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 October 2023

		Present	Apologies
Members			
Prof A Hingorani	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 R Urquhart	UCLH, Divisional Clinical Director	✓	
Dr K Tasopoulos	NMUH, DTC Chair	✓	
Ms A Stein	NMUH, Interim 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		✓
Mr V Raman	RNOH, DTC Chair		✓
Mr A Shah	RNOH, Chief Pharmacist	✓	
Prof A Tufail	MEH, DTC Chair		✓
Ms N Phul	MEH, Chief Pharmacist		✓
Ms K Delargy	BEH, Chief Pharmacist	✓	
Ms L Reeves	C&I, Chief Pharmacist		✓
Dr L Waters	CNWL, Consultant Physician in HIV		✓
Ms R Clark	NCL ICB, Head of Medicines Management (Camden)		✓
Mr P Gouldstone	NCL ICB, Head of Medicines Management (Enfield)	✓	
Ms E Mortty	NCL ICB, Interim Head of Medicines Management (Haringey)		✓
Ms M Singh	NCL ICB, Head of Medicines Management (Barnet)	✓	
Mr A Dutt	NCL ICB, Head of Medicines Management (Islington)	✓	
Dr D Roberts	NCL ICB, Clinical Director (Islington)		✓
Attendees			
Ms S Sanghvi	IPMO Programme Team, JFC Principal Pharmacist	✓	
Ms S Amin	IPMO Programme Team, Lead Pharmacist		✓
Ms S Maru	IPMO Programme Team, JFC Support Pharmacist	✓	
Ms P Varu	IPMO Programme Team, JFC Support Pharmacist	✓	
Mr G Grewal	RFL, Deputy Chief Pharmacist	✓	
Ms I Samuel	RFL, Formulary Pharmacist	✓	
Mr H Shahbakhti	RFL, Formulary Pharmacist	✓	✓
Ms H Bouattia	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 G Purohit	RNOH, Formulary Pharmacist		✓
Ms K Mistry	RNOH, Formulary Pharmacist	✓	

Ms S Ahmed	WH, Formulary Pharmacist		✓
Ms R Pointon	WH, Rotational Pharmacist		✓
Ms N Patel	NMUH, Formulary Pharmacist	✓	
Mr J Flor	WH, Finance, Business and Performance Pharmacist		✓
Ms M Thacker	GOSH, Deputy Chief Pharmacist	✓	
Ms J Bloom	MEH, Associate Chief Pharmacist	✓	
Ms H Weaver	NHSE, Specialised Commissioning Pharmacist (Observer)		✓
Ms A Fakoya	NCL ICB, Contracts & Commissioning Pharmacist		✓
Ms M Amran	Clinical Pharmacology Registrar, UCLH	✓	
Ms C Weaver	Senior Prescribing Advisor, NCL ICB (Camden)	✓	
Mr J Ross	Clinical Pharmacology Registrar, UCLH	✓	
Ms S Patel	Lead PCN Pharmacist (Federated4Health) (Observer)	✓	
Mr P Verasingam	Consultant Obstetrician, Gynaecologist and Endo-Pelvic Surgeon, NMUH	✓	
Mr A Fazal	Commissioning Pharmacist, RFL (Observe)	✓	

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 were declared at the meeting.

4. Minutes of the last meeting

Minutes and abbreviated minutes of the August meeting were ratified. Minutes and abbreviated minutes of the September meeting will be circulated to the Committee via email for consultation prior to ratification post meeting.

5. Matters arising

5.1 NHSE DOAC Letter

The Committee noted the letter from NHSE regarding national procurement for DOACs and agreed to await for a further update from NHSE, expected in October 2023, before assessing impact on the current NCL position statement for DOAC choice in non-valvular atrial fibrillation (NVAF).

6. Review of action tracker

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

6.1 Bempedoic acid monotherapy and NCL Lipid Pathway

In February 2023, the JFC approved an application for the use of bempedoic acid monotherapy for treating primary hypercholesterolaemia or mixed dyslipidaemia in patients in whom ezetimibe was not tolerated or not effective. The Committee approved the following:

i) Updating the JFC criteria for approval of bempedoic acid monotherapy to use in 'statin intolerant patients in whom ezetimibe is not tolerated.' The Committee noted that NICE TA 694 recommends the use of bempedoic acid with ezetimibe in patients where statins are not tolerated or contraindicated, and ezetimibe alone does not control LDL-C well enough. There are no objective criteria to define when bempedoic acid with ezetimibe therapy should be used versus bempedoic acid monotherapy for statin intolerant patients where 'ezetimibe is not effective'. This wording was therefore removed from the NCL JFC recommended criteria for bempedoic acid monotherapy, in agreement with the applicants, to make the pathway clearer for primary care clinicians and reduce the risk of bypassing a NICE recommended therapy.

ii) Harmonising the prescribing status for bempedoic acid monotherapy and bempedoic acid with ezetimibe to be suitable for initiation in primary or secondary care (green prescribing status). This position is supported by the lipid pathway working group and the Committee noted that discussions are underway to provide appropriate GP training sessions on the lipid pathway. These should be linked to the training hubs.

iii) The updated lipid pathway with the addition of bempedoic acid monotherapy.

Medicine: Bempedoic acid monotherapy

Decision: Approved for treating primary hypercholesterolaemia or mixed dyslipidaemia in patients in whom ezetimibe was not tolerated
Prescribing: Primary or secondary care initiation
Tariff status: In tariff
Funding: Trust/ICB
Fact sheet or shared care required: N/A - NCL Lipid Pathway updated and approved

7. JFC outstanding items & work plan

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

8. Local DTC recommendations/minutes

DTC site	Month	Drug	Indication	JFC outcome
RFL	August 2023	Bimatoprost eye drops	Alopecia	**Decision**: Approved - RFL only **Prescribing**: Secondary care only **Tariff status**: In tariff **Funding**: Trust **Fact sheet or shared care required**: N/A **Additional information:** Subject to clarification on specific types of alopecia with the local dermatology team
RNOH	July 2023	Teriparatide	Pregnancy and lactation associated osteoporosis	**Decision**: Approved pending development of a local protocol - RNOH only **Prescribing**: Secondary care only **Tariff status**: In tariff **Funding**: Trust **Fact sheet or shared care required**: N/A

UCLH	September 2023	Lenalidomide	Multiple myeloma pathway additions 1) Lenalidomide maintenance for multiple myeloma patients who have undergone 2nd ASCT and lenalidomide maintenance was not an option after 1st ASCT and they are not lenalidomide refractory. 2) Bortezomib, lenalidomide and dexamethasone (VLd) followed by lenalidomide and dexamethasone (Ld) maintenance as 1st line treatment for transplant ineligible patients. 3) VLd PACE (Bortezomib, lenalidomide, dexamethasone, cisplatin, cyclophosphamide, etoposide, doxorubicin) or Ld PACE (Lenalidomide, dexamethasone, cisplatin, cyclophosphamide, etoposide, doxorubicin) as salvage chemotherapy for patient's intolerant to thalidomide.	**Decision**: Approved - Place in therapy (2) will be re-reviewed when TA for DLd is published. **Prescribing**: Secondary care only **Tariff status**: Not routinely commissioned **Funding**: Trust **Fact sheet or shared care required**: N/A
UCLH	September 2023	Intravesical gentamicin (single 24-week course)	Recurrent UTIs due to a gentamicin sensitive uropathogen, in patients who are able to self-catheterise and adhere to treatment, as a last-line option where prophylactic oral antibiotics and other measures had failed.	**Decision**: Approved - UCLH only **Prescribing**: Secondary care only **Tariff status**: In tariff **Funding**: Trust **Fact sheet or shared care required**: N/A **Additional information:** To be offered in line with a formal protocol after discussion and approval at a urology/infection MDT
UCLH	September 2023	High intensity rivaroxaban	Continuation post-RISAPs trial for antiphospholipid syndrome	**Decision**: Not approved
UCLH	July 2023	Adagrasib + cetuximab † (FOC Scheme)	Metastatic colorectal cancer	**Decision**: Not approved

*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

9. New medicine reviews

9.1 Dienogest for endometriosis

The Committee considered an application for dienogest 2mg daily, a fourth-generation progestogen, for the treatment of endometriosis in women of childbearing age in:

a. Surgical patients - as an alternative to GnRH analogues for 3 months pre-surgery and 3-12 months post-surgery.

b. Non-surgical patients – a last-line option after failure of other progestogens, as an alternative to GnRH analogues to be used long-term.

The evidence considered was as follows:

Strowitzki et. al (2010a) was a 12-week, randomised, placebo-controlled, double-blind study to assess the safety and efficacy of dienogest for the treatment of endometriosis and endometriosis-associated pelvic pain (EAPP) (n=198). Patients were randomised to dienogest or placebo. The primary endpoint, absolute change in EAPP based on a change in the visual analogue scale (VAS) score (VAS score; 0mm represents the absence of pain and 100mm indicates unbearable pain) was significantly better with dienogest compared to placebo (-27.4mm vs. -15.1mm; difference -12.3mm, p<0.0001).

Petragalia et. al was a 52-week, open-label, single-arm extension study Strowitzki et. al 2010a to assess the safety and efficacy of dienogest for the treatment of endometriosis (n=152). All women received dienogest 2mg once daily. The primary endpoint, change in mean EAPP VAS score, was reduced to 11.52mm at the end of the study (9.72mm for those on prior dienogest vs. 13.49mm on prior placebo). The mean VAS score was statistically significantly reduced by -43.22mm (p<0.001) over the total treatment period of 65 weeks (i.e the placebo-controlled study plus the extension study).

Strowitzki et. al 2010b was a 24-week, randomised, open-label, parallel-group, non-inferiority study to assess the safety and efficacy of dienogest vs leuprorelin acetate 3.75mg 4 weekly in women with EAPP (n=252). A 15mm non-inferiority margin was set for the 95% CI for the difference between treatments, The primary endpoint, change in EAPP VAS score at 24 weeks was statistically significantly better with dienogest compared to leuprorelin (-47.5mm vs. -46.00; difference -1.5mm; 95% CI -9.26mm to 6.25mm; p<0004 for non-inferiority).

Lin et. al was a systematic review and meta-analysis of randomised controlled trials assessing the efficacy and safety of dienogest. Three of the studies (n=349) compared dienogest to GnRH analogues for EAPP. The primary endpoint of this subgroup analyses was a change in the mean difference of the VAS score at the end of the treatment period. Dienogest was found to be superior (mean difference: -2.41mm, 95% CI: -3.58 to -1.24; p=0.57). Inspection of the funnel plot of the changes in the VAS score revealed asymmetry, suggesting there was some degree of publication bias.

Samy et. al was a systematic review and meta-analysis of 36 randomised controlled trials investigating different medical treatments for endometriosis. Only three studies including dienogest were found to be suitable in this review. Network meta-analysis was performed to elucidate the ranking of treatments according to the P-score (a higher score indicates a higher likelihood of being most effective option, maximum score 1). For the change in the severity of pain according to VAS at 3 months, the ranking of treatments according to P score from best to worst was dienogest (0.94) followed by combined oral contraceptives (0.782). For the change in severity of pain according to VAS at 6 months, GnRH analogues (0.75) performed best, followed by, levonorgestrel intrauterine system (0.73), dienogest (0.65) and desogestrel (0.32).

Overall, the evidence base in relation to the intended use of dienogest was suboptimal.

One trial indicated the efficacy of dienogest but only in comparison to placebo rather than alternative progestogens or GnRH analogue treatment, only in relation in relation to pain (rather than shrinkage of endometrial tissue as needed in the run up to surgery). Another trial provided data showing non-inferiority of dienogest vs GnRH analogues for pain outcomes. The limitations are there is no data for use beyond 15 months of treatment. There is no evidence to suggest that dienogest is preferable to an alternative progestogen and it is unknown whether dienogest would be efficacious in patients who have already been trialled on other progestogen treatments.

In terms of safety, dienogest appears to be well-tolerated with no significant safety concerns. The contraindications for treatment are similar to other progestogens. The main adverse effects reported are

changes in bleeding patterns, headache, breast discomfort, depressed mood, and acne. Patients may prefer dienogest in comparison to GnRH analogues as it is an oral tablet.

In terms of budget impact, the application predicts that approximately 100 patients per year would be initiated on treatment in NCL. This equates to approximately £27,000 cost per annum for NCL. Compared to leuprorelin, dienogest would be approximately £64,000 cheaper (based on a 100% switch). There is also likely to be a reduction in healthcare costs as GnRH analogues require administration by a healthcare professional and ongoing monitoring e.g bone scans. Therefore, dienogest as an alternative treatment option to GnRH analogues is likely to be cost-saving overall.

The Committee heard from Dr Verasingam that patients referred into the NCL endometriosis service will usually have been trialled on progestogen treatment already for at least 6-12 months. He informed the Committee that dienogest is the only progestogen that can be used as a down-regulation agent and cause endometrial atrophy, which is a goal for patients who are due to undergo surgery for endometriosis. Patients eligible for surgery would use dienogest as an adjunct pre-surgery for 3 months and post-surgery for 3-12 months. The Committee highlighted that RCT data shows non-inferiority to the current standard of care (i.e GnRH analogues), but the outcomes are related to pain relief as opposed to endometrial tissue shrinkage. The applicant clarified that there is no comparative evidence in a randomised setting for dienogest which shows endometrial tissue shrinkage, however, there is non-comparative data available to show this effect with dienogest.

For patients not having surgery, the applicant proposes offering long-term dienogest therapy as an alternative last-line option to GnRH analogues for symptomatic management, noting that GnRH analogues can only be used for a maximum of 12 months. The decision to use one over the other will depend on patient preference, noting that some patients may prefer an oral option, but for others, the irregular bleeding associated with dienogest may be problematic. The use of dienogest would be incorporated into the endometriosis management guidelines and clear eligibility and stopping criteria can be provided, if approved.

In camera, the Committee acknowledged that the current evidence pertains to equivalence in terms of pain reported on the VAS score but does not pertain to shrinkage of endometrial tissues/implant size for patients being prepared for surgery. In the absence of comparative evidence, the Committee would benefit from reviewing the non-comparative evidence that supports the claim of dienogest reducing endometrial tissue prior to surgery, as this is the primary treatment goal.

For the patient cohort not having surgery, the purpose of using GnRH analogues is for symptom control and there is comparative evidence to show that dienogest is equivalent to GnRH analogues.

The Committee agreed that a treatment pathway was required to clearly define the proposed place in therapy with the current standard of care, including eligibility and stopping criteria. The Committee also requested the evidence cited by the applicant demonstrating that dienogest can shrink endometrial tissue.

In summary, the Committee agreed to add dienogest to the NCL Joint Formulary for the treatment of endometriosis pending receipt of:

1) Submission of the evidence base pertaining to the shrinkage of endometrial tissue following treatment with dienogest for pre-surgical patients.
2) A clearly defined treatment pathway for the proposed place in therapy, including eligibility and stopping criteria. The information we have currently on the two proposed patient cohorts for use is:
    a. Surgical patients - as an alternative to GnRH analogues for 3 months pre-surgery and 3-12 months post-surgery.
    b. Non-surgical patients – a last-line option after failure of other progestogens, as an alternative to GnRH analogues to be used long-term.

Decision: Approved – pending receipt of the evidence base for the surgical patient cohort and a treatment pathway including eligibility and stopping criteria.
Prescribing: Secondary care initiation, primary care continuation
Tariff status: In tariff
Funding: Trust/ICB
Fact sheet or shared care required: N/A

9.2 Abatacept for immune-checkpoint inhibitor induced myocarditis

The Committee considered an application *in absentia* for abatacept (proposed to be administered at an off-label dose of IV 200mg every 2 weeks for 5 doses), a selective co-stimulation modulator, for off-label use as a second-line agent for immune checkpoint inhibitor (ICI) induced myocarditis in patients that have not responded to steroids (IV methylprednisolone). The Committee noted that ICI-induced myocarditis is reported to have a prevalence of less than 1% and a mortality rate of 30 – 50%.

The Committee were informed that the majority of patients would respond to IV methylprednisolone and only a small number of patients would present as steroid refractory. There were several alternative treatment options in a second- or third-line setting recommended in international guidance (including mycophenolate mofetil, tacrolimus, tocilizumab, IVIG, alemtuzumab, infliximab and anti-thymocyte globulin (ATG)) but the level of evidence underpinning each treatment option was limited to case series and case reports.

No RCTs were available for abatacept in this indication.

Salem et al (2023, n=40) conducted a prospective cohort study, in patients with immune checkpoint inhibitor induced myocarditis which had not responded to IV methylprednisolone (n=40). The first cohort (n=10) received abatacept 10mg/kg every 2 weeks (n=7) in combination with other treatments, resulting in a mortality of 60%. The second cohort of patients (n=30) had an increased screening and management strategy for myositis. The treatment strategy was amended to abatacept 20mg/kg on days 0, 5 and 14 followed by dose adjustments based on CD86 receptor occupancy, with ruxolitinib and corticosteroids resulting in a mortality of 3%. Key limitations of the study were the non-randomised study design, small patient numbers and difficulty deciphering whether the treatment effect was due to the higher dose of abatacept, concomitant use of ruxolitinib and steroids or the increased screening and management strategy for myositis.

Nguyen et al (2022) reported a case report using abatacept 20mg/kg every week for 5 doses with concomitant ruxolitinib and IV methylprednisolone in a second-line setting resulting in resolution of myocarditis. Jesperson et al (2021) reported a case report using abatacept 500mg every 2 weeks for 5 doses with mycophenolate mofetil in a second-line setting. This patient was reported to have had a cardiac arrest 9 days post treatment. The third case report by Salem et al (2019) reported a dose of abatacept 500mg every 2 weeks for 5 doses resulting in myocarditis resolution. The main limitations of these case reports are the heterogeneous nature of interventions and outcomes that make it difficult to decipher the treatment effect of abatacept and optimal dose.

The Committee also noted local experience from Royal Free London NHS Foundation Trust (RFL) (n=4) where abatacept at varying doses was used for steroid resistant ICI-induced myocarditis, with mixed and inconclusive outcomes.

In terms of safety, the safety profile of abatacept was not reported in the prospective cohort study, case reports and local experience at RFL. Therefore, there is an unknown safety profile for the use of abatacept at an off-label dose for an off-label indication. However, there is a known safety profile noted from the licensed dose of abatacept as detailed in the Summary of Product Characteristics.

The Committee were informed that there are two ongoing clinical trials: i) a phase 2 abatacept dose-finding study in ICI-induced myocarditis patients (NCT05195645) and ii) a phase 3 placebo-controlled study investigating the efficacy of abatacept in ICI-induced myocarditis (NCT05335928). However, neither trial is currently recruiting in the UK. There are no known clinical trials investigating any other agents for this condition.

In terms of budget impact for NCL, abatacept for this indication would be an ICB-funded treatment and a business case would be required for funding approval for this cohort. Abatacept is expected to cost approximately £90,000 per annum, for 10 patients based on an average weight of 70kg. The Committee noted that costs may be offset by the avoidance of use of other high cost treatments e.g. IVIG or plasma exchange.

The Committee heard from Mr Jenkinson that cardio-surveillance (as recommended by the European Society of Cardiology) is being incorporated into RFL practice to enable identification of patients with poor cardiac function at the outset. This will allow for closer monitoring and management of patients but will not enable prediction of patients at risk of myocarditis or prevent patients developing myocarditis due to the immune-active nature of myocarditis development in this cohort.

The Committee agreed that there is a high unmet need and high fatality rate in patients who do not respond to treatment with steroids and therefore any treatment effect seen would be potentially significant. The Committee acknowledged that there is a lack of suitable alternative treatment options to treat this fatal condition in a second-line setting, and that other treatments mentioned in guidelines have an equally uncertain evidence base. There is a great uncertainty in the treatment effect derived from abatacept from the current

evidence base. The Committee agreed to support the clinical team to pursue this as a research question and contribute to the evidence base.

In summary, the Committee agreed that:

- Step 1: Clinicians across Barts, UCLH and RFL should work with pharmacy clinical trials teams and NCL research hubs (e.g. Joint Research Office or Biomedical Research Centre) to fully explore the feasibility of enrolling patients on to the available phase 3 clinical trial (NCT05335928) and address any barriers to inclusion of a trial site in North London.
- Step 2: If this is not successful, the feasibility of conducting a clinical trial across North London should be explored to add rigor to the evidence base collected.
- Step 3: If this research route was demonstrated to be unfeasible, clinical teams would be expected to design a robust evaluation across NCL, with support from JFC, aiming to collect clear outcome data, and publish results in order to contribute to the evidence base and support a business case proposal to the ICB.
- Step 4: If an opportunity to enter a clinical trial arose while conducting an evaluation across North London, patients should be enrolled into the clinical trial instead.
- In the interim until the research route is established, a North London pathway for the management of ICI induced myocarditis should be developed in collaboration with clinicians from Barts, UCLH and RFL clarifying the proposed dose, duration, initiation and stopping criteria for abatacept and any other treatment options included in the pathway. This interim pathway would require JFC clinical approval and ICB input regarding funding of medicines in the pathway.
- The interim pathway would be in place until trial recruitment can take place, subject to collection of outcome data for each patient, to contribute to any future North London wide evaluation. Alongside the pathway, clinicians should define the outcome data that would be collected for evaluation.

The Committee agreed that an update to this decision should be brought back to a future JFC meeting following discussion with clinicians and ICB colleagues.

Decision: Deferred pending consideration of JFC recommendations

10. Guidelines, Pathways and Position statements

10.1 Primary Care Pathways Update

The Committee was informed that three primary care pathways (headaches, dizziness and PCOS pathways) were previously brought to JFC and comments raised by the Committee have now been addressed by the Primary Care Pathways Group.

Following the formation of the ICB in April 2023, the JFC agreed to consider the medicines aspects of the primary care clinical pathways for approval as an interim measure. As the NCL ICB Clinical Reference Group (CRG) is now established, the function of approving the medicines aspects of the pathways is proposed to transfer to the CRG. JFC have developed a robust process for evaluating and risk assessing the medicines aspects of primary care pathways, and the CRG will adopt this process going forward.

The Committee approved the following recommended steps following transition of the governance process to CRG:

- JFC secretariat will support the CRG working group with queries relating to formulary status or evidence base for medicines within the primary care pathways.
- CRG approved pathways will be circulated to JFC members for noting.
- Any formulary implications for acute trusts and implementation requirements (e.g. Netformulary) can be considered following sight of the pathways.

10.2 NCL MON website transition update

The Committee was updated on the transition of the NCL MON website to the NCL ICS website. The new webpages and document links will go live by the end of October. For a period of 3 months, the NCL MON and NCL ICS websites will be running simultaneously. This is to ensure that organisations have sufficient time to update NCL MON hyperlinks within existing documents. A document with the new links will be circulated to all NCL organisations when the ICS webpages are live.

Prior to transfer to the ICS website, all documents on the NCL MON website were reviewed to consider which should i) be moved directly to the NCL ICS website, ii) have a disclaimer added due to outdated review dates prior to transfer or iii) reviewed for consideration of removal. All relevant stakeholders were consulted for

feasibility to exclude documents from transition to the ICS website where documents were considered severely outdated or irrelevant. A summary of the documents and proposed actions was shared, and it was noted that the proposed actions were approved by the NCL Medicines Optimisation Board in October 2023.

10.3 Next meeting

Thursday 16th November 2023

10.4 Any other business

Nil