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 10th July 2025 (via Microsoft Teams)

Name	Role and organisation	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-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 Chair)	✓	Deputy	✓	✓	Deputy (Dr Truman)	✓/Deputy Dr Truman
Mohammed Elnaggar (ME)	University Hospitals of Morecambe Bay	Joined May 25	Joined May 25	Joined May 25	✓	✓	✓
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	JO attending	JO attending	✓	✓	✓	✓
David Jones (DJ)	Lancashire Teaching Hospitals	✓	✓	✓	✓	Deputy (Judith Argall JA)	Deputy (Jennifer Whatton JW)
Ana Batista (AB)	East Lancashire Teaching Hospitals	✓	Apol	Apol	✓	✓	✓
Dorna Ghashghaei (DG)	Lancashire and South Cumbria Foundation Trust	✓	Matthew Ling (ML) Attending	Matthew Ling (ML) Attending	Matthew Ling (ML) Attending	Matthew Ling (ML) Attending	Matthew Ling (ML) Attending
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	Deputy	Deputy	✓	✓	✓

Clare Moss (CM)	Central	✓	✓	Apol	✓	✓	Apol
Lisa Rogan (LR)	Pennine Lancashire	Apol	Deputy (Laila Dedat)	Deputy (Laila Dedat)	Deputy (Laila Dedat)	Deputy (Laila Dedat)	Deputy (Laila Dedat)
Faye Prescott (FP)	Morecambe Bay	✓	✓	Deputy	Apol	✓	Deputy (Paul Elwood)
Other roles							
Nicola Baxter (NB)	ICB Lead for Medicines Governance and Medicines Safety	Apol	Apol	✓	✓	Apol	✓
	ICB Senior Commissioning Manager						
Lucy Parker (LP) Previously (LD)	ICB Finance Representative	✓	✓	✓	✓		Apol
	Provider finance representative						
Praful Methukunta (PM)	Local Medical Committee Representation	Joined May 25	Joined May 25	Joined May 25	✓	✓	✓
Adam Dedat (AD)	Local Medical Committee Representation	Joined June 25	Joined June 25	Joined June 25	Joined June 25	✓	Absent
Mubasher Ali (MA)	Community Pharmacy LSC				Absent		✓
Emma Coupe (EC)	Assistant Director of Pharmacy Clinical Services ELTH		✓	✓	Apol	✓	✓
John Miles (JM)	Clinical Lead for Primary Care Data and Intelligence Lancashire & South Cumbria ICB	Joined May 25	Joined May 25	Joined May 25	Joined May 25	✓	✓
IN ATTENDANCE:							
Domnic Sebastian (DS)	Divisional Medical Director for Surgery & Anaesthetics ELHT						✓
Brent Horrell (BH)	CSU Head of Meds Commissioning	Apol	✓	✓	✓	✓	Apol
Daivd Prayle (DP)	CSU Senior Meds Commissioning Pharmacist	✓	✓	✓	✓	✓	✓
Adam Grainger (AGR)	CSU Senior Meds Performance Pharmacist	✓	Apol	✓	✓	✓	✓
Jill Gray (JG)	CSU Meds Commissioning Pharmacist						
Emily Broadhurst (EB)	Medicines Optimisation Administrator (minutes)	✓	✓	✓	✓	✓	✓

Please note, there will be no meeting in August 2025. LSCMMG resumes in September 2025.

Key

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

	SUMMARY OF DISCUSSION	ACTION
2025/107	**Welcome & apologies for absence** Apologies were received from Lucy Dickinson, Brent Horrell, Lindsay Dickinson, Faye Prescott with Paul Elwood attending, Clare Moss, Andrea Scott with Jenny Oakly attending and Jennifer Whatton attending for David Jones.	
2025/108	**Declaration of any other urgent business** Dr Salwa and Dr Chintan from East Lancashire joined the meeting at 11am to raise their concerns around the Ophthalmology Macular pathway drug switches. East Lancashire are the highest users of Faricimab across the ICB, and they have concerns around frequency of attendance to clinic if the medication is changed. Dr Salwa added that clinicians are happy to use biosimilars as they already are doing so, however with Faricimab they are very effective and the duration after treatment can be extended which gives them a capacity reduction at clinics. Ideally while clinicians are happy to use biosimilars they would like to retain flexibility with clinical judgement on which drug they use for each treatment. Clinicians would also like to see saving figures as they haven't seen any, and while savings are important it is the clinicians who are putting their professionalism on the line and them that could potentially face legal issues should the treatment go wrong. Dr Chintan added stable patients they are happy to switch and moving from Eylea to the biosimilar will already create large savings. But again reiterated that a mandated change would not work well and clinicians should retain clinical judgement and decisions. It was also asked if the actual cost that will be implemented due to increased injections where would this come from as it can't come from the Ophthalmology department. It is noted that in the current projections there shouldn't be a significant change in admission frequency if patients are changed. AW also added there are current discussions to possibly have payment in block which would give clinicians flexibility on what drug they use within a set budget. It was agreed that further discussions outside of this meeting needs to be had and the move to switch all patients needs revisiting.	
2025/109	**Declarations of interest (DOI)** No declarations relevant to items discussed today were raised. However, DSR raised her long-standing DOI with Novo/Lilly.	

2025/110	**Minutes and action sheet from the last meeting 12th June 2025** The Minutes were approved and will be uploaded to the website.	
2025/111	**Matters arising (not on the agenda):** DSR raised the item previously discussed regarding the change in the meeting terms of reference and asked if there had been an update. AW informed the group that due to organisational changes this had not yet happened. But it had been agreed that as the budget holder for the prescribing budget for the ICB AW needs to remain as the chair. AW added that the new terms of reference will be ready for September's meeting and there is a draft to send around to members prior to this meeting. It was also discussed the different D&T/ Medicines groups and how they relate to LSCMMG. It was agreed for members to send current trust D&T/ medicines groups to send their terms of reference to EB for collation and to see if it is possible to create a more streamlined/ joined up way of working across the ICB. Members also discussed the current GLP-1 prescribing in primary/ secondary care and some concerns around not currently following NICE guidelines. Some members felt there should be some work done to start certain specialties such as Endocrinology prescribing GLP-1s. It was highlighted that the current statement is a holding statement until the ICB board agree the position/ treatment plans going forward. <u>Actions</u> AW to send out draft terms of reference to the group before September's meeting. Members to send current trust D&T/ medicines to be sent EB their terms of reference for collation.	**AW** **All Members**
	NEW MEDICINES REVIEWS	
2025/112	**Dienogest for treatment of the endometriosis – Major Change** This is a new medicine for the formulary and has been taken to the formulary working group who agreed an application needed to come to LSCMMG. During the application the formulary women's health group was consulted. Numbers were not included as the product is believed to cost less than GNRH drugs and cost about the same as the contraceptive products available. There would however be a service impact which could help reduce the surgical waiting list for Gynaecology. PM gave feedback from the LMC that generally they are happy with the majority of Amber 0 drugs, however the consensus was that there seems to be a lot of new medications moving into primary care. With this they felt it would be useful for further education on these for primary care colleagues as a lot of these new drugs will be unfamiliar to them. If this came with the clinician letter this would be helpful and again supported by primary care colleagues. It was added that current drug information is available however maybe key issues, things to be aware of and any monitoring could be included to primary care to give a brief overview with	

	more extensive information already available. It was suggested that it would be helpful to have a set of standards for discharge information to be sent out. AW to link in with medical leadership and Lizzie Macphie to discuss discharge standards. The group agreed for Amber 0 for Dienogest for treatment of endometriosis. <u>Actions</u> AW to link in with medical leadership and Lizzie Macphie to discuss medical discharge standards. Dienogest Amber 0 for endometriosis is approved, CSU team to take to CRG for approval.	**AW** **DP**
2025/113	**Nadolo for long QT syndrome – Abbreviated Medicine Assessment – Moderate Change** This item has been given a moderate change as the drug is already routinely used in cardiology. East Lancashire requested this review; this Beta Blocker is supposedly better for type two or type three long QT syndromes. It was asked if there was need for another beta blocker, and it was highlighted that they possibly have different profiles so adding another one could be justified. The proposed RAG rating is Amber 0 with titrations being carried out by the initiating cardiologist. It was asked if this would be replacing an existing beta blocker or added as an additional. It was raised that it would be a small number of patients and would have its place with certain patients. It was asked what monitoring would be required if any and what it would be. With this type of drug ECGs would be the type of monitoring required but it was asked if this would be required to be performed by primary care. After discussions it was proposed this would most likely be completed by the cardiologists as channel apathies are rare and general practice may not be the best place to monitor QT intervals. This item was approved. <u>Action</u> CSU team to add Nadolol to formulary as Amber 0 for long QT syndrome.	**DP**
2025/114	**New Medicines Workplan** Three new medicines for prioritisation were highlighted, they were: **<u>Itraconazole</u>** <u>– treatment for pityriasis versicolor.</u> Request to change the RAG to Green from a Red and was requested by advanced locality pharmacist in Pennine. **<u>L-Ornithine</u>** <u>– treatment of patients with overt hepatic encephalopathy unresponsive to lactulose and rifaximin.</u> Requested use from consultant Gastroenterologist at ELHT. This has been requested as it is being used locally as it was recommended via the Leeds transplant centre for patients unsuitable for liver transplant, who have progressed too far to prevent/ reduce risk of hepatic encephalopathy. This is an unlicenced special ordered from Lichtenstein so will be retained for consultant use. This item will be brought back in September. **<u>Clascoterone</u>** <u>– treatment of acne vulgaris in people 12 years and over.</u> Requested by Dermatology pharmacist at ELHT. This is a new drug and is	

	currently on NICE's workplan, it was requested it be kept for noting but wait for NICE to complete their work before bringing it here. This was agreed. **Mexiletine** RAG change – this has stalled as Liverpool have frozen supply, the team will aim to bring this back in September. All items excluding Clascoterone were agreed for prioritisation. Actions L-Ornithine and Mexiletine items to be brought back in September. Clascoterone to be kept on log but not prioritised until NICE has completed their work.	**DP** **DP**
2025/115	**New NICE Technology Appraisal Guidance for Medicines June 2025** The estimated cost impact of NICE TA's published this month in year one is £290,000. **TA1066- Somapacitan** for treating growth hormone deficiency in people 3-17 years. The proposed RAG rating for this is a RED. NICE did suggest this could be a primary or secondary care drug, however similar items on the formulary are RED accept Somatropin. This has a proposed saving of £14,00 at year 5 assuming equal share across all preparations. **TA1067- Linzagolix** for treating symptoms of endometriosis. The proposed RAG rating for this is AMBER 0 in line with similar therapies. NICE template indicated a cost impact of £170,000 per year from year 1. **TA1070- Spesolimab** for treating generalised pustular psoriasis flares. The proposed RAG rating for this is RED. The NICE template indicated a cost impact of £99,00 in year one, peaking at £101,000 in year two and then reducing to £4,000 by year five. **TA1074- Sparsentan** for treating primary IgA nephropathy. The proposed RAG rating for this is a RED. The NICE template indicated a cost impact of £21,000 per year in year one, peaking at £74,000 in year two, then reducing to £52,000 by year five. The proposed RAG ratings for the above NICE TAs were agreed by the group and will be added onto the formulary. Actions NICE TA's to be taken to CRG for approval. Once approved, CSU team to add drugs to the formulary.	**AGR** **AGR**
	FORMULARY UPDATES	
2025/116	**Formulary update:** The MSK chapter is now complete, the group will now move to the ENT chapter. After this Skin will be completed and then ongoing work with the paediatric formulary work will continue. The agreed blurb for the front page of the formulary is now live.	
2025/117	**Formulary Changes since last LSCMMG** The list of changes was provided to the group for information.	

GUIDELINES and INFORMATION LEAFLETS		
2025/118	**Psoriasis Pathway - update** A version of this was completed in March, however this version only included Biologics in the flow chart not the small molecules. These have now been added with the help of Will Price from East Lancashire. DP is aware of a formatting issue which will be amended before uploading but all requested changes have been made. A query was raised from a pathway point that if the treatment fails, it wasn't clear on the document if they should move to a small molecule or a biologic first. DP responded that the team were unable to get a clear definitive response for this as it is more down to clinical judgement. The difference in cost between biologic agents was raised and it was suggested to add some indication for which biologic clinicians would be directed to first. This was agreed. It was asked if further dermatological input would be required as it could not be confirmed that additional dermatologists had been consulted on this except Will Price. DS requested to send this out to East Lancashire Dermatology colleagues for their input, this was agreed. The group did not approve this item today. <u>Actions</u> DS to send out document to dermatology colleagues for feedback. CSU team requested to add a statement that biosimilars over branded should be used when possible. CSU team to look at a proposed order for selecting biologics and small molecule drugs, plus indication of most cost effective products to use. Bring back to September's meeting.	**DS** **DP** **DP**
2025/119	**Acamprosate and Varenicline Issues** There have been several queries around these two items in the medicines management inbox so have been brought here for discussion. Acamprosate does not currently have a requisition however particularly practice pharmacists are being asked to prescribe this for substance misuse. Unfortunately, there is a lack of clear guidance in primary care for this, and it was proposed to the group for some work to be undertaken to develop some form of guidance for primary care prescribers. For this to happen it will also require a RAG status. It was proposed for a Red RAG status, however, was also noted that a lot of the organisations currently recommending this don't have prescribing capabilities and are reliant on general practices taking on prescribing. It was also highlighted the need for better communication from the other organisations to general practice to recommend prescribing. MP has been involved in some work around Varenicline with ICB colleagues to get a consistent approach across the ICB. MP and AGR will meet up outside of LSCMMG to put together some wording for the website. <u>Actions</u>	

	CSU team to look at and bring a proposed RAG rating for Acamprosate to the next meeting. MP and AGR to meet to put together some wording for the website for Varenicline.	**AGR** **MP/AGR**
2025/120	**Infant Feeding Guide** This has been sent in from a task and finish group primarily looking at women's services and midwifery and it was asked to be brought to LSCMMG for approval as is. The CSU team reviewed it and there are several references to treatments for things such as thrush, so several medications are listed within the guide. It was also noted that the document is quite substantial in size. If approved the expectation is that it would go onto the ICB internet page along with the LSCMMG page. The group were asked if they would approve the document, request further scrutiny, return to the group for more clarity or for the CSU to produce a short form for the medicines to go onto the website. It was asked how this document crossed over with the Northwest ODN neonatal feeding guideline which would be used and then babies would be discharged into community. This was unclear if/ how it does, JO and AGR will meet outside of the group to discuss further but this will need to be put back to the task and finish group. Further feedback suggested that most medications within the document were ok, however a lot of clinicians were uncomfortable with Domperidone being included in the guidance. Pennine LMC have provided a strong comment that they are not happy taking on the prescribing for Domperidone at all due to the MRHA alert. Included in the guide are infant formulas, it was raised the previous feeding guidelines these caused a lot of back-and-forth discussions between primary and secondary care which took a long time to resolve. The size of the document was a clear issue as it proved difficult for the group to properly scrutinise it which could lead to important things being missed. It was also said due to its size it was not user friendly, and it was unclear if drug availability had been taken into consideration when creating the guide. It was also noted that several of the links do not work correctly. It was agreed by the group that this needs further work and that LSCMMG would be more of a consultation member, not co-author. AGR to feed back to the group that the document is too large, there are items that LSCMMG members were not comfortable with such as the inclusion of Domperidone and unlicensed oral contraceptives. The group did not approve this item at this time due to issues raised above. <u>Actions</u> AGR to link in with JO to discuss crossover with the Northwest ODN neonatal feeding guideline. AGR to feedback comments from members about the document.	 **AGR/JO** **AGR**
	Denosumab 120mg RAG consultation A consultation was sent out to members to ask if they were happy to keep the Amber RAG status rather than reverting to a Red RAG. The response	

2025/121	received supported keeping the Amber RAG status. Several members highlighted they felt they had missed the consultation and requested it be sent back around for consultation. It was also asked for the monitoring requirements to be clarified and what the rational for a Red RAG was in neighbouring areas. There was also mixed feedback from the LMC, and that the shared care agreement was not clear on doses and indications which is needed, and the LES only states the 60mg not the 120mg. With differing RAG positions, it was also requested to get patient numbers. It was highlighted there is a pre-filled syringe available, this could be a possibility but would need to be looked at in more detail. It was agreed to be resent out for consultation and brought back to September meeting. <u>Actions</u> AGR to get patient numbers for Denosumab 120mg. JB and LD to send AW/ AGR information they have on training patients to self-administer the pre-filled syringes. CSU team to investigate producing a patient information leaflet. AGR to resend the paper out for further consultation and bring back to September's meeting.	**AGR** **JB/LD** **AGR** **AGR**
2025/122	**Relugolix-estradiol-norethisterone RAG consultation** This was a RAG confirmation paper for a pre-proposed RAG status of Amber which is in keeping with other similar therapies. It was raised however the concerns over the responsibility for DEXA scans which are required when a patient is on this drug. This responsibility could move to primary care if this is agreed as an Amber RAG, however there are models where the specialist retain responsibility for the DEXA scans and the GPs continue prescribing. It was raised that at ELHT for Uterine Fibroids the GPs agreed to take over the DEXA scanning, this was then mirrored in Morecambe Bay. If there was a different pathway for this item, it could cause issues. It was noted that DEXA scans are readily available however determining the results could be challenging. It was suggested an information sheet on how to interpret T-scores could be produced to support this, this was agreed by the group. This item was approved as an AMBER RAG with the development of an information sheet for interpreting T-scores. <u>Action</u> JO to investigate if there are any current information sheets for interpreting T-scores and let AGR know outcome. CSU team to develop information sheet for interpreting T-scores if one not already available.	**JO** **AGR**
2025/123	**Fentanyl patch application guidance - update** This is a patient leaflet that was developed by Bolton CCG and the local Substance and Misuse group asked if it could be made into an LSCMMG	

	document. This was brought previously for members to view, the formatting has been updated and LSCMMG badging added. Members approved this item. Action AGR to upload to website.	**AGR**
2025/124	**LSC Hypertension pathway** This was requested to be brought to LSCMMG for approval by a multidisciplinary group that worked within Lancashire and South Cumbria and is based on the GMMMG pathway template. The group nor the CSU team have not seen this document prior to it being sent out for consultation. The group were asked for comments, and the CSU team did ask for an extension of deadline because it was new people also and it was unclear if anyone from LSCMMG had been involved with this multidiscipline group. It was thought that Rukaiya had been involved, and she had been liaising with that group and lightly with the CSU team but further than this it hadn't been fully reviewed. Rukaiya had emailed MP during the meeting and asked for a few additional comments to be made to the group. One comment was the inclusion of Empagliflozin along with Dapagliflozin as they will both soon have the same licence indication. Another note was that some of the links' need replacing. The group were keen to have this launched on the 1st of July to link in with the case findings are released for long term conditions that population health is compiling. A point was highlighted that the information in the document around step 2 medication initiation doesn't align with currant NICE guidance or patient wishes in a lot of cases, and this is a concern. It was added that from a medications point of view it was straightforward, but the detail and clarity mentioned around diagnosis and assessment and misalignment with NICE for step 2 medication initiation was an issue. The group did not approve this item today. Action AGR to liaise with the group with comments from today's meeting.	**AGR**
2025/125	**Mesalazine prescriber information leaflet** There have been a few requests for this, it is based on the SPC BNF and SPS monograph for Mesalazine. It includes different preparations and monitoring requirements based on SPS along with contraindications and precautions and is based from Nottingham's prescriber sheet. It was asked that due to Mesalazines similarities with Sulfasalazine why was Mesalazine not part of shared care, but Sulfasalazine is. The response was that Mesalazine has less systematic absorption as it is targeted. However, with the monitoring is the same, so again was asked why this isn't included in shared care. This was discussed by the group as clarity was requested. It was requested to take this item outside of LSCMMG to the shared care group to discuss if it should be shared care. Patient numbers were also requested.	

	This document was approved today with a follow up requested with the shared care group. <u>Actions</u> AGR to get patient numbers AGR to take patient numbers and document to shared care group for further discussion.	**AGR** **AGR**
2025/126	**Pathways and Guidance workplan** Nothing for discussion.	
NATIONAL DECISIONS FOR IMPLEMENTATION		
2025/127	**New NHS England Medicines Commissioning Policies June 2025** Nothing to discuss.	
2025/128	**Regional Medicines Optimisation Committees – Outputs June 2025** Nothing to discuss.	
2025/129	**Evidence Reviews Published by SMC or AWMSG June 2025** Paper sent to members for information only.	
ITEMS FOR INFORMATION		
2025/130	**LSCMMG Cost Pressures Log** This will be sent out to members after the meeting.	
DATE AND TIME OF NEXT MEETING **The next meeting will take place on** **Thursday 11th September 2025** **9.30 – 11.30** **Microsoft Teams**		