Minutes of the Lancashire and South Cumbria Medicines Management Group Meeting

Thursday 11th September 2025 (via Microsoft Teams)

Name	Role and organisation	Mar-25	Apr-25	May-25	June-25	July-25	Sept-25
Andy White (AW)	ICB Chief Pharmacist (Chair)	✓	✓	✓	✓	✓	✓
Trust senior medical representation from the following trusts							
Dr Hanadi Sari-Kouzel (HSK)	Blackpool Teaching Hospitals	✓	✓	✓	✓	✓	✓
	University Hospitals of Morecambe Bay						
	Lancashire Teaching Hospitals						
Dr Shenaz Ramtoola (SR)	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	✓	✓	✓	Apol
Trust senior pharmacist representation from the following trusts							
James Baker (JB)	Blackpool Teaching Hospitals	✓		✓	✓	✓	Deputy (Alex Davies)
Andrea Scott (AS) (Nima Herlekar (NH) or Jenny Oakley temporarily attending (JO))	University Hospitals of Morecambe Bay	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						

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Primary care Integrated Care Partnership senior pharmacist representation							
Melanie Preston (MP)	Fylde Coast	Deputy	Deputy	✓	✓	✓	✓
Clare Moss (CM)	Central	✓	Apol	✓	✓	Apol	✓
Lisa Rogan (LR)	Pennine Lancashire	Deputy (Laila Dedat)	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	✓	✓
	ICB Senior Commissioning Manager						
Lucy Parker (LP) Previously (LD)	ICB Finance Representative	✓	✓	✓		Apol	Apol
	Provider finance representative						
Lindsey Dickinson (LD)	Associate Medical Director LSC ICB						✓
Praful Methukunta (PM)	Local Medical Committee Representation	Joined May 25	Joined May 25	✓	✓	✓	✓
Adam Dedat (AD)	Local Medical Committee Representation	Joined June 25	Joined June 25	Joined June 25	✓	Absent	Absent
Mubasher Ali (MA)	Community Pharmacy LSC			Absent		✓	Apol
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	✓	✓	Apol
IN ATTENDANCE:							
Domnic Sebastian (DS)	Divisional Medical Director for Surgery & Anaesthetics ELHT					✓	
Brent Horrell (BH)	CSU Head of Meds Commissioning	✓	✓	✓	✓	Apol	✓
Daivd Prayle (DP)	CSU Senior Meds Commissioning Pharmacist	✓	✓	✓	✓	✓	Apol
Adam Grainger (AGR)	CSU Senior Meds Performance Pharmacist	Apol	✓	✓	✓	✓	✓
Jill Gray (JG)	CSU Meds Commissioning Pharmacist						✓

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Paul Tyldesley	CSU Meds Commissioning Pharmacist						✓

Key

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

	SUMMARY OF DISCUSSION	ACTION
2025/131	**Welcome & apologies for absence** Apologies were noted from Lucy Parker, John Miles, Adam Janja, James Baker, Mohammed Al Nagar and David Prayle.	
2025/132	**Declaration of any other urgent business**	
2025/133	**Declarations of interest (DOI)** No declarations relevant to items discussed today were raised. However, DSR raised her long-standing DOI with Novo/Lilly. BH mentioned that members should have received a link that went out approximately two weeks ago for people to complete declarations of interest utilising the new ICB process. A summary of those that have provided a response will be brought to the October LSCMMG meeting.	
2025/134	**Minutes and action sheet from the last meeting 10th July 2025** The Minutes were approved and will be uploaded to the website.	
2025/135	**Matters arising (not on the agenda):** AW highlighted that DJ had raised Acarizax for discussion. To be discussed as an AOB.	
	LSCMMG Terms of Reference AW noted that the terms of reference had not yet been finalised due to the need to get them onto the executive committee's agenda. There was a review of all committees within the ICB, and the terms of reference were pulled back into that review. AW expressed hope that the terms of reference would be finalised in the next round.	

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2025/136	It was clarified that AW, as an officer of the ICB, needed to be in the chair because he holds the budget. There was some confusion about which committee the terms of reference needed to be approved by, and different advice had been received from different places. SR inquired whether there would be a big Northwest-wide system rather than the current setup. AW explained that there is a Northwest Medicines Optimization Group and a national formulary expected by 2028. Until then, there is a requirement to do things locally, but the direction is to align things across the Northwest to stop the postcode lottery and border issues. SR suggested waiting for all medical directors to be in post before finalising the terms of reference to ensure they all agree. AW agreed that it has to be clinically agreed and appropriate but emphasised the need to keep things moving forward and not stop the work in the meantime. **Action** AW to bring an update to the October LSCMMG	**AW**
	NEW MEDICINES REVIEWS	
2025/137	**Request to Change Colour Classification (RAG): Mexiletine for the treatment of documented ventricular arrhythmias** JG mentioned that Mexiletine had been reviewed in 2022 and given a Red RAG rating for ventricular arrhythmia. A request from Liverpool Heart and Chest to review that RAG rating was noted, but the position in Cheshire and Mersey had been suspended due to the change not functioning as intended. The recommendation was to retain the current Red RAG status for Mexiletine. This was supported by consultations with the cardiology pharmacist network, cardiology formulary group, and the full LSCMMG consultation. JG noted that East Lancashire understood the need to retain the Red RAG status at the moment but would like to consider shared care in the future. They appreciated the issues with primary care and the drug tariff price of Mexiletine. AW and BH agreed that retaining the Red RAG status was a sensible approach, supported by consistent feedback. **Action** The existing Red RAG rating to remain, no actions required.	
	L-ornithine and L-aspartate (LOLA) granules 3g Sachets (Hepa-Merz® Granulat 3000) for the treatment of hepatic encephalopathy PT presented the request for LOLA granules, which came from specialists at East Lancashire Hospitals. The patients in question are those with persistent or refractory hepatic encephalopathy who have already used	

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2025/138	Lactulose and rifaximin but need an additional treatment option. The consultation was conducted on the basis of a Red RAG rating due to the unlicensed indication and limited evidence supporting its use. Concerns were raised by the Fylde Coast regarding the financial implications of keeping LOLA in hospitals, as it would impose a cost burden. The estimated drug costs could be an additional £100,000 to £200,000 per year. However, it was noted that if LOLA helps in reducing hospital admissions or shortening bed days, the overall cost might not be as high as initially projected. The consultation received broad support from East Lancashire, Fylde Coast, the LMC, and UHMB, with the primary concern being financial. AW highlighted that the number of patients in the Lancashire and South Cumbria health economy is estimated to be around 60 to 80, making it a relatively small patient group. The group discussed the potential impact on other trusts and the need for a consistent approach across the region. It was decided to defer the decision to the formulary working group for further consideration and to gather more precise numbers from each trust. **Actions** LOLA to be discussed at formulary working group to gather more precise numbers from each trust prior to agreeing a RAG position.	**DP**
2025/139	**Short Chain Fatty Acid Enema** JG mentioned that the request for Short Chain Fatty Acid Enema came from the gastroenterology department at East Lancashire Hospitals. It was noted that this was an existing practice at East Lancashire prior to the formulary development, and the request was more of a housekeeping exercise. The enema is used for a very small subset of patients with diversion colitis who are symptomatic and cannot be operated on. The estimated number of patients is approximately three per year. The cost of the enema is about £20 per enema, which translates to approximately £3,000 per year for the cohort of patients. The product is unlicensed. It was noted that most patients would be offered licensed treatments first, and only those who do not respond would be offered the Short Chain Fatty Acid Enema. The formulary working group had no objections to the product, and the consultation received no objections either. The proposal was to give the product a Red RAG rating, and there were no dissenting opinions during the meeting. **Action** Short Chain Fatty Acid Enema agreed as a Red RAG rating. The recommendation to be made to CRG for ratification by ICB Execs.	

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2025/140	**New Medicines Workplan** BH highlighted that there were several items coming up for discussion in October. He specifically mentioned the clascoterone for acne vulgaris and VSL#3 probiotic for pouchitis. The group discussed whether to review clascoterone for acne vulgaris in advance of NICE, given that NICE had deferred the review date. The group agreed to prioritise them both. There was a suggestion to get the views of the antimicrobial community regarding the gastro item to ensure that antimicrobial resistance concerns were addressed. BH mentioned that the new medicines workplan was relatively short but included several important items. **Actions** To prioritise clascoterone and VSL#3 probiotic and add to the workplan	**DP**
2025/141	**New NICE Technology Appraisal Guidance for Medicines July/August 2025** AGR highlighted the following ICB commissioned NICE TAs from July and August: NICE TA 753 Cenobamate (Updated TA753) is recommended for treating focal onset seizures in epilepsy, already agreed as an Amber 0 RAG rating. NICE TA 1075 Dapagliflozin for treating chronic kidney disease, recommended as a Green RAG rating. NICE TA 1077 Nemolizumab for treating moderate to severe atopic dermatitis in people 12 years and over, recommended as a Red RAG rating. NICE TA 1080 Mirikizumab for treating moderately to severely active Crohn's disease, recommended as a Red RAG rating. NICE TA 1087 Betula verrucosa for treating moderate to severe allergic rhinitis or conjunctivitis caused by tree pollen, recommended as a Red RAG rating. NICE TA 1088 Ruxolitinib cream for treating non-segmental vitiligo in people 12 years and over, recommended as a Do Not Prescribe RAG rating. NICE TA 1094 Guselkumab for treating moderately to severely active ulcerative colitis, recommended as a Red RAG rating. NICE TA 1095 Guselkumab for previously treated moderately to severely active Crohn's disease, recommended as a Red RAG rating. AW queried the place in therapy for some of the new treatments, particularly those with high-cost implications. There was a discussion about the need to review the IBD treatment pathways and prioritize the use of cost-effective treatments. **Actions**	**AGR**

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	Recommendations relating to the eight NICE TAs to go to CRG for consideration and ratification by ICB Execs.	
FORMULARY UPDATES		
2025/142	**Formulary update: Abidec shortage** BH mentioned that the shortage of Abidec has been ongoing for a while and that the Northwest Neonatal Network had drafted a document to address the vitamin and iron requirements for infants based on gestation periods and weights. AW noted that the document seemed sensible to adopt. The group agreed to approve the guidance document as written. **Action** To be uploaded to the formulary.	**BH**
2025/143	**Formulary Changes since last LSCMMG** The list of changes was provided to the group for information.	
GUIDELINES and INFORMATION LEAFLETS		
2025/144	**Paracetamol – prescribing weight-adjusted paracetamol in adults** AGR introduced the document. The paracetamol guideline has been reviewed by the Medicine Safety Task and Finish Group, the Medicine Safety Committee, and the Care Home Group. The document aims to assist in adjusting the paracetamol dose for patients with low body weight, e.g. those in care homes. AW noted that the document is not in the usual house style, and there was a suggestion to amend it to align with the standard format. PM mentioned that the document would involve a significant piece of work, especially for primary care, as many care homes are covered by primary care. It was suggested that the document be sent out as part of the monthly safety documents to ensure that the Medicines Management Team can pick it up and conduct an audit to see what is being prescribed. DJ raised a concern that the dosing in the document differs from what is in place and it was suggested we should ensure consistency across trusts. BH proposed engaging with trusts to ensure consistency of dosing recommendations and to bring the document back for review. **Actions** It was agreed to bring the document back in November after checking alignment with the trusts and ensuring it is in the usual house style.	**AGR**
	Ivabradine prescriber information sheet – update	

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2025/145	AGR told the group that the document was reviewed, and it was noted that there were no changes to the content of the document itself. The references were updated. **Actions** The group agreed to approve the document and it is to be uploaded to the formulary	**AGR**
2025/146	**Inclisiran position statement – update** AGR told the group that document was reviewed, and it was noted that there were no changes to the content of the document itself. The references were updated. PM raised a concern about the funding for the administration of inclisiran. He mentioned that the LMC had previously disputed the funding and had written to the ICB about it. There was confusion about whether GP practices were obliged to take on the prescription and administration of inclisiran. AW clarified that the initial inclusion of inclisiran in the complex injections list was withdrawn because it was being paid from a national fund, and there was no justification for paying twice for the same activity. AW emphasised that the discussion should focus on the clinical appropriateness of the information sheet, and any contractual issues should be addressed separately. SR highlighted the need for clarity on where inclisiran should be prescribed and administered, as there was confusion among endocrinologists and cardiologists. AW suggested that the position statement will be brought back to the next meeting with the position of inclisiran in the treatment pathway included to ensure everyone is clear on when inclisiran should be used. **Actions** Position statement will be brought back to the next meeting with the position of inclisiran in the treatment pathway clarified to ensure everyone is clear on when inclisiran should be used.	**AGR**
	Good prescribing guidance – update AGR said the update was prompted by a query from Pennine Lancashire regarding community pharmacies stopping MDS dispensing for patients not issued seven-day prescriptions. The concern was that this was putting undue pressure on GPs. Pennine Lancashire's clinical stance does not support the issue of seven-day prescriptions unless there is a genuine clinical need, aligning with the position of Greater Manchester. The group discussed the inclusion of the Pennine Lancashire position in the Good Prescribing Guidance to increase clarity and ensure community	

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2025/147	pharmacies continue to issue MDS with monthly prescriptions. It was suggested to link to the NW document on MDS and seven-day prescribing, despite it being lengthy, to provide comprehensive guidance. CM mentioned that there was a previous one-page document agreed with the LMC and LPC during the CCG days, which could be used as a template for a more concise version. BH proposed engaging with the LPC to ensure there are no unintended consequences and to get their input on the proposed update. The group agreed that having a shorter version of the NW document with a link to the full document would be the best approach. **Actions** To engaging with the LPC to ensure there are no unintended consequences and to get their input on the proposed update. Add a shorter version of the NW document with a link to the full document to the Good Prescribing Guideline.	**AGR** **AGR**
2025/148	**Insulin safety document** AGR told the group that the document "Six Steps to Insulin Safety" was developed following a never event in Blackpool. It was drafted by a pharmacist from Blackpool Teaching Hospital. The group discussed whether to approve the document as written or to engage in further consultation. AW suggested that the document should include the author's full designation and the support of the trust to provide context and credibility. It was noted that the document should follow the usual house style and include the LSCMMG logo if it is to be part of the formulary. The group agreed to link with NB to ensure that safety documents are consistently reviewed and approved by the appropriate groups. **Actions** The document should be in the house style and logo added before adding to the website.	**AGR**
	Denosumab 120mg re-consultation AGR outlined that document was circulated and discussed at the July meeting but members felt they had not had a chance to submit comments so it was re-consulted on. East Lancashire's comments remained the same, supporting the Amber 1 status, while ICB comments and the LMC supported reverting to a Red RAG status due to safety and monitoring concerns. Concerns were raised about the monitoring requirements aligning with the 60mg product. There was a suggestion for patient education and potential self-administration during hospital visits to optimize care and reduce costs.	

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2025/149	PM highlighted that the LMC feedback indicated a need for monitoring kidney function and potential DXA scans, which would shift the burden to primary care. LD mentioned that general practice would require a clear shared care process and appropriate funding to manage the additional workload if more prescribing was shifted to primary care. HSK noted the significant cost and administrative burden on departments if the prescribing shifts from primary to secondary care. AD from Blackpool Teaching Hospitals NHS Foundation Trust mentioned that they had started implementing shared care earlier in the year and felt it was safe to refer patients to primary care. The group discussed the need for consistency across the patch and the importance of engaging with the cancer network to address the growing patient numbers and capacity issues. It was decided to revert to a Red RAG status for Denosumab 120mg, with an action to work with the cancer network to develop a more planned system-wide approach. **Actions** Revert to a Red RAG status for Denosumab 120mg, but work with the cancer network to develop a more planned system-wide approach.	**AGR**
2025/150	**Degarelix prescriber information sheet – update** AGR told the group that the document was reviewed, and it was noted that there was only very minor changes to the content of the document itself. The references were updated. **Actions** The group agreed to approve the document and it is to be uploaded to the formulary	**AGR**
2025/151	**Testosterone shared care (post-menopause) – update** AGR told the group that the document was due to expire on the website and needed updates. A new MHRA alerts and additional safety advice were included in the updated document. The additional text was highlighted in red to indicate the changes. FP mentioned that there had been some communication between consultants and GPs with specialist interests regarding the trust asking for support and training to support consultants with the implementation of the shared care document. This was linked to the commissioning of a Tier 2 menopause service. It was noted that the Women's Health lead Commissioner was linking with primary care, and the commissioning of the Tier 2 menopause service was going to be included as a commissioning intention. AW mentioned that there is likely to be a licenced product coming soon for perimenopausal and postmenopausal use, which is supportive of NICE	

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	guidance. This would make the use of testosterone in this context less controversial. **Actions** The group agreed to approve the document and it is to be uploaded to the formulary	**AGR**
2025/152	**Osteoporosis: Secondary fracture prevention patient treatment pathway** BH introduced the paper and mentioned that the pathway was developed by the Rheumatology Alliance and consulted with rheumatologists, endocrinologists, and care of the elderly clinicians. Changes were made based on their feedback before presenting it to the meeting. It was noted that the pathway differs from the NICE TA for Teriparatide (TA161), which is nearly 20 years old. The restrictions on Teriparatide use were initially due to its high cost, but with the availability of a biosimilar, it is no longer a high-cost drug. SR suggested using consistent language for describing patient groups. Specifically, the term "postmenopausal people" should be changed to "postmenopausal biological females" to align with the language used for males. AW pointed out formatting issues where paragraphs were broken across pages, making the document difficult to read. HSK raised a concern about the scope of the pathway, noting that all parenteral therapies are for secondary care only. The document should clearly state which sector or setting these therapies are best administered in. SR suggested removing the line that specifies the pathway is principally for fracture liaison services and primary care, as the decision-making for secondary prevention seems to be primarily within secondary care. The group agreed to make the necessary changes to the language, formatting, and scope of the document. The updated document will be reviewed by the Rheumatology Alliance before final approval. **Actions** To be finalised and forwarded to the Rheumatology Alliance before final approval	**DP**
	Azathioprine shared care guideline – update (MHRA alert) AGR told the group that the update was prompted by a significant MHRA alert concerning cholestasis in pregnancy. This was considered important enough to warrant an immediate update to the shared care guideline, even though the document was due for a more comprehensive update in the autumn when new BSR guidance is expected. The changes involved incorporating the MHRA alert into the existing shared care guideline. The new safety advice and additional text were	

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2025/153	highlighted in red within the document to indicate the updates. The group agreed that the update was necessary for patient safety. **Actions** The group agreed to approve the document and it is to be uploaded to the formulary	**AGR**
2025/154	**Pathways and Guidance workplan** AGR told the group that team is currently working on several items, including the amiodarone and dronedarone shared care documents. These documents were transferred across to the Northwest template, and there is an expectation that Greater Manchester will update them. However, it was noted that Greater Manchester might not update them through the Northwest Medicines Optimisation Group. The team is keeping an eye on the updates and will liaise with Greater Manchester to obtain the updated documents. Depending on the significance of the changes, they might revert to their own version of the documents. AW emphasised the importance of maintaining consistency across the Northwest. He suggested that if the documents were agreed upon as Northwest documents, they should remain as such. Any changes should be made as a Northwest document to ensure uniformity. BH supported this view, stating that if a Northwest document is produced, it should be updated as a Northwest document. There was a discussion about the realism of the timeframes given the team's current workload and the transition of the team from the CSU to the ICB on 1st October. BH mentioned that the team is dealing with a significant amount of work related to information governance and document transfers, which might cause some delays. AW suggested that some items might need to be pushed to November to ensure that the team can focus on more substantial items and not rush through them.	
NATIONAL DECISIONS FOR IMPLEMENTATION		
2025/155	**New NHS England Medicines Commissioning Policies June 2025** Nothing to discuss.	
2025/156	**Regional Medicines Optimisation Committees – Outputs June 2025** Nothing to discuss.	
2025/157	**Evidence Reviews Published by SMC or AWMSG June 2025** Paper sent to members for information only.	
ITEMS FOR INFORMATION		

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2025/158	**LSCMMG Cost Pressures Log** This will be sent out to members alongside the draft minutes.	
AOB	DJ raised the issue of the RAG rating for Acarizax, a treatment for allergic rhinitis caused by house dust mite allergy, which had a NICE TA earlier in the year. LSCMMG reviewed it and gave it a Red RAG rating. DJ mentioned that Greater Manchester had placed Acarizax as Red, while Pan Mersey had rated it as Amber retained. He highlighted the potential significant impact on services and the need for a review of the RAG rating. AB noted that East Lancashire had requested Acarizax before the NICE TA was approved and had a lot of back and forth. She mentioned that their ENT consultant had requested it as Amber, but that was not possible the they would be supportive of a Red RAG status. AB indicated that East Lancashire would support a RAG rating review if needed. The group discussed the urgency of the review and the potential impact on services. It was decided to add the review of the RAG rating for Acarizax to the work plan for November. **Action** Review of the RAG rating for Acarizax to be added to the work plan for November.	
DATE AND TIME OF NEXT MEETING **The next meeting will take place on** **Thursday 9th October 2025** **9.30 – 11.30** **Microsoft Teams**		

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