Minutes of the Lancashire and South Cumbria Medicines Management Group Meeting

Thursday 12th September 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
Faye Prescott (FP)	Senior Medicines Optimisation Pharmacist	Morecambe Bay Locality
David Jones (DJ)	Assistant director of pharmacy Lancashire teaching hospitals	NHS Lancashire Teaching Hospitals
James Baker (JD)	Deputy Director of Pharmacy	Blackpool Teaching Hospitals
Lucy Dickinson (LD)	Finance Manager for Primary Care	Lancashire and South Cumbria ICB
Lisa Rogan (LR)	Strategic Director for Medicines Research and Clinical Effectiveness	East Lancashire and Blackburn with Darwen Locality
Melanie Preston (MP)	Head of Medicines Optimisation	NHS Lancashire and South Cumbria ICB (Fylde Coast)
Nicola Baxter (NB)	Head of Medicines Management	NHS Lancashire and South Cumbria ICB (West Lancashire locality)
Roger Scott (SC)	LMC GP Representative	Morecambe Bay
Dr Hanadi Sari-Kouzel (HSK)	Rheumatology Consultant	Blackpool Teaching Hospital
Dr Shenaz Ramtoola (DSR)	Consultant Physician	East Lancashire Hospitals NHS Trust
Sonia Ramdour (SR)	Chief Pharmacist	Lancashire and South Cumbria NHS Foundation Trust
William Price (WP)	Dermatology Clinical Pharmacist	East Lancashire Hospitals NHS Trust

IN ATTENDANCE:

Brent Horrell (BH)	Head of Medicines Commissioning	NHS Midlands and Lancashire CSU
Daivd Prayle (DP)	Senior Medicines Commissioning Pharmacist	NHS Midlands and Lancashire CSU
Paul Tyldesley (PT)	Medicines Commissioning Pharmacist	NHS Midlands and Lancashire CSU
Emily Broadhurst (EB) (Minutes)	Medicines Optimisation Administrator	NHS Midlands and Lancashire CSU

	SUMMARY OF DISCUSSION	ACTION
2024/170	**Welcome & apologies for absence** Rebecca Bond sent her apologies and James Baker attended on her behalf.	
2024/171	**Declaration of any other urgent business** Terms of reference for LSCMMG IMOC - The terms of reference for LSCMMG were due to be discussed at this meeting however they are interlinked with IMOC as their terms of reference are also being reviewed. IMOC members have until the end of this week for comments. The intent is to request delegated decision making at IMOC on behalf of the ICB, which would mean that LSCMMG outputs would go there for ratification instead of going to CRG as they are currently. Streamlining LSCMMG – the intention is that guideline consultations will be considered by clinical groups where available and would be passed to LSCMMG for ratification. In addition, minor amendments will be adopted outside of LSCMMG with a summary of the changes reported to LSCMMG. There will be significant time at the October meeting to discuss the LSCMMG terms of reference and how it links into IMOC. Members are asked if there are people they feel should be included in those discussions and don't currently attend LSCMMG to let BH and team know, and they can be added for that discussion. It was asked why clinical guidelines would be coming back here at all, and BH explained that from an ICB governance point of view they need to be ratified somewhere. The LSCMMG process with consultations would still happen but the comments wouldn't come back to LSCMMG they would stay within the clinical groups for them to update. They would ideally only come back to LSCMMG for sign off. It was queried whether guidelines needed to come to LSCMMG and if positions statements would suffice, issues relating to financial oversight, clinical and pharmaceutical issues were raised if guidelines were not ratified through LSCMMG. It was asked during the discussions on the actions about a possible future meeting to discuss plans around what happens with shared care. AW responded that there is a piece of work ongoing looking at shared care as a whole including what is and isn't commissioned. AW has also asked to escalate the issue up to the northwest around the issue of having different approaches in different areas and the need to try aligning where possible especially with items coming from tertiary centres.	
2024/172	**Declarations of interest** No new declarations of interest pertinent to the agenda were made.	
2024/173	**Minutes and action sheet from the last meeting 11th July 2024** The minutes from the last meeting were approved. The action logs will be updated following discussions today.	

2024/174	**Matters arising (not on the agenda)** No matters arising considered.	
	NEW MEDICINES REVIEWS	
2024/175	**Colesevelam for Cardiovascular Disease prevention in Hyperlipidaemia when the patient is intolerant of all other options. <u>Major Change</u>** This drug was previously reviewed in 2016 and given a 'Do Not Prescribe' RAG due to poor tolerance and weak clinical trial evidence. Since then a request has come from Pennine to add Colesevelam into the treatment pathway to be used as a potential for patients who are intolerant to all other options. Manchester have given it a Green RAG with specialist advice, which is equivalent to Amber 0 or a Green Restricted RAG here for a select number of patients. It is proposed as an Amber 0 as this could help keep patients who would normally be stepped up to secondary care within primary care. The cost implication is £879 per year. Inclisiran costs £100 (rising to £3,000 per year when the PAS scheme ends), Bempedoic acid would is £722 and Evolocumab is £4,400 per year. The consultation responses were mixed, however was generally positive with a variety of RAG ratings. It was asked if any of the clinical evidence changed to support the change of RAG, DP stated that it not had changed, however place in therapy was clearer and it was now being viewed as an exception. DSR added that there needs to be something available to those patients who clinicians have exhausted all other options for treatment. She asked if in other areas it has been listed for those intolerant to all other options and that this could be added to this RAG decision as to give patients and clinicians that last choice. It was also asked if agreed would the Lipid guidelines need to be taken back to the Lipid group to update. DP responded that this does reflect Manchester's position, and that Merseyside have this as 'on direction from a Lipid specialist'. As to the Lipid guideline, it would need to be put to those specialists and ask them if they would like the pathway updating with this item included. DSR added that there is a specialist group meeting next week and she could take it to them at that meeting. The decision on this item is deferred pending conversations next week with the specialists. AW added to note comments relating to if the evidence isn't great it would be a very niche treatment. DP will bring this item back next month. **<u>Actions</u>** DSR to take this to the specialist group meeting next week for discussion and update DP on the outcome. DP to bring this item back to the October LSCMMG following the specialist meeting outcome.	**DSR** **DP**
2024/176	**Vaginal devices for female urinary stress incontinence – adoption of NTAG guidance. <u>Moderate change.</u>**	

	This request came from Pennine, their GPs wanted guidance on vaginal devices. The Northern Treatment Advisory group have produced a guideline which effectively reiterates NICE Guidelines 123 and 210. The ask was LSCMMG to adopt those guidelines. DP added he felt this was a sensible piece of work as it does comply with NICE guidance. DSK asked if the current workforce agree with it and are they pushing for it. While it was acknowledged that this type of work is good to keep in line with NICE guideline, it was agreed that this should have been sent out for consultation. DP added that as it was a moderate change it didn't go out for consultation, however after points raised here it probably should go out for a consultation. It was also asked to clarify if this would be initiated in primary care or secondary care and what the RAG would be. It was agreed for this item to come back to the next meeting after it has been sent out for consultation. **Action** DP to send out for consultation to the specialist continence teams and bring back to the group.	**DP**
2024/177	**New Medicines Review Workplan** DP highlighted that he was hoping to take Dymista inhaler to the Northwest meeting, however the last meeting didn't go ahead. He is hopeful it will make the next one. Acarizax has a negative NICE draft, so this item needs to wait until NICE publish their final response. This also could theoretically relate to Itulazax as it works in a similar way to Acarizax. **Action** The following medicines were prioritised for review, dapoxetine for the treatment of premature ejaculation, this has been requested by the specialist sexual health service. Diclofenac oral for initiation of treatment by Rheumatologists. And Semaglutide has updated its license to include cardiovascular risk reduction. This was raised by Fylde ICB to be considered as it could become a large issue if people start to prescribe it.	**DP**
2024/178	**New NICE Technology Appraisal Guidance for Medicines July/ August 2024** There were several NICE TAs at this meeting as it includes decisions for July and August 2024. The following are ICB commissioned. **NICE TA986 Lebrikizumab – Proposed Red RAG rating –** For treating moderate to severe atopic dermatitis in people 12 years and older. Based on the list price the cost pressure is significant. AW asked DJ if he could provide BH with the PAS price in order to get a more accurate cost. Following receipt of the PAS prices, this item will go to CRG for approval. At this point it was raised if the expected health gains column was still needed as it was previously included at the request of this group. It was discussed and agreed it should stay for now. It was agreed that the dermatology specialist group will be contacted if there is a need for a pathway and where this drug would sit in therapy. The group also discussed the pathway of approving NICE TA's, in that it the group felt they should be able to approve them here once unless they had any concerns such as prior to the ICB's forming. AW and BH are	

	aware of this and have included a request for delegated decision making into the proposal for the groups updated terms of reference. However, items such as this with a large cost pressure would still need to go through additional approval process via the executives of the ICB due to the financial position of the ICB. **NICE TA990 Tenecteplase - Proposed Red RAG rating –** for treating acute ischaemic stroke. There is no significant cost pressure with this item this item will go to CRG for approval. It is an additional treatment item, but due to it being a new medicine this item will also need to be approved by CRG. DJ added this has been discussed at this local D&T committee. There have been supply issues with Alteplase so this will help. He also added that there may be a small cost saving and that the stroke network has put together some ICB guidance, and they are looking at using Alteplase outside the four-hour window that you would use Tenecteplase up to 9 hours dependant on scan results. It was agreed that once drafted, the proposed guideline will come to this group for approval and discussion on implications of Alteplase and position of Tenecteplase. **NICE TA991 Abaloparatide - Proposed Red RAG rating –** for treating osteoporosis after menopause. Another additional item but a new medicine. There is also no significant cost pressure, this item will go to CRG for approval. **NICE TA995 Relugolix – Proposed Amber 0 RAG rating –** for treating hormone-sensitive prostate cancer. There is also no significant cost pressure, this item will go to CRG for approval. **NICE TA996 Linzagolix – Proposed Amber 0 RAG rating –** for treating moderate to severe symptoms of uterine fibroids. This is an additional item, but there has only been one issue in primary care so it is felt that there is also no significant cost pressure, this item will go to CRG for approval. **NICE TA998 Risankizumab – Proposed Red RAG rating –** for treating moderately to severely active ulcerative colitis. There is no significant cost pressure, this item will go to CRG for approval. **Action** The NICE TAs above will be submitted to the next CRG for support then ratified through ICB Execs meeting.	**BH**
FORMULARY UPDATES		
2024/179	**Lancashire and South Cumbria Medicines Application Form** A medicines application form has been developed by Jenny Oakley and the formulary oversight group to be used across the ICB. The piece of work used forms from local trusts to try and amalgamate them into one form. DSR felt that the form was too long and cumbersome and inhibitory to clinicians instead of facilitatory. She also added in the sections where it asks for NICE guidance or NICE Technology appraisal information that it include all forms of guidance as some items will have specialist national guidance. AW asked where this had been sent for consultation, to which DP responded that it had just been through the formulary working group. He added the detail on the forms most likely comes from legacy forms from trusts. DSR added that clinicians need to be included in this as they	

	are the ones who are intended to complete the form. DP also added that he hoped that the trust directorate pharmacists would be included in completing this form and didn't expect clinicians to complete it on their own. The completion of the form by outside agencies was considered, it was highlighted that clinicians may want to use the support of outside agencies however concerns were raised about the independence of this approach and that other NHS colleagues should support clinicians. DJ added they had recently had an issue at their local D&T where they had a form for an item that was already on the ICB formulary, and with another item was raised but it didn't have a form, and another trust was already using it. So agreed the need for some consistency across the ICB, making sure work isn't repeated and that there is something listed about local implementation. DSK asked if new drugs still need to go through local D&T meetings before coming to LSCMMG and added that she felt that local D&Ts still have oversite to ensure that the forms are filled in and signed correctly. It was agreed for the need for an appropriate filter for these requests prior to coming to LSCMMG. DSR then asked if local D&Ts are actually still appropriate as LSCMMG oversees everything. AW added that this would be the next logical topic of conversation as some things would need to remain as local implementation and not ICB wide, however the point of the ICB formulary is to ensure the same things are happening across the ICB. This may mean that the way currently local D&Ts operate may need to change. Members agreed however some voiced that this may cause a delay in their current format. AW asked DP to meet with local D&T chairs and see how this form would link in to process and what needs to be done to make it work well. **<u>Action</u>** DP to meet with local D&T chairs to discuss the form and its processes and see what if any changes need to be made to the process. To then bring back to the November meeting for further discussion.	**DP**
2024/180	**Formulary Update: CNS N&V, Cancer Chapter** **CNS N&V changes:** This update is the outcomes from discussions with the clinical groups. Several RAG positions were either harmonised or rationalised. The document shared to the group lists all the decisions made for acknowledgment and agreement from this group. DP added if there was anything that the group wanted to be revisited to let him know. AW asked what category of change this would fall into, to which DP responded as this had happened through clinical groups they would be classed as moderate changes as the clinical groups have suggested any changes. So it has been brought to this group for ratification. The group were happy with the changes, they are all approved. **Cancer section:** The formulary oversight group are trying to work through and complete the unfinished chapters such as the cancer drugs section. It was proposed and agreed at the formulary group to not list cancer drugs and regimens that	

	are already included in an NHS England list which is very comprehensive. This list is updated nationally, and the group agreed to only keep on the formulary the drugs that cross into primary care such as Tamoxifen, Anastrozole and GnRH drugs. It was added that it might be helpful to include a link to the end of life drugs held in community pharmacy. And it was asked with the list updating would there be a need to add items to the list of drugs held for end of life care. DP responded that the list of end of life drugs pharmacies is on the LSCMMG website and there will be a separate palliative care section which will only list drugs to be used in palliative care. He added he has a meeting in October with the palliative specialists to expand the palliative clinical practice guideline and to add in the drugs that only specialists can use. He also added that a link could be included in the cancer section as well as the palliative care section. This was approved by the group. **Actions** The recommended RAG positions and proposal for the cancer chapter were approved and will be updated within the formulary.	
2024/181	**Formulary Changes since last LSCMMG** This is a standing agenda item. Changes added include minor, moderate and major since July's meeting. The team have been working with some primary and secondary care colleagues around the formatting. The intent is to have a document that will include a rolling 12 months of changes. It will be updated twice monthly, firstly when LSCMMG papers go out and then again one week after the LSCMMG meeting. The document will be included in the News section of LSCMMG and on NetFormulary also, this will be one document showing all changes. There is also the intent of a key at the beginning of the document, however this can't be added to the document until LSCMMG terms of reference have been ratified. AW added this could be added while the terms of reference are being ratified so that people are aware of what things are. BH agreed this could be added now if the group wanted it. **<u>Action</u>** The changes were noted and approved. BH to add the key to the document prior to LSCMMG terms of reference being ratified at the group's request.	**BH** **BH**
GUIDELINES and INFORMATION LEAFLETS		
2024/182	**Melatonin pathway – Adults. New guideline. <u>Major Change.</u>** DP felt this was ready to go, however it hasn't been well received. The guideline was written to support a series of RAG ratings, and the majority of comments received were on the clinical definitions and items that fall outside of this guideline. DP felt that due to the responses, this document may not yet be ready for approval. SR added that the majority of patients with mild to moderate LD are managed solely in primary care. So to have to refer back to secondary care to ask if they can be prescribed melatonin felt like an ineffective use	

	of specialist resources. DP felt that changes could be made with the comments already received and didn't feel it needed to go back out for further consultation and would bring it back to a future meeting. The group discussed this at length, some members felt that the first part of the document should be reduced down to links to NICE guidance instead of including information within the document. Other comments included the lack of LMC / GP input from the comments and the issues around shared care from a primary care perspective. RS added he felt that the document isn't ready to go and needs to be revisited. He added he was happy to be sent the document prior to it coming back to the group for viewing. AW also asked for it to be sent to the mental health GP lead. **Actions** DP and team to revisit comments made on the document and make any appropriate changes. DP to send the amended document to RS and the GP mental health lead prior to it returning to LSCMMG. Once all happy DP to bring back to LSCMMG for approval.	**DP** **DP** **DP**
2024/183	**Ophthalmology Macular Pathway - Update** This has been discussed previously and debates on what should be first and second line, with a large concentration on a place in therapy for Aflibercept. This is due to Aflibercept coming off patent next year. The team have attempted to get some data on the ability to treat and extend with Faricimab vs Aflibercept. They have been unable to get local data but have got some data from another ICB which shows that at one year, Faricimab is able to treat and extend very slightly more after one years treatment than Aflibercept. This is shown as 5.3 treatments per year vs 6 treatments per year. There is expected to be significant cost pressure when Aflibercept comes off patent next year. After a brief discussion it was agreed for BH and AW to take this discussion to medical directors for further input. AS asked if the Aflibercept 8mg dose could be included in those discussions as clinicians are wanting to start using it and it is causing some issues. AW agreed to include this in the discussions. **Action** BH and AW to take this discussion to medical directors for their input and if they support the pathway in its current form.	**BH/AW**
2024/184	**Neuropathic Pain guidelines – Moderate Changes – Agreed with specialists.** This was scoped with the specialist pain service at LSCFT, following that a full consultation has been done and taken specialist feedback from other specialist pain services also. The consultation responses have been taken into consideration when completing the update as well as a later request from ELTH about reference to referring into specialist palliative services as well as the pain services which has been added. The changes to the document were approved by the group, with an	

	additional comment from RS complementing the team on completing a very good useful guideline. **Action** The Neuropathic Pain guidelines will be added to the LSCMMG/NetFormulary websites.	**PT**
2024/185	**Position Statement: Prescribing HidraWear for Hidradenitis Suppurativa. Adoption of ELHT/ Pennine document – <u>Moderate change.</u>** This request came in from ELMMB, they support a document for HidraWear which is a dressing system for Hidradenitis Suppurativa. The document includes pricing and background information. There is a potential cost implication, but DP felt it wouldn't be substantial. This was approved for implementation across the ICB by the group. **Action** The Position statement will be added to the LSCMMG/NetFormulary websites.	**DP**
2024/186	**Somatropin information sheet – <u>Minor update</u>.** This has been discussed at the group previously with the committee being supportive of the information sheet. There was a previous query around the primary care position as RS was not present at the last meeting. BH raised this with RS outside of this meeting to share the document and any comments from the LMC. No major concerns were raised following that and now the group were asked if they were happy to approve the information sheet. **Action** The information sheet was approved by the group and will be added to the LSCMMG/NetFormulary websites.	**BH**
2024/187	**Liothyronine for the treatment of resistant (refractory) depression, Shared Care Protocol. New document – Major update.** LSCMMG has previously approved an Amber 1 RAG rating which is to be adopted following approval of the shared care document. The draft shared cared document went out for consultation and the responses are attached in the documents sent to the group. LSCFT were supportive of the document, ELHT requested some minor changes to make it clear that it is only for treatment resistant depression and link to the other RAG positions to make it very clear. It was asked where the monitoring guidelines had come from relating to the frequency of blood tests, ECGs and bone density tests. SR commented that while she hadn't been involved with the development of the document her colleague was and she looked at other shared care guidelines. DP also added that they had looked at the regional drug and therapeutics centres guidelines as part of this. DSR felt that some of the requirements were too frequent, BH added it is referenced to a document around safety considerations. He added if DSR wanted this deferred to get this checked, DSR suggested taking to a specialist group. SR suggested she meet with her colleague outside of the meeting to discuss it with clinicians. She added the numbers would be very small, but it is being done as it is referenced in the NICE guideline.	

	SR also added while she would like this to be approved, she was mindful of discussions around shared care and concerns from GPs and antipsychotics being NICE recommended for off label use. RS was asked if he had a feel for if GPs would have an issue with this. RS added he had some similar thoughts on frequency of monitoring, but as it was a very small number of patients and that the drug is reasonably safe as its similar to thyroxine. He felt because of these reasons that GPs would mostly say yes to this. AW added to check the requirements now for monitoring and see what is required now and bring it back to Novembers meeting. **Action** DP to review the monitoring for liothyronine with SR and bring back proposed wording to Novembers meeting.	**DP/SR**
2024/188	**Apomorphine Shared Care Guideline – Minor update** This update is to mainly include a new device that's available. Some of the background information on side effects has also been amended to be in line with the SPC. This was approved by the group. **Action** The shared care guideline to be added to the LSCMMG/NetFormulary websites.	**DP**
2024/189	**ADHD Shared Care Guidance – Minor change – adding in wording relating to payment for ECGs in primary care.** The addition of information in relation to ECGs in primary care has been previously discussed. There were some queries around the amount that is paid for this monitoring, this was previously suggested to be put on the LSCMMG website and not inside the shared care in case it changes. AW suggested looking at the clinical safety of this and what the shared care protocol should be and not the cost of individual treatments. SR added that LSCFT have not been involved in any of the discussions surrounding this the group possibly couldn't take a position on this as it will be prescribing it in LD and children. AW apologised to SR for the oversight and deferred this item until those discussions with LSCFT have happened. **Action** FP, DP and SR to meet and involve LSCFT in discussions had on this shared care and make any required changes. With a mind to bring it back to Novembers meeting for approval.	**FP/DP/SR**
2024/190	**Sulfasalazine Shared Care Guideline – Minor Change – Clarifying wording relating to monitoring guidance** The clinical content in this guidance hasn't changed, only the order of the wording has. This has been done to clarify that after 12 months of a patient being stable, there is no routine monitoring. LR asked if this could also be removed from the shared care agreement for ongoing long term monitoring for Amber shared care as the numbers are quite large. PT responded that once the patient is stable and they have had their three monthly monitoring phase, and this has gone on for 12 months then yes as it goes back to routine monitoring.	

	The amendments were approved by the group. **Action** The updated shared care document will be added to the LSCMMG/NetFormulary websites.	**PT**
2024/191	**Testosterone Shared Care Guideline female sexual dysfunction – <u>Minor Change –</u> adding in additional preparation.** There was a request for an additional preparation to be added to the guideline which is a sachet. At the time there was an issue as its difficult to give an accurate dose from a sachet. Since then, the British menopausal society has given guidance on this so there is now a precedent for this product and GPs have requested it. AW asked if this then necessitates a small change to the formulary to add this product and associated wording. PT agreed that the updated shared care guidance document will need to be added to the formulary. This was approved by the group. **Action** The updated shared care document will be added to the LSCMMG/NetFormulary websites.	**PT**
2024/192	**Guidelines Workplan** BH updated that the wording around Azithromycin and Sodium Zirconium will be amended to make it clear that they are on hold due to the ongoing discussions around shared care and payments. The opioid agreement form has been agreed with FP that it will be sent out for consultation and will come back to November's meeting. The Daridorexant position statement is being discussed and the team are looking into what would need to be included in the position statement. With the specialist infant formula feeds update, the team are linking in with specialists, but BH was unsure if this would make it to Octobers meeting. The good prescribing guidelines are in the process of being reviewed. There are large sections in that to be looked at and the team are again aiming for October for it to come back. However as previously mentioned October's meeting will largely focus on the terms of reference and it may be deferred to November.	**BH**
NATIONAL DECISIONS FOR IMPLEMENTATION		
2024/193	**New NHS England Medicines Commissioning Policies July/ August 2024** Nothing to discuss.	
2024/194	**Regional Medicines Optimisation Committees – Outputs July/ August 2024** Nothing to discuss.	
2024/195	**Evidence Reviews Published by SMC or AWMSG July and August 2024** All Wales have added Cytisine for smoking cessation. It is currently under	

	review, but the team will take into account the Welsh paperwork in the background which is very helpful. With some SMC decisions not meeting LSCMMG criteria but having a potential impact on the formulary, DP suggested reformatting this item for future meeting to reflect potential effect on formulary. DP will reformulate it so a column will read 'will affect LSCMMG/ Formulary positions.' AW added to note that there are different commissioning positions in England, Wales and Scotland so it is important to check that items are relevant to England.	
ITEMS FOR INFORMATION		
2024/196	**LSCMMG Cost Pressures Log** This will be circulated with the minutes from today's meeting.	
2024/197	**AOB** While discussing item number 2024/189, LR raised an issue and challenges around the supply problems for Methylphenidate and wanted it flagged as urgent. There have been incidents due to this including a parent trying to leave their child in a GP practice as they had no more medication and was unable to get any. There is a need for concise guidance, and she highlighted that Greater Manchester have put together a whole page dedicated to this, and it has been sent to some of her colleagues. She added it would be good to try and consolidate it and get something out to practices and specialist centres on how to manage this. AW responded he would be happy to adopt Greater Manchester's document if SR was happy with it. SR added that she would take a look and speak to some of her specialists and if they are happy it can be taken forward. LR shared the link in the meeting chat for SR. **Action** SR to look at the document and discuss with specialists as well as LR and if all are happy move forward to adopt the Greater Manchester's position with DP.	**SR**
2024/198	**Items for escalation** A commissioning position for Omalizumab for solar urticaria was approved at a tertiary provider in Greater Manchester. He added when people are being sent to specialist centres such as Manchester that are prescribing drugs that the ICB does not currently have a commissioning position on, can there be some flexibility in the way things are adopted cross region, DP acknowledged that there could be an impact in terms of cash however receiving IFRs over and over again causes a bit of an inequality between the regions. BH added that the North west has been asked about an ICB making a position on a tertiary centre could there be a process where LSCMMG is included in those consultations to be sighted on them. With that particular one mentioned, BH added that there is a need to consult on the Manchester guidance, which will be sent out with the next round of consultation documents, with a view to adopt the Manchester document. LR added around the possibility of having the discussion with the North west around the Tier three weight management clinic in Aintree and if the	

	ICB can link in with them or the Bury clinic. AW responded that he was due to have a call next week regarding Tirzepatide and how it's going to be implemented, and that weight management is going to be something that causes a lot of work with a huge patient demand. **<u>Actions</u>** Omalizumab for solar urticaria policy to go out for consultation and return to a subsequent LSCMMG meeting. BH to raise the issue of adoption of tertiary commissioning positions across the north west with the North West Medicines Optimisation Group. AW to escalate points made around Tier Three weight management services.	 **BH** **BH** **AW**

DATE AND TIME OF NEXT MEETING

The next meeting will take place on

Thursday 10th October 2024

9.30 – 11.30

Microsoft Teams