South East London Integrated Medicines Optimisation Committee (SEL IMOC) Meeting
Thursday 20th June 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. **Minutes, detailed action notes from the last meeting and action log:**
   The minutes and detailed action notes were accepted as an accurate record of the meeting subject to the correction of 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. **Updated SEL dermatology primary care guideline: Updates to the scabies section and associated formulary request**

   - **Formulary request to categorise ivermectin tablets as Green for the treatment of scabies in adults and children**

   The applicant making the formulary request (a GP specialist in dermatology) was in attendance to present this item. The request covers approval for updates made to the scabies section of the SEL dermatology primary care guideline, approved by the dermatology sub-group at its meeting in May 2024. There is also an associated formulary request to categorise ivermectin tablets as green for the treatment of scabies in children and adults. Ivermectin tablets are already included on both the adult and paediatric formularies for use in scabies. They are not “Red, Amber, Green, Grey” (RAGG) categorised on the adult formulary and categorised as red (hospital only) on the paediatric formulary. The presenter explained that previously ivermectin was available as an unlicensed special tablet, however it is now available as a licensed generic with a more regulated acquisition cost. An update to the scabies pathway was a priority because there have been significant problems with increased cases of scabies nationally and locally and shortages in topical treatments permethrin 5% and malathion 10%. As a result ivermectin prescribing in primary care has increased with resultant increased costs due to prescribing of unlicensed specials. In terms of the RAGG category, a Green category is being recommended for ivermectin tablets. This would be supported through the use of the OptimiseRx prescribing decision software in primary care to encourage selection of the generic product rather than the special, where ivermectin is indicated. The cost impact of implementing ivermectin as Green on the formulary is within the delegated financial threshold for the Committee. In reality, the cost is substituting for the previous costs of specials and could be cost saving.

   The presenter described the main updates to the scabies section, which included addition of information on the location of topical application. If after two full treatments of topical preparations the patient returned and it was clear that they still had scabies, ivermectin licensed generic tablets would be appropriate to prescribe. There is also an emphasis on additional measures such as treating scabies contacts and dealing with re-infection. The referrals and appendix sections of the dermatology guidance were also updated, main updates included revision of the advice on how to contact acute Trusts and information on the tele-dermatology pathway. The presenter confirmed that these changes are not medicines related and therefore not for the Committee to approve.

   As part of the Committee discussion, the presenter confirmed that that the request relates to both children and adults as ivermectin is suitable for all children over 15kg and has been used internationally for undiagnosed treatment, but advice and guidance could be sought if there were concerns. A query was raised regarding advice in the scabies pathway that two ivermectin doses should be used one week apart, however this differs from the National Institute for Health and Care Excellence (NICE) Clinical Knowledge Summaries and Summary of Product Characteristics, where a second dose is not recommended and should only be considered in certain circumstances. The presenter confirmed that the British Journal of Dermatology (BJD) had published examination of success rates of treatment,

which were significantly better with two applications. European guidance routinely advises 2 doses. It was agreed to highlight within the guidance that this was off-label use supported by clinical practice and British Association of Dermatologists. The presenter was also requested to add a reference for the advice relating to the use of a 7 – 10 day course of flucloxacillin in impetiginisation. The guidance will also be amended to make it clearer that ivermectin is a second line treatment option after topical options, given that supplies of topicals had now stabilised. In response to a concern regarding the necessary experience in primary care to start ivermectin tablets, the presenter noted that consultant connect can be used to obtain advice and adding a reference to consultant connect in the guidance will be considered.
Post meeting note: The author confirmed post meeting that reference to consultant connect is already made within the referrals appendix section.

Committee members agreed by consensus to approve the scabies pathway and the categorisation of ivermectin tablets as Green for scabies, pending amendments in line with discussions.

ACTION: Authors to update the scabies pathway and share with IMOC team to progress for ratification via Chair's action
ACTION: Formulary entry for ivermectin to be updated to Green once scabies pathway has been ratified

5. **SEL Acute Provider Collaborative (APC) ear, nose & throat (ENT) paediatric primary and secondary care interface guidelines: approval of the medicines content and associated formulary requests for the SEL paediatric formulary:**

Otitis media (abridged paediatric formulary request):
- Otigo™ (phenazone 40 mg/g with lidocaine 10 mg/g) as Green for the treatment of acute otitis media in under 18's

The following formulary requests were presented in a summary table – all being requested as Green RAGG category in the paediatric formulary in line with licensed uses:
Otitis Externa:
- Earcalm™ ear spray (acetic acid 2% ear spray, children 12 years and over)
- Betnesol-N™ ear drops (betamethasone sodium phosphate 0.1%, neomycin sulphate 0.5%) (children of any age)
- Otomize™ ear spray (dexamethasone 0.1%, neomycin sulphate 3250 units/mL, glacial acetic acid 2% - children 2 years and over)

Allergic rhinitis:
- Azelastine 0.1% (Rhinolast™) & 0.15% Azelair™, children 6 years and over
- Mometasone intranasal spray, children 3 years or over

Epistaxis:
- Naseptin™ (neomycin sulfate and chlorhexidine dihydrochloride) nasal cream as Green for the treatment of epistaxis (off-label) in children 1 month or over

The SEL APC Primary Care GP lead for ENT was in attendance to present this item. The guideline was written with a collaborative effort and has undergone wide consultation to this point. The request is for the Committee to approve the medicines related contents of the guideline and the associated formulary requests.

Otigo™ is being requested as a Green paediatric formulary entry for acute otitis media in line with NICE Guideline number 91 on antimicrobial prescribing in acute otitis media. The guideline notes Otigo™ as a second line treatment option after regular doses of paracetamol or ibuprofen for pain. Inclusion in the paediatric ENT guideline is important to support the reduction of antibiotic usage /resistance as it provides clinicians with more treatment options for otitis media before an antibiotic. The presenter also took the Committee through the additional formulary requests that were listed in the separate table. It was noted that for most of these, there is some existing non-formulary prescribing in primary care, suggesting there will be confidence in having these categorised as Green.
The total estimated cost impact of these formulary additions is within the financial threshold delegated to the Committee.

Committee members discussed the guideline and the following amendments were requested:

- Within the acute and recurrent otitis media section, clarification will be added that that in line with NICE criteria, where Otigo™ is considered, it is recommended for up to 7 days and only when an immediate oral antibiotic is not given.
- Within the allergic rhinitis - moderate or severe section, Dymista™ & Ryaltris™, would be changed to Dymista™ *or* Ryaltris™ as treatment is with one or the other combination preparation in primary care before referral.
- Under the nasal congestion/rhinorrhoea section, there is reference to the use of fluticasone and mometasone nasal sprays, which is not listed as part of the formulary requests and is off-label use. Members agreed by consensus that a statement should be added that the use of fluticasone and mometasone nasal sprays for nasal congestion/rhinorrhoea that is not related to seasonal or perennial allergic rhinitis is off-label.
- The product names of the combination topical antibiotic /topical steroids being recommended in the acute otitis externa section will be included, in line with the formulary requests being made for clarity (Betnesol-N™ ear drops & Otomize™ ear spray).
- The "Chronic Otitis Externa with Effusion (Glue Ear)," heading will be updated to "Chronic Otitis Media with Effusion (Glue Ear)" as this is what the contents of the page refers to.

ACTION: Authors to update the APC ENT paediatric primary and secondary care interface guidelines and share with IMOC team to progress for ratification via Chair's action
ACTION: Paediatric formulary to be updated to include Otigo™, Naseptin™, Earcalm™ ear spray Betnesol-N™ ear drops, Otomize™ Ear spray, Rhinolast™ & Azelair™ and Mometasone as Green for their agreed indications once the APC ENT guideline has been ratified via IMOC Chair and signed off via APC governance processes

6. **Updated formulary recommendation 084 - Triple combination therapy inhalers (Trelegy® Ellipta & Trimbow® (including Trimbow® NEXThaler®) for adults with COPD**

Following approval of the COPD inhaler pathway, this formulary recommendation has been updated to reflect the recategorisation of triple combination therapy inhalers in COPD from Amber 1 to Green. The updated criteria for triple therapy agreed use have been included in the recommendation. No feedback was received via the virtual Triage Panel review process. The Committee approved by consensus the updated formulary recommendation.

7. **Formulary inclusion of long-acting octreotide and lanreotide injections as Amber 2 for the following indications:**

    - **Specified palliative care indications as per the abridged formulary request**
    - **High output ileostomy**
    - **Short bowel syndrome**
    - **Intestinal obstruction**
    - **Diarrhoea of malignancy**

The applicant (a Consultant in palliative care) was in in attendance to present this item with the lead Formulary Pharmacist. With respect to the rationale for the request, short-acting octreotide injection is already available on the SEL Joint Medicines Formulary (JMF) as Amber 1 for palliative care indications. Various off-label indications are also formulary included, including: high output ileostomy, short bowel syndrome, palliative management of intestinal obstruction, and diarrhoea associated with malignancy. Lanreotide long-acting injection is on formulary for use in its licensed indications.

This request is for the formulary inclusion of the long-acting injection (LAI) variation of octreotide and lanreotide as Amber 2 in off-label palliative care indications. The LAI versions of octreotide and lanreotide would prove beneficial as the short-acting octreotide injection is given multiple times (usually 3 times) a day or via a continuous subcutaneous infusion and some palliative care patients could be receiving this for several weeks or months. This often requires district nurses to administer to patients three times a day often three different nursing staff, or the set-up of a syringe driver every day, whereas

the LAI could be given once a month in a single administration of a deep intramuscular injection or a subcutaneous injection depending on the preparation (intramuscular for octreotide, subcutaneous for lanreotide). Both preparations are required for inclusion onto the formulary as patient factors may determine which preparation is used. Additionally, there have been shortages in the past of one where the other has been used as an alternative.

The treatment is recommended in both the national Palliative Care Formulary and the Scottish Palliative Care Guidelines. Costs for the LAI preparation is similar to the short acting formulation, but there are potential cost savings for the system in reducing the district nursing costs from a once-a-monthly visit for an injection versus multiple times a day. The request for LAI formulations has been discussed and is supported by the SEL Palliative Care Medicines Improvement Group. Historically Trusts have submitted individual funding requests (IFR) to request approval to use the long-acting injections in the off-label indications noted. The IFR requests submitted are summarised within formulary request. Members noted that the majority of the IFR requests were not for palliative care indications, with the majority being for high output stoma and short bowel syndrome.

The short-acting octreotide injection has a RAGG category of Amber 1 in the palliative care setting, however an Amber 2 RAGG category is being sought for the LAI as this category is deemed more suitable for the LAI's following discussions at the Palliative Care Medicines Improvement Group. This is because there is a need for the palliative care team to monitor response to the immediate release injection first before recommending transfer to a LAI. Primary care would not be required to do any additional monitoring in comparison to the immediate release injection and the palliative care team would continue to monitor patients and their symptoms.

During the Committee's discussion of the request, the applicant confirmed that the LAI would only be given if the patient had received the short-acting formulation and this was successful in proving efficacy. Given the indications requested under IFR, members queried who would be responsible for recommendation, initiation and monitoring for the indications such as high output stoma or short bowel syndrome for non-malignant and non-palliative care cases. The applicant agreed that palliative care could not take on monitoring of the non-palliative care patients. The formulary lead explained that in relation to the non-palliative care gastroenterology indications (short bowel syndrome & high output stoma), historically these require IFR applications, which can be a time and staff resource intensive process. As prescribing of the LAIs would remain in the secondary care setting for these two gastroenterology indications and they formed the bulk of the IFR requests, Committee members were requested to consider approving these as Red. Patients would already be on the short-acting version of octreotide. It was confirmed that patient numbers are low – less than 10 a year and the cost similar to use of the short-acting version. Members felt this was reasonable for the two gastroenterology indications but requested that the formulary wording for the gastroenterology indications and the palliative care indications is presented at the next IMOC meeting for review. Support from the gastroenterology teams should also be confirmed along with any potential cost impact.

For the palliative care indications, it was confirmed that the estimated patient numbers quoted within the agenda paperwork were based on IFRs and may increase slightly due to higher incidence rates particularly colorectal cancer in younger people but will likely remain low overall. It was also clarified that the octreotide and lanreotide LAI prescribing would be initiated with one month's supply from specialist care before requesting primary care to continue prescribing.

The Committee approved by consensus the inclusion of LAI of lanreotide and octreotide for palliative care indications described as Amber 2. It was also agreed that the non-palliative gastroenterology off-label indications of short bowel syndrome and high output stoma would be categorised as Red on the formulary. This is pending a review of the proposed formulary wording and confirmation of support from the gastroenterology teams at the next IMOC meeting, along with clarification on whether any additional cost impact is expected. Until the formulary wording is agreed, the formulary status for LAI octreotide and lanreotide remains as non-formulary for both palliative care and the agreed gastroenterology indications.

ACTION: Formulary leads to present proposed formulary wording for lanreotide and octreotide LAI in palliative care and gastroenterology indications (short bowel syndrome and high output stoma) at a future IMOC meeting.

8. Outcome data for the use of safinamide for the management of Parkinson's disease in adults and safinamide prescribing data for primary care

A Consultant Pharmacist in neurology and a Consultant Parkinson's disease nurse were in attendance to present this item. Safinamide was originally added to the SEL formulary in 2020 under a red RAGG category for a time limited period of 1 year. The status was reviewed in September 2021, when the RAGG category was approved as Amber 2 but another time limit was applied to enable some further data on use and outcomes to be shared back. An outcomes report was included in the agenda paperwork and a previously unshared slide set was presented to highlight two positive patient case studies of safinamide use to demonstrate safinamide is beneficial in reducing Parkinson's disease related symptoms. In summary, the outcomes report for KCH and LGT (covering two and a half years of data) included the total number of patients treated at the two Trusts (n = 37). Two-thirds of patients were started on safinamide in line with the formulary recommendation. Ten patients at KCH were not started in line with the formulary recommendation and feedback was given to the individual prescriber responsible for the prescribing. It was also noted that a shortage of rasagiline may have contributed to increased safinamide prescribing outside of the formulary recommendation. The outcome data presented focused on 30 patients (seven patients were too early in their treatment to assess outcomes) and found that approximately 57% of patients experienced an improvement in Parkinson's symptoms and less wearing off periods with safinamide. A small number of patients showed improvement with safinamide but eventually needed advanced treatment. GSTT provided 7 months' worth of outcome data because they had not started using safinamide at the point of IMOC approval, the GSTT data were mainly consistent with KCH and LGT data. There were no issues identified in primary care taking on prescribing of safinamide., The total numbers of patients prescribed safinamide in primary care is slightly higher than expected but this is likely due to shortages in rasagiline.

The Committee agreed by consensus to remove the time limitation previously set on the formulary inclusion of safinamide for management of Parkinsons disease in adults.

ACTION: Formulary recommendation to be updated to remove time limit and presented at a future meeting

9. Formulary recategorisation of octenidine (Octenisan™) nasal from Red to Amber 1 for MRSA decolonisation

The Lead pharmacist for Infectious Diseases was in attendance to present this item and explained that octenidine (Octenisan™) nasal gel was introduced in GSTT for MRSA decolonisation in 2015, primarily due to audits showing some chlorhexidine-resistant MRSA particularly in critical care patients. Octenidine was found to be as effective as other nasal treatments as an antiseptic. It would also be suitable for patients with nut, chlorhexidine or neomycin allergies. When it was included in the formulary in 2015 it was not intended that it would require primary care prescribing. However it is now being requested as Amber 1 as it would be beneficial because all patients attending SEL Trusts for inpatient admission, or certain day cases are screened for MRSA carriage at the pre-assessment clinic. If the patient requires decolonisation a request would go to the GP practice in order to prescribe the decolonisation treatment plan prior to surgery. Other MRSA treatment agents are on the formulary with Green categories, however the presenter clarified that the request for octenidine is for Amber 1, solely for MRSA decolonisation, and not for any other indication. Expected patient numbers for nasal decolonisation are low at about 10 patients per month. The associated cost is estimated to be negligible and therefore within the financial threshold delegated to the Committee.

Members queried whether a unified approach to decolonisation across the three SEL acute Trusts be agreed as currently all three Trusts prescribe different preparations. The presenter responded that these discussions are underway and that infection control leads are currently working with all Trusts to agree a unified approach. It was agreed that this should be further discussed via the SEL Infection Prevention and Control Committee and the SEL Forum for Antimicrobial Stewardship (SEL FAS). A

comment was also raised regarding whether provision of treatment should be under the responsibility of the clinic as part of the package of care. The presenter advised that where patients attend pre-assessment clinic for screening, the test takes hours to turn around and these are patients with community acquired MRSA, it would therefore be more practical if patients are treated in primary care.

The Committee agreed by consensus to approve the recategorisation of octenidine (Octenisan™) nasal from Red to Amber 1 for MRSA decolonisation.

ACTION: Formulary to be updated to reflect recategorisation of octenidine nasal gel to Amber 1 for the indication of MRSA decolonisation

10. Updated primary care antimicrobial guidelines for SEL - section on urinary tract infections (UTI)

The Borough lead for the primary care antimicrobial stewardship group presented this item. As presented at the February 2024 IMOC meeting, 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 urinary tract infections (UTI's). The updated UTI section has been reviewed and agreed by the SELFAS primary care working group and the SELFAS.

Each segment of the UTI section of the guideline was presented with the main updates presented to Committee members. Members reviewed the changes presented and raised the following queries:

- In relation to the section on lower UTI in children with no fever or flank pain, it was queried whether children under 3 months requiring urgent referral, would need to be referred the same day to a paediatrician or whether this would be a referral to the emergency department? *In response it was noted that in general children feverish and unwell would be referred to the emergency department. In some cases, paediatricians would give same day advice and guidance. It was agreed to add a comment in brackets noting that local arrangements would be followed for referral, this statement will be added to each section for consistency.*
- Referring to the acute pyelonephritis section, a concern was raised about the advice in the guidance that any children over three months old with pyelonephritis could be treated by a GP without reference to a specialist. GP members present noted that in their experience, they would not usually treat these patients without specialist input. *It was noted that the document is a prescribing guide rather than a clinical guideline, the guide provides a reference point to give information about choice of treatment and is not intended to replace clinical guidelines which exist separately for UTIs and include key steps such as risk assessment for sepsis. Some primary care prescribers may feel confident to prescribe however, it was agreed that a statement would be included noting that referral to the emergency department or paediatric specialist advice should be sought based on clinical judgment. This statement will be added as an overarching statement within the introductory section of the guide as it will apply to all sections of guide.*
- In relation to lower UTI in adults no fever or flank pain excluding pregnancy, this refers to high risk as travel to a country with increased antimicrobial resistance outside Northern Europe and Australasia. Further clarity was requested on the countries in Northern Europe that this relates to and how recent "recent travel" is.
- Under the recurrent UTI in non-pregnant women section, it was agreed that a link to MHRA guidance or information about the risk of lung fibrosis with prolonged nitrofurantoin use be included.
- For the acute prostatitis section, it was agreed that the reference to GP's referring patients to sexual health clinic needed clarifying as usually patients self-refer to sexual health clinics. For the same section, members noted that the first line choice is clear; however, the second line choice notes seek advice from specialist but then lists trimethoprim as a treatment option. It will be clarified that treatment is intended to be prescribed whilst waiting for specialist appointment. The guidance will be updated throughout to clarify similar areas where this may cause confusion.

The Committee agreed by consensus to approve the UTI section of the antimicrobial guidelines, pending amendments in line with discussions.

ACTION: Authors to update the UTI section of the guideline and share with IMOC team to progress for ratification via Chair's action.

11. Guidance on alternatives to prescribing unlicensed specials in SEL

The Lead Paediatric formulary pharmacist and senior Paediatric Formulary Pharmacist presented this item. The guidance is intended to support primary care prescribers in choice of the most cost-effective product for selected medicines listed for adults and children. The list is based on the most commonly prescribed specials products. Members requested that clarification is added to the first page that it is intended for use by primary care prescribers. It was noted that the context of what led to the selected medicines being listed in the two tables is not clear. Detail should be included in the introduction that that the guidance covers commonly prescribed specials in SEL but that this list is not exhaustive. The Committee agreed by consensus to approve the guidance, pending amendments in line with discussions.

ACTION: Authors to update the guidance and share with IMOC team to progress for ratification via Chair's action

12. Updated paediatric Proton-Pump Inhibitor (PPI) prescribing guideline for SEL

The Senior Paediatric Formulary Pharmacist remained in the meeting to present this item. The existing guidance has been updated, and the main updates include the addition of information about prescribing proton pump inhibitors for patients prescribed clopidogrel. This information is already available in the paediatric formulary. A weight banded dosing table has been included as well as information on the administration of lansoprazole orodispersible tablets. The lansoprazole unlicensed special is recommended as an option for patients with enteral tubes who required clopidogrel, however this is a rare occurrence. The liquid recommended is noted within the Drug Tariff. Members queried if the tablets can easily be quartered. The presenters confirmed this is relatively easy to do with a tablet cutter and information can be added to the formulary monograph. A minor formatting amendment was also noted. The Committee agreed by consensus to approve the guidance, pending amendments in line with discussions.

ACTION: Authors to update the guidance and share with IMOC team to progress for ratification via Chair's action

13. Standing Items /Items for information only

- Formulary submissions tracker

Noted.

- NICE TA Guidance Summary - ICS & NHS England attributed medicines:

The summary was noted, and RAGG categories were agreed by consensus.

- For information and noting:
- RMOC update – Nil for this meeting as RMOC meetings are paused
- Adult and paediatric formulary updates - noted by Committee members

Any Other Business:

The Chair noted that in the context of the current impact of reduced pathology capacity during the Synnovis incident there has been some rapid guidance produced on blood test monitoring for high-risk drugs, undergoing urgent approval via the IMOC Triage Panel. This will be disseminated once available.

It was noted that this would be the last meeting of the current Bromley borough GP representative. The Committee thanked the GP representative for their contributions to the Committee.

IMOC dates for next 3 months

Date	Time	Venue
Thursday 18th July	2pm-4:30pm	MS Teams
Thursday 15th August	2pm-4:30pm	MS Teams
Thursday 19th September	2pm-4:30pm	MS Teams