North Central London Integrated Care System

NHS
North Central London
Medicines Optimisation Network

Joint Formulary Committee (JFC): Minutes

Minutes from the meeting held on 19th March 2026

		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	✓	
Dr A Scourfield	UCLH, DTC Chair		✓
Mr J Harchowal	UCLH, Chief Pharmacist		✓
Mr A Barron	UCLH, Deputy Chief Pharmacist (deputising for J Harchowal)	✓	
Ms W Spicer	RFL, Chief Pharmacist	✓	
Dr J Cross	RFL, DTC Chair		✓
Dr P Jasani	RFL, DTC Deputy Chair		✓
Dr K Boleti	RFL, DTC Deputy Chair		✓
Dr K Tasopoulos	RFL, DTC Deputy Chair	✓	
Ms S Stern	RFL, Deputy 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 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 S Sanghvi	IPMO Programme Team, JFC Principal Pharmacist	✓	
Ms K Leung	IPMO Programme Team, JFC Senior Pharmacist	✓	
Ms S Maru	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	✓	
Ms N Patel	RFL, Formulary Pharmacist	✓	
Mr S O'Callaghan	UCLH, Formulary Pharmacist	✓	
Mr D Sergian	MEH, Formulary Pharmacist	✓	
Mr W Li	MEH, Formulary Pharmacist	✓	
Ms A Bathia	RNOH, Formulary Pharmacist	✓	
Mr J Flor	WH, Lead Pharmacist	✓	
Mr A Fazal	RFL, Principal Pharmacist	✓	
Ms J Modha	NHSE, Specialist Commissioning Pharmacy Advisor	✓	

Ms H Shah	NCL ICB, Senior Prescribing Advisor – Quality & Improvement	✓	
Ms A Farook	NCL ICB, Prescribing Support Pharmacist	✓	
Dr J Lambert	UCLH, Consultant Haematologist	✓	
Dr H Richards	RFL, Consultant Haematologist	✓	
Ms E Green	UCLH, Clinical Pharmacist	✓	
Dr M Castelino	UCLH, Consultant Rheumatologist	✓	

2. Meeting attendees

Prof Hingorani welcomed members, observers, and applicants to the meeting (see above). The Committee noted that Dr Samina Ishaq (WH, Consultant Anaesthetist) and Dr Michael Kelsey (WH, DTC Chair) are retiring in March 2026 and will step down from their roles. The Committee thanked Dr Ishaq and Dr Kelsey for their valuable contributions to the Committee over the years and wished them a restful retirement. Dr Halima Amer has been appointed as the WH DTC Chair from April 2026 and will join JFC as a member accordingly.

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.

4. Minutes and abbreviated minutes of meetings on 19th February 2026

Minutes and abbreviated minutes of the 19th February 2026 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 Sanghvi.

7. Local DTC recommendations/minutes

Date	DTC Decision and Details	JFC recommendation
February 2026	**Reviewed by:** UCLH **Drug:** Granisetron transdermal patch **Dose:** 3.1mg/24 hour patch applied for up to 7 days (removed at least 24 hours after completing chemotherapy) **Indication:** Patients with refractory CINV and prolonged QTc who have not achieved adequate symptom control with cyclizine and aprepitant, referred to palliative care, and other causative factors of QT prolongation have been fully explored and mitigated. **Decision:** Approved **Prescribing status: [RED]** Restricted to secondary care only (on the advice of palliative care) **Funding source:** In tariff **Additional information:** Nil	**To add to the NCL Joint Formulary**
February 2026	**Reviewed by:** UCLH **Drug:** Tisotumab vedotin **Dose:** As per license **Indication:** Second line treatment option for adult female patients with persistent, recurrent or metastatic cervical cancer **Decision:** Approved **Prescribing status: [RED]** Restricted to secondary care only **Funding source:** Free of charge scheme **Additional information:** Nil	**To add to the NCL Joint Formulary**
February 2026	**Reviewed by**: UCLH **Drug:** Venetoclax in combination with high-intensity chemotherapy regimens **Dose:** 50 to 100mg daily for 7 days (up to 2 cycles) **Indication:** Relapsed refractory T-ALL in transplant eligible patients **Decision:** Approved	**To add to the NCL Joint Formulary**

	Prescribing status: [RED] Restricted to secondary care only **Funding source:** Internally funded high cost drug **Additional information:** Nil **Drug:** Venetoclax in combination with non-intensive chemotherapy regimens **Indication:** Relapsed refractory T-ALL in patients not eligible for transplant **Decision:** Not approved	
February 2026	**Reviewed by**: UCLH **Drug**: MMRV (measles, mumps, rubella and varicella vaccine) **Indication**: As part of the childhood vaccination schedule (instead of MMR) **Decision**: Approved in line with JCVI recommendations **Prescribing status**: **[GREEN]** Suitable for initiation in primary and secondary care **Funding source**: In-tariff **Additional information:** Nil **Drug**: Prevenar (PCV20 pneumococcal vaccine) **Indication**: As part of the adults over 65 years and at-risk programme and expected to replace Pneumovax 23 (PPV23) in late 2025/early 2026 **Decision**: Approved in line with JCVI recommendations **Prescribing status**: **[GREEN]** Suitable for initiation in primary and secondary care **Funding source**: In-tariff **Additional information:** Nil	**To add to the NCL Joint Formulary**
November 2025	**Reviewed by**: RFL **Drug:** Vancomycin topical application **Dose:** To soak the ACL graft in a solution of 200mls of saline, with Vancomycin at a concentration of 5mg per ml for 20 minutes. **Indication:** To soak anterior cruciate ligament grafts to reduce the incidence of post-operative infection **Decision:** Approved **Prescribing status: [RED]** Restricted to secondary care only **Funding source:** In tariff **Additional information:** Nil	**To add to the NCL Joint Formulary**
January 2026	**Reviewed by:** RFL **Drug:** Infliximab, 5mg/kg every 8 weeks after initial induction therapy **Indication:** Immune Checkpoint Inhibitor-Related Enterocolitis for continuation of treatment after the NCL JFC-approved 3-doses followed by vedolizumab thereafter **Decision:** Approved **Prescribing status: [RED]** Restricted to secondary care only **Funding source:** ICB for first 3 doses then internal Trust funding for further treatment. **Additional information:** Nil	**RFL only**
January 2026	**Reviewed by:** RFL **Drug:** Imatinib, 200-400mg daily. **Indication:** Pulmonary hypertension **Decision:** Approved **Prescribing status: [RED]** Restricted to secondary care only **Funding source:** Internal Trust funding **Additional information:** Nil	**To add to the NCL Joint Formulary**
January 2026	**Reviewed by:** RFL **Drug:** Pocapavir, 1600mg once daily **Indication:** Chronic enterovirus meningoencephalitis **Decision:** Approved	**RFL only**

	Prescribing status: [RED] Restricted to secondary care only **Funding source:** Free-of-Charge scheme **Additional information:** Review response to treatment after two weeks to decide treatment outcome. Request for a current viral PCR.	

*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. Semaglutide (Wegovy®) for managing obesity in adolescents

The Committee were informed that NCL JFC received an application from Whittington Hospital for the use of semaglutide (Wegovy®) for severe obesity in patients aged 12-18 years old. This application has support from NCL colleagues at GOSH, NMUH, RFL and UCLH.

Semaglutide is licensed for weight loss in this cohort, however the NICE Technology Appraisal (TA 910) for adolescents was terminated. This also precludes NHSE from conducting a policy review for this cohort.

The Committee noted concerns highlighted by the applicants regarding equity of access to specialist services and treatment, and EDI implications.

The Committee agreed on the following recommendations:

- NICE TAs facilitate equitable access. Novo Nordisk chose not to proceed with a NICE submission for Wegovy in adolescents as they felt the available evidence was insufficient to support economic modelling and assessment of long-term outcomes. The applicants are encouraged to raise their concerns regarding clinical unmet need and equity of access with Novo Nordisk to establish whether there are plans to gather further evidence (e.g. clinical trial) or resubmit to NICE. NCL JFC could provide a statement of support.
- JFC and NCL ICB do not consider it appropriate for the application for semaglutide for weight loss in adolescents to proceed further at a JFC or local DTC level. This is based on the terminated NICE TA, lack of specialist weight management service for adolescents in NCL and the current NCL restrictions on prescribing for adults. The applicants will be notified if that position changes.
- The application highlights a gap in specialist service provision in NCL. NCL ICB are requested to review the equity of access concerns raised by this, and review options under WNL ICB. During the current merger it has been challenging to establish the correct point of contact to take this forward, but it would be helpful for the applicants to have a named point of liaison at NCL/WNL ICB.

8.2. NCL JFC Strategic Updates

Ms Coughlan provided an update on developments with the Single National Formulary (SNF) and the merger of the NCL and North West London ICBs.

9. Medicine Reviews

9.1 [FOC Scheme] Ibrutinib in combination with chemoimmunotherapy for untreated mantle cell lymphoma (Applicants: Dr J Lambert, UCLH; Dr H Richards, RFL; Dr S Mohamedbhai, RFL (in absentia))

The Committee considered an application for a free-of-charge (FOC) scheme for ibrutinib, a small-molecule inhibitor of Bruton's tyrosine kinase (BTK), to be used in combination with immunochemotherapy, for licensed treatment of adult patients with previously untreated mantle cell lymphoma (MCL) who would be eligible for autologous stem cell transplantation (ASCT). MCL is a rare type of B-cell non-Hodgkin lymphoma, symptoms include painless nodal swelling, along with B symptoms such as night sweats, fever, and unexplained weight loss. Despite being incurable at present, treatment aims to achieve durable remission.

The proposed place in therapy for FOC ibrutinib is during R-CHOP induction (rituximab, cyclophosphamide, doxorubicin, vincristine, and prednisolone), alternating with R-DHAP (rituximab, dexamethasone, high-dose cytarabine, and cisplatin) in which ibrutinib is omitted. Responders to the induction regimen would subsequently receive a two-year maintenance course of rituximab in combination with FOC ibrutinib. The use of ibrutinib during the R-CHOP component of R-CHOP/R-DHAP induction and for 2 years maintenance in place of ASCT is recognised by the British Society of Haematology (BSH) ('Diagnosis and management of MCL Guideline', 2023), the European Haematology Association (EHA, 'EGA-EU network guidelines for the diagnosis and treatment of MCL', 2025), and the National Comprehensive Cancer Network ('NCCN Guidelines - B-Cell

Lymphomas', 2025). The Committee were informed that the use of ibrutinib for this indication is currently under review by NICE (ID 6596) with a decision expected in late 2026.

In terms of efficacy, the TRIANGLE study (Dreyling et al, 2024; n= 870), an open-label, randomised, three-arm, parallel-group, superiority trial investigated whether the addition of ibrutinib to immunochemotherapy and ASCT results in a superior clinical outcome compared with existing standard of care treatment with immunochemotherapy with ASCT or an ibrutinib-containing immunochemotherapy without ASCT. The trial recruited adults with previously untreated, Ann Arbor stage II-IV MCL suitable for ASCT with an Eastern Cooperative Oncology Group performance status of 2 or less. The three trial arms were:

- Arm A (comparator): Standard induction immunochemotherapy (R-CHOP/ R-DHAP) followed by ASCT
- Arm A+I (Experimental add-on): Ibrutinib (560mg daily) on days 1-19 of R-CHOP cycles, followed by ASCT, then maintenance ibrutinib (560mg daily for 2 years)
- Arm I (Experimental add-on without ASCT): Ibrutinib (560mg daily) on days 1-19 of R-CHOP cycles then maintenance ibrutinib (560mg daily for 2 years)

The study reported that 3-year failure-free survival was superior for group A+I (88%, 95% CI 84 – 92) compared to group A (72%, 95% CI 67 – 79) after 31 months median follow-up (HR 0.52, one-sided p= 0.0008). The Committee were informed that during the planning stages of the TRIANGLE trial, the results from the LYSA-LYMA trial (Gouill et al, 2017) were published demonstrating that rituximab maintenance therapy prolongs progression-free survival and overall survival after cytarabine-containing induction and ASCT. Consequently, the TRIANGLE trial protocol was amended to permit rituximab maintenance across all three trial arms in line with national guidelines. Rituximab maintenance treatment was adopted as standard of care in most European countries during the TRIANGLE trial, however, heterogeneity in its uptake into routine care meant that not all participants in the TRIANGLE trial received it, with approximately 56% of patients across all arms received rituximab in the maintenance treatment phase. Subgroup analyses stratified by rituximab maintenance intention-to-treat and modified as-treated did not alter the primary study findings with the study authors reporting that arm A+I remained superior to arm A.

In terms of safety, the TRIANGLE trial reported no relevant differences during the induction phase between patients treated with R-CHOP/ R-DHAP versus those treated with ibrutinib-R-CHOP/ R-DHAP across the two ASCT-containing arms. During the maintenance and follow-up phase, substantially more Grade 3-5 haematological adverse events and infections were reported after ASCT plus ibrutinib compared to ibrutinib-only group (arm I) or after ASCT (arm A).

In terms of convenience, the FOC scheme is likely to obviate the need for ASCT (although not the primary outcome of the study), which is associated with significant morbidity and prolonged inpatient admission. The Committee were informed that ASCT is an invasive, resource-intensive procedure that carries risks of infection.

The Committee heard from Dr Lambert and Dr Richards that the MCL community in the UK were supportive of adopting ibrutinib in the first-line treatment setting should it be commissioned as it reduces the need for ASCT. The Committee were satisfied that the FOC scheme complies with the NCL FOC scheme guidance and the NHSE FOC medicines scheme national policy recommendations.

In summary, the Committee agreed to approve the FOC scheme for ibrutinib in combination with immunochemotherapy for untreated MCL in line with the terms of the FOC scheme only.

Drug: [FOC Scheme] Ibrutinib; as per licensed dose
Indication: Treatment of adult patients with previously untreated MCL who would be eligible for ASCT (in combination with immunochemotherapy)
Decision: Approved
Prescribing status: Restricted to secondary care only
Funding source: Free of Charge Scheme
Fact sheet or shared care required: N/A
Additional information: N/A

9.2 NCL High-Cost Drugs Psoriatic Arthritis Pathway (Applicant: Dr M Castelino, RFL)

The Committee reviewed the rationale underpinning the proposed changes to the NCL Psoriatic Arthritis High Cost Drug Pathway which was updated in line with the NCL High-Cost Drug Commissioning Principles and reflects four new NICE TAs.

The Committee approved the following changes to the NCL Psoriatic Arthritis pathway:

- Inclusion of four new NICE TAs: upadacitinib (TA768), guselkumab (TA815), risankizumab (TA803) and bimekizumab (TA916).

- Incorporation of disease domains with corresponding treatment options as follows: i) peripheral arthritis/ enthesitis/ dactylitis, ii) axial disease, iii) moderate to severe psoriasis and iv) inflammatory bowel disease.
- Inclusion of ustekinumab biosimilar and generic apremilast.
- Use of subcutaneous instead of intravenous infliximab.
- Inclusion of British Society of Rheumatology advice on the use of TNF-inhibitors during pregnancy and breastfeeding.
- Dose escalation of secukinumab and guselkumab.
- Sequential use of bimekizumab as a second IL-17 inhibitor following primary or secondary loss of response to a previous IL-17 inhibitor (secukinumab or ixekizumab).

The Committee then considered the evidence for two changes to the pathway proposed by the NCL psoriatic arthritis short life working group (SLWG) that deviate from the NCL High Cost Drug Principles.

9.2.1 Comparative efficacy of apremilast (PDE4 inhibitor)

First, the Psoriatic Arthritis SLWG proposed reserving the use of apremilast (a low cost option) to only be used for needle-phobic patients where a JAK-inhibitor (other oral option) is contraindicated, on the basis that apremilast has inferior efficacy to other psoriatic arthritis treatments.

NICE TA433 reviewed an indirect treatment comparison to estimate apremilast's relative effectiveness compared to TNF inhibitors. The NICE committee concluded that apremilast was less effective than comparator biologics but recommended it as an alternative treatment as it is less costly than other treatments, has a different mechanism of action and can be taken orally. The Committee noted that TNF inhibitors were not the ideal comparator, and that this recommendation came before the approval of JAK inhibitors as an alternative oral option.

Additionally, network meta-analyses by Ruyssen-Witrand et al (2020) and Mease et al (2021) reported a signal for lower efficacy for apremilast, albeit with small absolute differences and wide confidence intervals. The results from these network meta-analyses are listed in section 9.2.2.

9.2.2 Comparative efficacy of Ustekinumab (IL-12/23 inhibitor)

Second, the Psoriatic Arthritis SLWG proposed placing ustekinumab last-line, due to perceived inferior efficacy to JAK inhibitors, IL-23 inhibitors and IL-17 inhibitors.

The Committee considered direct evidence comparing IL-17 inhibitors to ustekinumab including evidence from the AgAIN (2025) abstract and a retrospective cohort study by Guillaume-Letarouilly et al (2021). The Committee acknowledged that these studies were reviewed but not focused on due to limitations in the study design and relevance of the primary outcome measures.

Therefore, indirect evidence from three network meta-analyses were considered. These network meta-analyses had several limitations. They were largely based on indirect placebo-controlled comparisons. There was a variability in the timepoint of reporting outcomes (12, 16 or 24 weeks) across the included studies within each network meta-analysis which may bias results in favour of treatments that have had more time to reach their efficacy potential. There was heterogeneity in patient populations and characteristics across the included studies within each network meta-analysis. There was no differentiation by the various psoriatic arthritis domains listed within the NCL pathway.

Gao et al (2025) compared the odds ratios (95% confidence interval) of achieving an ACR20 (defined as a 20% improvement in arthritis symptoms) of various agents (IL-17 inhibitors, IL-23 inhibitors and IL-12/23 inhibitors) compared to placebo as below:

- Secukinumab 300mg Q4W (IL-17 inhibitor): 4.6 (3.6 – 5.9)
- Ixekizumab 80mg Q4W (IL-17 inhibitor): 3.9 (2.6 – 5.9)
- Bimekizumab 160mg Q4W (IL-17 inhibitor): 6.9 (5.0 – 9.6)
- Guselkumab 100mg Q8W (IL-23 inhibitor): 3.7 (2.8 – 4.9)
- Risankizumab 150mg (IL-23 inhibitor): 2.7 (2.1 – 3.5)
- Ustekinumab 90mg Q12W (IL-12/23 inhibitor): 3.4 (2.4 – 4.8)
- Ustekinumab 45mg Q12W (IL-12/23 inhibitor): 2.8 (1.9 – 4.0)

The results from this study reported small differences in the odds ratios of ACR outcomes across all treatments. The confidence intervals were wide and overlapping indicating that the findings do not provide a robust ranking of treatments.

Ruyssen-Witrand et al (2020) reported the standard deviation difference of ACR response of various agents compared to placebo in a forest plot but did not report the underlying numerical numbers. This network meta-analysis did not include all IL-23 inhibitors, bimekizumab (IL-17 inhibitor) and upadacitinib (JAK inhibitor), but included other relevant treatment options. The forest plot once again showed small differences in standard deviations and wide overlapping confidence intervals.

Mease et al (2021) reported the relative risk of achieving an ACR20 of various agents indirectly compared to guselkumab. This network meta-analysis did not include risankizumab (IL-23 inhibitor), bimekizumab (IL-17 inhibitor) and upadacitinib (JAK inhibitor). The results, reported below, once again showed only small differences in standard deviations and wide overlapping confidence intervals.

- Secukinumab 300mg Q4W (IL-17 inhibitor): 0.99 (0.80 - 1.19)
- Ixekizumab 80mg Q4W (IL-17 inhibitor): 1.02 (0.82 - 1.28)
- Tofacitinib 5mg BD (JAK inhibitor): 1.18 (0.93 – 1.49)
- Ustekinumab 90mg Q12W (IL-12/23 inhibitor): 1.18 (0.93 - 1.49)
- Ustekinumab 45mg Q12w (IL-12/23 inhibitor): 1.31 (1.02 - 1.68)
- Apremilast 30mg BD (PDE4 inhibitor): 1.46 (1.17 - 1.79)

Only apremilast and ustekinumab (45mg dose) demonstrated statistically significantly lower efficacy compared to other treatments, although the Committee questioned the clinical significance of the small absolute differences.

In terms of current use of the various treatment options (based on a point-in-time snapshot that does not account for line of therapy), the Committee was informed that TNF inhibitors (particularly adalimumab) accounted for the greatest use, followed by IL-17 inhibitors (specifically secukinumab, the higher-cost IL-17 agent). Use of IL-17 inhibitors is higher than would be preferred based on the evidence base, cost, and their positioning within the NCL pathway. Therefore, the pathway is expected to result in a substantial change in clinical practice.

The Committee also heard that there is a significant difference between current prescribing practice and the proposed audit standards as follows (noting limitations in the data available):

- 90% of patients are initiated on adalimumab first-line (currently at 49%).
- 60% of patients are initiated on a JAK inhibitor after TNF inhibitors (currently at 14%).
- 85% of patients are initiated on guselkumab after exhausting treatment options with a green and amber RAG rating for cost (currently at 7%)
- Suggested additional standard: 60% of IL-17 inhibitor prescribing is for ixekizumab as the preferred choice (currently at 10%).

The Committee heard from Dr Castelino that secukinumab was available before other IL-17 inhibitors, JAK inhibitors and IL-23 inhibitors, and there is therefore greater clinical experience and confidence in the use of secukinumab. There was some hesitancy from the clinical working group to adjust the pathway to prioritise treatments above IL-17 inhibitors, due to limited experience with alternative classes and the need to tailor treatment choices to individual patient phenotypes and comorbidities (disease domains). In addition, the clinical working group had not previously discussed a preferred IL-17, which would require greater prescribing of ixekizumab over secukinumab on the basis of cost. Dr Castelino noted that this may raise concerns, and would require further consultation, particularly in relation to any proposed audit standard. Anecdotal feedback from the clinical working group suggests that ustekinumab is perceived to have lower efficacy and is therefore used infrequently. The clinical working group are also concerned about being held to audit standards and emphasised the importance of maintaining the ability to prescribe based on clinical need rather than cost.

The Committee discussed evidence from pivotal clinical trials, noting that approximately twice as many patients achieved an ACR20 response with ustekinumab compared to placebo. IL-17 inhibitors were noted to be around 1.2 times more effective than ustekinumab, but at a substantially higher cost (11 times more expensive). Overall, the Committee considered that differences in efficacy between treatments are relatively small when compared with the differences in cost. Based on the available evidence, including network meta-analyses and real-world data, ustekinumab was considered an appropriate second-line treatment option. The Committee also noted the importance of using newer treatments, with proven efficacy and cost-effectiveness, in order to build clinical experience.

The Committee clarified that audit standards are intended to apply at a system-level rather than to individual clinicians. Where a pathway specifies an order of treatment, it is expected that a proportion of patients across NCL will be treated in line with that pathway. The audit standards are not set at 100%, to allow for flexibility

based on individual patients needs. If the proposed audit proportions are challenging to achieve, there would be an opportunity to review these in consultation with clinicians to ensure they are realistic and reflective of the local patient population. Audit standards are intended to be agreed on by clinician consensus and reviewed over time to assess progress.

In camera, the Committee discussed that ustekinumab is currently used infrequently in clinical practice, and that there is a perceived inferior efficacy that is not evidenced by the meta-analyses. Based on the evidence and NCL Commissioning Principles it would be reasonable for ustekinumab to be a second-line option within the pathway from a cost-effectiveness perspective. However, the Committee acknowledged that transitioning from low use to positioning ustekinumab as a second-line option may be challenging initially. The Committee supported a pragmatic and phased approach, working with the clinicians to balance best value with clinical acceptability. The Committee noted that there was a stronger signal for inferior efficacy of apremilast from the evidence considered. The meta-analyses did not demonstrate significant efficacy differences within drug class, and therefore, the Committee agreed that the principle of prescribing the cheapest drug within each class as a preferred option, should be encouraged, to derive best value within the treatment pathway.

In summary, the Committee agreed that the JFC and HCD teams will meet with the Psoriatic Arthritis SLWG to provide an update on the evidence evaluations and JFC discussions to date. The aim will be to clarify the evidence base and agree next steps to support a transition towards a pathway that improves value for the system while remaining clinically appropriate and implementable.

10. Position statements and guidelines

Nil

11. Sub-Group Updates

11.1. NICE TA Implementation Group Report

Nil

11.2. NCL Pathways Group

Ms Amin presented a report on the activity of the NCL Medicines Pathways Group, which was established in October 2024, as a subgroup of NCL JFC, and aimed to provide oversight and assurance of NCL HCD pathways. Since its inception, the Group has supported the update and development of HCD pathways, established a HCD pathway development flowchart to ensure standardised processes are in place across NCL, and formalised methods for developing audit standards to provide clinical and financial assurance that HCD pathways are being used as intended.

In April 2026, the HCD function will transfer from the IPMOP team back to the newly merged WNL ICB. Suggested future developments for the group are the inclusion of wider treatment pathway work, including primary care pathways, and establishing clearer lines of accountability with the NICE TA Implementation Group to streamline approval processes.

12. Next meeting

Thursday 16th April 2026

13. Any other business

Nil