Lancashire & South Cumbria Medicines Management Group

NHS Midlands and Lancashire Commissioning Support Unit

Minutes of the Lancashire and South Cumbria Medicines Management Group Meeting

Thursday 12th March 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
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
Mohammed Elnaggar (ME)	University Hospitals of Morecambe Bay	Joined May 25	Joined May 25	✓	✓	✓	Apol	Absent	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	✓	✓	Apol
Trust senior pharmacist representation from the following trusts													
James Baker (JB)	Blackpool Teaching Hospitals	✓		✓	✓	✓	Deputy lex Davies)	✓	✓	✓	✓	✓	✓
Andrea Scott (AS) (Nima Herlekar or Jenny Oakley temporarily attending)	University Hospitals of Morecambe Bay	JO attending	✓	✓	✓	✓	✓	✓	✓	✓	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	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 (Laia Dedat)	Deputy (Laia Dedat)	Deputy (Laila Dedat)	Deputy (Laila Dedat)	Deputy (Laila Dedat

Faye Prescott (FP)	Morecambe Bay	✓	Deputy	Apol	✓	Deputy (Paul Elwood)	✓	✓	✓	✓	✓	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	✓	✓	✓	✓	✓	✓
	Provider finance representative												

Lindsey Dickinson (LD)	Associate Medical Director LSC ICB						✓	Apol	Absent	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	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 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
2026/47	**Welcome & apologies for absence** AW opened by expressing thanks to Lizzie Macphie for Chairing at the previous meeting in his absence. He noted that her contribution was, as always, excellent. Apologies received from Dr Ramtoola, Faye Prescott, Melanie Preston (Rukaiya Chand attending) and Andrea Scott (Jenny Scott Attending).	
2026/48	**Declaration of any other urgent business** No items of urgent business were raised.	
2026/49	**Declarations of interest (DOI)** No declarations of interest were noted. BH will update the group of any new declarations each month.	
2026/50	**Minutes and action sheet from the last meeting 12th February 2026** The minutes were approved and will be uploaded to the website.	
2026/51	**Matters arising (not on the agenda)** Nothing discussed.	
2026/52	**Cequa (ciclosporin) 0.9mg/ml eye drops for the treatment of moderate to severe dry eye disease in adult patients who have not responded adequately to artificial tears Moderate change** It was clarified that ciclosporin drops are used when artificial tears have not been effective, and in practice Cequa may be used as an alternative where Ikervis is not suitable or has not worked. It was agreed that both ciclosporin formulations could be considered usable, but they should remain clearly positioned as second-line options, following an adequate trial of artificial tears. Members highlighted the importance of presenting this clearly on the formulary, so the drops are not used routinely for mild or general dry eye symptoms. The current formulary entry does not explicitly restrict them, but because the products are categorised as Amber 0, they are inherently intended for later-line use after other treatments have been tried. The group agreed it would be helpful to add a statement specifying use only after failure of artificial tears. Noted that the required	

	three-month specialist review implies that initiation should occur in secondary care. Consensus reached to approve the recommendation with the agreed clarification wording. **Actions** Cequa (ciclosporin) 0.9mg/ml eye drops for the treatment of moderate to severe dry eye disease in adult patients who have not responded adequately to artificial tears to be added to the formulary with an Amber 0 RAG rating. Addition of a statement to restrict usage to those patients who have failed treatment with artificial tears to be added to the formulary.	
2026/53	**Amantadine for Fatigue in Multiple Sclerosis Moderate change** Amantadine has been used for many years to manage fatigue in MS and appears in the longstanding NICE MS guideline as an option that may be offered. However, the evidence base remains weak, with studies showing inconsistent benefit. Local MS specialists report that some patients do experience meaningful improvement, and they are willing to initiate and manage treatment where appropriate. It is believed that amantadine is already being used for this indication locally but "under the radar," without formal recognition within the LSCMMG formulary. The proposal presented was to classify amantadine as Amber 0, legitimising specialist-initiated use with continued prescribing in primary care. Consultation feedback included a strong point from Fylde Coast, recommending that patients be stabilised on amantadine before transfer to primary care, due to variable dosing requirements and the potential for side effects, which may counterbalance the benefits. Estimated financial impact is low, with potential additional prescribing costs of around £2,700 per year. The group agreed that formalising its use would be recognising current clinical practice rather than expanding it. **Action** Amantadine for MS-related fatigue to be added to the formulary as an Amber 0 RAG rating following advice of Neurology.	
2026/54	**Testosterone for postmenopausal women with low sexual desire if HRT alone is not effective: RAG change review Major change** The request originated from the ICB Women's Health Lead, following issues where patients crossing borders were recommended testosterone therapy, but neighbouring areas lacked shared care arrangements. This created inconsistency in prescribing and prompted a review of the current RAG rating. The proposal on the paper included an error: the intended recommendation is Green (Restricted), not Amber. JO noted that without a Green Restricted status, the system fails to utilise the expertise of BMS-trained practitioners, who can provide improved access for women. Other ICS areas (Cheshire & Merseyside, Greater Manchester)	

	appear to be using such pathways, so lack of access in LSC creates inequity for local patients. Key concerns were raised about current workforce capacity. Although BMS-trained clinicians can manage testosterone prescribing, there are currently very few such specialists in primary care across LSC. Even if the RAG rating is changed, the shortage of appropriately trained clinicians remains the main barrier. Women's Health within the ICB is actively trying to expand BMS training, with a push for a larger cohort to reduce reliance on gynaecology. It was unclear whether this training expansion was already resourced and imminent. CM emphasised that BMS training is included within shared care guidance, and a "specialist" is a specialist irrespective of setting — but the lack of trained specialists in primary care remains the limiting factor. The group acknowledged that a licensed product for female testosterone therapy may progress in the coming months, which could affect the guidance. The group agreed to delay the decision on changing the RAG rating until further clarification is received from Women's Health regarding BMS training timelines; and possible MHRA developments are known. AW noted there are insufficient BMS-trained clinicians locally to support equitable and consistent prescribing of testosterone for low sexual desire in women. This workforce limitation is the primary barrier to changing the RAG rating. **Actions** To contact Sarah Bibby (Women's Health Lead) before she leaves to confirm the timeline for BMS training rollout.	**DP**
2026/55	**Capsaicin 0.025% cream RAG rating** A request came from the QIPP group to classify capsaicin cream as Do Not Prescribe (DNP), specifically in relation to its use for osteoarthritis. Capsaicin has historically been unavailable, so the issue had not required attention previously. Now that the product has returned to market, prescribing concerns have resurfaced. Importantly, capsaicin appears in the LSC neuropathic pain guideline, meaning it cannot simply be assigned DNP across all indications without review. Capsaicin has evidence-based use in neuropathic pain, including post-herpetic pain, and is part of the current step-wise titration approach: o Start with 0.025% cream	

	○ Escalate to 0.075% if beneficial The 0.025% strength is licensed for osteoarthritis, NICE guidance for osteoarthritis highlights capsaicin as an area requiring further research, and alternatives (e.g. topical NSAIDs) are preferred. Members agreed that a blanket DNP would not be appropriate, as it would undermine its legitimate place in neuropathic pain management. The group supported maintaining capsaicin as an option for neuropathic pain, while clearly excluding osteoarthritis. **Actions** • Capsaicin 0.025% cream to be assigned a Do Not Prescribe (DNP) RAG rating for osteoarthritis. • Retain capsaicin for neuropathic pain indications, following existing LSC neuropathic pain guidance: ○ 0.025% formulation may be used for titration in neuropathic pain. ○ 0.075% formulation remains available for neuropathic pain and post-herpetic neuralgia.	
2026/56	**New medicines workplan** DP explained that the planned review item for bevacizumab ophthalmic use outside NICE guidance appears unnecessary, as existing guidance already aligns with current clinical practice and indications. DJ added that the bevacizumab landscape is changing, as a licensed ophthalmic preparation is now available. Because of this, the group needs to be cautious not to "muddy the water" by reviewing or altering local guidance prematurely. The availability of a licensed preparation may eventually result in the unlicensed products becoming unavailable, which would change the picture entirely. DJ also noted that an ophthalmic pharmacist is due to start in the Trust in the coming weeks. This new specialist may review the area, and if any gaps are identified, the item could be brought back to LSCMMG for further consideration. The area may return to the work plan if the forthcoming ophthalmic pharmacist identifies issues or if market changes affect availability of licensed vs unlicensed products. **Action** Remove the bevacizumab (ophthalmic use) review from the work plan for now.	**DP**
2026/57	**New NICE Technology Appraisal Guidance for Medicines February 2026** AGR confirmed that there was only one NICE TA to discuss, NICE TA 1128 targeted release of budesonide for IgA mediated nephropathy (replacing TA 937) with an expanded eligible population. Estimated cost pressure of £831k in year 1, rising to £1.32m in year 3 (flagged as significant/high risk). It was noted that the formulation is PBR excluded; would be managed via Blueteq	

	and requires formulary update. AW wanted to know whether local clinician demand matches the NICE assumptions. **Action** Check/confirm anticipated local demand with clinicians and check these are in keeping with NICE assumptions.	**AGR**
2026/58	**Formulary update** It was noted that there has been no significant change in the work plan since last month. The team is working towards aligning formulary chapter updates with guideline updates, with the aim of improving consistency and reducing duplication. While this alignment will not always be perfect some items may expire before the guideline updates occur this remains the preferred approach going forward. Overall, the work plan remains on track.	
2026/59	**Formulary Changes since last LSCMMG – TO FOLLOW** BH summarised that most significant changes to the formulary have been in response to actions agreed at the February LSCMMG, no other significant issues were highlighted for discussion.	
2026/60	**Hypertension guidelines – update** AGR presented the item. The pathway was previously brought to the group (July meeting) and returned to the specialist group for revisions; requested changes have now been incorporated and the updated version has been resubmitted via RC and the MDT group. The document is largely based on the GM pathway but has been adapted for Lancashire & South Cumbria (local service links, referral routes, formulary choices, and version control). The scope of the document extends beyond medication to include wider hypertension management: case finding, referrals (including community pharmacy), and supporting services. AGR confirmed that there is currently no local hypertension pathway; the group highlighted an increasing number of identified patients (including ~6,000 additional patients found recently) and a need to support effective management to meet local targets. It was discussed whether specialist cardiology input was required; RC noted it has been developed by the Hypertension Oversight Group (primarily primary care) and is not considered controversial. RC confirmed that the GM pathway initially proposed starting with two antihypertensive agents; this was rejected by the hypertension group as not aligning with national guidance and potentially risky if patients were lost to follow-up. The revised pathway removes this as routine practice and positions it as an individualised option (explicitly not recommended for everyone). JM highlighted that the pathway was particularly helpful for prescribers who are less confident navigating medication changes, especially for newly	

	diagnosed patients, recognising that complex intolerance histories cannot be fully captured in a flow diagram. **Action** The group approved the hypertension guideline/pathway for Lancashire & South Cumbria and should be added to the website.	
2026/61	**Morphine (High dose) prescribing for chronic non-cancer pain: Position Statement – update** AGR informed the group that the Faculty of Pain Medicine guidance had been updated—upper limit now described as 90 mg/day morphine equivalent, with an ideal target of 50 mg/day. Evidence cited of increased harm without meaningful added benefit above 90 mg/day. The current LSCMMG position recommends a ceiling of 80 mg/day morphine equivalent (40 mg twice daily) before referral to secondary care. AGR proposed agreeing an interim position statement aligned to the Faculty of Pain Medicine update and retire the existing LSCMMG “assessing suitability for strong opioid use” guidance, pending a broader suite of supporting documents being developed via the substance misuse workstream (noted Faye leading, currently off). It was highlighted that the document should not serve to “name/shame” patients/clinicians and is accompanied by a clear plan for managing individuals already on very high doses. Additionally, JO raised concerns that chronic pain services are already stretched; lowering dose targets and/or increased referrals could create significant additional demand. Examples given of patients being referred on high doses and reportedly reassured by pain services that this is acceptable. JM highlighted that managing the cohort already on high doses was noted as primarily a commissioning/service issue ("turning the taps off" for new starts vs managing existing backlog). Need to clarify referral criteria and ensure appropriate commissioned pathways and support for primary care. The group noted that the decommissioning of pain clinic services (Fullwood Hall Hospital) has resulted in many patients being diverted back to primary care, increasing workload and complexity; any changes must account for this system pressure. It was agreed in principle to approve the updated position statement reflecting Faculty of Pain Medicine guidance (90 mg/day upper limit; 50 mg/day ideal target). However, this should be accompanied by follow-up work with commissioning/planned care to ensure services and pathways can	

	support safe dose reduction and appropriate referral, without overwhelming chronic pain services. **Actions** Finalise interim position statement and confirm retirement/supersession of the existing LSCMMG opioid suitability guidance. Write to the commissioning/planned care team and request assurance on: chronic pain service capacity and referral criteria/pathways.	**AGR** **AW**
2026/62	**Amiodarone and dronedarone shared care – update** These documents were originally North West Collaborative guidelines. The intention had been for them to be updated collaboratively at regional level, but this has not progressed. As a result, the documents have now been updated locally. AGR confirmed that both guidelines (Amiodarone and Dronedarone) have been updated with changes highlighted in red. No issues were raised by the group regarding the clinical content or the update process. **Action** The updated Amiodarone and Dronedarone shared care documents were accepted. The updated versions will be published on the LSCMMG website.	
2026/63	**Headache pathway – update DEFERRED to April**	
2026/64	**Antipsychotic shared care – update** AGR outlined that the changes were primarily updates in line with current SPCs and the BNF, with no intended policy change. However, additional section summarising cautions and common side effects applicable across antipsychotics (reflecting BNF), updates to individual drug entries, and updates to drug–drug interactions (aligned to SPC/BNF). AGR told the group that Comments from LSCFT were delayed due to staff absence; DG advised she would confirm later that day and provide any additional feedback. DG noted ongoing concerns about what is included within shared care where treatments may be BNF-licensed but not NICE-recommended, and advised LSCFT is developing narrative/recommendations via Trust Drugs &	

	Therapeutics next week (DG chairing in SRs absence), to inform future shared care documentation. The group agreed the update is not controversial and should proceed as an SPC/BNF-aligned refresh to avoid the guidance becoming out of date but to allow LSCFT an additional week to confirm any final comments before the update is treated as final. **Actions** The shared care document was agreed in principle. To obtain final internal comments from LSCFT and email any required amendments to AGR by end of next week (or sooner if possible). AW to provide Chair's approval once incorporated.	**DG/AGR**

2026/65	**ADHD shared care – update**
	The ADHD shared care guideline required an update, and AGR has revised it in line with SPC information.
	
	• Updates included:
	  ○ Significant changes to adverse effects, contraindications, and cautions — all strictly based on SPC content.
	  ○ No changes to treatment pathways or structure; this is a housekeeping / accuracy update.
	
	The draft was sent to LSCFT for review. LSCFT requested clarification on age categories, as previous wording was ambiguous.
	
	  ○ Original: "Over 17 years"
	  ○ Updated following feedback:
	  ▪ Adults: "18 years and over"
	  ▪ Children & Adolescents: "6 to 17 years"
	  ○ The group agreed this wording is clearer and aligns with clinical reality.
	• No further issues were raised.
	
	Action
	
	The ADHD shared care document was approved and will be updated on the formulary website.	

2026/66	**Denosumab shared care – update** The denosumab shared care document was approaching its expiry date and therefore required updating. The biosimilar had already been incorporated into the guideline during a previous update, following earlier requests from the group. AGR confirmed that this update is purely housekeeping, bringing the document in line with the current SPCs. No changes have been made to pathways, responsibilities, or the previously added biosimilar information.	

	The update consists solely of clinical accuracy and safety information refreshes based on SPC content. **Action** The denosumab 60mg injection shared care document was approved and will be updated on the formulary website.	

2026/67	**Testosterone shared care – update**
	This update relates specifically to testosterone for hypogonadism, not the separate women's HSDD/HRT discussion earlier in the meeting. The guideline was due to expire and required routine review.
	
	AGR confirmed that the document has been updated in line with the latest SPCs. A small number of formulations no longer marketed have been removed.
	
	• Updates include:
	  ○ Revised side-effects information
	  ○ Updated cautions and contraindications
	  ○ Updated drug interactions section
	• No changes to clinical pathway, prescribing oversight, or shared care responsibilities.
	• This update is a housekeeping refresh only, ensuring clinical accuracy.
	
	Action
	
	The testosterone shared care document was approved and will be updated on the formulary website.	

2026/68	**Neuropathic pain guidance – update** This update was brought forward to ensure alignment with the recently approved gabapentinoid deprescribing guideline. The intention was not to revise treatment pathways wholesale, but to ensure consistency in emphasis and messaging across documents. AGR highlighted that the main issue was ensuring the neuropathic pain guideline reflects the ethos of the gabapentinoid deprescribing guidance. • A minor amendment was therefore added: ○ "Consider amitriptyline in preference to pregabalin or gabapentin where clinically appropriate." AW asked whether the neuropathic pain guideline currently includes a direct link to the gabapentinoid deprescribing guideline. AGR confirmed it does not, but agreed to add a hyperlink / cross-reference to strengthen alignment. No further comments were raised, and the group was satisfied with the proposed update.	

	Action Subject to adding a link to the gabapentinoid deprescribing guideline the neuropathic pain guidance document was approve and will be uploaded to the LSCMMG formulary website.	
2026/69	**Drugs of misuse formulary chapter: alcohol dependence – update DEFERRED to April**	

2026/70	**Asthma Treatment Guideline for Children aged 11 and under, update**
	The group reviewed feedback from paediatric respiratory specialists regarding the paediatric asthma guideline.
	
	• Key issues related to:
	  ○ Use of dry-powder inhalers (DPIs) in 5–11-year-olds.
	  ○ Mention of Symbicort 100/3 pressurised MDI as an alternative.
	  ○ Early work underway in hospitals on updated paediatric asthma guidance, which may eventually feed into future NICE updates, though timelines are uncertain.
	
	DP raised the question of whether children aged 5–11 can reliably use DPIs, given this affects multiple recommendations. The group agreed the guideline should include a clear requirement that DPIs must only be used following assessment of the child's ability to use them correctly. AW noted that safe prescribing already assumes this assessment, but adding explicit wording will strengthen safeguards.
	
	PHENO (FeNO) testing availability was queried. JM confirmed that within primary care, FeNO testing is available across general practice, though operational models vary by practice. Paediatric feedback largely related to clinical pathway issues, not medication choices, and may sit better with the specialist pathway group.
	
	The group acknowledged that paediatric asthma practice is still adapting after major NICE changes ("the big bang"). Variation across practice and specialism is expected to continue for 1–2 years. Any new paediatric recommendations (e.g., from hospital paediatricians) should sit within their clinical pathway group rather than LSCMMG.
	
	AW emphasised the importance of unbiased inhaler training, not reliant on manufacturer support. Noted as outside LSCMMG scope but an important system need.
	
	JO requested adding a statement referencing NPPG guidance regarding:
	
	  ○ Issuing steroid cards for children on steroid treatments, especially those under 5.	

	o Ensuring both secondary care and primary care issue cards appropriately. • The group agreed this addition is necessary for clarity. • Community pharmacies were acknowledged as an appropriate issuing point. AW referenced ongoing concerns raised by respiratory teams regarding inhaler choices in the adult pathway. DJ noted that expiry dates after opening affect cost-effectiveness of some devices. DP agreed to pick this up urgently, needing clarity due to staff changes. Approved: Paediatric asthma guideline update approved with the following additions: 1. Explicit statement requiring assessment of child's ability to use dry-powder inhalers before prescribing. 2. Addition of NPPG steroid card guidance, especially concerning under-5s. **Actions** DP to urgently follow up with respiratory team contacts regarding ongoing adult inhaler pathway concerns including identification of alternative contacts due to multiple staff departures. Paediatric asthma guideline update approved and to be uploaded to the LSCMMG website with the following additions: • Explicit statement requiring assessment of child's ability to use dry powder inhalers before prescribing. • Addition of NPPG steroid card guidance, especially concerning under 5s.	**DP** **DP**
2026/71	**Pathways and Guidance workplan** AGR had an important update regarding NHSE updating their gender dysphoria guidance. NHSE has launched a public consultation on a new clinical commissioning policy regarding the use of masculinising and feminising hormones for children and adolescents (noted as a 90-day consultation). Consequently, NHSE have decided to pause all new prescriptions for these hormones within NHS gender services for under-18s with immediate effect, pending the consultation. Patients already receiving these hormones may continue treatment but should be reviewed (noted for 16–17 year olds: review by lead clinician/consultant, shared decision-making, and enhanced informed consent). AGR made it clear that the update does not apply to adults (over 18s). The local gender dysphoria guidance is currently classed as Amber 0 and will need review/amendment to reflect the NHSE pause for new under-18 prescriptions and the requirement to review existing patients.	

	The group agreed that the current gender dysphoria guidance should be updated to reflect the change and some GP comms should also be drafted to keep primary care informed of the changes. **Actions** Update/amend the local gender dysphoria guidance to reflect NHSE position (pause on new under-18 prescriptions; review requirements for existing patients) and bring back to the group. Arrange GP comms to clarify the position and keep primary care informed	**AGR** **AGR**

2026/72	**New NHS England medicines commissioning policies February 2026** Nothing urgent to consider not on the agenda.	
2026/73	**Regional Medicines Optimisation Committees – Outputs February 2026** Nothing for discussion.	

2026/74	**Evidence reviews published by SMC or AWMSG February 2026**
	
	• Scotland has not recommended zuranolone for postnatal depression.
	• NICE status remains TBC.
	• The group agreed no action is required at this stage.
	• LSCMMG will await:
	  ○ A formal expression of interest, or
	  ○ A positive NICE / NHSE development before scheduling a review.
	
	Donanemab was not recommended for mild cognitive impairment and mild dementia due to Alzheimer's disease. It is important to monitor due to:
	
	  ○ Potential very high cost impact if approved in future.
	  ○ Possible implications for service planning, particularly regarding diagnostics and monitoring requirements.
	• Highlighted as a risk for future horizon scanning cost projections.
	
	All Wales Medicines Strategy Group (AWMSG) has recommended infliximab for pneumonitis associated with chemotherapy.
	
	• Action:
	  ○ DP will contact Dave at Preston to determine:
	  ▪ Whether the medicine is already in use locally.
	  ▪ Whether any local patients may be "held up" due to commissioning gaps.
	• Aim: ensure no delays to treatment where clinically appropriate.
		DP

2026/75	**LSCMMG cost pressures log** This will be updated following the meeting and circulated with the minutes.	

2026/76	**Any Other Business**
	LSCFT has recently identified several incidents involving the twice-weekly rivastigmine transdermal patch (brand: *Zeyzelf*). These incidents appear to relate to prescribing selection errors caused by poor clarity in EMIS drug drop-down lists. These patches were only added to the formulary in July 2023, so the affected cohort is likely small — but still clinically significant.
	
	JM demonstrated that the EMIS medication list for rivastigmine:
	
	• Displays several entries with minimal differentiation between:
	• 24-hour daily patches (Exelon)
	• Twice-weekly patches (Zeyzelf)
	• The dosing frequency is not visible in most generic entries.
	• Only the branded items clearly indicate frequency, creating a high risk of clinical error.
	
	• Dorna noted that the issue affects community pharmacists as well, not just prescribers.
	• Mis-selection could lead to:
	  ○ Incorrect dosing frequency.
	  ○ Safety incidents.
	  ○ Unintentional supply of non-formulary or incorrect products.
	
	LSCFT has already undertaken initial due diligence. Consultants have been reassured that their clinic letters do specify the brand name, which should reduce ambiguity — but not eliminate risk.
	
	LSCFT Internal Actions
	Continue reviewing prescribing records to identify any patients where:
	• The incorrect patch type may have been prescribed.
	• Appropriate rectification is required.
	
	No change to formulary position requested at this stage.
	
	Voluntary Redundancy
	AW closed the meeting with several important acknowledgements, noting that this was the final LSCMMG meeting for several members.
	
	The group expressed sincere thanks and appreciation to the following colleagues for their contributions over the years:
	
	• Adam Grainger – attending his final meeting today; thanked for his extensive work and support.
	• Andrea Scott – not present, but to be formally thanked via Jenny for her significant contributions over many years.	

	• Melanie Preston and Rukaiya Chand– both leaving at the end of March; their commitment and expertise were recognised and appreciated. • Sharon Andrew – left last month, having produced several papers for this and previous meetings. • Lisa Rogan – not present for some time but also leaving at the end of March; acknowledged for her past input. AW noted that many staff are leaving the ICB at the end of the month, and several have already departed. The group expressed good wishes for all colleagues moving on to new roles or opportunities. He also acknowledged the impact of reduced workforce capacity, reminding members that: • Prioritisation will be essential moving forward. • High-importance items must remain the focus of agendas. • Lower-priority work should, where possible, be progressed via minor amendments processes rather than requiring full agenda time.	
The next meeting will take place on Thursday 9th April 2026, 9.30 – 11.30 Microsoft Teams		