Joint Formulary Committee (JFC): Minutes

Minutes from the meeting held on 24th April 2025

		Present	Apologies
Members			
Prof A Hingorani (Chair)	NCL JFC Chair	✓	
Dr B Subel	NCL JFC Vice Chair	✓	
Ms L Coughlan	NCL ICB, Deputy Chief Clinical Officer & ICS Chief Pharmacist	✓	
Ms W Spicer	RFL, Chief Pharmacist	✓	
Dr P Jasani	RFL, DTC Chair		✓
Dr K Boleti	RFL, DTC Chair		✓
Dr A Scourfield	UCLH, DTC Chair		✓
Mr J Harchowal	UCLH, Chief Pharmacist	✓	
Dr K Tasopoulos	NMUH, DTC Chair	✓	
Ms S Stern	NMUH, Chief Pharmacist	✓	
Dr M Kelsey	WH, DTC Chair		✓
Mr S Richardson	WH, Chief Pharmacist	✓	
Dr S Ishaq	WH, Consultant Anaesthetist		✓
Dr A Worth	GOSH, DTC Chair		✓
Ms J Ballinger	GOSH, Chief Pharmacist		✓
Dr M Henley	RNOH, DTC Chair	✓	
Mr A Shah	RNOH, Chief Pharmacist	✓	
Prof A Tufail	MEH, DTC Chair	✓	
Ms N Phul	MEH, Chief Pharmacist		✓
Ms L Reeves	NLMHP, Chief Pharmacist		✓
Dr L Waters	CNWL, Consultant Physician in HIV		✓
Ms R Clark	NCL ICB, Assistant Director of Medicines Optimisation	✓	
Ms M Kaur-Singh	NCL ICB, Head of Medicines Planning & Operations		✓
Ms EY Cheung	NCL ICB, Head of Quality and Improvement	✓	
Ms K Petrou	NCL ICB, Community Pharmacy Clinical Lead		✓
Dr S Ghosh	Enfield Unity PCN, Clinical Director; Enfield GP Federation, Co-Chair	✓	
Dr D Heaney	UCLH, Consultant Neurologist		✓
Mr S Jenkinson	RFL, Lead Pharmacist Cancer Services		✓
Attendees			
Ms C Tse	IPMO Programme Team, JFC Principal Pharmacist	✓	
Ms K Leung	IPMO Programme Team, JFC Senior Pharmacist	✓	
Ms M Darjee	IPMO Programme Team, JFC Senior Pharmacist	✓	
Ms M Butt	IPMO Programme Team, Director	✓	
Ms S Amin	IPMO Programme Team, Lead Pharmacist	✓	
Ms I Samuel	RFL, Formulary Pharmacist	✓	
Mr H Shahbakhti	RFL, Formulary Pharmacist	✓	
Mr A Barron	UCLH, Principal Pharmacist	✓	
Mr S O'Callaghan	UCLH, Formulary Pharmacist	✓	
Ms H Thoong	GOSH, Formulary Pharmacist	✓	
Mr D Sergian	MEH, Formulary Pharmacist	✓	
Mr W Li	MEH, Formulary Pharmacist	✓	
Ms J Bloom	MEH, Associate Chief Pharmacist	✓	
Ms A Bathia	RNOH, Formulary Pharmacist	✓	

Ms S Ahmed	WH, Formulary Pharmacist		✓
M A Sehmi	NMUH, Formulary Pharmacist		✓
Ms Y Lam	UCLH, Formulary Pharmacist		✓
Ms M Thacker	GOSH, Deputy Chief Pharmacist		✓
Mr J Modha	NHSE, Specialised Commissioning Pharmacist		✓
Ms A Blochberger	NHSE, Chief Pharmacist – Specialised Commissioning	✓	
Mr J Flor	WH, Lead Pharmacist		✓
Ms R Allen	UCLH, Commissioning Pharmacist		✓
Mr A Fazal	RFL, Principal Pharmacist	✓	
Mr G Grewal	RFL, Deputy Chief Pharmacist		✓
Ms J Collins	WH Rotational Pharmacist	✓	
Ms C Weaver	NCL ICB, Senior Prescribing Advisor – Quality and Improvement	✓	
Dr R Maclean	UCLH, Clinical Pharmacology Specialist Registrar	✓	
Mr L Nicholson	MEH, Consultant Ophthalmologist	✓	
Mr D Hanumunthadu	RFL, Consultant Ophthalmologist	✓	
Dr T Davidson	UCLH, Post-CCT Clinical Fellow Paediatric and Adolescent Gynaecology	✓	
Ms J Pang	IPMO Programme Team, Lead Pharmacist (Observer)	✓	
Mr K Simpson	IPMO Programme Team, Principal Population Health Analyst (Observer)	✓	

2. Meeting attendees

Prof Hingorani welcomed members, observers, and applicants to the meeting (see above).

3. Members' declaration of interests

The Declarations of Interests register for Committee members was included for information. No further interests relevant to the agenda were declared by members or attendees present. Mr Nicholson and Mr Hanumunthadu declared interests from the manufacturer for Eylea® (aflibercept) (Bayer) and Vabysmo® (faricimab) (Roche).

4. Minutes and abbreviated minutes of meetings on 20th March 2025

Minutes and abbreviated minutes of the 20th March 2025 meeting were ratified.

5. Review of action tracker

Action tracker included for information. Closed actions have been updated on the tracker.

6. JFC Outstanding items and workplan

These items were included for information only. Any questions should be directed to Ms Tse.

7. Local DTC recommendations/minutes

Date	Drug and Indication	DTC Decision and Details	JFC recommendation
February 2025	Indocyanine Green (Verdye®) for visualisation of multiple structures	**Reviewed by**: RFL **Drug:** Indocyanine Green (Verdye®) **Indication:** visualisation of multiple structures **Decision:** Approved **Prescribing status**: Restricted to secondary care only **Funding source:** Divisional budget **Additional information:** Develop a suitable consenting process to inform patients that ICG is unlicensed and informing them of the risk of anaphylaxis. **Fact sheet or Shared Care required:** N/A	**To add to the NCL Joint Formulary**

*Subject to funding consideration; †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. Matters arising

8.1. JFC Terms of Reference – Voting procedure

The Committee reviewed changes made to the NCL JFC Terms of Reference. The key updates include:

- Section 6: Requirement for JFC members, including the Chair and Vice Chair to attend at least 80% of the scheduled meetings within any 12-month period, and
- Section 11: Details regarding the voting process for new medicine decisions.

The updated JFC Terms of Reference will be circulated for consultation and the Committee was invited to send any comments back to the JFC secretariat team within 2 weeks.

9. Medicine Reviews

9.1 Drospirenone for menstrual dysfunction in adolescents and management of androgen excess (Applicants: Dr H Learner (in absentia), Dr T Davidson; UCLH)

The committee considered an off-label application for drospirenone (Slynd®), a fourth-generation progestin and spironolactone analogue for the treatment of menstrual dysfunction and androgen excess in adolescents where desogestrel (DSG) or combined hormonal contraceptives (CHC) are ineffective or contraindicated. Drospirenone is licensed for contraception at the dose of one tablet (4mg) to be taken daily for 28 consecutive days: one white (active) tablet daily during the first 24 days and one green (inactive or placebo) tablet during the following four days, known as the 'hormone-free interval'.

At UCLH, 110 adolescent patients have been seen to date with menstrual dysfunction, featuring symptoms such as heavy menstrual bleeding, irregular periods, painful periods, learning needs associated with distress from menses, premenstrual syndrome, and premenstrual dysphoric disorder. Common features of androgen excess in adolescents include hirsutism and irregular cycles. The most prevalent cause is polycystic ovary syndrome (PCOS), affecting approximately 6-10% of adolescent girls, while congenital adrenal hypertrophy (CAH) occurs in about 0.1%.

The applicants suggest that the main contraindications to CHC in this cohort include raised BMI, migraine, congenital cardiac disease, significant family history of VTE, prescription of enzyme inducing medications, SLE and vasculitis. The current treatment pathway for menstrual dysfunction in adolescents commences with CHC as first line treatment, followed by desogestrel (progestin only) as the second- line treatment and levonorgestrel Intrauterine system (LNG-IUS, Mirena®) or depo- medroxyprogesterone as the third-line treatment. The proposed place in therapy for drospirenone is as a third-line alternative to LNG-IUS (Mirena®) or depo-medroxyprogesterone.

For the treatment of androgen excess in adolescents, the current pathway includes CHC and lifestyle measures as first-line treatment, with eflornithine (Vaniqa®) or spironolactone as second-line treatment options. drospirenone is proposed as second-line treatment for this indication.

The benefits of drospirenone over LNG-IUS include avoiding invasive procedures, lowering the risks of IUS insertion, and removing the need for general anaesthetic and theatre time. Unlike depo-medroxyprogesterone (DPMA), drospirenone does not lead to accelerated bone loss and has no significant adverse effects on bone mineral density. DMPA can cause weight gain, particularly in overweight adolescents. Spironolactone carries risks such as hypotensive symptoms, irregular bleeding, and teratogenic potential (feminising male offspring), necessitating reliable contraception and follow-up appointments with a paediatric endocrinologist to monitor treatment. Eflornithine is less effective than drospirenone in treating menstrual dysfunction and drospirenone also addresses other features of androgen excess beyond hirsutism.

Drospirenone is not specifically recommended in any national, international, or societal guidelines in relation to adolescent patients.

Garbo et al (2025, n=136) conducted a retrospective chart review in adolescent patients prescribed continuous oral drospirenone for menstrual suppression. The study examined improvement in menstrual symptoms, reasons for discontinuation, and the frequency of breakthrough bleeding and other side-effects. The participants included adolescent patients with dysmenorrhea (n = 80/136) and endometriosis (n = 61/136). The results showed that pelvic pain or dysmenorrhea resolved or improved in 84.6% (44/52) of dysmenorrhea patients. Regarding adverse effects, approximately 41.3% of patients reported breakthrough bleeding on drospirenone (n = 48/116) and 22.4% (n = 26/116) discontinued drospirenone during the study period. Among those who discontinued DRSP-C, the most common reason was breakthrough bleeding (42%, n = 11/26). The

study concluded that drospirenone is a viable option for menstrual suppression in adolescents. The limitation to this study was that it was not a randomised clinical trial and had no comparator arm.

Palacios et al (2019, n=1190) a phase 3, randomised, double-blind, active controlled trial that investigated a reduction in bleeding or spotting among females aged 18 to 45 with a chance of pregnancy The primary endpoint of the study was the contraceptive effectiveness of drospirenone compared to desogestrel. Although the primary endpoint was not directly related to menstrual dysfunction in adolescents, the study reported that the median number of total bleeding days per cycle was 10 days for drospirenone compared to 12 days for desogestrel ($p < 0.05$) between cycle 2-4, with no significant difference between the two arms for cycle 7-9.

In terms of safety, Apter et al (2020, n=102) reported 42 treatment related adverse drug events, with 5% of patients discontinuing treatment due to irregular bleeding. Addtionally, 22.5% (23/102) reported mood changes, reproductive system disorders or breast disorder events following treatment with drospirenone. There were no cases of VTE, or hyperkalaemia reported in this study. The side effects reported in Palacios et al and Kimble et al were mostly known side effects of POPs, such as headache, acne, and irregular bleeding patterns. Palacios et al reported one patient with an elevated potassium level of 5.7 mmol/L following completion of the study treatment with drospirenone. However, the patient did not present with any clinical signs of hyperkalaemia, and the condition resolved within a week without medical intervention. Kimble et al reported five cases of asymptomatic hyperkalaemia, defined as two serum potassium measurements higher than the reference range of 3.5–5.3 mmol/L. Palacios et al did not perform any routine blood tests, whereas Kimble et al checked urea and electrolytes (U&Es) of each patient every cycle.

In terms of convenience, drospirenone offers a longer missed pill window of 24 hours compared to other progestin options. It also provides an alternative oral treatment for patients who prefer not to undergo LNG-IUS insertion under anaesthesia.

In terms of budget impact, drospirenone is more costly than other POPs. In 2024, 550 adolescent patients were seen by UCLH adolescent gynaecology service with menstrual dysfunction including PCOS. Of these, 100 patients were recommended drospirenone and 150 patients were considered for commencement of treatment with drospirenone. Therefore, is it estimated that 100 to 250 patients per annum would be treated with drospirenone resulting in a cost pressure of approximately £6000-£15,000 for this cohort of patient.

The Committee heard from Dr Davidson that although drospirenone is considered a third-line treatment, factors such as clinical history, contraindications and patient choice are also considered when offering contraception or hormonal treatment options. The menstrual dysfunction service for adolescents at UCLH is well-established, and the use of oral contraception is supported nationally by guidelines from the British Society for Paediatric & Adolescent Gynaecology (BritSPAG). Dr Davidson mentioned that at a recent conference in March, drospirenone was recommended as a treatment option for adolescents with menstrual dysfunction. She clarified that the service at UCLH caters to adolescent patients aged 12 to 18 years old. Dr Davidson also shared plans to collaborate with the endocrinology team, particularly for patients with PCOS. The Committee were informed that the stopping criteria would include a lack of improvement in symptoms of menstrual dysfunction, side effects such hyperkalaemia although rare in this cohort, intolerance, or contraindication to the medicine.

In camera, the Committee discussed offering drospirenone to this cohort based on its known pharmacological action rather than results from randomized clinical trials. This approach aims to limit the use of invasive treatment and reduce procedural time in the theatre. The Committee also addressed the need for additional monitoring requirements and the impact on prescribing in primary care, given drospirenone is off-label for this indication.

The Committee agreed to approve the use of drospirenone for adolescents for the treatment of menstrual dysfunction and androgen excess, pending confirmation of the place in therapy as a third-line alternative to LNG-IUS (Mirena®) or depo-medroxyprogesterone for the indication of contraception; and as a second-line treatment option for the indication androgen excess, replacing spironolactone. Approval is also contingent on development of a patient information leaflet, which is to highlight the off-label use and any additional monitoring requirement for primary care.

Drug: Drospirenone (Slynd®); off-label; 4mg daily
Indication:

1. Treatment of menstrual dysfunction in adolescents where treatment with desogestrel (DSG) or combined hormonal contraceptives (CHC) are ineffective or contraindicated.
2. Treatment of androgen excess where combined hormonal contraceptive (CHC) is contraindicated or not tolerated.

Decision: Approved for menstrual dysfunction as a third-line alternative to LNG-IUS (Mirena®) or depo-medroxyprogesterone and approved for androgen excess as second-line treatment pending development of an information leaflet for prescribing in primacy care (information on off–label use and additional monitoring requirement such drug interactions and side effects).
Prescribing status: Suitable for secondary care initiation, primary care continuation
Funding source: In tariff
Fact sheet or shared care required: N/A
Additional information: Nil

9.2 nAMD HCD Pathway – First-line anti-VEGF treatments, and positioning of bevacizumab gamma and brolucizumab as third-line anti-VEGF treatments (Applicants: Mr Nicholson, MEH; Mr Hanumunthadu, RFL; Mr Haris Papanikolaou (in absentia), RFL)

The Committee reviewed the rationale and evidence underpinning the proposed changes to the NCL High-Cost Drug pathway for neovascular age-related macular degeneration (nAMD). nAMD is a serious eye condition characterised by the growth of abnormal blood vessels in the retina, leading to leakage and macular scarring. It is the leading cause of blindness in people over 60 years of age and affects over 700,000 people in the UK. The primary treatment for nAMD is vascular endothelial growth factor (VEGF) inhibitors, which bind to circulating VEGF, thereby inhibiting the growth of new blood vessels.

The key updates for the NCL nAMD pathway for patients with best-corrected visual acuity (BCVA) between 6/12 and 6/96 include:

- The preferential use of aflibercept 2mg as first-line treatment
- Faricimab as an alternative first-line treatment for patients requiring reduced treatment burden, and
- Bevacizumab gamma and brolucizumab as third-line treatment options.

Anti-VEGF treatments for nAMD with positive NICE recommendations include: Ranibizumab (TA 155, 2008), aflibercept 2mg (TA 294, 2013), brolucizumab (TA 672, 2021), faricimab (TA 800, 2022), and bevacizumab gamma (TA 1022, 2024). These agents are administered as intravitreal injections by clinicians in - secondary care setting. Evidence indicates that these NICE-recommended treatments are broadly equivalent in efficacy, though they differ in dose, frequency, and scheduling. Therefore, decisions on the positioning and sequencing of anti-VEGF agents should consider cost, frequency of dosing, and safety profiles. The Committee were informed that anti-VEGF treatments were high-cost and high-volume drugs.

9.2.1 Preferential use of aflibercept 2mg as first-line treatment

Heier et al (2012, n= 2419), a double-masked, multicentre, parallel-group, active-controlled, randomised non-inferiority trial investigated the efficacy and safety of aflibercept 2mg in nAMD compared to ranibizumab. The primary outcome measure was non-inferiority (margin of 10%) of aflibercept regimens to ranibizumab in the proportion of patients maintaining vision at week 52. The study reported that the aflibercept groups were non-inferior and clinically equivalent to ranibizumab; with similar adverse event profiles reported across both treatment groups.

In terms of convenience, aflibercept 2mg requires, on average, 6 fewer injections compared to ranibizumab biosimilar over a 3-year period. The benefits of this reduced injection frequency include improved capacity for ophthalmology services, and a reduced burden for patients and caregivers.

In terms of cost, ranibizumab biosimilar has a lower acquisition cost compared to aflibercept (prices redacted due to confidentiality). The use of aflibercept incurs additional costs of approximately £3000 per patient over three years, including appointment costs. However, the patent for aflibercept 2mg expires in November 2025, with biosimilars expected to be available from December 2025. The Committee was informed that the proposal to preferentially use aflibercept 2mg align with existing practice in NCL.

9.2.2 Faricimab as an alternative first-line treatment for patients requiring reduced treatment burden

Faricimab is the first bispecific monoclonal antibody that targets both the vascular endothelial growth factor and angiopoietin 2. Heier et al (2022, n=1329), TENAYA and LUCERNE were two randomised, multicentre, active comparator-controlled, double-masked, parallel-group, 112-week trials that investigated the efficacy, durability, and safety of intravitreal faricimab up to every 16 weeks in comparison to aflibercept. The primary endpoint was the mean change in best-corrected visual acuity (BCVA) from baseline averaged over weeks 40, 44, and 48 (with a prespecified non-inferiority margin of four letters), in the intention-to-treat population. The study reported that TENAYA and LUCERNE met their primary endpoint, with the mean change from baseline

in BCVA at primary endpoint visits for faricimab administered at fixed intervals of up to every 16 weeks being non-inferior to aflibercept administered every 8 weeks. Faricimab demonstrated sustained efficacy with extended fixed treatment intervals of every 16 weeks, addressing a key unmet need for effective, it is a more durable therapy that optimise clinical benefits while reducing overall visit and treatment burden.

In terms of convenience, faricimab requires 8 fewer injections compared to ranibizumab biosimilar and 2 fewer injections compared to aflibercept. The durability effect of faricimab aids reduce injection frequency, providing benefits such as reduced patient and caregiver burden and improved service capacity. As first –line treatment option, faricimab is reserved for patients with advanced dementia, learning difficulties that impact treatment regimen, those requiring hospital transport or treatment under sedation or general anaesthesia in theatre or patients with co-morbidities necessitating frequent hospital appointments or inpatient admissions.

In terms of cost, faricimab has a similar acquisition cost compared to aflibercept however, it is more costly than ranibizumab biosimilar. Faricimab is expected to go off patent in 2034.

9.2.3 Bevacizumab gamma and brolucizumab as third-line treatment options

Bevacizumab gamma (Lytenava®) is licenced and has a positive NICE technology appraisal for use in nAMD. Rahhal et al (2025, n=228) NORSE TWO is a prospective, phase 3, randomised, multicentre, double-masked, active-controlled study that investigated the efficacy and safety of bevacizumab gamma in comparison to ranibizumab in nAMD. The primary end point was the proportion of patients who gained ≥ 15 letters from baseline in BCVA at 11 months, along with evaluating the safety and tolerability of monthly intravitreal injections of bevacizumab gamma administered monthly from baseline to 12 months. The study reported bevacizumab gamma was superior to ranibizumab and displayed a comparable safety profile.

In terms of convenience, bevacizumab gamma required an average of 6 further injections compared to aflibercept 2mg over a 3-year period. The need for more injections to achieve the desired therapeutic outcome increased the treatment burden on patients and caregivers. Therefore, bevacizumab gamma is reserved as a third-line treatment option for patients at risk of intraocular inflammation, such as those with a history of uveitis, or previous inflammatory reaction to first- or second-line treatment.

Brolucizumab is an effective treatment options for nAMD and exhibits equivalent efficacy as aflibercept. Dugal et al (2020, n=1817) HAWK and HARRIER were two randomised, double-masked, multicentre, active-controlled trials that investigated the efficacy and safety of brolucizumab compared to aflibercept. The primary endpoint of both trials was to demonstrate noninferiority of brolucizumab to aflibercept in BCVA change from baseline to Week 48. The study reported that at week 48, brolucizumab demonstrated noninferiority to aflibercept in BCVA change from baseline.

In terms of safety, HAWK and HARRIER trials reported that the rate of adverse effects with brolucizumab was similar to aflibercept; however, there were safety concerns, particularly the risk of intraocular inflammation and retinal vasculitis associated with brolucizumab. The MERLIN trial was a non-inferiority, phase 3, randomised, multicentre, double-masked study, reported that the incidence of intraocular inflammation (IOI), including retinal vasculitis and retinal vascular occlusion, was higher for brolucizumab at 11.5% (0.8% and 2.2%) versus 6.1% (0% and 0.6%) for aflibercept. Additionally, there was a higher frequency of visual loss (15 letters or more) in the brolucizumab arm (4.8%) compared to the aflibercept arm (1.7%). In 2022, the MHRA published an alert stating that the risk of intraocular inflammation and retinal vascular occlusion increases with short dosing intervals. For this reason, brolucizumab is reserved as a third-line treatment option for patients experiencing worsening vision with early reactivation or persistent disease activity, or for patients who fail to achieve the desired therapeutic outcome despite optimum treatment with first- and second-line treatments.

The Committee heard from Mr Nicholson and Mr Hanumunthadu that anti-VEGF treatments are administered intravitreally in a sterile environment which can be distressing for patients and their caregivers. The pathway and placement of treatments should include strategies to reduce injection frequency, thus, optimising treatment outcomes and compliance. The Committee was also informed about capacity concerns due to challenges in training staff to administer treatments. Mr Nicholson explained that treating nAMD requires a patient-focussed approach, as the disease varies widely, and treatment extension differs from patient to patient. Licensing trials detail the maximum treatment intervals for each drug, however, in practice, patients cannot reach the upper limits without experiencing a decline in visual acuity.

In camera, the Committee discussed several concerns:

i) The pan-London (NHS London Procurement Partnership, LPP) pathway was published in March 2025 and the NHS England pathway is expected to be published by end of May 2025. There were concerns

regarding potential unwarranted variation in practice and the impact the NCL nAMD pathway may have on MEH satellite sites across London.

ii) Uncertainty regarding service delivery capacity across NCL ophthalmology units.

iii) The proportion of patients maintained on faricimab at 16-weekly dosing regimen.

iv) The cost modelling data presented did not reflect the cost-saving and benefits realised in practice, as treatment effects in real-world settings were smaller than those reported in clinical trials.

v) The positioning of faricimab compared to aflibercept 8mg, which was not subject to evaluation by NICE.

In summary, the Committee agreed to defer their decision on the proposed changes to the NCL nAMD pathway pending the relevant evidence reviews of all lines of treatment at the subsequent JFC meeting. The specific questions raised in camera will also be addressed at the next meeting.

10. Position statements and guidelines

11. Sub-Group Updates

11.1 NICE TA Implementation Group Report

The Committee heard from Ms Weaver who provided a summary of updates from the NICE TA Implementation Group. The Committee noted the current workplan, which was included in the agenda pack for information. This workplan covers the ongoing implementation of atogepant for migraine prevention (NICE TA973), including the development of the primary care pathway. Additionally, a proposal is being drafted to use vibegron (NICE TA999) as the first-line treatment for overactive bladder syndrome. Regarding 12 SQ-HDM SLIT (Acarizax) for allergic rhinitis and allergic asthma caused by house dust mites (NICE TA1045), the JFC has previously reviewed Acarizax as part of the immunotherapy treatment pathway. Therefore, the NCL JFC formulary position will be updated to reflect the NICE recommendation.

11.2 NCL Pathways Group

Nil

11.3 Shared Care Group Updates

The Committee was informed that Shared Care Group meetings occur bi-monthly, with no meeting held in March and May. The next Shared Care Group meeting is scheduled for Tuesday 10th June 2025.

The current workplan includes presenting the new governance proposal to Medicines Clinical Reference Group (MCRG) for approval in May, forming a working group to adopt LPP's RAG rating standardisation and establishing amber drug tier assessment criteria. Following these steps, the Group will review and re-categorise existing interface documents to implement the new governance concept and RAG definitions.

12 Next meeting

Thursday 15th May 2025

13 Any other business

Nil