Minutes of the Lancashire and South Cumbria Medicines Management Group Meeting

Thursday 11th May 2023 (via Microsoft Teams)

PRESENT:

Andy Curran (AC)	Chair of LSCMMG	Lancashire and South Cumbria ICB
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
Sonia Ramdour (SR)	Chief Pharmacist/Controlled Drugs Accountable Officer	Lancashire and South Cumbria NHS Foundation Trust
Andrea Scott (AS)	Medicines Management Pharmacist	University Hospitals of Morecambe Bay NHS Foundation Trust
David Jones (DJ)	Assistant director of pharmacy Lancashire teaching hospitals	NHS Lancashire Teaching Hospitals
Faye Prescott (FP)	Senior Medicines Optimisation Pharmacist	Morecambe Bay Locality
Ana Batista (AB)	Medicines Information Pharmacist	East Lancashire Hospitals NHS Trust
Nicola Baxter (NB)	Head of Medicines Management	West Lancashire locality
Lisa Rogan (LR)	Strategic Director for Medicines Research and Clinical Effectiveness	Lancashire and Blackburn with Darwen locality
Vince Goody (VG)	Assistant Director, Pharmacy ELTH	East Lancashire Teaching Hospital
Mohammed Ahmad	Assistant Director, Pharmacy BTH	Blackpool Teaching Hospitals NHS Foundation Trust

IN ATTENDANCE:

Jenny Oakley (JO)	Lead Pharmacist - Surgery, Critical Care and WACS	Morecambe Bay Hospitals Trust
Brent Horrell (BH)	Head of Medicines Commissioning	NHS Midlands and Lancashire CSU
Adam Grainger (AGR)	Senior Medicines Commissioning Pharmacist	NHS Midlands and Lancashire CSU
David Prayle (DP)	Senior Medicines Commissioning Pharmacist	NHS Midlands and Lancashire CSU
Emily Broadhurst (EB)	Administrator	NHS Midlands and Lancashire CSU

	SUMMARY OF DISCUSSION	ACTION
2023/312	**Welcome & apologies for absence.** There were apologies from Melanie Preston and Rukaiya Chand was unable to attend on her behalf. This meant that there was no representation for Fylde Coast at the meeting.	
2023/313	**Declaration of any other urgent business** AC had one item of urgent business. AC and David Levy met with the acute trust medial directors on Friday 5th May, one of the areas discussed was membership of LSCMMG. Each acute trust has been asked to look at having a prescriber or other clinician to attend LSCMMG. AC added he felt that the local D&T committee chairs would be a good place to start from but not necessarily for them to attend. Also, with the progression towards a Single Lancashire formulary, this would in theory affect some elements currently covered in existing D&T meetings.	
2023/314	**Declarations of interest** None.	
2023/315	**Minutes and action sheet from the last meeting 20th April 2023** AW highlighted an action for Keppra on the action log was put under the ONS guideline actions. EB will amend this. Aside from this change the minutes were agreed and ratified. The group went through the action log and updates are included below. **Action** EB to amend the minutes before uploading them to the website.	**EB**
2023/316	**Matters arising (not on the agenda)** None.	

NEW MEDICINES REVIEWS

	SUMMARY OF DISCUSSION	ACTION
2023/317	**Trifarotene (Aklief®) 50 microgram/g cream for the cutaneous treatment of acne vulgaris of the face and/or the trunk in patients from 12 years of age and older, when many comedones, papules and pustules are present** This review was conducted as the drug was previously approved by SMC and it was felt there could be interest in prescribing the drug in Lancashire and South Cumbria. None of the other ICBs in the North West have a position on this, however Manchester have proposed a Green RAG rating and Mersey have it as Grey which means they haven't had an application for it yet. It has an equivalent cost to other acne treatments at that level of the treatment pathway so there are no cost implications. The consultation responses indicated agreement by all respondents for the proposed Green RAG rating. The Green RAG Status was agreed by the group. This will be sent for approval at the relevant committee. **Action**	

	Trifarotene (Aklief®) 50 microgram/g cream for the cutaneous treatment of acne vulgaris, a Green RAG rating will be considered for ratification at the next Medicines Policy Subgroup.	**DP**
2023/318	**TheraBite® Jaw Rehabilitation Device for the treatment of trismus and mandibular hypomobility** This request came from Speech and Language at Blackpool as a Jaw Rehab device. This is for people who can't open their jaws very well usually following treatments such as for Cancer. The patient numbers were not clear, so the cost predictions were calculated for 100 patients which would cost £25,000. DP spoke with a specialist at Morecambe Bay, and he thought it would be around a maximum of 10 patients per year so around 40 a year across the patch. This means the cost implication would be about £12,000 if approved. Greater Manchester has adopted a "do not prescribe" position and Pan Mersey have not considered TheraBite®. The review recommended it as Red specialist only product as second line therapy, secondary to Radiotherapy, Surgery or Trauma for those who still have problems despite using the jaw stretching exercises. All responses supported its availability but with varying RAG statuses. Two places said Red, Lancashire Teaching Hospital didn't give a RAG but said it should be available. There were two responses from Morecambe Bay and one of these was from the MaxFax Specialists and they felt it should be Green. AC asked if it was a single use device, as there is the initial cost for the device and accessories and then the bite pads. DP responded that the pads are disposable, but the device is a one-off cost. He was unsure of the cost for just new bite pads on their own but felt the costing would still be quite low. AC added that in the paper it states changing the pads every three months and asked what the length of treatment time was. DP was not clear what that would be. Due to this AC felt the evidence isn't out there so it should be Red for the specialists to decide who it is most suitable for, but added he could see why the MaxFax specialists would say Green. It was then highlighted that it is included in the appliances list in the Drug Tariff. It was agreed for the Red RAG status and AC asked if members from Morecambe Bay were happy to go back to the MaxFax specialists to explain why it is not Green. AS was on the call and said she was happy to feedback to them. **<u>Action</u>** TheraBite® Jaw Rehabilitation Device for the treatment of trismus and mandibular hypomobility, a Red RAG rating will be considered for ratification at the next Medicines Policy Subgroup. AS to feedback discussion on the Red RAG decision to MaxFax specialists.	**DP** **AS**

2023/319	**Budesonide M/R 9mg tablets (Cortiment MMX) for induction of remission in adults with mild to moderate active ulcerative colitis where 5-ASA (aminosalicylate) treatment is not sufficient - RAG status change proposal** Budesonide M/R 9mg tablets currently has a Red RAG rating on the LSCMMG website. A clinician has requested that this is changed to Amber but didn't state which designation of Amber. The team conducted a short review and recommended that it should be amended to one of the Amber categories. The consultation comments supported Amber 0, and it was highlighted that this only for Cortiment brand. There is another brand named Budenofalk which is not listed anywhere on LSCMMG as it has not been reviewed, East Lancs questioned why both have not been considered at the same time. It was highlighted that one product is licensed for Ulcerative Colitis and the other is for Crohn's disease. DJ highlighted that the two preparations may have different release profiles, as they don't all act in the same part of the GI tract, so they do need to be prescribed by brand and that there may be a need to review the other preparation as well. AC agreed that we should only be considering the requested brand and indication, as the presentation is different along with the age group and location in the GI tract. DJ put the request forward for consideration as patients are initiated on this and stop treatment once they are controlled, if they have a flare up again, there could be delays in them getting the treatment with the existing RAG rating. Whereas, if it has been initiated and was successful, a flare up could be a year later and if it is recommended in their care plan it gives a structured approach with the information provided, there would be a referral pathway back in should they not respond. The Amber 0 gives better access to treatment. FP asked if the patient would get put on a maintenance dose, then if there is a flare up would it then be increased or is it just a course of treatment until they are in remission. AC answered that he felt it was a short course of treatment until the symptoms settle back down so it is a fixed course of treatment. However different patients will require different doses which is why it needs specialist initiation. FP added she had not been able to discuss this with primary care colleagues but said she would be interested to hear from LD, and its more about the pathway and how to refer the patient back quickly. AC added that this is an ongoing chronic condition and the comment about having good communication between primary and secondary care is important. Another aspect is that all of the acute trusts will hold these patients within their services, so it is important to have consistency across the board. LR put in the chat about stipulating which brand for which indication. AC agreed and asked the question as to why Manchester rejected the application. DP was unsure as to why but said he could look to find out. AW commented that the main evidence in support of the application was published following the adoption of the Manchester position which is the likely basis for the rejection. LD then commented as GPs they would follow the advice from the consultants on how to manage a flare up. Most of these patients will have a specialist nurse if they do not see a consultant regularly but a lot do present to primary care as first port of call. This is due to the time it can take to get advice back from specialists, which can be a few days or even longer in	

	some cases. With advice and guidance, while it does turn around quite quickly it doesn't always, the expectation is that it comes back within 5 working days. However, for a patient having a flare up that is too long, and they are at potential risk of admission to hospital if they become too dehydrated. LD repeated that GPs would normally follow the advice by consultants on how to handle a patients flare up and that she agreed with all the comments made. AC summarised that there is support for Amber 0 with clear advice. He asked if there is a need for guidance to come out with the Amber 0 or is it a case of each individual patient has their own guidance plan that needs to go to the GP for them to then be able to prescribe. It was agreed that there is no requirement for supporting guidance as patients will have individual management plans. Amber 0 was agreed stipulating the indication and brand. AC added the need to go onto the LSCMMG under the acute trust section of it to be added - prescribed by brand and also for individual patients to enable flare ups being managed in a timely manner. **Action** Budesonide M/R 9mg tablets (Cortiment MMX) to be recommended for a change in RAG position from Red to Amber 0, highlighting the requirement to prescribe by brand, at the next Medicines Policy Subgroup.	**DP**
2023/320	**Estradiol (as estradiol hemihydrate) and progesterone 1mg/100mg Soft Capsules (Bijuve®) For continuous combined hormone replacement therapy (HRT) for oestrogen deficiency symptoms in postmenopausal women with intact uterus and with at least 12 months since last menses** This request was considered by LSCMMG a few months ago, however the group did not feel that a position could be agreed due to the lack of primary care input brought about by the transition from CCGs to the ICB. It was sent out to primary care leads again however a response has only been received from Central Lancashire. It is back with a proposal of Green Restricted RAG rating. DP asked as the group have seen the paper before could this now go through or did the group want further discussions. AC asked the group if there were any objections for Green Restricted. There were no objections raised. He asked if the cost was looked at previously. DP answered that they did, it was in the guideline before it was approved then it was taken out, so it just needs to be re-added to the document. AW added that has now come through with the menopause items in Manchester. The Green Restricted was agreed. **Action** Estradiol (as estradiol hemihydrate) and progesterone 1mg/100mg Soft Capsules (Bijuve®) for continuous combined hormone replacement therapy (HRT) to be considered for ratification at the next Medicines Policy Subgroup.	**DP**

2023/321	**MHRA Alert: JAK inhibitors – actions to update web site** DP included the link to the JAK inhibitor MHRA alert for the group to consider. JAK inhibitors have been approved by LSCMMG for various indications and they are included in guidelines such as the Rheumatology guidelines, IBD guidelines and Dermatology guidelines. DP said he felt there should be some link or maybe brief details about the warning at least in the new medicines section of the LSCMMG website. AC asked if this was from the point of view of commencement of these medicines or is it for patients who are already on them. DP said he felt like it could be both. AC then said there needs to be thought on who would be doing the review, and asked what the JAK inhibitors RAG status was. It was highlighted that due to the specialist nature and PBRe classification that they will all be Red RAG rated. AC added that if he was in primary care and got this alert, they would possibly think that it's not down to them to review as it would be with the acute trusts where they are being prescribed. AC suggested adding the link to the website whilst being mindful that we are still figuring out the best way to actually do the work for Sodium Valproate for the guidance for came out before. AC also added for SR to include LSCFT when they are talking about acute trusts. AC summarized that this needs to be sent to the relevant people and a link being added to the website. **<u>Action</u>** DP to send the link to relevant specialists, in addition the link with be added onto the LSCMMG website in each of the relevant guidelines and each JAK inhibitor drug entry.	**DP**

2023/322	**New Medicines Review Workplan** DP presented the workplan, there were no requests included on the work plan for consideration of prioritization. However, following circulation of the papers DP has received a few requests for addition. The first related to Naltrexone for chronic fatigue, following review is has been established that this was a request from a noncommissioned private provider, the request has been addressed with locally, however DP but felt that the group needed to be aware in case other requests are received. There is a request from Lancashire Teaching hospital for Actimorph which is a tablet presentation of morphine. It was initially looked at during COVID for care homes. However, the current application is for palliative care and relates to when patients are dosing themselves or are not able to do that or have problems with the liquid. It would be small numbers; however, the group wouldn't normally look at what is effectively a brand of Morphine but there is a full application so DP that Actimorph could be considered. DJ commented that they discussed this at their governance meeting yesterday. It is clinically approved; it will be in outpatients and there's the potential for GPs to prescribe. He added it is a very small number of patients, but they were unsure if the request fit the criteria for this group, but it is also like a formulary option that needs to go somewhere for the wider review. VG commented that it was his understanding that Blackpool have had a mixed results with this, and they have reviewed locally and decided not to adopt the product. He did agree there might be some individual situations where its useful to have but as a wholesale switch they believe there is too much risk with it. MA then commented that they may not necessarily agree with VG, they have seen a lot of benefits from it in terms of reducing CD errors, liquid balance discrepancies etc. They are keeping for inpatients only and if supply is given on discharge to provide some pain relief it is not to be continued into primary care. They are not asking primary care to prescribe it currently, but it is something they are considering to roll out further for some of their areas. At the moment it is in surgery, but they are looking at women's and potentially in cardiology. AC added it again links to the acute trusts having that formulary available and where it sits and gets discussed and what impacts it has. FP said she had a palliative care consultant ask about it and she had said it probably needs to be brought to this meeting. But she was unsure of the circumstances on where they wanted to use it if it was just in the acute setting or if they wanted it to be prescribed in primary care. AC said he felt it does need to go on for consideration it to be better understood and to work out what position the group takes on it. He added the group needs to be careful of it being used in other areas than palliative before the benefits have really been examined. There is also a risk due to the area's misuse of opioid medication, and adding a slightly different way to take this medication could be seen as easier to take. This needs to be done with eyes wide open to the unintended consequences of having something else available. AW added this is a perfect case for a single formulary and having a system wide approach. DJ added on a separate note that Ibandronic Acid was also requested and asked if it could have a nudge to be prioritized on the work plan as I could potentially free up beds on the chemo unit instead of using Zoledronic acid. In Chemo across the ICB the resources are scarce, and this means there is	

	some sharing of patients happening which is putting added pressure on services so if something can free up half an hour it would be really important. This was agreed to be moved up the work plan as a priority. DJ asked for a possible time frame. DP said if it needs a full consultation it could come to the September LSCMMG, however as it is specialist oncology, he asked if it needed to have a full consultation. AC added that he presumed it would be a Red status to which DP agreed it would be. DJ then commented that it may not be a Red as it is an oral option to keep patients calcium low. AC responded that it could be done faster if it was for the Red RAG, however if they are looking at Amber it will take longer for a decision to ensure everyone has had fair chance to look at it. DJ said he would check what they were proposing. AW added at the end of this conversation a request to add proposed time frames to the work plan to help reduce matters arising and could help reprioritise things clinically if it is also on the website with proposed time frames. DP said this would be easily done as they have the dates on the teams master work programme, however they aren't included on this document. DP added that there was a request for Triptorelin for precocious puberty. The group agreed for this to go onto the work plan. There was also a request to look at glucose blood monitors. There is already NHSE guidance on that so there may not be much to do but DP brought it for people to be aware. Aintree have got in touch for the sleep pathway asking for Pitolisant again. Manchester have adopted Mersey's sleep pathway. This is wider than a medicines review but again DP brought it so people are aware that it is being looked into. **<u>Actions</u>** Actimorph to be added to the work plan. Ibandronic Acid to be moved up the prioritisation list. DJ to find out the requested RAG status for Ibandronic Acid. DP to add proposed time frames for items on the Work plan.	**DP** **DP** **DJ** **DP**

GUIDELINES and INFORMATION LEAFLETS		
2023/323	**Sodium Zirconium Cyclosilicate – Evidence Review** AGR summarized what LSCMMG had previously considered in relation to sodium zirconium cyclosilicate. It was previously presented to the group that NICE have stated that sodium zirconium cyclosilicate should now be available in both primary and secondary care. Specifically, the criteria have changed in recommendation 1.1 to include those not on dialysis. Sodium zirconium cyclosilicate is currently RAG rated 'Red' by LSCMMG. A LSCMMG consultation was circulated to consider whether it should remain a Red RAG status, with secondary care absorbing the cost, as it is not on the high-cost drug list, or should it be an Amber 0 status and prescribable in primary care. Two areas supported a Red RAG rating, four areas supported Amber 0. However, there were ongoing concerns, and it was requested that prescribing guidance should be developed and brought back to the group before altering the RAG status. This guidance was produced in September 2022 and was sent out for consultation with responses to be received by 4th November 2022. One of five ICB places and two of five provider trusts responded by the closing date. Responses were also received from the Heart Failure Team at UHMB and the Morecambe Bay LMC. Both provider trusts agreed with the guidance, the remaining respondents disagreed/requested amendments. The main point raised within the consultation responses was whether additional information needs to be added to specify when care is transferred to primary care and how responsibility for blood monitoring is allocated; or whether shared care is more appropriate. The guideline was also discussed at the November meeting of the LSCMMG. It was agreed that further comments would be collated from LTH renal team and East Lancashire. Following this meeting, it was further agreed that the hub team would meet with clinicians specifically in East Lancashire to listen to their concerns. In summary, East Lancashire clinicians felt that the evidence is not great for the long-term use of sodium zirconium cyclosilicate, including a lack of outcomes data. It was proposed that a summary of the evidence would be presented at a later meeting before agreeing whether to change the RAG status from Red to Amber 0. AGR confirmed that both NICE and the SMC had produced reviews. The SMC considered two indications for sodium zirconium cyclosilicate: chronic hyperkalaemia in adults with chronic kidney disease (CKD) stage 3b to 5 and/or heart failure, and acute life-threatening hyperkalaemia in adults., NHS Scotland endorsed use for patients with hyperkalaemia (defined as a serum potassium of >6.0mmol/L) with chronic kidney disease (CKD) stage 3b to 5 and/or heart failure, who would otherwise need to down-titrate or discontinue their renin-angiotensin-aldosterone system inhibitor (RAASi) therapy to maintain a clinically acceptable serum potassium level (normokalaemia). In summary, the SMC reviewed three phase III RCTs that compared sodium zirconium cyclosilicate with placebo or standard of care in patients	

	with CKD and/or heart failure. The trials showed that sodium zirconium cyclosilicate was more effective than placebo or standard care in reducing serum potassium levels and maintaining them within the normal range over 12 months. In all three studies efficacy was assessed in patients who had received at least one dose of study drug and had at least one post-baseline assessment during the relevant period (that is acute phase or maintenance phase). AGR highlighted that the study ZS-005 was the longest and most relevant study for primary care use. In study ZS-005 the primary outcome in the acute phase was the proportion of patients who achieved normal serum potassium (3.5 to 5.0 mmol/L). This was achieved in 78% (583/748) of patients within 72 hours, and in 66% (494/748) of patients in the initial 24 hours. In the maintenance phase the primary efficacy endpoint, proportion of patients maintaining normal serum potassium (defined as mean ≤5.1mmol/L between months 3 and 13) was achieved by 88% (571/646) of patients. The maintenance phase of study ZS-005 was 1 year (365 days). There were subgroup analyses of outcomes from ZS-003, ZS-004 and ZS-005 which were generally consistent with analyses in the total study populations. The EMA review noted that the applicant concluded that sodium zirconium cyclosilicate reduced serum potassium and maintained normokalaemia independently of the underlying cause of hyperkalaemia, demonstrating similar efficacy in subjects with CKD, heart failure, and diabetes mellitus, as well as in subjects receiving concomitant treatment with RAASi medication. The SMC also reviewed cost-effectiveness, comparing sodium zirconium cyclosilicate with standard care in patients with acute life-threatening hyperkalaemia. The analysis estimated that sodium zirconium cyclosilicate was associated with lower costs and higher quality-adjusted life years (QALYs) than standard of care, but there was uncertainty due to limited clinical data and assumptions in the model. NICE also reviewed the evidence for TA 599 for its use in treating hyperkalaemia in adults. NICE recommended that sodium zirconium cyclosilicate as an option for treating hyperkalaemia in adults only if used. In summary, NICE acknowledged that there is no direct evidence that sodium zirconium cyclosilicate extends life or improves quality of life, but it may allow people to stay on RAAS inhibitors for longer, which may have these benefits. NICE reviewed the same studies that were reviewed by the SMC. AGR highlighted that ZS005 was the longest trial, with follow up of 52 weeks. The company provided no evidence for the effectiveness of sodium zirconium cyclosilicate beyond 52 weeks. The NICE committee concluded that, although the trial results showed that continuing sodium zirconium cyclosilicate was associated with lower serum potassium than stopping the drug, there was no direct evidence that sodium zirconium cyclosilicate improves survival or quality of life over other treatments for people with chronic hyperkalaemia. NICE also noted the following: In the population being considered, stopping RAAS inhibitors would generally be associated with an increased risk of adverse outcomes and	

	disease progression. The committee was not satisfied that the company had presented robust data on how sodium zirconium cyclosilicate alters dosing of RAAS inhibitors compared with standard care, or the extent to which such alterations improved length and quality of life. AGR summarized that both SMC and NICE acknowledged the clinical need for effective and well-tolerated treatments for hyperkalaemia, especially for patients with CKD and/or heart failure who are at risk of cardiovascular complications. Both also recognised the limitations of the current evidence base for sodium zirconium cyclosilicate, such as the lack of long-term data on clinical outcomes, the indirect comparisons with other potassium binders, and the uncertainty in the cost-effectiveness analyses. AGR also mentioned that a recent meta-analysis was available in the literature but as the longest trial included was 14-days it was not directly applicable to the indication being considered. AW then added that patiromer is Red so in his opinion either make them both Red or both Amber, and that they both have such small numbers it felt specialist to him. AC agreed and added he was surprised it was such small numbers of Sodium Zirconium Cyclosilicate, he felt it would be higher due to the population. FP added that when they first discussed this around six months ago with the prescribing lead the concern was around monitoring and it being very specialist. She said she was still inclined to say Red looking at the patient numbers, but added if the numbers rise and the NICE guidance doesn't change then would potentially look at it again. She acknowledged that members shouldn't look at patient numbers for decisions but added the need to be pragmatic with services. And if it was looked at again that it would need to be looked at as shared care. To conclude she would want Red due to small numbers, and if these number increases and the services are put under pressure then she would assume shared care would be an option. DJ added he felt there definitely is an appetite from the renal team at Lancashire Teaching hospitals to move this forward in terms of Amber or possibly shared care. This would enable these patients to be prescribed other medicines that their GP would be prescribing, but that he agreed that the monitoring requirements for this are key. So, there would need to be clear direction on who's doing what. AS said that the heart failure team at UHMB were keener to get Patiromer as Amber rather than Sodium Zirconium and AC asked if this was being looked at. AGR said that it wasn't with this piece of work an DP said he wasn't looking at it either. He added this is all about the management of heart failure in primary care and he was unsure how this could be done. He added it could be possible to make this some form of Amber but there needed to be a support mechanism in the community which is probably a sticking point. So maybe a bigger piece of work needs to be done should the group want to consider moving it forward. In conclusion it was agreed for Sodium Zirconium to remain Red due to patient numbers, ongoing monitoring requirements and the limited evidence base and that if the numbers increase it would be reviewed. Patiromer should be considered for a review as discussed, as Heart Failure links with wider cardiovascular issues AC and AW to consider the best avenue for this to be progressed.	

	Action AC and AW to consider the best avenue for work relating to Heart Failure to be progressed.	
2923/324	**Gout Guidance – Update** AGR introduced the paper. There were some comments after the initial approval, they were primarily from East Lancashire which AGR has actioned. He has come up with a compromise with the second point of low dose corticosteroid, it did have 10-20mg and with looking at it again with different sources the consensus seemed to be the range to be between 5-15mg. The exact wording AGR has put in the guideline is: 'short term low dose corticosteroid at the lowest effective dose (range: prednisolone 5 – 15mg daily). He said he could add 'recommended or possible range' to make it softer if preferred. AC commented that it was trying to blend both the NICE and British Society for Rheumatology documents which were slightly different and independent, but he felt it explains it and was content with it. AB mentioned that another comment sent in was about the bottom left box on page one, which is headed Chronic Gout Management, under alternative first line Febuxostat it says the target SUA is more then 300 but it should read to be 360 the same as for Allopurinol. Other comments have been resolved. AGR will look into the dosing for Febuxostat. AW also added a comment about having consistency with the documents style. LD asked if the guidance included that patients on Febuxostat needing to have annual assessments for cardiac risk and also added that it is one of their CQC requirements. It's one of the searches that they do to see if all patients on Febuxostat have had an CVD assessment so is something primary care are very aware about, but it should be in the guidance as well. AGR said he would get it added in. AC commented that it does say 'treat cardiovascular risk factors and review annually' in the box about acute management but possibly needs highlighting specifically for Febuxostat. AC added once the changes have been made the document can go onto the website without returning to this meeting. **Action** AGR will look into the dosing for Febuxostat to change from 300 to 360. AGR to make the style of the document consistent with other documents on the website. AGR to add in cardiovascular risk assessments to be completed annually for patients on Febuxostat.	**AGR** **AGR** **AGR**

2023/325	**Camouflaging Products – Update** AGR confirmed there was a very slight change in the background information, but no material changes, it was a change for clarity. FP asked what specialist service are available for this. AGR said there is one nurse who accepts referrals in the ICS. FP then asked if prescribers are aware of the service to which AC asked if LD was aware if it was in the wider prescriber information. LD said that there are a number of other services that she had come across through patients knowing of them such as veteran service. FP then added if it was worth listing them all and AW suggested adding the link into the service if available. **Action** AGR to add link into the service to the document if available, the final document to be uploaded to the LSCMMG website.	**AGR**
2023/326	**Guidelines Workplan** AGR has re-ordered it to make it more realistic. He has also added in some of the ELMMB/ LSCFT LSCMMG website transfer items that were agreed last time. He has tried to order things in order of urgency, they aren't all on there, but he has tried to squeeze things in based on discussions he has had with John in the past and they will start coming through next month. MP has emailed and asked for a review of the RAG of Cenobamate for focal seizures. It is currently Red and this is based on the level of evidence that NICE defined in the TA which wasn't great as it included some uncertainties in the trial date, it had no direct comparison studies. The request is to review for an Amber RAG rating, so if the group is happy AGR will add it to the work plan, and they will do a review and maybe go out for consultation. This was agreed to go onto the work plan. The next request was from UHMB, they have sent a draft azithromycin shared care guideline through, and they are asking for consideration for adoption by LSCMMG. LSCMMG doesn't currently have a RAG rating for this, just the ones from ICB, and the indication is for respiratory use long term. The draft is not in the usual format and there is a PIL in there as well, so the ask is for it to be added and to the work plan with prioritization as well. So, for LSCMMG to look at with a view to adopting the shared care for it as AGR was not aware of any other shared care for this. FP and AS said they didn't think the document was for shared care, but more of an information leaflet on what should be done. For it to be Amber 0 initiation by specialist and continued in primary care. AGR gave apologies as the document sent through to him was for a shared care agreement and asked if it was just an information sheet that was wanted. Both FP and AS agreed for just an information sheet, FP also added for discussions on the proposed RAG of Amber 0 with consultations with other microbiologists to ensure all are in agreement. AW added that in conversations that CM had earlier in the week around QIPP there was a need for policy rather than guidelines. So, if there are things people would like in particular any do not prescribe, and they can be put into policy it would be helpful and to get them in quickly. He added that the ones discussed at the meeting were Cyanocobalamin tablets and Infant feeds. This was also agreed to go onto the guidelines work plan.	

NATIONAL DECISIONS FOR IMPLEMENTATION		
2023/327	**New NICE Technology Appraisal Guidance for Medicines March 2023** There were no NICE TAs for discussion this month.	
2023/328	**New NHS England medicines commissioning policies April 2023** Nothing urgent to consider, not on the agenda.	
2023/329	**Regional Medicines Optimisation Committees – Outputs for April 2023** None.	
2023/330	**Evidence reviews published by SMC or AWMSG March/April 2023** Nothing for us at the moment.	
ITEMS FOR INFORMATION		
2023/331	**Lancashire and South Cumbria NHSFT Drug and Therapeutic Committee** Nothing to update apart from the next meeting date which is the 25th May 2023.	
2023/332	**Cost Pressures Log** The log has been updated as highlighted earlier during the action log in terms of Finerenone and IQoro. There is only one decision that is felt will have a cost impact from today's meeting which is TheraBite. No cost pressure was included on the log when circulated, as information from the clinician was awaited. Now they have had the estimated cost pressure the log will be updated, but there is nothing else to note this month.	

2023/333	**AoB** AS had an item of AoB. She said that UHMB have some local shared care guidelines which aren't generated by LSCMMG. They are now having resistance from the ICB local team about implementing them. She asked if in the future will there be a facility to have local guidelines or will everything be ICB wide. AW answered that ideally it they will all be ICB wide having one standard across the patch, but he understands there is some rurality issues particularly in Morecambe Bay. He also said his understanding was that these guidelines hadn't gone through local D&T but through some other mechanism. AS said, they had all been through the local D&T at the trust and were approved by the CCG over the years. AW asked if they are different to positions elsewhere or, do they not have a position in the system at all for them. AS responded that the main one for query is Denosumab 120mg as LSCMMG have it as Red and they have it as Amber with shared care mainly due to the rurality. AW then said if you look at the LSCMMG website there is a mix of different RAG status as this group was advisory previously and things were agreed locally. Now with it moving to a decision-making group all places will have the same RAG status for each place. In this case it may need to come back here for review to which AS said she would be happy to have it reviewed. FP asked if AS had sent them to LSCMMG, AGR commented that he had received them, and the plan is to bring an update to the next meeting. BH added that Denosumab should be considered as a priority to be looked at. **Action** AGR to look at the documents from AS for review with Denosumab being a priority with a view to bring an update to the next meeting.	**AGR**

DATE AND TIME OF NEXT MEETING

The next meeting will take place on

Thursday 8th June 2023

9:30am – 11:30am

ACTION SHEET FROM THE
LANCASHIRE AND SOUTH CUMBRIA MEDICINES
MANAGEMENT GROUP 11.05.2023

ACTION SHEET FROM THE MEETING 13th October 2022				
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.	**CSU**	**Closed**	**13.10.2022**
	November 2022 update: AGR will contact LMC regarding this item.	**AGR**	**Closed**	**10.11.2022**
	December 2022 update: AGR has met with LMC, now awaiting their further feedback.	**AGR**	**Closed**	**08.12.2022**
	January 2023 update: AGR still awaiting feedback from the LMC, AGR will chase.	**AGR**	**Closed**	**12.01.2023**
	February 2023 update: AGR still needs to chase, will bring back to the next meeting.	**AGR**	**Closed**	**09.02.2023**
	March 2023 update: AGR is struggling to engage. AGR to link in with LD for her to support.	**AGR/LD**	**Open**	**09.03.2023**
	April 2023 update: AGR still progressing	**AGR/LD**	**Open**	**20.04.2023**
	May 2023 update: Still ongoing.	**AGR/LD**	**Open**	**11.05.2023**
ACTION SHEET FROM THE MEETING 10th November 2022				
2022/180	**Keppra Position Statement** **February 2023 update:** DJ updated from neurology, the summary being that they support the prescribing of generics but not for switching patients already on Keppra. Patient anxieties around switching is acknowledged, but due to costing the switch needs to happen. The group thanks the neurology services for their input and AC is going to raise up to Jerry Skills and Medical Directors.	**AC**	**Open**	**09.02.2023**
	March 2023 update: AC will link in with Mark Brady as Jerry is now on leave, AC will	**AC/DJ**	**Open**	**09.03.2023**

	also bring in DJ into the discussions. **April 2023 update:** Communication has taken place with the directorate; they have raised 3 areas. First could there be support for implementing the changes, secondly there needs to be support from the ICB in terms of communication and finally there needs to be provision for patients who have any adverse issues associated with the switch. Work is ongoing. AC updated that David Levy, Andy White and AC are meeting on the 27th, to discuss the issue and it's become a must do piece of work to switch patients to the generic. DJ highlighted that if the switch is undertaken in primary care that this would address some of the specialists concerns in relation to resource. To be agreed by medical directors on the 5th of May as a system approach. **May 2023 update:** Further conversations have been had, it was decided to move ahead with this and if neurology needs additional support to do this then there may need to be a look to see where the funding could come from. It is noted that their nervousness around having more work to do, and that it is not necessarily that the increased resource is in the neurology specialist service but maybe more in primary care for people doing the switch. It may have to go out without the full support of the neurology team. AW agreed this needs doing sooner due to being a QIPP win. AC asked for it to be brought back to the next meeting with the idea of closing it at that meeting. DJ requested it be added to a risk register if not already done, DP said it hadn't been done one a quality/ equality impact assessment report. A new action here for AW to complete and share the QIA and EIA with members for comments.	**AC/DJ** **AC/DJ** **AW**	**Open** **Open** **Open**	**20.04.2023** **11.05.2023** **11.05.2023**
ACTION SHEET FROM THE MEETING 8TH December 2022				

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. **February 2023 update:** AGR met with East Lancashire and updated the group. The evidence is not great with a lack of outcomes data. It was proposed to do an updated review including the pressure on primary care and bring back to a later meeting. This was agreed and AGR will bring back to a future meeting. **March 2023 update:** Smaller evidence review will come to April's meeting. **April 2023 update:** Deferred to May so that AG can present. **May 2023 update:** On the agenda, close this action.	**AGR/LR** **AGR/LR** **AGR** **AGR** **AGR** **AGR**	**Closed** **Closed** **Closed** **Closed** **Closed** **Closed**	**08.12.2022** **12.01.2023** **09.02.2023** **09.02.2023** **20.04.2023** **11.05.2023**
ACTION SHEET FROM THE MEETING 12TH January 2023				
2023/226	**Menopause guidance – Update** AGR to change patches to the first choice in the document instead of oral. **February 2023 update:** AGR has made the amendments and is waiting for BH to look over the document to send over to Kath Gulson. Once ready, AGR to include Kath Gulson and community pharmacy in the circulation of the document. Still awaiting final checks before send out. **March 2023 update:** BH and AGR to meet to finalize before sending Kath Gulson. LD to also support bringing someone from primary care to this group. **April 2023 update:** Work ongoing, this will be prioritised over the coming weeks. **May 2023 update:** It was more difficult to set up the automated updates, but the draft is done and is awaiting to be QA'd. Will bring the final draft version to the next meeting	**AGR** **AGR** **AGR** **AGR/BH** **AGR/BH**	**Closed** **Closed** **Closed** **Open** **Open**	**12.01.2023** **09.02.2023** **09.03.2023** **20.04.2023** **11.05.2023**

ACTION SHEET FROM THE MEETING 9TH February 2023				
2023/244	**Estradiol (as estradiol hemihydrate) and progesterone 1mg/100mg soft capsules (Bijuve®) HRT** Leads to take this discussion to their places and find out if prescribers are happy with the amendment to the status only and feedback to DP. **March 2023 update:** This was difficult to approve due to recent changes in response to formation of the ICB. DP to link in with LR around what was required of this as she wasn't present for this original item. **April 2023 update:** Responses received from GP/CSR supporting a Green Restricted RAG rating. Agreed to be an agenda item for the next meeting where a final RAG position to be agreed. **May 2023 update:** On the agenda, closed.	**CM,NB, MP,LR, FP** **DP/LR** **DP** **DP**	**Open** **Open** **Open** **Closed**	**09.02.2023** **09.03.2023** **20.04.2023** **11.05.2023**
ACTION SHEET FROM THE MEETING 9th March 2023				
2023/268	**Melatonin RAG rating** Leads to send out this information to GPs and getting feedback on proposed RAG status. DP to take back comments received and split into areas of adult and children. To add additional indications on to the workplan and to review the evidence. **April 2023 update:** Work ongoing, there is a new product available which is cheaper than current alternatives. Recognised this is a large piece of work to complete. **May 2023 update:** Still on going, take off from here and add to the new meds work plan.	**CM,NB, MP,LR, FP** **DP** **DP** **DP**	**Open** **Open** **Open** **Closed**	**09.03.2023** **09.03.2023** **20.04.2023** **11.05.2023**
2023/271	**COPD guideline – update** DP and team to revisit the document and create a simplified version like done previously with the asthma inhaler guideline and bring back to the group. **April 2023 update:** Has been reviewed by the project group, work ongoing. To remain on the action log until complete, aim to come to the May	**DP** **DP**	**Open** **Open**	**09.03.2023** **20.04.2023**

	LSCMMG. **May 2023 update:** Comments proposed by respiratory group, to be incorporated and further discussion with respiratory group	**DP**	**Open**	**11.5.2023**
2023/274	**Gout guideline – update** AGR to upload to the website. **April 2023 update:** Queries from ELMMB on a couple of the elements in the guideline including the dose of prednisolone. AB forwarded comments to AGR yesterday in relation to the Antipsychotic shared care, gout guideline and another document. AGR to review and bring an update to a further meeting. **May 2023 update:** Lots of updates so still in production, will bring back to a future meeting. Close here as is on the work plan.	**AGR** **AGR** **AGR**	**Open** **Open** **Closed**	**09.03.2023** **20.04.2023** **11.05.2023**
2023/278	**Managing convulsive (tonic-clonic) status epilepticus (adults) guideline** DP to prepare the document to be sent out to acute trust leads for them to feed back to him or AGR any comments. Then bring back to the group. **April 2023 update:** Responses received from BTH, ELHT and UHMB. All are in agreement with the guideline. The document was approved. To be placed on a new section of the LSCMMG website for Acute Trust documents, an update on this section will be brought to the next meeting to ensure members are in agreement with the position of the document on the website. **May 2023 update:** On the website, under new section, closed.	**DP** **DP** **DP**	**Open** **Open** **Closed**	**09.03.2023** **20.04.2023** **11.05.2023**
2023/286	**Developing a single joint formulary for Lancashire and South Cumbria** EB/BH to send an email detailing the ask for volunteers for the single formulary working group. **April 2023 update:** A few names have been provided. AW / BH to meet to agree the oversight group membership. Members to contact BH with any nominations. **May 2023 update:** There is the first meeting of the Formulary oversight group this afternoon.	**EB/BH** **AW/BH**	**Open** **Closed**	**09.03.2023** **20.04.2023**

ACTION SHEET FROM THE MEETING 20th April 2023				
2023/291	**Ogluo (glucagon solution for injection in pre-filled pen, 0.5mg and 1.0mg)** Ogluo to be given a Green RAG rating with the development of prescribing guidance to support the identification of appropriate patients in whom Ogluo should be initiated. **May 2023 update:** DP still to do prescribing guidance then will send to the Medicines Policy Subgroup for ratification, can be closed once it goes to the Medicines Policy Subgroup.	**DP** **DP**	**Open** **Open**	**20.04.2023** **11.05.2023**
2023/292	**IQoro for treatment of hiatus hernia and for treatment of stroke related dysphagia.** IQoro to be given a Red RAG rating for stroke related dysphagia and a Do Not Prescribe RAG rating for hiatus hernia. **May 2023 update:** Done, to go to Medicines Policy Subgroup.	**DP** **DP**	**Open** **Closed**	**20.04.2023** **11.05.2023**
	DP to recalculate the cost pressure and update the cost pressure log **May 2023 update:** Log has been updated, will now go to the quality meeting. BH added there needs to be another Medicines Policy's task and finish group to ratify the outputs from the last few meetings.	**DP** **AW**	**Open** **Open**	**20.04.2023** **11.05.2023**
2023/293	**Sevelamer generic** Sevelamer carbonate to be made available. The information leaflet will be adopted by LSCMMG and will be amended to include the LSCMMG Logo and housed on the LSCMMG website. **May 2023 update:** In the process of being adopted and will be uploaded to the LSCMMG website once complete.	**DP** **DP** **DP**	**Open** **Open** **Closed**	**20.04.2023** **20.04.2023** **11.05.2023**

2023/294	**Baricitinib in the Treatment of Patients Hospitalised Due to COVID-19** DP to contact Jenny Oakley to gain feedback from the Chief Pharmacists and the policy will be considered at the next meeting. **May 2023 update:** Jenny Oakley (JO) presented the feedback to the group. Most trust critical care and respiratory consultants would like continued access to Baricitinib. There is a request for further clarity and consistency across the patch. Small numbers have been recorded so now the estimated cost needs to be checked. BH to work with JO to reword the NHSE Blueteq form for adoption across LSC and look at creating guidance to go on LSCMMG. JO to collate data for it to go onto the LSCMMG.	**DP** **BH/JO** **JO**	**Open** **Open** **Open**	**20.04.2023** **11.05.2023** **11.05.2023**
2023/295	**New Medicines Review Workplan** Avanafil, Ibandronic Acid, Flupentixol oral, Tacrolimus and Softacort to be added to the workplan. The formulary approach was agreed in principle for final sign off by the formulary oversight group. **May 2023 update:** Items added to the workplan and the first formulary meeting is this afternoon.	**DP** **DP** **DP**	**Open** **Open** **Closed**	**20.04.2023** **20.04.2023** **11.05.2023**
2023/296	**Trans anal irrigation devices – update** The updated version of the position statement will be uploaded to the LSCMMG website. **May 2023 update:** On the website, closed.	**AGR/PT** **AGR/PT**	**Open** **Closed**	**20.04.2023** **11.05.2023**
2023/297	**Vitamin D position statement – update** The position statement will be amended to alter “Black” RAG positions to “Do Not Prescribe” and will then be added to the LSCMMG website. **May 2023 update:** On the website, closed.	**AGR/PT** **AGR/PT**	**Open** **Closed**	**20.04.2023** **11.05.2023**

2023/298	**Colomycin® prescriber information sheet – update** The colomycin® position statement will be updated in line with the discussions at the meeting and added to the LSCMMG website.	**AGR/PT**	**Open**	**20.04.2023**
	May 2023 update: On the website, closed.	**AGR/PT**	**Closed**	**11.05.2023**
2023/299	**Benzodiazepine withdrawal draft guideline** AGR will liaise with the contacts outlined in the meeting and form a working group to produce a benzodiazepine resource section on the website. AGR will also consult on the benzodiazepine guidance document.	**AGR**	**Open**	**20.04.2023**
	May 2023 update: Ongoing, put onto the work plan close this action.	**AGR**	**Closed**	**11.05.2023**
2023/300	**MHRA PIL – safe use of fentanyl patches** AGR to bring the MHRA risk of addiction and dependence document to the next LSCMMG meeting for approval.	**AGR**	**Open**	**20.04.2023**
	May 2023 update: AGR will bring to the next meeting.	**AGR**	**Open**	**11.05.2023**
	A link to the MHRA safe use of fentanyl patches document will be added to the website resources (and fentanyl patch medicines entries) and the MLCSU will contact the MHRA querying the recommendation to dial 999 in the safe use of fentanyl patches document.	**AGR/PT**	**Open**	**20.04.2023**
	May 2023 update: Done, closed.	**AGR/PT**	**Closed**	**11.05.2023**
2023/301	**Erectile dysfunction guideline – update** MLCSU to conduct a review of Avanafil® including comparing the side effect profiles of different agents.	**AGR**	**Open**	**20.04.2023**
	May 2023 update: Ongoing, put onto the work plan close this action.	**AGR**	**Closed**	**11.05.2023**
	Once the position of avanafil has been finalised, an updated Erectile dysfunction guideline to be brought back to LSCMMG.	**AGR**	**Open**	**20.04.2023**
	May 2023 update: Ongoing, put onto the work plan close this action.	**AGR**	**Closed**	**11.05.2023**

2023/302	**Asthma guideline, minor update** The updated Asthma guideline will be added to the LSCMMG website.	**DP**	**Open**	**20.04.2023**
	May 2023 update: Done, closed.	**DP**	**Closed**	**11.05.2023**
2023/303	**Guidelines Workplan – Lipids** The LSCMMG supported the approach of re-endorsing the existing national document with a simplified document.	**DP**	**Open**	**20.04.2023**
	May 2023 update: Has been split into primary and secondary. One is complete, the other is still being drafted. Will try to bring to next month's meeting.	**DP**	**Closed**	**11.05.2023**
2023/304	**New NICE Technology Appraisal Guidance for Medicines March 2023** AGR to review the cost template and RAG status for Finerenone.	**AGR**	**Open**	**20.04.2023**
	May 2023 update: There is not costing template so AGR is unable to be more specific with costing. The proposed RAG status is Green as the renal cut off is around the same as Dapagliflozin. There was some reservation in primary care as clinicians are not familiar with it. MLCSU to draft information sheet with a recommendation of Green to the next meeting.	**AGR**	**Open**	**11.05.2023**
	MLCSU to liaise with AW and MP to draft a risk register entry and liaise with colleagues to produce an EIRA in relation to Saxenda® and Wegovy®.	**BH**	**Open**	**20.04.2023**
	May 2023 update: Paul is working on the new Equality and Health Inequality impact and risk assessment which is the new EIRA. Would be helpful to take to a commissioner and wider than medicines, Jane Miller or Steve Flynn would be good to link into.	**BH**	**Open**	**11.05.2023**
	MLCSU to contact Jenny Oakley to ascertain which drugs are being requested by clinicians in intensive care to manage COVID.	**AGR**	**Open**	**20.04.2023**
	May 2023 update: AGR has some other people to contact which he will do after this meeting.	**AGR**	**Open**	**11.05.2023**

2023/311	**LSCMMG cost pressures log** DP/BH to update the cost pressure log with revised costs for IQoro and Finerenone. **May 2023 update:** Has been updated to include IQoro. Is now costed for 70 devices a year (£8,000 a year). As there is no cost template for Finerenone it remains at £9,000 per 100,000 at a cost for £144 for the ICB. Closed.	**BH/DP** **BH/DP**	**Open** **Closed**	**20.04.2023** **11.05.2023**
ACTION SHEET FROM THE MEETING 11th May 2023				
2023/315	**Minutes and action sheet from the last meeting 20th April 2023** EB to amend the minutes before uploading them to the website.	**EB**	**Open**	**11.05.2023**
2023/317	**Trifarotene (Aklief®) 50 microgram/g cream for the cutaneous treatment of acne vulgaris of the face and/or the trunk in patients from 12 years of age and older, when many comedones, papules and pustules are present** Trifarotene (Aklief®) 50 microgram/g cream for the cutaneous treatment of acne vulgaris, a Green RAG rating will be considered for ratification at the next Medicines Policy Subgroup.	**DP**	**Open**	**11.05.2023**
2023/318	**TheraBite® Jaw Rehabilitation Device for the treatment of trismus and mandibular hypomobility** TheraBite® Jaw Rehabilitation Device for the treatment of trismus and mandibular hypomobility, a Red RAG rating will be considered for ratification at the next Medicines Policy Subgroup. AS to feedback discussion on the Red RAG decision to MaxFax specialists.	**DP** **AS**	**Open** **Open**	**11.05.2023** **11.05.2023**
2023/319	**Budesonide M/R 9mg tablets (Cortiment MMX) For induction of remission in adults with mild to moderate active ulcerative colitis where 5-ASA (aminosalicylate) treatment is not sufficient - RAG status change proposal** Budesonide M/R 9mg tablets (Cortiment MMX) to be recommended for a change in RAG position from Red to Amber	**DP**	**Open**	**11.05.2023**

	0, highlighting the requirement to prescribe by brand, at the next Medicines Policy Subgroup.			
2023/320	**Estradiol (as estradiol hemihydrate) and progesterone 1mg/100mg Soft Capsules (Bijuve®) For continuous combined hormone replacement therapy (HRT) for oestrogen deficiency symptoms in postmenopausal women with intact uterus and with at least 12 months since last menses** Estradiol (as estradiol hemihydrate) and progesterone 1mg/100mg Soft Capsules (Bijuve®) for continuous combined hormone replacement therapy (HRT) to be considered for ratification at the next Medicines Policy Subgroup.	**DP**	**Open**	**11.05.2023**
2023/321	**MHRA Alert: JAK inhibitors – actions to update web site** DP to send the link to relevant specialists, in addition the link with be added onto the LSCMMG website in each of the relevant guidelines and each JAK inhibitor drug entry.	**DP**	**Open**	**11.05.2023**
2023/322	**New Medicines Review Workplan** Actimorph to be added to the work plan. Ibandronic Acid to be added to the work plan and prioritised. DJ to find out the request RAG status for Ibandronic Acid. DP to add proposed time frames for items on the Work plan.	**DP** **DP** **DJ** **DP**	**Open** **Open** **Open** **Open**	**11.05.2023** **11.05.2023** **11.05.2023** **11.05.2023**
2023/323	**Sodium Zirconium Cyclosilicate – Evidence Review** AC and AW to consider the best avenue for work relating to Heart Failure to be progressed.	**AC / AW**	**Open**	**11.05.2023**

2023/324	**Gout Guidance – Update** AGR will look into the dosing for Febuxostat to change from 300 to 360. AGR to make the style of the document consistent with other documents on the website. AGR to add in cardiovascular risk assessments to be completed annually for patients on Febuxostat.	**AGR** **AGR** **AGR**	**Open** **Open** **Open**	**11.05.2023** **11.05.2023** **11.05.2023**
2023/325	**Camouflaging Products – Update** AGR to add link into the service to the document if available, the final document to be uploaded to the LSCMMG website.	**AGR**	**Open**	**11.05.2023**
2023/333	**AGR to look at the documents from AS for review with Denosumab being a priority with a view to bring an update to the next meeting.** AGR to look at the documents from AS for review with Denosumab being a priority with a view to bring an update to the next meeting.	**AGR**	**Open**	**11.05.2023**