

**Minutes of the Lancashire and South Cumbria Medicines Management Group Meeting
Thursday 12th February 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
Andy White (AW)	ICB Chief Pharmacist (Chair)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Lizzy Macphie
Trust senior medical representation from the following trusts												
Dr Hanadi Sari-Kouzel (HSK)	Blackpool Teaching Hospitals	✓	✓	✓	✓	✓	✓	✓	✓	Absent	Absent	Absent
Mohammed Elnaggar (ME)	University Hospitals of Morecambe Bay	Joined May 25	Joined May 25	✓	✓	✓	Apol	Absent	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) / 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	ML Attending	✓
Primary care Integrated Care Partnership senior pharmacist representation												
Melanie Preston (MP)	Fylde Coast	Deputy	Deputy	✓	✓	✓	✓	✓	RC Attending	Apol	RC Attending	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 (Laila Dedat)	Deputy (Laila Dedat)	Deputy (Laila Dedat)
Faye Prescott (FP)	Morecambe Bay	✓	Deputy	Apol	✓	Deputy (Paul Elwood)	✓	✓	✓	✓	✓	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	✓	✓	✓	✓	✓
	Provider finance representative											

Lindsey Dickinson (LD)	Associate Medical Director LSC ICB						✓	Apol	Absent	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						
Mubasher Ali (MA)	Community Pharmacy LSC			Absent		✓	Apol	✓	Absent	✓	✓	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	Absent	Absent

Key

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

	SUMMARY OF DISCUSSION	ACTION
2026/22	Welcome & apologies for absence Apologies received from Andrew White, Melanie Preston, Faye Prescott and Amy Lepiorz.	
2026/23	Declaration of any other urgent business No items of urgent business were raised.	
2026/24	Declarations of interest (DOI) No declarations of interest were noted. There have been no additional Declarations of Interest submitted via the ICB process this month. BH will update the group of any new declarations each month.	
2026/25	Minutes and action sheet from the last meeting 8th January 2026 The minutes were approved and will be uploaded to the website.	
2026/26	Matters arising (not on the agenda) Potassium permanganate (RAG discussions from safety group) This item was raised following actions from the Medicines Safety Group, concerning incidents and patient harm risks associated with potassium permanganate use. Sought clarification on whether a Red RAG rating would be workable. DJ is aware of previous incidents involving potassium permanganate, including cases raised via regional safety networks and suggested linking with dermatology to understand what safety measures or educational packages are currently in place. Proposed exploring an amber RAG rating, whereby specialists initiate treatment and patients receive comprehensive counselling and instructions. Primary care could safely continue prescribing for suitable patients. JM confirmed potassium permanganate is prescribed in general practice, though in small volumes. Community nursing teams also use it, especially for patients with chronic wounds and leg conditions requiring regular soaking. Usage appears low: EMIS search showed five patients in the past five years (not including community nurse prescribing). Often used for patients with multiple comorbidities who do not regularly attend hospital clinics. EM added that potassium permanganate is used across primary care, secondary care, and community services and risks are not eliminated by restricting prescribing to one sector, as errors may occur anywhere. EM Emphasised the need for clear, consistent patient instructions, regardless of the prescriber and noted that the product is also available over the counter, adding further complexity. EM confirmed the need to involve dermatology in pathway development and safety planning.	

	<p>AGR agreed with the summary and actions and will link with dermatology and obtain specialist input before further decisions are taken.</p> <p>Action AGR to obtain dermatology input on current safety measures, patient instructions, and recommendations regarding RAG status.</p> <p>LSCMMG member responsibilities in relation to consultation and representation It was noted that although the shared care agreement forms had previously been reviewed within the Shared Care Group and LSCMMG, further issues emerged when the forms were taken to a wider committee for information. Some organisational leads had been unaware of the forms prior to this and raised questions regarding implementation and operational implications. Members were reminded of the importance of engaging with their respective organisations and specialties early, particularly when proposed changes may affect service delivery or require local process adjustments. As a result of the queries raised, further rollout to primary care has been paused until outstanding concerns can be addressed. It was highlighted that while improvements to the forms are necessary, delaying too long risks negatively impacting patients who currently experience fragmented care between services. Emphasis was placed on balancing the need for thorough consultation with the importance of progressing solutions that improve patient access and continuity without striving for perfection before launch. Ongoing post-implementation engagement was suggested, similar to previous approaches used for other system changes. A plan was proposed to review all outstanding comments at the next shared care meeting and determine the most efficient way to resolve them and move forward. Groups and departments were encouraged to provide timely feedback to avoid repeated cycles of late comments.</p>	AGR
NEW MEDICINES REVIEWS		
2026/27	<p>Progesterone pessaries (Cyclogest®) for treatment of premenstrual syndrome, including premenstrual tension and depression Major</p> <p>A request had been submitted regarding the use of cyclogest pessaries for PMS / premenstrual tension depression. The query had been reviewed by the Formulary Working Group, escalated via LMC/LSCMMG, and presented to the Women’s Health Group for further consideration. Evidence presented showed no clinical support for cyclogest in PMS. The existing formulary status is RED for use in specialist pre-term birth clinic and for patients with recurring miscarriage following IVF (unlicensed indication). The paper recommended a DNP RAG for treatment of premenstrual syndrome, including premenstrual tension and depression, with a caveat for consideration acknowledging specialist-led use in rare circumstances. Feedback received (one response from Fylde Coast) recommended a stronger stance, preferring “Do Not Prescribe” rather than adding a permissive caveat. Members debated whether adding a caveat offered any benefit over the standard management of unlicensed uses. Several members expressed concern that a caveat could open the door to increased demand and place pressure on clinicians. Consensus formed around clearly stating: Cyclogest should be “Do Not Prescribe” for PMS, while retaining the existing formulary position for unlicensed indications.</p> <p>Cyclogest will be marked “Do Not Prescribe” for PMS. The existing RED indication remains unchanged.</p>	

	<p>Action DP to update the formulary entry to reflect “Do Not Prescribe for PMS” and retain existing RED indication.</p>	DP
2026/28	<p>Clascoterone for treatment of acne vulgaris in people 12 years and over Major</p> <p>A request was submitted to consider Clascoterone as a new product for the formulary. This case is unusual because NICE did not complete a technology appraisal as the company did not submit, which normally results in a default Do Not Prescribe stance. Despite this, dermatology specialists requested the product be considered due to potential clinical value for certain patients. A full evidence review was carried out. Evidence was limited and not comparative, making it difficult to place the drug reliably within existing treatment pathways. External bodies (e.g., Canadian health agencies) also reviewed the drug and concluded no clear place in therapy based on current evidence. Concerns included lack of NICE endorsement, weak evidence base and no demonstrated superiority over standard treatments. Dermatology team from ELHT and a community dermatology specialist argued against a DNP RAG rating, noting it is a novel treatment class not comparable to existing options. Costs may not be excessive when compared with alternatives such as isotretinoin, which require frequent monitoring. It may address an inequality gap for male patients, who cannot use certain female-only hormonal acne therapies (e.g., oral contraceptives). Even if evidence is limited, the product may be useful for a small cohort of appropriate patients. These groups suggested RED (specialist-only) status rather than a complete block. Red status would allow dermatology specialists to initiate and monitor Clascoterone, while preventing routine prescribing in primary care. Concerns were raised about practical implications for patient access (e.g., attending hospital to collect prescriptions), the need to avoid creating unintended inequalities or barriers to care. It was noted that some other regions suggested reviewing again in 12 months if more evidence becomes available.</p> <p>While the initial recommendation was “Do Not Prescribe”, the group felt there was a reasonable case for RED status, allowing specialist-led prescribing for selected patients. No objections were raised to adopting RED status. The medicine will therefore be added to the formulary as RED.</p> <p>Actions DP to update formulary entry to reflect RED status for Clascoterone.</p>	DP
2026/29	<p>VSL#3 Probiotic for maintenance of remission of ileoanal pouchitis only in adults as induced by antibiotics Major</p> <p>A request for review of VSL#3 was submitted by the Lead Pharmacist for Digestive Diseases and Hepatitis C at East Lancashire Hospitals. Historically, VSL#3 appeared on the East Lancashire formulary but was not included in the pan-ICB formulary during chapter-by-chapter consolidation because it was not raised by clinical groups at the time. The product is not a medicine but a food supplement, which may explain its omission from previous formal listings. Other regional formularies do not currently include VSL#3, so a unified decision was required. Usage is believed to be very low, with around 150 patients across the patch potentially eligible, although actual prescribing numbers may be far smaller. Multiple members expressed support for a RED rating, enabling gastroenterologists to prescribe when clinically appropriate, given the low patient volume and its specialist nature.</p> <p>A check of dispensing history showed no recent LTHTr use since 2019, suggesting limited interest among local gastroenterologists. Members agreed</p>	

	<p>that before assigning a final RAG status, the group should actively seek responses from all gastroenterology units across the patch to determine current clinical interest and practice. Cost comparisons between OTC purchase and potential NHS supply were also identified as necessary.</p> <p>The group expressed initial support for a RED rating, but a final decision will be deferred pending further information from all gastroenterology departments and cost considerations.</p> <p>Action DP to contact gastroenterology teams across all trusts to confirm whether VSL#3 is being used locally and whether clinicians support adding it to formulary.</p>	DP
2026/30	<p>New medicines workplan Three new products were presented for prioritisation and addition to the LSCMMG work plan:</p> <p>Tapentadol for Cancer Pain</p> <ul style="list-style-type: none"> • Requested by the Palliative Care Medicines Group. • Current position statements cover non-palliative pain, but do not explicitly address palliative care use. • An explicit formulary position is therefore required. <p>The group agreed it should be added to the work plan for formal review, acknowledging the gap in current guidance.</p> <p>Visio-XL</p> <ul style="list-style-type: none"> • Initial request came indirectly via an ophthalmologist at a Manchester trust. • Follow-up discussion with local ophthalmology at East Lancashire indicated historic small-scale use and support for review. • Possible omission from formulary plausibly due to its classification as a non-medicine (device), which is a known issue for some ophthalmic products. <p>The group agreed to include Visio-XL in the prioritisation list and undertake a review of evidence and usage.</p> <p>Inhaled Levodopa</p> <ul style="list-style-type: none"> • Requested by clinicians at Lancashire Teaching Hospitals. • Parkinson’s nurse specialists expressed significant interest in the product. • NICE currently lists it under “selection status,” meaning guidance is not expected soon. • Expected to be very high cost — approx. £8 per inhalation, with potential regional impact estimated at £3 million annually if used once daily across 1,000 patients. • Specialists are exploring alignment with Salford and Merseyside to take a coordinated regional approach. 	

	<p>The group agreed to list it on the work plan but may pause if NICE signals imminent guidance. A wider regional review is required due to potential financial impact.</p> <p>Actions DP to add Tapentadol (palliative care use), Visio-XL, and Inhaled Levodopa to the LSCMMG work plan for full review.</p> <p>DP & BH to refine cost modelling for inhaled levodopa and monitor signals from NICE regarding expected review timelines.</p>	<p>DP</p> <p>DP/BH</p>
2026/31	<p>New NICE Technology Appraisal Guidance for Medicines January 2026 Nothing to discuss.</p>	
FORMULARY UPDATES		
2026/32	<p>Formulary update - Chapter review dates timetable A full review plan for all formulary chapters has been developed. Although chapters undergo continuous incremental updates throughout the year (hundreds of small changes), it was agreed that a comprehensive review of each chapter is still required. This is because the method and depth of chapter reviews have evolved over the past three years, and a full refresh will ensure consistency and accuracy across the formulary. The revised timetable places the earliest chapter reviews in the middle of the year, due to anticipated ICB organisational changes involving staffing and structural adjustments. Each formal chapter review will be allocated six months, with overlapping timelines. Reviews will extend beyond the medicines list to include associated guidelines within each chapter to ensure alignment. Clinical groups will be convened for each chapter, and combining guideline and formulary review within the same meetings is expected to make the process more efficient and reduce fragmentation. The timetable is acknowledged as a first draft, subject to change once implementation begins. The group was informed so that all stakeholders are aware of the upcoming structured work programme.</p>	
2026/33	<p>Formulary Changes since last LSCMMG – TO FOLLOW Nothing to discuss.</p>	
GUIDELINES and INFORMATION LEAFLETS		
2026/34	<p>DXA scan PIL – update An information leaflet on DXA scan interpretation was requested at the July meeting, linked to previous discussions on the Relugolix TA. A draft leaflet has been produced and reviewed by rheumatology, primary care, endocrinology and women’s health group. Minor amendments were made following feedback; no substantial changes were required. The group was asked to confirm whether the leaflet could now be uploaded to the website or whether further consultation was necessary. No objections were raised to publication, indicating group approval to proceed. LMC representatives highlighted a key concern: - The significant workload shift to primary care caused by widespread DXA scanning and FRAX assessments, particularly where primary care is expected to interpret results and take responsibility for follow-up.</p>	

	<p>Leaflet approved for publication on the website. The group formally acknowledged concerns regarding unintended workload transfer to primary care arising from increasing use of DXA scanning and associated FRAX assessments. This does not alter the approval decision but should be noted for awareness and future discussions.</p> <p>Action The Prescriber Information Leaflet to be uploaded onto NetFormulary.</p>	AGR
2026/35	<p>Rimegepant and atogepant RAG review and headache pathway update</p> <p>Rimegepant and atogepant (new oral migraine treatments) were previously proposed for a RAG status change at the October meeting from Amber 0 to Green Restricted. This was intended as a temporary interim status, with the plan to move them to full Green once the revised Headache Pathway was completed.</p> <p>Neurology had expressed concern at that time about increasing referrals for the sole purpose of initiating these agents. However, LMC representatives stated that GPs are not referring for gepant initiation, instead referrals occur due to diagnostic uncertainty after multiple treatments have failed.</p> <p>LMC confirmed a firm stance that concerns raised by secondary care do not reflect GP referral behaviour. Referrals are for clinical assessment, not to delegate prescribing responsibility. Feedback was shared via recent LMC correspondence, which reinforced that the matter remains unresolved from the LMC perspective.</p> <p>The newly digitalised Headache Pathway has now been updated, which was a prerequisite for reconsidering further amendment to Green. However, wider system engagement issues were highlighted. Rheumatology was not aware that the headache pathway was being digitalised until very recently. This raised concerns about stakeholder engagement and inter-specialty impacts (e.g., implications for GCA referral pathways).</p> <p>Acknowledgement that this issue cannot be resolved today, as further consultation is needed between neurology, primary care, headache pathway leads, and stakeholders affected by pathway digitalisation.</p>	
2026/36	<p>Post-bariatric surgery nutrition guidelines – update</p> <p>The position statement has been updated as it was due to expire on the website. The document was been reviewed by the specialist weight management service at BTH prior to being presented at LSCMMG.</p> <p>It was noted that the Bariatric LES (Local Enhanced Service) programme launched earlier this year and is expected to continue into next year. The LES includes monitoring requirements, including blood tests, that overlap with those referenced in the guidance currently under review. There is a need to ensure consistency between the monitoring requirements outlined in the migraine-related guidance under discussion, and the monitoring requirements already defined within the LES. Concerns were raised regarding practical deliverability, particularly inconsistent access to specific tests in primary care laboratories and historical difficulties obtaining tests such as selenium levels, which caused operational challenges during LES</p>	

	<p>rollout and inconsistency of monitoring recommendations received by patients.</p> <p>It was recognised that discrepancies may exist between what is written in guidance and what can realistically be delivered across the system. Aligning the two sets of requirements would prevent duplication, re-work, or conflicting instructions across primary and secondary care.</p> <p>The group agreed that work should be joined up to ensure consistent guidance across LES and the current clinical pathway. Incorporating learning from LES into the migraine-related guidance development work was welcomed.</p> <p>Actions JM to review the bariatric LES monitoring requirements and identify any overlap or mismatch with the guidance currently under development. JM to work directly with AGR to align LES requirements with the new guidance to ensure consistency and practicality.</p>	<p>JM JM/AGR</p>
<p>2026/37</p>	<p>Drugs of misuse formulary chapter: opioids dependence</p> <p>Work has been ongoing for several months to review opioid dependence medicines within the formulary, led in conjunction with the Substance Misuse Group. The opioid section has undergone a full formulary-standard review, consistent with the process used for all other chapters. For all medicines used in opioid dependence, the current RAG statuses were supported and retained, except for one item: Buvidal (buprenorphine prolonged-release injection) which was not currently in the formulary. Specialist services unanimously recommended a RED rating for Buvidal. Cross-border considerations were acknowledged: Cheshire & Merseyside already have RED and a shared care for Buvidal. However, local specialist teams within Lancashire & South Cumbria are aligned in recommending RED.</p> <p>The group agreed to adopt a Red RAG rating as the formulary status for Buvidal.</p> <p>Action</p> <p>Buvidal to be added to the formulary with a Red RAG rating.</p>	
<p>2026/38</p>	<p>Drugs of misuse formulary chapter: alcohol dependence</p> <p>The drugs used in alcohol dependence formulary subsection has been reviewed as part of the formulary harmonisation process. Local drug and alcohol services were consulted as part of the review.</p> <p>AGR presented the drugs used in alcohol dependence paper. The paper includes feedback and recommended RAGs from local drug and alcohol services, along with cross border RAG positions. Utilising this information, alongside NICE guidance and known monitoring requirements, the paper makes RAG recommendations for LSCMMG to discuss.</p> <p>LSCMMG accepted the recommendations for Nalmefene to retain the Red RAG rating, Disulfiram for an Amber 1 (Shared Care) and Baclofen to add a</p>	

	<p>statement to the formulary stating that the use of baclofen in alcohol or substance dependence is not supported locally.</p> <p>Naltrexone: the recommendation considered was an Amber 0 and if there is a suspicion of opioid use the RAG should be Red. LMC support an Amber 1 if monitoring responsibilities transfer to primary care.</p> <p>Action: information relating to monitoring requirements, to be brought to the next meeting to support whether the RAG position should be Amber 0 or Amber 1.</p> <p>Chlordiazepoxide: the recommendation considered was to retain the Red RAG rating however it was noted that inspire has requested a Green restricted. DG mentioned that the request for Green (Restricted) could be logical but believed that further discussion is required.</p> <p>JM asked if specialist services prescribe in the community should this count as Red, which was confirmed, he felt that prescribing in primary care is not appropriate but having associated guidance to support this position would be helpful.</p> <p>DJ patients rarely discharged on chlordiazepoxide, queried whether community services have prescribers. LM need some clarity on this.</p> <p>Action: Clarify if alcohol withdrawal services have prescribers that can issue and supervise chlordiazepoxide in order to understand the request for Green (Restricted).</p> <p>Acamprosate: the recommendation considered was to retain Amber 0 RAG (with a handover letter from specialist services).</p> <p>DG asked that this be considered for MH services also. Intent is that those service user that will not engage with SM services can be supported by MH and prescribe acamprosate as an alternative.</p> <p>LMC supported Amber 1 as monitoring is required. Wording is 'supervision' is required in the papers, AGR to check the format this would take.</p> <p>Action: information relating to monitoring requirements, to be brought to the next meeting to support whether the RAG position should be Amber 0 or Amber 1.</p> <p>Actions</p> <p>Bring information relating to monitoring requirements, to the next meeting to support whether the RAG position for naltrexone and acamprosate should be Amber 0 or Amber 1.</p> <p>Clarify if alcohol withdrawal services have prescribers that can issue and supervise chlordiazepoxide in order to understand the request for Green (Restricted).</p>	<p>AGR</p> <p>AGR</p>
2026/39	<p>Gabapentin withdrawal guidance</p> <p>The Substance Misuse Group requested development of a gabapentin/gabapentinoid withdrawal guideline. A draft was previously</p>	

	<p>brought to the committee, and original agreement was that approval could be given outside LSCMMG once finalised, however the chair of the Substance Misuse Group is currently unavailable. Therefore, the guideline was brought back to LSCMMG for formal approval before publication. The guideline is based on the Sheffield Medicines Optimisation Team resource, with very minor local amendments such as removing hyperlinks to Sheffield local pain resources, which are unsuitable for Lancashire & South Cumbria. Links will be added to local pain resources once go live on the LSCMMG website. The overall content and tapering approach align with local clinical expectations and good practice.</p> <p>Members of the group expressed strong support. The patient information elements were praised as particularly useful. Clinicians confirmed the tapering advice aligns well with current real-world practice.</p> <p>The group approved the gabapentin withdrawal guideline as drafted. The document will be updated with local pain-resource links once they become available, but approval does not need to wait for those updates.</p> <p>Actions AGR to finalise the gabapentin withdrawal guideline and upload it, with placeholders for local pain-resource links.</p>	AGR
2026/40	<p>Dapsone Shared Care Guideline update Moderate</p> <p>The committee had previously approved a Dapsone shared care guideline, including a defined monitoring schedule. Since then, issues have emerged regarding how monitoring is managed for patients under the tertiary immunology service at Lancashire Teaching Hospitals. Many of these patients are referred from a wide geographical area, which complicates shared-care arrangements.</p> <p>Following consultation, the tertiary immunology team at LTHTR submitted late comments requesting alternative monitoring arrangements. They proposed that their own version of the monitoring schedule be retained and asked whether other trusts could adopt their monitoring model locally. It is unclear whether local acute trusts outside LTHTR could participate in this alternative monitoring approach.</p> <p>Dapsone is a relatively common drug used in several specialties, making divergent monitoring models more difficult to implement safely. The challenge appears to be a legacy system issue, predating the harmonised formulary, where immunology prescribing practices were not fully integrated. The group agreed this issue cannot be resolved immediately. Further work is required with immunology colleagues to understand their prescribing and monitoring practices, identify whether other medicines require similar review and determine feasible, equitable monitoring arrangements across the system.</p> <p>Action DP to liaise with LTHTR immunology to clarify their requested Dapsone monitoring model. Whether local acute trusts could support their preferred monitoring schedule and whether other immunology-prescribed medicines require review.</p>	DP
2026/41	<p>Blood Glucose Testing Strips for Gestational Diabetes</p> <p>NHS England has updated its list of cost-effective and clinically effective blood glucose meters and test strips. The updated list includes new meters</p>	

	<p>which offer potential savings of approximately £85,000 per year across the health economy. The change represents a modification from the original NHSE recommendations, and this is the first time the group has needed to manage a change.</p> <p>Practices have recently received prescription requests from antenatal clinics specifying Contour Next meters. Some GPs queried whether this matched the formulary; in some cases, prescriptions were instead issued for GlucoRx Q. Antenatal consultants clarified that Contour Next and Ego Matrix were historically used because they offer remote monitoring functionality, allowing antenatal teams to remotely review glucose results for gestational diabetes patients. The key question raised by primary care was whether the new NHSE-recommended meters also support remote monitoring.</p> <p>The new recommended meters do support remote monitoring. New patients should be started on the new recommended meters. Existing patients already using Contour Next should continue on their current devices; no switching is needed due to the time-limited nature of gestational diabetes monitoring.</p> <p>Multiple communications have occurred between primary care and local maternity/diabetes teams across the patch regarding test strip selection. Engagement undertaken by diabetes leads indicates that all relevant services have been consulted. There is agreement with the updated recommended meters, including confirmation that they meet remote-monitoring needs.</p> <p>The group agreed it is appropriate to proceed with implementing the updated NHSE-aligned meter recommendations.</p> <p>Actions DP to update formulary and associated guidance to include the new NHSE-recommended glucose meters for gestational diabetes.</p> <p>CM to ensure communication is cascaded to antenatal and diabetes teams confirming remote monitoring capability of the new meter and expectations around new-patient starts versus continuation for existing users.</p>	<p>DP</p> <p>CM</p>
2026/42	<p>Pathways and Guidance workplan</p> <p>There were no major updates to report on the pathways and guidance work plan. Several items remain in progress and are scheduled for review or completion over the coming months.</p> <p>AGR mentioned that the updated hypertension guideline will be presented at the March meeting.</p> <p>One additional item now requires inclusion in the work plan which is the Penicillin Allergy Document, which has been returned to AGR for finalisation and subsequent progression through LSCMMG. Aside from this addition, all existing work plan items remain unchanged and continue as scheduled.</p> <p>Action The Penicillin Allergy Document to be added to the work plan.</p>	<p>AGR</p>

NATIONAL DECISIONS FOR IMPLEMENTATION

2026/43	New NHS England medicines commissioning policies January 2026 Nothing urgent to consider.	
2026/44	Regional Medicines Optimisation Committees – Outputs January 2026 Nothing for discussion.	
2026/45	Evidence reviews published by SMC or AWMSG January 2026 Two recent evidence reviews were highlighted for awareness. <ul style="list-style-type: none"> • These related to: <ol style="list-style-type: none"> 1. Dupilumab for chronic spontaneous urticaria in patients aged 12+ 2. Ciclosporin (ophthalmic) eye drops • Dupilumab – Chronic Spontaneous Urticaria (12+) <ul style="list-style-type: none"> ○ No local interest has been expressed to date. ○ NICE is expected to publish guidance on this indication, but no publication date is currently available. ○ If local clinical interest arises, the group may need to review this ahead of NICE, but at present no action is required. • Ciclosporin Eye Drop (various brands) <ul style="list-style-type: none"> ○ Scotland has approved a ciclosporin formulation for ophthalmic use. ○ All ciclosporin eye drop brands are already listed on the local formulary. ○ No requests or interest have been received from local ophthalmology teams to prompt a review. • Overall, the group agreed the above items should be noted only, and will not be actively reviewed unless: <ul style="list-style-type: none"> ○ Clinical interest emerges locally, or ○ NICE publishes guidance requiring action. 	
ITEMS FOR INFORMATION		
2026/46	LSCMMG cost pressures log This will be updated following the meeting and circulated with the minutes.	
The next meeting will take place on Thursday 12th March 2026, 9.30 – 11.30 Microsoft Teams		