Minutes of the **Medicines Programme Board** held via Microsoft Teams, on **Wednesday, 21st May 2025.**

Present:	Dr Andrew Tresidder (AT)	Chair, NHS Somerset, Clinical Lead for Medicines Management and Evidence Based Interventions
	Peter Berman (PB)	Lay Representative
	Daniela Broughton (DB)	Prescribing Technician, NHS Somerset
	Bernice Cooke (BC)	Director of Nursing and Deputy Chief Nursing Officer Patient Safety Specialist, NHS Somerset
	Dr Orla Dunn (OD)	Consultant in Public Health, Somerset Council
	Dr David Davies (DD)	West Somerset Representative
	Tess Dawoud (TD)	Community Pharmacy Clinical Lead, ICB
	Peter Fee (PF)	Taunton Representative
	Shaun Green (SG)	Chief Pharmacist, NHS Somerset
	Dr Matthew Hayman (MH)	Chair of Drugs & Therapeutics Committee, SFT
	Carly Jackson (CJ)	Transformation Manager, Neighbourhood Development Team, ICB
	Esther Kubiak (EK)	Medicines Manager, and MSO NHS Somerset
	Yvonne Lamb (YL)	Operations Manager, CPS
	Sam Morris (SM)	Medicines Manager, NHS Somerset
	Andrew Prowse (AP)	Director of Pharmacy, Chair of Drugs and Therapeutics committee, SFT
	Dr Rob Tippin (RT)	LMC and Mendip Representative
	Mihaela Tirnoveanu (MT)	Taunton Representative
	Donna Yell (DY)	Pharmacoeconomics Lead and Formulary Manager, YDH
Apologies:	Dr Val Sprague (VS)	Bridgwater Representative
	Zoe Talbot (ZT)	Prescribing Technician, NHS Somerset

1 APOLOGIES AND INTRODUCTIONS

SG welcomed everyone to the Medicines Programme Board.

2 REGISTER OF MEMBERS' INTERESTS

2.1 The Medicines Programme Board received the Register of Members' Interests relevant to its membership.

The Medicines Programme Board noted the Register of Members' Interests.

3 DECLARATIONS OF INTEREST RELATING TO ITEMS ON THE AGENDA

3.1 Under the NHS Somerset's arrangements for managing conflicts of interest, any member making a declaration of interest is able to participate in the discussion of

the particular agenda item concerned, where appropriate, but is excluded from the decision-making and voting process if a vote is required. In these circumstances, there must be confirmation that the meeting remains quorate in order for voting to proceed. If a conflict of interest is declared by the Chairman, the agenda item in question would be chaired by a nominated member of the Medicines Programme Board.

There were no declarations of interest relating to items on the agenda.

4 MINUTES OF THE MEETING HELD ON 26th March 2025

4.1 The Minutes of the meeting held on 26th March were agreed as a correct record.

4.2 **Review of action points**

Action 5: YL - The EHC service was going to be taken over and commissioned by the ICB, then it was announced that a national EHC PGD will be coming out, hopefully in October if all goes to plan. Therefore, it has been agreed that the Council will retain EHC for now and wait for the national one to come in. The Council have made it available to everyone, so the 25 years and under criteria has been removed and they have upped the fee for the PGD for Pharmacists from £11 to £14. They've extended it to March 2026, but with the national one expected in October, that will supersede so it was agreed that it would be easier to keep it with the Council for now, rather than making lots of changes.

5 Matters Arising

5.1 **Supplying take home naloxone without a prescription**

YL provided a list of pharmacies supplying naloxone without a prescription, under the service commissioned by Turning Point. YL will share updated lists as and when she receives them.

Pharmacies are able to sign up to the service free of charge, whether or not they provide the needle exchange service. Those signed up to the needle exchange service will automatically be offered naloxone with their needles. When the Pharmacy sign up to provide naloxone, they are given posters and stickers to display on their door advertising the service discreetly.

Find out if there are any geographic gaps.	**Action: OD**
Bring usage report to next meeting.	**Action: YL**
Add list of participating Pharmacies to CPS website.	**Action: YL**
Add links to formulary.	**Action: DB**

5.2 **NetFormulary update**

DY attended to provide an update on progress. We are around 65% complete, most chapters have been done and we are in the process of mopping up and making it user-friendly. Due to be published at the end of June / beginning of July. We are really proud of the achievement we have made.

The intention is to bring together the Primary Care and Trust formularies into one place and make it easier for all prescribers to use. Traffic light statuses will be included.

Once we have launched, issues may come to light. We very much welcome feedback via the email addresses on the homepage, to help us make improvements.

YL and SM to liaise outside of the meeting to see if CPS have anything they'd like added to make it more user-friendly, particularly for the contraceptive service.

Thanks to Dorset for allowing us a copy of their formulary to edit.

We will do a planned launch once we are ready to go live. It will also be discussed at the Prescribing Leads conference.

5.3 **Heart Failure Service (information on practices who have signed up)**
Carly Jackson, Transformation Manager in the ICB Neighbourhood Development Team was introduced to the group. Carly has taken on some of the heart failure and diabetes workstreams from Vicky Wright.

CJ provided an update on the AstraZeneca (AZ) sponsored Heart Failure Interface Service, whereby they are offering support to GP practices:

- ~10 practices have had the service completed, as of the end of April
- 5 practices have declined the service
- ~10 have arranged for the service to start

There are quite a few practices which they have not yet heard back from. The plan over the fortnight is to make contact with these practices and explain the benefits of the service, to get a decision, as AZ will likely want to move on to another area at some point. Noted that most of the practices yet to respond are Symphony practices. SM is happy to link CJ up with contacts in Symphony.

Link CJ with Symphony. **Action: SM**

EK asked if a list of practices can be shared with us, as we can discuss in the annual medicines management meetings.

CJ to provide list of practices yet to respond. **Action: CJ**

Where we have Interface working on behalf of pharmaceutical companies, providing services in primary care, we try to ensure that the work is aligned to ICB priorities. We have had no negative feedback about the service so far, any feedback is welcome.

6 Other Issues for Discussion

6.1 AstraZeneca Services
Optimise – Discussion seeking ICB approval
COPD Cardiopulmonary Risk Reduction Service
In Somerset we have over 41k people living with diabetes, of which over 38k are living with type 2 diabetes. In the last year, only 62% had all eight of their care

processes completed and there is evidence to suggest that good quality care processes will have benefits for admissions and outcomes. We have the highest prevalence of diabetes across the South West (~8%) and the worst mortality rate.

CJ provided an overview of the AZ sponsored Optimise service, which aims to identify and review certain adult patients with type 2 diabetes with, or at risk of cardiovascular disease (CVD). The service supports the adoption of best clinical practice assisting the practice to implement NICE NG28 type 2 diabetes and local guidelines to ensure patients are being optimally managed in alignment with their recommendations.

SG has agreed to be the project sponsor and CJ the project manager.

We have done a lot of work in recent years on increasing uptake of the 8 care processes. We need to improve achievement against the clinical goals, for type 2 patients especially. We would much rather reverse diabetes through diet and exercise, etc., and that aim to do some metabolic health work across the system remains, but obviously for those patients who, for various reasons aren't able to do that, then optimising their medication will improve their longer term outcomes.

RT raised that he believes according to Interface internal funding rules, practices can't have two Interface projects running at the same time, you would have to complete the heart failure service before starting the diabetes service. CJ understood that Optimise is a different arrangement, falling under the national services for health improvement, rather than Interface, but she will check and clarify this.

Clarify service arrangements. **Action: CJ**

Another service offered is the COPD Cardiopulmonary Risk Reduction Service. SG is happy to act as the sponsor for this service and will discuss with Vicky Wright whether she is happy to be the programme manager. This is supporting something we have been advocating for quite a while, which is appropriate COPD patients moving from multiple inhalers over to triple inhalers, where that is clinically appropriate, etc.
Discuss COPD Cardiopulmonary Risk Reduction Service with Vicky Wright.
Action: SG

6.2 Draft MOU for sign off process for Public Health PGDs + Varenicline PGD
Legislation around PGD authorisation is complex and requires the commissioner of the service to authorise the PGDs, which has created some difficulties with the Council in that they don't directly employ Pharmacists or Doctors. The ICB has been asked if we could, via a memorandum of understanding (MOU), become the body that reviews the PGDs and signs them off from a clinical perspective. The governance perspective remains with Public Health as the commissioner.

Approved.

The first PGD which requires authorisation via this process is the varenicline PGD. Varenicline is now back in stock and there is a list of potential patients who can't

access it at present. The group approved the PGD, subject to a few minor amendments (Somerset Medicines Group to be changed to Medicines Programme Board, plus a few typos).

Make amendments to PGD as discussed and sign. **Action: AT / EK**

6.3 Menopause Optimal Pathway Toolkit (OPT)
MOPT was discussed. The board had concerns that this tool could lead to confusion among clinicians, and that we should be encouraging use of our formulary position and website at all opportunities.

Feedback to Gaynor and Julia. **Action: SM**
Review toolkit for any additional resources not currently in use. **Action: SM**

7 Other Issues for Noting

7.1 Chickenpox as a notifiable disease: information for health professionals
Chickenpox (varicella) is now included on the list of notifiable diseases, since the Joint Committee on Vaccination and Immunisation (JCVI) has recommended inclusion of varicella vaccination within the routine childhood immunisation schedule. Chickenpox cases are mostly self-limiting and many do not need to seek healthcare. However, monitoring trends among those that do attend health services informs an understanding of the impact of any future vaccination program on those services. It also shows how such a vaccination programme could be optimised.

-Noted.

Add to newsletter. **Action: EK**

There was a discussion around this and the fact that only medical professionals can make notifications. There is concern that well-meaning educational settings and Pharmacies may refer patients with mild self-limiting chickenpox to the GP unnecessarily. Hopefully the LMC will issue some advice on this. DD tried making a notification using the form and reported that it did take some time to do.

Bring back to MPB in a few months. **Action: ZT**

7.2 Update on the Government pandemic stockpile of COVID-19 antivirals
The government provided stockpiles of covid antivirals have now expired. Both Paxlovid and monopuvir are now in the Drug Tariff at their national price. Should we get a future large outbreak where we potentially need to use a lot of these products, there will be a significant cost to the system.

Because of the change in price, NICE have re-assessed their cost-effectiveness of both products, and the proposed extension of the eligible groups for Paxlovid that was due to come into place from June has been rolled back now to the original list, so that less people will be eligible for both drugs. Also some people will no longer be eligible for free lateral flow tests.

-Noted.

7.3 A Tier 2 Medicine Supply Notification (MSN) for: Triamcinolone acetonide 10mg/ml (Adcortyl® ampoules) and 40mg/ml (Kenalog® vials) suspension for injection
We have a primary care PGD for these products, which have now been discontinued. We have discussed with the OASIS service which product they will use instead and EK will amend the existing PGD accordingly.

Update OASIS service PGD to reflect change in products. **Action: EK**

-Noted.

7.4 Pharmacy Quality Scheme
The Pharmacy Quality Scheme for 2025/25 was announced in March and most community pharmacies in Somerset are taking part. YL explained that there is gateway criteria – pharmacies must be signed up to deliver the pharmacy first service, pharmacy contraception service and hypertension service. Then they can start to work through the scheme. There are a number of workstreams including sepsis, respiratory, mental health and palliative care. Community Pharmacy Somerset will support pharmacies to work through the scheme.

SG highlighted that we are supportive of implementing the new NICE / BTS respiratory guidance and more practices are looking to adopt the MART approach, rather than the SABA / ICS approach. We will be having a push on this over the next few weeks and we encourage respiratory nurses to work with local pharmacies to enable a joined up approach.

Feedback to pharmacies re MART. **Action: YL**

8 Additional Communications for Noting

8.1 **New 25/26 CVD Scorecard indicator**
-Noted.

8.2 **Updated National funding arrangements for Inclisiran**
National funding arrangements for Inclisiran have been revised. The removal of 'clawback' and increase in tariff price compared to wholesaler prices now provides a margin of £15 per injection.

Inclisiran remains a green drug in Somerset for treating primary hypercholesterolaemia or mixed dyslipidaemia. For patients fulfilling the criteria set out in NICE TA733 (Oct 21) - and the national pathway

-Noted.

8.3 **Progesterone 200mg and 100mg caps**
A reminder that we recently approved progesterone 200mg capsules onto formulary. Following the change to the HRT scorecard indicator we now also recommend generic prescribing of both 100mg and 200mg progesterone capsules. (from Geprexit and Utrogestan). For patients taking 100mg x2 there is a lower carbon footprint in moving to the 200mg strength.

-Noted.

Bring uptake of progesterone 200mg capsules data to next MPB. **Action: SM**

8.4 **Drug Safety Update: Short-acting beta 2 agonists (SABA) - risks from overuse in asthma**
-Noted.

8.5 **Tirzepatide for Type 2 Diabetes additional tools**
Tirzepatide currently remains non formulary for obesity and weight management. Approval starts from the end of June for a very limited cohort of patients (BMI>=40 plus 4 clinical co-morbidities). Additional pathway and patient communications will follow in due course.

Approval for Type 2 diabetes remains in place for patient fulfilling criteria in NICE [TA924].

Additional resources NICE has produced for assessment, counselling and follow up have been shared with practices.

-Noted.

We have around 5k patients using tirzepatide in Somerset, of which around half are prescribed on the NHS for Diabetes and the other half are using privately.

RT reported that patients are requesting dose increases once they have lost weight and their HbA1c has come down and he requested clear communications regarding this. Clinicians can increase doses as appropriate, in discussions with patients. It is important to incorporate diet and lifestyle into these discussions.

9 Formulary Applications

9.1 **Trokide (tiotropium) 18mcg inhalation powder capsules, Genus Pharmaceuticals Ltd.**
£12.50 (30 inhalation capsules) with Vertical-Haler device.
£8.50 for refills (30 inhalation capsules).
Preferred brand for those remaining on tiotropium alone.

Approved.
Add to formulary & TLS GREEN. **Action: ZT**

9.2 **UroFlush urinary catheter maintenance solutions, TriOn Pharma**
Cost-effective brand.
The Continence Service would like to add these to their preferred product list, when they review the list following the joint work that is going on with YDH / MPH and community.

Approved.

Inform Catherine Weller this has been approved. **Action: DB**

10 Reports From Other Meetings
Feedback

10.1 Primary Care Network Feedback

Progress updates on:

- Structured medication reviews (SMR)
- Deprescribing
- Social prescribing options e.g., Pain, sleep etc.
- PCN workforce

DD – The focus in West Somerset at the moment is on medicine reviews, with the QOF changes in terms of blood pressure principally, but also diabetes, with the thresholds increasing. Teams are looking at priorities to see if they can support the PCN. Exmoor are doing a push on deprescribing, as the care home team is being reformed there.

YL - highlighted that via the EMIS button for local enhanced services, you can refer patients out to community pharmacy for blood pressure checks as well as ambulatory blood pressure monitoring, and pharmacies send the results back, which might help with QOF. RT reported issues with local pharmacies not having access to working BP monitors. YL advised that all pharmacies should have a working monitors as she has recently checked. They might be out on loan so patients may have to wait a day or two but they should definitely have working monitors. If there are any issues at particular pharmacies / areas then please report this back to YL. RT to email YL about this outside of the meeting and YL will look to address.

RT – SMRs are continuing, as they always have done, deprescribing work is ongoing, as is social prescribing. Have their own Sleep Station links. There is no more money to employ anybody in the PCN workforce, if you're using ARRS, then the rise in ARRS should cover pay rise and NI changes and nothing else. RT is taking over the CD role from Rebecca Duffy in September. Realigning some of their pharmacy hours with the reduction in network requirement on the PCN DES to do some of the pharmacy specific jobs. Realigning them into practices to do more work on cholesterol and blood pressure management directly. Most practices have already hit the QOF targets for cholesterol, after work done last year, so will be tidying that one up and moving on to a blood pressure project.

MT – Continuing with QOF, also focusing on hypertension and cholesterol.

There was a discussion around the QOF 95% targets, which were felt to be difficult to achieve without exception reporting, which would reduce funding.

There was also a discussion around the new CVD scorecard indicator, following some comments the MM team have received on practice visits around QRISK scores. The aim of the NHS going forwards is to do primary prevention work, to stop people progressing to secondary prevention, and so this indicator should not be looked at in isolation but as part of a wider picture. There was a discussion around potentially adding a minimum figure of QRISK calculations into the target – this may be looked at in future if necessary.

Summary

10.2 **Community Pharmacy Somerset Feedback**

10.2a **Pharmacy First Data Update**

YL presented an update on the Pharmacy First service data. Over the previous 3 months 387 patients were uncontactable. Practices are asked to check the phone number with the patient and advise them that the Pharmacy call may be from a withheld number.

PB queried the name of the service, as it may be confusing. YL and SG confirmed that the service is for a cohort of patients who are presenting at the practice when they should be seen at the pharmacy, and the pharmacy will get paid for providing the service.

If any of the group want to see their PCN data they can contact YL.

CPS have been focusing training on clinical pathways, which may explain the drop in minor ailments service referrals.

10.2b **Community Pharmacy Independent Prescribing (CPIP) Pathfinder Programme Update**

TD provided an update on] CPIP. She mentioned the selected pharmacies and the progress made in terms of clinical support, digital aspects, and GP engagement.

There was a discussion around progress in clinical support, including setting up digital access to GP records and ensuring Pharmacists can request and review blood tests through the ICE system, ensuring proper monitoring of patients.

TD highlighted the importance of GP engagement and is working on improving engagement and communication with practices.

10.3 **LMC Feedback**

Nothing to report.

10.4 **Somerset NHS Foundation Trust D&TC Meeting** – Last meeting 21st March Highlights of the meeting were shared, AP suggested embedding the minutes into future agendas for noting to streamline discussions.

Add D&TC minutes into the MPB agenda for subsequent meetings. **Action: ZT**

10.5 **Somerset NHS Foundation Trust Mental Health Medicines Group** – Last meeting 4th March

Discussed at last meeting

10.6 **Somerset NHS Foundation Trust Medicines Governance Committee** – Last meeting 14th May

Valproate work is ongoing and from a governance perspective there are no further updates. There are outstanding patients in the adult and paediatric services that are being followed up. The challenge in paediatrics is parental engagement so there have been a few delays, though the vast majority have been reviewed.

The topiramate review position from Neurology is that they don't have capacity to review those patients. This is a contractual issue, which will need to go to the contracts team and be dealt with outside of the governance meeting.

During MPB, concerns were raised about epileptic patients with LD or additional disabilities who require an in date epilepsy plan to access day services.

Neurology have confirmed that they will prioritise patients with the highest clinical need.

SG asked AP to pass on our thanks to Neurology for the valproate work completed.

A reduction in incident reporting has been noted across the board, this has been escalated to the quality assurance meeting.

-Noted.

Part 2 – Items for Information or Noting

11 Current Performance

11.1 **Prescribing Report**

No formal report this month, however SG gave a verbal update.

Positive news - We have had the end of financial year prescribing data and we have spent ~£750k less than the previous year. We are one of only around 3 of the 42 ICBs that have spent less than last year. A chunk of savings came from the arrival of generic DOACs, however we also absorbed ~2.5k patients being started on tirzepatide, and the SGLT2 programmes for heart failure, diabetes, CKD, etc. A lot of great work has been going on around deprescribing and moving to more cost-effective products which has meant we have come in under budget. Well done to all in Somerset for such quality work. We have a good starting point for this year.

-Noted.

12 Rebate Schemes

12.1 **Lixiana (Edoxaban), Daiichi Sankyo.**

Rebate restarted on 01/04/25, further to its previous termination on 31/12/21.

-Noted.

12.2 Combisal (Salmeterol/Fluticasone) pMDI, Aspire Pharma.

- ❖ Start date: 01/04/25
- ❖ Termination date: 31/03/27

-Noted.

13 NICE Technology Appraisals

13.1 [TA1057] Relugolix–estradiol–norethisterone (Ryeqo) for treating symptoms of endometriosis

Commissioners	Integrated care boards
Providers	NHS hospital trusts/GPs

-MPB approved
Add to TLS Amber[2] drug. **Action: ZT**

A DXA scan is recommended after 1 year of treatment. In patients with risk factors for osteoporosis or bone loss, a DXA scan is recommended prior to starting Ryeqo treatment.

13.2 [TA1056] Molnupiravir for treating COVID-19

Commissioner(s)	Integrated care boards
Provider(s)	Primary care providers and NHS hospital trusts

Add to TLS Green. **Action: ZT**

The covid medicines pathway has been revised to include molnupiravir and updated guidance on the progression to severe covid.

Replace covid pathway version on website. **Action: DB**

-Noted.

13.3 [TA878] Nirmatrelvir plus ritonavir, sotrovimab and tocilizumab for treating COVID-19

Commissioner(s)	Integrated care boards
Provider(s)	Primary care providers and NHS hospital trusts

-MPB approved
Add to TLS Green drug. **Action: ZT**

13.4 [TA753] Cenobamate for treating focal onset seizures in epilepsy

Commissioner(s)	Integrated care boards

Provider(s)	Primary care providers and NHS hospital trusts

-MPB approved
Add to TLS Amber[2] drug. **Action: ZT**

13.5 **[TA1050] Fenfluramine for treating seizures associated with Lennox–Gastaut syndrome in people 2 years and over**

Commissioners	NHS England
Providers	NHS hospital trusts – Tertiary Care

-MPB approved
Add to TLS Red drug / Non-Formulary (Specialist centre only) **Action: ZT**

13.6 **[TA1049] Blinatumomab with chemotherapy for consolidation treatment of Philadelphia-chromosome-negative CD19-positive minimal residual disease-negative B-cell precursor acute lymphoblastic leukaemia**

Commissioners	NHS England
Providers	NHS hospital trusts

-MPB approved
Add to TLS Red drug. **Action: ZT**

13.7 **[TA1048] Lisocabtagene maraleucel for treating relapsed or refractory large B-cell lymphoma after first-line chemoimmunotherapy when a stem cell transplant is suitable**

Commissioners	NHS England
Providers	NHS hospital trusts

-MPB approved
Add to TLS Red drug. **Action: ZT**

13.8 **[TA1052] Pegylated liposomal irinotecan in combination for untreated metastatic pancreatic cancer**
Terminated appraisal

-Noted.

13.9 **[TA1051] Efanesoctocog alfa for treating and preventing bleeding episodes in haemophilia A in people 2 years and over**

Commissioners	NHS England
Providers	NHS hospital trusts

-MPB approved
Add to TLS Red drug. **Action: ZT**

13.10 **[TA1054] Ruxolitinib for treating acute graft versus host disease that responds inadequately to corticosteroids in people 12 years and over**

Commissioners	NHS England
Providers	NHS hospital trusts – Tertiary providers

-MPB approved
Add to TLS Red drug. **Action: ZT**

13.11 **[TA1053] Cladribine for treating active relapsing forms of multiple sclerosis**

Commissioners	NHS England
Providers	Secondary care: acute

-MPB approved
Add to TLS Red drug. **Action: ZT**

13.12 **[TA1055] Rucaparib for maintenance treatment of advanced ovarian, fallopian tube and peritoneal cancer after response to first-line platinum-based chemotherapy**

Commissioners	NHS England
Providers	NHS hospital trusts

-MPB approved
Add to TLS Red drug. **Action: ZT**

13.13 **[TA1058] Tislelizumab in combination for untreated advanced non-small-cell lung cancer**
Terminated appraisal.

-Noted.

13.14 **[TA1061] Omaveloxolone for treating Friedreich's ataxia in people 16 years and over**
Terminated appraisal.

-Noted.

13.15 **[TA1059] Brentuximab vedotin in combination for untreated stage 3 or 4 CD30-positive Hodgkin lymphoma**

Commissioners	NHS England
Providers	NHS hospital trusts

-MPB approved
Add to TLS Red drug. **Action: ZT**

13.16 **[TA1060] Osimertinib with pemetrexed and platinum-based chemotherapy for untreated EGFR mutation-positive advanced non-small-cell lung cancer**

Commissioners	NHS England
Providers	NHS hospital trusts

-MPB approved
Add to TLS Red drug. **Action: ZT**

13.17 **[TA1062] Erdafitinib for treating unresectable or metastatic urothelial cancer with FGFR3 alterations after a PD-1 or PD-L1 inhibitor**

Commissioners	NHS England
Providers	NHS hospital trusts

MPB approved
Add to TLS Red drug. **Action: ZT**

13.18 **[TA1063] Capivasertib with fulvestrant for treating hormone receptor-positive HER2-negative advanced breast cancer after endocrine treatment**

Commissioners	NHS England
Providers	NHS hospital trusts

MPB approved
Add to TLS Red drug. **Action: ZT**

14 **NICE Clinical Guidance**

14.1 **[NG101] Early and locally advanced breast cancer: diagnosis and management**
– Update
Reviewed the evidence and made new and updated recommendations on neoadjuvant treatment and gonadal function suppression.
-Noted.

14.2 **[NG249] Falls: assessment and prevention in older people and in people 50 and over at higher risk**

-New.

-Noted.

We have workstreams to reduce the inappropriate use of hypnotics, opioids, etc., which can potentially be related to falls. These workstreams will continue, as will our work on reducing anticholinergic burden.

14.3 **[NG12] Suspected cancer: recognition and referral**
– Update.

May 2025: Amended recommendations 1.2.1 and 1.2.7 to recommend a suspected cancer referral for people with symptoms indicating a 3% or more probability of having oesophageal or stomach cancer (rather than an urgent, direct access referral for an endoscopy).
April 2025: Amended the recommendations on blood tests for myeloma in response to a series of NHS England National cancer programme reviews looking at opportunities for earlier diagnosis, including for myeloma.

-Noted.

14.4 **[NG191] COVID-19 rapid guideline: managing COVID-19**
Update
Amended the recommendation on nirmatrelvir plus ritonavir in line with NICE's technology appraisal guidance on nirmatrelvir plus ritonavir, sotrovimab and tocilizumab for treating COVID-19.

-Noted.

15 Medicines Safety Summary

15.1 **ICB Medicines Safety update**
EK provided an overview of recent medicine safety updates, including prevention of future deaths reports, and supply notifications. She highlighted risks associated with various medications, including respiratory depression with gabapentin, liver disease with fezolinetant, and QT interval prolongation with certain antidepressants. Also raised awareness of suspected adverse drug reactions in infants through breastfeeding, highlighting the need to report adverse drug reactions through the yellow card scheme and prescribe appropriately using evidence based resources.

-Noted.

16 Risk Review and Management

16.1 **General Risk and Management**
Nothing to add this month.

17 Any Other Business

17.1 NHSE will be abolished and absorbed into DHSC over an extended time period.

ICBs have been asked to reduce their running costs by 50%, which has led to discussions across the South West. The proposal is that there will be 3 larger ICB configurations in the SW, firstly working more closely together, and then formally merging. Somerset will be clustering with Dorset and Bath, Swindon and Wiltshire (BSW). We will go from looking after a population of ~600k in Somerset, to ~2.5mil over the wider footprint.

What that means for individual teams going forwards is not yet clear, but the pace of change is quick. The magnitude of the savings wont be made from merging teams alone, there will be certain functions that ICBs will no longer have the the remit to continue doing. There is likely to be a voluntary redundancy scheme, and if that doesn't deliver enough savings, potentially a mandatory redundancy scheme as well. So it's a time of turbulence for medicines optimisation teams, not only within Somerset but across the country. We value the engagement and support

we've had from GP practices over the last 20 years or so since SG has been involved. The intention from the medicines management team is to continue to work with practices and prescribers for better improvements for our patients.

The group will be kept up to date at the next meeting with where we are with the process.

DATE OF NEXT MEETING
Wednesday 23rd July 2025
Wednesday 24th September 2025
Wednesday 26th November 2025