost Pressures Log** BH to make chances to the cost pressures log. **March 2024 update:** No update at this meeting.	**BH** **BH**	**Open** **Open**	**08.02.2024** **21.03.2024**
2024/035	**AOB** AGR to bring back a proposal to adopt GMMMG PGD authorisation. **March 2024 update:** On the agenda, closed here.	**AGR** **AGR**	**Open** **Closed**	**08.02.2024** **21.03.2024**
2024/027	**Dosulepin review guidance for primary care** Guideline to be uploaded once LSCFT and LSCMMG logos have been added. **March 2024 update:** Action complete and the guideline has been added to the website.	**DP/SR** **DP/SR**	**Open** **Closed**	**08.02.2024** **21.03.2024**
ACTION SHEET FROM THE MEETING 21st March 2024				
2024/039	**Aflibercept (Eylea) 8mg – Line Extension** DP to ask Sharon at CSU to do a cost analysis for this item. 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.	**DP** **DP** **DP**	**Open** **Open** **Open**	**21.03.2024** **21.03.2024** **21.03.2024**
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.	**DP**	**Open**	**21.03.2024**

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.	**DP** **DJ** **DP**	**Open** **Open** **Open**	**21.03.2024** **21.03.2024** **21.03.2024**
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.	**All Members** **DP** **DP** **DP**	**Open** **Open** **Open** **Open**	**21.03.2024** **21.03.2024** **21.03.2024** **21.03.2024**
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 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.	**AGR** **AGR** **AGR**	**Open** **Open** **Open**	**21.03.2024** **21.03.2024** **21.03.2024**
2024/045	**ELHT – Insulin Biosimilar Statement** DP to rebrand the document and generalise it, then bring back to the group for approval before adopting.	**DP**	**Open**	**21.03.2024**
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.	**AGR** **AGR/AW**	**Open** **Open**	**21.03.2024** **21.03.2024**
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	**AGR**	**Open**	**21.03.2024**

	be published as soon as more information is released from NHSE.			
2024/048	**Lipid Pathway Update** The approved pathway to be added to the LSCMMG website.	**DP**	**Open**	**21.03.2024**
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 to produce and bring back the patient information leaflet along with LMC confirmation to the next meeting.	**AGR** **AGR**	**Open** **Open**	**21.03.2024** **21.03.2024**
2024/050	**PGD Authorisation Policy – Scope** AGR to create the policy for organisational authorisation sign-off for PGDs.	**AGR**	**Open**	**21.03.2024**
2024/051	**Recurrent UTI Guideline – Update** The group approved the updated document. To be uploaded to the LSCMMG website.	**AGR**	**Open**	**21.03.2024**
2024/052	**Care Home Depot Injections** SR to engage with representatives across LSC around this proposal, bring back to LSCMMG when appropriate.	**SR**	**Open**	**21.03.2024**