Lancashire & South Cumbria Medicines Management Group

NHS Midlands and Lancashire Commissioning Support Unit

Minutes of the Lancashire and South Cumbria Medicines Management Group Meeting

Thursday 6th February 2025 (via Microsoft Teams)

Name	Role and organisation	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25
Andy White (AW)	ICB Chief Pharmacist (Chair)	✓	✓		✓		
Trust senior medical representation from the following trusts							
Dr Hanadi Sari-Kouzel (DHSK)	Blackpool Teaching Hospitals	✓	✓		✓		
	University Hospitals of Morecambe Bay						
	Lancashire Teaching Hospitals						
Dr Shenaz Ramtoola (DSR)	East Lancashire Teaching Hospitals	Deputy	✓		✓		
	Lancashire and South Cumbria Foundation Trust						
Trust senior pharmacist representation from the following trusts							
James Baker (JB)	Blackpool Teaching Hospitals	✓	✓		✓		
Andrea Scott (AS) (Nima Herlekar (NH) or Jenny Oakley temporarily attending (JO))	University Hospitals of Morecambe Bay	✓	NH		JO attending		
David Jones (DJ)	Lancashire Teaching Hospitals	✓	✓		✓		
Ana Batista (AB)	East Lancashire Teaching Hospitals	✓	✓		✓		
Sonia Ramdour (SR)	Lancashire and South Cumbria Foundation Trust	✓	✓				
Primary care Integrated Care Partnership senior medical representation							
To be recruited	Fylde Coast						
To be recruited	Central						
To be recruited	Morecambe Bay						
To be recruited	Pennine Lancashire						
Primary care Integrated Care Partnership senior pharmacist representation							
Melanie Preston (MP)	Fylde Coast	✓	✓		Deputy		
Clare Moss (CM)	Central	Apol	Apol		✓		
Lisa Rogan (LR)	Pennine Lancashire	Apol	Apol		Apol		
Faye Prescott (FP)	Morecambe Bay	✓	✓		✓		
Other roles							
Nicola Baxter (NB)	ICB Lead for Medicines Governance and Medicines Safety	✓	✓		Apol		

	ICB Senior Commissioning Manager						
Lucy Dickinson (LD)	ICB Finance Representative	✓	✓		Absent		
	Provider finance representative						
Roger Scott (RS)	Local Medical Committee Representation	✓	✓		Apol		
Mubasher Ali (MA)	Community Pharmacy LSC	✓	✓		✓		
Emma Coupe (EC)	Assistant Director of Pharmacy Clinical Services EHTL		✓				
IN ATTENDANCE:							
Brent Horrell (BH)	CSU Head of Meds Commissioning	✓	✓		Apol		
Daivd Prayle (DP)	CSU Senior Meds Commissioning Pharmacist	✓	✓		✓		
Adam Grainger (AGR)	CSU Senior Meds Performance Pharmacist	Apol	Apol		✓		
Jill Gray (JG)	CSU Meds Commissioning Pharmacist	✓					
Emily Broadhurst (EB)	Medicines Optimisation Administrator (minutes)	Deputy	Deputy		✓		

As the Jan 25 meeting was due to fall close to the Christmas break it was cancelled and the February meeting brought forward by a week

Key

Present	✓
Apologies received	Apol
Apologies received / Deputy Attended	Deputy
Absent	Absent

	SUMMARY OF DISCUSSION	ACTION
2025/001	**Welcome & apologies for absence** Apologies were received from Lisa Rogan, Nicola Baxter, Brent Horrell and Melanie Preston with Rukaiya Chand attending as deputy for Melanie. As this meeting was changed and a new meeting link sent some members were on leave and others didn't respond or send apologies.	
2025/002	**Declaration of any other urgent business** The ICB has been placed into special measures due to a substantial overspend of around £360 million. Any decisions made at this meeting today won't be directly approved and implemented but will need to go through further discussions within the ICB and involved agencies and may not be implemented until April 2025. This could continue into next year; with this information the group were reminded that with this information	

	decisions made here should attempt to help the ICB reduce costs and/ or save money where possible and relevant. DSR raised previous discussions around cost savings such as switching Biologics and suggested this should be a focus for the group to then also still be able to do additional things for patients. AW agreed and suggested looking closely at the workplans to ensure they are working with this. DSR mentioned a paper she had seen aligning with this and AB gave more context. The original document is from Leeds which is a position statement that patients will be switched to the biologic available unless it is not appropriate. There is also a Lancashire and South Cumbria paper in process which states the switch will be done after discussion with the health care professional. AB added that work is ongoing and the document will be shared once this has been done and brought to this group to review the current position statement which is due for review in November 2025. AW asked if the Leeds document would be adoptable as some of their other work has been used as good examples and asked AB to forward the documents to DP and EB for circulation before the next meeting. It was agreed to adopt the Leeds document in principle and the relevant information/ details will be refined next week. AW also mentioned the closure of Lloyds pharmacy and it being transferred to Lancashire Teaching Hospital. He had spoken with members outside the meeting who felt it was going well and asked members attending if they felt the same. Members from East Lancashire Hospital agreed it was going well. **Actions** AB to forward the Leeds biosimilars document position statement to DP and EB for circulation to the group after today's meeting. EB/DP to circulate to Leeds biosimilars document to members for comments with responses to be received by Wednesday 12th February.	**AB** **EB/DP**
2025/003	**Declarations of interest (DOI)** DSR raised her long standing DOI with Novo Lilly and AZ.	
2025/004	**Minutes and action sheet from the last meeting 12th December 2024** AB raised that Emma Coupe needs to be added to the front page as a regular attendee. EB to amend this, the minutes are otherwise approved and will be uploaded to the website. **Action** EB to amend minutes to include Emma Coupe on the front page.	**EB**
2025/005	**Matters arising (not on the agenda):** Nothing raised.	
NEW MEDICINES REVIEWS		
2025/006	**Cytisine for Smoking Cessation and reduction of nicotine cravings in smokers who are willing to stop smoking – Major Change** NICE guidance has now been published and includes Cytisine. This option	

	is equal in preference to Varenicline dependant on patient characteristics. Manchester have done a large project on this, and it shows that the return is £2.12 per £1 invested, this is a predicted cost saving of £115,000 per 1000 patients which is around £250,000 back based on Manchester's calculations. It was proposed as either Green or Amber 0, however DP suggested Green as there doesn't seem to be any reason for it not to be, but discussion should focus on how it is supplied and smoking service. This relates to how it will be supported as it isn't just prescribed there needs to be support and there may not be resources to do this. There has been a lot of emails around Varenicline which is now available also and there is now a national PGD to support Cytisine. DP added if this is supported there may need to be an accompanying hold statement stating that there isn't currently a cleared supply route. AW added the comment regarding possible Amber 0 RAG was that it should only be started on the recommendation of smoking cessation or that someone is within a smoking cessation service. CM added if it could be Green Restricted with the restriction being about the accompanying counselling. And that the pathway does need to be sorted before anything goes out, but she was unsure how easy it would be to sort out. MA added this is what they have been waiting for in community pharmacy and with this he was hopeful that something could be set up after additional meetings including with the Director of Public Health to get it out as soon as possible for the public. RC commented they recommended Green Restricted also so it can align with Varenicline and not create any disparity. AW agreed that both Cytisine and Varenicline could be Green Restricted and then allow Trevor Morris and the Tobacco Control members to decide on any order of preference. **Action** It was agreed as a Green Restricted subject to commissioning arrangements – for ratification at CRG/CEG.	**DP**
2025/007	**Nefopam – Major Change** There is a large body of clinicians that would like access to nefopam in palliative care, liver disease and care of the elderly and as an alternative option for pain management. While there is little published evidence the evidence available does show its treatment effect. DP added that it is important to acknowledge that there are recognised side effects and downsides to this drug. The proposal is for Amber 0 for persistent pain, unresponsive to other non-opioids. Along with caveats about prescribers carefully considering if potential benefits outweigh the risk, prescriber should be cautious of anticholinergic burden particularly in the elderly and treatment should be reviewed and stopped if no benefits. Concerns were raised relating to its anticholinergic burden, understanding of this term and its use in the elderly, GMMMG have it restricted on their formulary to only to be used in patients who have moderate to severe chronic liver disease who require analgesia stronger than paracetamol and then who non-steroidal and a moderate opioids are contraindicated. While Pan Mersey have it as Green. It was agreed that it needs to go regional for discussion and decision and to get a consistent North West position. DHSR commented that in practice patients will be on lower doses than the license so will be exposed to a lower anticholinergic burden.	

	DHSR asked if there were any GPs had comments but AW added unfortunately the GP representative was unable to attend today's meeting last minute. So there are no comments from primary care at this stage. DSR asked if this is widely prescribed or kept to more restricted groups. DP gave the numbers for clarity, in a 6 month period there were 8222 prescriptions and from those 5897 were from Blackpool and Fylde and Wyre. It was agreed that this item should come back to a future meeting with a review from the North West MOG. AW added that if anyone could find out the motivations for the uptake in Blackpool and Fylde coast it would be helpful. **Action** This item to be brought back with a review from the North West MOG.	**DP**
2025/008	**Menopause products RAG review: Ospemifene oral tablets and Prasterone vaginal pessaries – Moderate Change** These are two newer products that were previously do not prescribe. Since the development of the formulary, a Women's Health Group has been created. While the evidence hasn't changed the Women's Health Group pointed out that they are now included in NICE Guidance. NICE have indicated quite specialist use, with this the proposal is for select patients whom standard treatments don't work. It is difficult to find or predict patient numbers for this, however the proposal for both items is for a Green Restricted RAG. AW added that it didn't feel right for Red or Amber as there are discussions about having community based women's hubs, but Green Restricted felt right. **Action** A RAG of Green Restricted was agreed by the group for both ospemifene and prasterone – for ratification at CRG/CEG.	**DP**
2025/009	**Ivermectin for Scabies – Moderate Change** This is currently Amber initiation on the formulary, however there were some queries around if it should be Green following an outbreak in Blackpool. While it is an alternative for some patients for example in care homes where using the cream could be more difficult. However, the UKHSA guidance states that the decision to prescribe lies with a local specialist dermatology and infectious disease services. This is also not in the current guidelines, and it isn't clear who is responsible. While the regulation could be changed but DP felt it couldn't be changed to a Green RAG. AW added here has been a demand from care homes for this also. RC offered to clarify on some points. There was confusion around that the current RAG rating Amber is for crusted scabies, and in a care home with dementia patients they automatically requested Ivermectin in preference to Permethrin. She added to clarify the request was not to downgrade the current RAG of Amber for crusted scabies. It was for a different indication for use in patients specifically dementia patients or other patients where there is a complexity of applying the cream. This decision does need to remain with the clinician and not be driven by care homes, but also not limited to care homes.	

	CM added they had a similar issue in central where there were repeated outbreaks of scabies within a dementia care home, which were probably linked with the difficulties of proper application of permethrin. Clarity would be welcomed by GPs as there is some reluctance to prescribe. In addition to anything done here CM would like further discussions with specialist colleagues as the GP she had spoken to had spoken to microbiology who had backed his decision not to prescribe Ivermectin in that case. DHSR added that she could understand the demand for Ivermectin as the application of Permethrin has to be precise and all of the infected area has to be covered. She asked what the risks would be as it is a licenced medication for a licenced indication. While the group were unsure, RC added that there are some risks. However there was also confusion as to why it is not widely used as other countries widely use both and Ivermectin is preferred. Also to add that with using Permethrin there were questions raised around being able to give personal care to patients such as bathing. But it was requested to bring here for more clarity for prescribers. DSR added she felt it should be available and should be Green and any prescriber unsure on prescribing should be able to reach out to their local microbiologist or dermatologist for support. JO added that they have used it quite extensively due to outbreaks in care homes with almost no issues. She added there has been difficulties with supply as they sometimes prescribe for outpatients so the Green RAG would be useful for secondary care. DJ raised the cost element, being £50 versus £8 for Permethrin. He also raised the point of Ivermectin resistance and where would they go after Ivermectin. AW added he felt there should be a national view on this and asked the group if a suggestion should be made to UKHSA to update their protocol and this group fill the gap in the meantime. He also asked if this is agreed who would update the Scabies pathway as LR is not currently at work. DP agreed that the CSU team would be able to do this. AW asked along with updating the pathway if Mark McGivern and UKHSA colleagues could be contacted to ask if there is any likely hood of them updating the national guidance. He added that the ICB is also looking to commission a single outbreak service for the whole ICB, which would include infectious diseases. It was agreed for the new indication for Scabies as Green and for the pathway to be updated. The group agreed they did not need it to come back for approval but can be approved virtually. **Actions** DP to update RAG rating of ivermectin to be Green – for ratification at CRG/CEG. Scabies pathway to be updated and shared with group.	**DP** **DP**
2025/010	**Dapoxetine tablets (Priligy®) for the treatment of premature ejaculation – Moderate Change** This was previously discussed and agreed as a Do Not Prescribe due to it being very expensive. Originally SSRIs do the same thing, but it's a licenced indication for the drug. There has since been recent	

	communication from with a sexual health specialist service in Blackpool, who have requested they use it but only for their service. The drug costs around £203-£266 per patient per year, however this is on the high side as DP pointed out they most likely wouldn't have it prescribed for a whole year. The service also said they would expect the patient to improve with treatment as well. Patient numbers are around 30 patients per year into the service for this condition and out of those only three have requested for Dapoxetine tablets. The drug is supported by guidelines, but it is a premium for using a licensed product and the specialists do want it. The group were asked if the RAG rating should be changed or kept as Do Not Prescribe. DSR added that as it's on the guidelines she felt it should be made available. And that if it is of no benefit people won't come back for the repeat prescriptions, also being only available through the sexual health services would create a reasonable restriction in its self. The group continued to discuss patient numbers, and the potential costs outlined above. DSR added that if it is in the MHRA guidance and a GP is comfortable prescribing it for the service they should be able to as there are already long waiting lists for specialist services which has its own costs and delaying treatment options could increase this further. **Action** The proposal was agreed by the group with restrictions for initiation only by specialist sexual health services. Amber 0 RAG rating - For ratification at CRG/CEG	**DP**
2025/011	**Co-Trimoxazole RAG – Moderate Change** While going through the antimicrobial section of the formulary, it was highlighted that there are quite varied RAG ratings across trusts for various indications listed in the accompanying paper. Neighbouring trust RAG ratings indicate some level of specialist involvement before prescribing. There were lots of responses from trusts and the recommendation to the group today is for Amber 0 for long and short term use with a proviso that for long term use some sort of prescribing information should be produced to support. This would include what to look for and any potential monitoring required. AW asked if people found having three statements against this confusing and if there was a place for long term prescribing. People agreed the need for long term prescribing in certain cases and DHSR added she felt it was confusing with the different statements. DP cleared up some confusion that should this be approved all other existing entries will come under either Amber 0 for short term use and Amber 0 for long term use with additional prescribing support materials. This was agreed by the group for two Amber 0 RAG ratings. Once for short term use and one for long term use with additional prescribing support information. **Action** Agreed Amber 0 RAG positions for co-trimoxazole to be included in formulary	**DP**

2025/012	**New Medicines Review Workplan:** **Acarizax –** NICE have drafted a positive TA which is due in March so this can be removed from the workplan. **Semaglutide-** DP requested to remove this from the workplan as Cardiovascular risk reduction is now under a NICE TA and it could have a large budget impact. This was agreed to be removed from the workplan. **Drugs for prioritisation –** A few have come via email, but the majority have come from the formulary working group for review. **Actimorph –** AW asked FP if this was something she was working on becoming restricted. FP commented that it was something that UHMB were working on. JO added that they were using Actimorph for in patients only and had not looked at out patient use. JB agreed it is being used in Blackpool. JO added they are looking to bring an application for use in primary care for a wider group such as in palliative care patients to hep restrict Opioids in the community. However this is not yet ready to be brought to this group. JB commented that it is only being used in house and then on discharge patients are given Oramorph. CM added this had been discussed previously with palliative care teams previously. RC added they had the same discussions and added that they would not come to primary care at the time. To be discussed further at the March meeting. Under this item RC raised a request she had received about more support for entering shared care agreements with private providers. This is because there are many more now providing NHS services, so the ask is for some clarity and guidance on this. Other members agreed with this. It was noted that it is currently out for consultation. FP added she had a request for a document to support clinicians when someone is not engaging in Opioid reduction. This is being worked on with AGR and could be added onto the Pathways and Guidance workplan. AW added that there is an awful lot to discuss under item 2025/018 and there should be more of a focus on these for March's meeting.	
2025/013	**New NICE Technology Appraisal Guidance for Medicines November 2024** NICE TA0122 – Bevacizumab gamma for treating wet age-related macular degeneration. The predicted cost saving for this is around £18,000 in year one through to a cost pressure of £46,000 in year five. This is under the assumption of 2% uptake each year against Faricimab, however Blueteq data 56% of patients are receiving Faricimab. With this large number of patients the expectation is for around 10% reduction by year five, however this will depend on any pathways put through so this may change significantly. Bevacizumab was agreed as a Red RAG rating. NICE TA1026 – Tirzepatide for managing overweight and obesity. The NICE costing template predicts a 7% uptake from the eligible population, which is felt to be a significant underestimate. Based on NICE assumptions there will be a £1.8 million per year drug pressure in year one and £1.1 million in year three. While this is felt to be out by a large amount there are no other figures published by NHSE for the team to run. The total	

	cost estimated for England nationally it is around £15 million but there is nothing else to support this in their document. The cost growth in Lancashire and South Cumbria is estimated to be £7.5 million next year (total estimated spend of £11 million). There is a national roll out plan for England so initially this will be a Red RAG, but AGR felt the intention is that the restrictions will be relaxed as part of that process. AW added that commissioners are working on pathways for this as primary care have said they do not have capacity for this. NHSE have said it will be around 12 years for the full cohort of patients with a BMI over 35 to receive this with the first two years being for patients with a BMI over 40 with three comorbidities which they felt was around 220,000 people across the whole country which feels like a vast underestimate. GPs have asked for a holding statement on who is eligible for clarity when they get requests. There was a lot of discussion under this item, with several requests for clarity and if there will be room for clinical discretion with prescribing this. AW concluded for now the NHSE prioritisation roll out needs to be followed as a starting point. Unless there is a local commissioned service in the future which are currently being looked at, but for now patients are going to their GPs demanding this and they don't have much to point them where to go. He agreed the importance and need for clarity for clinicians and prescribers. He added that although this came out in December 2024, there is a six month implementation, so they have until June before any prescription is expected, although in reality it is probably already happening due to the noise from the media. AW asked for this one to be noted and a holding statement to be produced and to align with the NHSE cohorts. This is needed urgently so AGR will draft something this week and send around for virtual approval. **Action** Bevacizumab gamma for treating wet age-related macular degeneration was agreed as a Red RAG rating - For ratification at CRG/CEG Tirzepatide for managing overweight and obesity was agreed as a Red RAG rating (in alignment with the NICE recommendations for implementation, although phased supply from primary care is recommended by NICE from 6 months after publication of NICE TA1026) - For ratification at CRG/CEG AGR to produce holding statement for Tirzepatide and send around to the group within the next week for virtual approval.	**AGR**
FORMULARY UPDATES		
2025/014	**Formulary update:** The eye section is now complete, and the group are now moving on to the Nutrition and Blood chapter. DP is meeting with the primary care network in Pennine next month and will feedback if it is useful which he feels it will be, and he would like to do this with other regions also. JO raised a request that came to the formulary working group that DP felt would be good to be raised here. Paediatricians have requested insulin diluting media for NovoRapid and Levemir for the very young babies on	

	insulin pumps who can't manage 100 units per ml and need it diluting to 10 units per mil. It is an unlicenced product, but it is made by Novo Nordisk, however after long discussions about its place it was felt that a Red RAG would be appropriate and hopefully this would only be a short phase. This is due to the young babies being able to increase their insulin requirements as they grow. This was agreed as a Red RAG by the group and will be added to the formulary as a minor amendment.	
2025/015	**Formulary Changes since last LSCMMG** The list of changes was sent around to the group for information. AW added a thank you to the team for the large amount of work they have done.	
GUIDELINES and INFORMATION LEAFLETS		
2025/016	**Dapsone Shared Care Guideline – Moderate Change** Morecambe Bay had a Dapsone shared care agreement, other localities didn't however the consensus is that all localities support shared care. The proposal is to adopt the Morecambe Bay shared care which has been translated into the new format. One point DP raised is that the monitoring is in line with Morecambe Bay, and there doesn't seem to be any standard method for monitoring, so it has stayed as what is done in this region. There are currently around 88 patients currently prescribed Dapsone in primary care, however DP estimates the patient numbers will be around 200 with the shared care. **Action** Dapsone shared care guideline was approved by the group – for upload to LSCMMG web site and formulary.	**DP**
2025/017	**Erectile Dysfunction Guidance Update – Minor Change** This has come from communication from the sexual health service. They requested a change in terminology to Psychosexual Services rather than mental health. There was also a change to the necessity for a specialist to prescribe Tadalafil post prostatectomy which mirrors the changes made to the Tadalafil RAG rating which is now Green. They also asked to put Tadalafil in the algorithm which had already been done and to also remove the NHS criteria for things such as Viagra and Cialis. The restrictions can't be removed as they are in the drug tariff and there is no way around this. The changes have been made and are in the attachment highlighted in yellow which will be removed once approved. RC raised the question for ED pumps and how those patients access those and the specialist nature as there is still issues coming up. While DP apricated the issue this was not requested for this update so have not been included. **Action** The update of the erectile dysfunction guideline was approved – for upload to LSCMMG web site and formulary.	**DP**

2025/018	**Pathways and Guidance workplan:** Although majority of discussions were held under item 2025/012, DSR raised another item for discussion. With previous discussions around Biosimilars, she felt this should probably come within two to three months possibly by April. While this was agreed to be done relatively quickly, DSR felt there needs to be some detailed guidance. AW agreed and asked AGR to add Biosimilar adoption on the workplan and bring to something to March's meeting. During discussions FP raised an email she had received regarding Dronedarone and a GP's concerns with monitoring requirements. AW commented that it was his understanding that Dronedarone would fall under the shared care LES with the GP's. **Action** AGR to add Biosimilar adoption to the work plan and bring back to March's meeting.	**AGR**
NATIONAL DECISIONS FOR IMPLEMENTATION		
2025/019	**New NHS England Medicines Commissioning Policies December 2024** Nothing to discuss.	
2025/020	**Regional Medicines Optimisation Committees – Outputs December 2024 and January 2025** Nothing to discuss.	
2025/021	**Evidence Reviews Published by SMC or AWMSG December 2024 and January 2025** There is a new Ciclosporin eyedrop which has been approved by SMC. Ciclosporin is already on the formulary, but this is a different strength. DP is going to take this to the formulary working group to see if there is any interest and it might take a few months to work through the system.	
ITEMS FOR INFORMATION		
2025/022	**LSCMMG Cost Pressures Log** This will be circulated with the minutes from today's meeting.	
DATE AND TIME OF NEXT MEETING **The next meeting will take place on** **Thursday 13th March 2025** **9.30 – 11.30** **Microsoft Teams**		