South East London Integrated Medicines Optimisation Committee Meeting
19 May 2022 (Meeting held via MS Teams)
Final Minutes

1. Welcome, introductions and apologies

The Chair welcomed attendees to the meeting followed by a round of introductions. 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 annual declarations be returned. No conflicts were declared.

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

The minutes were accepted and approved as an accurate record pending a correction to a minor grammatical error and the addition of "disease" to any reference to "Parkinson specialists". Members were provided with an update on progress against actions due for this month, these were noted, and items closed were agreed.

4. Updated guideline for the use of sodium glucose co-transporter 2 inhibitors (SGLT2i) in patients with heart failure with reduced ejection fraction (HFrEF) without diabetes mellitus

The authors were in attendance to present this item, the main updates to the guideline are:

- Inclusion of empagliflozin as a treatment option for the management of HFrEF without diabetes mellitus in line with NICE TA 773.
- Proposed amendment to the "Red, amber, green, grey" (RAGG) categorisation from Amber 2 to Amber 1. This reflects a consensus view from local HF specialists regarding the RAGG rating for SGLT2i in this setting as this is in line with NICE guidance, which recommends SGLT2i can be initiated on the advice of a HF specialist.

It was noted that in terms of the resource impact, NICE do not expect their guidance to have a significant resource impact as empagliflozin represents an additional option to dapagliflozin for the management of HFrEF.

Comments were raised regarding the recategorisation of SGLT2i from Amber 2 to Amber 1 in this patient cohort as the use of SGLT2i for this indication is fairly new and involves in depth knowledge by both the GP and the patient in regards to aspects such as sick day rules. The author outlined that the specialist HF teams provide in depth education to patients regarding aspects such as sick day rules, a document is provided to all patients regarding sick day rules which the Trust would be happy to share with primary care. In addition to this educational events can also be delivered to primary care to support the management of patients.

Further comments were raised regarding suggested changes to the guideline which included amending all references to"SGLT2i" within the guideline to "NICE approved SGLT2i" or specify the names of the NICE approved SGLT2i agents, as there are differences in the licensing for SGLT2i's and only dapagliflozin and empagliflozin are currently licensed/NICE approved in this indication.

The Committee agreed **in principle** to the recategorisation of SGLT2i for the management of HFrEF from Amber 2 to Amber 1 and the guideline by consensus. Final approval is pending the presentation of the SGLT2i in HFrEF patient information document and the updated guideline in line with the discussion at the next SEL IMOC meeting.

ACTION: Updated guideline and SGLT2i in HFrEF patient information document to be re-presented at next SEL IMOC meeting.

5. Updated type 2 diabetes mellitus (T2DM) glycaemic control management guideline and associated resources

The deputy chair of the diabetes sub-group was in attendance to present this item. The main update to the T2DM glycaemic control guideline is to align to the updated NICE guideline on the management of Type 2 diabetes which now differentiates the treatment of T2DM based on a patient's risk of cardiovascular disease

(CVD). For patients with T2DM at high risk of CVD or with established CVD or HF, it is now recommended this cohort of patients should receive treatment with a SGLT2i alongside metformin.

From a cost impact perspective, Committee members were asked to note that based on the assumptions of the cohorts of patients who would be eligible for treatment with a SGLT2i in line with the updated guidance, at steady state (year 3) the estimated cost is above the threshold the Committee is permitted to approve. In line with this, the decision to approve the updated guideline and associated resources is on a clinical basis only. Further approval will be required from a financial perspective once the figures have been scrutinised and escalated to senior finance colleagues.

The associated resources - SGLT2i prescribing guide for HbA1c reduction in T2DM has been produced to support the safe and appropriate prescribing of SGLT2i. The GLP-1 analogue pathway has been updated to reflect the terminology in the updated T2DM glycaemic control guideline.

The Committee thanked the authors of the guideline and associated resources who were unable to attend the meeting for all their work in updating the glycaemic control guideline and associated resources.

Committee members approved the T2DM glycaemic control guideline and associated resources by consensus on a clinical basis only and acknowledged that the cost analysis will be reviewed again and escalated as appropriate if it exceeds the SEL IMOC approval threshold. Members and the presenter were requested to note that until this process is complete, the revised guidance cannot be published.

ACTION: Cost impact of updated T2DM glycaemic control guideline to be further scrutinised via the diabetes sub-group to confirm if further escalation for approval of the guideline is required.

6. Updated flash glucose patient-prescriber agreement

The deputy chair of the diabetes sub-group was in attendance to present this item. The current flash glucose patient-prescriber agreement form requires patients to sign the form acknowledging that the use of flash glucose is on a trial basis. The updated NICE guidance now includes a wider cohort of patients who are eligible for flash glucose and there are no stopping rules within the revised guidance. A process is underway at London level to develop pan-London guidance for the new cohorts of patients approved by NICE. To reduce the bureaucratic process of requesting a patient signature upon initiating flash glucose, the Committee were asked to consider an updated form without the patient signature box. The form has been updated following a recommendation from NHS England and Improvement.

Committee members approved the updated flash glucose patient-prescriber agreement by consensus.

7. Updated clinical guidance for the management of vitamin D deficiency and insufficiency in infants, children and young people up to the age of 18 years

The author was in attendance and presented this item with support from the Greenwich Assistant Director of Medicines Optimisation team. The main update to the guideline is the recommendation of only one vitamin D formulation for the treatment of vitamin D deficiency and insufficiency to support the reduction in prescribing of unlicensed vitamin D products.

The guideline has also been updated to include the prescribing of high dose vitamin D for the management of vitamin D insufficiency due to children experiencing worsening of symptoms when advised to buy vitamin D over the counter.

A comment was raised regarding the choice to include only one vitamin D option in the guideline and how a supply issue would be managed if this was to occur. The author clarified that the recommendation of one vitamin D formulation helps to standardise the advice being provided from a safety perspective and should a supply issue occur, the authors would review alternative options as soon as a shortage was identified and communicate this to clinicians.

Committee members discussed the addition of an ergocalciferol monograph within the paediatric formulary will require the submission of an abridged formulary application and will need to be discussed for approval at a future SEL IMOC meeting if this is to be prescribed/administered in primary care. The author confirmed that this will be progressed.

Additional updates to the guideline were discussed which included the addition of a recommendation to the guideline asking primary care clinicians to seek advice and guidance as opposed to a referral to a specialist when they are not sure on how to manage a child with vitamin deficiency/insufficiency.

Committee members approved the guideline by consensus pending the amendments as per the discussion.

ACTION: Guideline to be amended as per discussion and progressed for ratification via Chair's action.
ACTION: Authors to progress abridged application to IMOC for ergocalciferol inclusion in the paediatric formulary.

8. Request to add Relvar Ellipta™ (fluticasone furoate/vilanterol) 184/22 and 92/22 to the paediatric formulary for the management of asthma

The Formulary Pharmacist presented this item to add Relvar Ellipta™ to the SEL paediatric formulary for the management of asthma in children 12 years and above as Amber 1 (specialist recommendation). Relvar Ellipta™ will be an alternative option to Symbicort™ for this patient cohort, which is similar in cost but Relvar Ellipta™ has the added benefit of being once a day dosing.

It was noted that the prescribing of Relvar Ellipta™ is already occurring and this request would formalise the status on the formulary. The anticipated cost impact is within the thresholds the Committee can approve. A comment was raised as to whether a steroid card is required with Relvar Ellipta™. The presenter confirmed this would be clarified and included within the formulary monograph if required.

The Committee agreed by consensus the inclusion of Relvar Ellipta™ (fluticasone furoate/vilanterol) 184/22 and 92/22 as Amber 1 (specialist recommendation) to the paediatric formulary for children with asthma aged 12 years and over.

ACTION: Relvar Ellipta™ 184/22 and 92/22 to be added to the paediatric formulary as Amber 1 for the management of asthma for patients aged 12 years and over.

9. Updated South East London intravitreal ophthalmology pathways and outcomes and monitoring framework

The author was in attendance to present this item with support from the Greenwich Assistant Director of Medicines Optimisation, who leads the Ophthalmology sub-group. The wet age-related macular degeneration (wet AMD) section of the guideline has been updated to include the third NICE approved agent brolucizumab for treating wet AMD and the use of biosimilar agents. Locally, the use of brolucizumab has been low due to its safety profile which has limited its role. The wet AMD section has also been updated to include an outcomes and monitoring framework.

The diabetic macular oedema (DMO) and central and branch retinal vein occlusion (CRVO and BRVO) sections of the guide are still to be updated in line with 2 new NICE approved agents coming to the market and the recent publication of the retinal vein occlusion guidance by the Royal College of Ophthalmologists. Comments were raised regarding updates to the guideline which include adding the statement regarding the use of biosimilars in the wet AMD section to the DMO section and creating a standalone document for the outcomes and monitoring framework.

Committee members approved the updated guideline and outcomes and monitoring framework by consensus for a period of 6 months in line with the further updates required to the guideline and the inclusion of ranibizumab biosimilar.

ACTION: Guideline and outcomes and monitoring framework to be amended as per discussions and progressed for ratification via Chair's action.

10. Request to add cyanocobalamin to the formulary for the management of vitamin B12 deficiency where administration of IM hydroxocobalamin is not possible or not tolerated

The Formulary Pharmacist presented a request to add cyanocobalamin tablets to the formulary as a Green medicine based on the historical use of cyanocobalamin for this indication. Currently there are unlicenced versions of cyanocobalamin tablets being prescribed in primary and secondary care, which is subject to cost fluctuation however, there is a 1mg licensed product available – Orobalin™.

It was noted the anticipated cost impact is within the thresholds the Committee can approve. Most of this cost is likely to be in the baseline as prescribing is already occurring in primary care.

A comment was raised whether brand prescribing of cyanocobalamin tablets would need to be encouraged to ensure the most cost effective formulation is dispensed for patients. The presenter confirmed brand prescribing is encouraged and would be reflected in the formulary entry.

Committee members agreed by consensus for the inclusion of cyanocobalamin tablets to the SEL JMF for the management of vitamin B12 deficiency where administration of IM hydroxocobalamin is not possible or not tolerated.

ACTION: Cyanocobalamin tablets to be added to the SEL JMF for the management of vitamin B12 deficiency where administration of IM hydroxocobalamin is not possible or not tolerated.

11. Updated guideline for the management of Cow's milk allergy (CMA) and prescribing of hypoallergenic formula in primary care and summary presentation

The authors were in attendance to present the updated CMA guideline which has been updated to better support the diagnosis and management of CMA, promote breastfeeding, support clinicians to appropriately prescribe CMA products and reduce the waste of CMA products.

Comments were raised on how best to manage parent/carer expectations when waiting times for referral to a dietician is high and the request to prescribe CMA is often requested by parents/carers. The authors confirmed the new local rapid access dietetic service should address the long waiting times following referral. There are also plans for educational webinars to support the implementation of the guideline and the local paediatric dietetic service are happy to attend GP practices to provide training. A Committee member shared it would be useful to have access to short videos with CMA advice which can be used to signpost parents/carers to in scenarios where a request for CMA is made but is not appropriate.

The Committee also noted the appendices within the guideline will be uploaded to a dedicated webpage on the SEL CCG website as opposed to additional pages within the guideline.

Committee members approved the guideline by consensus.

ACTION: Southwark Medicines Optimisation Team to support authors with upload of the guideline appendices to a dedicated page on the SEL CCG website. Once complete, guideline to be uploaded to SEL IMOC webpage.

12. Standing items

- Formulary submissions tracker

Noted.

- NICE Technology Appraisal Guidance Summary

The summary was noted and Red, Amber, Green, Grey (RAGG) categories were agreed by consensus for NICE TAs published since the last meeting.

- RMOC update

Feedback from the London RMOC meeting was provided to the Committee, in particular the role of the London Formulary Medicines Group (LFMG) and its outputs. The Committee noted there will be various outputs from the LFMG. As these outputs will be advisory to integrated care system (ICS) areas, the Committee will need to make local decisions on these outputs. There should be consultation with local ICS areas as part of the LFMG guidance development process, to help streamline the decision process at ICS level.

13. Any other business

The Chair thanked the Business Support Officer for their work to support administration of the Committee over the last 18 months. Committee members wished the Business Support Officer well in their new role.

IMOC dates for next 3 months

Date	Time	Venue
16th June 2022	2:00pm – 4:30pm	MS Teams
21st July 2022	2:00pm – 4:30pm	MS Teams
18th August 2022	2:00pm – 4:30pm	MS Teams