NHS
North East London

North East London Formulary & Pathways Group (FPG)

Tuesday 6th May 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
Present	Ruth Crowley	RC	GP Partner, Avon Road Surgery, Havering	NHS NEL
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
Absent	John McAuley	JM	Consultant Neurologist, DTC Chair	BHRUT
Present	John Booth	JB	Consultant Nephrologist	BH
Trusts' Pharmacy Representatives				
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
Absent	Abu Baker Eltayeb	AE	Clinical Pharmacology IMT Resident Doctor	BH
Present	James Steckelmacher	JS	Clinical Pharmacology IMT Resident Doctor	BH
Present	Dawud Masieh	DM	Clinical Pharmacology IMT Resident Doctor	BH
Absent	Emma Magavern	EM	Clinical Pharmacology IMT Resident Doctor	BH
Apologies	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
Present	Kiran Dahele	KD	Formulary & Governance Pharmacist	NELFT
NEL Pharmacy & Medicines Optimisation Team's Representatives				
Apologies	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
Present	Sheetal Patel	ShP	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
Present	Zafiat Quadry	ZQ	Head of Medicines Optimisation - Commissioning and Transformation	NHS NEL
Other Representatives				
Absent	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
Apologies	Yasmine Korimbux	YK	Head of Medicines Optimisation – Place Based Partnerships	NHS NEL
Absent	Jiten Modha	JMo	Specialised Commissioning Senior Pharmacy Advisor	NHSE
Absent	Anudeep Riyat	AR	Deputy Chief Pharmacist, Specialised Commissioning (NEL ICB link pharmacist)	NHSE
Guests				
Present	Christopher Primus (6)	CP	Consultant Cardiologist	BH
Present	Ben Waters (6)	BW	Lead Cardiac Pharmacist	BH
Present	Miriam Fortune (6)	MF	Specialist Cardiac Pharmacist	BH
Present	Purushthoman Premchand (7)	PP	Consultant Gastroenterologist	BHRUT
Present	Stuart Hill (7)	SH	Lead Pharmacist Surgery and Gastroenterology	BHRUT
Present	Ximena Gonzalo (8)	XG	Consultant in Infectious Diseases and Microbiology	BH
Present	Lisa Boateng (8)	LB	Lead Antimicrobial Pharmacist	BH
Absent	Tiba Hikmat (8)	TH	Senior Rotational Pharmacist	BH
Present	Arron Jones (9)	AJ	Lead Hepatology Pharmacist	BH

Present	Bola Sotubo (10)	BS	Lead Medicines Optimisation Pharmacist	NHS NEL
Present	Elaine Flaherty (10)	EF	Tissue Viability Nurse	NELFT

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. The NHSE Deputy Chief Pharmacist, Specialised Commissioning was welcomed to the group and would attend future meetings as the NEL ICB link pharmacist. The previous NHSE representative was thanked for their attendance and participation at the NEL FPG meetings.
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 to enable an updated register to be available.
4.	**Minutes**
	The minutes of the previous meeting (April 2025) were reviewed and approved. The redacted minutes from March 2025 were also approved.
5.	**Matters Arising**
	FPG action log

	202504_01 - Ibuprofen 400mg Solution for infusion - for use in acute moderate pain at a dose for 400mg IV TDS for 3/7 only in appropriate patients (update) – It was confirmed that the applicants for this item had been informed that a trust protocol was required to support the management of Ibuprofen IV use and this was currently in progress. **Noted.** **202504_02 – Stimulan beads for soft tissue and bone infections** – BHRUT colleagues were working with other stakeholders to produce the additional information requested to support the re-submission of this item to a future FPG meeting. **Noted.** **202504_02 – High Cost Drugs Treatment Pathway for Ankylosing Spondylitis (AS) and non-radiographic Axial Spondyloarthritis** It was confirmed that the 12 week review following dose escalation of secukinumab in AS had been added to the monitoring section of the pathway. **Completed.** **202504_03 – Vadadustat for treating symptomatic anaemia in adults having dialysis for chronic kidney disease** – The request for a trust pathway to be produced to support the use of both Vadadustat and Roxadustat had been shared with the applicants and this was in progress. BH have indicated that they were unlikely to use these agents, but if they did, they would produce a pathway which would be handled internally. **Completed.** **202503_04 - Stage 1 harmonisation log** – It was confirmed that the status of ursodeoxycholic acid had been reviewed and changed from green to amber formulary status. **Completed.** TA 1050 Fenfluramine (Update) – Seizures associated with Lennox-Gastaut syndrome in people 2 years and over. It was confirmed that BH was also commissioned for treating Adults and children as per SSC2788 and this had been ratified by the SyPMO Board.
6.	**Vericiguat for Chronic Heart Failure with reduced Ejection Fraction (HFrEF) in patients remaining symptomatic on optimal medical therapy**
	Declarations of interest: Nil declared The application for vericiguat to be added to the formulary enabling an additional therapeutic option to be available for patients with HFrEF was explained. It was highlighted that a previous formulary submission (2023) had resulted in treatment requests for patients being agreed via Chairs Action due to limited experience in using the medication. The group were advised that the Victoria study had shown positive results for the selected cohort of patients (5000+) who had been identified with unstable heart failure despite optimal medical managements. Whilst treatment of vericiguat in the study had shown an overall reduction of CV death and hospitalisation, this had not led to a significant change to outcomes. The cohort of patients suffering with the following would be eligible for vericiguat and would be discussed by a heart failure multi-disciplinary team (MDT) before treatment commenced: • Worsening heart failure

	• Hospital admission within the preceding six months • An increase in their diuretic medication Patients who were candidates for heart transplantation would be referred to local centres for assessment. Whilst vericiguat was well tolerated by most patients the following symptoms were known to be exacerbated and would be monitored and treated: • Hypotension: patients with Systolic BP<100mmHG are excluded as per SmPC • Anaemia • Gastrointestinal upset Data had been shared relating to BH patients that had been initiated with vericiguat which confirmed the rigorous monitoring that had been undertaken by the heart failure specialists with patients remaining under a dedicated heart failure service. It was highlighted that currently vericiguat prescribing costs were currently being met by BH as the tertiary centre within NEL. A treatment pathway for the Management of HFrEF had also been provided to support the application. A rapid titration service has been launched, funded by North East London ICB with a dedicated pharmacist working in the pan trust team which ensures that patients are provided with a further prescription at 3 months. The following points were discussed: • 10 mg maintenance dose for patients but data shared highlighted that patients did not reach the target dose – it was explained that due to the drug being used for low cardiac failure, patients were getting benefit at the lower doses without further increase • It was confirmed that vericiguat was 'in tariff 'and costs were directed to the Trust – patient numbers were restricted to support costs and the heart failure MDT, as the gatekeepers, enabled monitoring, monthly dose titration and outcomes to be audited • As BH was the tertiary centre some patients were seen from out of area – it was suggested that prescribing could be done within secondary care rather than all patients being seen at the BH tertiary centre although wider conversations regarding commissioning would need to be had locally • Palliative care - initially both services were working together in tandem to start with but due to waiting times for the palliative care service, the heart failure team were initiating patients on vericiguat independently which had provided stability for some patients who were then no longer considered as palliative • Leicester Hospital had published their initial experiences of vericiguat prescribing in conjunction with the manufacturers whilst BH had decided to note their experiences independently of the manufacturer. • Concern was raised regarding inequity of service within NEL as patients currently only had the option of attending BH with the only alternative service provided in University College London Hospital (NCL sector). It was explained that there is a weekly heart failure MDT for all BH hospitals and ULCH, most patients were currently from St Barts and The Royal London Hospitals, due to the reluctance of patients to attend from Whipps Cross and Newham hospitals. Although the HF MDT was available to and attended by all NEL Trusts, there remained financial

	implications only for BH who currently continued to fund all prescribing of vericiguat. BHRUT have not yet referred any patients to this service although they do attend the weekly MDT. Community palliative heart failure patients may be missed as they are no longer under secondary care • New interface processes were requested within primary and secondary care to ensure that vericiguat became a treatment option offered for this specific cohort of patients across the whole sector • It was confirmed that if a patient was not responding or tolerating vericiguat then treatment would cease; if benefits were not seen then treatment would be stopped to support polypharmacy rather than over burden and the patient's other medications would not be reduced to enable the continuation of vericiguat • Inpatient Heart Failure teams could capture eligible patients who could be brought back into secondary care for treatment but concerns regarding virtual wards. In NEL, virtual wards did not have heart failure input, which was concerning, the group were advised that in NCL heart failure patients were not placed on virtual wards It was suggested that the heart failure MDT should continue to 'gatekeep' the use of vericiguat and patient numbers should be shared at a future BH Oversight Group meeting, to provide assurance of equitable access for patients and advise of the system in place to alleviate any inequity of treatment. The financial implications for the Trust could also be a further discussion at the BH Oversight Group. It was mentioned that presenters had demonstrated that the drug was a valid treatment option for a selective group of patients with a specific clinical need. It was requested that outcome data should be provided for the next 12-18 months to the BH Oversight Group. It was confirmed that although approval would be for all NEL Trusts, vericiguat would only be available for patients via the heart failure MDT at BH as the NEL tertiary centre. **Outcome:** Approved (BH only) Formulary status: Red, Hospital only Decision for ratification by the SyPMO Board.
7.	**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)**
	Declarations of interest: Nil declared It was explained to the group the application for Pylera® which was a combination (bismuth subcitrate potassium/ metronidazole/ tetracycline hydcrochloride) licensed product that is easily accessible to treat the eradication of H. Pylori, replacing the unlicensed DeNoltab® which had been discontinued. It was highlighted that the Pylera® formulation provided savings due to the combination of drugs within the tablet which would no longer need to be prescribed separately. The H. Pylori resistance testing service had been stopped and the UK Health Security Agency (UKHSA) had provided guidance which advised the use of bismuth subcitrate potassium ahead of the schedule than that advised by NICE and the BNF and this

	was reflected in the flowchart; all other options aligned with both NICE/BNF recommendations. The group were also advised that failure of triple therapy was being experienced for some patients and the addition of Pylera® to the NEL formulary would provide an alternative treatment, increasing options for patients. It was confirmed that formatting needed to be updated on the flowchart to show that there were two routes of treatment that could be considered under the 'non-penicillin allergic' heading. It was noted that if both treatment options failed for the patient, advice would be sought from either microbiology or gastroenterology team depending on the Trust; GPs were to seek advice for their patients via the *e*-referral system. Patient numbers were discussed and it was confirmed that a cost saving would be made with the addition of Pylera® to the formulary. It was mentioned that Pylera® was 'off label' for children and would discuss its use with the BH gastroenterology team. It was confirmed that this application was for adults only and an additional application would be required for children. The following comments had been received regarding the flowchart from the NEL ICB Lead Medicines Optimisation Pharmacist for Antimicrobial Stewardship: • Do doses need to be included • Clarithromycin, metronidazole or quinolone if used in the past year for any infection, were not to be used as each additional course increased the risk of resistance • Omeprazole or lansoprazole to be used as PPI of choice It was requested that the protocol is re-formatted to ensure first line and second line treatment options were clearly defined and the flowchart was easy to follow. **Outcome:** Approved (adults only) Formulary status: Amber, specialist recommendation or initiation Decision for ratification by the SyPMO Board.
8.	**Cefepime, fourth generation cephalosporin, broad spectrum antibacterial to treat infections due to susceptible micro-organisms**
	Declarations of interest: Nil declared The application for Cefepime was presented and the group were advised that it had been used worldwide since the 1990s for both adults and children and would be an additional option to treat a variety of infections which would support antibiotic resistance and antimicrobial stewardship. It was a

	well-tolerated treatment option for patients with a very-well known side effect and safety profile and the advantages of Cefepime when compared with alternative cephalosporin treatments were shared. It was highlighted that Cefepime was already used by other London trusts. It was explained that the IV drug is given three times per day and is available as an elastomeric device (pump), remaining stable for 24 hours. It was highlighted that the extended use of carbapenems was contributing to the selection of carbapenem-resistant organisms rendering them ineffective and the option to use Cefepime in some cases would allow carbapenems to be protected for longer. Whilst Cefepime was not the cheapest treatment option its addition to formulary would support antimicrobial stewardship providing an alternative to carbapenems in some situations It was explained to the group that Cefepime would only be prescribed under microbiologist advice with most treatment being provided by BH and minimal prescribing at BHRUT and HHFT and is supported by the ARC (Antimicrobial Review Committee). The group were advised that Cefepime would not be added to EOLAS and would only be considered for individual patients on a case by case basis. Any switch from IV to an oral treatment for patients would depend on the infection and recommendation of a microbiologist. It was confirmed that the application was for the drug only to be used in hospitals and did not include the use of an elastomeric device or infusion device, this currently would need to be requested under chairs action. It was requested that 12 months data of Cefepime prescribing should be presented to the BH Oversight to monitor usage and inform on the specific indications that Cefepime had been used to treat. **Outcome:** Approved for use following microbiologist advice only. Formulary status: Red, Hospital only Decision for ratification by the SyPMO Board.
9.	**Position Statement: Initiation Of Statins for Primary Prevention of Cardiovascular Disease in Patients with Liver Disease**
	Declarations of interest: Nil declared It was explained to the group that the position statement had been produced to support primary care queries and patient concerns as to when and when not to take their prescribed statins. Monitoring guidance had been produced by Specialist Pharmacy Service and the position statement provided a single resource for prescribers outlining a variety of scenarios for statin therapy including treatment options, required monitoring and referral to hepatology teams. It was confirmed that the document had been shared with relevant stakeholders, including lipid teams and the Hepatology Network within NEL for comments and input. **Outcome**: Approved

	Decision for ratification by the SyPMO Board.
10.	North East London Primary Care Wound Dressing Formulary
	Declarations of interest: Nil declared The draft Wound Care formulary which was a consolidation of four legacy formularies that had existed within NEL was presented to the group. A variety of stakeholders had been involved in the draft document with engagement with NEL community health nursing teams, the acute trusts procurement teams and the Community Interest Company (CIC) Accelerate, who are the provider for the dressing optimisation scheme across NEL. Although it was confirmed that this formulary was for primary care, there was concern as to how both primary and secondary care would link together to follow the formulary choices. The group were advised that joint working on formulary did not occur and it was suggested that the primary care formulary should be shared for information with the diabetic foot teams and vascular teams. The BH diabetic foot team had questioned whether the community teams would advise on the use of specific dressings. It was explained that the BHRUT podiatry team worked closely with the local TVNs and requested dressings from the same provider. It was advised that secondary care colleagues would be able to access the formulary on net.Formulary. The group acknowledged the immense work that had been undertaken to produce the single NEL wound dressing formulary. **Post meeting note**: Due to the omission of a brand of compression bandages that had previously been agreed for inclusion in the formulary by the Wound Care Working Group, an updated version of the document would be submitted to the June FPG meeting under matters arising to acknowledge this amendment. **Outcome:** Approved
12.	**Updated Guidelines**
	Updated Atopic Dermatitis Guideline – the group were advised that Lebrikizumab (TA 986) had been added to the guideline and additional areas (highlighted in yellow) within the document that had subsequently been updated were outlined. **Outcome:** Approved Decision for ratification by the SyPMO Board.
13.	**NICE TA approval and Horizon Scanning**

	ICB Commissioned: **TA 1045 12 Standard Quality House Dust Mite Sublingual Lyophilisate (SQ-HDM SLIT) (Acarizax) for treating allergic rhinitis and allergic asthma caused by house dust mites-** the group were advised that 12 SQ-HDM SLIT is recommended, within its marketing authorisation, as an option for treating moderate to severe house dust mite allergic rhinitis in people 12 to 65 years that have been: • diagnosed by clinical history and a positive test of house dust mite sensitisation (skin prick test or specific immunoglobulin E [IgE]) and • persistent symptoms despite use of symptom-relieving medicine The implementation date for NHS hospitals and primary care providers is 03/06/25. This is ICB commissioned, providers are NHS hospitals and primary care providers. Clarity was requested as to who would be initiating the treatment and whether the patient criteria should be severe allergic rhinitis and not moderate/severe. It was agreed that clarity was needed from the specialist teams around initiation and continuation of prescribing and if the therapy was to be managed entirely by specialists who would decide on the severity of symptoms (moderate/severe). This was to be confirmed and the item return to the FPG under matters arising. **Outcome:** Approved. Formulary status and patient cohort to be confirmed and the item to return to a future FPG meeting under matters arising. Decision for ratification by the SyPMO Board. **NHSE commissioned:** **TA105**1 **Efanesoctocog alfa for treating and preventing bleeding episodes in haemophilia A in people 2 years and over -** BH shared patient numbers; HHFT and BHRUT were yet to respond with patient numbers. **Outcome:** Approved. Formulary status: Red, Hospital only (BH is the only NEL commissioned centre) Decision for ratification by the SyPMO Board.
14.	**NICE TAs/ NHSE commissioned policies for discussion**
	• **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** – Barts Health Only. It was confirmed that requests for medication were to be made directly to the manufacturers who would also provide the training to administer. **Outcome:** Approved Formulary status: Red, Hospital only (BH only) Decision for ratification by the SyPMO Board.

	• **Leniolisib for activated phosphoinositide 3-kinase delta syndrome (NICE FAD):** available via the IMF from 28th March until TA publication – Barts Health Only for adults **Outcome:** Approved Formulary status: Red, Hospital only (BH only for adults) Decision for ratification by the SyPMO Board.
15.	**NHSE Circulars**
	• **SSC2817** Switching immunoglobulin products under the new framework in 2025 Patient information leaflet (1) • **SSC2817** Switching immunoglobulin products under the new framework in 2025 (1) • **SSC2807** EAMS Sebetralstat for hereditary angioedema in adults and adolescents 12 yrs and older • **SSC2804** NICE Appraisals, published in March 2025, which are due to be commissioned in June 2025 • **SSC2788** NICE Technology Appraisal Final Draft Guidance Fenfluramine for treating seizures associated with Lennox–Gastaut syndrome in people 2 years and over (updated) • **SSC2772** NICE Appraisals published in January 2025 due to be commissioned in April 2025 (reissue) • **SSC2801** - NICE Technology Appraisal Final Draft Guidance Leniolisib for activated phosphoinositide 3-kinase delta syndrome **Noted.**
16.	**Commissioning update**
	• **ICB** **Medicines Value Group Highlight Report** The following update was provided: • M12 forecast outturn to deliver planned savings with an over-delivery vs target, YTD M10 actual savings shared • The NEL ICB Prescribing Efficiency Team have supported delivery and annual savings to date shared • BHRUT Achieved savings • Barts Health on track with biosimilar switches and forecast with a slight under delivery to plan, figures are to be verified and made available at next MVG meeting • Homerton is on track with planned efficiency savings delivery, figures are to be verified and made available at next MVG meeting • Natalizumab switches were progressing well, Tocilizumab stock now available for IV, BHRUT had already switched to subcutaneous Tocilizumab and BH were ready to go with Tocilizumab switch when stock becomes available

	• All Trusts had a collaborative meeting to discuss CIP for 2025/2026; these were discussed and being finalised. It was agreed that detailed plans would be brought to the next MVG meeting with financial targets • Primary Care- 2025/26 feedback had been collated for the Prescribing Efficiency Scheme (PES) after stakeholder engagement and the scheme had been launched on the 30th April 2025 • **NHSE –** update not available at the meeting **Noted.**
17.	**Formulary Working Group – electronic formulary update**
	The latest 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. A concern was raised regarding the red formulary status of tetracaine 4% gel and it was agreed to review this at the next weekly formulary meeting. **Outcome:** Approved subject to the removal of tetracaine 4% gel which would require further review of its formulary status. 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 This item was deferred to the June FPG meeting.
20.	**Papers from committee reporting into the FPG:** • BH Cancer Drugs & Therapeutic Committee – Nil
21.	**Local Medicines Optimisation group updates:** • BH Summary of Chairs Actions – March 2025 • NELFT Medicines Optimisation Group (MOG) Highlight Report - Nil • ELFT Medicines Committee minutes – Nil • BHRUT MOG Minutes – February and March 2025 • Homerton Medicines Committee agenda and minutes - Nil
22.	**NEL FPG recommendations ratified at SyPMO Board**
	• SyPMO Board April 2025 Highlight Report

	NEL FPG Outcome Letters: • High Cost Drug Treatment Pathway - Ankylosing Spondylitis and non-radiographic Axial Spondyloarthritis • Local commissioning of dose escalation of secukinumab for the treatment of Ankylosing spondylitis • Hexvix® – Hexaminolevulinate for the detection of bladder cancer – Formulary Alignment with BH **Noted.**
23.	**Finalised Minutes – March 2025**
24.	**Any Other Business** Agenda items – It was suggested that the placing of items for discussion and approval should appear higher on the agenda to ensure that all clinical members have the opportunity to comment, as unfortunately some colleagues had to leave the meeting early due to existing clinical commitments. The possibility of a BHRUT clinician deputising to provide representation was discussed. The group were advised that a HHFT clinician would be joining future meetings. It was confirmed that a paediatrician would be welcome to attend and agreed to liaise with the paediatric team for future representation.
	Time & date of next FPG meeting: **12:30 – 15:00pm, Tuesday 3rd June 2025 via MS Teams**