# NHS GRAMPIAN
## Minute of Formulary Group Meeting
## Tuesday 17 March 2026 at 14:30 via Microsoft Teams

**APPROVED**

| ITEM | SUBJECT | ACTION |
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WELCOME

The Chair opened the meeting, welcomed members, and confirmed that a quorum was present.

### 1. ATTENDANCE, APOLOGIES AND DEPUTIES

#### 1.1. CHAIR

Dr L Elliot, Chair.

#### 1.2. MEMBERS PRESENT

| Present | Apologies | Deputy Attending |
|---|---|---|
| Dr V Chieng | Mr Y Al-Obaidi | Mrs E Bruce |
| Ms L Cameron | Mr G Burt | Mr K Stout |
| Ms F Doney | Mrs M Galvin | Mrs S Howlett |
| Dr L Elliot | Mr M Paterson | |
| Mrs E Milne | | |
| Mrs S O'Beirne | | |

#### 1.3. IN ATTENDANCE

Ms D Bruce, Specialist Pharmacy Technician, Formulary Team.
Mrs C Standen, Formulary and Medicines Management Pharmacist.

#### 1.4. NOTES

Members who sent apologies are recorded with deputies where provided.

The Chair invited members to introduce themselves to welcome Mr Stout, attending as the Finance Representative Deputy, and to provide context on the member's role.

### 2. MINUTE AND DECISIONS

#### 2.1. DRAFT MINUTE OF THE MEETING HELD 17 FEBRUARY 2026

Members endorsed the draft note of the meeting, pending minor typographical amendments.

The final approved minute will be made publicly available within 21 days of formal approval. **FD**

#### 2.2. FORMULARY GROUP DECISIONS FEBRUARY 2026 - PUBLISHED 02/03/2026

Members formally ratified the February 2026 decisions document as published.

### 3. MATTERS ARISING

#### 3.1. ACTION LOG

The Group noted the item.

#### 3.2. DRAFT FORMULARY ENTRY FOR DROSPIRENONE

The Group reviewed and accepted the draft entry for drospirenone that noted the requirement for urea and electrolytes monitoring in some individuals.

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| | The Formulary Team will liaise with the Sexual and Reproductive Health (SRH) Service to coordinate publication of the formulary entry alongside the update to the local progestogen-only pill guidance. | FTEAM |

## 4. DISCUSSION/PRESENTATION

None.

## 5. NEW PRODUCT REQUESTS

### 5.1. SMC 2824 - MERCAPTAMINE (NEUROPATHIC CYSTINOSIS)

There were no declarations of interest recorded in relation to this product.

The Group considered the request for mercaptamine bitartrate gastro-resistant capsules as the brand Procysbi® as an additional treatment option for proven nephropathic cystinosis.

The Group noted that:

- mercaptamine reduces the lysosomal accumulation of cystine that characterises cystinosis
- mercaptamine (Procysbi®):
  - [for this indication] meets SMC orphan equivalent criteria, and was accepted for use in NHS Scotland following a third resubmission assessed under the orphan equivalent medicine process, the output from the PACE process, and application of SMC decision modifiers that can be applied when encountering high cost-effectiveness ratios
  - dosing is titrated to an assay-dependent target. The daily-targeted maintenance dose for newly diagnosed patients is 1.3g/$m^2$ increasing to a maximum dose of 1.95g/$m^2$ administered every 12 hours. The determination of white blood cell (WBC) cystine and/or plasma cysteamine must be obtained 12.5 hours after the evening dose the day before and therefore 30 minutes after the following morning dose is given.
- the current treatment of proven nephropathic cystinosis is with an immediate-release formulation of mercaptamine hard capsule (Cystagon®) which is administered as four doses each day (6 hours apart)
- evidence for Procysbi® comes from RP103-03 an open-label, phase III crossover comparative study:
  - after a two to three week run-in period where patients received their usual dose of mercaptamine (Cystagon®), patients were randomised equally to either mercaptamine (Cystagon®) for three weeks followed by crossover to mercaptamine (Procysbi®) for 3 weeks or the reverse sequence
  - the primary outcome was peak WBC cystine levels measured every morning over 3 consecutive days at the end of each 3-week treatment crossover period
  - Procysbi® was non-inferior to Cystagon® for control of WBC cystine levels in the primary analysis in the per protocol population and in the intention-to-treat population
- cystinosis is a rare genetic disorder and patient numbers are expected to be small
- Procysbi® is limited to hospital supply only
- cost off-set is available as patients will receive Procysbi® as an alternative to Cystagon®
- Procysbi® offers the advantage of twice-daily dosing rather than the four times a day dosing of Cystagon®. The reduced frequency of administration provides the opportunity to improve adherence and disease control, and reduce the rate of renal and other organ dysfunction resulting in later start on dialysis/transplant.
- the SMC advice takes account of the benefits of a PAS that improves the cost-effectiveness of Procysbi®

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The Group accepted the restricted local need for mercaptamine bitartrate gastro-resistant capsules as the brand Procysbi® as an additional treatment option for proven nephropathic cystinosis.

**FG1SMC 2824 - Mercaptamine bitartrate 25mg, 75mg gastro-resistant capsules (Procysbi®) is routinely available in line with national guidance (SMC 2824).**
**Indication under review: treatment of proven nephropathic cystinosis. Cysteamine reduces cystine accumulation in some cells (e.g. leukocytes, muscle and liver cells) of nephropathic cystinosis patients and, when treatment is started early, it delays the development of renal failure.**
**A phase III, open-label, crossover study demonstrated that extended-release mercaptamine (Procysbi®) was non-inferior to immediate-release mercaptamine in control of white blood cell cystine levels in patients with nephropathic cystinosis who were previously controlled on mercaptamine therapy.**
**This advice applies only in the context of an approved NHS Scotland Patient Access Scheme (PAS) arrangement delivering the cost-effectiveness results upon which the decision was based, or a PAS/list price that is equivalent or lower.**
**This advice takes account of the views from a Patient and Clinician Engagement (PACE) meeting.**
**It was classified 1b - available for restricted use under specialist supervision and 8b - recommended for hospital use only. Treatment should be initiated under the supervision of a physician experienced in the treatment of cystinosis.** FTEAM

### 5.2. SMC 2817 - DELGOCITINIB (CHRONIC HAND ECZEMA)

There were no declarations of interest recorded in relation to this product.

The Group considered the request for delgocitinib cream for the treatment of moderate to severe chronic hand eczema (CHE) in adults for whom topical corticosteroids are inadequate or inappropriate.

The Group noted:

- delgocitinib is a pan Janus kinase (JAK) inhibitor that targets all four members of the JAK family of enzymes consisting of JAK1, JAK2, JAK3, and tyrosine kinase 2 (TYK2)
- the recommended dose of delgocitinib is a thin layer applied twice daily to the affected skin of the hands and wrists until the skin is clear or almost clear. It is recommended to apply the cream at regular intervals, approximately 12 hours apart. Treatment should be discontinued if no improvement is seen after 12 weeks of continuous treatment.
- first-line treatment of CHE involves topical corticosteroids and emollients, second-line treatment options include phototherapy and alitretinoin
- evidence for delgocitinib comes from the DELTA 1, DELTA 2 and DELTA FORCE trials
  - in DELTA 1 and DELTA 2 patients with CHE were randomised 2:1 to delgocitinib cream or cream vehicle. The primary outcome was Investigator's Global Assessment for Chronic Hand Eczema (IGA-CHE) at week 16:
    - in DELTA 1: IGA-CHE was 20% for delgocitinib vs 9.9% for cream vehicle
    - in DELTA 2: IGA-CHE was 29% for delgocitinib vs 6.9% for cream vehicle
  - in DELTA FORCE patients were randomised to delgocitinib until week 16 or oral alitretinoin capsules until week 12. The primary outcome was the change in Hand Eczema Severity Index (HECSI) score from baseline to week 12. This was -67.6 in the delgocitinib cream group and -51.5 in the alitretinoin group.
- patient numbers are expected to be small in year one but increase in subsequent years
- the service stated that:
  - delgocitinib cream will be used second-line as an alternative to phototherapy or alitretinoin

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- current treatments are not effective for some people and can cause significant side effects. Alitretinoin can cause birth defects and phototherapy is inconvenient for most people due to regular hospital visits and long-term use may increase the risk of skin malignancy.
- the SMC advice takes account of the benefits of a PAS that improves the cost-effectiveness of delgocitinib

The Group accepted the restricted local need for delgocitinib cream for the treatment of moderate to severe CHE in adults for whom topical corticosteroids are inadequate or inappropriate, as outlined in SMC 2817.

**FG1SMC 2817 - Delgocitinib 20mg/g cream (Anzupgo®)▼ is routinely available in line with national guidance (SMC 2817).**
**Indication under review: treatment of moderate to severe chronic hand eczema (CHE) in adults for whom topical corticosteroids are inadequate or inappropriate.**
**In two phase III studies, delgocitinib significantly improved treatment success at 16 weeks, based on the Investigator's Global Assessment for Chronic Hand Eczema, in patients with moderate to severe CHE, compared with vehicle cream. In a third phase III trial, delgocitinib also led to a significantly greater reduction in the Hand Eczema Severity Index score than alitretinoin in patients with severe CHE at week 12.**
**It was classified 1b - available for restricted use under specialist supervision and 8b - recommended for hospital use only. Treatment should be initiated and supervised by physicians with experience in the diagnosis and treatment of chronic hand eczema.** **FTEAM**

### 5.3. FG1 484/25 - SPIRONOLACTONE (OFF-LABEL TREATMENT OF ACNE VULGARIS)

There were no declarations of interest recorded in relation to this product.

The Group considered the off-label request for spironolactone for the treatment of acne in adult females with persistent acne.

The Group noted:
- spironolactone:
  - is included on the Scottish Drug Tariff
  - [for this indication] is off-label use
  - is currently included on formulary for its licensed indications as the first-line choice aldosterone antagonist
- the Primary Care Dermatology Society (PCDS) acne guidance under the Treatment - additional considerations section notes that "*Spironolactone can be very effective in acne and is generally safe, although it can take up to 6 months to work effectively*"
- the PCDS guidance recommended dosing for spironolactone for acne is to start at 50mg daily, increasing up to 100mg daily after 4 weeks if tolerated
- the service stated that the maximum dose for this indication is 200mg daily
- NHS Tayside and NHS Greater Glasgow and Clyde formularies include off-label use of spironolactone for the treatment of acne
- evidence comes from a multicentre, phase 3, double-blind, randomised controlled trial comparing spironolactone to placebo
- the primary outcome was Acne-Specific Quality of Life symptom subscale at week 12 which was 19.2 for spironolactone and 17.8 for placebo
- the service could not accurately estimate patient numbers, but there is the potential that patient numbers will increase as clinicians become familiar with this treatment option
- the service places spironolactone as a second-line choice if oral antibiotics are ineffective. Spironolactone would be used as an alternative in primary care that targets an alternative causative factor (anti-androgen) to antibiotic options.

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- the availability of spironolactone in primary care for appropriate cases may help avoid delays in patient treatment

Members were supportive of the request noting that Primary Care has experience prescribing and monitoring spironolactone for the management of heart failure. However, members raised queries regarding the proposed dosing regimen, particularly the suggested maximum dose, and the recommended monitoring schedule for urea and electrolytes at initiation and following dose changes.

Queries:
*Monitoring requirements*
- given the different patient population and mindful of the need to avoid unnecessary blood tests, how should monitoring differ from the more intensive protocols used in heart failure?

*Dosing*
- what dosing regimen do you recommend for spironolactone in acne (starting dose, titration, and maximum dose)?
- what evidence is there to support doses above 100 to 150mg, and under what circumstances would these higher doses be appropriate?

*Pathway Clarification*
- is there an agreed clinical pathway for dosing increments, monitoring, and review for spironolactone in acne?

The Formulary Team will contact other Health Boards (Glasgow and Tayside) for their protocols/monitoring guidance. **FTEAM**

The Group was minded to support prescribing for adult females with persistent acne who had failed two courses of antibiotics, but requested clarification of the dosing regimen and required monitoring.

**Decision deferred to a future meeting.** **FTEAM**

## 6. FORMULARY REVIEW

### 6.1. FORMULARY UPDATES

There were no declarations of interest recorded in relation to these products.

ULTRA-ORPHAN PATHWAY MEDICINE SMC 2836 - LENIOLISIB 70MG FILM-COATED TABLET (JOENJA®)

There were no declarations of interest recorded in relation to this product.

Ms Bruce reported that:
- SMC 2836 is an ultra-orphan medicines assessment report (UMAR). Medicines undergoing an initial assessment of evidence by the SMC are considered outwith remit for the Formulary Group; these medicines will ultimately be accessed via the Scottish Government ultra-orphan pathway.
- December 2025, using the ultra-orphan framework, the SMC completed its initial assessment of the evidence for leniolisib (Joenja®) for the treatment activated phosphoinositide 3-kinase delta (PI3K-delta) syndrome (APDS) in adult and paediatric patients 12 years of age and older
- January 2026 leniolisib (Joenja®) was added to the formulary as '*Not routinely available in NHS Grampian. If local need identified contact the Pharmacist Team Leader/Principal Pharmacist – Supply (ARI).*'
- the Scottish Government confirmed that from 05 March 2026 leniolisib (Joenja®) can be prescribed within the ultra-orphan pathway while further evidence on its

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effectiveness is generated. After 3 years the company will provide an updated submission for reassessment to allow a decision on its routine use in NHS Scotland.

In line with local processes, the Group supported updating the formulary decision to '*Not routinely available in NHS Grampian. If local need identified treatment is available through the National Services Scotland Ultra orphan medicines Risk Share Scheme*.'

**SMC 2836 – Leniolisib 70mg film-coated tablet (Joenja®)▼ is not routinely available in NHS Grampian.**
**Indication under review: treatment of activated phosphoinositide 3-kinase delta (PI3K-delta) syndrome (APDS) in adult and paediatric patients 12 years of age and older.**
**Not routinely available in NHS Grampian. If local need identified, treatment is available through the National Services Scotland Ultra orphan medicines Risk Share Scheme.** **FTEAM**

DEBRANDING

Ms Bruce reported that Xtandi® has been de-branded and will now be known as Enzalutamide Astellas®. The PAS agreement has been updated to novate the current agreements for Xtandi®.
The formulary entry will be updated to remove the brand name, and the name change will be highlighted to the local and regional Hospital Electronic Prescribing and Medicines Administration (HEPMA) Teams.

**Members supported update of the formulary entry to remove the brand name, only the generic name will be noted on the formulary.** **FTEAM**

FORMULATION CHANGE

Ms Bruce reported that selpercatinib 40mg, 80mg hard capsules have been discontinued and replaced by film-coated tablets. The hard capsule and film-coated tablet dosage forms are bioequivalent. The NHS List price and PAS discounts are unchanged and the PAS agreement has been updated to novate the current agreements for the new formulation.

**Members supported update of the formulary to note the formulation change.** **FTEAM**

DISCONTINUATIONS

Ms Bruce reported that the following medicines/presentations were being discontinued:
- apraclonidine 5mg/mL (0.5%) eye drops (Iopidine®)
- chloroquine phosphate 250mg tablets (Avloclor®)
- cobicistat 150mg tablets (Tybost®)
- crisantaspase 10,000unit powder for solution for injection vials (Erwinase®)
- defatted powder of Arachis hypogaea L, semen 0.5mg, 1mg, 10mg, 20mg, 100mg oral powder in capsules for opening and 300mg oral powder in sachet (Palforzia®)
- inotersen 284mg solution for injection in pre-filled syringe (Tegsedi®)
- lusutrombopag 3mg film-coated tablets (Mulpleo®)
- sulfadiazine silver 1% cream (Flamazine®)

The changes are considered low risk discontinuations.

**Members supported update of the formulary to note the discontinuations.** **FTEAM**

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### 6.2. SBAR - PEMBROLIZUMAB SUBCUTANEOUS INJECTION

There were no declarations of interest recorded in relation to this product.

Ms Doney reported that pembrolizumab is now available in a subcutaneous injection formulation, and the service wishes to have it considered for inclusion on the formulary.

The Group noted that:

- the new formulation is considered outwith remit for SMC
- pembrolizumab as the intravenous formulation is included on the formulary for multiple indications
- the new subcutaneous preparation was licensed in December 2025
- the 200mg intravenous dose is equivalent to 395mg/2.4mL subcutaneous [given every three weeks], and the 600mg intravenous dose is equivalent to 790mg/4.8mL subcutaneous [given every 6 weeks]
- the clinical safety profile is comparable to intravenous pembrolizumab, and no new or unexpected safety concerns have been identified
- other centres in Scotland are planning to switch to the subcutaneous formulation, and NHS England is also expected to switch
- introduction will be cost-neutral for the medicine costs, but there is the potential for a significant chair-time saving
- use of the subcutaneous formulation will be reviewed when biosimilar intravenous pembrolizumab is available

Members acknowledged the potential benefits of the new formulation for patients, the service and the Board.

The Group accepted the restricted local need for subcutaneous pembrolizumab without the need for a full submission. It was agreed that the new subcutaneous formulation will be added to the formulary, aligned with the existing positioning of the intravenous preparation, subject to the product's current licensing status.

**SBAR - Pembrolizumab 165mg/mL solution for injection (Keytruda®) is routinely available in line with local guidance.**
**Indications under review: subject to the product's licensing status for adults and in line with the current formulary acceptance for the intravenous infusion, including any restrictions.**
**It was classified 1b - available for restricted use under specialist supervision and 8b - recommended for hospital use only. Treatment must be initiated and supervised by physicians experienced in the treatment of cancer.** **FTEAM**

### 6.3. REQUEST TO CONSIDER CHANGE IN FORMULARY STATUS OF ATOGEPANT AND RIMEGEPANT FOR MIGRAINE PREVENTION

Ms Doney discussed a potential request to review the formulary classification of the oral calcitonin gene-related peptide (CGRP) receptor antagonists, atogepant and rimegepant, used for the migraine prevention.

To support a submission, members requested updated information from the headache service, including:

- estimated patient numbers
- experience of side effects based on the service's experience to date
- monitoring requirements, for example blood pressure monitoring and
- a draft revised treatment pathway incorporating the oral CGRP receptor antagonists

The Group noted the request and agreed that further consideration will be undertaken once the additional information is available. **FTEAM**

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### 6.4. BIOSIMILAR CONTRACT CHANGES

There were no declarations of interest recorded in relation to this product.

Ms Doney reported that aflibercept 40mg/mL as the brand Eylea® has lost exclusivity, with biosimilar products now available.

The Group noted that:

- aflibercept 40mg/mL is accepted for use in NHS Grampian for the treatment of adults with:
  - neovascular (wet) age-related macular degeneration – SMC 857/13 (April 2013)
  - visual impairment due to macular oedema secondary to central retinal vein occlusion – SMC 954/14 (April 2014)
  - visual impairment due to diabetic macular oedema (DMO) with best corrected visual acuity (BCVA) 75 Early Treatment Diabetic Retinopathy Study (ETDRS) letters or less at baseline – SMC 1003/14 (Nov 2014)
  - visual impairment due to macular oedema secondary to branch retinal vein occlusion – SMC 1074/15 (Sept 2015)
  - visual impairment due to myopic choroidal neovascularisation (myopic CNV) – SMC 1186/16 (Oct 2016)
- the Principal Pharmacist for supply has confirmed that in the Ophthalmology Service the proposal is to:
  - change the preferred biosimilar for aflibercept 40mg/mL to Mynzepli®
  - switch current patients on Eylea® to the new biosimilar Mynzepli®
  - start new aflibercept patients on Mynzepli®

The Group accepted the restricted local need for Mynzepli® as the preferred biosimilar for aflibercept, without the need for a full submission. Use is supported within established treatment pathways for appropriate patients identified by treating clinicians and must comply with the biosimilar prescribing framework.

**Aflibercept 40mg/mL solution for injection in pre-filled syringe (Mynzepli®)▼ is routinely available in line with local guidance.**
**Indications under review: for adults for the treatment of:**

- **neovascular (wet) age-related macular degeneration (AMD)**
- **visual impairment due to macular oedema secondary to retinal vein occlusion (branch RVO or central RVO)**
- **visual impairment due to diabetic macular oedema in those with best corrected visual acuity (BCVA) 75 Early Treatment Diabetic Retinopathy Study (ETDRS) letters or less at baseline.**
- **visual impairment due to myopic choroidal neovascularisation (myopic CNV)**

**It was classified 1b - available for restricted use under specialist supervision and 8b - recommended for hospital use only. For intravitreal injection only. Mynzepli® must only be administered by a qualified healthcare professional experienced in administering intravitreal injections.** — **FTEAM**

### 6.5. ADDITIONAL ITEM – CAPSAICIN CREAM

An item not included on the agenda was raised regarding the availability of licensed capsaicin cream.

There were no declarations of interest recorded in relation to these products.

Ms Doney presented information regarding the availability of licensed capsaicin creams.

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The Group noted that:

- licensed capsaicin creams, Axsain® (0.075%) and Zacin® (0.025%), were discontinued mid-2024 after their only manufacturer went bust, creating a nationwide shortage affecting neuropathic pain and osteoarthritis patients
- both preparations were noted as discontinued on the formulary
- June 2025 Teva UK transferred ownership and UK marketing authorisations for Axsain® and Zacin® to Ennogen Healthcare International Ltd
- February 2026, licensed Axsain® and Zacin® preparations available on the market
- since the discontinuation, unlicensed capsaicin cream has been prescribed at a higher cost than the licensed products
- Ennogen has reintroduced capsaicin cream at the same List prices as previously - Axsain® (0.075%) - £14.58/45g; Zacin® (0.025%) - £17.71/45g
- capsaicin cream, both strengths, was previously established with products included in local guidance, e.g., neuropathic pain pathways

The Group accepted the restricted local need for capsaicin cream (0.025% and 0.075% w/w) as licensed, without the need for full submissions.

**Capsaicin 0.025% w/w cream (Zacin®) is routinely available in line with local guidance.**
**Indication under review: for adults for the symptomatic relief of pain associated with osteoarthritis.**
**It was classified 1a - available for general use and 8e - treatment may be initiated in either Primary or Secondary care.** **FTEAM**

**Capsaicin 0.075% w/w cream (Axsain®) is routinely available in line with local guidance.**
**Indications under review: for adults for the:**

- **symptomatic relief of neuralgia associated with and following Herpes Zoster infections (post-herpetic neuralgia) after open skin lesions have healed.**
- **symptomatic management of painful diabetic peripheral polyneuropathy**

**It was classified 1a - available for general use and 8e - treatment may be initiated in either Primary or Secondary care.** **FTEAM**

## 7. PUBLISHED ADVICE

### 7.1. SCOTTISH MEDICINES CONSORTIUM ADVICE PUBLISHED MARCH 2026

The Group noted the SMC advice published March 2026.

Following publication of the negative SMC recommendations for omaveloxolone (Skyclarys®▼ - SMC 2845), seladelpar (Livdelzi®▼ - SMC 2899) and zilucoplan (Zilbrysq®▼ - SMC 2830) and the non-submission statements for isatuximab (Sarclisa® - SMC 2914), pembrolizumab (Keytruda® - SMC 2915) and sacituzumab govitecan (Trodelvy®▼ - SMC 2916) these medicines will not be included on the Grampian Joint Formulary for the indications in question.

The following SMC accepted medicines have not been processed within a 60-day timescale:

- SMC 2800 Alyftrek®▼ (deutivacaftor/ tezacaftor/ vanzacaftor) (submission received)
- SMC 2844 vorasidenib (Voranigo®▼) (submission received)

Local advice for these medicines and indications will be included in the March 2026 decisions as ‘Not routinely available as the ADTC is waiting for further advice from local clinical experts’. **FTEAM**

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**8. PROVISIONAL ADVICE**

**8.1. SCOTTISH MEDICINES CONSORTIUM ADVICE ISSUED MARCH 2026**

The Group noted the SMC provisional advice issued March 2026.

If the SMC issues negative recommendations or non-submission statements next month, these medicines will not be included on the formulary for the specified indications. **FTEAM**

**9. OTHER BUSINESS**

**9.1. POLYPHARMACY GUIDANCE: APPROPRIATE PRESCRIBING, MAKING MEDICINES SAFE, EFFECTIVE AND SUSTAINABLE 2026 - 2029**

The Group noted the item.

**9.2. UPDATED UK MEDICAL ELIGIBILITY CRITERIA FOR CONTRACEPTIVE USE (UKMEC)**

Ms Doney reported that updated UK Medical Eligibility Criteria for Contraceptive Use (UKMEC) were published in December. Discussion with Dr Cook, Sexual Health Consultant, highlighted that a key change was the revised MEC category for the progestogen-only injectable: depot medroxyprogesterone acetate (DMPA).

Ms Doney will contact the Sexual Health Consultants to ask whether they would prepare and distribute a summary of key UKMEC contraceptive guidance updates for primary care, either via the primary care brief or alternative distribution route. **FD**

**10. DOCUMENTS FOR INFORMATION**

Items 10.1 (MHRA Safety Round-up February 2026), 10.2 (Grampian Medicines Guidelines and Policies Group meeting minute December 2025), were noted.

**11. AOCB**

None.

**DATE OF NEXT MEETING**

Tuesday 21 April 2026 starting at 14.30 via Microsoft Teams.

**Signature on file**

**CHAIR'S SIGNATURE** **Dr Louise Elliot** **DATE** **21 April 2026**