South East London Integrated Medicines Optimisation Committee (SEL IMOC) Meeting
20th March 2025 (Online via MS Teams)
Final Minutes

1. **Welcome, introductions and apologies**
   The Chair welcomed the attendees to the meeting. Apologies were noted. The meeting was noted to be quorate.

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. A declaration was noted from a Committee member in relation to agenda item 5 - update on the implementation of tirzepatide (Mounjaro®) and semaglutide (Wegovy®) for managing overweight and obesity in SEL. No further conflicts were raised by members.

3. **Detailed action notes of the last meeting, minutes, and action log:**
   The minutes and detailed action 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. **Formulary submission: Fidaxomicin as a second line treatment for relapse clostridium difficile infection (CDI) in children from birth to under 18 years of age.**

   This formulary submission originates from a Consultant in Paediatric Immunology & Infectious Disease and requests the use of fidaxomicin as a first line treatment for relapsed CDI in children from birth to under 18 years of age or second line where vancomycin is ineffective. Fidaxomicin is excluded from the NHS Payment Scheme (tariff excluded drug) and is commissioned through the ICB, therefore the Committee is making a commissioning decision for the use of fidaxomicin in this setting. In line with this, the application requests a Red RAGG category (hospital only) for the use of fidaxomicin in this setting.

   - **Evidence review**

   The Formulary Pharmacist provided an overview of the evidence base - a detailed evidence review was provided within the meeting agenda pack, covering background to the condition, a review of the evidence base with strengths and limitations and rationale for use of fidaxomicin in this setting. The information presented also included the estimated resource impact for use of fidaxomicin. The resource impact of the submission is within the financial threshold that the Committee has delegated authority to approve.

   Clostridium difficile (C. *diff*) associated diarrhoea (CDAD) is caused by an overgrowth of C. *diff* in the colon and is the leading cause of infectious nosocomial diarrhoea in industrialised countries. CDAD has historically been considered a disease of adults and not a clinical problem in the paediatric population. However, the disease has been recognised to be increasing in children and younger adults with a growing proportion of these cases exhibiting the onset of symptoms in the community.

   Guidance from the National Institute for Health and Care Excellence (NICE) on the management of C. *diff* recommends for a first episode that adults are treated with oral antibiotics, starting with vancomycin orally, and fidaxomicin is used second line (if vancomycin is ineffective). In adults, NICE recommends fidaxomicin is used as the first line treatment in the event of a relapse (re-infection within 12 weeks of symptom resolution). For paediatric patients, it recommends an oral antibiotic is offered, but doesn't recommend a specific regimen, guiding clinicians to obtain advice from a microbiologist, infectious diseases specialist or gastroenterologist. The UK Paediatric Antimicrobial Stewardship (UKPAS) network guidance recommends fidaxomicin as second line treatment after vancomycin for the first episode, and as first line in the event of relapse of CDAD within 12 weeks.

   A recent license extension has been obtained for the management of C. *diff* infection in paediatric patients from birth to aged 18 years (previously only licensed for use in adults), and a new oral suspension formulation has been produced to facilitate use in the paediatric population. In line with the

request to use fidaxomicin as second line treatment after vancomycin for the first episode, metronidazole which is the current second line treatment, will no longer be recommended locally as a treatment option for CDAD.

The evidence base for the use of fidaxomicin in this setting is primarily from a phase 3 single blinded randomised controlled trial (RCT) which the licence extension approval was based on. The multicentre phase 3 RCT investigated the use of fidaxomicin compared to vancomycin for the management of CDAD. The primary efficacy assessment was confirmed clinical response (CCR), defined as the initial response at the end of treatment, with no further requirement for CDAD therapy 2 days after the end of treatment. The results over the study period demonstrated that proportion of patients with CCR was greater for fidaxomicin in comparison to vancomycin. Among those with a CCR, CDAD recurrence within 30 days was less frequent with fidaxomicin in comparison to vancomycin. Additionally, the median time to diarrhoea resolution was also greater for fidaxomicin in comparison to vancomycin and the overall rate of global cure (CCR without recurrence) was higher with fidaxomicin in comparison to vancomycin. However, due to the sample size of the RCT, the trial was not specifically powered for any endpoint, i.e. not designed as a superiority or non-inferiority trial. From a safety perspective, drug related adverse effects experienced were lower for fidaxomicin in comparison to vancomycin. No patients had serious adverse effects relating to the study drug.

- **Applicant's presentation**

The applicant was in attendance to present the submission and field any questions. The applicant's declaration of interest was noted. The applicant clarified that the place in therapy for fidaxomicin in this setting is second line where vancomycin is ineffective. I It has been agreed locally there is no clinical need to offer fidaxomicin first line in the paediatric population as failure of treatment with oral vancomycin does not occur frequently in the paediatric population and CDAD is less prevalent.

Across the Trust, work is underway to review and align local antimicrobial guidance with the UKPAS network guideline and this formulary application forms part of this review. The applicants also clarified that patients will be reviewed by the paediatric infectious disease team prior to fidaxomicin initiation, and the full course will be supplied for either inpatient treatment or continued outpatient treatment in line with the desired RAGG category of Red.

A comment was raised in relation to the UKPAS network guideline which includes intravenous (IV) metronidazole alongside oral vancomycin for the management of life-threatening cases of C. *diff* in paediatrics. However, the proposed update to the local paediatric antimicrobial guideline no longer includes metronidazole as a treatment option. The applicant clarified that life threatening cases of C. *diff* in paediatrics is exceptionally rare and was not taken into consideration when updating the local guideline. However, in such cases it is likely IV metronidazole alongside oral vancomycin may be used as per the national guidance, but microbiology colleagues would also be consulted for advice on treatment.

- **IMOC discussion after departure of the applicant**

Committee members discussed the application and members acknowledged that whilst the patient cohort is small, fidaxomicin is beneficial to paediatric patients who require treatment for relapsed CDI or where vancomycin is ineffective, additionally the use of fidaxomicin in this setting is licensed and aligns to national guidance.

Committee members approved by consensus the formulary inclusion of fidaxomicin as Red (hospital only) as first line treatment for the management of relapsed clostridium difficile infection or second line treatment where vancomycin is ineffective as initial treatment of clostridium difficile infection in children from birth to under 18 years of age.

ACTION: Formulary recommendation to be drafted and presented at a future meeting

5. Update on the implementation of tirzepatide (Mounjaro®) and semaglutide (Wegovy®) for managing overweight and obesity in SEL and associated cost modelling

The authors were in attendance to present this item. An updated version of the paper that was provided within the agenda pack paperwork was presented to committee members on screen.

The NICE Technology Appraisal (TA) 1026 - tirzepatide (Mounjaro®) for managing overweight and obesity was published in December 2024. As per NICE TA 1026, tirzepatide is recommended for prescribing within specialist weight management services (SWMS) as well as settings outside of a SWMS and can be prescribed long term where patients achieve the agreed outcome.

As the implementation of NICE TA 1026 recommends the availability of tirzepatide outside of SWMS and covers a large patient cohort, the availability of wrap around care in primary care is required to support implementation, in line with this a funding variation from NHS England (NHSE) has been made available to support the implementation of tirzepatide in this setting. As part of the funding variation, NHSE plan to produce a prioritisation statement led by clinical need which will consider both referral prioritisation in SWMS and priority cohorts in other settings, including primary care-based services. The NHSE interim commissioning policy, which will include the prioritisation statement, is underway.

The current weight management services available across SEL include a specialist Tier 3 and Tier 4 weight management service. Semaglutide (Wegovy®) is available across SEL in specialist Tier 3 and 4 services for a two-year period. The initial roll out of semaglutide was via a phased approach to those within a locally agreed phase 1 criteria. Further roll out of semaglutide across SEL has been agreed in principle and aims to align with the expected NHSE roll out of tirzepatide. Recurrent funding for semaglutide phase 2 roll out is available and further information regarding this funding is awaited from NHSE.

Liraglutide (Saxenda®) is also available in specialist Tier 3 and 4 weight management services. However there has been an ongoing medicines shortage notification in place for liraglutide and therefore there have been no new initiations since 2023. Access to treatment is limited to a specific population who have non-diabetic hypergylcaemia and a risk factor for cardiovascular disease for a 2-year treatment period.

The three-year cost modelling for implementation of the drug only (not service delivery) based on the NICE TA resource impact model was presented, as described within the agenda pack. The three-year cost modelling is based on the eligible population based on NICE and not the streamlined phased patient cohort, which is expected within the NHSE interim commissioning policy. From year three onwards the cost modelling indicates that the implementation of tirzepatide in phase 1 or semaglutide phase 2 would exceed the IMOC financial threshold delegated to the committee. In line with the committee's terms of reference, the cost modelling will need be escalated to the Executive Committee for information.

The risks associated with the implementation of tirzepatide and semaglutide include the unknown patient cohort phasing criteria from NHSE which will prevent local implementation until this has been formally published. It is also unknown if funding will be allocated centrally from NHSE for drug costs, wrap around care and/or management costs.

In line with the NICE TA for tirzepatide and expected NHSE interim commissioning policy, a RAGG rating of Red is recommended in the interim for tirzepatide in this setting. In line with the proposed Red category, tirzepatide will currently be available for prescribing in SWMS only (Tier 3 and Tier 4 services). Once guidance is available in relation to the primary care provision of tirzepatide in accordance with the NICE TA for other eligible cohorts, the Red category will be reviewed.

The presenter clarified it is not unknown what the likely spilt between primary and secondary care is in terms of the estimated cost modelling for tirzepatide as the patient cohort phasing is not available from NHSE. It is also unknown if there will be patient phasing within Tier 3 and Tier 4 services or whether all prescribing will be recommended in primary care.

Committee members approved by consensus the formulary inclusion of tirzepatide as Red (hospital only) during the first implementation phase for managing overweight and obesity in line with NICE TA 1026.

ACTION: Tirzepatide as Red for the management of overweight and obesity to be added to the SEL JMF
ACTION: Estimated resource impact based on NICE modelling to be escalated to the Executive Committee for information

6. Updated lipid management medicines optimisation pathways

The authors were in attendance to present this item on behalf of the cardiovascular sub-group of the IMOC. The local lipid management medicines optimisation pathways have been updated and consulted on locally. The main aim of the updated lipid management medicines optimisation pathways is to simplify the pathways and reflect how lipid management is carried out in practice. The main updates to the lipid management medicines optimisation pathways include the following:

- New section for lipid management in people living with human immunodeficiency virus (HIV)
- New information on lipid management in women of child-bearing age
- An updated statin intolerance pathway which has been optimised for clarity and ease of use
- New muscle symptoms pathway (based on the UCL Partners pathway)
- New abnormal liver function test pathway (based on the UCLP pathway)

A comment was raised in relation to the NHS England (NHSE) guidance for lipid management - secondary prevention of CVD. Within the NHSE guidance injectable therapies are recommended in patients with a statin intolerance when non-HDL cholesterol remains above 2.6 despite other lipid lowering therapies and this has not been reflected in the updated local guideline. The presenter clarified that the national guideline does not reflect current NICE guidance, the local guideline has been updated to reflect NICE guidance which recommends bempedoic acid alongside ezetimibe or injectable therapies when patients are not achieving their lipid targets with ezetimibe monotherapy. The presenter confirmed the pathway will be updated to make this clearer.

A comment was also raised regarding the recommendation for primary care clinicians to assess eligibility for inclisiran. As inclisiran has a RAGG rating of amber 1 it would be useful if the pathway recommended a referral to specialist lipid clinics for consideration of inclisiran. The presenter clarified there is an inclisiran initiation checklist available to support primary care clinicians assess the eligibility for inclisiran. Once completed, the initiation checklist should be sent for advice and guidance from a lipid specialist. The pathway will be updated to reflect this and a link added to the inclisiran initiation checklist.

Committee members noted that the pathway has categorised atorvastatin, rosuvastatin and ezetimibe as Green, which is in line with current practice, however these medicines are currently uncategorised within the local adult Joint Medicines formulary (JMF). Committee members agreed the local adult JMF should be updated to reflect the Green categorisation.

The presenters also agreed to make the following amendments to the pathway:

- Update to the pathway to note that the advice on statin choice and starting dose will be provided to primary care clinicians by the HIV specialist.
- Update to the “statin intolerance” sections of the pathway to clarify that bempedoic acid should be added alongside ezetimibe in patients not achieving their lipid targets with ezetimibe monotherapy. The pathways should also clarify that the combination ezetimibe/bempedoic acid preparation should be prescribed as this particular combination has a RAGG category of Green and bempedoic acid tablets (for bempedoic monotherapy) is Amber 1.

Committee members approved by consensus the updated lipid management medicines optimisation pathways pending amendments to the pathways in line with the discussions and the RAGG categorisation of Green for atorvastatin, rosuvastatin and ezetimibe in line with current practice.

ACTION: Author to amend pathways in line with meeting discussions and share with the IMOC team to progress for IMOC Chair's ratification
ACTION: Atorvastatin, rosuvastatin and ezetimibe to be categorised as Green in the SEL JMF

7. Change in place in therapy from 2nd line to 1st line for rivaroxaban and apixaban in left ventricular thrombus (LVT) in adults.

The author was in attendance to present this item with support from the Formulary Pharmacist. Rivaroxaban and apixaban are approved for use locally as Amber 2 for the management of left ventricular thrombus (LVT) as second line treatment if warfarin is not tolerated or is contraindicated. The use of rivaroxaban and apixaban in this setting is off-label. This is a request to change the place in therapy from second line to first line for rivaroxaban and apixaban in the management of LVT specifically in adults post myocardial infarction (MI). For patients with heart failure (HF) and LVT, warfarin will remain as 1st line treatment. Committee members were requested to consider this change in THE place in therapy following recent evidence which demonstrates that direct oral anticoagulants (DOACs) are superior to warfarin in this setting.

The Formulary Pharmacist provided a brief overview of the evidence briefing to support this request. The 2023 European Society of Cardiology Guidance recommends that anticoagulation is used for 3-6 months in patients with LVT after an MI, and that vitamin K antagonists (VKAs) or DOACs could be chosen as treatment. The 2022 American Heart Association (AHA) published a scientific statement for managing LVT, which recommends anticoagulation for a minimum of 3 months for LVT following an MI, however the AHA statement notes that VKAs, predominantly warfarin, have been used for anticoagulation in LVT, but it also refers to more recent evidence for the use of DOACs in this setting.

The systematic review which supported the 2022 AHA statement found 21 studies and only 3 randomised controlled trials (RCT). Overall, there was no difference between DOACs or VKA for the primary endpoint of stroke or systemic embolism and there was also no difference in all-cause mortality, thrombus resolution or bleeding. For the RCT analysis alone, there were also no significant differences and for the RCT plus prospective study analysis there was no significant difference in stroke and systemic embolism, all-cause mortality, thrombus resolution, but the rate of bleeding was lower with DOACs.

The new evidence published in September 2024 to support this request, is a systematic review and meta-analysis which reviewed RCTs and uncontrolled studies which compared VKAs to DOAC for LVT following acute MI. A total of eight studies were included, three of which were RCTs (two of which were published since the AHA meta-analysis), and the rest being observational studies. All the studies used exclusively warfarin as the VKA, and two exclusively used apixaban, with the other studies using any DOAC. The primary outcomes investigated LVT thrombus resolution, incidence of systemic embolic events and major and clinically relevant non-major bleeding. A composite outcome of bleeding, systemic embolism, any cardiovascular hospitalisation, and all-cause mortality was also reviewed. DOACs were superior to VKAs for all outcomes. A subgroup analysis of the RCT data alone was performed but found no statistically significant differences between DOAC and warfarin for any of the endpoints, likely owing to the small sample size.

From a safety perspective, the use of DOACs in this setting has demonstrated a reduced rate of major bleeding in comparison to VKAs. The presenter clarified that dual antiplatelets are included in the treatment regimen for patients with LVT post MI, which contributes to the lower bleeding risk associated with DOACs in comparison to warfarin in this setting.

From a resource perspective, the resource impact of the submission is within the financial threshold delegated to the committee This additional cost with DOACs in comparison to warfarin may be offset by the costs associated with follow up appointments for drug monitoring with warfarin. The overall cost to the healthcare system may reduce if implementing DOAC first line ahead of warfarin in this setting.

A comment was raised in relation to post MI patients who may have some degree of HF and the rationale for not recommending DOACs in patients with LVT and HF. The presented clarified that HF failure associated LVT is heart failure without MI which is deemed more chronic and unlikely to resolve.

In patients with LVT post MI, in many cases the LV thrombus resolves, and anticoagulation can be stopped. A comment was also raised in relation to existing patients who are currently on warfarin for the management of LVT post MI and whether these patients will be actively switched to a DOAC based on the new evidence. The presenter clarified that a switch from warfarin to a DOAC will be on a case by case basis where there is a clinical need, for example, if a patient's warfarin time in range is low. The majority of patients initially on warfarin have been switched to a DOAC due to the increased risks with warfarin, such as bleeding.

Committee members approved by consensus the change in place in therapy from second line to first line for rivaroxaban and apixaban in the management of left ventricular thrombus in adults post myocardial infarction.

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

8. **Formulary request for budesonide 4mg suppositories for the treatment of acute mild to moderative ulcerative proctitis in adult patients**

The author was in attendance to present this item with support from the Formulary Pharmacist on behalf of the IBD sub-group of the IMOC. This is a formulary inclusion request for budesonide 4mg suppository as Green (initiation in primary or secondary care) for the treatment of acute mild to moderative ulcerative proctitis in adults. In line with the current pathway and local formulary, the only steroid suppository treatment available is prednisolone 5mg suppository which has previously had supply issues. The request has been discussed at the IBD sub-group and is supported by the sub-group.

Budesonide 4mg suppository is a recently launched product which is currently more cost effective than prednisolone 5mg suppository. The dosing for budesonide 4mg suppository is recommended as one 4mg suppository daily, in comparison to prednisolone 5mg suppository which is recommended as one 5mg suppository twice a day. Clinically, the main difference between budesonide 4mg suppository and prednisolone 5mg suppository is that budesonide suppository is licenced for the short-term treatment of mild to moderate ulcerative proctitis (6 – 8 weeks treatment), whereas prednisolone 5mg suppository is licenced for the management of ulcerative proctitis and rectal complications associated with Crohn's disease.

The use of prednisolone suppository would continue to be available alongside budesonide suppository, however budesonide suppository would be the preferred first line option in line with its cost effectiveness and once daily administration.

From a resource perspective, the resource impact of the submission is within the financial threshold delegated to the committee and there is a cost saving associated with prescribing budesonide 4mg suppository in comparison prednisolone 5mg suppository if prescribed in the same SEL eligible population.

Committee members approved by consensus the formulary inclusion of budesonide 4mg suppository as Green for the treatment of acute mild to moderative ulcerative proctitis in adult patients.

ACTION: Budesonide 4mg suppository as Green to be added to the SEL JMF

9. **Paediatric formulary "Red, Amber, Green" RAG rating review: Phase 3 - medicines used in neurology and metabolic disorders**

The author presented this item, which aims to update the formulary RAG categories for paediatric medicines used in neurology and metabolic disorders in line with their actual use in practice. This is part of a larger ongoing project where a full review is being undertaken to consider the appropriate RAGG category for a medicine in paediatrics considering the different indications and specialties it may be used in and liaising with the relevant teams across SEL hospital trusts. This process is not being used to consider down recategorising of Red or Amber 3 medicines, which will remain the same. There

are also existing Green, Amber 1 and Amber 2 medicines which are appropriate and do not require a change in RAGG category.

The table provided within the agenda pack summarises the drug class, the indications and the current and proposed RAGG categories. The majority of the medications reviewed, are being proposed to move from Green or Amber 1 to Amber 2 or red. These patients may require specific monitoring on initiation and dose titration which is carried out by the specialist team. In general medications within the same class are assigned the same RAGG category, however there are some instances where 2nd or 3rd line agents and or those indications with little experience or use in paediatrics may be given a higher RAGG category meaning a greater amount of specialty input on initiation.

Some of the medicines included for the management of metabolic conditions, include vitamins and minerals. It is proposed, alongside the change in RAG rating, that all monographs for vitamins and minerals will include a statement, which reflects that in line with NHSE guidance, vitamins and minerals are not prescribed unless the patient has a medically diagnosed deficiency, including for those patients who may have a lifelong or chronic condition, or have undergone surgery that results in malabsorption

Overall, the proposals reflect current practice and the request to the committee is to approve the proposed changes in RAGG category for the paediatric medicines used in endocrine and metabolic.

A query was raised in relation to the medicines used for the management of metabolic conditions which may also be used in palliative care for example diazepam, and whether the change to a Red category for intravenous preparations may prevent its use in primary care when needed for palliative care. The presenter clarified that diazepam as well as lorazepam and glycopyrronium are not currently noted within the paediatric formulary for use in paediatric palliative care. However, there may be instances where a paediatric patient is treated with these medicines under palliative care, although this is not currently covered by the paediatric formulary.

Committee members approved by consensus the proposed changes to the RAGG categories for paediatric medicines used in endocrine and metabolic.

ACTION: Paediatric formulary to be updated with approved RAGG category changes for paediatric medicines used in endocrine and metabolic disorders

10. Updated formulary recommendations

- **050 - Brivaracetam for the adjunctive treatment of partial onset seizures in people with epilepsy**

This formulary recommendation has been updated following a review and approval of the RAG category ratings for epilepsy in adults and paediatrics at the February 2025 IMOC meeting. Committee members agreed by consensus the change in prescription supply from secondary care for brivaracetam in adults following initiation, from 6 months to the first prescription as Amber 2. Committee members also agreed by consensus the formulary inclusion of brivaracetam in line with NICE as Amber 2 for paediatrics. The formulary recommendation has been updated to reflect these changes.

The formulary recommendation has also been updated to reflect the current use of brivaracetam in line with NICE. The existing formulary recommendation only covers the use of brivaracetam for the adjunctive treatment of partial onset (focal) seizures. The KCH epilepsy team confirmed that the use of brivaracetam is in line with the current NICE guideline and is no longer only used for the management of partial onset (focal) seizures as per the current formulary recommendation. In regard to costings, the KCH epilepsy team also confirmed the broader use of brivaracetam in line with NICE is not expected to have a significant cost impact locally.

Two comments were received via the virtual triage panel; the first comment was in relation to the change in prescription supply from secondary care for brivaracetam in adults following initiation, from 6 months to the first prescription as Amber 2. In primary care, clinicians tend to take on the prescribing of epilepsy medication once patients are titrated to a stable maintenance dose. The first prescription

supply from secondary care may cover a patient's titration period, however in some instances this may not be covered by the first prescription. Committee members noted, alongside the first prescription supply for brivaracetam, primary care clinicians will also be provided with a clinic letter/individualised management plan which outlines the necessary titration steps to be carried out in primary care. This is also standard practice for all antiepileptic treatments.

To ensure patients initiated on brivaracetam are provided with a prescription supply from secondary care which covers any required titration in primary care, committee members agreed by consensus the removal of "first prescription" from the formulary recommendation.

The second comment received via the virtual triage panel was in relation to the initiating clinician noted within the formulary recommendation. The formulary recommendation states brivaracetam should be initiated by a consultant neurologist, however for paediatrics, the initiation of brivaracetam is also carried out by paediatricians with a specialist interest in epilepsy or clinical fellows/registrars within paediatric neurology. In line with this, the formulary recommendation will be updated to note that the initiation of brivaracetam should be by an "epilepsy or paediatric neurology specialist".

Committee members approved the formulary recommendation by consensus pending amendments in line with the discussion.

- **012 - Diltiazem 2% cream for the post-operative management of anal spasm**

This formulary recommendation has been updated in line with the recategorisation of diltiazem 2% cream for the management of anal fissures from Red to Amber 1 at the February 2025 IMOC meeting. This formulary recommendation previously included the use of diltiazem 2% cream for the management of anal fissure and post-operative management of anal spasm as Red, in line with the recategorisation this formulary recommendation now only covers use for post-operative management of anal spasm. A new recommendation has been drafted for use in anal fissure.

A view from Committee members was requested in relation to whether there is a need for this formulary recommendation as the majority of the content is now covered in the formulary recommendation for diltiazem 2% cream in the management of anal fissure. Committee members agreed by consensus it would be useful to have this recommendation available and approved the formulary recommendation by consensus.

- **Diltiazem 2% cream for the management of anal fissures**

This formulary recommendation has been drafted in line with the recategorisation of diltiazem 2% cream for the management of anal fissures from Red to Amber 1 at the February IMOC. Committee members approved the formulary recommendation by consensus.

11. Medicines Optimisation Joint Forward Plan refresh for 25/26

The author presented this item which provides an overview of the Medicines Optimisation Joint Forward Plan (MO JFP) refresh for 2025/2026. The Joint Forward Plan is a statutory requirement for Integrated Care Boards and their partner NHS trusts and Foundation Trusts under the Health and Care Act 2022. The Joint Forward Plan is a five-year plan and has undergone a minor refresh for 2025/2026 ahead of the 10-year NHS plan.

The MO JFP outlines a long-term approach to delivering health and care services that align with the objectives of the SEL Integrated Care Strategy and the NHS Long Term Plan. The plan forms the basis of the single workplan for the ICS Integrated Pharmacy Stakeholder group to deliver, cross sector. It also forms the basis of a single workplan across the ICB for the Medicines Optimisation team.

The MO JFP includes the following three strategic shifts:
- Moving more care from hospitals to communities
- Making better use of technology in health and care
- Focusing on preventing sickness, not just treating it

Based on the three strategic shifts, four priority areas have been identified for the MO JFP:

- Developing “one pharmacy workforce”, adoption of digital technology and the neighbourhood NHS
- Community Pharmacy integration, moving care closer to home and primary prevention
- Medicines Value, Medicines Safety and Antimicrobial stewardship
- Long Term Conditions (secondary and tertiary prevention), genomics, overprescribing and sustainability

Engagement with the wider health system in SEL in relation to the medicines optimisation joint forward plan has taken place which has provided useful and positive feedback which has been fed into the proposed medicines optimisation joint forward plan. Committee members were encouraged to share any feedback or suggestions in relation to the joint forward plan.

Committee members noted the MP JFP for 2025/26 and thanked the presenter for the summary.

12. Standing Items

- Formulary submissions tracker

Noted.

- NICE Technology Appraisal (TA) Guidance Summary – ICS & NHSE attributed medicines:

The summary was noted, and RAGG categories were agreed by consensus, where it was possible to confirm the RAGG status

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

IMOC dates for next 3 months:

Date	Time	Venue
Thursday 17 April 2025	2pm – 4:30pm	MS Teams
Thursday 15th May 2025	2pm – 4:30pm	MS Teams
Thursday 19th June 2025	2pm - 4:30pm	MS Teams