South East London Integrated Medicines Optimisation Committee (SEL IMOC) Meeting
Thursday 15th February 2024, 2pm - 4:30pm (Meeting held via MS Teams)
FINAL Minutes

1. Welcome, introductions and apologies

The Chair welcomed attendees to the meeting. Apologies and observers were noted.

2. Conflict of interests – declarations and DOI refresh

The Chair asked that any conflicts of interest with the meeting agenda be declared and that any outstanding declarations be returned. No conflicts were raised.

3. Detailed action notes of the last meeting, minutes, and action log:

The notes were accepted as an accurate record of the meeting subject to the correction of minor typographical errors. Members were provided with an update on progress against actions due for this month, these were noted, and items closed were agreed.

4. SEL Chronic Obstructive Pulmonary Disease (COPD) inhaler pathway and associated formulary requests

The development of this inhaler pathway and associated formulary requests resulted from a recent update to the Global Initiative for Chronic Obstructive Lung Disease (GOLD) international COPD guidance, which recommends first line treatment with triple inhaler therapy (long-acting beta-2 agonist (LABA), long-acting muscarinic antagonist (LAMA) & inhaled corticosteroids (ICS)) in a specified cohort of patients. This recommendation differs from the current NICE COPD guidance; however, it is expected that NICE guidance will be updated to reflect the updated GOLD recommendations. The Committee is being asked to consider the following:

(i) SEL Inhaler pathway - based on the London wide inhaler pathway developed through the London Respiratory Network.
(ii) Formulary request for recategorisation from Amber 1 to Green for the following inhalers in maintenance treatment of COPD:

- Trimbow® NEXThaler® 88 micrograms/5 micrograms/9 micrograms dry powder inhaler
- Trimbow® pMDI 87 micrograms/5 micrograms/9 micrograms pressurised inhalation, solution.
- Trelegy® Ellipta® 92 micrograms/55 micrograms/22 micrograms inhalation powder line

(iii) Formulary inclusion of triple inhaled therapy (with the inhalers outlined above) as first line treatment targeted for people with COPD who have had ≥1 severe [hospitalised] or ≥ 2 moderate exacerbations in the last year, and eosinophil count ≥100 cells per microlitre. This is in line with updated GOLD guidance. Patients with fewer exacerbations or lower eosinophil counts would receive LABA+LAMA inhaled therapy first line.

The Formulary Pharmacist presented an overview of the evidence base to support the formulary inclusion of the requested triple therapy inhalers for first line use in the specific cohort of patients described. The appropriate choice of treatment is based on patients' clinical characteristics and biological information. Overall, pharmacological treatment of patients with COPD is underpinned by use of inhaled LAMA and LABA bronchodilators. Inhaled corticosteroids are also used, in fixed combinations with LABAs, or as part of triple therapy, as they can improve lung function, health status and reduce exacerbations. Current NICE guidance recommends LAMA+LABA combination treatment for those with spirometry confirmed COPD, but that LABA+ICS should be considered in those with asthmatic features, or other features that suggest steroid responsiveness. LABA+LAMA+ICS can be considered should dual therapy be insufficient. Post-hoc analyses of large RCTs found that eosinophil count can predict exacerbation risk and ICS response in COPD and as a result GOLD updated guidance now includes triple inhaled therapy as an option to consider (as an alternative to LABA+LAMA) for first line treatment of patients who have had ≥1 severe [hospitalised] or ≥ 2 moderate exacerbations per year, and eosinophil count ≥300 cells per microlitre). Data from these post-hoc analyses found that the relationship between blood eosinophil counts, and ICS benefits was continuous, with thresholds of <100 cells per microlitre and ≥300 cells per microlitre proposed for identifying individuals with the lowest and greatest likelihood of benefit from ICS treatment, respectively. For those with eosinophil count <300 cells per microlitre, GOLD guidance recommends

LABA+LAMA as the first line treatment, and for those with further exacerbations on this first line strategy, two separate pathways are suggested. For those with eosinophil counts ≥100 cells/microlitre, escalation to LABA+LAMA+ICS is recommended, and in those with <100 cells/microlitre, the options would be addition of either roflumilast or a macrolide. This strategy targets those at high risk of exacerbations - triple therapy would be a first line option in those with an eosinophil count of >100 cells per microlitre and would result in a larger cohort of patients receiving triple inhaled therapy in COPD at point of diagnosis. The evidence base was set out in the evidence briefing enclosed in the paperwork.

With respect to safety, triple therapy regimens are generally well tolerated, evidence suggests a small risk of non-fatal pneumonia, however no major new safety signals are expected from their use compared to the already documented adverse effects.

With respect to the estimated cost impact, the estimated cost impact is within the thresholds the Committee has delegation to approve. However, it was also noted that it is not possible to accurately model the costs, as the rate of current rate of escalation to triple therapy from dual therapy as per criteria in the current SEL guidance is unknown.

The authors (from the respiratory sub-group) were in attendance to present and field any questions. They outlined that the new pathway was developed because the previous SEL guideline is now out of date and not aligned to the current evidence base. It is intended that the inhaler pathway will replace the existing SEL COPD guideline. A full update of the overall COPD guidance is to be undertaken via the respiratory sub-group and completion is anticipated within a few months.

Members queried the eosinophil threshold of >100 cells per microlitre being used to determine suitability for use of triple inhaled therapy first line and whether this was in line with GOLD guidance, which seems to suggest a threshold above 300 cells per microlitre. The presenters clarified that the pathway is in line with GOLD guidance, however there is a different emphasis within the pathway, GOLD guidance *strongly* favours triple inhaler therapy use in patients with an eosinophil count of more than 300 cells per microlitre, however the guidance also favours use in patients with eosinophil counts greater than 100 cells per microlitre. GOLD does not recommend triple therapy use in patients with eosinophil counts less than 100 cells per microlitre. The pathway being presented highlights use of triple therapy being recommended or not recommended based on eosinophil count of more or less than 100 cells per microlitre to make the decision making on choice of treatment simpler. The threshold of 100 cells per microlitre is in line with GOLD recommendations. It was also clarified that the costings presented include the patient cohort that would be initiated on triple therapy with eosinophils above 100 cells per microlitre.

The authors agreed to make a number of amendments to the pathway to make it clearer, including:

- Clarifying the triple therapy of the pathway to include the threshold for blood eosinophil counts as dual therapy side does.
- Clarifying who is responsible for organising the blood test, is it the patients' GP, and the timeframe for this blood test to be completed to remain relevant.
- Include that, for patients who have a raised eosinophil count but have never had an exacerbation, remaining on treatment with just bronchodilators would be appropriate as exacerbation prevention is the main benefit of ICS inclusion.
- Updating the reference to pneumonia to "recurrent pneumonia." In relation to pneumonia, the authors noted that whilst the risk of pneumonia occurring is there, it is lower than the development of uncontrolled disease, which could have worse consequences.
- Including a statement in the pathway noting that available inhalers can be found on the SEL Joint Medicines formulary (SEL JMF), this is to encourage users to prescribe in line with the formulary.
- The reference to EOS in the top box on the main flowchart will be amended to include the units for EOS (cells per microlitre).

It was noted that Trimbow NEXThaler™ is not actually on the SEL formulary, as part of this pathway approval, the request would be to also approve the addition of Trimbow NEXThaler™ onto the formulary.

The presenters also informed the Committee that the current SEL COPD guideline, which includes an inhaler pathway and wider COPD information will be withdrawn and this new inhaler pathway would replace it. Members raised concerns regarding this plan and requested clarity on when the detailed SEL COPD guidance would be available. As it stands the new inhaler pathway alone does not cover important aspects of COPD management that are included in the existing COPD guideline. For example, smoking cessation, management of exacerbations, use of rescue packs and pulmonary rehabilitation and deprescribing/stepping down. Members suggested that the new inhaler pathway could replace the previous inhaler pathway by inserting it into the current SEL guideline meaning that the wider COPD information would remain available. The presenters explained that a review of the full COPD guideline is expected to be completed within a few months via the respiratory sub-group. Many aspects of the wider information within the current SEL guideline are out of date and require an update. The CESEL team will also be creating a full COPD guideline at a later date but as this is not imminent, a rapid review of the existing COPD guideline will be undertaken through the RRPG, with plans to make it more interactive. In the interim clinicians would be encouraged to use the GOLD guidance as this is up to date and referenced within the pathway. As a follow up point, members requested the authors to make signposting to non-pharmacological options in the GOLD guidance more prominent in the new inhaler pathway. Members also noted that the existing formulary recommendation for Trimbow™ and Trelegy™ will need to be updated in line with the new recommendations.

The presenters were asked how outcomes from this new approach to the management of COPD will be measured and responded that the respiratory sub-group is developing a dashboard and would be happy to provide an outcome report in the future. The Committee agreed by consensus to approve the pathway and the following formulary requests relating to the first line use of triple inhaler therapy in COPD in the specific cohort of patients noted, pending amendments in line with discussions:

- Formulary request for recategorisation from a “Red, Amber, Green, Grey” (RAGG) category of Amber 1 to Green and first line use for the following inhalers:
  - Trimbow® NEXThaler® 88 micrograms/5 micrograms/9 micrograms dry powder inhaler
  - Trimbow® pMDI 87 micrograms/5 micrograms/9 micrograms pressurised inhalation, solution.
  - Trelegy® Ellipta® 92 micrograms/ 55 micrograms/22 micrograms inhalation powder line
- Formulary inclusion of Trimbow NEXThaler with a RAGG category of Green

ACTION: Authors to update the inhaler pathway in line with discussions and return to the IMOC team to progress for ratification via Chair’s action.
ACTION: Formulary team to update SEL JMF entries for Trimbow® pMDI and Trelegy® Ellipta from Amber 1 to Green RAGG category and to include Trimbow Nexthaler to SEL JMF as Green once pathway ratified.
ACTION: Formulary recommendation 084 to be updated by SEL IMOC team to remove FEV1 criteria in line with pathway and presented at a future IMOC meeting.
ACTION: Broader COPD guideline to be reviewed and presented back to Committee
ACTION: Authors to develop an outcome monitoring framework to measure suitable outcomes from the new approach to managing COPD

5. Formulary requests relating to the use of melatonin in sleep disorders/insomnia:
i. Request to recategorise melatonin from Amber 3 to Amber 2 in children and young people aged less than 18 years old with sleep disturbance and insomnia
ii. Request to include a licensed melatonin 1mg/ml oral solution (Ceyesto™) in adults and paediatrics to replace the unlicensed preparation (Kidmel™)

This item was deferred to another meeting at the request of the presenter.

6. Updated formulary recommendation dienogest (Zalkya™) tablets for the treatment of endometriosis

Following presentation of the outcome data at the last IMOC meeting, the associated formulary recommendation has been updated to remove the time limited approval as agreed by Committee members. A query was raised in relation to a statement within the recommendation which notes that review would be needed by the initiating specialist. It was clarified that this statement was the initial

agreement when the recommendation was originally drafted, however the statement would be amended to note that a review should take place regularly, without reference to the specialist thus allowing flexibility in which clinician conducts the review.

The Committee approved by consensus the updated formulary recommendation pending amendment in line with discussions.

ACTION: IMOC Team to update the formulary recommendation in line with the amendment and progress for ratification via Chair's action.

7. **Draft proposals for regional arrangements for Medicines Optimisation in London**

The Regional Medicines Optimisation Committees (RMOC) were set up as part of 7 national regional forums for medicines optimisation in 2017 by NHS England (NHSE), including the London RMOC. Following changes to structures in the NHS and the introduction of ICS's, many RMOCs across England regions are no longer meeting. There is an appetite to continue with a forum across London, given the large and mobile population. The draft proposal from NHSE seeks to gauge views on a potential successor to the London RMOC. The proposal sets out the details around the structure, governance, and membership of the new London group. Members were invited to comment on the proposals – no immediate comments were raised in the meeting. Members were informed that a survey is due to be published by NHSE London region to gauge views on the proposals and this will be consulted on via the Committee's membership.

8. **Formulary request to re-include Anthelios® SPF50+Sunscreen for protection from UV radiation in specific patient cohorts**

A specialist dermatology pharmacist and the borough dermatology lead presented this item, explaining that Anthelios® was previously on the formulary however due to its reformulation, it was removed from the Advisory Committee on Borderline Substances (ACBS) list and as a result removed from the SEL JMF. A new reformulated product is now available and has been re-included on the ACBS list. The request is for the formulary re-inclusion of the new Anthelios® SPF50+Sunscreen preparation for protection from UV radiation in specific patient cohorts in line with the ACBS criteria as the preferred sunscreen for prescribing in this setting. The alternative sunscreen products on the formulary have frequent supply issues and are less cosmetically acceptable to patients whereas Anthelios® has been reported by patients to be well tolerated. It is also requested that Sunsense Ultra® remains on the formulary and that Uvistat® is also added once the supply issues resolve to provide alternatives in case supply issues arise. The suggested formulary RAGG category is Amber 1 in this setting as the dermatology specialist teams would recommend the initiation of Anthelios® to primary care. There would be no additional cost to include this product onto the formulary because it would be prescribed in substitution to the available products and could provide cost saving because it is cheaper per millilitre than the available products. Members requested that the formulary entry for Antheolios® clearly states the indications accepted for use to distinguish between indications where prescribing is recommended versus self-care indications, where sunscreen should be purchased over the counter. It should also be noted as the first line choice and to be prescribed on dermatology specialist recommendation only. Members agreed that Sunsense Ultra®, which is uncategorised on the formulary will be categorised as Amber 1 to provide consistency of RAGG categories in this setting. It was noted that Uvistat® is not on the formulary, currently it has long term supply disruptions, it was agreed that once supply is available Uvistat™ would be added to the formulary as a treatment option but not first line, with a RAGG category of Amber 1.

The Committee approved by consensus the formulary re-inclusion Anthelios® SPF50+Sunscreen as Amber 1-and as the 1st line sunscreen option for protection from UV radiation in specific patient cohorts meeting the ACBS criteria. Members also approved the categorisation of Sunsense Ultra® and Uvistat® (once supply issues resolve) to Amber 1. In line with discussions, the formulary entry must make clear the specific indications for use (in line with ACBS criteria) and that prescribing in primary care is on dermatology specialist recommendation only.

ACTION: Sunscreens Anthelios®, Sunsense Ultra® and Uvistat® to be added to the SEL JMF in line with the discussions

9. Valproate safety update following publication of the national patient safety alert (NPSA)

The medicines safety lead presented this update for information to the Committee. The risk of valproate is well known, since 2018, valproate prescribing has been contraindicated in women of child-bearing age unless an individualised pregnancy prevention programme (PPP) has been in place. The Medicines and Healthcare Products Regulatory Agency (MHRA) issued a National Patient Safety Alert (NPSA) for action by Integrated Care Boards (ICBs) in England, with a deadline for completion of 31st January 2024. The MHRA asked organisations to put in place an Action and Improvement Plan across the ICS to implement the new regulatory measures for sodium valproate, valproic acid and valproate semisodium prescribing**.** ICBs were tasked with designating a valproate group to co-ordinate the implementation of the new regulatory measures in providers with oversight from senior quality.

The regulatory change in January 2024, for oral valproate medicines means that:

- Valproate must not be started in new patients (male or female) younger than 55 years, unless two specialists independently consider and document that there is no other effective or tolerated treatment, or there are compelling reasons that the reproductive risks do not apply.
- At their next annual specialist review, women with childbearing potential and girls should be reviewed using a revised valproate Risk Acknowledgement Form, which will include the need for a second specialist signature if the patient is to continue with valproate and subsequent annual reviews with one specialist unless the patient's situation changes

Within SEL, a system-wide Valproate Working Group was convened in December 2023, with appropriate quality and Medicines Optimisation leadership. The group has representation from all providers within SEL and has convened 3 meetings to date with 2 more planned. To support the implementation of the regulatory changes, ICBs were required to document progress towards the 5 actions noted below. In SEL progress has been made for each action as follows:

- Update all local guidance and protocols relating to prescribing of valproate to reflect the new regulatory position, including definitions of the roles and responsibilities of clinicians and provider organisations, and the recording of compliance with the risk forms. *Revision of local guidelines and protocols are underway in all provider organisations, roles and responsibilities of clinicians are being defined and compliance of risk forms are being determined.*
- Commissioning work if necessary to understand the needs of the affected population, including those people most at risk of health inequalities*. Several areas of work are underway including but not limited to: The development of a data dashboard, utilisation of SNOMED codes in primary and secondary care, work with Ardens on templates for men and force launch templates and primary care audits.*
- Reviewing the results of local audit(s) of compliance with the existing pregnancy prevention programme (PPP) measures for girls and women of childbearing potential prescribed valproate. *All reviews are underway in provider organisations and some providers already have appropriate audits in place.*
- Commissioning/determining the local pathways of care for women of childbearing potential and girls in relation to the prescribing and review of valproate*. All providers are in the process of developing a single page patient pathway which makes patient entry and exit from the system clear. The planning and identification of clinical resources is underway at all provider organisations and plans for second signatures include the use of a mixture of multidisciplinary team approach, clinical nurse specialists or pharmacists as independent clinicians to review a clinical decision to prescribe valproate.*
- Planning for and identification of clinical resource to meet the identified needs of the population and implement the new regulatory measures. *Progress as per action noted above.*

In addition to the 5 actions above requested by the NPSA, there are several additional actions that the SEL Valproate Working Group deemed necessary to complete within SEL, such as developing the roles and responsibilities of community pharmacists in relation to valproate prescribing. Overall,

progress in SEL has been positive. Members noted the presentation and acknowledged that the speed of progress will be dependent on the staff capacity involved.

10. Updated SEL formulary feedback letter

The borough lead presented this item, which is an update to an existing letter template which was due a review. The letter provides support for primary care in the referral of patients back to their specialist where appropriate, where it is felt the transfer of prescribing is inappropriate. The letter provides a checklist for the practice to complete to describe the reasons to the specialist for declining the prescribing request. The intention is for formulary pharmacists and Medicines Optimisation Teams (MOTs) to be provided with a copy of this letter when sent to the specialist, which would allow for prescribing themes and trends to be captured and analysed. The main updates to the letter were changing mentions of the previous medicines group – Area Prescribing Committee (APC) to IMOC and updating the Trust and MOT contact details. The presenter noted a couple of minor formatting changes that were requested after the version of the letter had been circulated within the agenda pack.

GP members felt that, if feasible, a separate template letter in patient friendly language would be useful to notify patients, especially as the language in the specialist letter may be too advanced for some patients. A couple of minor amendments were requested to make clear to those completing not to send patient identifiable data to the MOTs and to separate the Trust and MOT contact details from the main letter.

Members approved the updated practice letter by consensus, pending amendments in line with discussions.

ACTION: Authors to update the formulary feedback letter and return to the IMOC team to progress for ratification via Chair's action
ACTION: Authors to develop a patient letter for presentation to the Committee

11. Updated primary care antimicrobial guidelines for SEL – sections on upper and lower respiratory tract infections

The Borough leads for this guideline presented this item. A process is underway through the Primary Care Antimicrobial Stewardship Group to harmonise antimicrobial prescribing guidelines across the 6 SEL boroughs. This is being taken forward in a cyclical way, section by section and the current section being presented is for upper respiratory tract infections (UTRI) and lower respiratory tract infections (LTRI).

The URTI section covers: Acute otitis externa (AOE), acute otitis media (AOM), acute sore throat / pharyngitis / tonsillitis, malignant otitis externa, scarlet fever, and sinusitis. The LRTI section covers: Acute cough, bronchitis, infective exacerbation of COPD, community acquired pneumonia, COVID-19 (community management) and influenza. The oversight for this work is through the SEL Forum for Antimicrobial Stewardship (SEL FAS); the primary care group is a sub-group of the SEL FAS. Once approved, the guidance in this section (upper and lower respiratory tract infections) will be added to the online platform MicroGuide for primary care to access (launch pending). The presenters took Committee members through the recommendations for the respiratory tract infections sections. It was noted that for all lower respiratory tract infections, all recommendations to use quinolones have been removed following the recently published MHRA safety alert regarding fluoroquinolones.

A point was raised regarding the national MO opportunities and the opportunity relating to moving to a course duration of 5 days for amoxicillin. Some sections of the guidelines are recommending 5 – 7 days of amoxicillin, which is not in line with the national opportunity. The presenters confirmed that this had been discussed with the specialists involved and it was agreed that a 5 -7 day treatment range would be clinically suitable as it was felt that clinical judgement would be needed to determine course duration. Prescribing a shorter duration could lead to treatment failure and subsequently the need for further courses of antibiotics. In all guides, for antibiotics that have varied options for treatment duration the statement "prescriber should consider the shortest effective course of antibiotics" will be included, this is to encourage the shortest duration of antibiotics where clinically appropriate.

Other comments raised related to making self-care and prescribable options clearer, for example, moving Otomize® in the AOE section is a prescription only medicine, EarCalm® is an over the counter remedy. The presenters also explained that a varied dose range is being recommended for erythromycin in pregnancy or breastfeeding. Instead of 500mg four times daily, the dose would be 250mg - 500mg four times daily with the caveat that the higher dose of 500mg would be for more severe infections and the lower dose for less severe.

Members noted the inclusion of a herbal medicine (pelargonium) for acute cough and bronchitis and requested that the evidence base for this recommendation is confirmed. It was agreed that the sore throat guidance would be updated to specify that the dose options for phenoxymethylpenicillin are to be prescribed as 5 *or* 10 days depending on severity rather than a range choice of 5 *to* 10 days. A link to the SEL JMF will also be added along with signposting to the acute provider collaborative adult ENT guidelines in the appropriate sections.

Committee members approved the URTI and LRTI guideline sections by consensus pending the amendments discussed.

ACTION: Guideline to be updated by authors and returned to the IMOC team to progress for ratification via Chair's action

12. Standing items/Items for information only

- Formulary submissions tracker

Noted.

- NICE Technology Appraisal (TA) Guidance Summary

ICS related TAs:

- Since the last meeting there were no new NICE TAs issued which were relevant to ICBs.
- RAGG categories were agreed by consensus for the NHSE commissioned NICE TAs.

- RMOC Update

Nil for this meeting. Proposals for a successor to the London RMOC were discussed earlier in the meeting,

- For information and noting:
  - Adult and paediatric formulary updates

These were noted by Committee members.

13. Any Other Business

Nil items raised.

IMOC dates for next 3 months

Date	Time	Venue
Thursday 21st March	2pm - 4:30pm	MS Teams
Thursday 25th April	2pm - 4:30pm	MS Teams
Thursday 16th May	2pm – 4.30pm	MS Teams