North Central London
Medicines Optimisation Network

JOINT FORMULARY COMMITTEE (JFC) – MINUTES
Minutes from the meeting held on 18th November 2021

Present:	Prof R Sofat	NCL JFC Chair	(Chair)
	Mr S Semple	NCL ICS, Interim Chief Pharmacist	
	Dr M Kelsey	WH, DTC Chair	
	Dr K Tasopoulos	NMUH, DTC Chair	
	Ms K Delargy	BEH, Chief Pharmacist	
	Mr P Gouldstone	NCL CCG, Head of Medicines Management (Enfield)	
	Ms M Singh	NCL CCG, Head of Medicines Management (Barnet)	
	Ms E Mortty	NCL CCG, Deputy Head of Medicines Management (Haringey)	
	Mr A Dutt	NCL CCG, Head of Medicines Management (Islington)	
	Ms W Spicer	RFL, Chief Pharmacist	
	Dr A Scourfield	UCLH, DTC Vice Chair	
	Mr S Richardson	WH, Chief Pharmacist	
	Dr A Sell	RNOH, DTC Chair	
	Mr A Shah	RNOH, Chief Pharmacist	
	Mr T Dean	Patient Partner	
In attendance:	Ms S Sanghvi	North London Partners, JFC Principal Pharmacist	
	Mr G Grewal	North London Partners, JFC Support Pharmacist	
	Mr R Rajan	North London Partners, JFC Support Pharmacist	
	Ms S Amin	IPMO Programme Team, Lead Pharmacist	
	Mr A Barron	UCLH, Principal Pharmacist	
	Ms I Samuel	RFL, Formulary Pharmacist	
	Mr D Sergian	MEH, Formulary Pharmacist	
	Ms M Kassam	MEH, Senior Pharmacist	
	Ms S Y Tan	NHS London Shared Service, Contract and Commissioning Support Pharmacist	
	Ms A Fakoya	NHS London Shared Service, Contract and Commissioning Support Pharmacist	
	Ms A Sehmi	NMUH, Formulary Pharmacist	
	Ms H Thoong	GOSH, Formulary Pharmacist	
	Dr M George	UCLH, Consultant Clinical Pharmacologist	
	Dr R Maclean	UCLH, Clinical Pharmacology Registrar	
	Mr G Purohit	RNOH, Deputy Chief Pharmacist	
	Dr D Burrage	WH, Consultant Clinical Pharmacologist	
	Ms R Pankhania	Bedfordshire Hospitals, Formulary Pharmacist	
	Dr P Bodalia	Bedfordshire Hospitals, Chief Pharmacist	
	Mr G Cairns	UCLP, Healthcare Technology Advisor	
	Ms M Hoti	UCLP, Project Manager	
	Dr R Sweis	UCLH, Consultant Gastroenterologist	
	Dr S Warren	RNOH, Consultant Microbiologist	
	Mr T Azamgarhi	RNOH, Lead Antimicrobial Pharmacist	
	Dr R Roylance	UCLH, Consultant Oncologist	
	Ms P Panesar	UCLH, Lead Antimicrobial Pharmacist	
	Ms M Lanzman	RFL, Lead Antimicrobial Pharmacist	
	Dr H Booth	UCLH, Respiratory Consultant	
Apologies:	Dr B Subel	NCL JFC Vice Chair	(Vice Chair)
	Mr A Tufail	MEH, DTC Chair	

Dr A Worth	GOSH, DTC Chair
Ms G Smith	RFL, DTC Chair
Mr J Harchowal	UCLH, Chief Pharmacist
Mr S Tomlin	GOSH, Chief Pharmacist
Ms S Stern	NMUH, Chief Pharmacist
Ms L Reeves	C&I, Chief Pharmacist
Ms H Weaver	NHSE, Specialised Commissioning Pharmacist
Ms R Clark	NCL CCG, Head of Medicines Management (Camden)
Dr S Ishaq	WH, Consultant Anaesthetist

2. Meeting observers

Prof Sofat welcomed observers of the meeting.

3. Minutes of the last meeting

The minutes and abbreviated minutes of the 21 October 2021 meeting were accepted as an accurate reflection of the meeting.

4. Matters arising

4.1 Accelerated Access Collaborative (AAC) Rapid Uptake Products

The Committee heard that the Rapid Uptake Products (RUP) programme sits under the NHS AAC and is designed to support stronger adoption of products with NICE approval that support the NHS Long Term Plan priorities, but which have lower than expected uptake to date. The AAC have shortlisted 8 products for 2022/23, and are now seeking consultation on the preferred products to take forward. The Committee have been asked to provide feedback on the shortlist by UCL Partners AHSN. A consultation document will be circulated by JFC support to gather feedback.

5. JFC Outstanding Items & Work Plan

These items were included for information only. Any questions should be directed to Mr Grewal.

6. Members declarations of conflicts of interest

Dr Sweis stated he received honoraria from *Dr Falk Pharma®* to speak at conferences.

7. Local DTC recommendations / minutes

7.1 Approved

DTC site	Month	Drug	Indication	JFC outcome
NCL CCG (NPR)	Oct 2021	Bupropion	For use in treatment of tobacco dependence following failure of two forms of appropriately dosed NRT (and varenicline, if available) in patients who do not have any contraindications to therapy (see SPC); discontinue if abstinence not achieved in 7 weeks	Decision: Added to the NCL Joint Formulary Prescribing: Primary and Secondary care Tariff status: In tariff Funding: Trust and CCG Fact sheet or shared care required: No
NCL CCG (NPR)	Oct 2021	Shingrix	Shingles vaccine for eligible patients (immunosuppressed individuals aged 70-79 years) as per Green Book guidance, for whom Zostavax® shingles vaccine (herpes zoster, live) is clinically contraindicated	Decision: Added to the NCL Joint Formulary Prescribing: Primary and Secondary Care Tariff status: Excluded from tariff Funding: NHSE in Primary care; funded by the Trust in Secondary care Fact sheet or shared care required: No Additional information: Routinely administered in primary care as part of national vaccination programme; may be considered for use in secondary care for exceptional patients (e.g. long-term inpatients)

RFL	Sept 2021	Nivolumab with chemotherapy† (FOLFOX or XELOX)	Untreated HER2-negative advanced gastric or gastro-oesophageal junction cancer (MHRA EAMS)	Decision: Added to the NCL Joint Formulary Prescribing: Secondary care Tariff status: N/A – free of charge Funding: N/A – free of charge Fact sheet or shared care required: No

† The relevant commissioner should be notified in line with NCL Free of Charge scheme guidance. Approval is conditional on the provision of a free of charge scheme agreement and funding statement.

8. New Medicine Reviews

8.1 Jorveza for maintenance treatment following induction in patients with eosinophilic oesophagitis (Applicant: Dr R Sweis, UCLH)

The Committee considered an application for budesonide orodispersible tablet (BOT), for maintenance therapy in eosinophilic esophagitis (EoE) in adults who have achieved remission with induction therapy.

EOS-2 (n=206) was a 48-week, phase III, placebo-controlled, double-blind study to assess the safety and efficacy of BOT for adults with proton pump inhibitor (PPI)-refractory EoE who were in clinicohistologic remission immediately following induction therapy. Patients were randomised to 0.5mg twice a day (n=68), 1mg twice a day (n=68), or placebo (n=68). The primary endpoint, clinicohistologic remission at week 48, was significantly better with BOT 0.5mg twice daily versus placebo (73.5% vs 4.4% [p<0.001]) and 1mg twice daily versus placebo (75.0% vs 4.4% [p<0.001]). Clinicohistologic remission was defined as rate of patients fulfilling none of the following criteria: clinical relapse (patients report a score of ≥4 points on a numerical rating scale (1-10, higher scores indicating more severe symptoms of dysphagia or odynophagia)); histological relapse (≥15 eos/hpf) at the end of treatment; food impaction that required endoscopic intervention, need for dilation or premature withdrawal.

Key limitations of the study are that the composite primary outcome was reliant on subjective patient reported symptoms on a simple numerical rating scale. In addition, there was potential recall bias as patients report symptom scores over the preceding 7 days, with lengthy intervals between assessments. A stricter histologic inclusion criterion (<5 eos/hpf) was specified than that accepted for the primary outcome (<15 eos/hpf). A key limitation is that the study did not assign active comparators like off-label fluticasone inhaler (first-line) or budesonide nasules (second-line) against BOT.

In terms of safety, BOT (0.5mg twice daily and 1mg twice daily) had a higher risk of mild to moderate symptoms of oral candidiasis compared to placebo (16.1% and 11.8% vs. 0%, respectively).

In terms of budget impact, BOT is expected to cost £58,500 extra per annum for an estimated 60 patients at UCLH as compared to the current formulary option of off-label budesonide nasules mixed with sucralose.

The Committee heard from Dr Sweis that EoE is a chronic disease that requires continued life-long management. Use of the licensed BOT for maintenance therapy may reduce patients relapsing and suffering complications such as stricture formation, perforation and food bolus obstruction, which are associated with emergency management and endoscopy costs. The Committee noted that NICE only considered induction therapy for BOT and the guidance did not clarify whether multiple induction courses may be used for relapses or whether/when maintenance therapy should be started. Dr Sweis advised that he is an author on EoE guidelines which are due to be published by the British Society of Gastroenterology and will include BOT as a management option.

Dr Sweis outlined that some patients find the current options of fluticasone and budesonide slurry challenging to administer and adhere to. The Committee questioned the use of an off-label dose of 1mg each night, and Dr Sweis responded that in his experience this dose appeared to be as effective as the licensed dose (1mg twice daily).

The Committee noted the request for prescribing to be transferred to primary care and expressed concern at potential safety risks associated with long-term prescribing of steroids without clear review or stopping criteria. Dr Sweis outlined that patients initiated on maintenance therapy would remain under secondary care for 3 months to check for remission and adherence. Thereafter, prescribing would be transferred to GP if appropriate.

In camera, the Committee raised concerns regarding the cost-effectiveness and budget impact of BOT for maintenance compared to the current formulary options. The Committee questioned the off-label dose proposed and why NICE had not considered maintenance therapy as part of their review of BOT. In addition, the Committee were concerned about long-term steroid use without definitive review/stopping criteria for patients potentially being discharged to primary care. The Committee would like to view the EoE guidelines that are being produced to also help in its decision making.

The Committee heard from Ms Hong (GOSH formulary pharmacist) that BOT is used for maintenance therapy at GOSH to support children's adherence to treatment. All prescribing is retained in secondary care and there is a treatment pathway locally in development.

In summary, based on the evidence available and (1) the significant budget impact for primary care long-term, (2) lack of NICE or comparative cost-effectiveness review to the current NCL formulary option for maintenance, (3) the proposed off-label dose, and (4) the lack of clarity over long-term stopping/review criteria, the Committee could not recommend the use of budesonide orodispersible tablet for maintenance therapy of EoE. However, the Committee were open to reviewing this decision once national EoE guidelines were available and if an NCL treatment pathway with cross-organisation consensus on dose, mechanism for prescribing and clear review/stopping criteria was developed. Consensus across NCL clinicians on the pathway, dose and potential patient numbers would be essential to guide budget impact considerations.

Decision: Not approved

8.2 Dalbavancin for bone and joint infections (Applicant: Dr S Warren and Mr T Azamgarhi, RNOH)

The Committee considered an application for dalbavancin, a glycopeptide antimicrobial, as a second line option for bone and joint infection in adults following approval from an MDT including a consultant microbiologist. Dalbavancin would be restricted to patients where either antimicrobial resistance limits the choice to outpatient parenteral antibiotic therapy service (OPAT) daptomycin and no suitable oral option exists, or there are significant concerns of compliance with a daily antimicrobial administration or line care.

Rappo et al. (NCT02685033) was a phase II, active-comparator controlled, unblinded study to compare the efficacy and safety of dalbavancin as a 2-dose regimen (on day 1 and day 8) with standard antibiotic therapy based on baseline pathogen, for adults with first episode of gram-positive acute or chronic osteomyelitis (without prosthetic material, sacral decubitus ulcer, multiple sites of osteomyelitis, septic arthritis that was non-contagious to osteomyelitis, gram-negative bacteraemia, or concomitant endocarditis or necrotising fasciitis) (n=80). Patients were randomised 7:1 to dalbavancin 1,500mg or antibiotic therapy consistent with standard of care. The primary endpoint, clinical response at day 42 in patients without need for additional antibiotic therapy, was not superior with dalbavancin compared to standard of care antibiotic therapy (difference not reported). Key limitations of the study were that non-inferiority was not tested by design and that the difference between the two arms was not reported. The Committee noted that several small retrospective observational studies have reported 'clinical success' in 61% to 85% of patients with bone and joint infections who received dalbavancin.

In terms of safety, dalbavancin had a lower risk of treatment-emergent adverse events compared to standard of care antibiotic therapy as demonstrated in a meta-analysis of 6 RCTs (n=3,073) (30.6% vs. 38.1%, OR 0.79, p = 0.01).

The Committee heard that dalbavancin offers potentially significant benefits in terms of convenience and healthcare resource utilisation, as the dosing regimen consists of IV infusions administered on day 1 during inpatient admission and day 8 (off-label indication and dose). This would reduce vascular access, district nurse and refrigerated transport requirements in comparison to OPAT daptomycin and reduce hospital bed days in comparison to inpatient vancomycin.

The Committee noted that no formal health economic analysis was available, however local cost comparison analysis suggested that dalbavancin therapy would be cost-saving taking into account activity costs. In terms of budget impact, dalbavancin is expected to be used in 24 patients across NCL resulting in savings of approximately £130,000 per annum compared to vancomycin, or approximately £125,000 per annum compared to daptomycin.

The Committee heard from Dr Warren who reiterated the restricted place in therapy for dalbavancin as a second- or third-line therapy option. The Committee questioned the place in therapy of teicoplanin for these patients, and were informed by Dr Warren that dalbavancin would only be considered for patients with teicoplanin-resistance.

In camera, the Committee discussed potential limitations of the budget impact model, noting that many patients seen at RNOH would be tertiary referrals from outside NCL. Despite the limited evidence, the Committee noted the benefits in reducing OPAT and district nurse requirements and potential cost-savings with no significant safety concerns. The Committee agreed that initiation under local microbiology teams would promote stewardship and safeguard against inappropriate use.

In summary, the Committee agreed to add dalbavancin to the NCL Joint Formulary as a second line treatment option for bone and joint infections in adults where antimicrobial resistance limits the choice to outpatient parenteral antibiotic therapy service (OPAT) daptomycin and no suitable oral option exists, or there are significant concerns of compliance with a daily antimicrobial administration or line care. Initiation should be restricted to approval by an MDT including a consultant microbiologist.

Decision: Approved subject to local Antimicrobial Committee approval and initiation under an MDT with microbiology input.
Prescribing: Secondary care only
Tariff status: In tariff
Funding: Trust
Fact sheet or shared care required: N/A

8.3 Sacituzumab govetican for metastatic triple-negative breast cancer (Applicant: Dr R Roylance, UCLH)

The Committee considered a free of charge (FOC) scheme application for the use of sacituzumab govetican for unresectable locally advanced or metastatic triple-negative breast cancer (TNBC) in patients who have had at least two prior therapies.

The ASCENT study was a phase 3 open-label randomised controlled trial comparing efficacy and safety of sacituzumab govitecan to single-agent chemotherapy (eribulin, vinorelbine, capecitabine or gemcitabine) in patients with relapsed or refractory metastatic TNBC. The primary endpoint was progression free survival (PFS), assessed by blinded independent review. Median PFS was significantly longer at 5.6 months (95% CI 4.3 to 6.3) with sacituzumab govitecan, compared to 1.7 months (95% CI 1.5 to 2.6) with chemotherapy (HR 0.41; p<0.001). The median overall survival (secondary outcome) was 12.1 months (95% CI 10.7 to 14.0) with sacituzumab govitecan and 6.7 months (95% CI 5.8 to 7.7) with chemotherapy (HR 0.48; p<0.001). Key limitations were the open-label design however this was mitigated with blinded assessment of primary outcome. In addition, the study was not powered to detect differences between the different control arm chemotherapy options, each of which present different safety risks.

In terms of safety, serious (≥ grade 3) treatment related adverse events were reported more frequently for sacituzumab govitecan compared to standard chemotherapy, namely neutropenia (51% vs 33%), leukopenia (10% vs 5%), diarrhoea (10% vs <1%), anaemia (8% vs 5%) and febrile neutropenia (6% vs 2%). However, treatment discontinuation due to adverse events occurred at a similar rate in both arms.

Sacituzumab govitecan is being offered under a FOC scheme with treatment available for patients accepted on to the scheme until a commissioning decision has been made and funding is available. FOC supply will be continued for patients established on treatment who fall outside of NICE or NHS England criteria for access. The Committee questioned the terms of the scheme which state 'limited capacity' and that the scheme would operate on a 'first come first served' principle with a waiting list, and whether this raised a risk of inequity of access. The Committee heard from Dr Roylance that the restricted supply is linked to the complex mechanism of action of the drug and lead time for production, but that the company is currently scaling up production so this is not anticipated to be a problem.

The Committee heard from Dr Roylance that TNBCs are aggressive cancers with poor prognosis, and that the significant improvement in PFS seen with sacituzumab govitecan in the ASCENT study made this a very promising treatment option to offer patients. The Committee asked about the more significant adverse event profile and how this would be managed. Dr Roylance acknowledged that clinicians would need to consider if patients were fit for treatment and weigh up risks and benefits as a shared decision with

patients. However, clinicians were experienced in supporting these conversations and in treating the adverse events associated with sacituzumab govitecan.

In camera, the Committee agreed that sacituzumab govitecan offered a significant benefit in PFS from robust RCT evidence. The Committee noted that a robust consent process would be important in supporting a shared decision with patients, to weigh up the survival benefits against the risk of significant adverse effects

In summary, the Committee agreed to add sacituzumab govitecan to the NCL Joint Formulary for unresectable locally advanced or metastatic TNBC for patients who have had at least two prior therapies in line with the free of charge scheme.

Decision: Approved
Prescribing: Secondary Care Only
Tariff status: N/A - Free of Charge
Funding: N/A - Free of Charge
Fact sheet or shared care required: N/A

8.4 Nebulised amikacin for patients with non-tuberculous mycobacterial pulmonary disease (Dr H Booth, WH)

The Committee considered an application for nebulised amikacin, an aminoglycoside, for non-tuberculous mycobacterial pulmonary disease (NTM-PD), for use in community TB clinics in patients who have severe disease (caused by mycobacterium within M. abscessus complex or M. avium complex, or by *M. xenopii* or *M.malmoense*) and limited treatment options (due to being treatment refractory, developed resistance or have contraindications). The Committee were informed that a licensed amikacin liposomal suspension (ALIS) has recently become available, though this application was for parenteral amikacin administered off-label via nebulisation.

There were no randomised controlled trials investigating the use of parenteral amikacin administered via nebulisation for NTM-PD. There were, however, six single-arm retrospective case series, which utilised a variety of doses (such as commencing from a higher initial dose or starting at a lower initial dose and titrated upwards based on tolerability). Although outcomes varied between studies, sputum conversion was a common outcome investigated, reported at a rate of 18% to 68%. Limitations of the studies are the retrospective and single-arm design, difficulty in standardising multi-drug regimen within studies, unstandardised criteria for efficacy or reporting of microbiological data, variation in dosing regimes of amikacin used amongst studies, and lack of a pre-defined primary outcome.

One study by Kang et al analysed data from a prospective observational registry to assess the safety and efficacy of parenteral amikacin administered via nebulisation for patients with NTM-PD caused by *M. massiliense* or *M. abscessus* (n=82). An outcome of interest includes sputum culture conversion at 12 months (defined as at least 3 negative cultures 4 weeks apart), which was achieved in 56 patients (68%). Other outcomes include microbiologic cure (maintaining negative cultures after 12 months) in 55 patients (67%), clinical cure (improvement in symptoms without available cultures) in 6 patients (7%), and symptomatic improvement seen in 72 patients (88%). Whilst data was taken from a prospective registry with standardised eligibility criteria and outcomes could be pre-defined, there were several limitations (such as not being powered to statistically analyse the data, and the risk of bias in the study design).

A NICE evidence review of the licensed formulation was available, and described the supporting evidence for amikacin liposomal suspension (ALIS) from Griffith et al (2018) in adults with non-cystic-fibrosis lung disease caused by M. avium complex. The primary endpoint, sputum culture conversion by month 6, was significantly better with ALIS compared to standard of care alone (29.0% vs 8.9%; adjusted OR = 4.22 [95% CI 2.08 to 8.57]). ALIS had a significantly better sustained improvement 3 months after treatment stopped compared with standard of care alone (16.1% vs 0% [p<0.0001]). As outlined by NICE, limitations of the RCT include that it was an open-label study with a high risk of bias, patients may have received inadequate treatments prior to study entry, and on-treatment sputum culture conversion remained uncertain. The Committee were informed that product licensing was restricted to adult patients with non-cystic-fibrosis lung disease caused by M. avium complex only.

In terms of safety, ALIS is known to cause nephrotoxicity and ototoxicity. Similarly, the parenteral preparation administered via nebulisation demonstrated a risk of nephrotoxicity and ototoxicity. Safety data between the preparations could not be compared, although it was assumed that nebulised amikacin would carry a substantially lower risk of serious adverse effects compared to intravenous amikacin.

In terms of budget impact, ALIS is expected to cost up to an additional £295,000 for 31 patients per annum, as compared to £22,500 if the parenteral preparation was administered via nebulisation.

The Committee heard from Dr Booth that NTM-PD is a severe condition experienced by patients with limited treatment options. Nebulised amikacin is an option in guidelines from the British Thoracic Society (which was produced prior to the licensed ALIS coming to market, hence the preparation being recommended was parenteral amikacin used off-label). ALIS is currently not cost-effective and is only licensed for the treatment of M. avium complex, hence any use for other mycobacterial infections would also be considered off-label. Dr Booth has used parenteral amikacin off-label via IFR requests in the past and has experience in its use, and demonstrated a guideline to support its use from community TB centres.

In camera, the Committee considered that there is a place in the treatment pathway for nebulised amikacin for a subset of patients with NTM-PD, and considered that only one product should be kept to reduce risk and improve familiarity with administration. ALIS was deemed not to be a cost-effective use of NHS resource. Due to experience (both locally and nationally) with the parenteral product administered via nebulisation, the Committee accepted that it is currently the most appropriate treatment option to address an unmet need, and were reassured with the supportive guideline produced. However, if the licensed ALIS product became cost-effective in the future, then this would be the preferred option (e.g., via NICE technology appraisal process).

In summary, the Committee agreed to add parenteral amikacin administered via nebulisation to the NCL Joint Formulary for adult patients with severe NTM-PD and limited treatment options.

Decision: Approved
Prescribing: Secondary care only
Tariff status: In tariff
Funding: Trust
Fact sheet or shared care required: N/A

9. Proposal for a pilot penicillin de-labelling programme (Presented by Ms P Panesar, Ms M Lanzman and Mr T Azamgarhi)

The Committee reviewed a proposal for a pilot penicillin de-labelling programme. The service is proposed to operate initially from UCLH, RFL and RNOH, assessing the feasibility of implementing a pharmacist led penicillin de-labelling programme for low-risk patients. The protocol was developed with NCL antimicrobial pharmacists, microbiology and allergy consultants, with stakeholder engagement including CCG HoMMs and Medicine Safety Officers. The Committee were very supportive of the pilot, but encouraged the authors to engage with other sites in NCL to assess whether broader implementation across NCL Trusts would be feasible, with local governance sign-off and oversight from NCL MOC.

10. Update: Guidance for the implementation of flash glucose monitoring prescribing in NCL

The Committee approved an update to the criteria for flash glucose monitoring prescribing in NCL to allow initiation in people with type 1 or insulin treated type 2 diabetes who are recorded on their GP Learning Disability register as living with learning disabilities, in line with the June 2020 NHSE/I funding statement update.

11. Review of JFC Terms of Reference

The Committee were asked to review the interim update of the NCL JFC Terms of Reference and submit and comments to the JFC support team by the end of November. Thereafter the documents will be updated and ratified via Chair's action.

12. NCL psoriasis pathway

An update to the NCL adult high-cost drug treatment pathway for psoriasis was approved, to include bimekizumab as per NICE TA723.

13. Update: Ronapreve for patients with confirmed SARS-CoV-2 infection who are hospitalised for a reason other than COVID-19

The Committee ratified approval of casirivimab/imdevimab (Ronapreve) for high-risk patients with confirmed SARS-CoV-2 infection who are 'hospitalised for a reason other than COVID-19' in line with the NHSE/I commissioning policy.

14. Updated NPIS antidotes list

The Committee were presented with an updated NPIS antidotes list and were informed of the added and removed antidotes. The Committee agreed that Trusts should update their stock lists to include those within category A (i.e., kept within the emergency department) and category B (i.e. required to be accessible within one hour). NetFormulary would be updated with the amended list and those listed within category C (i.e. antidotes kept supra-regionally) would be updated with instruction of how to procure out of working hours.

15. Any Other Business

The Committee thanked Prof Sofat for her outstanding leadership as Chair of the JFC and wished her well in her new role.

16. Next meeting

Thursday 21st January 2022