Minutes of the Lancashire and South Cumbria Medicines Management Group Meeting Thursday 8th January 2026 (via Microsoft Teams)

Name	Role and organisation	Mar 25	Apr 25	May 25	June 25	July 25	Sept 25	Oct 25	Nov 25	Dec 25	Jan 26
Andy White (AW)	ICB Chief Pharmacist (Chair)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Trust senior medical representation from the following trusts											
Dr Hanadi Sari-Kouzel (HSK)	Blackpool Teaching Hospitals	✓	✓	✓	✓	✓	✓	✓	✓	Absent	Absent
Mohammed Elnaggar (ME)	University Hospitals of Morecambe Bay	Joined May 25	Joined May 25	✓	✓	✓	Apol	Absent	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	✓	✓	✓	✓	✓	✓	✓	✓	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	✓	✓	✓	✓	✓	✓	✓	✓
Dorna Ghashghaei (DG)	Lancashire and South Cumbria Foundation Trust										

/ Matthew Ling (ML)		ML Attending	ML Attending	ML Attending	ML Attending	ML Attending	DG Attending	ML Attending		ML Attending	ML Attending
Primary care Integrated Care Partnership senior pharmacist representation											
Melanie Preston (MP)	Fylde Coast	Deputy	Deputy	✓	✓	✓	✓	✓	RC Attending	Apol	RC Attending
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 (Laia 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	Apol
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	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	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	✓	✓
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						✓		✓	Absent	Absent

Key

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

	SUMMARY OF DISCUSSION	ACTION
2026/01	**Welcome & apologies for absence** Apologies from Nicola Baxter, Zuber Patel and Melanie Preston.	
2026/02	**Declaration of any other urgent business** No items of urgent business were raised.	
2026/03	**Declarations of interest (DOI)** No declarations of interest were noted. BH will update the group of any new declarations each month.	
2026/04	**Minutes and action sheet from the last meeting 11th December 2025** The minutes were approved and will be uploaded to the website.	
2026/05	**Matters arising (not on the agenda)** It was agreed to discuss potassium binders sodium zirconium cyclosilicate and patiromer at the end of the meeting.	
2026/06	**Tryptophan RAG rating** Tryptophan was reviewed despite very low prescribing numbers. DP noted it is currently Amber 1 but without a shared care guideline; reclassification to Amber 0 is proposed as it is similar to other antidepressants and rarely used. ML raised wider concerns about primary care support for patients discharged from mental health services, noting uncertainty around re-entry pathways if issues arise. He felt a shared care guideline would add little value given the low use. AW confirmed only 1–2 patients currently receive tryptophan. He acknowledged some GP practices have struggled to re-access mental health services for discharged patients but felt this is a system issue rather than a reason to retain Amber 1. AW and SR agreed the medicine fits Amber 0 criteria, and pathway concerns should be addressed separately. **Decision** Tryptophan reclassified as Amber 0. Wording of formulary entry to be updated to support use of a rarely prescribed drug, DP to link with specialist Trust **Action:** ML to take mental health re-entry pathway issues to the shared care group/LSCFT.	**DP** **ML**

2026/07	**Vancomycin oral liquid RAG change review** DP presented Blackpool Teaching Hospitals' request to change the RAG status of oral vancomycin liquid from Red to Green (restricted). After reviewing evidence and supply considerations, the recommendation to LSCMMG was to retain the Red RAG rating. DP explained that fidaxomicin is now first line, so oral vancomycin use should be minimal. Although cost differences were noted, occasional acute trust supply remains appropriate where needed. Clear formulary wording will reinforce treatment sequence. Practical formulation issues were discussed: • Capsules cannot be opened. • Queried using injectable vancomycin solution orally (per SPS), but noted issues with administration, stability, and practicality, making it unsuitable for routine use. AW considered that, with fidaxomicin first line, vancomycin capsules remain appropriate as Green, and oral vancomycin liquid could move to Amber 0 with very careful wording focusing on specific need. RC recommended restricting use to patients unable to swallow solid dosage forms. LD highlighted potential delays in community procurement; JB confirmed supply is available from specialist wholesalers but may require lead time. AW summarised that a pragmatic approach is needed to avoid treatment delays. The group supported Amber 0 for the oral liquid with restrictive wording and agreed that detailed formulary drafting would continue outside the meeting. **Decision** • Oral vancomycin liquid to be reclassified as Amber 0, with restricted wording for patients unable to swallow and noting supply considerations. • Vancomycin capsules remain Green. • Red retained for routine prescribing of oral liquid outside defined situations. **Actions** • DP to liaise with formulary team to draft precise, restrictive formulary wording for oral vancomycin liquid reflecting Amber 0 use, defined cohort, and supply considerations.	**DP**
2026/08	**Horizon scanning for 2026/27** BH shared the horizon-scanning workbook and outlined the annual process used to estimate prescribing cost pressures for the upcoming financial year. A detailed document had been circulated in advance, containing multiple tabs with forecasting information. The Group was informed that primary care spend for the current financial year had increased from an earlier projection of £353 million to £355 million. For 2026/27, modelling currently indicates a spend of approximately £388 million. This projected figure includes a significant tirzepatide rebate that returns to the ICB through financial reconciliation. After taking this rebate into account, the expected net position is closer to £370 million.	

	The purpose of bringing the update to the meeting was to highlight the medicines expected to drive the largest cost increases next year and to ensure systemwide visibility of these pressures. **Workforce considerations:** FP noted that some high-impact medicines may lead to increased monitoring requirements or additional clinical reviews. FP suggested that further guidance may be needed to support wider clinical teams and recommended that this work is progressed within the next week due to anticipated timing pressures. AW confirmed that preparatory work is already under way and emphasised that waiting until the February meeting would be too late if pressures materialise earlier. AW indicated that the Group should expect an update or interim report before the next meeting. AW also commented that the overall forecast may increase by a further £5 million following discussions at the meeting based on increase semaglutide usage, the effect of the US trade agreement and the impact of Voluntary Redundancies on the Meds Optimisation team) and highlighted the importance of tracking cost pressures throughout the year. This requirement was noted explicitly for inclusion in the minutes. **Action** It was agreed that BH would draft a paper for escalation to the Executive Committee, highlighting the significant cost pressures anticipated.	**BH**
2026/09	**New medicines workplan** DP advised the group that the top three items on the new medicines work plan are currently out for consultation. The consultation was circulated on 22nd December and will remain open until 29th January. DP noted that only a small number of responses have been received to date and reminded members to participate in the consultation, particularly if the initial communication was missed. DP also requested that an additional item be added to the proposed work plan: • Fenofibrate for diabetic retinopathy, submitted by Lancashire Teaching Hospitals NHS Foundation Trust. He described this as likely to be a moderate change and asked the group to confirm that they were content for this item to be included in the work plan. **Actions:** • Members to submit consultation feedback by 29th January. • Fenofibrate for diabetic retinopathy to be added to the forthcoming work plan schedule.	**All** **DP**
2026/10	**New NICE Technology Appraisal Guidance for Medicines December 2025** Nothing to discuss.	
	FORMULARY UPDATES	

2026/11	**Formulary update** PD provided an update on recent formulary working group activity held the previous day. A number of key changes and emerging issues were highlighted: **Natamycin eye drops added to formulary** • Natamycin has been added as the antifungal eye drop option. • This update was required due to issues with clotrimazole availability. • Natamycin is already widely used within local trusts, making the formulary change consistent with current practice. • The product is designated Red – specialist initiation only. **Analgesic plasters – high usage under review** • Usage of analgesic plasters was identified as unusually high. • A working group will be established to investigate prescribing patterns and underlying causes. • AW recommended liaising with Cheshire & Merseyside, where substantial reduction work is already underway, as this may provide useful insight. **Levothyroxine liquid** • A proposal had initially been made to not list levothyroxine liquid on formulary due to the balance between licensing considerations and significant cost implications. • Following discussion with Nicola, DP now intends to prepare a paper for the next LSCMMG meeting to support formal decision-making. **Tapentadol for cancer pain** • Current reviews have focused on non-cancer indications. • Pain and palliative care specialists indicate there is no difference in clinical approach between cancer and non-cancer pain, making the current position ambiguous. • DP will discuss the issue further with relevant specialists and anticipates bringing this item forward for prioritisation at next month's meeting. **Denosumab biosimilar considerations** • Feedback has been received regarding the introduction of new denosumab biosimilars. • The safety group has reviewed potential risks, particularly concerns around confusion between brands used for different indications and doses. • No major issues were identified; however, clarity is essential to avoid prescribing errors. • DP has requested that all trusts confirm which brands they intend to adopt. • A minor update is expected to the shared care document and formulary to include the relevant brands.	

2026/12	**Formulary Changes since last LSCMMG** Item not discussed.	
	GUIDELINES and INFORMATION LEAFLETS	
2026/13	**Recurrent UTI guideline – update** AGR reported that the recurrent UTI guideline update has been ongoing for a number of months. The AMR Committee originally requested the revision in March last year. Multiple attempts to obtain input from the urology specialist group were unsuccessful. The guideline returned to LSCMMG in October with proposed amendments, and the Group agreed it could be finalised with AMR Committee input. AGR confirmed that Appendix 1 is now complete, based mainly on NICE guidance with a small number of AMR-requested clarifications to reflect local priorities. AGR advised that consultation has been carried out as fully as possible and no further comments are anticipated. AW asked whether the guideline would be added to MicroGuide or similar secondary-care platforms. AGR confirmed this guideline is primarily for primary care, so updates to hospital MicroGuide systems are not expected. **Outcome** • Consultation with specialist groups complete. • Updated guideline reflects NICE recommendations and AMR Committee amendments. • No further feedback required. • Guideline approved by the Group. **Action** To upload to website	**AGR**
2026/14	**Rimegepant and atogepant RAG review and headache pathway update** AGR noted that this item had been considered by the group recently. LSCMMG previously agreed that rimegepant and atogepant would be included within the updated headache pathway, with the intention of progressing both agents towards a Green RAG rating. AGR explained that implementation had been expected to take longer, but an ICB task-and-finish group is actively working on integrating the revised headache pathway into an electronic solution via EMIS. The purpose of this work is to reduce unnecessary referrals into secondary care neurology and headache specialist services, which have been receiving increasing referral volumes linked to these agents. The task-and-finish group, comprising a wide range of clinicians, including Prof Chhetri and other relevant specialists has requested for this change to be expedited and presented to LSCMMG. **Consultation feedback:**	

	• AGR confirmed that only two consultation responses had been received so far. • One response came from the LMC, indicating that insufficient time had been available to provide detailed feedback due to the festive period. • Another response arrived too late to be fully incorporated into the paper. • AGR acknowledged that consultation has been limited and that this may affect the readiness for approval. AW noted that the limited response and timing issues suggest the proposal is not yet ready for final approval. AW commented on the need for assurance that red-flag cases continue to be referred appropriately and that primary care prescribing remains aligned with safe practice. AW also acknowledged that some clinicians, including members of the headache specialist group, are supportive of progressing the Green RAG status. **Decision** • The Group agreed the proposal requires further consultation, given the timing and limited feedback received. • LSCMMG will use this meeting as the formal start of the consultation period. • A revised version of the pathway and RAG proposals will be brought back to the February 2026 meeting for a final decision. **Action** A revised version of the pathway and RAG proposals will be brought back to the February 2026 meeting for a final decision.	
2026/15	**Shared care refusal form** AGR introduced the final outstanding document from the shared care suite: the Shared Care Refusal Form. This completes the set of documents that had previously been approved in late 2025. AGR presented the form and confirmed that: • The form has been finalised by the Shared Care Subgroup. • It uses a consistent format with the existing acceptance form. • The “medicine” field will be a drop-down menu, while dose and frequency will remain free-text. • The criteria for refusing shared care are abridged from the AMR criteria, with several refinements made following subgroup discussion. • The subgroup is satisfied with the content and is seeking final approval from LSCMMG. AW noted that the refusal form complements the acceptance form, helping ensure clearer communication around reasons for declining shared care and supporting consistent decision-making. **Comments and Recommendations:**	

	• FP advised that the form will be particularly useful in relation to Right to Choose ADHD providers and recommended ensuring this is highlighted in communications. • FP also suggested adding an optional comments section to capture additional context where required. **Implementation and Communication:** • AW asked when implementation could begin, noting that trust-wide communication would be required. • AGR confirmed that the intention is to launch the form following discussion at the next Shared Care Group meeting and will add it to that agenda. • Further communications will follow to support a coordinated launch. **Integration and Record Management:** • DJ queried how refusal forms will be stored within clinical records, and whether they will automatically transfer into GP records or remain within consultant documentation. • AW noted that the electronic version provides better security than previous word-based documents and prevents inappropriate editing. • AGR indicated that future integration may be supported as part of wider work linked to EMIS and electronic pathway development, but initial use will likely involve email workflows. **Monitoring Use and Trends:** • It was asked whether it would be possible to track shared care requests, refusal rates, involved specialties, and reasons for refusal to support quality improvement. • AW agreed and asked the Shared Care Group to explore options for collecting and reporting this information, particularly given observed variations in ADHD shared care refusals. **Outcome:** • Form content supported with minor additions to be considered (comments box, comms emphasis). • Implementation to follow via the Shared Care Group. • Monitoring of refusal activity to be explored. **Action:** Implementation to be discussed at the shared care subgroup	**AGR/CM**
2026/16	**Mycophenolic acid – addition to mycophenolate shared care and formulary** DP introduced a request relating to mycophenolic acid, a salt form of mycophenolate used when patients are unable to tolerate standard mycophenolate. A rheumatologist from the Morecambe Bay area has asked for this medicine to be added to the formulary and incorporated into the shared care guidance, as the dosing differs from the standard preparation. DP summarised the key points from the supporting paper:	

	• Mycophenolic acid is clinically valuable for a small cohort of patients who cannot tolerate mycophenolate mofetil. • Prescribing numbers are very low, indicating limited current use. • The estimated cost impact is approximately £2,469 per year, reflecting small volumes but higher per-unit costs. • The medicine is included within British Society for Rheumatology (BSR) guidelines. • Although the cost is around four times higher than standard mycophenolate, usage is expected to remain low. • Open Prescribing data shows patchy use nationally, with very small local volumes and limited comparative reliability due to the small dataset. AW observed that mycophenolic acid is more expensive than standard mycophenolate but still significantly cheaper than biologics and appears clinically appropriate. **Decision** No concerns were raised by the group, and approval was noted. Mycophenolic acid to be added to the formulary and shared care guideline to be updated to reflect appropriate dosing and use.	
2026/17	**Pathways and Guidance workplan** The Group noted that several updates have recently been added to the work plan, resulting in a significant increase in workload for the forthcoming period. No additional items were raised for discussion. The group acknowledged the volume of work required and agreed to progress through tasks as efficiently as possible. **Gabapentin and pregabalin withdrawal guidance** The group received an update regarding the gabapentin and pregabalin withdrawal guidance. BH informed members that discussions had taken place earlier in the week with FP, and that primary care had been asked to commence work reviewing the guidance ahead of its scheduled return to the group in February. Members were advised that the guidance has been adopted from another ICB, has been subject to governance processes elsewhere, and only requires minor local amendments. Given the number of practices requesting this guidance, BH proposed that approval be sought via Chair's Action prior to the February meeting, with the final version to be formally received by the Group in February. **Decision** No objections were raised, and the group supported progressing the guidance via Chair's Action.	

	NATIONAL DECISIONS FOR IMPLEMENTATION	
2026/18	**New NHS England medicines commissioning policies December 2025** Nothing urgent to consider.	

2026/19	**Regional Medicines Optimisation Committees – Outputs December 2025** Nothing for discussion.	
2026/20	**Evidence reviews published by SMC or AWMSG December 2025** Nothing for discussion.	
	ITEMS FOR INFORMATION	
2026/21	**LSCMMG cost pressures log** This will be updated following the meeting and circulated with the minutes.	
2026/05	**Potassium binders sodium zirconium cyclosilicate and patiromer** The Group revisited ongoing issues relating to the potassium binders sodium zirconium cyclosilicate and patiromer. These medicines had previously been discussed on several occasions, and LSCMMG had agreed in principle that sodium zirconium was suitable for shared-care prescribing. Despite this, the required shared care arrangements are still not fully in place. DJ noted that the last LSCMMG minutes indicated that these items were due to be picked up by the Shared Care Group, but this had not occurred. As a result, there remains no clear route for addressing the outstanding issues. DJ also highlighted that patiromer use is increasing, and both agents are now used across the system, reinforcing the need for formal shared care clarification. BH acknowledged the situation and explained that several similar unresolved items exist. BH referenced previous concerns raised prior to PM joining the group around sodium zirconium and other medicines with unclear shared care pathways. BH confirmed that a meeting is scheduled for next week to begin early discussions on how best to address the outstanding issues. **Action**: BH and colleagues to explore solutions and return with a proposed approach at the next LSCMMG meeting.	**BH**
The next meeting will take place on Thursday 12th February 2025, 9.30 – 11.30 Microsoft Teams		