NHS
North East London

North East London Formulary & Pathways Group (FPG)
Tuesday 25th April 2023 at 12.30pm via MS Teams

Meeting Chair: Gurvinder Rull

Minutes

Attendance	Name	Initials	Designation	Organisation
Clinical Representatives				
Present	Sarah Hall	SH	GP, Medicines Optimisation Lead for Tower Hamlets (FPG Co-Chair)	NHS NEL
Present	Gurvinder Rull	GR	Consultant Clinical Pharmacology (FPG Co-Chair)	BH
Present	Louise Abrams	LA	Clinical Pharmacologist, DTC Chair	HHFT
Absent	John McAuley	JM	Consultant Neurologist, DTC Chair	BHRUT
Present	Maisarah Amran	MA	ST Clinical Pharmacology	BH
Present	John Booth	JB	Consultant Nephrologist	BH
Absent	Vikas Kapil	VK	Consultant Clinical Pharmacology	BH
Trusts' Pharmacy Representatives				
Present	Jaymi Teli	JT	Lead Formulary & Pathways Pharmacist	BH
Present	Nick Cooley	NC	Deputy Chief Pharmacist, Clinical Quality	BH
Present	Suzanne Al-Najim	SA	NHSEI Commissioning Pharmacist	BH
Present	Maruf Ahmed	MA	Formulary Pharmacy Technician	BH
Present	Dinesh Gupta	DG	Assistant Chief Pharmacist, Clinical Service	BHRUT
Apologies	Iola Williams	IW	Chief Pharmacist	HHFT
Apologies	Chinedu Ogbuefi	CO	Interim Deputy Chief Pharmacist for London Services	ELFT
Present	Iffah Salim	IS	CAMHS Directorate Lead, Medicines Information Pharmacist	ELFT
Present	Kiran Dahele	KD	Formulary & Governance Pharmacist	NELFT
Present	Sibel Ihsan	SI	Lead Directorate Pharmacist for Waltham Forest	NELFT
NEL Pharmacy & Medicines Optimisation Team's Representatives				
Present	Belinda Krishek	BK	Director of Medicines Optimisation	NHS NEL
Present	Denise Baker	DB	Medicines Optimisation Business Manager	NHS NEL

Present	Anh Vu	AV	Joint Formulary Pharmacist	NHS NEL
Present	Ann Chan	AC	Senior Prescribing Advisor	NHS NEL
Present	Natalie Whitworth	NW	Commissioning & Contracting Pharmacist	NHS NEL
Present	Niloufar Nourishad	NN	Commissioning & Contracting Pharmacist	NHS NEL
Present	Nicola Fox	NF	Commissioning & Contracting Senior Pharmacy Technician	NHS NEL
Other Representatives				
Present	Mohammed Kanji	MK	Prescribing Advisor (Representing NEL Primary Care Non-Medical Prescribers)	NHS NEL
Apologies	Yasmine Korimbux	YK	Senior Transformation Manager/Lead Pharmacist, NICE Medicine and Prescribing Associate	NHS NEL
Present	Annett Blochberger	AB	Deputy Head of Regional Specialised Commissioning - Pharmacy	NHSE
Guests				
Present	Anthony Bewley **(6, 7)**	ABe	Consultant Dermatologist	BH
Present	Hannah Marrison **(6, 7)**	HM	Specialist Pharmacist, Rheumatology & Dermatology	BH

North East London organisations:

- Barts Health NHS Trust (BH)
- Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT)
- Homerton Healthcare NHS Foundation Trust (HHFT)
- East London NHS Foundation Trust (ELFT)
- North East London NHS Foundation Trust (NELFT)
- North East London Integrated Care Board (NHS NEL)

No.	Agenda item and minute	Action
1.	**Quoracy check**	
	The meeting was quorate.	
2.	**Welcome, introduction and apologies**	
	The Chair welcomed all to the meeting and apologies were noted as above. GR advised that Dr Sarah Hall would be leaving the group and she was thanked for all her hard work in supporting the group as co-chair. BK advised that Dr Mehul Mathukia would be joining the group in June as an interim GP representative.	

3.	**Declarations of interest from member and presenters**	
	The Chair reminded members and presenters of their obligation to declare any interests relating to agenda items.	
4.	**Minutes from previous meeting**	
	The minutes of the previous meeting (March 2023) were reviewed and approved. The redacted minutes for December 2022, January and February 2023 were agreed.	
5.	**Matters Arising**	
	1. <u>Review of Action Log</u> AV advised that the format of the action log had been updated and it was agreed that a copy of the action log outlining the updates that would be required at each meeting, would be included with the circulation of the agenda going forward. AV advised of the following: **ADHD Shared Care Guideline** – a draft document has been prepared and is to be reviewed by the Shared Care & Transfer of Care Working Group (STWG). **Betesil medicated plaster** - a one-page guidance document had been provided by Professor Bewley and is to be reviewed by JT and the specialist medicine team for presentation to the Guidelines & Pathways Working Group (GPWG) in July. **Relugolix-estradiol-noresthisterone acetate (Ryeqo)** – HHFT would commence work on the production of a NEL wide pathway for fibroids. **NEL HCD pathway for psoriasis** – NW advised that the pathway was to be reviewed by the GPWG. **Atopic dermatitis pathway** – NN advised that the pathway was awaiting comments from clinical colleagues and would chase for feedback with the intention to submit to FPG in June. **<u>Blood glucose testing information booklet – FINAL DRAFT</u>** This document had been circulated for information only, having previously been approved subject to suggested amendments which had now been incorporated into the booklet. **Noted.** **2. <u>Betesil prescribing in primary care clarification of position</u>** This item had been discussed as part of the action log review above.	

	3. <u>Enoxaparin shared care comments update and decision (BHRUT)</u> SH requested that the following line be removed from the document 'shared care will be assumed if no response' as this contradicted section 17 of the document which follows the RMOC guidance. It was suggested that if response to a shared care request was not received then secondary care colleagues could contact the NEL pharmacy and medicines optimisation team who would provide support. A NEL MO enquiry line was currently being set up and this could be included once established, within shared care documents as they were reviewed by the STWG. BK highlighted that brand prescribing was not mentioned within the shared care and following a concern raised by Kam Takhar it was agreed to include wording that would enable substitution to an alternative brand. This would be for exceptional circumstances such as an emergency where stock issues had been identified. **Outcome:** approved subject to amendments. **4. <u>Upadacitinib FOC scheme – updated numbers from BHRUT and HHHT</u>** The group were advised that the following information had been added to the March FPG minutes as post-meeting notes: • BHRUT – 2 patients and were yet to sign the contract; awaiting a new patient to be initiated on the medication • HHFT - 5 patients and the contract had been signed **Noted**. **5. <u>SGLTi checklist FINAL</u>** DG provided the following comments: • Euglycemic – spelling to be corrected • Checklist – to elaborate wording to include 'cautions' **Noted.**	**AV** To feedback comment **AV** To update the shared care document with appropriate wording **AV** To feedback comments
For discussion – items submitted for approval		
6 & 7.	**Secukinumab dose escalation in psoriasis (full application and discount scheme)**	
	Professor Bewley, Consultant Dermatologist and Hannah Marrison, Specialist Pharmacist, Rheumatology & Dermatology, BH were welcomed to the meeting to present the above items. Declarations of interest had been submitted electronically and would be reviewed by the Chair prior to the publication of any decision. It was explained that the application was to support dose escalation of secukinumab for patients suffering with severe chronic plaque psoriasis with a body weight of 90kg or higher. The recommended monthly maintenance does of 300mg was to be increased to 300mg every two weeks for this selected cohort of patients. Each 300mg	**GR** To review electronically submitted DOIs **NW** To discuss use of Blueteq to gather data

	dose would be given as one subcutaneous (SC) injection or as two SC injections of 150mg and the patient or carer could administer once the required training had been completed. The group had an extensive discussion around the patient selection criteria for the escalated dose. It was noted that treatment failure in the trial was defined as not achieving a Psoriasis Area and Severity Index (PASI) of 90 (i.e. 90% reduction from baseline), whereas NICE only require a PASI 75. Concerns were raised that patients would be given escalated therapy (based on the need to achieve a PASI 90) when they would have met NICE criteria for treatment response. NICE defines treatment response at the 12-week review point as either: • a 75% reduction in the PASI score from when treatment started (PASI 75) or • a 50% reduction in the PASI score (PASI 50) and a 5-point reduction in DLQI from when treatment started. The group agreed that the NICE criteria would be used. There was also concern raised around the lack of evidence for escalated dosing of secukinumab in secondary failure (which was the proposed use from the application). The trial randomised patients at the start of treatment based on weight and did not specifically look at the evidence for secondary failure. However, it was noted that the drug's summary of product's characteristics states that 'secukinumab clearance and volume of distribution increase as body weight increases.' The group were informed that Novartis had offered a three-year scheme that would enable patients meeting the above criteria with a body weight of 90kg or over, to receive the fortnightly 300mg dose at the same cost as those patients who were receiving the monthly maintenance dose of 300mg. It was noted that the three-year scheme had started in June 2022 and there is approximately two years left for this discount. The company have provided written assurance that any patients started on treatment within the timeframe of this scheme and before a notice of termination is issued will continue to receive treatment at the reduced rate until the end of their treatment at the direction of the healthcare professional or for any other reason. Concern was raised regarding the increased cost of an alternative medication being provided at the escalated dosing of fortnightly treatments. The referencing to the Young study to support efficacy and its suitability as a reliable indicator when NICE parameters and the trial parameters differed was also highlighted. The group discussed the appropriateness of the scheme and the inequity that would occur for new patients who met the criteria, but were unable to receive the increased dosing regimen due to the end of the three- year period. It was noted that only two years remained of the Novartis three-year contract. However, the group did agree that it would be preferable to escalate doses of secukinumab rather than move to the next line of therapy, thus ensuring that alternative options remained within the treatment pathway for patients.	**NW** To consider inclusion of treatment option within the NEL Psoriasis pathway

	It could not be confirmed that similar schemes had been approved within other local areas. However, GR advised that 'chairmans action' had already been requested to enable dose escalation of secukinumab for patients within BH. It was suggested that Blueteq could be used to monitor and collate the necessary data for a 12- month review and this would be looked into. This treatment option was also to be considered for inclusion in part two of the NEL Psoriasis pathway review. **Outcome:** Approved for secondary failure within the discount scheme as per current NICE guidance and with the understanding that should a patient have an inadequate response after three months on the escalated dose then another drug would be offered as per the NEL Psoriasis pathway. A review would be expected in 12 months to include response and patient numbers. Decision for ratification by the NEL Integrated Medicines Optimisation committee (IMOC). **Funding**: Discount Scheme on the escalated dose **Formulary status:** hospital only	
8.	**Fentanyl lozenges addition to BHRUT formulary as part of NEL alignment**	
	DG presented the above item in the absence of BHRUT colleagues, Dr Paul Greaves and Kimberley Asinobi. It was confirmed that fentanyl lozenges were already on the BH formulary and therefore the request was for formulary alignment across the Trusts. The group were advised that as young adults' transition from paediatric services to the adult sickle cell service they were not offered fentanyl lozenges and received oral morphine sulphate solution; fentanyl lozenges were fast acting and therefore provided additional pain relief whilst the oral morphine started to take effect. Monitoring of patients would be within the usual standard of monitoring for opiates. AV advised of her role as a clinical pharmacist in the chronic pain service at HHFT and had requested patient numbers from HHFT colleagues; a response was awaited. It was acknowledged that fentanyl lozenges were a 'hospital only' drug and not to be prescribed within primary care. ***Information received post meeting*** Homerton Sickle Cell Lead has confirmed that they would like to have Fentanyl lozenges for Homerton and have also provided estimated patient number 200. **Outcome:** approved – decision for ratification by IMOC. **Funding:** in-tariff drug **Formulary status:** hospital only	

9.	**Terms of Reference for six-month review**	
	AV and BK highlighted areas for consideration during the review of the document and the following were discussed and agreed: ○ **Background** – to review wording in one year. ○ **Purpose** – to include link with the Medicines Safety & Quality Group (add a bullet point). Update bullet point referring to medical devices and amend wording to 'devices closely associated with a medicine'. To discuss devices within the formulary working group once established. ○ **Governance** – add the sub-working groups including cancer, IVIG to the pathway under the NEL FPG Group. Update the MSQG wording. ○ **Scope** – to add pharmacogenomics as a bullet point. ○ **Receive reports from** – To add reports from London Formulary Medicines Group, Hospital Only List (HOL), Respiratory and Ophthalmology. The NEL FPG highlight reports would also be shared. The five Integrated Care Systems would also share reports to enable a form of horizon scanning across London. ○ **Urgent clinical decisions** – to add wording stating that Trust chairmans' actions were reviewed to help inform drug submissions to the FPG. To add reference to TA's where chairs action would be sought to enable implementation deadlines to be met whilst IMOC ratification was awaited. ○ **Membership** – agreed to remove Senior nurse representative and amend Community pharmacy clinical lead to NEL Local Pharmaceutical Committee (LPC) representative. To add NICE Associate who will be Yasmine Korimbux and also add NHSE Specialised Commissioning (Annette Blochberger). It was agreed to add an additional Non-medical prescribing representative as both Mohamed Kanji (primary care) and Dinesh Gupta (secondary care) attend the meetings. Discussion took place regarding lay member and BK informed that IMOC would be seeking lay representation and it was suggested that this would not be a requirement for other groups; it was agreed to reduce lay representation to one person. It was also agreed to remove Public Health representation and include reference to this role in the wording below enabling advice to be sought when required. ○ **Quorum for decision-making** – to add 'or nominated deputy' to the Primary Care Prescribing Lead ensuring the Chair is advised of any change to attendance. To remove the nurse representative. ○ **Running of the meeting** – to state the process for the meeting e.g. quoracy check, members declarations of interest prior to the commencement of items; this would support the appeals process. To amend Publications of outcomes to state 'will follow ratification at each IMOC meeting'. ○ **Decision making** – to remove the first sentence and add 'All approved decisions will be ratified by IMOC'; ensure IMOC is in full within the document. ○ **Appeals Process** – it was confirmed that IMOC only ratify positive decisions and therefore the wording in this section would stay as is.	**AV/BK** To update and share revised version with the FPG members **LA** To ensure HHFT chairmans' actions are submitted to FPG **AV/NW** To liaise with potential lay representatives

	○ **Documentation** – to add monthly highlight reports to IMOC and decisions for ratification and end of year report. Remove ethical decision framework. ○ **Prescribing Support** – remove reference to ScriptSwitch. **Outcome:** It was agreed that the document would be updated and re-submitted to the group for agreement.	
NICE TA/NHSE circulars for ratification/implementation		
10.	**NICE TA ratification and horizon scanning**	
	NF shared an updated spreadsheet that now included a part year cost implication column and was available in the shared folder. AV agreed to share contact details for colleagues who could be contacted regarding patient numbers on behalf of HHFT.	**AV** To share details for Homerton colleagues with NF
11.	**NICE TAs for discussion - nil**	
	The following was shared: • Note that TA 868 Vutrisiran for the treatment of relapsed or refractory multiple myeloma after three or more therapies (NHSE) is not commissioned across NEL (Royal Free is the commissioned centre)	
12.	**NHSE circulars- nil**	
Standing items		
13.	**Commissioning update**	
	NW provided the following update: **Semaglutide position statement** - NW advised that a draft document had been shared with the working group supporting weight management services and a meeting had been arranged for the 5th May. A further update would follow. **NEL ICB commissioning arrangements** - awaiting approval from the Chief Finance Officers (CFO) regarding financial arrangements which included High Cost Drugs (HCD). It was confirmed that the ICB would continue with 'cost and volume' and there would be a set limit cap for each Trust for monies from the Elective Recovery Fund (ERF) with no further additional funding being made available. A draft HCD contract had been prepared and this was to be shared with the Trusts; the document would be included as an information item for the group. A meeting on Thursday (4th May) was planned to discuss the financial arrangements for transferring responsibility for Covid-19 drugs to the ICB (from 1st April 2023). It was agreed that adequate time would be made available to support a follow-on discussion at the next FPG meeting in June or an additional meeting arranged if deemed necessary.	

	AB provided the following update: **NHS payments scheme** – this had been published at the beginning of April and from that the HCD specialist commissioning NHS England list of drugs had been published. It was confirmed that the budget would remain with Spec Comm for this financial year with the exception of Covid-19 drugs.	
14.	**London Formulary Medicines Group (LFMG) meeting update - nil this month**	
15.	**FPG workplan review – not discussed**	
16.	**Equality: monitoring of usage and outcomes – nil at present**	
17.	**Items for Ratification – this item will be removed from future agendas**	
Information items (18 – 21)		
18.	1. BH Cancer Drugs and Therapeutic Committee (DTC) agenda and minutes – March 2023 2. NEL Sub-regional immunoglobulin assessment panel agenda – March 2023 **Noted**	
19.	**Local Medicines Optimisation Group (MOG) updates:** 1. BH summary of chairs actions – March 2023 2. BHRUT MOG agenda and minutes – February 2023 **Noted**	
20.	**NEL FPG outcome letters** March NEL FPG recommendations ratified by IMOC April 2023: • Mydrane at BHRUT for mydriasis and intraocular anaesthesia during cataract surgery as part of formulary harmonisation • Upadacitinib FOC scheme for use in Crohn's disease • NEL treatment pathways for inflammatory bowel disease in adults • NEL management of infection guidance for primary care v1.6 • NEL guidance for safe fasting during Ramadan • NICE TA860 – Maribavir for treating refractory cytomegalovirus infection after transplant • NICE TA871 – Eptinezumab for preventing migraine • NICE TA856 – Upadacitinib for treating moderately to severely active ulcerative colitis **Noted.**	

21.	**Documents approved via NEL FPG chairs actions – nil**	
22.	**Finalised Minutes – February 2023**	
23.	**Any other business**	
	Methylphenidate supply – IS raised a concern regarding the supply of methylphenidate and the confusion that has arisen regarding the generic prescribing for patients and the need for some patients to remain on the specific brand prescribed by the clinician. To support the understanding of prescribing/dispensing methylphenidate medications IS has produced a bulletin which outlined bioequivalent products and when brand prescribing should be adhered to. BK suggested the availability of a bypass number for community pharmacists to contact specialist clinicians should there be any issues with dispensing. However, IS advised that there were numerous services supporting patients and the FP10 would include a service number for contact. There were concerns raised and it was agreed that the bulletin should be circulated to the group for comments before wider circulation. **Outcome:** Bulletin draft to be circulated to FPG members for comment.	**IS** To share bulletin with the group for comments **ALL** To provide comments back to IS
	Next meeting: **Tuesday 6th June at 12.30 via MS Teams –** calendar invite to be circulated.	