Lancashire & South Cumbria Medicines Management Group

NHS Midlands and Lancashire Commissioning Support Unit

Minutes of the Lancashire and South Cumbria Medicines Management Group Meeting

Thursday 11th July 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
Emma Coupe (EC)	Assistant Director of Pharmacy Clinical Services	East Lancashire Hospitals NHS 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
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)
Mubasha Ali (MA)	Chief Executive Community Pharmacy	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	
Roger Scott (RS)	LMC GP Representative	Morecambe Bay
Dr Shenaz Ramtoola (DSR)	Consultant Physician	East Lancashire Hospitals NHS Trust
Tara Gallagher (TG)	Network Pharmacy Director	Lancashire And South Cumbria Foundation Trust

IN ATTENDANCE:

Adam Grainger (AGR)	Senior Medicines Performance Pharmacist	NHS Midlands and Lancashire CSU
Brent Horrell (BH)	Head of Medicines Commissioning	NHS Midlands and Lancashire CSU
Daivd 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
2024/138	**Welcome & apologies for absence** Apologies were received from Kam Mom, Lindsey Dickinson, Manjo Rajajopal, Jennifer Graham, Sonia Ramdour and Melanie Graham.	
2024/139	**Declaration of any other urgent business** None.	
2024/140	**Declarations of interest** DSR highlighted her longstanding declaration of interest with Nova Lily and AZ.	
2024/141	**Minutes and action sheet from the last meeting 9th May 2024** LR requested her name to be corrected via email to EB. The minutes were approved and will be uploaded to the website. It was requested to have a review of the minute format due to the length and level of description in them. BH, EB and AW to meet outside of the meeting to discuss this.	**BH/EB/AW**
2024/142	**Matters arising (not on the agenda)** None.	
	NEW MEDICINES REVIEWS	
2024/143	**Branded Generics** This was originally brought to the meeting in May; however updates have been delayed due to CM not able to attend meetings. The one issue raised in May by the LMC has been actioned and the group is asked to approved the amended document from May which had already been discussed. The group approved the document.	
2024/144	**LSCMMG Terms of Reference update and format for minor/moderate/major updates** This item was raised at the May meeting then at the June consultation period was extended. The 1st paper summarizes the responses received. The group are reminded that this version is not the final version of the Terms of Reference for LSCMMG. Some more changes are to be made to ensure everyone is comfortable with the document and what it states and to be recirculated to the group. It will then also go through a process at the ICB. Appendix 1 goes through the responses received and what amendments have been made to align with those comments. Where the comments were straight forward and clear they have been incorporated into the document, others have not yet been included and will be raised for discussion at this meeting today. BH shared his screen while going through the comments so far incorporated into the document. Then the group moved to discuss items BH had flagged for the group. One item raised was a request around the consultation responses and	

	whether they can be copied into the trust or not, this is currently being looked into. Other comments from DSR where highlighted and some suggested wording was shown to the group. Finance and what level of finance representation is needed at the group was also highlighted, and BH suggested this be marked for discussion with finance. The main point of discussion at this meeting was the wording around a chair for the meeting. There are comments from secondary care members relating to the chair being a senior medic with 5 years of experience. Three points raised by LR were: consultation responses and their importance, that people have knowledge of place in terms of their community and its demographics, and to look at streamline the decision making which she noted that the aim of the ask for the delegated decision making for LSCMMG could go a long way to aid this. The group discussed these points and agreed them. BH brought discussions back to the wording around a new chair, and DSR raised a few more points relating to the chair. She raised that the chair shouldn't be decided by this group and that the ICB should appoint someone. She also raised concerns on membership for the group and having too much to do in a small amount of time referring to agendas. She then raised that while it is felt by some members that the clinical expertise are already at the group, she felt that there is a gap and not enough expertise at this group to make effective decisions on modern medicines. BH agreed with DSR's comments and added that there is ongoing work outside of this group such as the Formulary Working Group but that resources with these outside groups need to be examined. LR echoed the comments and also added that as leads they need to ensure engagement is happening at place to help LSCMMG decisions go through in a more timely way. Following NICE and National guidance and adapting them for local use was also raised and BH added that discussions are ongoing outside of the meeting to try and bring more clinicians to this meeting especially when major changes are being made. The group agreed they were happy with the proposed wording relating to a chair that was displayed on screen. It was decided that BH and AW would have further discussions and circulate a further draft terms of reference document highlighting points raised at todays meeting and also take the discussion about delegated decision making to the ICB. The aim is to bring this back in September for the group. As there is no meeting in August, members are asked to comment virtually on anything circulated in order to make sure all comments are seen. <u>Actions</u> AW and BH to have further discussions and circulate and updated draft of Terms of Reference round to members. All members are to comment virtually on items sent out in August with a proposal to bring this item back in September.	**BH/AW** **All Members**
2024/145	**Alfacalcidol RAG rating** There was a GP query raised as to why this had a Green RAG when it is used in renal failure, and they also asked about monitoring. The formulary	

	working group looked at this and felt it didn't need a shared care document but that an Amber 0 RAG would be more appropriate. DP proposed it went through the moderate change process and there is no financial impact with this change, therefore it doesn't need to go through the other committees for approval. The group discussed this and agreed that GPs are happy to prescribe following monitoring and guidance from the specialist consultants. This change was agreed to Amber 0.	
2024/146	**Cyanocobalamin for Vitamin B12 deficiency** There are now oral preparations which should be cheaper than current and previously 1mg was not available. The proposal is to allow a Green RAG for the 1mg Cyanocobalamin, which also brings it in alignment with NICE guidance and neighbouring ICBs. This is a moderate change and was felt the impact wouldn't be significant cost wise and possibly actually cost saving. This was agreed by the group for a Green RAG.	
2024/147	**Tadalafil Once Daily** It was requested that this be looked at for treating BPH as well as erectile dysfunction and the recommendation is not to use for BPH which is also inline with NICE guidance. It was also requested to look at the 2.5mg daily for erectile dysfunction and this is also recommended as do not use as it is more expensive than the 5mg dose. This is a moderate change and the shouldn't be a cost impact, however there may be possible impact to access for patients who can't tolerate the 5mg and wish to try the 2.5mg. DP was unable to find any information on splitting the tablet and the SPC does not recommend splitting the tablets. The proposal for the group is to have the 2.5mg as do not prescribe and also do not prescribe for BPH. The group discussed this and while they were happy with the Do not prescribe for BPH, it was felt that the 2.5mg should be available for the small number of patients who may suffer adverse effects from the 5mg but may still see some benefit from the 2.5mg. It was agreed for the 2.5mg to go onto the formulary with a restriction notice relating to prescribing only for people who suffer adverse effects from the 5mg dose.	
2024/148	**Melatonin Liquid** There are different decisions on neighbouring ICBs, Alder Hey feel that the brand Ceyesto should be used as it is licensed for children from the age of 3 and Manchester have said not to prescribe as they are worried about some of the excipients. DP has explored this, and the proposed pathway is for the tablets to be used first line, Ceyesto in children from the age of 3 as per the licensing and if there are concerns about benzyl alcohol levels or other excipients to contact the trust pharmacy for advice. While the team acknowledge this may not be the best recommendation, they felt this was the most appropriate way forward. AW asked if the two neighbouring trusts would possibly pull together on a decision as they would be receiving patients to both from Lancashire and South Cumbria. DP responded that they are putting together a paediatric clinical group to discuss having a paediatric section on the formulary and he suggests having those neighbouring ICBs involved in those discussions. It was also highlighted the difficulty in making decisions at this group is that with patients going to both Alder Hey and Manchester they	

	would get different advice and if this group agrees on something that conflicts that it could put clinicians and pharmacy staff in a challenging position. AB shared this issue was already happening as they had an issue recently with a baby and locally they lean towards Manchester's recommendations which was not the Ceyesto brand. It was suggested to have both brands on the formulary with the Consilient brand for under 3 year olds. It was suggested to ask the formulary working group to have a look at this issue and see what they would recommend. It was agreed to defer decisions here until the formulary working group could take a look and offer any recommendations and for it to be raised at the North West MOG meeting. <u>Action</u> DP to take this item to the Paediatric formulary working group for their recommendations. BH to escalate this item to the North West MOG meeting.	**DP** **BH**
2024/149	**Safinamide for Parkinson's Disease – Updated Review** This was raised previously and was agreed that there was insufficient evidence to justify, and it was relatively expensive. Other areas have since approved it, it has been reviewed and again there is not a massive difference in the evidence previously viewed and it has been sent out for consultation with a recommended Amber 0 RAG. If this is not agreed it would mean that the ICB is different from both its neighbours. As there was only one response which didn't come from the main neurology department, it was suggested to defer until further responses are received. It was also asked if the prescribing in the region is being done by GPs or secondary care. RS felt it would be specialist initiation not GP and would agree with the need for the neurology feedback. But also added in general the monitoring would need to be evaluated and its place in therapy, generally GPs are happy to prescribe medication for Parkinson's as there isn't much monitoring required but this needs to be clarified. AS responded that they don't employ their own neurologist but have them from local areas and have been getting requests for this for a number of years. The neurologist from Carlisle is very keen on using it as well as the local nurse for Parkinson's in Cumbria. It hasn't yet been used in Morecambe Bay but felt it would possibly come as second or third line in therapy. It was agreed to defer until the review from neurology has been included and to ensure this is being done for the right reasons. <u>Action</u> DP to get input from neurology and bring back to September's meeting.	**DP**
2024/150	**Ivabradine for POTS** This request has come from Blackpool as it seems to be affective in a small number of patients. There are no big clinical studies to support this however this view comes from the experience of clinicians. No other ICBs have this locally as it is quite new for POTS. The proposed RAG is a Amber 0 RAG and to also update the prescribing information sheet for Ivabradine to include POTS. The consultation responses were mixed with some supporting the Amber 0, some suggesting a Green Restricted with	

	also one GP with special interest adding that GPs wouldn't prescribe even with speciality advice. AW asked how many patients this would be for, and DP responded the requesting clinician felt it would be a very small number from his clinic and would be used after failure with other treatments. The group discussed this and the comments from Morecambe Bay. It was felt as this is an off label indication and little evidence base that more work needs to be done with primary care and to get a more accurate patient numbers as if it is a very small number this may be better staying with the specialist however if it is a large number it may need to come into primary care. <u>Action</u> DP to get a more accurate number for patients and if they will only be from Blackpool. More conversations with primary care to see what their concerns are and if they would be comfortable prescribing this for the small number of patients.	**DP** **DP**
2024/151	**Navina Smart** This is a new anal irrigation pump which is linked to an app which makes for easier monitoring of use. The financial impact is very small and looking at the currently used devices and evidence (which is small) it appears to support use in Neurogenetic bowl dysfunction and not in Non-Neurogenic bowl dysfunction, which aligns with the current guidelines. The proposed RAG for this is Amber 0 with Neurogenetic bowl dysfunction and a Do Not Prescribe for Non-Neurogentic bowl dysfunction. The only response received from was from East Lancashire and they agreed with both proposed RAG statuses. It was raised if this should possibly be managed through the service rather than put into primary care, as they will have the specialist overview for prescribing the best product. MP responded where this has come up in discussions previously and there is no specialist service the GPs have been happy to prescribe under the recommendation from specialists, and that the requests have come from areas such as Salford and Liverpool. AW asked if the group should be deciding a position when Manchester don't have one and they are the ones requesting it, to which MP responded that this is just another device, and the main difference is that it is a smart device. The cost impact should be around the same as other devices although the pricing structure is slightly different. It was felt this should be provided by the commissioned service rather than the GP, to which MP felt it would initially be provided it would be the on going consumables that would need to be prescribed by the GP. The issue of commissioned services was raised again as some members felt this should be kept within a specialist commissioning service. However they agreed that a path to accessing this for patients whose area doesn't have a specially commissioned service needs to be agreed. It was suggested that a position be agreed on this item inline with other products similar to this and then flagging the issue of commissioned services up to appropriate levels to again highlight the need for these services. It was agreed by the group to approve the proposed RAG statuses of Amber 0 for Neurogenetic bowl dysfunction and Do Not Prescribe for Non-Neurogenetic bowl dysfunction.	

2024/152	**New Medicines Review Workplan** This was shared to the group prior to the meeting for information.	
GUIDELINES and INFORMATION LEAFLETS		
2024/153	**Stoma and Continence Products Prescription Guide - Update** There were minor changes made to the document, the group were asked if they were happy to approve the changes or if they wanted it to go out for consultation. AW raised that the provider collaborative are looking at procuring stoma and continence products and asked that group if they had seen this and were happy with this guideline in the interim. AGR to check this with them. It was agreed by this group pending approval from the provider collaborative group. Action AGR to take to the provider collaborative group for approval.	**AGR**
2024/154	**Linezolid Prescriber Information Sheet - Update** This was due to expire on the website so have been updated, with new information around Hypernatremia and SIADH but AGR felt these were only substantive changes made. All the information is now in line with SPC guidance. This was approved by the group.	
2024/155	**Gender Dysphoria Information Sheets - Update** There is one policy and one piece of legislation published, which have been put together into this information sheet. It highlights that the NHSE no longer commission puberty suppressing hormones, but they do still commission gender affirming hormones. The document highlights that patients going through puberty should not be prescribed puberty suppressing hormones either via NHS prescriptions in line with NHS commissioning service. There is also the statutory instrument highlights that private patients under the age of 18 should not be prescribed puberty suppressing hormones as of 3rd June 2024. Aside from this the clinical information remains the same as previous versions of the document. It was suggested that the document should say that for the whole of Lancashire & South Cumbria no patient under the age of 18 should be prescribed these puberty suppressing hormones regardless of who is providing the prescription to make it very clear for NHS and private prescribers. This was agreed to be added to the document. Once this amendment has been added AW will take chairs action to approve as the group approves the document with this addition. Action AGR to add in agreed wording making it clear no one under the age of 18 should be prescribed the puberty suppressing hormones. Once done AW will approve via chairs action.	**AGR/AW**
2024/156	**DMARD Shared Care – Transition to NW Template** The ask for the group is to extend the current DMARD shared care document until September to allow for transition over to the new North	

	West shared care documents. The reason for the delay is to allow engagement with the Rheumatology alliance to ensure they are happy with the shared care documents prior to their launch. It was agreed to extend the documents until December in case there were any issues raised that needed to be looked into prior to the documents being released. Action AGR to liaise with the Rheumatology alliance to go over the documents before they are launched and bring them back to Decembers meeting for approval.	**AGR**
2024/157	**Headache Guideline – Including NICE TA 973 – Atogepant Place In Therapy – Update** Atogepant has been added into the document, along with Topiramate pregnancy prevention program information from a recent MHRA alert. Professor Chhetri is happy with the changes and this document was previously approved by this group prior to adding the Atogepant and not many changes have been made since that approval. TG raised a few points, one with that Topiramate remains first line in those not of childbearing potential however this does not appear like this in the document, so the formatting needs to be reviewed. Secondly the issue of Propranolol and its toxicity in overdose. It has been identified that the NICE guidance for headaches specifically refers to people with depression and migraine are at increased risk of self-harm with propranolol. The document was approved pending the amendments suggested are made and sent to Professor Chhetri for approval. Action AGR to make changes relating to the formatting for Topiramate and the toxicity in overdose for Propranolol. The document is then to be sent to Professor Chhetri for approval before launching.	**AGR** **AGR**
2024/158	**Testosterone Shared Care – Post Menopausal Women - Update** This was brought to the group previously and changes were recommended. The team have contacted the Women's Health Leads and Doctor Craven, and they are happy that it will be prescribing pharmacists and nurses alongside specialist GPs with BMS accreditation, so this has been added to the document. It was asked if it was known when the service was due to start and AGR felt it was eminent. It was also raised that the accreditation felt like a grey area as there are GPs running special clinics for HRT which will include Testosterone but there isn't a formal system where they can get accreditation. This is an important issue but something separate from this item and not necessarily for this group, as the need for competent staff to provide this service is high. AGR added that they were told specifically that the staff will be BMS accredited so that's why it was included in the document. The group approved the document.	

2024/159	**Dapsone Shared Care** The request is if the group are happy for the Dapsone Shared Care document to go onto the guidelines work plan and be prioritised as there isn't a current shared care document. This was agreed to go onto the guidelines work plan. Action AGR to add to the guidelines work plan and prioritise it.	**AGR**
2024/160	**Ritlecitinib – Place In Therapy (NICE TA 958) -Update** AGR has linked in with Will Price from East Lancashire on this as well as Jenny Oakly from UHMB. They looked at the British Association of Dermatologists (BAD) position statement, which is in support of Alopecia TA for Ritlecitinib. The feeling from trusts is that the BAD statement is a good for the place in therapy is very clear unlike the TA which was vague. It is recommended for a Red RAG status with a Blueteq form and use the BAD definition of severe in order to determine when the treatment can be started and their review criteria of 36 weeks to determine continuation or not. There is a significant cost impact with this drug of £3.6 million for one year as there is no existing treatment to replace. There is push from clinicians as there are people waiting on this to be given a position. It was asked if expected patient numbers were known due to the large cost impact and is this seen as medical, cosmetic or mental health. AGR added it had the mental health element as it was highlighted within the BAD position statement, and according to the NICE TA they estimate around 367 patients for Lancashire and South Cumbria. DJ commented that they have had requests from four patients in LTH and the dermatologists estimated 8-10 patients a year. AW asked if the number could be checked again against the more realistic number predictions, to which AGR agreed this could be done. He also requested speaking to the IFR and policy teams at the ICB to see how this may relate to other baldness treatments which are non- drug related and been around for a long time. AGR also agreed to do this. Another question raised was what positions do neighbouring ICBs have, AGR also will look into this. Other members agreed with these requests and added this would need to go for further approval due to the cost implication. It was raised when the NICE TA was published, and it was highlighted this is now outside the implementation period and this needs to be taken into consideration. Actions AGR to recheck the costing with the more accurate predicted patient numbers. AGR to liaise with the IFG and policy teams at the ICB to see where this fits in with other non-drug related treatments for baldness. AGR to check what positions are from neighbouring ICBs.	 **AGR** **AGR** **AGR**
2024/161	**Denosumab 120mg Shared Care Guideline – Update** The ask was to add the pre-filled syringe for 120mg dose of Denosumab to the document which has been done. The group approved this document.	

2024/162	**Antipsychotic Shared Care Guideline - Update** Sonia Ramdour has been through the changes made following the previous meeting and she was happy with the changes and additional changes have been made in addition to these from Sonia. The group were asked to approve the document. RS added he was planning to take to his local LMC meeting later on today and asked if he could prevent giving his approval until it had been viewed by the LMC group. This was agreed. The group approved the document pending RS's approval from his LMC meeting later today. Action RS to take the document to his LMC meeting and provide feedback to AW and AGR. Pending no required changes from the LMC the document is approved and can be published. If there is changes required the document will come back to the September meeting.	**RS/AGR/ AW** **AGR**
2024/163	**Asthma Guideline Update** DP gave a brief overview of the document and new legislation to the group. The group were asked if they were happy for the proposed change to move to the international guideline to use a strategy first line. There are a few issues with this, firstly it will be more expensive to procure the drugs, and the second is that NICE are due to produce a guideline, which currently supports the Anti-Inflammatory Reliver (AIR) regiment but will not be finalized until November. The group were asked if they wanted to move to the proposed change now or wait until NICE release their guidance in November. The group discussed this and raised the feeling of moving forward with this to help improve management of the condition regardless of the possible cost impact. MP also advised that the respiratory group were happy with the new proposal for the same reasons as the group and felt that the NICE guidance would not change much from the draft document already circulated. AW raised a few formatting issues on the document but that the content was fine, and MP agreed that a few things need looking at on the document. AW also raised the major change from going to step up and step down in the document so there is a large amount of clinician training that will need to be done. MP agreed this and added that there is a planned clinical training set up and the respiratory group would be looking into this further. And that this version hasn't been to the respiratory group yet for their full approval although they are happy with the content. AW asked also for the AIR definition to be added to the document. It was raised the issue would be embedding this into practice and MP added that this wouldn't be a full-scale switch but for new patients initially and stable patients would remain on their current plan for now. It was agreed that if no major changes are needed the group approves it and AW would sign off on the document with chairs approval. However, MP felt that there may need to be more significant changes to the document, and if this was the case it will come back to the group for further discussion and approval. Actions MP and the respiratory group are to look at the document and make any	**MP**

	changes. If they are minor changes AW will approve the document via Chairs approval. If they are major changes MP/ DP will bring this back to the group for approval.	**MP/AW** **MP/DP**
2024/164	**Guidelines Workplan** Nothing additional to raise to the group, just for information. It was raised that if there is a local or national guideline does there need to be all this additional work on guidelines locally. AGR added that the ones all on the workplan are all local and there is not currently any NICE, local or national guidelines in place which is why they are on the list. BH added that the request for the guidelines normally comes from specialists or primary care who ask for one, however this may be possible to take through the formulary working group to see if they are all still needed. BH also highlighted that there was a mention in the executive's summary around ECGs and ADHD. Modality are the company who provide the ADHD service and they apparently do not have access to ECG equipment. The program leads highlighted that there is a reimbursement available if practices were to undertake ECGs and that it might be appropriate for Modality to request ECGs from primary care. The group were asked if they were happy for that information to be added to the shared care document or if they wanted some work done to double check that it is appropriate. It was asked if they were commissioned to do the ECGs and BH responded that the adult ADHD lead felt that it was appropriate for them to ask primary care to undertake the ECGs, which would possibly mean they are not specifically commissioned to undertake them. RS commented that this has been raised before and it is something that isn't available across the whole area as some practices do not have the facilities to do them and patients are sent to outpatients. However those who are able to facilitate would be happy to undertake them as long as there is a clear way to claim the reimbursement. It was also raised about a piece of work that is needed to scope which practices are actually able to undertake them and pass this up to commissioners. FP agreed to flag this again up to commissioners. It was agreed to add this into the shared care document and bring it back to this group for approval in September. <u>Actions</u> Guidelines work plan to be taken to the formulary working group for them to check over items and ensure they are still relevant and to see if they can be ranked as minor, moderate or major to help streamline the process. The wording around ECGs being performed at practices where possible to be added to the ADHD shared care document and brought back to September's meeting for group approval.	 **DP** **AGR**
NATIONAL DECISIONS FOR IMPLEMENTATION		
2024/165	**New NICE Technology Appraisal Guidance for Medicines June 2024** No ICB commissioned NICE TAs for this month.	

2024/166	**New NHS England Medicines Commissioning Policies June 2024** Nothing to discuss.	
2024/167	**Regional Medicines Optimisation Committees – Outputs June 2024** Nothing to discuss.	
2024/168	**Evidence Reviews Published by SMC or AWMSG June 2024** Tirzepatide has been accepted with a BMI of 30 and one weight related comorbidity in Scotland for weight loss.	
ITEMS FOR INFORMATION		
2024/169	**LSCMMG Cost Pressures Log** This will be circulated with the minutes from today's meeting.	
DATE AND TIME OF NEXT MEETING **The next meeting will take place on** **Thursday 12th September 2024** **9.30 – 11.30** **Microsoft Teams**		