Minutes of the Lancashire and South Cumbria Medicines Management Group Meeting

Thursday 12th January 2023 (via Microsoft Teams)

PRESENT:

Andy Curran (AC)	Chair of LSCMMG	Lancashire and South Cumbria ICS
Andy White (AW)	Chief Pharmacist	Lancashire and South Cumbria ICB
Clare Moss (CM)	Head of Medicines Optimisation	Greater Preston, NHS Chorley, and South Ribble locality
Rebecca Bond (RB)	Director of Pharmacy	Blackpool Teaching Hospitals NHS Foundation Trust
Paul Elwood (PE)	Medicines Optimisation Pharmacist Team Lead	NHS North of England Commissioning Support Unit
Sonia Ramdour (SR)	Chief Pharmacist/Controlled Drugs Accountable Officer	Lancashire and South Cumbria NHS Foundation Trust
David Jones (DJ)	Assistant director of pharmacy Lancashire teaching hospitals	NHS Lancashire Teaching Hospitals
Ana Batista (AB)	Medicines Information Pharmacist	East Lancashire Hospitals NHS Trust
Vince Goodey (VG)	Assistant Director of Pharmacy	East Lancashire Hospitals NHS Trust
Nicola Baxter (NB)	Head of Medicines Management	West Lancashire locality
Rukaiya Chand (RC)	Prescribing Project Manager- Medicines Optimisation Pharmacist	NHS Lancashire and South Cumbria ICB
Lisa Rogan (LR)	Strategic Director for Medicines Research and Clinical Effectiveness	Lancashire and Blackburn with Darwin locality

IN ATTENDANCE:

David Prayle (DP)	Senior Medicines Commissioning Pharmacist	NHS Midlands and Lancashire CSU
Adam Grainger (AGR)	Senior Medicines Commissioning Pharmacist	NHS Midlands and Lancashire CSU
Emily Broadhurst (EB)	Administrator	NHS Midlands and Lancashire CSU

	SUMMARY OF DISCUSSION	ACTION
2023/217	**Welcome & apologies for absence** Apologies were received from Andy Curran for the first 30 minutes, Brent Horrell, Melanie Preston, and Rukaiya Chand is in attendance for Fylde Coast.	

2023/218	**Declaration of any other urgent business** None.	

	SUMMARY OF DISCUSSION	ACTION
2023/219	**Declarations of interest** None.	
2023/220	**Minutes and action sheet from the last meeting 8th December 2022** The minutes were approved after a change to Vince Goody's title has been made. Once the change is made, they will be uploaded to the LSCMMG web site.	
2023/221	**Matters arising (not on the agenda)** None.	
NEW MEDICINES REVIEWS		
	SUMMARY OF DISCUSSION	**ACTION**
2023/222	**Oritavancin, treatment of acute, complicated bacterial skin and skin structure infections** DP brought this item; the request was from East Lancashire Medicine Management board via the East Lancashire Hospital Trust Antimicrobial Group. It is given as a single dose and the cost for this single dose is around £1,500. Despite the relatively high cost of Oritavancin, the overall cost of treatment is similar to that for antibiotics when the cost of inpatient stay and OPAT services is considered. SMC has approved only for MRSA, partially due to a similar cost calculation. There is a possible service impact as there would be fewer OPAT specialist attendance and fewer stays in hospital and could open access to therapy. Pan Mersey and Greater Manchester have not reviewed and so do not currently have it on formulary. This is proposed as a RED indication and states that it must be reserved for patients who would otherwise be required to have prolonged inpatient stays due to unsuitability for OPAT. Responses received by consultees were supportive of availability, DP added to outline that Fylde Coast did have a lot of comments along with the comments that it should be RED, and DP has listed them in the paper. AB commented that the response form East Lancashire was originally sent as GREEN, this is incorrect and should be RED. This is to be amended in the responses. RC commented on the Fylde Coast response in that it has a long half-life, it is a novel drug as it is a one-off dose so how would patients respond to any side effects they encounter after a time (although it is noted that if a patient stayed in hospital for seven days, they may still suffer some side effects from a long half-life over 200 days). The main concerns, even though they agreed with a RED status, were around choice and microbiology input. RC also added in the paper there is a table with overall costs in and this drug seems to be similar to others but is	

	slightly more in cost so she was unsure what the overall advantage of this drug would be other than a reduced hospital stay. AW added that while he took her comment onboard with the cost, a reduction in hospital stays and relieving pressure on OPAT capacity would be important at the moment. LR asked AB if this drug would be used in place of Teicoplanin as a first option rather than if there was resistance and Teicoplanin isn't effective, which AB agreed that yes that was the ask from the consultants. VG agreed that this drug would be replacing Teicoplanin which also has its own safety issues, and that while it may feel like there is a lack of knowledge on it, it is replacing a drug that does have issues.* AW asked about possible patient numbers and DP responded that he had been unable to get this information from places for this report which is why it was left out of the report but that he also felt that the numbers would be small. AW asked members if they had any possible usages in their areas. VG added that Cellulitis is a significant condition which may benefit from this drug and added the importance that it will have a good impact on OPAT capacity. While it was agreed that this is an important plus for the drug AW asked for DP to put a number on the report for clarity. LR asked if there would be a proposal to add this to the virtual ward service in the future as they are currently updating the policy. VG answered that this would be a later choice for virtual wards as it would be coming under guidance from Microbiology and OPAT to begin with. DJ added that his Microbiologists weren't overly interested in using this drug as they have Dalbavancin so their patient numbers would be quite small initially. AW asked DP to add in some wording that states initially used under supervision of microbiology as inpatient and then this can be reviewed once there is more usage. **<u>*After meeting amendment*</u>** - After speaking with AB after the meeting, she has highlighted some incorrect information. When LR asked if Oritavancin was replacing Teicoplanin and AB/ VG concluded that it was, this is not correct. Teicoplanin will not be replaced by Oritavancin, it will actually use if there was resistance to Teicoplanin. The requester said that it would be used to *'speed the discharge of patients having ABSSI with no alternative option.'* **<u>Actions</u>** DP to add patient number data to the paper and to bring back to February meeting for agreement. DP to add additional wording supporting comments of patients being under microbiologist supervision as inpatient until further usage information is available and appropriate to review.	**DP** **DP**
2023/223	**Degarelix for treatment of adult male patient with advanced hormone-dependent prostate cancer without spinal metastases** DP brought this paper, there are some patients already getting this drug and they were outside of the NICE approval. These patients are those at risk of bladder outlet issues, who might have cardiovascular morbidities and also those that are at potentially at risk of spinal cord compression. Mersey and Manchester only use within NICE TA404 so this might put Lancashire and South Cumbria out of step. It was also felt that there	

	wouldn't be a significant cost impact as there wouldn't be much of a change in practice. The draft recommendations specify the groups of patients eligible for treatment. In the draft there was also information around a potential to switch patients to LHRH agonists after three to six months, further minimising the cost impact. DP added it is not clear how many patients could be switched onto an LHRH agonist. There is a confidential patient access scheme for Degarelix which should bring costs to a similar level of LHRH agonists. DP added it would be difficult to identify enough of a group of patients to demonstrate sufficiently that these patients would definitely benefit but in theory they may do. There was a lot of detailed commentary in consultation responses, most in support of the proposed RAG rating. East Lancashire Medicines Management Board only supported within TA404 restrictions. LR commented that the original request came from ELHT through to LR's team as they already had patients on this drug for this indication so DP was asked to look at it so that there would be a standard approach across Lancashire and South Cumbria. AB added that she responded on behalf of ELMMB. AW asked if the proposed RAG rating would influence the current PAS price as it the drug be used outside NICE restrictions. DP agreed to check whether the PAS would be affected. LR added this was raised in the feedback which states that '*Degarelix is only recommended by NICE when available at discount price and only in secondary care'.* She also added that it has always been a struggle to get this drug in primary care so it would most likely only be used in secondary care. DP checked and the primary care discount does apply so the rebate will be granted but agreed with AW's comments and added that it is unknown what will happen in the future however it is very unusual for companies to backtrack when their drugs are being used. It was agreed by the group for this to be approved as Amber 0 provided the PAS is in place for the hospital and the rebate available for any community usage. It was also added that while it is proposed small patient numbers for usage, should the company not comply with the PAS, this may need to be reviewed. **<u>Action</u>** Approved as Amber 0 following DP confirming the rebate is active, if the rebate isn't active to come to LSCMMG for discussion.	**DP**
2023/224	**New Medicines Review workplan** DP presented this item. There was one addition to the workplan that came in after this document had been produced, but there is nothing to approve for review. A request to look at Efudix 5% fluorouracil cream which is currently approved for basal cell carcinoma. The request from East Lancashire Hospital Trust dermatology department and was for the use in Precancerous Lesions. LR asked if the request was for Actinic Keratosis, as that was already on the formulary and is GREEN. DP said he would clarify the request as he was unsure if Actinic Keratosis was one step before Precancerous Lesions and he had been unable to dig deeper	

	before the meeting due to the time the request came in.	
GUIDELINES and INFORMATION LEAFLETS		
2023/225	**ONS Guidance - Update** AGR brought this item. It was brought in November originally with some requested changes to the document. Firstly, the product information table was removed. Secondly there was a question about the MUST scores if the monthly review is mandatory. Looking at the MUST guidelines states that it is a recommendation rather than a 'must be done', however there is a greater risk of malnutrition if there is rapid weight loss. This is why it is recommended as a monthly check in care homes. If the patient loses weight quickly as a result of illness, again there is the risk of malnutrition, this is why it is recommended as a weekly check in trusts. MUST recommendation is hospitals weekly check, care homes are monthly check, and, in the community, it is six monthly reviews. It has been added that if the patient's MUST score is stable this can move to annual reviews. AGR asked the group if they would like further adjustments made to the document. SR added her comment that in box two it has moved from 'patients under renal consultant, should be assessed by a renal dietitian' to 'patients with renal disease' and asked if it needed to be clearer and more specific. She also added the possible need for including 'people with age related decline in renal function would be referred to a renal dietitian? She added there needs to be further definition on information. AGR agreed with this and said it would be revisited. AW added it doesn't state in the document who is expected to complete the MUST score in the document so was he expectation on dieticians or other staff, and that the document may need to be more explicit to who the group felt should be completing the MUST score. AC added it was left as primary care practitioners to suggest who and that it doesn't need to be a dietician. The group discussed the issue of this becoming mandatory, but that rather this is a guideline and advise to use the MUST score, but also acknowledge and add that it is available to use as prescribing guidance and when medicine reviews are done, for them to use as an aid to help them decide if the medication is still needed. It was agreed for AGR to make the adjustments regarding the wording around renal physician consultants and then for it to be uploaded to the website. **<u>Action</u>** AGR to make the amendments to the document and then upload onto the LSCMMG website.	**AGR**
	Menopause guidance – Update AGR brought this item. It was due to go onto the website, however, has made some substantial changes to the document so has brought it back to the group for review. The list has been completely changed and AGR has put in different formulations following on from the last discussions regarding the document. There is now oral, patches and other	

2023/226	formulations. Some of the more useful/ practical parts of the guideline have been included in case this document is used in isolation. The preparations have been listed in price order (pound signs are yet to be added) but this is almost the final format that is to be put onto the website. AGR asked the group if they were happy with the new formatting and with the changes made to the document so far. He also added this format is the type of formatting that is to be used for all guidance documents going forward if the group agreed. AC added in AW's earlier comments on BIJUVA ® being in the current guidelines but is being reviewed next month. DP answered that he was unsure of the actual date but that the review was imminent and added that he was unsure if BIJUVA ® should actually be included in the current document as it is yet to be reviewed. AGR added that it could be removed should the group want. AC asked for it to be removed for now and added this is a difficulty in having a list such as in this document with products constantly changing. AGR added the way it has been formatted now will include formulas that will work in the background of the document and auto update any changes so that it will reflect the most accurate information at the time. AW added that it doesn't recommend transdermal first instead of oral as the risk of VTE is lower. AGR will change the order to have patches first. Will also be publicizing it and making people aware that it is available, but to emphasize it is not prescribing guidance but a product list. AW then asked if there is a need to put a link to the SPS website due to all of the stock issues currently happening. AGR agreed this would be a good addition to the document. AC added to maybe link in with Kath Gulson and community pharmacy as well for awareness of the document to help get it into circulation and being used by clinicians. **<u>Actions</u>** AGR to remove BIJUVA ® until it has been reviewed by the group. AGR to change patches to the first choice in the document instead of oral. Once ready, AGR to include Kath Gulson and community pharmacy in the circulation of the document.	**AGR** **AGR** **AGR**
	Out of Area Prescribing Position Statement - Update AGR brought this item. The out of area position was developed to support GPs when requested to prescribe by out of area specialists. Things are different now in the way areas work together/ are linked such as the ICBs, so the ask for the group was if they are happy to keep the document. AW asked for the comment 'Do not Prescribe' instead of a Black status as previously discussed to be added in. AC noted it should say 'Lancashire and South Cumbria GPs/ Prescribers' and also Lancs and South Cumbria title as MMG's title has been changed. LR thanked AGR for the document as she felt it was really helpful. She added to maybe send this further afield to other areas such as Cheshire and Mersey and Greater Manchester as there still comes queries from them when a product is Amber in their area and Do Not Prescribe here,	

2023/227	they felt it should still be prescribed by Lancashire and South Cumbria so felt sharing wider would help to get the message across. AC added agreement as this document is essentially for other areas not Lancashire and South Cumbria. He also added to AW to share regionally to get it out further afield, to which AW agreed. RC asked for some clarity for point B about a request for a tertiary center should be considered individually, so is it down to the GP to consider individually? As some of these could be quite specialist and they have already had practices take on prescribing then query it months down the line. AGR said that he felt that was correct, and that the medicines teams often receive special requests and felt that with this it is important to know when it is appropriate to push back and ask for further support/ clarification from the hub team or medicines op teams. AC commented that AGR's description was clearer than the document and AGR agreed to alter the document. LR agreed with this and asked for emphasis on if there is something more unusual or exceptional things need further push back to meds op teams. RC added if there could be a separate tertiary comment within this document to highlight the differences with tertiary centers. AGR agreed and will look to see if it would be better to change the wording within the current section or create a separate section for tertiary centers. AGR will make changes to the document then alongside AW will share out with regional teams. As there may be further changes made to the document from regional teams to make one inclusive document for all then bring back to this group. AGR also added about the possibility of making it clearer to find on the website and for it to be better signposted so others outside of Lancashire and South Cumbria would be able to find it. **<u>Actions</u>** AGR to reword section to either include tertiary center information or create separate section. AW to share this document with colleagues and to check with Cheshire and Mersey and Greater Manchester to see if it is possible for a whole Northwest approach.	**AGR** **AW**
2023/228	**Axial Spondylarthritis Pathway** DP presented this item. It is an update to include new NICE TAs that have already been approved via LSCMMGs NICE process. It is felt there wouldn't be any financial impact to what has been done. The update is also to improve the wording of the guideline, it has been discussed with specialist clinicians and the feedback received has been used to update the guideline. In the equality section, it differs slightly from Greater Manchester's position as theirs was last updated in 2018, so this is why it is not in line with theirs. There was a list in the introduction detailing all of the changes made. In the consultation comments there was almost universal support, where there some who 'would support' raised the question of whether there should be a third line of therapy instead of two. This update is what is called a quick update which is to just bring the document up to date. A future full update could be done where the third line of treatment could be looked into but would require more work than what was needed for this quick update. DP asked members to take this into consideration when members look at the consultation comments.	

	AW asked if there were more than two modes of drug action that were now NICE approved, and if so, why would the document only state two and asked if this would be a breach of the NHS constitution. DP agreed that specialist would absolutely ask for additional lines of therapy, however the constitution states that there needs to be an evidence base to allow additional lines, and that feedback/ evidence has not been provided to the team to support that. The plan is to look further into this in the future. However, in the absence of that evidence, it could only be put as theoretical rationale such as 'you may try a different mode of action' but agreed further work into this in the future would need to be looked at for a large update, but not for this small update. AW asked why it wasn't being done now as it is being updated now instead of waiting. DP answered that when the team spoke with specialist and asked for the case to be made for the evidence to show that three lines of therapy are effective and safe, they had not received any substantial feedback to support this. AW responded that it had been the view if an agent was NICE approved then prescribers should not be blocked from prescribing. As there are 8 drugs available, it felt odd to stop at only two lines. DP explained that more than two agents could be prescribed in cases of intolerance or primary nonresponse. AW asked if there was a way to get the usage data for the treatment lines. DP responded that when this was done for arthritis, the information was collected from the BSSR, so the team had sufficient evidence to back them up. The team have asked the Rheumatology alliance for the additional information to support the other lines, but they have not produced evidence to support the update. So, in the interim the team have done a small update which brings it out of step with NICE. And then the next step is to bring the larger update once they have enough supporting evidence. This smaller update could be passed over, and the team could do the full update but that will take several months. AC added this could go out as an interim or developing guidance as it wouldn't be possible to pull a document each time a new NICE TA is approved. Furthermore, if a third line is something nationally recommended that should be considered. AW added he would send DP the sequential use of biologics paper done in GM as it might be useful as it highlights the benefit on not having lots of patients going through the IFR process. AC concluded that the group agreed and were happy for the document to go out. However, there needs to be additional or a change to current wording 'failure of second line treatment constitutes the end of the commission biologics pathway'. Something to indicate that other options are still coming out. Then to bring it back to this group next month. **Action** DP to make suggested changes (the potential to allow a 3rd line treatment) and bring back to the group next month.	**DP**
2023/229	**Psoriasis Biologic Treatment Guideline** DP presented this item. A new NICE TA has been added, the flow chart has been made easier to read. The NICE TA numbers have been taken out, and the new flow chart has been added to the appendices so both	

	versions are there to be viewed. In the consultation all members were in support of the document. AC suggested adding that sequential use of additional biologics approved could be used (referring to the AxSpA discussions earlier). DP agreed this could be done, however there are already six lines documented so possibly not needed for this document. AW asked about liking in the Greater Manchester Psoriasis document. DP added that this document was developed with Professor Warren in Salford. AW agreed this is who worked on the GM document so agreed this one is in alignment with that one. AW raised a formatting issue on the document – Blackpool PCT is still mentioned. DP agreed he would correct this before it goes out. AC confirmed that this document was agreed and could be uploaded to the LSCMMG web site. **Action** DP to amend the formatting issue (Blackpool PCT appears on pdf version) and put on website.	**DP**
2023/230	**Guidelines workplan** AGR has completely rewritten the workplan and now includes NICE criteria used when they prioritize guidelines, and there is also a financial risk level definition that has been taken from SPS. AGR added this is the same one used by DP for new medicine reviews and horizon scanning. There are some bits missing currently as this is historic data and AGR has not completed a full scope to include new updates. AGR is hopeful that this will be more robust and will help to inform the team prioritization more robustly. The other thing to highlight is the DMARD shared care guidelines. It's been an approved for a six-month interim. The clinical content has been updated but this has been based on the discussions had on pathways. These pathway issues are going through other groups that Brent is leading on. The request today from the group was as the clinical content had been updated, was the group happy to award another six-month extension while the pathway discussions continue as then there isn't expired shared care guidelines on the website. The team do not want to put trusts at risk of using out-of-date documents. Secondly, AGR has been asked to look at the Vitamin D guideline. He has linked into the national osteoporosis society substantive guideline for vitamin D and there is something that doesn't match the one they have produced so AGR has asked for time to review and bring it back next time. AC thanked AGR for the format as it made things very obvious. DJ added some items he thought would be on the workplan including the request from Neurology about status epilepticus having an ICB position guideline and he added he felt there was a draft for this item already. AGR commented that this item was on the guideline. DJ then asked about a discussion that was had previously possibly in October or November about things such as Benzodiazepine withdrawal as there was interest particularly from LTH about putting in some guidance and that they had liaised with LSCFT colleagues and asked if this would also go onto the	

	work plan. AGR commented that it will and that he was waiting to have a conversation with LR around this so is aware it will go on once these discussions have happened. LR said she would resend the information to AGR as she felt she had already sent it. SR asked is there is a process to flag six months in advance for documents that are expiring as she had noticed the shared care guideline for Lithium expired in June. AGR commented that there is a s process so was surprised this one had not been raised prior and he would look into this and bring it back next month as an urgent to be reviewed. AGR asked again before moving on to the next agenda item about the extension for the shared card guidelines and offered to the group that three months could be possible as the clinical information had been updated, they were just waiting on the pathway information to be agreed from the other group. AC asked if three months would be sufficient to get things updated and then out for consultation. AGR commented that he would need to check with Brent as he is leading the group that are discussing it and asked as Brent was absent from the meeting if he could liaise with Brent then contact AC outside of the meeting to agree a realistic timescale for these to be extended by to get them completed. AC agreed to this and will use chair action to agree the extension time outside of the meeting. **<u>Actions</u>** AGR to liaise with Brent on the timescale for extension to the DMARD shared care guidelines. AC will use chairs action to extend them by a realistic timeframe once the above action is complete.	**AGR** **AC**
NATIONAL DECISIONS FOR IMPLEMENTATION		
2023/231	**New NICE Technology Appraisal Guidance for Medicines December 2022** There was one NICE TA to update which was TA853 Avatrombopag for treating primary chronic immune Thrombocytopenia. This is ICS commissioned with a significant cost impact. There was no costing template, NICE only issued a cost statement. The estimated potential maximum impact is £144,000 per annum across Lancashire and South Cumbria and this feeds from NICE's maximum estimate of £9000 per 100,000 of the population. Brent has put this on the cost impact list, however AGR is looking to do some more data to try and firm it up and also run some Blueteq data for usage.	
2023/232	**New NHS England medicines commissioning policies December 2022** N/A	
2023/233	**Regional Medicines Optimisation Committees - Outputs December 2022** N/A	
	Evidence reviews published by SMC or AWMSG December 2022	

2023/234	N/A	
ITEMS FOR INFORMATION		
2023/235	**Lancashire and South Cumbria NHSFT Drug and Therapeutic Committee** SR brought an update for information only. The D&T group have formalised actions on the back of a paper that came here a few months ago. These are changing some of the approval processes for certain medicines within the trust, but they are outlined in the minutes from the last meeting.	
2023/236	**LSCMMG cost pressures log** As Brent was not present at the meeting DP presented this item. The document shows three new things on the list. Oritavancin which it was unclear of the cost pressure as the patient numbers are unknown. Degarelix which had already been discussed in this meeting and it showed no cost impact. Avatrombopag AGR has already mentioned with a possible maximum of £144,000. The only other change is Keppra to levetiracetam generic switch proposal, which hasn't been resolved yet. The group discussed Keppra and how it will be resolved. DP stated the group are going back to clinicians to question why they have the current position of only prescribing generically for new patients to when in other regions such as Manchester switching is allowed. However, Mersey have a similar position to the proposal for Lancashire. DP is still awaiting feedback from Mersey as they have challenged this decision. The Lancashire position was discussed at the Governance Committee in Preston Hospital; the team hope to continue to pursue the issue of inconsistency with the MHRA. PE raised there was a similar issue with another two drugs pregabalin and Lyrica where initially the guidance was it could be changed if the patient was not epileptic, and this has now changed. AC added this raised that this isn't something new. CM added the reason that neurologists were approached was that GPs were unsure of switching. She added she felt that backing from Neurologists supporting this would give extra confidence for GPs, but that she was unsure how to move it forward as she felt it isn't a consistent decision. The group discussed it further and it was felt that having an overall prescribing guidance would work best. DP will bring the update to on Keppra to the next meeting after he has received further feedback from other areas. Then would look to create a document for Lancashire and South Cumbria. **<u>Actions</u>** DP to follow up with Neurologists to discuss current position.	**DP**
	Horizon Scanning 2023/24	

2023/237	Brent asked DP to present this item in his absence. The document was emailed out this morning before the meeting as a summary of the forthcoming cost pressures, the full horizon scanning document will follow. This document shows that for primary care, there will be a potential 11.22% increase in costs next year. DP highlighted the main issues within the document. The increase in DOAC prescribing will continue to grow as there is pressure to find 'lost patients' with AF. Glucose monitoring sensors will also potentially have a large impact. SLGT2 prescribing will increase not only for diabetes but for renal failure and heart failure. HRT is also a potential cost pressure. There are also secondary care cost pressures which are estimated to be around £5.4 million across a number of different areas. DP asked members to consider if any actions are required in response to the paper's findings. AC added that a patient shouldn't be denied a drug due to costs especially when there are other areas within a prescribing budget where savings could be made. The average growth across the system in secondary care is between 10-15%. Next year it is believed that tariff will return, which means that it's important that tariff exclusions are documented properly. AW commented that it is important to have reliable figures to present. AW felt the figures from BH were accurate and that the group needs to consider what should be to be prioritised. LR added that there needs to be an examination of added value for interventions and whether they are making a difference to patients. With her work around Diabetes, they have been triangulating data sets and linking outcomes with cost and prevalence. This has shown that in some areas of prevalence it is much lower than expected in terms of public health predictions. This would suggest that people are being underdiagnosed and more people need to be found and treated. This information would also suggest the need to look at places where the outcomes are good at low cost to see what can be implemented from those areas to other areas of low outcomes. The conversation then moved to discuss more of focus going toward preventative working with the prevention agenda. Lifestyle factors should also be addressed, including for patients who are identified and need medication. LR added in agreement that prior to COVID she had discussions to maybe move around the prescribing budget from the end other pathway to the start with more preventative measures instead of spending large portions of the budget on expensive drugs. AC agreed that he would need to check the data, but the feel is that preventative healthcare may have reduced during COVID and now this could have repercussion. LR added that comms have a large part to play in this as patient attitudes have changed due to COVID so whereas before they would make sure they went to medication reviews etc. they are now not as they are not used to going to appointments unless they are feeling unwell. AW then picked up a comment from PE in the chat which he asked if putting lifestyle interventions and non-pharmacological interventions first in	

	everything done and promoting the fact that there are other options that the drugs. **<u>Action</u>** DP will summarise discussions and report back to BH.	**DP**

DATE AND TIME OF NEXT MEETING

The next meeting will take place on

Thursday 9th February 2023

9.30am – 11.30am

Microsoft Teams

ACTION SHEET FROM THE
LANCASHIRE AND SOUTH CUMBRIA MEDICINES
MANAGEMENT GROUP 12.01.2023

ACTION SHEET FROM THE MEETING 09th December 2021				
2021/154	**Ketamine survey results** Ketamine for chronic pain current position to be discussed at November LSCMMG meeting. CSU to work with LTHT to develop mechanisms to provide assurance that a new initiation has carefully been considered and all other options exhausted. An MDT approach and proforma capturing rationale and previous treatments plus higher level sign off to be explored. **November 2021 update:** DJ will have internal conversations with pain team, LTH to review and await information back to LSCMMG. **December 2021 update:** Ongoing awaiting feedback **January 2022 update:** Discussed at LSCFT medicines committee, requests received from diabetes wider pain treatments specialist to use Sativex and broaden beyond ketamine and non-pharmacological interventions. MM group to provide evidence for new initiation. DJ suggested there is a criteria and local Blueteq form developed. CSU agreed that a local Blueteq form could be developed once the clinical and review criteria are agreed. **February 2022 update:** Audit delayed due to covid pressures. Focused meeting on ketamine to take place shortly. **March 2022 update:** DJ has been unable to meet, has had a draft list of criteria, which could be put into local Blueteq. This includes confirming patient has persistent pain, referred to pain management service, has tried long term opiates, has tried other relevant pain	**DJ** **DP/DJ** **DP/DJ** **DP/DJ** **DP/DJ** **DP/DJ**	**Closed** **Open** **Open** **Open** **Open** **Open**	**14.10.2021** **14.10.2021** **11.11.2021** **13.01.2022** **10.02.2022** **10.03.2022**

	management. **April 2022 update:** Not drafted yet, to defer until next meeting. DJ drafted internal Blueteq form, received positively, some suggestions for follow ups so will be completing this and will hopefully be on agenda for next month, will send to DP/AGR. **June 2022 update:** DP to circulate form from DJ and will bring back to next meeting. **July 2022 update:** DP had feedback from one from East Lancashire Trust and this was they have no comment. After discussions AGR to draft a Blueteq form and DP/BH to draft RAG position wording and bring back to the next meeting. **September 2022 update:** Has been drafted, DP to check over and then will propose website wording. **October 2022 update:** Blueteq form has been drafted. DP to link in with LTH to discuss wording and RAG position for the website as to not flood LTH with referrals. **November 2022 update:** DP has contacted DJ, DP is not attending today, but the discussions are what the wording will be on the Website. Once decided this action will be closed. **December 2022 update:** DP has sent some proposed wording to DJ but has not heard back. DJ was not in attendance. **January 2023 update:** DP will send proposed wording around to the group for confirmation regarding oral use and NHS only. Once this has happened it will go onto the website, Closed.	**AGR/DJ/DP** **AGR/DJ/DP** **DP/DJ** **AGR/DP** **DP/DJ** **DP/DJ** **DP/DJ** **DP**	**Open** **Open** **Open** **Open** **Open** **Open** **Open** **Closed**	**14.04.2022** **09.06.2022** **14.07.2022** **08.09.2022** **13.10.2022** **10.11.2022** **08.12.2022** **12.01.2023**
ACTION SHEET FROM THE MEETING 13th October 2022				
	Hydrocortisone Modified-Release Capsules (Efmody) For Treatment of Congenital			

2022/161	**Adrenal Hyperplasia (CAH) in Adolescents aged 12 years and over, and adults** DP to look into possible pre-approval processes for access to the drug and bring back to a future meeting. **November 2022 update:** Defer. **December 2022 update:** This was also discussed outside of this meeting, MP had some queries, DP to meet with MP to discuss these and wording then put onto websites. **January 2023 update:** Wording has been sent to members; DP is awaiting feedback.	**DP** **DP** **DP/MP** **DP/MP**	**Open** **Open** **Open** **Open**	**13.10.2022** **10.11.2022** **08.12.2022** **12.01.2023**
2022/164	**Nutritional Supplements Post Bariatric Surgery – Post Private Surgery** CSU to put wider work onto the work plan about reviewing the information we currently have in documents and look whether they need to be refreshed or have a stand-alone policy position relating to private treatment. **November 2022 update:** AGR will contact LMC regarding this item. **December 2022 update:** AGR has met with LMC, now awaiting their further feedback. **January 2023 update:** AGR still awaiting feedback from the LMC, AGR will chase.	**CSU** **AGR** **AGR** **AGR**	**Open** **Open** **Open** **Open**	**13.10.2022** **10.11.2022** **08.12.2022** **12.01.2023**
ACTION SHEET FROM THE MEETING 10th November 2022				
2022/180	**Keppra Position Statement** DJ to speak to neurologists regarding the paper and get input from them. BH and the hub team to support. **December 2022 update:** Still not received formal approval, DP/ JA to chase with neurology. **January 2023 update:** DP has had some feedback; some issues need to be further discussed.	**DJ/BH** **DP/JA** **DP**	**Open** **Open** **Open**	**10.11.2022** **08.12.2022** **12.01.2023**

2022/182	**ONS Guidance – Update** AGR to further clarify MUST scores. **December 2022 update:** Ongoing, will bring back to January. **January 2023 update:** On the agenda, closed.	**AGR** **AGR** **AGR**	**Open** **Open** **Closed**	**10.11.2022** **08.12.2022** **12.01.2023**
	AGR to remove the table from page 4 with the first-choice items. **December 2022 update:** Ongoing, will bring back to January. **January 2023 update:** On the agenda, closed.	**AGR** **AGR** **AGR**	**Open** **Open** **Closed**	**10.11.2022** **08.12.2022** **12.01.2023**
	AGR to follow up with formal letter to procurement. **December 2022 update:** Ongoing, will bring back to January. **January 2023 update:** On the agenda, closed.	**AGR** **AGR** **AGR**	**Open** **Open** **Closed**	**10.11.2022** **08.12.2022** **12.01.2023**
2022/186	**Menopause pricing information table for website** AGR to make changes outlined in the discussions today and bring back at a later meeting before it gets sent out. **December 2022 update:** AGR is finalising, will go straight on the website, will update at the next meeting. **January 2023 update:** On the agenda, closed.	**AGR** **AGR** **AGR**	**Open** **Open** **Closed**	**10.11.2022** **08.12.2022** **12.01.2023**
2022/187	**Guidelines Workplan** BH/AGR to pick up LR's email and information about the cancer drug. **December 2022 update:** AGR to meet with LR to discuss. **January 2023 update:** Actioned, closed.	**BH/AGR** **AGR** **AGR**	**Open** **Open** **Closed**	**10.11.2022** **08.12.2022** **12.01.2023**
2022/192	**Freestyle Libre/ Blood Glucose Testing Strip Analysis** Each locality to review the data to identify which practices need further guidance and support. **December 2022 update:** Has been discussed at Place leads, will continue to monitor through there, CSU to bring	**Place Meds Leads** **CSU**	**Open** **Open/ Closed**	**10.11.2022** **08.12.2022**

	quarterly reports going forward, closed?			
ACTION SHEET FROM THE MEETING 8th December 2022				
2022/198	**Delta-9-Tetrahydrocannabinol (THC) and Cannabidiol (CBD) (Sativex®) for Refractory Neuropathic Pain** The recommended RAG position of BLACK (Do not prescribe) for this indication to be referred to the Pharmacy and Medicines Policies Task and Finish group for ratification. Following ratification, the website will be updated. **January 2023 update:** Position supported, closed.	**DP** **DP**	**Open** **Closed**	**08.12.2022** **12.01.2023**
2022/199	**Ryaltris financial impact** The recommended RAG position of BLACK (Do not prescribe) for this indication to be referred to the Pharmacy and Medicines Policies Task and Finish group for ratification. Following ratification, the website will be updated. **January 2023 update:** Position supported, close.	**DP** **DP**	**Open** **Closed**	**08.12.2022** **12.01.2023**
2022/200	**RAG rating updates Agomelatine and Duloxetine** A GREEN RAG position for Duloxetine in the treatment of depression to be consulted on. SR to look over the documents before they go to consultation to ensure all relevant information is included. **January 2023 update:** SR looked over the docs and they have gone out for consultation, closed.	**SR** **SR**	**Open** **Closed**	**08.12.2022** **12.01.2023**

	DP to contact Greater Manchester and Cheshire and Mersey to discuss any reviews they have already completed for Duloxetine. **January 2023 update:** Went out for consultation, Greater Manchester and Cheshire had a GREEN and they said it is historical, will discuss at the next meeting.	**DP** **DP**	**Open** **Open**	**08.12.2022** **12.01.2023**
2022/202	**Psoriatic arthritis guidance – update** The updated guidance to be uploaded to the LSCMMG website. **January 2023 update:** Is on the website, closed.	**DP** **DP**	**Open** **Closed**	**08.12.2022** **12.01.2023**
2022/203	**Dementia Medicine Prescribing Information Sheet – update** AGR to amend the wording around local formularies. **January 2023 update:** Is on the website, closed.	**AGR** **AGR**	**Open** **Closed**	**08.12.2022** **12.01.2023**
	SR to follow up about the 'Management of behavior and psychological effects of dementia summary document for primary care' document outside of this group. **January 2023 update:** Is going to the best practice group next week and will be discussed. SR will email FP with outcome, closed here.	**SR** **SR**	**Open** **Closed**	**08.12.2022** **12.01.2023**
2022/204	**Riluzole SCG and PIL – update** Shared care document and Patient Information Leaflets to be updated on the LSCMMG website. **January 2023 update:** On the website, closed.	**AGR** **AGR**	**Open** **Closed**	**08.12.2022** **12.01.2023**
2022/206	**Zuclopenthixol decanoate RAG position** AGR to send the document out for consultation with an Amber 0 recommended RAG position. The	**AGR/SR**	**Open**	**08.12.2022**

	content to be agreed with SR before going out for wider consultation. **January 2023 update:** Is out for consultation, will bring it back to the next meeting. AGR to run prescribing data at place level. **January 2023 update:** AGR will bring go the next meeting. AGR to link in with SR.	**AGR** **AGR** **AGR**	**Open** **Open** **Open**	**12.01.2023** **08.12.2022** **12.01.2023**
2022/207	**Sodium zirconium cyclosilicate – update** AGR and LR to link in and discuss clinician concerns. **January 2023 update:** LR and AGR still need to link in due to people being on leave over the festive period.	**AGR/LR** **AGR/LR**	**Open** **Open**	**08.12.2022** **12.01.2023**
2022/208	**Palliative care medicines formulary – adopting consistent RAG status** GREEN restricted to be applied to all localities. **January 2023 update:** On the website, closed.	**AGR** **AGR**	**Open** **Closed**	**08.12.2022** **12.01.2023**
2022/209	**Dapagliflozin for treating chronic kidney disease – Change of RAG status** The recommended RAG amendment to be referred to the Pharmacy and Medicines Policies Task and Finish group for ratification prior to being updated on the website with the inclusion of renal function thresholds. **January 2023 update:** Went to the Pharmacy and Medicines Policies Task and Finish group, was supported and is on the website, closed.	**DP** **DP**	**Open** **Closed**	**08.12.2022** **12.01.2023**
2022/216	**LSCMMG cost pressures log** Agreed that with the agreed amendments that the cost pressure log will be included as a standing agenda item for all subsequent meetings. **January 2023 update:**	**BH**	**Open**	**08.12.2022**

	On the agenda as a standing item, closed here.	**BH**	**Closed**	**12.01.2023**
ACTION SHEET FROM THE MEETING 12th January 2023				
2023/222	**Oritavancin, treatment of acute, complicated bacterial skin and skin structure infections** DP to add patient number data to the paper and to bring back to February meeting for agreement.	**DP**	**Open**	**12.01.2023**
	DP to add additional wording supporting comments of patients being under microbiologist supervision as inpatient until further usage information is available and appropriate to review.	**DP**	**Open**	**12.10.2023**
2023/223	**Degarelix for treatment of adult male patient with advanced hormone-dependent prostate cancer without spinal metastases** Approved as Amber 0 following DP confirming the rebate is active, if the rebate isn't active to come to LSCMMG for discussion.	**DP**	**Open**	**12.01.2023**
2023/225	**ONS Guidance – Update** AGR to make the amendments to the document and then get it uploaded onto the website.	**AGR**	**Open**	**12.01.2023**
2023/226	**Menopause guidance – Update** AGR to remove BIJUVA ® until it has been reviewed by the group.	**AGR**	**Open**	**12.01.2023**
	AGR to change patches to the first choice in the document instead of oral.	**AGR**	**Open**	**12.01.2023**
	Once ready, AGR to include Kath Gulson and community pharmacy in the circulation of the document.	**AGR**	**Open**	**12.01.2023**
2023/227	**Out of Area Prescribing Position Statement – Update** AGR to reword section to either include tertiary center information or create separate section. AW to share this document with colleagues and to check with Cheshire and Mersey and Greater	**AGR**	**Open**	**12.01.2023**

	Manchester to see if it is possible for a whole Northwest approach.			
	AW to share this document with colleagues and to check with Cheshire and Mersey and Greater Manchester to see if it is possible for a whole Northwest approach.	**AW**	**Open**	**12.01.2023**
2023/228	**Axial Spondylarthritis Pathway** DP to make suggested changes (the potential to allow a 3rd line treatment) and bring back to the group next month.	**DP**	**Open**	**12.01.2023**
2023/229	**Psoriasis Biologic Treatment Guideline** DP to amend the formatting issue (Blackpool PCT appears on pdf version) and put on website.	**DP**	**Open**	**12.01.2023**
2023/230	**Guidelines Workplan** AGR to liaise with Brent on the timescale for extension to the DMARD shared care guidelines.	**AGR**	**Open**	**12.01.2023**
	AC will use chairs action to extend them by a realistic timeframe once the above action is complete.	**AC**	**Open**	**12.01.2023**
2023/236	**LSCMMG cost pressures log** DP to follow up with Neurologists to discuss current position and update next meeting.	**DP**	**DP**	**DP**
2023/237	**Horizon Scanning 2023/24** DP will summarize discussions and report back to BH.	**DP**	**DP**	**DP**