North Central London
Medicines Optimisation Network

JOINT FORMULARY COMMITTEE (JFC) – MINUTES

Minutes from the meeting held on 17 June 2019
Boardroom 1st Floor, Maple House, London, W1T 7NF

Present:	Dr A Sell	RNOH, DTC Chair	**(chair)**
	Dr R MacAllister	NCL JFC Chair	**(via telephone)**
	Dr M Kelsey	WH, DTC Chair	
	Mr A Dutt	Islington CCG, Head of Medicines Management	
	Ms R Clark	Camden CCG, Head of Medicines Management	
	Ms A Fakoya	NEL CSU, Senior Prescribing Advisor	
	Mr S Richardson	WH, Chief Pharmacist	
	Ms P Taylor	Haringey CCG, Head of Medicines Management	
	Mr G Purohit	RNOH, Deputy Chief Pharmacist	
	Ms K Delargy	BEH, Deputy Chief Pharmacist	
	Mr C Daff	Barnet CCG, Head of Medicines Management	
	Mr T Dean	Patient Partner	
	Mr S Semple	MEH, Chief Pharmacist	
In attendance:	Mr A Barron	NCL MEP, Lead Pharmacist	
	Ms M Kassam	NCL JFC, Support Pharmacist	
	Mr G Grewal	NCL JFC, Support Pharmacist	
	Ms I Samuel	RFL, Formulary Pharmacist	
	Dr P Bodalia	UCLH, Principal Pharmacist	
	Ms S Sanghvi	UCLH, Formulary Pharmacist	
	Mr F Master	RFL, Formulary Pharmacist	
	Ms H Mehta	NMUH, Formulary Pharmacist	
	Dr V Talaulikar	UCLH, Associate specialist in Reproductive Medicine	
	Mr A Milligan	RFL, Clinical Nurse Specialist Skin Cancer	
	Dr S McBride	Consultant Dermatologist	
Apologies:	Ms K Davies	NEL CSU, Deputy Director Medicines Management	
	Prof D Hughes	RFL, Consultant Haematologist	
	Dr S Ishaq	WH, Consultant Anaesthetist	
	Dr R Sofat	UCLH, DTC Chair (NCL JFC Vice Chair)	
	Prof L Smeeth	NCL JFC Vice-Chair	
	Dr M Dhavale	Enfield CCG, GP Clinical Lead Medicines Management	
	Mr G Kotey	NMUH, Chief Pharmacist	
	Dr A Bansal	Barnet CCG, GP Clinical Lead Medicines Management	
	Prof A Tufail	MEH, DTC Chair	
	Mr A Shah	RNOH, Chief Pharmacist	
	Dr T Rashid	NHS Haringey, GP Clinical Lead Medicines Management	
	Mr S Tomlin	GOSH, Chief Pharmacist	
	Dr S Yardley	CNWL, Consultant in palliative medicine	
	Dr K Tasopoulos	NMUH, DTC Chair	
	Dr A Stuart	Camden CCG, GP Clinical Lead Medicines Management	
	Dr R Urquhart	UCLH, Chief Pharmacist	
	Mr P Gouldstone	Enfield CCG, Head of Medicines Management	
	Ms L Reeves	C&I, Chief Pharmacist	
	Ms W Spicer	RFL, Chief Pharmacist	

2. Meeting observers

Nil

3. Minutes of the last meeting

The minutes were accepted as an accurate reflection of the meeting

4. Matters arising

4.1 Eflornithine (Vaniqa®) for hirsutism

RFL Endocrinologists agreed with the eligibility and continuation criteria suggested by the Committee although one Consultant raised concern that retaining prescribing responsibility for the first four months until review could be problematic unless RFL pharmacy could support a four-month supply (2 x 60g tube) at the point of initiation. RFL representatives were not present for this agenda item.

4.2 Atezolizumab EAMS (in combination with nab-paclitaxel) for the treatment of unresectable locally advanced or metastatic triple-negative breast cancer

EORTC QLC-C30 data from Impassion130 trial (available as abstract only) indicated that atezolizumab had similar Quality of Life scores to placebo (both in combination with nab-paclitaxel). The Committee therefore confirmed that the EAMS should be available for patients within NCL.

4.3 Removal of dulaglutide for Type 2 diabetes from the NCL Joint Formulary

A written appeal against the removal of dulaglutide from the NCL Joint Formulary is underway.

4.4 Adult Asthma Inhaler guideline

The path for approval of Relvar was queried with a view to make this more transparent.

Post meeting note: Timeline is described below

- **Nov 2016:** JFC agreed Revlar was cost-minimising and supported its use but asked the RRP find the appropriate place in therapy (link)
- **Feb 2017:** RRP met and agreed the place in therapy (date which the Relvar guideline was updated; link)
- **May 2017:** Guideline approved (Chair's Action) and uploaded

5. JFC Work Plan & outstanding actions

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

6. Declarations of relevant conflicts of interest

No additional declarations were noted for the new medicine applications.

7. Local DTC recommendations / minutes

DTC site	Month	Drug	Indication	JFC outcome
MEH	Feb-19	Chlorhexidine 0.05% eye drops	Topical antiseptic for use prior to intravitreal injections/ implants in those intolerant to povidone iodine who develop corneal epitheliopathy despite irrigation	Decision: Approved Prescribing: MEH Medical retina injection service only Tariff status: In tariff Funding: Trust Fact sheet or shared care required: No
MEH	Apr-18	Intravitreal clindamycin +/- dexamethasone	Toxoplasmosis chorioretinitis	Decision: Approved pending protocol Prescribing: MEH only Tariff status: In tariff Funding: Trust Fact sheet or shared care required: No

MEH	Feb-19	Dexmedetomidine	Appeal: Procedural sedation in surgeries performed via the microscope where patient's cooperation is paramount	Decision: Approved Prescribing: MEH only Tariff status: In tariff Funding: Trust Fact sheet or shared care required: No
MEH	Feb-19	Verkazia® (ciclosporin 1mg/mL) eye drops	Children >4 years and adolescents (up to 18 years old) after first-line agents have failed or are not tolerated for atopic keratoconjunctivitis, vernal keratoconjunctivitis and blepharokeratoconjunctivitis	Decision: Added to NCL Joint Formulary Prescribing: Primary and secondary care Tariff status: In tariff Funding: Trust and CCG Fact sheet or shared care required: Yes. The NCL ciclosporin factsheet requires an update
UCLH	May-19	Vinorelbine (oral)	Sarcoma patients requiring maintenance regimens	Decision: Approved pending budget sign off by divisional manager Prescribing: UCLH only Tariff status: In tariff Funding: Trust Fact sheet or shared care required: No
UCLH	May-19	Indocyanine green +/- ^{99m}Tc-nanocolloid	First line for sentinel node detection during biopsy for suspected head and neck cancers	Decision: Approved Prescribing: UCLH only Tariff status: In tariff Funding: Trust Fact sheet or shared care required: No
UCLH	May-19	Ruxolitinib free of Charge scheme	Second line therapy polycythaemia vera in patients who are unresponsive or intolerant to hydroxycarbamide	Decision: Approved Prescribing: UCLH only Tariff status: N/A Funding: FoC Fact sheet or shared care required: No
RFL	Apr-19	Metronidazole 10% ointment (Ortem®)	Non-healing pilonidal sinus surgical wounds in patients without inflammatory bowel disease	Decision: Added to NCL Joint Formulary Prescribing: Secondary care Tariff status: In tariff Funding: Trust Fact sheet or shared care required: No

8. New Medicine Reviews

8.1 Everolimus for refractory focal onset seizures associated with tuberous sclerosis complex (Applicant: Prof M Koepp, UCLH)

The Committee considered an application *in absentia* for everolimus to treat refractory focal onset seizures associated with tuberous sclerosis complex (TSC) in line with NHS England Commissioning Policy 170093P, as an adjunct to existing antiepileptic drug (AED) treatment for patients aged 2 years and over with drug resistant epilepsy, due to TSC, in whom the following criteria are met:

- Inadequate response to treatment with at least 2 different, appropriate AED at therapeutic doses
- Epilepsy surgery has failed or is not a suitable option
- Vagal nerve stimulation has failed or is not considered an appropriate next step by the patient or their carer in discussion with the treating clinician

- Everolimus is considered more appropriate than a trial of an alternative AED in the opinion of a multidisciplinary team including expertise in epilepsy, tuberous sclerosis (including experience with everolimus), neuroradiology and epilepsy surgery
- For patients in whom a mechanism to monitor seizure burden has been defined, and monitoring process agreed with the patient/carer prior to initiation

EXIST-3 was a double-blind, randomised, multi-centre trial evaluating the efficacy and safety of everolimus in patients who have TSC-related refractory seizures (N=366). Patients aged age 2 to 65 with a confirmed diagnosis of TSC and treatment resistant epilepsy, with 16 or more seizures during the baseline phase and receiving between 1 - 3 AED at a stable dose for at least 12 weeks before randomisation were included. At the end of an 8-week baseline period, eligible patients were randomised 1:1:1 to receive 'low exposure' everolimus (target trough concentration of 3-7 ng/mL), 'high exposure' everolimus (target trough concentration of 9-15 ng/mL) or placebo; dose were up-titrated during the 'titration phase' then maintained during the 12 week 'maintenance phase'. The primary outcomes were 'response of at least 50% reduction in partial-onset seizure frequency from baseline to week 12' and 'median percentage reduction in partial onset seizure frequency from baseline through to week 12.' Baseline characteristics were similar in each treatment arm; the median baseline seizure frequency was 9 per week. Results at week 12 indicate that both doses of everolimus are superior to placebo both of the primary endpoints, with the higher intensity therapy being associated with a larger treatment effect (response rate was 28.2%, 40.0% and 15.1% for 'low exposure', 'high exposure' and placebo respectively; median percentage reduction was 29.3%, 39.6% and 14.9% respectively).

The follow-up study (n=361) transitioned all patients to a target range of 6-10 ng/mL and then allowed investigators to make their own dose titrations within the target range of 3-15 ng/mL. Efficacy endpoints were the same as that for EXIST-3 and were assessed every 12 weeks for up to 2 years. Results show that that the benefit of treatment with everolimus increases over time.

In terms of safety, the phase III extension study indicated that the most frequent treatment-related adverse effects were stomatitis (33.5%), mouth ulceration (26.0%), diarrhoea (10.5%), aphthous ulcer (10.2%), and pyrexia (10.2%). During the study there were 2 treatment-related deaths one due to pneumonia and one due to septic shock; both in children.

The Committee concluded that there was sufficient evidence to support the use of everolimus in accordance with the NHSE Commissioning Policy.

Decision: Approved in line with the NHSE commissioning policy
Prescribing: Secondary care only
Tariff status: In tariff
Funding: NHSE
Fact sheet or shared care required: No

8.2 Rifaximin for the treatment of small intestine bacterial overgrowth in patients with systemic sclerosis (Applicant: Dr C Murray, RFL)

The Committee considered an application *in absentia* for rifaximin to treat small intestine bacterial overgrowth (SIBO) in patients with systemic sclerosis (SSc). Multiple conditions are associated with SIBO, each with different pathology, however patients with SSc commonly present with SIBO and at the point of diagnosis the underlying disease can be irreversible.

A meta-analysis to establish eradication rates of rifaximin for 'any-cause' SIBO included 26 studies in the ITT analysis (n=1,331). This analysis identified a pooled eradication rate of 70.8% [95% CI: 61.4 to 78.2]. A subgroup analysis for 'non-GI cause' SIBO (including a study in SSc patients) demonstrated a pooled eradication rate of 74.0% [95% CI: 62.9 to 83.7]. The analysis also identified that the majority of eradicated patients (67.7% [95% CI: 44.7 to 86.9]) reported an improvement or resolution of symptoms.

A pooled analysis of two active-comparator studies for 'any-cause' SIBO found a statistically significant difference in the overall eradication rate found in patients treated with rifaximin versus other antimicrobials in favour of rifaximin (absolute difference 24%; HR = 1.50 [95% CI: 1.11 to 2.04]). The studies, however, compared rifaximin against metronidazole or chlortetracycline – both potentially unsuitable comparators due to the difference in their spectrum of activity.

In terms of safety, a pooled analysis found an adverse events incidence rate of 4.6% in patients treated with rifaximin, with common adverse effects including dizziness, headache and GI disorders. Rifaximin has low systemic absorption therefore few drug-drug interactions are expected.

Dr Murray provided comment via email that SIBO is ubiquitous in the scleroderma population and the underlying pathology can have a dramatic effect on quality of life and nutrition. Since SIBO recurs regularly in most patient with SSc, most other systemic antibiotics have already been trialled and a new antibiotic is needed in this population.

The Committee heard that the risk of developing rifaximin resistance was unknown and that structurally similar antibiotics including rifamycin (rifampicin) only require a one point mutation to develop resistance. The meta-analysis reporting "eradication rates" was considered misleading as the recurring nature of SIBO means that "suppression of symptoms with corresponding negative hydrogen test" was a better descriptor. The Committee was in agreement that SSc associated SIBO requires treatment and the recurrent nature of the condition would benefit from the availability of novel antimicrobial treatment. Rifaximin has been used outside of the UK for a long time successfully with evidence to demonstrate its efficacy in symptom improvement. In summary, the Committee approved the use of rifaximin to treat SIBO in patients with SSc only.

Decision: Approved as monotherapy (restricted to patients suffering from systemic sclerosis only)
Prescribing: Secondary/Tertiary only
Tariff status: In tariff
Funding: Hospital
Fact sheet or shared care required: No
Additional information: Usual dose is 400mg TDS for two weeks; up to four treatment courses per year

8.3 Osmpemifene (Senshio®) for the treatment of moderate to severe symptomatic vulvar and vaginal atrophy (VVA) in post-menopausal women (Applicant: Dr V Talaulikar, UCLH)

The Committee considered an application for the use of ospemifene for the treatment of moderate to severe symptomatic vulvar and vaginal atrophy (VVA) in post-menopausal women who are not candidates for local vaginal oestrogen therapy. Ospemifene is a selective oestrogen receptor modulator (SERM) that binds to oestrogen receptors resulting in activation of some oestrogenic pathways and blockade of others.

A 12-week double-blind placebo-controlled study assessed the efficacy of ospemifene in postmenopausal women aged 40–80 years, with ≤5% superficial cells on the vaginal smear (maturation index), vaginal pH >5.0 and at least one moderate or severe symptom of VVA. The co-primary outcome measures were change from baseline to week 12 in the percentage of parabasal cells, the percentage of superficial cells, vaginal pH and the severity of vaginal dryness or dyspareunia. After 12 weeks, patients randomised to ospemifene 30 mg and 60 mg resulted in an increase in superficial cells (absolute difference of 5.6% and 8.6% respectively; p<0.001), decrease in parabasal cells (absolute difference of −25.9% and −34.1% respectively; p<0.001) and decrease in vaginal pH (absolute difference of 0.6 and 0.9; p<0.001). The symptom score for vaginal dryness decreased more with 30 mg and 60 mg ospemifene (−1.2 and −1.3, respectively) compared with placebo (−0.8; p=0.04 and p=0.021, respectively). The change in dyspareunia score with ospemifene compared with placebo was statistically significant for 60 mg daily (−1.2 vs −0.9; p=0.023) but not for 30 mg daily.

Two identically designed 12-week double-blind placebo-controlled studies were conducted in parallel in women aged 40–80 years with dyspareunia and/or vaginal dryness. The co-primary outcomes were the same as the first study. In the ITT analysis, ospemifene produced statistically significant changes in the mean change from baseline for each of the of the four co-primary outcome measures compared with placebo except the severity score of vaginal dryness (mean change from baseline −1.3 vs −1.1 respectively [p=0.080]). The reduction in severity score for dyspareunia was greater with ospemifene compared with placebo (−1.5 vs −1.2; p=0.0001).

A 52-week double-blind placebo-controlled study assessed the safety of ospemifene in women aged 40–80 years with VVA and an intact uterus. The most common treatment-related adverse effect was hot flushes which was higher in the ospemifene arm (12.6% vs. 6.5%) and corresponded to a higher discontinuation rate due to hot flushes (2.2% vs. 0%). In the ospemifene group three cases of proliferation on endometrial biopsy, an increase in endometrium thickness (0.75mm vs. 0.17mm at week 52), one

uterine polyp, one treatment-related non-fatal ischaemic stroke and one treatment-related DVT were observed.

The Committee heard that NICE NG23 recommends "vaginal oestrogen for women with urogenital atrophy in whom systemic HRT is contraindicated, after seeking advice from a healthcare professional with expertise in menopause." The guideline concludes that alternatives to hormonal treatment for menopausal symptoms are less effective, and the evidence for the safety and effectiveness of ospemifene is limited in women who have received treatment for breast cancer.

Dr Talaulikar informed the Committee that 1-2 patients per month present with severe VVA and report symptoms such as ulceration and pain. The applicant identified that patients with a history of cancer who are contraindicated to use local oestrogen therapy are the cohort of patients at greatest need for an alternative treatment option. From a gynaecologist perspective, hormonal therapies are considered in patients with a history of breast cancer, although anecdotally oncologists do not recommend patients use vaginal oestrogen. Recommendations on the formulation of vaginal oestrogen varies amongst gynaecologists within NCL, however there is long-term evidence to support the safe use of local oestrogens in patients with a history of breast cancer. Dr Talaulikar indicated that unpublished trials in patients with a history of breast cancer support that ospemifene is safe; however the data are not yet available. The Committee heard that patients treated with ospemifene will undergo annual screening and follow-up in secondary care.

In camera, the Committee agreed that ospemifene demonstrated a small but inconsistent benefit in terms of symptomatic improvement over placebo and there was no evidence of superiority of ospemifene over local oestrogen treatment. Ospemifene is considerably more expensive than local oestrogen treatment which was considered unjustified if oestrogen was a viable treatment option. The Committee agreed that if local oestrogen treatment was unsuitable for some cohorts (potentially including women with a history of breast cancer) there was a need for second-line treatment option for the treatment of symptomatic, very severe VVA. The Committee were concerned that women with a history of breast cancer were excluded from all licensing studies therefore the risk of breast cancer recurrence with ospemifene is entirely unknown. The Committee highlighted two areas of uncertainty that required further investigation before a decision could be reached – firstly to identify long-term safety studies in women with a history of breast cancer using ospemifene; and secondly to assess the safety profile of vaginal oestrogen in women with a history of cancer to determine if this is a safe treatment option in this cohort of patients.

Decision: Deferred

8.4 5-aminolaevulinic acid (Ameluz®) for the treatment of actinic keratosis and superficial/nodular basal cell carcinoma (Applicant: Dr F Ismail, RFL)

The Committee considered an application to use 5-aminolaevulinic acid for the treatment of actinic keratosis (AK), basal cell carcinoma (BCC) and Bowen's disease. Ameluz is proposed as a topical application prior to photodynamic therapy (PDT) to induce apoptosis in order to remove superficial lesions. Although the application originally requested Ameluz to replace the current formulary product (Metvix) for all three indications listed above, Ameluz does not hold a Marketing Authorisation for Bowen's disease – the applicant subsequently retracted their request for use of Ameluz in this indication in order to retain use of the licensed product.

Evidence for the efficacy of Ameluz comes from two randomised, single-blind, placebo-controlled trials. Both studies intended to demonstrate non-inferiority of Ameluz with Metvix by a margin of 15%. The AK study included adults with four to eight lesions; patients were randomised 3:3:1 to Ameluz, Metvix or placebo applied three hours pre-PDT. Results demonstrated non-inferiority of 'complete response' with Ameluz compared with Metvix at both assessment points (absolute difference of 14.0% 12 weeks after last PDT [$p<0.05$ for superiority] and 11.4% 12 weeks after first PDT). The BCC study included adults with one to three lesions; patients were randomised 1:1 to Ameluz or Metvix. Results again demonstrated non-inferiority of complete response with Ameluz compared to Metvix at both assessment points in the per protocol population (absolute difference of +1.6% 12 weeks after last PDT [$p<0.001$ for non-inferiority] and +1.5% 12 weeks after first PDT). Both studies were found to demonstrate similar relapse at one year and similar cosmetic outcomes between Ameluz and Metvix groups.

In terms of safety, Ameluz and Metvix have similar adverse event profiles.

Ameluz has a longer shelf-life, longer expiry once opened and costs £12 less per 2g tube. If Ameluz displaces all Metvix use in NCL an annual cost saving of £4,656 can be expected.

Alan Milligan (CNS in skin cancer) discussed the use of both Ameluz and Metvix in AK and BCC, including the utilisation of daylight as a light source in AK treatment, with prescribing restricted to the specialist clinic.

The Committee were satisfied that Ameluz represents a non-inferior and cost-minimising treatment option. In summary, the Committee agreed to include Ameluz on the NCL Joint Formulary as a first-line treatment in AK and BCC, whilst retaining Metvix on formulary as a first-line treatment for Bowen's disease and second-line treatment in AK and BCC.

Drug: Ameluz (5-aminolaevulinic acid)
Decision: Approved (First-line treatment in actinic keratosis and superficial basal cell carcinoma)
Prescribing: Secondary care only
Tariff status: In tariff
Funding: Hospital
Fact sheet or shared care required: No

Drug: Metvix (methyl aminolaevulinic acid)
Decision: Approved (First-line treatment in Bowen's disease)
Prescribing: Secondary care only
Tariff status: In tariff
Funding: Hospital
Fact sheet or shared care required: No

9. JFC Process for reviewing NHS England Commissioning Policies

In November 2015 the JFC agreed that NHS England Commissioning Policies should remain subject to the full JFC / DTC application process due to uncertainty over the quality of the evidence reviews. A recent audit of local reviews of NHSE Commissioning Policies by UCLH and JFC found that all were accepted. Significant local resources are used to produce each independent evaluation. The Committee heard that the number of NHSE Commissioning Policies may reduce as NICE have committed to review all new medicines and indications for existing medicines by April 2020 (except where there is a clear rationale not to do so) therefore NHSE Commissioning Policies will likely only be produced for off-licence and off-label medicines.

The Committee agreed it was unnecessary to the duplicate the review of NHSE Commissioning Policies, and recommended NHS England Commissioning Policies should undergo the same abbreviated process as NICE TAs to ensure governance and resource implications are addressed.

For individual sites this necessitates:

- RFL: Full application without an independent evaluation of the literature
- UCLH/NMUH/WH/GOSH: Abbreviated application designed to assess impact of intervention on pathways/resources and applicability to the Trust

Resource implications and safety concerns will be disseminated across JFC if applicable to multiple sites and any concerns can be discussed in full at regional or local level.

10. Factsheet: Denosumab [update for ratification]

The denosumab Fact Sheet has undergone a major revision including the Committee's recent decision to restrict treatment of patients with renal impairment to secondary care only due to the risk of hypocalcaemia. The update has been approved by the NCL Shared Care Group. The Committee approved the Fact Sheet.

11. Position Statement: Sacubitril Valsartan (Entresto®) [update for ratification]

The Committee approved an updated version of the Position Statement which now excludes a patient information leaflet.

12. Position Statement: Safe Prescribing of Fluoroquinolones

The Committee reviewed a Position Statement drafted by an NCL task group on the safe prescribing of fluoroquinolones. The position statement follows recent MHRA warnings on the risk of aortic aneurysm and potentially irreversible adverse events (such as tendinopathies) following treatment with fluoroquinolone drugs.

The Position Statement promotes Trust/NICE antibiotic guidance which themselves minimised the use of fluoroquinolones where possible, contraindicates the use of fluoroquinolones in patients with abdominal aortic aneurisms (unless no other antibiotic therapies are available) and suggests caution in other high risk groups. The most at risk groups were thought to be patients with bronchiectasis who are colonised with pseudomonas and discussion is underway with the Responsible Respiratory Prescribing Group to address this. The Position Statement also signposts to the MHRA PIL and the national abdominal aortic aneurisms screening programme.

The Committee approved a final version of the Position Statement which was currently out for consultation subject to no major amendments to the content.

13. Position Statement & Guidance: Flash Glucose Monitoring

The NCL Position Statement and supporting guidance were updated in line with the 2019 NHS England funding statement. The Committee approved a final version of the Position Statement which was currently out for consultation subject to no major amendments to the content.

14. Pathway: High-cost drug therapy for psoriasis

NEL CSU has coordinated the development of a high-cost drug treatment pathway for psoriasis; led by RFL with input from UCLH and WH. The pathway recommends the use of first-line biosimilar adalimumab as the most cost-effective agent with other agents used subsequently in the treatment pathway; this represented a change of practice as ustekinumab was the most commonly used first-line agent. Alternative therapies could be used first-line in up to 20% of cases where adalimumab is not clinically appropriate (e.g. where adalimumab is contraindicated, or non-adherent patients who would benefit from nurse-led administration [ustekinumab]; or if rapid onset of action is required to avoid an admission [brodalumab]). The pathway included high impact site psoriasis with DLQI ≥ 15 which had previously been approved clinically by JFC.

The pathway was approved clinically and referred to NCL Commissioners for funding consideration.

15. Next meeting

Monday 15th July 2019, 4.30 – 6.30pm, Venue: LG01, 222 Euston Road, London, NW1 2DA

16. Any other business

Nil