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 9th October 2025 (via Microsoft Teams)

Name	Role and organisation	Mar 25	Apr 25	May 25	June 25	July 25	Sept 25	Oct 25
Andy White (AW)	ICB Chief Pharmacist (Chair)	✓	✓	✓	✓	✓	✓	✓
Trust senior medical representation from the following trusts								
Dr Hanadi Sari-Kouzel (HSK)	Blackpool Teaching Hospitals	✓	✓	✓	✓	✓	✓	✓
Mohammed Elnaggar (ME)	University Hospitals of Morecambe Bay	Joined May 25	Joined May 25	✓	✓	✓	Apol	Absent
	Lancashire Teaching Hospitals							
Dr Shenaz Ramtoola (SR)	East Lancashire Teaching Hospitals (Deputy Chair)	Deputy	✓	✓	Deputy (Dr Truman)	Deputy Dr Truman	✓	✓
Trust senior pharmacist representation from the following trusts								
James Baker (JB)	Blackpool Teaching Hospitals	✓		✓	✓	✓	Deputy (Alex Davies)	✓
Andrea Scott (AS) (Nima Herlekar or Jenny Oakley temporarily attending)	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) / Matthew Ling (ML)	Lancashire and South Cumbria Foundation Trust	ML Attending	ML Attending	ML Attending	ML Attending	ML Attending	DG Attending	ML Attending
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)	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							

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Lindsey Dickinson (LD)	Associate Medical Director LSC ICB						✓	Apol
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	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)	ICB Head of Meds Commissioning	✓	✓	✓	✓	Apol	✓	✓
David Prayle (DP)	ICB Senior Meds Commissioning Pharmacist	✓	✓	✓	✓	✓	Apol	✓
Adam Grainger (AGR)	ICB Senior Meds Performance Pharmacist	Apol	✓	✓	✓	✓	✓	Apol
Jill Gray (JG)	ICB Meds Commissioning Pharmacist						✓	
Paul Tyldesley	ICB Meds Commissioning Pharmacist						✓	

Key

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

	SUMMARY OF DISCUSSION	ACTION
2025/159	**Welcome & apologies for absence** Apologies were noted for Adam Janja, Dorna Ghashghaei, Lindsay Dickinson, Zuber Patel and Adam Granger.	
2025/160	**Declaration of any other urgent business**	
2025/161	**Declarations of interest (DOI)** No declarations relevant to items discussed today were raised. However, DSR raised her long-standing DOI with Novo/Lilly. SR asked if, considering declarations of interest have now been made using the ICB process, declarations of interest need to be made at each meeting. BH stated that once a full set of responses have been received,	

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	declarations need not be made at each meeting. BH reminded the group to declare their interests using the link sent to comply with ICB processes. DJ let the group know that he participated in ophthalmology research for Bayer. SR suggested that the LSCMMG distribution list is reviewed as it contains names of some people who do not attend. AW agreed this should be done.	
2025/162	**Minutes and action sheet from the last meeting 11th September 2025** The Minutes were approved and will be uploaded to the website.	
2025/163	**Matters arising (not on the agenda):** DJ asked when the Acarizax RAG rating was to be reviewed at LSCMMG. DP replied stating that the review is due for discussion at November LSCMMG. It will be sent for a quick consultation before the meeting. DJ asked then the gastroenterology high cost drug pathway was due for review at LSCMMG. DP stated that professional society guidance was now available so the guideline can now be prioritised. BH stated that the formulary entry for tirzepatide for weight loss has not been updated to reflect the ICB commissioning position. AW stated that the commissioning position has not been clarified. BH stated that the formulary will be updated as soon as the commissioning position is clarified. **Actions**: Acarizax RAG review to be presented at November LSCMMG Gastroenterology high cost drugs pathway to be prioritised **LSCMMG Terms of Reference** AW let the committee know that the terms of reference for LSCMMG have been approved by the ICB executive committee. AW will remain as chair as this is required by ICB delegation rules. The ratification of outputs of LSCMMG should now be streamlined and where necessary will go straight to the executive committee. Following a query from SR, AW clarified that the scheme of delegation of the ICB is established and that LSCMMG can sign off items with an impact of up to £100,00 as long as a senior ICB employee is Chair of the meeting . JM stated that he liked the approved document as it gives the group enough flexibility to do its work in a meaningful, safe and robust manner, it was queried how the new terms of reference will be implemented with senior primary care representatives. AW stated that LSCMMG is always looking to recruit senior primary care representatives. SR asked if the terms were up for discussion at the meeting, AW stated that such discussions should be held outside the LSCMMG meeting as the terms of reference have been approved. SR asked for clarity on the definition of senior clinician leadership role in relation to the chair of LSCMMG and whether this can include clinicians in management. AW clarified that registration with a clinical body was the	**DP** **DP**

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	important element of clinician characterisation as opposed to direct patient contact. SR highlighted that no joint meeting took place, and that AW met the MD without SR present and she wished for this to be recorded, and agreed with AW to close the item. **Ophthalmology macular pathway** BH reported back on a meeting with clinicians to discuss the pathway held in September 2025. There were some challenging discussions, mostly with clinicians based in Blackpool who had drafted their own pathway. BH proposed that the draft LSCMMG pathway has minor adjustments to align with the Blackpool document, it will then be consulted with specialists, with a request that specialists agree where second line agents can be used first line, with a recommendation that it is ratified at the November LSCMMG. **Action** Pathway to be updated, consulted and presented at the November LSCMMG for ratification.	**BH**
2025/164	**5-Fluorouracil – Tolak, new medicines request Moderate change** DP introduced the new medicine application for Tolak. The application for Tolak was produced by a consultant dermatologist and specialist dermatology pharmacist, ELHT. Tolak is a 4% 5-fluorouracil cream for the treatment of non-hyperkeratotic, non-hypertrophic actinic keratosis (Olsen grade I and II) of the face, ears, and/or scalp in adults. This is an alternative product to the normally used 5% cream (Efudix), it has been expedited for review as there are supply issues with Efudix which are expected to continue until at least Q2, 2026. The product would be used as an alternative to Efudix in situations where Tolak has a licence. Tolak has a much more circumscribed list of licensed indications as compared to Efudix, so there is still a need for Efudix for various patient groups requiring a 5-FU product. This product would be added as an addition option to make use of, particularly when stocks of Efudix or other topical treatments are in short supply. Efficacy of Tolak vs 5% 5-fluorouracil cream shows similar results. Adverse events are also similar. WP added that it is something that has been talked about at the British Association of dermatologists meetings about medicines access, and they've sent national communications as part of their bimonthly meeting updates and to recommend that people consider including Tolak on formularies. AW stated that, given the stock supply issues and the fact is cheaper and there is a defined usage, he would recommend approval. PM stated that the LMC supported approval. **Action** The application for Tolak was approved, formulary to be amended.	**DP**
	New medicines workplan DP presented the new medicines work plan. Clascoterone for treatment of	

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2025/165	acne vulgaris in people 12 years and over had previously been removed from the work plan due to being scheduled for NICE review. The latest NICE position on the drug is that the review is suspended as the manufacturer has decided not to submit evidence. WP stated that clascoterone is a hormonal topical product which would present for the first time a licenced product that men could use that is hormonal, as all of the other agents like spironolactone and or overall conceptive type products are not licensed in this patient cohort. The cream is relatively inexpensive and could provide sufficient relief to some people to avoid going down expensive routes where monitoring is required. It was agreed that clascoterone should remain on the work plan. Cequa (ciclosporin) 0.9mg/ml eye drops for treatment of moderate-to-severe Dry Eye Disease (keratoconjunctivitis sicca) in adult patients who have not responded adequately to artificial tears was also agreed for addition to the work plan. **Action** Cequa (ciclosporin) 0.9mg/ml eye drops to be added to work plan and clascoterone to remain on the work plan.	**DP**
2025/166	**New NICE Technology Appraisal Guidance for Medicines September 2025** BH stated that there were no major items from NICE last month. The tirzepatide costing template has been updated by NICE. The impact of this is still being worked on – an update will be brought to the next LSCMMG if significant.	
2025/167	**Formulary update** DP let the group know that the final chapter of the formulary, which is the skin chapter, will be finalised within the next two weeks. A plan is in development for the ongoing update of formulary chapters. **Action** Plan for the rolling review of completed chapters to be presented at November or December LSCMMG	**DP**
2025/168	**Formulary Changes since last LSCMMG** **Actions** BH updated members that the new terms of reference allow more flexibility, therefore when minor changes are made to guidelines, amendments will be made outside of the meeting and a verbal update will be presented to LSCMMG to inform the group of the nature of any minor changes made.	
2025/169	**Hydroxychloroquine prescriber information sheet – update** BH introduced the update of the hydroxychloroquine prescriber information sheet. The update is considered a minor change to align with new SPC information. HSK noted that the new 300mg strength of hydroxychloroquine had not been included in the update. BH stated that he was not aware of who had been consulted as part of the review but that the 300mg strength will be considered, in addition he informed the group that all minor changes that are made outside of LSCMMG will be consulted with a specialist or specialist group.	**AGR**

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	Actions The 300mg strength will be added to the information sheet. Specialists/specialist groups to be consulted for any future minor guideline updates.	
2025/170	**Recurrent UTI guidelines – update** BH stated that the guideline had previously been presented at LSCMMG, it was presented at the current meeting as specialist urologists had now been consulted however no responses were received. BH asked if the next steps should be to work with the antimicrobial group to finalise. NB stated that this approach was acceptable. JM asked that the document be as clear as possible in relation to review and appropriate antibiotic treatment. The proposed approach was accepted. **Action** Recurrent UTI guideline to be further developed with antimicrobial group	**AGR**
2025/171	**Inclisiran position statement – update** BH introduced this update. BH proposed that the guideline and commissioning (which is arranged nationally) is separated for inclisiran. AW stated that this is acceptable. JM stated that GPs are starting to prescribe the drug as the commissioning position has become clearer. PM stated that Preston GPs may not yet be prescribing because of confusion caused by the LES and the national scheme. BH stated that prescribing uptake is closely monitored. The document was approved. **Action** Inclisiran position statement to be uploaded to formulary	**AGR**
2025/172	**Penicillin allergy in primary care** BH introduced this item. The presented document is also being reviewed by the AMS tasks and Finish Group and the AMS Committee who are also engaging with an immunologist from LTH. The regional antimicrobial pharmacist has also been consulted. BH asked LSCMMG members if they felt the document is now suitable for wider, full consultation. NB stated that penicillin allergy is often inappropriately recorded, this can lead to antimicrobial resistance if other nonpenicillin agents are used in their place. PM stated that EMIS software could hamper the effect of the guideline as patients will be coded as penicillin allergic on EMIS. Also, there could be as many as 6% of the population coded as penicillin allergic therefore the workload would be very large. JM stated that the guideline would be welcomed. PM raised the issue of legal liability – BH welcomed this feedback. DJ stated that LTH has produced their own penicillin de-labelling guideline and felt that the LTH document should be considered alongside the ICB guideline. AW stated that guidelines and clinical coding should align, suggesting that Data Quality should be involved. AW also stated that the guidelines should be aligned. **Actions** Guideline to be further developed. Consideration of EMIS coding issues should be taken into account. Data Quality should be involved. Guideline should align with those being produced at trusts.	**AGR / Suzanne Penrose**

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2025/173	**ADHD shared care – update** BH introduced the item explaining that many ADHD providers work remotely and there had been requests to include remote consultations in the shared care guideline. DJ made a suggestion to add in some information about bioequivalence of products as this could help to alleviate supply problems caused by stock shortages. FP stated that she advises prescribers to follow SPS guidance and this could be included in the shared care document. BH suggested the SPS link could be put on formulary. ML stated that his Trust often refers prescribers to SPS. **Action**: Guideline approved, consideration to be given about inclusion of SPS link before formulary upload.	**AGR**
2025/174	**Headache pathway – atogepant and rimegepant – update** BH introduced this item stating that the proposed update was requested by neurologists who felt that the two drugs could be Green (restricted) RAG rated to allow initiation following advice and guidance referrals to reduce pressure on the secondary care service. BH also requested that the Blueteq forms for the drugs be suspended and a pass through payment system introduced. JM urged caution for patients with symptoms who are difficult to diagnose. HKS stated that the term 'secondary care' may be leading patients to hospitals whereas the term 'specialist' would allow other options and thereby reduce secondary care pressures. AW stated that the review of patients after initiation is important, this is not captured by a Green (restricted) RAG rating. BH stated that Dr Chhetri was happy with the proposed change in RAG status. **Actions** Guideline to be updated to show 1. where advice and guidance is indicated, 2. Where referral is indicated, 3. Follow up requirements following initiation. This will be included in the headache pathway. Updated guideline to be sent to Prof Chhetri and JM for review and comment.	**AGR** **AGR**
2025/175	**Lithium shared care guideline – update** BH introduced this item stating that LSCFT have developed a lithium side effect rating scale that has been added to the end of the shared care guideline. ML stated that LSCFT did not develop the tool – it was adopted from another organisation, he stated that the original source reference will be forwarded to BH. JM questioned the realistic expectation of uptake in primary care due to the length of the questionnaire within the scale. NB stated that a protocol has been included in EMIS to indicate lithium toxicity. BH suggested that more work be done to help show where the toxicity scale is triggered for use alongside the EMIS protocol. **Action**: side effect scale to be reviewed alongside EMIS protocol to ensure clarity on when each are used to allow a more workable proposal to be brought back to LSCMMG	**AGR / NB**
2025/176	**Atrial Fibrillation pathway update Moderate change** DP introduced this update to the atrial fibrillation pathway. The update recommends monitoring DOACs every 4 months in frail patients or those aged 75 years and above – previously the recommendation was every 6 months. The NICE Clinical Knowledge summaries for monitoring of	

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	DOACs has changed in line with recommendations in the 2021 European Heart Rhythm Association Practical Guide on the Use of Non-Vitamin K Antagonist Oral Anticoagulants in Patients with Atrial Fibrillation. References have also been updated to reflect the update. The L&SC Cardiac Network - Pharmacist Forum recognises that the guideline is due a full clinical review – this will be prioritised after the monitoring update. DP stated that the update could cause practical issues in primary care due to the quantity of monitoring this would entail. AW reminded the group members that their role is to review clinical changes and that commissioning considerations would normally be dealt with elsewhere. JM stated that clinical considerations were important in making decisions about monitoring. AW concluded that the proposal should be accepted and then asked how the practicalities of the additional monitoring could be addressed. DP stated that risk based stratification of patients based on clinical criteria such as extremes of weight or renal function could be investigated. DJ stated that the harms of DOACs should be taken into account as the trust are seeing patients with bleeds and have shown that a proportion are being treated with DOACs. **Actions** Update accepted, guideline to be uploaded to formulary Risk based stratification to be investigated	**DP** **DP**
2025/177	**Over The Counter (OTC) Items That Should Not Be Routinely Prescribed in Primary Care Policy** DP introduced this item. Currently the 'Over the Counter Items that Should not be Routinely Prescribed in Primary Care Policy' is a 19 page document that mirrors NHSE's 'Policy guidance: conditions for which over the counter items should not be routinely prescribed in primary care'. This paper proposes that the Lancashire and South Cumbria policy is shortened to a position statement linking to NHSE's guidance. The position statement emphasises that it applies to prescribing of over-the-counter items in primary care and prescribing of medicines to hospital out-patients. AW stated that his only reservation was that the NHSE web site can be hard to read. **Action**: Update approved, to be uploaded to formulary	**DP**
2025/178	**Position Statement on Prescribing Shower Protection Pouches** DP introduced this item stating that the document was drafted by Paul Elwood, it mirrors the positions previously held by the CCGs. AW stated that the document is acceptable but should be formatted to be in house style. He also note comments from some clinicians, which can be addressed after the position statement is uploaded to formulary. **Action**: Position statement to be drafted in 'house style' and uploaded to formulary	**DP**
2025/179	**Pathways and Guidance workplan** This was accepted	
2025/180	**New NHS England medicines commissioning policies September 2025** Nothing urgent to consider	

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2025/181	**Regional Medicines Optimisation Committees – Outputs September 2025** Nothing was presented for discussion	
2025/182	**Evidence reviews published by SMC or AWMSG September 2025** DP introduced this item stating that AWMSG have approved infliximab for the treatment of grade 3–4 steroid-refractory myocarditis induced by immune checkpoint inhibitor therapy. This could be relevant to Lancashire and South Cumbria as we would expect to see the same type of patients. HSK asked how we would implement similar guidance, considering the cost of the drug is relatively low. AW stated that there could be multiple individual funding requests. **Action**: DP to have conversation with chemo units to assess developing a policy in line with AWMSG OW31 (infliximab for the treatment of grade 3–4 steroid-refractory myocarditis induced by immune checkpoint inhibitor therapy)	**DP**
2025/183	**LSCMMG cost pressures log – will be updated following the meeting and circulated with the minutes** This will be sent out to members alongside the draft minutes	**BH**
The next meeting will take place on Thursday 13th November 2025, 9.30 – 11.30 Microsoft Teams		

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