Minutes of the Lancashire and South Cumbria Medicines Management Group Meeting

Thursday 9th April 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	Feb 26	Mar 26	April 26
Andy White (AW)	ICB Chief Pharmacist (Chair)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	EM Attending	✓	✓
Trust senior medical representation from the following trusts														
Dr Hanadi Sari-Kouzel (HSK)	Blackpool Teaching Hospitals	✓	✓	✓	✓	✓	✓	✓	✓	Absent	Absent	Absent	Absent	Absent
Mohammed Elnaggar (ME)	University Hospitals of Morecambe Bay (Joined May 2025)			✓	✓	✓	Apol	Absent	Absent	Absent	Absent	Absent	Absent	Absent
	Lancashire Teaching Hospitals													
Dr Shenaz Ramtoola (SR)	East Lancashire Teaching Hospitals (Deputy Chair) (Deputy Dr Truman)	Dep	✓	✓	Dep	Dep	✓	✓	Dep	Dep	✓	✓	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 JO temporarily attending)	University Hospitals of Morecambe Bay	JO	✓	✓	✓	✓	✓	✓	✓	✓	JO	✓	JO	Apol
David Jones (DJ)	Lancashire Teaching Hospitals (Deputies Judith Argall JA and Jennifer Whatton JW)	✓	✓	✓	Dep JA	Dep JW	✓	✓	✓	Dep JA	✓	✓	✓	Dep JW
Ana Batista (AB)	East Lancashire Teaching Hospitals	Apol	Apol	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Dorna Ghashghaei (DG) / Matthew Ling (ML)	Lancashire and South Cumbria Foundation Trust	ML	ML	ML	ML	ML	DG	ML		ML	ML	✓	✓	✓
Primary care Integrated Care Partnership senior pharmacist representation														
	Fylde Coast	Dep	Dep	✓	✓	✓	✓	✓	RC	Apol	RC	RC	RC	
Clare Moss (CM)	Central	✓	Apol	✓	✓	Apol	✓	✓	✓	✓	✓	✓	✓	Absent
Laila Dedat	Pennine Lancashire	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	

Faye Prescott (FP)	Morecambe Bay	✓	Dep.	Apol	✓	Dep	✓	✓	✓	✓	✓	Apol	Apol	Apol
Other roles														
Nicola Baxter (NB)	ICB Lead for Medicines Governance and Medicines Safety	Apol	✓	✓	Apol	✓	✓	✓	✓	Absent	Apol	✓	✓	✓
Amy Lepiorz	Associate Director of Primary Care									✓	✓	Apol	✓	✓
Lucy Parker (LP) Previously (LD)	ICB Finance Representative	✓	✓	✓		Apol	Apol	✓	✓	✓	✓	✓	✓	Absent
	Provider finance representative													

Lindsey Dickinson (LD)	Associate Medical Director LSC ICB						✓	Apol	Absent	Absent	Absent	Absent	Absent	Apol
Praful Methukunta (PM)	Local Medical Committee Representation (Joined May 2025)			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Adam Dedat (AD)	Local Medical Committee Representation (Joined June 2025)				✓	Absent	Absent	Absent	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 2025)				✓	✓	Apol	✓	Apol	✓	✓	✓	✓	Absent
IN ATTENDANCE:														
Domnic Sebastian (DS)	Divisional Medical Director for Surgery & Anaesthetics ELHT					✓			Absent	Absent	✓	✓	✓	Absent
Brent Horrell (BH)	ICB Head of Meds Commissioning	✓	✓	✓	✓	Apol	✓	✓	✓	✓	✓	✓	✓	Apol
David Prayle (DP)	ICB Senior Meds Commissioning Pharmacist	✓	✓	✓	✓	✓	Apol	✓	✓	✓	✓	✓	✓	✓
	ICB Senior Meds Performance Pharmacist	Apol	✓	✓	✓	✓	✓	Apol	✓	✓	✓	✓	✓	N/A
Jill Gray (JG)	ICB Meds Commissioning Pharmacist						✓							✓
Paul Tyldesley	ICB Meds Commissioning Pharmacist						✓		✓	Absent	Absent	✓	✓	✓

	SUMMARY OF DISCUSSION	ACTION
2026/76	**Welcome & apologies for absence** Apologies were received from Adam Janjua, Zuber Patel, Lindsey Dickinson, Brent Horrell, Lucy Parker, Jenny Oakley and Rebecca Bond. Jennifer Whatton (JW) attended on behalf of David Jones.	
2026/77	**Declaration of any other urgent business** AB noted the Semaglutide CVD Technology Appraisal (TA). It was agreed that this matter would be discussed under the relevant TA agenda item when reached. AB raised an ongoing issue regarding the biosimilar patient information leaflet, noting that this had been outstanding for some time. AW agreed that this should be captured as an action, specifically to establish a clear timescale for completion. **Action:** Agree and confirm a timescale for delivery of the biosimilar patient information leaflet.	**AW**
2026/78	**Declarations of interest (DOI)** No declarations of interest were noted. BH will update the group of any new declarations each month.	
2026/79	**Minutes and action sheet from the last meeting 12th March 2026** The minutes were approved and will be uploaded to the website.	
2026/80	**Matters arising (not on the agenda)** Nothing discussed.	

NEW MEDICINES REVIEWS		
2026/81	**Fenofibrate to reduce progression of diabetic retinopathy Moderate change** JG highlighted the need for a pragmatic approach, noting that fibrates are well established and familiar to primary care, with GPs regularly initiating and continuing treatment for other indications without secondary care consultation. It was emphasised that, where primary care is content to continue prescribing following specialist initiation, this aligns with usual practice; where concerns exist, responsibility would remain with the initiating consultant. Members acknowledged that many medicines are commonly prescribed without explicit discussion of licensed versus unlicensed indications, and that it would not be proportionate to require such discussions for every prescription, particularly where use is supported by NICE guidelines and a robust evidence base. Concerns relating to unlicensed use were discussed and understood.	

	However, members agreed that fenofibrate use for this indication introduces no additional monitoring requirements or safety risks beyond existing fibrate use. Retaining prescribing solely within secondary care was felt to offer no clinical benefit and could negatively impact the patient experience. Colleagues supported this position, noting that restricting prescribing to secondary care would increase burden for patients and services without added value. AW summarised that this represents normal clinical practice and routine transfer of care for a long-established medicine. **Action** Fenofibrate to be added to formulary with an Amber 0 formulary position for fenofibrate for the reduction of progression of diabetic retinopathy, following initiation by an ophthalmologist.	**DP**
2026/82	**New medicines workplan** DP advised that a late addition to prioritisation had been received following circulation of the meeting papers. This was a request from Lancashire Teaching Hospitals NHS Trust to review nabilone for the treatment of pain. Members noted that nabilone is a synthetic cannabinoid, historically used for chemotherapy-induced nausea and vomiting, and is not currently on the formulary. It was confirmed that a high-quality application had been submitted. Given the completeness of the application, it was proposed that the request be prioritised directly for review, without requiring further consideration by the Formulary Working Group. AW agreed that the request could proceed directly to Committee review. Further discussion focused on an existing item within the work plan regarding tapentadol for pain management in palliative care patients. AW queried the wording, noting potential ambiguity between chronic pain and palliative care, and emphasised the importance of clarity around the specific patient cohort and indication, particularly in the context of high opioid and patch usage. It was clarified that there is an existing formulary position for tapentadol in chronic non-palliative pain, and that any revised or additional position would need to be explicitly worded to differentiate use in palliative care. Members agreed that when the item is reviewed, the indication and scope should be clearly defined to avoid confusion between chronic pain management and palliative treatment. **Actions** The Committee agreed to prioritise the review of nabilone for the treatment of pain and add it to the medicines review work programme. It was agreed that items relating to pain management, including tapentadol, should be clearly scoped and worded to distinguish between chronic pain and palliative care indications when brought forward for review.	
2026/83	**New NICE Technology Appraisal Guidance for Medicines March 2026** The Committee considered NICE Technology Appraisal TA1140: Ruxolitinib cream for the treatment of vitiligo. DP advised that, although patient numbers are expected to be small, the financial impact is significant, with projected costs of around £1 million each year. Treatment would be initiated and continued by specialist clinicians. Due to the Patient Access Scheme (PAS) being available only via secondary	

	care, there is no PAS mechanism for primary care prescribing; therefore, the medicine must retain a Red (hospital-only) formulary status. It was noted that patients are expected to require an average of approximately four tubes per year, and that homecare arrangements should be implemented to support supply directly to patients. AW queried anticipated uptake across Trusts, noting that vitiligo has historically been managed conservatively and that this represents a significant step change to a high-cost specialist treatment. Clarification was sought regarding financial impact, and it was confirmed that the treatment is PbR-included, meaning costs would fall within tariff, creating pressure on departmental budgets. Members discussed the uncertainty surrounding real-world uptake, including: • the number of patients who may be identified and referred for treatment, • the capacity of services to assess and initiate treatment within the first year, • and whether NICE-modelled uptake assumptions are realistic. It was acknowledged that initial uptake may be lower than modelling assumptions, particularly in the first year, due to identification, referral pathways, and clinical workload. Members emphasised the need for a realistic assessment of activity and financial impact while recognising potential longer-term benefits associated with improved disease control. Trusts will be asked to provide an indication of expected clinical interest and likely uptake within the first year of implementation. These figures will be compared with NICE uptake estimates to assess realism and affordability. Feedback will be collated and returned to DP to inform ongoing financial and formulary planning. NICE TA TA1142 Dupilumab for maintenance treatment of uncontrolled chronic obstructive pulmonary disease with raised blood eosinophils was also discussed. The costs provided in the accompanying paper illustrate a cost of around £4 million in year 1, based on an estimated high level of year 1 uptake. This was discussed as it is a deviation from the initial NICE costing template. It was agreed that the provider Trusts should be approached to ascertain projected uptake to factor into a final projection. **Actions** Approach Trusts to gauge estimated uptake of Ruxolitinib, as per NICE TA1140. Update projected costs, if necessary. Approach Trusts to gauge estimated uptake of dupilumab, as per NICE TA1142. Update projected costs, if necessary.	**DP** **DP**
FORMULARY UPDATES		
2026/84	**Formulary update** JG advised that there were no significant updates to report. The formulary change log had been circulated to members and is available on the website as per usual process.	
2026/85	**Formulary Changes since last LSCMMG** Attached for information.	

GUIDELINES and INFORMATION LEAFLETS		
2026/86	**Drugs of misuse formulary chapter: alcohol dependence** JG provided an update regarding alcohol dependence section of formulary. It was noted that, historically, medicines within this section had been widely used but had not been formally validated with RAG statuses. At the February LSCMMG meeting, significant progress was made, with RAG ratings agreed for the majority of medicines, many of which have since been published. Two medicines, acamprosate and naltrexone, remained inconclusive pending clarification of primary care monitoring requirements. JG advised that substance misuse services have since provided clear and specific confirmation of the monitoring arrangements expected of primary care. A short supporting paper summarising these requirements was circulated. It was confirmed that: • The recommended RAG status remains Amber 0 for both acamprosate and naltrexone. • Follow-up requirements are in place, but blood monitoring is minimal, typically annual and patient-dependent. • Patients are transferred with comprehensive handover letters, which GPs are generally familiar with. Discussion highlighted the importance of consistency across substance misuse providers, including alignment between council-commissioned services and specialist services, to ensure clarity and confidence in shared prescribing arrangements. PM advised that the LMC would not be able to accept the patient follow-up recommendations in their current form. JG suggested discussions continue out-side of the meeting as a resolution is required. DG requested that LSCFT also be kept up to date as they have some service users who will not engage with substance misuse services and remain under the care of LSCFT for their substance misuse issues. **Actions** The Committee noted the clarification provided by substance misuse services. The Amber 0 status for acamprosate and naltrexone may be supported, dependent on further clarification on the expected frequency of follow-up by GPs. JG is to liaise with the substance misuse services and PM (on behalf of the LMC) outside of the meeting. DG to be kept up dated on outcomes.	

	Antipsychotic shared care NICE approved off label indications	
2026/87	The Committee considered a paper on antipsychotic shared care, introduced by DG, on behalf of mental health services. It was explained that the paper had been brought forward as the current shared care document does not include NICE-recommended off-label indications for antipsychotic medicines. The paper, developed by Sonia Ramdour (Chief Pharmacist, LSCFT), sought to address this gap and provide greater clarity and consistency. Discussion focused on the practical implications for specialist services and primary care, including the balance between retaining prescribing within secondary care versus transferring appropriate patients to shared care arrangements. Members highlighted the importance of understanding: • the total number of patients currently managed within specialist services, • the proportion who might be suitable for shared care, • and the impact on service capacity and pathway flexibility if prescribing responsibility were shared. AW noted that moving suitable patients into shared care could potentially allow specialist services to be more responsive to patients with higher acuity, but acknowledged the need for a clear, system-wide understanding of the trade-offs involved. It was agreed that this was not for decision at this meeting. Further discussion and engagement across relevant forums were required to refine the proposal and ensure it reflects the needs and capacities of all providers involved. A revised or more developed proposal will be brought back to the Committee at a future meeting.	
2026/88	**Sativex RAG consultation and Naloxone RAG rating** **Sativex – RAG Rating Consultation** It was confirmed that the proposed consultation on the RAG rating for Sativex had not been progressed for discussion. This was because the definitions of the RAG categories had not yet been finalised and agreed. Members were reminded that only draft definitions are currently available. Once the finalised RAG definitions are agreed, the Sativex paper will be taken through the relevant group to provide additional information and context, enabling the Committee to make a fully informed decision. **Naloxone – RAG Rating** DP also advised that consideration of naloxone had been deferred. There had been suggestions that naloxone could move from a Red RAG rating to a less restrictive status, reflecting the view that wider availability may be beneficial. However, there remains insufficient clarity on the circumstances in which naloxone would be used in practice, and how a change in RAG status would operate across services. Further clarification and development work is therefore required before the item can be brought to the Committee. **Outcome** • The Committee noted the update.	

	• Both items will be brought back to a future meeting once:
	  o RAG definitions have been finalised (Sativex), and
	  o greater clarity on practical use and implications has been established (Naloxone).
		DP
		
		DP

2026/89	**Lancashire & South Cumbria Penicillin Allergy Assessment Primary Care Guideline for Adult consultation** The Committee considered the penicillin allergy guidance, which aims to address the high prevalence of patients incorrectly labelled as penicillin-allergic. DP advised that the paper and supporting documents had been developed following extensive consultation across relevant groups. Minor updates were required to align the document with LSCMMG house style, including logos and formatting, but the content and intent were unchanged. It was noted that multiple versions of the document had been included within the papers to demonstrate the consultation process and incorporation of comments. The final version had now been produced and consultation feedback through the LSCMMG process had been positive. NB confirmed that feedback from previous discussions had been addressed and that all requested amendments had been incorporated. Members agreed that the guidance clearly supports safe, evidence-based de-labelling of penicillin allergy, which is in the interest of improved patient care and antimicrobial stewardship. AW highlighted that incorrect penicillin allergy labels can lead to suboptimal antibiotic use and increased risk to patients, noting the importance of accurate documentation. Members commented that the guidance provides a clear, practical and accessible approach to penicillin de-labelling, bringing together existing evidence in a usable format. It was agreed that the guidance is now ready for approval and dissemination, and that wide communication will be important to ensure system-wide adoption and benefit. **Actions** The Committee approved the penicillin allergy de-labelling guidance. The final document will be formatted in house style and widely disseminated across the system to maximise uptake and impact.	
2026/90	**Gender dysphoria guidance – update** JG provided an update on an item raised at the March meeting regarding the NHS consultation on gender dysphoria, specifically relating to the use of masculinising and feminising hormones in under-18s. It was confirmed that the opening statements of the two relevant local documents had been updated to reflect the ongoing national consultation and the associated pause on prescribing. Updated documents had been circulated to members. AW queried whether additional wording should be included within the formulary entries themselves, to clearly direct clinicians to the gender dysphoria guidance and to reinforce that prescribing for under-18s should not take place at present.	

	A query from primary care was noted where a gender identity service had requested GP prescribing for a patient awaiting assessment, with very long waiting times reported. It was confirmed that such requests had been declined, consistent with current Amber status and national expectations. Clinical representatives highlighted that this is a highly specialised area of practice, involving very small patient numbers, and that most primary and secondary care clinicians do not feel confident initiating or continuing prescribing without assessment and direction from a tertiary Gender Identity Development Service (GIDS). Members emphasised the importance of guidance that supports clinicians in declining prescribing where it falls outside their competence or governance arrangements. The Committee reviewed existing wording referencing NHS England guidance, which states that gender identity clinics should retain prescribing and monitoring responsibility until a GP has explicitly agreed transfer of care. Members discussed whether additional wording was required to explicitly state that prescribing should not occur prior to specialist assessment, including in the context of "bridging" requests. ML raised the use of mandatory ("must") versus advisory ("should") language within the documents, and the need to ensure that wording accurately reflects source NHS guidance, without local reinterpretation. JG clarified that the wording used was drawn directly from national documentation and previously agreed LSCMMG wording, with changes limited to formatting and inclusion of new national statements rather than policy amendment. Members agreed that redrafting should not take place during the meeting, and that any changes must be carefully checked against source documents, given the clinical, legal and reputational sensitivities involved. **Actions** A link to the GMC advice for prescribers will be added to the document. Following this amendment the documents were approved to be uploaded to the NetFormulary website.	
2026/91	**Morphine (High dose) in chronic non cancer pain: Position Statement – clinician feedback** The Committee considered a paper on high-dose morphine prescribing, which had been brought back following discussion at the previous meeting. PT presented the updated paper, thanking members for prior feedback. The purpose of the paper was to agree an updated position statement with a revised dose threshold, proposing a range of 50–90 mg oral morphine equivalent (OME) per day as the point at which prescribing should trigger increased review and risk consideration. Members broadly supported the updated threshold and the intent of the document, recognising the need to: • support safer prescribing, particularly for new initiations; • reduce unwarranted variation; • and address Lancashire and South Cumbria's high overall opioid usage. AW highlighted ongoing concerns from primary care regarding patients already prescribed very high opioid doses, with limited access to pain services and uncertainty over clinical responsibility. It was emphasised that	

	patients should not be passed between services without clear ownership and agreed actions. Members discussed the value of including a practical appendix within the document to support clinicians, specifically: • guidance on opioid dose conversion to oral morphine equivalents; This was supported as a pragmatic step to increase confidence and consistency in applying the guidance. Wider discussion acknowledged that while the position statement provides an important clinical standard, it must sit within a coherent system response, including commissioning, pain services and primary care working together. AW noted significant work already underway across the system to curb inappropriate opioid use, including changes in emergency department prescribing and reduction of high-volume products. Members agreed that addressing long-standing high-dose prescribing would require incremental, sustained action, supported by appropriate services, and could not be resolved by guidance alone. **Actions** The Committee approved the position statement on high-dose morphine prescribing, subject to the inclusion of: • an appendix on opioid conversion to oral morphine equivalents. A small round-table group will be convened, involving primary care, pain specialists, commissioners and medicines management, to: • clarify responsibility for existing high-dose patients, • and identify any service gaps requiring commissioning solutions. AW thanked contributors for their work on a challenging but essential area of patient safety.	**PT** **TBC**
2026/92	**Testosterone for postmenopausal women with low sexual desire if HRT alone is not effective: RAG change review – update** The Committee considered a paper on the formulary RAG status of testosterone for post-menopausal women, which was brought back following discussion at the previous meeting. PT reminded members that the current position is shared care, and that the proposal was to revise this to either Amber 0 or Green Restricted, subject to clarification around clinician capability and monitoring requirements. PT clarified that the monitoring expectations for this indication differ from those used for testosterone in males. The previously referenced shared care monitoring arrangements were more intensive and aligned to higher-dose male regimens. In contrast, guidance from the British Menopause Society (BMS) indicates that monitoring for post-menopausal use should be limited to: • total testosterone measurement, • initially at approximately 6 months, • then annually thereafter. No additional routine blood monitoring would be expected for this indication.	

	Members agreed that further delay in decision-making would not be helpful and that clarity was required to support clinicians. The Chair proposed a Green Restricted formulary position, noting that a restricted green status enables prescribing where clinicians feel competent, without obligating those who do not to prescribe, who may still refer appropriately. No objections were raised. AW additionally noted that, should a licensed female testosterone product (e.g. Androfem) become available, this should be prioritised for rapid review and inclusion on the formulary. Members commented that a Green Restricted position would help reduce barriers to access and improve equity of care, while still allowing clinicians to work within their confidence and competence. It was also noted that an Amber 0 status could unnecessarily restrict prescribing by capable clinicians. **Action** • The Committee approved a Green Restricted formulary position for testosterone for post-menopausal women. **Additional Notes** • Monitoring requirements to reflect BMS guidance (6-month review, then annual total testosterone). • Licensed female testosterone products, once available, should be prioritised for formulary review. • Training and education remain key to supporting safe and confident prescribing. The Chair thanked members and confirmed closure of the item.	
2026/93	**Pathways and Guidance workplan** The Committee noted the Pathways and Guidance Work Plan. DP advised that there were no significant updates at this time and that the work plan is shorter than previously, with current timelines felt to be broadly accurate. It was noted that the work plan may change significantly in future months. AW requested that an item be added to the next meeting agenda to consider recent NHS England correspondence on commissioned medicines policies, specifically relating to medicines moving into tariff. This would allow the Committee to consider the implications alongside upcoming NICE guidance. Further discussion highlighted concerns regarding the growing disconnect between NICE technology appraisals and available allocations, with significant financial impact anticipated locally in the coming year. This was noted for awareness. **Diabetes Guidance** PT advised that work was underway regarding the current local diabetes guidance, with a proposal to retire the existing guideline and instead direct clinicians to the new NICE Type 2 Diabetes guideline. The Diabetes Clinical Lead supported this approach, recommending: • retirement of the local guidance, • replacement with a direct link to the NICE Type 2 Diabetes guideline, and	

	• no requirement for additional local supplementary guidance at this time. It was noted that while some diabetes treatments may lead to deprescribing, cardiac indications associated with diabetes medicines are additive and therefore cost pressures would remain. AW highlighted the usefulness of the NICE visual summary for Type 2 diabetes and suggested that any future local work should focus only on preferred product choices, where required.	
NATIONAL DECISIONS FOR IMPLEMENTATION		
2026/94	**New NHS England medicines commissioning policies March 2026** NHSE have produced guidance on a number of high cost drugs that will now be considered within tariff. This will be discussed fully at the May LSCMMG meeting.	**DP**
2026/95	**Regional Medicines Optimisation Committees – Outputs March 2026** Nothing for discussion.	
2026/96	**Evidence reviews published by SMC or AWMSG March 2026** Item not discussed.	
ITEMS FOR INFORMATION		
2026/97	**LSCMMG cost pressures log** This will be updated following the meeting and circulated with the minutes.	
The next meeting will take place on Thursday 14th May 2026, 9.30 – 11.30 Microsoft Teams		