NHS
North East London

North East London Formulary & Pathways Group (FPG)

Tuesday 3rd June 2025 at 12.30pm via MS Teams

Meeting Chair: Dr Gurvinder Rull

Minutes

Attendance	Name	Initials	Designation	Organisation
Clinical Representatives				
Present	Gurvinder Rull	GR	Consultant Clinical Pharmacology (FPG Chair)	BH
Apologies	Narinderjit Kullar	NK	Clinical Director for Havering	NHS NEL
Absent	Ruth Crowley	RC	GP Partner, Avon Road Surgery, Havering	NHS NEL
Present	Nishani Jayasooriya	HHFT	Consultant Gastroenterologist, Medicines Committee Chair	HHFT
Absent	Mehul Mathukia	MM	Medicines Optimisation Clinical Lead for Redbridge	NHS NEL
Apologies	Jo Howard	JH	Clinical Group Director, Cancer & Clinical Support Division Consultant Haematologist and Responsible Officer	BHRUT
Apologies	John McAuley	JM	Consultant Neurologist, Drugs & Therapeutic Committee Chair	BHRUT
Present	John Booth	JB	Consultant Nephrologist	BH
Present	Jaymi Teli	JT	Lead Formulary & Pathways Pharmacist	BH
Present	Farrah Asghar	FA	Lead Clinical Pharmacist, Medicines Commissioning & Pathways	BH
Present	Maruf Ahmed	MA	Formulary Pharmacy Technician	BH
Present	Chloe Benn	CB	Lead Women's & Children's Consultant Pharmacist and non- medical prescriber	BH
Present	Abu Baker Eltayeb	AE	Clinical Pharmacology IMT Resident Doctor	BH
Absent	James Steckelmacher	JS	Clinical Pharmacology IMT Resident Doctor	BH
Present	Dawud Masieh	DM	Clinical Pharmacology IMT Resident Doctor	BH
Present	Awat Ghafour Ibrahim	AG	Clinical Commissioning Pharmacist	BH
Present	Dinesh Gupta	DG	Assistant Chief Pharmacist, Clinical Service	BHRUT
Absent	Oluakemi Aregbesola	OA	Palliative Care Pharmacist	BHRUT
Present	Tomisin Antwi	TA	Formulary & Medicines Information Pharmacist	BHRUT
Absent	Iola Williams	IW	Chief Pharmacist	HHFT

Present	Rikesh Patel	RP	Lead Pharmacist for Medicines Information and Formulary Pathways	HHFT
Apologies	Iffah Salim	IS	CAMHS Directorate Lead, Medicines Information Pharmacist	ELFT
Apologies	Kiran Dahele	KD	Formulary & Governance Pharmacist	NELFT
NEL Pharmacy & Medicines Optimisation Team's Representatives				
Present	Belinda Krishek	BK	Deputy Director of Medicines Optimisation	NHS NEL
Present	Denise Baker	DB	Senior Administrative Officer, Medicines Optimisation	NHS NEL
Present	Ann Chan	AC	Formulary Pharmacist	NHS NEL
Apologies	Nicola Fox	NF	Commissioning & Contracting Senior Pharmacy Technician	NHS NEL
Present	Kalpna Bhudia	KB	Commissioning and Contracting Pharmacist	NHS NEL
Apologies	Zafiat Quadry	ZQ	Head of Medicines Optimisation - Commissioning and Transformation	NHS NEL
Other Representatives				
Present	Dalveer Singh Johal	DJ	Chief Operating Officer	NEL LPC
Present	Mohammed Kanji	MK	Senior Medicines Optimisation Pharmacist (Representing NEL Primary Care Non-Medical Prescribers)	NHS NEL
Absent	Yasmine Korimbux	YK	Head of Medicines Optimisation – Place Based Partnerships	NHS NEL
Present	Jiten Modha	JMo	Specialised Commissioning Senior Pharmacy Advisor	NHSE
Absent	Anudeep Riyat	AR	Deputy Chief Pharmacist, Specialised Commissioning (NEL ICB link pharmacist)	NHSE
Present	Kamaljit Takhar	KT	Associate Director of Pharmacy - Quality & Safety	NELFT
Guests				
Present	Laia Castro (5)	LC	Severe Asthma & Allergy Specialist Pharmacist at Barts Health NHS Trust	BH
Present	Anna Chapman (6)	ACh	Consultant Dermatologist Clinical Lead	HHFT
Present	Fatimah Rana (6)	FR	Lead Pharmacist for Biologics	HHFT
Present	Saira Sundar (7)	SS	Consultant Obstetrics and Gynaecology	BH
Present	Nikita Thanki (7)	NT	Highly Specialist Pharmacist, Women's and Children's Health	BH
Present	Paul Wright (8)	PW	Consultant Cardiovascular Pharmacist	BH
Present	Bobby Sandhu (8)	BS	Lead Medicines Optimisation Pharmacist – Newham Place	NHS NEL

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)**
- **North East London Local Pharmaceutical Committee (NEL LPC)**

No.	Agenda item and minute
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. It was noted that a GP representative had not joined the meeting.
3.	**Declarations of interest from members and presenters**
	The Chair reminded members and presenters of their obligation to declare any interests relating to agenda items. A reminder for all members of the group to submit their reviewed DOI, if they have not recently completed their submission to enable an updated register to be available.
4.	**Minutes**
	The minutes of the previous meeting (May 2025) were reviewed and approved. The redacted minutes from April 2025 were also approved.
5.	**Matters Arising**
	FPG action log **202504_02 – Stimulan® beads for soft tissue and bone infections** – BHRUT colleagues are working with other stakeholders to produce the additional information requested to support the re-submission of this item to the July FPG meeting. **Noted.** **202505_01 – Vericiguat for Chronic Heart Failure with reduced Ejection Fraction (HFrEF) in patient with remaining symptomatic on optimal medical therapy** – It was confirmed that the presenters had been informed that 12-18 months data would need to be provided to a future BH Oversight Group and a further discussion would take place at this time regarding the financial implications of vericiguat prescribing. **Completed.**

	202505_02 – Pylera® for the eradication of *H. Pylori* – the amendments required to the protocol were currently being undertaken and an updated document would be shared with the FPG Chair once completed. **Noted.** **202505_04 – Stage 1 harmonisation log** – It was confirmed that the status of tetracaine 4% gel on formulary would be 'red' hospital only for the eye drops formulation but for other indications would be stated as 'green' status. **Completed.** <u>North East London Primary Care Wound Dressing Formulary – update</u> The group were advised that following the approval of the above document a minor addition had been required to include compression therapy items to section 8 (page 20). It was confirmed that these had been included in the wound dressing formulary working group consultation and should have been included in the initial version considered. **Approved.** <u>TA 1045 12SQ-HDM SLIT (Acarizax®) for treating allergic rhinitis and allergic asthma caused by house dust mites</u> This item had returned to the FPG so that formulary status could be confirmed for Acarizax®. The group were advised that other London ICBs had Acarizax® on their formularies as 'red' hospital only and this was generally noted to be the formulary status of the drug nationally. The BH pharmacist agreed this should be hospital only for now but advised that it was anticipated in future that following specialist initiation and with the patient stabilised, prescribing could be transferred to primary care; all patient reviews would remain within secondary care. Following previous FPG approval for Acarizax® to be added to the NEL formulary, it was agreed that a 'red' hospital only status be assigned. Any future discussions and review of formulary status should also take into consideration the status at a pan London level. **Formulary status:** Red, hospital only. Decision for ratification by the Systems Pharmacy & Medicines Optimisation (SyPMO) Board. <u>TA1051 Efanesoctocog alfa for treating and preventing bleeding episodes in haemophilia A in people 2 years and over – guideline for BH updated to include Efanesoctocog alfa</u> – <u>for information</u> The BH Haemophilia Centre Guidelines (June 2025) had been shared within the agenda papers and it was confirmed that the guideline included information to support Efanesoctocog alfa as a treatment option for the defined cohort of patients. Formulary Status: Red, Hospital only (BH only as the commissioned centre in NEL). **Acknowledged.** <u>Information leaflet for Parents and Caregivers: Intranasal Dexmedetomidine – for information</u> The above information leaflet had been updated to specify 'off license' use of the medicine. **Acknowledged -** for approval at BH Trust internal governance.

6.	**Delgocitinib (Anzupgo®) for Severe Chronic Hand Eczema (CHE) Free of Charge (FOC) Scheme**
	Declarations of interest: Declaration of interested was noted on the application form. Clinical representative from HHFT was welcomed to the meeting and presented the Free of Charge (FOC) scheme that had been offered by LEO Pharma who were the manufacturers for Delgocitinib. It was explained to the group that Delgocitinib, a topical JAK inhibitor, was a beneficial treatment for Severe Chronic Hand Eczema (CHE) which was an indication that was not currently included in the Atopic Dermatitis (AD) pathway. The current licensed treatment was oral Alitretinoin which was often poorly tolerated and required blood monitoring; also contraindicated for patients with hypercholesterolaemia. The severe impact of the condition on patients and the current lack of effective treatments was emphasised to the group. The group considered the details of the scheme offered. It was mentioned that Delgocitinib was to be discussed by NICE the following day and therefore the outcome of the decision would be available in August. Subsequently, the group considered whether the FOC scheme was required, bearing in mind the decision by NICE was relatively imminent. It was also felt the case for unmet need was not clearly demonstrated. There appears to be other potential treatment options and more understanding needed on its place with other options. Concern was also raised regarding the wording in point 3.3 of the scheme document which referred to the company having the option to provide written notice, not less than 30 days, to the Trust to terminate the agreement. HHFT representative highlighted the immediate clinical need of treatment for patients and advised that she would refer the wording of point 3.3 back to the company for further clarification. The group were made aware that the FOC scheme had already been signed up to by HHFT via chair's action and Delgocitinib treatment had already commenced within the Trust for CHE. It was stated that consideration of any future FOC schemes would only be undertaken by the FPG to ensure that any scheme would have equitable access across NEL. The FOC checklist that had been produced and was on the FPG agenda for discussion included appropriate considerations to support this process. Each Trust will still be responsible for signing their own contracts. **Outcome:** Not approved. Whilst the NICE decision was awaited, any request for Delgocitinib would require sign off by the individual Trust chair's action process and would be funded by the respective Trust.
7.	**Doxylamine succinate 10mg/pyridoxine hydrochloride 10mg gastro-resistant tablets (Xonvea®) for Hyperemesis Gravidarum (HG)**
	Declarations of interest: Nil declared BH clinical representatives presented the request for Xonvea® to be included in the formulary to treat women with refractory cases of Hyperemesis Gravidarum (HG). It was explained that whilst 80% of women suffer with nausea and vomiting during pregnancy (NVP), the severe symptoms for HG did not respond to other conservative management, profoundly affecting women's mental health, hydration levels and dietary intake. It was also

	highlighted that NVP was one the most common indications for hospital admission amongst women with typical stays of three to four days per patient. The applicant stated that whilst the Royal College of Obstetrics and Gynaecology and NICE recommend Xonvea® as a first line treatment for NVP and HG, the request being made was for NEL to consider Xonvea® as a second line treatment due to financial implications. Therefore, Cyclizine was to remain as the first line treatment except for women with a refractory hyperemesis that had responded to Xonvea® in a previous pregnancy. It was noted that 35 patients in BH had received Xonvea® via chair's action, during June 2024 to April 2025. Xonvea® is a licensed treatment of NVP in pregnant women who do not respond to conservative management. To support appropriate primary care usage in this scenario, it was requested that an information/fact sheet is produced detailing its place in therapy, including when to use the medication, when to review the medication and if any tapering dose is required, similar to the document produced to support Relugolix prescribing. It was mentioned that the benefits of starting patients on Xonvea® within primary care could support a reduction in hospital admissions and improve patient wellbeing enabling daily routines to be maintained and reduce psychological impact as well. Xonvea® is a licensed treatment of NVP in pregnant women who do not respond to conservative management. It was agreed that Xonvea® would be approved as a second line treatment option for HG with the request for a fact/information sheet to be produced to support GPs with prescribing. The formulary status was agreed as 'green' for Xonvea®, as suggested at the NEL Medicines Value Group (MVG) meeting following their discussion regarding the drug. It was also mentioned that the NEL MVG also wanted considerations to be given to manage and monitor the usage and spend. **Outcome:** Approved with the development of a factsheet to support appropriate primary care prescribing. Formulary status: Green, 2nd line treatment option in HG. First line in subsequent pregnancy if there was successful response in a previous pregnancy with HG diagnosis. Decision for ratification by the SyPMO Board.
8.	**Direct Oral Anti-Coagulants (DOACs) in the prophylaxis of stroke and systemic embolism in non-valvular Atrial Fibrillation (AF) change in formulary status**
	Declarations of interest: Nil declared It was explained to the group the request to amend the NEL formulary status for Direct Oral Anti-Coagulants (DOACs) in AF from 'amber' to 'green' (i.e. GP can initiate in primary care without any restrictions). Due to the significant experience now gained over the past 15 years with the prescribing of apixaban, rivaroxaban, dabigatran and edoxaban the change in formulary status would support the initiation of the DOACs within primary care. It

	was noted that this change to formulary status would align NEL with other sectors such as North West London, Cambridge, Peterborough and Nottinghamshire who already had DOACs defined as 'green' status in AF. North Central London were also currently considering the formulary change from 'amber' to 'green' for DOACs in AF. The group were advised that there should be some familiarity in primary care as the current annual follow up review for patients within primary care involves assessing renal function/weight and monitoring patient characteristics that may require any dose adjustment and these are similar principles used for to initiating DOAC treatment in patients. It was also highlighted that there were numerous informative documents available to support primary care clinicians including training videos, along with 'Advice & Guidance'. A NEL DOAC initiation and continuation document was available which also included a counselling checklist. It was confirmed that for patients commencing treatment on DOACs in primary care there are patient videos, medication cards and information leaflets available which would also provide safety netting as well as signposting to the British Heart Foundation and community pharmacy medicine schemes. It was mentioned the concern regarding the current wait for initiation of DOACs which could be between 6-8 weeks for patients in some areas. Therefore, amending the formulary status would enable primary care to support initiation allowing treatments to be accessed sooner. It was also confirmed that comments received from GPs when first reviewing this formulary change in status had been addressed. However, BK highlighted that a GP representative was not in attendance at the meeting and therefore further discussion and decision making would be made by the SyPMO Board where Local Medical Committee (LMC) members would be present. Specialist clinical representation was offered to attend the SyPMO meeting to support the item, if required. It was reiterated that this request to change the formulary status was for DOACs treating AF only and would not include other indications such as Pulmonary Embolism (PE) and Venous Thromboembolism (VTE). **Outcome:** Recommended for formulary status change to green, subject to further SyPMO Board discussion for approval.
9.	**Interim commissioning guidance of obesity drugs across NEL**
	This item had been withdrawn from the agenda prior to the meeting.
10.	**Application of a Free of Charge (FOC) Scheme Checklist**
	Declarations of interest: Nil declared The FOC Scheme Checklist that had been produced to support the FPG when considering any future FOC schemes was presented and would require completing for all FOC schemes submitted. The checklist was based on NHS England recommendations and when fully completed would provide the group with the assurance that approval of the scheme would not create inequity within NEL and that all NEL Trusts who wished to adopt the scheme had the opportunity to do so. A link to the national policy was included in the document. It was reiterated that if the medicine is due to be

	assessed by NICE/ NICE is due to publish and if this was less than six months, an FOC may not be suitable. A concern was raised regarding exit strategies for patients who would receive treatment from the FOC scheme and the plans to ensure that funding arrangements were in place for patients to continue receiving treatment who may not fit the set funding criteria once NICE approved. It was agreed that FOC schemes would no longer be considered via chair's action by individual NEL Trusts. All FOC schemes would require completion of the checklist to support FPG consideration, thus ensuring a thorough standardised review process occurs. NEL Trust teams should bring any FOC application requests they receive to FPG for consideration first before signing up. It was also suggested that a standardised patient consent template is created to ensure that patients are fully aware of the details in accepting treatment as part of an FOC scheme; other Trusts would be contacted to establish if a template was already available for adoption. **Outcome:** Approved Decision for ratification by the SyPMO Board.
12.	**Updated Guidelines**
	COVID-19 Guidelines – May 2025 Update The above document was presented which had been updated to reflect recent changes to NICE TAs for Paxlovid (TA878), Molnupiravir (TA1056) and Remdesivir (TA971) as outlined below: • TA878 – changes to the recommendations for Paxlovid which is no longer recommended for patients with diabetes, obesity, heart failure or those aged 70 and over; for all settings • TA1056 – Molnupiravir is now only a treatment option in the community and no longer recommended for hospitalised patients • TA971 – Remdesivir is now only a treatment option for hospitalised patients and no longer recommended for non-hospitalised setting Subsequently, amendments had been made to the treatment algorithms to reflect the above information. The contact details for the NEL COVID Medicines Delivery Unit (CMDU) had also been updated in the guideline. **Outcome:** Approved Decision for ratification by the SyPMO Board. Post meeting note: A further amendment has been made to the guideline. The updated version will be brought to the July FPG for noting under matters arising.
13.	**NICE TA approval and Horizon Scanning**

	ICB Commissioned: **TA1056**: Molnupiravir for treating COVID-19 – details as advised in agenda item 12, with the changes to the TA reflected in the guidelines/treatment algorithms. **Outcome:** Approved Formulary status: Hospital or Specialist centre (CMDU) only Decision for ratification by the SyPMO Board. **TA1057**: Relugolix–estradiol–norethisterone for treating symptoms of endometriosis – the group discussed Relugolix combination treatment (Ryeqo®) which had already been approved for addition to the formulary to treat uterine fibroids. With the additional indication of endometriosis, it was agreed that formulary status should remain as 'red' hospital only, until a further review for both indications by the Women's & Children's teams and a pathway or transfer of care information became available. Patient numbers with NEL Trusts were yet to be shared and will come back to matters arising at the July FPG. **Outcome:** Approved Formulary status: Red, hospital only Decision for ratification by the SyPMO Board. **NHSE commissioned:** **TA1053** Cladribine for treating active relapsing forms of Multiple Sclerosis (MS) (BH and BHRUT are the commissioned centres) – it was explained to the group the Cladribine was now recommended for treating active relapsing forms of MS regardless of the severity and was already on formulary to treat severe disease. BH patient numbers provided were 15 per year; BHRUT patient numbers were awaited. **Outcome:** Approved (BH and BHRUT are NEL commissioned centres). It was requested that patient numbers be provided at the next meeting as a 'matters arising' item. Formulary status: Red, hospital only Decision for ratification by the SyPMO Board.
14.	**NICE TAs/ NHSE commissioned policies for discussion - Nil**
15.	**NHSE Circulars**

	SSC2809 NICE TA 1031: Vamorolone for treatment Duchenne muscular dystrophy in patients 4 years and over – clarification was requested as to whether any of the NEL Trusts were a commissioned centre for treatment and if any prescribing was being undertaken by individual trusts. **SSC2411** NICE appraisals commissioned during July to October 2022 (reissue) **SSC2804** NICE appraisals published in March 2025, due to be commissioned June 2025 **SSC2824** NICE guidance published in April 2025 (due to be commissioned July 2025) **SSC2828** NHSE service spec amputee rehabilitation and prosthetics services **SSC2596** CCP Infliximab for refractory sarcoidosis (excluding neurosarcoidosis) re-issue of 2204 **Noted.**
16.	**Commissioning update**
	• **ICB** **Medicines Value Group Highlight Report** The following update was provided: o The financial year 2024-25 report had shown an over delivery of savings, with the NEL ICB Prescribing Efficiency Team having supported the delivery of annual savings o The Prescribing Efficiency Scheme (PES) had been launched on the 30th April 2025 o BHRUT had over-delivered with savings o Barts Health had delivered savings o NELFT had reported a saving due to waste reduction, melatonin switches and clozapine liquid formulation o All NEL Trusts had finalised their CIPs for 2025/2026 and details would be shared at the next MVG meeting on the 10th of June The group were advised that Xonvea® had also been discussed at the MVG meeting. Upcoming plans would include the scoping of Oral Nutritional Supplements (ONS) and the High Cost Drugs (HCD) dashboard which was expected to be available soon. • **NHSE** The following update was provided: o Immunoglobulins - change in products available on the framework and providers would have received information relating to financial support for switching patients on home based immunoglobulin therapies to the new products that were now available. Liaison was taking place with the providers and clinical commissioning pharmacists within each trust. A financial incentive was available to support the implementation of the switch with the recommendation for providers to ensure that the finances obtained were reimbursed within the service o Tenofovir Alafenamide Fumarate (TAF) – It was confirmed that blueteq forms were to be inputted within a 12 month period and not as previously stated (1 month); Specialist colleagues in HIV medicine had been made aware of this update via a circular.

	Noted.
17.	**Formulary Working Group – electronic formulary update**
	The group were advised that the NEL joint formulary had been fully published and explained the immense task of considering over 10,000 lines of legacy formulary information across the seven individual legacy formularies within NEL. Seventeen chapters were currently available within netFormulary and the final Wound Care chapter was to be uploaded and published following the FPG approval. As part of the process, a SOP was developed to ensure consistency; any discrepancies were discussed on a weekly basis at the formulary working group and any changes were presented at FPG for due governance. All those who had been involved in the collaborative working across NEL to complete the project were thanked for their support. The formulary working group would now focus on phase 2 of the work to consider the more complex therapeutic areas for harmonisation and review. The chair expressed her gratitude on behalf of the FPG for the excellent work that had been undertaken so far to create the NEL electronic joint formulary. **Stage 1 harmonisation** The final list of drugs/formulations and their indications as part of stage 1 harmonisation had been circulated with the agenda for FPG approval as part of the governance process. Line 63 (Lecanemab) and line 64 (Donanemab) were highlighted and had been included following a request to add wording to the netformulary for both drugs, whilst a position statement was awaited; NHS prescribing was not expected of either drug whilst awaiting the NICE decision but some could occur from the independent sector. It was confirmed that the link to the guidance to support the prescribing of varenicline tablets (line 4) had been updated on netFormulary. It was highlighted that Rifaximin's (line 7) major usage was to treat traveller's diarrhoea (Small Intestinal Bacterial Overgrowth (SIBO)) and therefore requested that wording is added to the amber formulary status that this amber status did not relate to the indication of SIBO. The green status of Lofepramine oral tablet (line 18) was queried and it was confirmed that mental health trust colleagues had been consulted and agreed the status for it to align with the mental health psychotropic drugs chapter. **Outcome:** Approved Decision for ratification by the SyPMO Board.
18.	**Equality – Monitoring of usage and outcomes** (Nil at present)
19.	**Items for Ratification / Approval**
	NEL Medicines Formulary RAG rating The group were advised that the RAG rating definitions for a pan-London approach had been considered by the London Procurement Partnership (LPP) with representation on behalf of the NEL ICS and the final recommendations document was now available for agreement. The pan-London RAG definitions would ensure the same clarification was used across London to facilitate better communication between clinicians and ensure that

	patients received the most appropriate care. The definitions within the document were outlined and a more detailed explanation for the proposed changes to the previous agreed RAG rating definitions were highlighted below:
	
	Non-Formulary: Medicines not listed on the local formulary and not recommended for routine use in primary or secondary care
	• Two types of 'non-formulary':
	  o Passively non-formulary, where treatment has not been reviewed or applied for and no formal position exists (e.g. new medicines)
	  o There is an active position from the Area Prescribing Committee /Joint Formulary Committee (or equivalent) not recommending this treatment
	• Non-formulary medicines would not have a colour (previously colour coded as grey)
	
	Amber: Medicines considered suitable for prescribing in primary care, following a recommendation or initiation by a specialist/hospital. The following sub- categories exist to support amber classification:
	• **Amber 1:** Suitable for initiation in primary care, following specialist recommendation. The first prescription can originate from primary care after recommendation by an appropriate specialist. The recommendation may be provided in writing, verbally, or based on clinical guidelines
	• **Amber 2:** Specialist initiation with maintenance in primary care: These medicines require specialist involvement during initiation and may require a period of treatment stabilisation before primary care prescribing is appropriate. Initial prescription(s) are issued by the specialist. If a specified minimum duration of specialist prescribing is required, this will be detailed in local recommendations
	• **Amber 3:** Specialist Initiation with shared/collaborative/transfer of care documentation: These medicines require specialist initiation/first prescription and a period of stabilisation. However, it may not be appropriate for full transfer of clinical responsibility to primary care prescribers, therefore a sharing/collaborative agreement should be in place
	
	It was highlighted that there would need to be a review of the amber classifications that had been added to netFormulary to support the new RAG definitions. There are over 500 entries falling into the amber 1 and amber 2 definitions. Amber 3 would be the current “purple” category. Following a meeting with the netFormulary developer it had been agreed that the formulary would not need to be removed in order for these updates to be undertaken.
	
	It was requested that the document is considered at the NELFT Medicines Group meeting in July and highlighted that ratification of the document would be considered at the SyPMO Board meeting on the 24th June. Therefore, it was agreed to circulate the document to NELFT colleagues for information and request any comments back, prior to the SyPMO Board meeting.
	
	It was agreed that any drugs where an agreement cannot be reached / there is uncertainty at the Formulary Working Group would be brought to FPG for discussion and decision.
	
	Outcome: Approved

	Decision for ratification by the SyPMO Board.
20.	**Papers from committee reporting into the FPG:** • BH Cancer Drugs & Therapeutic Committee – April 2025
21.	**Local Medicines Optimisation group updates:** • BH Summary of Chairs Actions – April 2025 • NELFT Medicines Optimisation Group (MOG) Highlight Report - Nil • ELFT Medicines Committee minutes – Nil • BHRUT MOG Minutes – Nil • Homerton Medicines Committee agenda and minutes - Nil
22.	**NEL FPG recommendations ratified at SyPMO Board**
	• SyPMO Board May 2025 Highlight Report **NEL FPG Outcome Letters:** • Cefepime, fourth generation cephalosporin, broad spectrum antibacterial to treat infections due to susceptible micro-organisms • North East London Primary Care Wound Dressing Formulary • Pylera® 140mg/125mg/125mg (bismuth subcitrate potassium/ metronidazole/ tetracycline hydrochloride) hard capsules, in combination with omeprazole, for the eradication of H.Pylori with a penicillin allergy, with previous exposure to clarithromycin or in line with antimicrobial susceptibility testing (AST) • Position Statement: Initiation Of Statins for Primary Prevention of Cardiovascular Disease in Patients with Liver Disease • Vericiguat for Chronic Heart Failure with reduced Ejection Fraction (HFrEF) in patients remaining symptomatic on optimal medical therapy • Early Access to Medicines Scheme – Sebetralstat is indicated for the treatment of hereditary angioedema (HAE) attacks in adult and adolescents aged 12 years and older • Leniolisib for activated phosphoinositide 3-kinase delta syndrome (NICE FAD HST33) • TA1051 Efanesoctocog alfa for treating and preventing bleeding episodes in haemophilia A in people 2 years and over **Noted.**
23.	**Finalised Minutes – April 2025**
24.	**Any Other Business**

	• NELFT shared care guideline for Treatment of Attention Deficit Hyperactivity Disorder (ADHD) in children and adolescents (under 18 years of age) Methylphenidate, Dexamfetamine, Atomoxetine, Lisdexamfetamine and Guanfacine: A query was received from one of the LMCs that they noticed it had a line which says "*If there is no response within two weeks of the date of this letter, it will be assumed that shared care has been agreed*". This is an anomaly as this statement is not seen elsewhere. As an interim measure it has been agreed that this line will be removed. ADHD is an area that is likely to be retained as shared care in future, so this will be reviewed when new SCGs are being developed. **Noted.** • Any HHFT chair's action will be shared in future FPG in line with BH and BHRUT 's current practice.
	Time & date of next FPG meeting: **12:30 – 15:00pm, Tuesday 15th July 2025 via MS Teams**