Minutes of the Lancashire and South Cumbria Medicines Management Group Meeting

Thursday 11th December 2025 (via Microsoft Teams)

ame	Role and organisation	Mar 25	Apr 25	May 25	June 25	July 25	Sept 25	Oct 25	Nov 25	Dec 25
Andy White (AW)	ICB Chief Pharmacist (Chair)	✓	✓	✓	✓	✓	✓	✓	✓	✓
Trust senior medical representation from the following trusts										
Dr Hanadi Sari-Kouzel (HSK)	Blackpool Teaching Hospitals	✓	✓	✓	✓	✓	✓	✓	✓	Absent
Mohammed Elnaggar (ME)	University Hospitals of Morecambe Bay	Joined May 25	Joined May 25	✓	✓	✓	Apol	Absent	Absent	Absent
	Lancashire Teaching Hospitals									
Dr Shenaz Ramtoola (SR)	East Lancashire Teaching Hospitals (Deputy Chair)	Deputy	✓	✓	Deputy (Dr Truman)	Deputy Dr Truman	✓	✓	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)	✓	✓	✓	Deputy (Judith Argall JA)
Ana Batista (AB)	East Lancashire Teaching Hospitals	Apol	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		ML Attending
Primary care Integrated Care Partnership senior pharmacist representation										
Melanie Preston (MP)	Fylde Coast	Deputy	Deputy	✓	✓	✓	✓	✓	Deputy (Rukaiya Chand)	Apol
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)	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	✓	✓	✓	✓	Absent
Amy Lepiorz	Associate Director of Primary Care									✓
Lucy Parker (LP) Previously (LD)	ICB Finance Representative	✓	✓	✓		Apol	Apol	✓	✓	✓
	Provider finance representative									
Lindsey Dickinson (LD)	Associate Medical Director LSC ICB						✓	Apol	Absent	Absent
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	Absent	Absent
Mubasher Ali (MA)	Community Pharmacy LSC			Absent		✓	Apol	✓	Absent	✓
Emma Coupe (EC)	Assistant Director of Pharmacy Clinical Services ELTH	✓	✓	Apol	✓	✓	✓	✓	Absent	✓
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	✓	Apol	✓
Zuber Patel	GP									✓
IN ATTENDANCE:										
Domnic Sebastian (DS)	Divisional Medical Director for Surgery & Anaesthetics ELHT					✓			Absent	Absent
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
2025/211	**Welcome & apologies for absence** Amy Lepiorz was welcomed to the meeting and would be providing the link between LSCMMG and commissioning. Apologies were noted for Rukaiya Chand, Melanie Preston, Ana Batista, Dr Shenaz Ramtoola and David Jones.	
2025/212	**Declaration of any other urgent business** Nothing to discuss.	
2025/213	**Declarations of interest (DOI)** An attachment containing submitted declarations of interest from LSCMMG members was provided and will continue to be circulated monthly. The paper also includes a list of members from whom declarations have not yet been received. It was noted that Lucy Dickinson has recently changed her name, which may account for the missing declaration. This will be updated for the next report. **Action** A declaration has not been received from JA. BH to send JA a DOI form.	**BH**
2025/214	**Minutes and action sheet from the last meeting 13th November 2025** The minutes were approved and will be uploaded to the website.	
2025/215	**Matters arising (not on the agenda)** Declarations of Interest – See item 2025/213	
2025/216	**Itraconazole for treatment of Pityriasis Versicolor – Moderate change** Itraconazole on formulary already as Red RAG rating. Noted that NICE CKS recommends prescribing in primary care. NICE guidance supports prescribing in primary care and provides clear instructions for diagnosis and treatment. Following consultation, responses were received from Blackpool and East Lancashire, both of which supported the proposal. Fylde Coast raised queries regarding the timing, which was explained as aligning with current practice trends. Clinicians are considered to have the necessary expertise to diagnose in primary care, as the process is straightforward. Recommendation to assign Green restricted rating for this indication. **Actions** The recommended RAG rating of Green Restricted was approved by the group and will be updated on NetFormulary.	**DP**
2025/217	**Pentosan for treatment of Ketamine Bladder Syndrome – Moderate change** This request originated from MBHT who have patients treated for ketamine-induced bladder pain with pentosan. The trust suggested a less restrictive rating (currently Red) to facilitate discharge; however, following review, the Hub Medicines Team recommended that the drug should remain Red due to the complexity of diagnosis, patient profile, and management requirements. **Consultation feedback**:	

	• Two responses indicated the treatment is too complex for primary care. • Fylde Coast highlighted the lack of evidence and noted that these cases involve ketamine addiction, creating a challenging cycle of pain and relapse. Discussion acknowledged that while cases may increase over time, current evidence is limited, and the indication remains off-label. **Action** Maintain Red RAG rating for this indication. It will remain listed on the formulary but restricted to secondary care due to small patient numbers and the level of specialist input required.	
2025/218	**Fidaxomicin RAG change – Moderate change** The proposal is to change the formulary status from Amber 0 to Green (restricted) for *C. diff* treatment, in line with NICE guidance and antimicrobial group recommendations. This change aims to improve timely access for patients, particularly in care homes, and supports strategic stock placement in community pharmacies due to the high cost and limited availability. Prescribing should only occur on the advice of a microbiologist to maintain safeguards and prevent inappropriate use. Overall agreement that patient safety and timely treatment take priority. **Actions** Reclassify to Green Restricted for *C. diff* treatment, with prescribing limited to microbiologist recommendation and strategic stock to be placed in community pharmacies to avoid delays. AMS Group to monitor usage and review impact after six months, reporting back to the group.	**BH** **NB**
2025/219	**Melatonin product choice** Lancashire Care Trust proposed prescribing unbranded melatonin tablets for children and adolescents with Autism Spectrum Disorder (ASD) and Smith-Magenis Syndrome where sleep hygiene measures have been insufficient. The group discussed the balance between using licensed products for their licensed indications versus generic alternatives off label. While generic melatonin is not fully licensed for these indications, it offers significant cost savings (estimated at £47,000 annually). Given melatonin's long-standing use and safety profile, the group agreed this approach is reasonable. Communication between trusts and primary care is essential to ensure robust discharge processes and clarity on licenced and off label drugs. Commissioning intentions due to be implemented next year should include discharge standards and electronic prescribing to reduce risk and improve continuity of care. **Actions:** NetFormulary to be updated approving the use of melatonin modified release for children and adolescents with Autism Spectrum Disorder (ASD) and Smith-Magenis Syndrome.	**DP**

	DP to liaise with specialist trust colleagues regarding pathway update. Minor guideline updates to be made. AW to raise discharge standards under commissioning intentions.	**DP** **AW**
2025/220	**Raloxifene – new indication – Moderate change** A request was received from a Fylde Coast GP following a proposal from Manchester Royal Infirmary to prescribe raloxifene as breast cancer chemoprevention. This indication is off-label but supported by NICE Clinical Guideline 164 as a second-line option after tamoxifen. Manchester has adopted this approach in line with NICE guidance. Proposal to adopt Amber 0 status for raloxifene in the same patient cohort, aligning with NICE guidance and neighbouring ICB practice. Equity of access across Lancashire and South Cumbria should be considered, as patients often receive treatment in Manchester or Liverpool due to local capacity constraints. It is likely that local trusts already prescribe raloxifene in some cases where tamoxifen is unsuitable. **Actions** Raloxifene to be listed as Amber 0 for breast cancer chemoprevention in line with NICE CG164 on NetFormulary.	**BH**
2025/221	**New medicines workplan** One new medicine was identified for prioritisation this month: Amantadine for fatigue in MS patients. For prioritisation as a moderate change as its use aligns with NICE guidance, where it has been listed as a potential therapy for several years. Clinicians have expressed interest in initiating treatment. The group noted upcoming changes highlighted in NICE forward look, including potential major updates in areas such as diabetes and new licensing for existing medicines. **Discussion:** • BH confirmed that a summary of horizon scanning, including cost growth areas and medicines expected in the next 12–18 months, will be presented at the January meeting. • AW requested trust colleagues assess potential uptake for new therapies and report back, as this may influence future prioritisation and commissioning decisions. • Consideration needed for tariff-excluded drugs and associated funding implications. • Emerging topics such as PrEP were discussed; local authorities may not currently have this on their radar. Public health engagement will be required to ensure awareness and avoid inequities in service provision. **Actions** BH to present horizon scanning summary at January meeting.	**BH**

2025/222	**New NICE Technology Appraisal Guidance for Medicines November 2025** There is one new NICE TA for Delgocitinib for moderate to severe hand eczema. No significant cost impact in Years 1 and 2; estimated moderate impact of £91,000 in Year 3. Not listed as a high-cost drug, but the tariff price is significant (£600 per tube). Current outpatient tariff would not cover the cost of medication, raising concerns about funding arrangements. Trust colleagues were asked to provide an indication of expected uptake to inform planning and potential mitigation strategies. **Actions** AGR to review and re-establish public health contacts and raise awareness of potential new responsibilities in relation to PrEP. NICE TA for Delgocitinib to be added to NetFormulary as a moderate change with a Red RAG rating. Trust members to provide an indication of expected uptake of Delgocitinib to inform planning and potential mitigation strategies.	 **AGR** **AGR** **Trusts**
2025/223	**Formulary update** The team discussed the need for a systematic review of the formulary to ensure accuracy and currency. While incremental updates are made monthly, a full review is required periodically to capture major changes. It was proposed to review each formulary chapter every 36 months (approximately four chapters per year). Begin with the oldest chapter, which has not been fully reviewed for over a year and may require methodology updates. An SOP outlining the review process has been developed, including checks on clinical links, MHRA updates, NICE guidance, and engagement with relevant clinical groups. A schedule of planned chapter reviews should be published on the website to improve transparency and reduce unnecessary queries or FOI requests. Flexibility will be maintained to prioritise chapters with significant recent changes. This systematic review is separate from monthly incremental updates. **Action** Commence systematic review process in the new year. A schedule of planned chapter reviews to be published on NetFormulary in the new year.	 **DP** **DP**

2025/224	**Formulary Changes since last LSCMMG** Updates since the last meeting were presented. Changes on pages 3 and 4 reflect actions agreed at the last LSCMMG and have been closed off in the action log. Page 5 lists updates made since 20 November, including: • **Buprenorphine (sublingual):** Clarified use for licensed indications. • **Cyanocobalamin:** Updated wording around maintenance therapy and self-care advice for 50 mcg and 100 mcg tablets. • **Fexofenadine:** Added 180 mg strength to the formulary. • **Capsaicin cream:** Advised against unlicensed preparations; directed use to neuropathic pain guidance or self-care for osteoarthritis. • **Demeclocycline:** Updated formulary position as previously discussed. • **Erythropoietin (EPO):** Added advice to confirm strength availability with pharmacy before prescribing. **Discussion:** • Significant work is being completed under the new Terms of Reference, enabling timely implementation of minor and moderate updates without escalation to execs. • This process has improved efficiency, with all actions implemented within a week of meetings. • Suggested that a report be prepared for execs highlighting the benefits and volume of minor updates managed under the revised governance structure. **Action** BH to prepare a summary report for execs in the new year demonstrating improvements in timeliness and workload reduction under the new Terms of Reference.	**BH**
2025/225	**Paracetamol guidance – update** The guideline, originally presented in September, has been reformatted into LSCMMG house style and circulated to local trusts for feedback. Responses received: • **LHT and LSFT:** Confirmed they are happy to adopt the guideline. • **LTH:** Raised concerns about alignment with their acute pain guideline, particularly dosing for post-surgical patients. To address this, a note has been added stating that trust-specific guidelines should take precedence for trust patients. The guideline remains titled as a community setting guideline and has been reviewed by the Care Home Group and Safety Group. **Discussion:** • LTH concerns relate to IV and oral prescribing on the same prescription and ensuring dose adjustments to avoid overdose. • Additional considerations include older patients, eating disorders, and weight-based dosing (eGFR).	

	• Trusts without specific paracetamol guidance are invited to adopt this guideline. • Feedback from ELHT and other colleagues indicates the guideline aligns with current practice and can be implemented across both primary and secondary care. • Implementation requires integration into OptimiseRx for primary care and EPMA systems in trusts to provide prompts. • Discharge communications must clearly reflect dosing guidance to prevent unintentional overdoses. • Challenges noted with weight and eGFR data accuracy in GP systems; reliance on these alone is not recommended. Care home patient coding also needs improvement. **Approved**: Community paracetamol dosing guideline, with clarification that trust-specific guidelines take precedence for trust patients. Trusts to review adoption and EPMA integration options. Ensure discharge communications include clear dosing guidance. Consider coding improvements for care home patients and weight/eGFR data accuracy. **Actions:** AGR to confirm consultation email delivery to UHMB and follow up. Link with Julie Lawson to explore OptimiseRx integration and evaluation.	**AGR** **AGR**
2025/226	**Good prescribing guideline – update** Following the September meeting, the 7-day prescribing section of the Good Prescribing Guidelines has been reviewed to ensure accuracy and appropriate tone. Feedback received confirmed the need to link to the new national guideline and update terminology from the previous version. The revised section now reflects these changes and aligns with the intent of the East Lancashire document, with a softer tone. LPC is satisfied with the revised content, subject to inclusion of a link to the new guideline. Consideration given to producing a standalone position statement for ease of reference, particularly for community pharmacies and GPs, due to frequent queries and pushback. Previous statements signed off by LPC and LMC carried weight; replicating this approach would provide assurance and demonstrate cross-professional support. It was suggested inclusion of wording regarding potential charges for patients falling outside the scope, similar to the Greater Manchester statement, and branding with organisational logos. **Actions:** Updated section to be added into the Good Prescribing Guidelines, with link to new national guidance. Draft standalone statement based on updated guidance. Seek sign-off from LPC and LMC to ensure alignment and professional endorsement.	**AGR** **AGR** **AGR**

2025/227	**Shared care agreement forms** The Shared Care Subgroup has been meeting for the past four to five months with the primary objective of improving communication between primary and secondary care. As part of this work, it was agreed to prioritise the development of shared care agreement forms. To date, the following templates have been approved: **Shared Care Request Letters** – for specialists requesting prescribing support from primary care (including mental health). **Acceptance Letters** – confirming primary care's agreement to shared care. **Decline Letters** – currently in development due to complexity. These will be reviewed by the subgroup next Wednesday and presented to January's meeting for sign-off. The letters are provided as PDF templates. Each includes dropdown options for diagnosis and medication, limited to those covered by shared care agreements. Dosage and frequency remain free-text fields to reduce complexity and minimise errors. Implementation considerations are ongoing. Suggestions include oversight through IMOC and engagement with relevant stakeholders such as medical and nursing directors, informatics teams, and the Primary-Secondary Interface Group to ensure smooth adoption across sectors. **Actions** Shared care subgroup to discuss and plan the implementation of the new shared care forms.	**AGR**
2025/228	**Sativex – request for additional guidance** A recent request has raised concerns that Sativex should be prescribed under a Shared Care Agreement rather than via an information sheet. This was previously considered in 2020, when a draft agreement was produced. At that time, the group opted for a prescriber information sheet instead, as there were no long-term monitoring requirements. Consequently, Sativex was classified as Amber 0 rather than Amber 1. The current concern is whether this classification remains appropriate and whether a formal Shared Care Agreement should now be implemented. Key points discussed: • Consistency across the region is essential; prescribing responsibilities should not vary between localities. • The cost implications of moving to shared care are minimal, but designation must follow the agreed checklist and categorisation process. • In the interim, linking to the EMC information sheet on the website was suggested, as it includes the titration schedule and is regularly updated. **Actions**	

	Consult on whether Sativex should move to shared care. Link to EMC information sheet until a decision is made.	**AGR** **AGR**
2025/229	**ADHD shared care – update** A request from East Lancashire highlighted the need to clarify wording regarding medication supply on discharge. The current expectation is that secondary care provides approximately three months' supply; however, ELHT suggested revising this to "usually two to three months" for greater clarity. This change has been highlighted in red for review. Key discussion points: • The intent is not to mandate a strict three-month supply but to set a clear expectation. • Questions were raised about whether this applies during titration or post-titration. • From a commissioning perspective, setting a timeframe would be helpful, but achieving a stable dose can vary significantly (e.g., two months to over a year). • The Shared Care Subgroup will review this as part of the broader shared care framework discussions next week. Updates may be deferred until that framework is agreed. Additional concern: • There is inconsistency in interpreting "stable." Definitions vary (e.g., haemodynamically stable vs. clinically stable), and clarity is essential for safe transitions of care. A standard definition will be developed to avoid ambiguity and improve patient safety. **Actions** Review definition of stable at the Shared Care Subgroup. Align discharge supply expectations with commissioning requirements and shared care framework.	 **AGR** **AGR**

2025/230	**Pathways and Guidance workplan** The Safety Subgroup has requested the development of a GLP-1 Safety/Support Guideline. This follows concerns about private prescriptions initiated inappropriately and subsequently transferred to NHS GPs, associated safety risks and side effects and the need for a comprehensive "catch-all" safety guideline. Work is expected to begin in February–March, though prioritisation may be adjusted due to urgency highlighted by the Safety Subgroup. **Additional Considerations** • **Emerging Medications:** There is awareness of new drugs in late-stage trials internationally, which may enter the market soon. Guidance should address risks from private or illegitimate purchases. • **DMARD Guidelines Update:** The recent BSR guideline changes require significant updates to DMARD checks. Current checks have expired; a three-month extension will be requested while updates are completed. A working group will be established. • **Interim Action:** Existing DMARD documents should include a note stating that BSR guidelines have been published and updates are in progress. • **Workload Management:** Prioritisation and collaborative support will be essential given the volume of work. Feedback suggests that labelling documents as "Clinical Pathways" rather than "Medicines Pathways" may improve visibility and adoption in secondary care. Consider categorising pathways on the website by clinical area, BNF category, or guideline type to improve navigation. **Actions:** Extend existing DMARD SCGs until March 2026 and set up working group to implement BSR changes.	**AGR**

2025/231	**New NHS England medicines commissioning policies November 2025** Nothing urgent to consider.	
2025/232	**Regional Medicines Optimisation Committees – Outputs November 2025** Nothing for discussion.	
2025/233	**Evidence reviews published by SMC or AWMSG November 2025** The Scottish Medicines Consortium (SMC) did not recommend Slenyto for children with ADHD. This decision was due to the absence of a manufacturer submission, rather than an assessment of clinical or cost-effectiveness. While this does not directly impact our position, it is worth noting as it limits insight into the arguments and evidence that might have been considered.	
	ITEMS FOR INFORMATION	
2025/234	**LSCMMG cost pressures log** This will be updated following the meeting and circulated with the minutes.	

The next meeting will take place on Thursday 8th January 2025, 9.30 – 11.30 Microsoft Teams		