South East London Integrated Medicines Optimisation Committee (SEL IMOC) Meeting
17th April 2025 (Online via MS Teams)
Final Minutes

1. Welcome, introductions and apologies

The Chair welcomed attendees to the meeting. Apologies and observers 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. 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 typographical errors and the following updates:

- Agenda item 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: Note added that the Committee is making a commissioning decision for the use of fidaxomicin in this setting as fidaxomicin is excluded from the NHS Payment Scheme (tariff excluded drug)
- Agenda item 5 - Update on the implementation of tirzepatide (Mounjaro®) and semaglutide (Wegovy®) for managing overweight and obesity in SEL and associated cost modelling: Update to the sentence in relation to semaglutide phase 1 implementation, noting that further information is awaited from NHS England (NHSE).

Members were provided with an update on progress against actions due for this month, these were noted, and items closed were agreed. An update on the following action was provided by the formulary pharmacist:

- Colchicine for the secondary prevention of ischaemic heart disease in adults: Outcome data to be presented back to the Committee at a future meeting (12-month time limited approval) – *usage across SEL is very limited currently. A request was made to delay this action for another 12 months; Committee members agreed the extension of the time limited approval by consensus.*

Action: Formulary recommendation for colchicine in IHD to be updated to reflect extension

4. Paediatric formulary "Red, Amber, Green" RAG rating review: Phase 4 medicines used in Gastroenterology, Haematology, Hepatology, Renal, Rheumatology, Allergy and Metabolic Disorders

The author presented this item, which aims to update the formulary RAG categories for paediatric medicines used in gastroenterology, haematology, hepatology, renal and rheumatology in line with their actual use in practice. Paediatric medicines used in allergy and metabolic disorders which were missed when presented at the February 2025 and March 2025 IMOC meetings are also included. This is part of a larger ongoing project where a full review is being undertaken to consider the appropriate RAG 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 RAG category.

The table provided within the agenda pack summarises the drug class, the indications and the current and proposed RAG categories. The majority of the medications reviewed, are being proposed to move from Green to Amber 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 RAG category, however there are some instances where 2nd or 3rd line agents or those indications with little experience or use in paediatrics may be given a higher RAG category meaning a greater amount of specialty input on initiation.

The medicines in this setting which are covered within the paediatric immunomodulatory shared care guideline are being reviewed by the various clinical teams are excluded from this presentation and will be presented at a later date.

A comment was raised in relation to the appropriateness of the Amber 1 categorisation for tranexamic acid for the treatment of haemorrhage as treatment is normally acute without the need for a GP to prescribe. The presenter clarified that tranexamic acid is generally prescribed by the hospital without the need for the GP to prescribe, however there may be instances where *a* GP may be asked to prescribe in the cases of preventive treatment and the patient is in primary care.

Clarification was requested in relation to the Amber 1 categorisation for alendronic acid for the inhibition of bone turnover and management of osteoporosis, which is not a common indication in paediatrics. It was suggested an Amber 2 categorisation may more appropriate. The presenter agreed to discuss this with the specialist team.

A query was raised regarding the proposed Amber 2 categorisation for domperidone and whether a Red categorisation may be more appropriate as domperidone is not licensed for gastro-oesophageal reflux disease (GORD) in children. In addition to this, the British National Formulary for Children (BNFC) states that domperidone is for specialist use only. In April 2014, the Medicines and Healthcare products Regulatory Agency (MHRA) advised that domperidone should no longer be prescribed to treat conditions such as GORD and heartburn, due to the risk of cardiac side effects. A suggestion was made to consider changing the category for domperidone in this setting to Red. The presenter agreed to discuss this with the specialist team

Committee members approved by consensus the proposed changes to the RAG categories for paediatric medicines used in gastroenterology, haematology, hepatology, renal, rheumatology, allergy and metabolic disorders.

ACTION: Paediatric formulary to be updated with approved RAG category changes for paediatric medicines used in gastroenterology, haematology, hepatology, renal, rheumatology, allergy and metabolic disorders
ACTION: Presenter to share committee feedback in relation to the proposed RAG categories for alendronic acid and domperidone with the specialists and advise on outcome

5. Formulary recommendations

- **New - Prazosin tablets for the management of nightmare disorder in adults with Post-Traumatic Stress Disorder (PTSD)**

This time limited formulary recommendation (12 months limit) has been drafted following the formulary submission in April 2024 and discussions relating to the associated pathway for the management of nightmare disorder in adults with PTSD at the February 2025 IMOC meeting. There were no comments received via the virtual triage pane review. A comment was raised in relation to amending the date of decision from “April 2024” to “February 2025”, as the decision was based on the development and approval of a nightmare disorder in PTSD pathway.

- **New - Fidaxomicin tablets and oral suspension for the treatment of Clostridium difficile associated diarrhoea in children from birth to under 18 years of age**

This formulary recommendation has been drafted following the approval of fidaxomicin in this setting at the March 2025 IMOC meeting. A comment was received via the virtual triage panel review in relation to the wording for the age range stated within the title of the formulary recommendation. A suggestion was made to update the age stated within the title to “children under 18 years of age”. Committee members agreed to this amendment by consensus.

- **Updated – 122: Rivaroxaban and apixaban for the treatment of left ventricular thrombus in adults (off-label use)**

This formulary recommendation has been updated following the approval of the change in place in therapy from second line to first line in this setting at the last IMOC meeting. There were no comments received via the virtual triage panel. Minor amendments to the formulary recommendation were shared by a member to make the recommendation more concise. A comment was raised in relation to the formulary recommendation noting that the off-label nature of rivaroxaban and apixaban in this setting should be discussed at each medication review to ensure patients are kept informed if there are changes in practice.

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

6. Pan London "Red Amber Green" (RAG) definitions for local adoption

A member of the SEL ICB Integrated Medicines Optimisation team presented this item which aims to standardise RAG definitions for use across London. The definitions have been developed by the London Procurement Partnership (LPP) in collaboration with the five London Integrated Care System Chief Pharmacists.

The main change from this work for SEL is the removal of the Grey category which denotes non-formulary medicines within the adult and paediatric joint medicines formularies (JMF). The new pan-London RAG definition is simply "non-formulary" without the assignment of a colour. The category "non-formulary" will include:

- medicines that are passively non-formulary i.e. where treatment has not been reviewed or applied for and no formal position exists for example new medicines.
- medicines where there is an active position locally for not recommending the treatment.

The definition for the Amber 1 category has also been strengthened.

Local implementation of the pan-London RAG definitions will require updates to existing "grey" formulary recommendations, the adult and paediatric formularies, the existing SEL "Red, Amber, Green, Grey" (RAGG) definitions document as well as other local resources which refer to RAGG. Local communication across SEL will need to be developed to enable a phased implementation of the pan-London RAG definitions.

Clarification was requested in relation to the definition for the Green category and whether it overlaps with the Amber 1 category. The Pan London RAG definition notes Green medicines are considered suitable for prescribing in primary care, following a recommendation or initiation by a specialist or hospital. The presenter explained Green medicines can be initiated in any sector which is well accepted across London and if there any issues in practice with the Pan London Green definition this can be fed back via the ICS Chief Pharmacists.

A comment was raised in relation to Grey medicines on the local adult JMF and the importance of highlighting that these medicines are not recommended for prescribing once the Grey categorisation is removed. The presenter clarified there are existing definitions for the current "RAGG" categories on the formulary and the updated definitions will be made clear on the formulary. Where useful, medicines which are non-formulary and not recommended for prescribing can be noted as such on the formulary, for example medicines included within the NHSE items which should not be routinely prescribed in primary care guidance

A query was raised as to whether the changes to the local RAGG definitions have an impact on the use of over the counter (OTC) medicines and low priority prescribing medicines in primary care. The presenter explained the formulary will need to be made clear where an OTC or low priority medicine is not recommended for prescribing. There are also local position statements in place to support prescribing decisions in primary care in relation to OTC and low priority medicines, in particular those included within NHSE guidance. Promotion and raising awareness of these at borough level and through the relevant sub-group will be important to support implementation.

Committee members approved the local adoption of the Pan London “Red Amber Green” (RAG) definitions by consensus.

7. Long-acting antipsychotic injections (LAI) primary care project update

The authors were in attendance to update the committee on progress with this initiative and present the work that is being undertaken to create a pathway for the use of LAI’s across healthcare settings in SEL. The purpose of the pathway is for the use of LAI in secondary care settings, but also to enable treatment with LAIs to be transferred to primary care where appropriate.

There are ongoing discussions across the local healthcare system with various stakeholders in relation to this project with the aim to run a workshop in the near future to progress this work further. The workshop will build on current work to develop a model which provides patient choice, in line with national and local strategies, as well as ensuring there is a mechanism for patient follow up by specialist mental health teams when patients are transferred to primary care for the management of their LAI treatment.

A programme in relation to the transfer of LAI treatment to primary care has been underway in Bromley since 2022. Mental health practitioners were placed within Primary Care Networks (PCNs) to support the review of patients within primary care. It was identified there was a need for discharging stable patients on LAIs from specialist mental health teams to primary care. GPs shared their concerns regarding the transfer of patients on LAIs to primary care including how acutely unwell patients can be transferred back to the specialist mental health teams once they have been transferred to primary care in a safe and timely manner. Additionally, how patients who refuse their LAI treatment can also be transferred back to the specialist mental health teams. The concerns shared by GPs was tackled through the development of a shared care depot protocol.

Currently there are psychiatrists within the PCN as well as mental health practitioners, and collectively they provide support and reassurance to GPs in relation to the prescribing of LAI treatment in primary care. The arrangement is reviewed on a yearly basis with the aim to gradually increase the number of patients on LAI treatment transferred to primary care. The aim is to roll out this work further in SEL within Bexley and Greenwich.

Feedback and interest to implement the transfer of LAI treatment to primary care across SEL boroughs has been varied, including the importance of trialling LAI transfer of care to primary care within a pilot initially, before rolling out widely.

The committee welcomed and noted the update on the LAI primary care project and thanked the presenter for their ongoing work in this area. Committee members agreed the next update to the committee on the LAI primary care project would be welcomed once the LAI pathway development has progressed.

8. Formulary request for the use of azithromycin in the prophylaxis of asthma exacerbations as Amber 2 (off-label)

The applicant was in attendance to present this item on behalf of the respiratory sub-group. The request has also been considered by the SEL Forum for Antimicrobial Stewardship (SEL FAS) and is supported by them. The request is to use azithromycin in the prophylaxis of asthma exacerbations (off-label use) as Amber 2 and aims to reduce exacerbation frequency in adults, where exacerbations are driven by bacterial infections and reduce the need for oral corticosteroids as azithromycin has an anti-inflammatory effect.

The use of azithromycin in this setting is in line with recommendations within the 2024 Global Strategy for Asthma Management and Prevention (GINA) report and British Thoracic Society (BTS) Guideline for Long Term Macrolide Use. However, the BTS guideline recommends the use of azithromycin in this setting in people aged 50 – 70 years only and this request does not restrict use to this age group. The presenter clarified that the place in therapy for azithromycin is for the prophylactic treatment in patients

with severe asthma who experience asthma exacerbations, despite optimised inhaler treatment, good adherence and good inhaler technique.

All monitoring associated with the use of azithromycin in this setting will be carried out by the specialist team and patients will be monitored for tolerance and clinical efficacy at 4 weeks, then at 6-12 months, then annually thereafter by the specialist team. If the desired outcome of a reduction in exacerbation frequency is achieved, some patients may take treatment breaks to reduce treatment burden and potentially reduce the risk of bacterial resistance. Where the patient does not tolerate azithromycin or it is not clinically effective, azithromycin will be stopped.

The Formulary Pharmacist provided a brief overview of the evidence to support this request. Recommendations on macrolide treatment in this setting is not included in the current combined National Institute for Health and Care Excellence (NICE)/BTS/ Scottish Intercollegiate Guidelines Network (SIGN) asthma guidelines. The 2024 GINA report positions azithromycin in step 5 of its treatment pathway, as an add-on option after specialist referral for adult patients with persistent symptomatic asthma despite high-dose inhaled corticosteroid (ICS) – long acting beta agonist (LABA) (ICS/LABA) treatment. The 2019 BTS guideline recommends that oral macrolide therapy could be considered to reduce exacerbation frequency in asthmatic adults aged 50-70 years old with ongoing symptoms despite >80% adherence to high-dose inhaled ICS, and at least one exacerbation requiring oral steroids in the past year. The BTS guideline recommends azithromycin for a minimum of 6 to 12 months to assess the efficacy and noted that oral macrolide therapy should not be used to reduce oral steroid dose.

Both the GINA and BTS guidelines based their recommendations on data from two randomised controlled trials (RCT) AZISAST and AMAZES. The AZISAST trial was a double-blind, placebo-controlled RCT and investigated the effects of azithromycin as add-on treatment to combination therapy of ICS + LABA for 6 months. At the ned of the 26-week treatment phase, there were no differences in the rate of primary endpoints (severe asthma exacerbations and/or lower respiratory tract infections requiring antibiotics) between the azithromycin and placebo groups. Overall, the study found that azithromycin was well tolerated but was associated with increased oropharyngeal carriage of macrolide-resistant streptococci.

The AMAZES trial was a larger double-blinded, placebo-controlled RCT and involved a slightly older cohort in comparison to the AZISAST trial and also used a higher dose of azithromycin in comparison to the AZISAST trial. This AMAZES trial demonstrated that azithromycin reduced a greater proportion of asthma exacerbations compared with placebo and the proportion of patients experiencing at least one asthma exacerbation was reduced by azithromycin treatment. Azithromycin was also found to significantly improve asthma-related quality of life outcomes with benefits seen across all Asthma Quality of Life Questionnaire (AQLQ) domains.

From a safety perspective, though azithromycin appeared well tolerated in the studies reviewed, there were higher rates of diarrhoea reported. The GINA report recommends that before considering add-on azithromycin, sputum should be checked for atypical mycobacteria, ECG should be checked for long QTc (repeating after a month of treatment) and the risk of increasing antimicrobial resistance should be considered. The BTS guidance recommends performing similar monitoring prior to starting treatment with azithromycin, including liver function tests every 6 months.

From a resource perspective, the cost impact of this formulary application is within the financial threshold delegated to the committee. However, given this is historic use, the use of azithromycin in this setting is not expected to be a significant additional cost to the local health economy.

Committee members noted that this request is supported by SEL FAS with the caveat that an audit is completed a year after approval (if approved) which reports back on patient numbers, whether use is in line with the approved criteria for use and patient outcomes. A query was raised regarding the broader age range that has been requested for the use of azithromycin in this setting in comparison to the BTS recommendation. The presenter clarified that patient numbers are generally low and treatment is dependent on the phenotype of the patients' asthma. Historically locally an age range has not been

applied, however data in relation to patient age ranges can be collected as part of the audit report for SEL FAS.

Clarification was requested in relation to whether azithromycin in this setting will be used at step 5 of the asthma treatment pathway. The presenter clarified that 95% of asthma patients can be appropriately managed with ICS plus LABA (plus or minus an inhaled long acting anti-muscarinic) with good inhaler technique and adherence. There are some patients (less than 5%) who are more inclined to have bacterial infections which drive their exacerbations and this is the cohort that will benefit from azithromycin prophylaxis.

A comment was raised regarding how the 23 patients in SEL who may be eligible for treatment with azithromycin in this setting will be identified. The presenter explained that the severe asthma service is good at identifying and managing patients who are experiencing an exacerbation and a helpline is available for patients to contact. Exacerbations would be characterised via appropriate tests (including phenotyping) and observations as well as a sputum sample. Patients without a bacterial component (type 2 inflammation) will be managed with oral steroids/biologics and azithromycin would be recommended for patients with a bacterial element to their exacerbation.

Clarification was requested in relation to the treatment course length for azithromycin in this setting. The presenter explained that this is dependent on various factors including the patient's pattern of exacerbations. Most patients will be given at least 6 months of treatment, and if efficacious will continued until 12 months of treatment. At this point, the patient will be reviewed and a decision will be made regarding the continuation of treatment.

Committee members noted, if approved, the formulary will need to include the criteria for use of azithromycin and the stopping criteria. The CESEL asthma adult guide will also need to be updated to include the use of azithromycin in this setting as prescribing will be transferred to primary care. The presenter agreed this will be possible.

Committee members approved by consensus the formulary request for the use of azithromycin in the prophylaxis of asthma exacerbations as Amber 2.

ACTION: Azithromycin in the prophylaxis of asthma exacerbations as Amber 2 to be added to the SEL JMF including the criteria for use and stopping criteria
ACTION: CESEL asthma adult guide to be updated to include the use of azithromycin in the prophylaxis of asthma exacerbations as Amber 2

9. Formulary request to remove the restriction of combined use of rasagiline with levodopa for the management of Parkinson's disease

The applicant presented this item which requests to remove the restriction on the local adult JMF which prevents the combined use of rasagiline with levodopa in line with national guidance. Rasagiline has historically been available on the joint formulary since 2006 as an alternative treatment option to levodopa in Parkinson's disease (PD). At the time of approval, rasagiline was only available as a branded product, therefore, the formulary approval for rasagiline had restrictions, including that it is not to be used in combination with levodopa.

Rasagiline is a monoamine oxidase B (MAO-B) inhibitor and is recommended as one of several first line options, or as add on therapy for the management of PD in line with NICE guideline (NG) number 71. Since the publication of the NG71, locally, rasagiline has been used both as initial treatment and as an add on therapy and this request aims to align to this practice. Additionally, rasagiline is now available generically, and other MAO-B inhibitors, such as selegiline and safinamide, are included in the formulary without the same restrictions and their use is in line with the NICE guidance.

From a resource perspective, as this is historical use and in line with current practice, the use of rasagiline in this setting is not expected to be an additional cost.

Committee members approved by consensus the removal of the restriction on monotherapy rasagiline and the use of rasagiline as add on therapy with levodopa for the management of PD.

ACTION: Restriction associated with rasagiline to be removed from the SEL JMF

10. Updated chronic open angle glaucoma and ocular hypertension treatment pathway and associated cost modelling for SEL

The author was in attendance to present this item with support from the GSTT Formulary Pharmacist. This treatment pathway has been updated to include latanoprost/netarsudil mesylate (Roclanda®) for the management of previously treated primary open-angle glaucoma or ocular hypertension in line with NICE technology appraisal (TA) 1009. Latanoprost–netarsudil is a new combination product with a prostaglandin analogue and a new class of glaucoma agents - Rho-kinase inhibitor.

Additional updates to the guideline include:

- Addition of selective laser therapy (SLT) for the management of ocular hypertension or chronic open angle glaucoma in line with NICE guideline 81.
- Additional product options for existing medicines within the pathway to meet the different needs of patients as well as to manage frequent manufacturing issues with existing products recommended within the pathway.

The presenter clarified that Roclanda® is a once daily treatment which enables drainage of aqueous via the ocular trabecular meshwork, which helps to reduce the intraocular pressure. The once daily application helps to improve compliance in this patient cohort and is also favourable in terms of cost. In line with the criteria for use outlined in NICE TA 1009, Roclanda® has been placed as a second-line treatment within the pathway.

The cost impact associated with implementing NICE TA 1009 was discussed at the November 2024 IMOC meeting. The cost impact of latanoprost-netarsudil is within the committee's financial threshold based on the NICE costing template. An amber 2 category was also agreed for Roclanda® at the November 2024 IMOC meeting.

It was noted that comments from the IMOC team had been shared with the author prior to the meeting. Additional comments were raised during the meeting, including the request to add the use of SLT as first-line treatment for people with newly diagnosed ocular hypertension or newly diagnosed chronic open angle glaucoma in line with NICE guideline 81 within the pathway, noting this is non-pharmacological treatment. In line with this, the overall title of the treatment pathway should also be updated to include "pharmacological treatment".

A comment was also raised regarding the Amber 2 categorisation for some glaucoma treatments within the local adult JMF and a recommendation to formally categorise the uncategorised glaucoma treatments noted within the pathway as Amber 2 to enable consistency. The presenter confirmed that in their practice they tend to issue the first prescription to the patient, in line with the Amber 2 category. Committee members agreed by consensus an Amber 2 category for the uncategorised glaucoma treatments, however, the Formulary Pharmacist noted this categorisation request will need to be discussed with local clinicians to ensure they agree with the Amber 2 categorisation.

The presenter agreed to update the pathway in line with the suggested amendments.

Committee members approved by consensus the updated chronic open angle glaucoma and ocular hypertension treatment pathway pending amendments in line with the discussion.

ACTION: Author to amend treatment pathway in line with the meeting discussions and share with the IMOC team to progress for review and IMOC Chair's ratification
ACTION: KCH Formulary Pharmacist to discuss Amber 2 categorisation for the uncategorised glaucoma medicines within the local adult JMF
ACTION: Uncategorised glaucoma medicines to be categorised as Amber 2 once the pathway is approved via IMOC Chair's ratification

11. Formulary requests for medicines used to treat cholestatic pruritis
(i) Historical addition of bezafibrate, naltrexone, sertraline and rifampicin as Amber 2
(ii) Categorisation of colesevelam and colestyramine as Green

The author was in attendance to present this item with support from the Formulary Pharmacist. This request is for the formulary inclusion of bezafibrate, naltrexone, sertraline and rifampicin as Amber 2 for the management cholestatic pruritis (off-label) and is based on historical use. This formulary request also aims to formally categorise colesevelam and colestyramine as Green as both treatment options are uncategorised within the local adult JMF in this setting.

Bezafibrate, naltrexone, sertraline and rifampicin are used off-label in this setting and are considered standard practice with many of the treatments noted within the British National Formulary (BNF). These treatments are also detailed within the European Association for the Study of the Liver (EASL) guidelines for management of cholestatic liver disease. These treatments have historically been prescribed by the Trust with GPs taking over prescribing once the patient is stable. The transfer of prescribing to GPs also includes regular monitoring within primary care. Patients will usually continue to be reviewed by the specialist team every 3 – 6 months.

The applicant shared an internal KCH guideline for the management of cholestatic pruritis to Committee members on screen. The guideline outlines the treatment pathway for cholestatic pruritis, place in therapy of the available treatments, information on the transfer of prescribing to primary care and the prescribing responsibilities of the specialist team, GP and patient. Committee members noted the guideline included useful information for primary care, particularly in relation to the monitoring of the treatments and queried if the guideline is intended for secondary care only or for primary care also. The presenter clarified that the guideline is intended for internal use within secondary care. As the guideline is an internal KCH guideline, it will be discussed and approved via the Trust Drugs and Therapeutic Committee (DTC) once the formulary approvals are in place via IMOC.

The costings associated with this formulary request are negligible and within the committee's financial threshold. However, as this is historical use and in line with current practice, the use of these treatments is not expected to be a significant additional cost.

Whilst committee members agreed the guideline would be useful as a SEL wide guidance, members agreed clarity is needed on the intended audience for the guideline (secondary care only or primary and secondary care). Committee members were minded to approve the formulary inclusion of bezafibrate, naltrexone, sertraline and rifampicin as Amber 2 and the categorisation of colesevelam and colestyramine as Green in this setting in principle pending clarity on the audience and a SEL wide consultation of the guideline if it is intended to be used in primary care. This will be followed by a presentation of the guideline at a future IMOC meeting for approval.

Post meeting note: Following discussion with the Trust, the guideline for the management of cholestatic pruritis will remain as an internal Trust guideline. The guideline will be updated to remove the sections in relation to primary care/GP information. The formulary entries for bezafibrate, naltrexone, sertraline and rifampicin will have clear information for each drug detailing starting criteria, stopping criteria or criteria for moving to the next treatment and the place in therapy i.e. 1st line treatment. The formulary entries will also include a note to indicate that the monitoring requirements will be detailed in the patient clinic letter. Once drafted, the formulary entries for bezafibrate, naltrexone, sertraline and rifampicin will be presented at a future IMOC meeting for approval.

ACTION: The formulary entries for bezafibrate, naltrexone, sertraline and rifampicin to be presented at a future IMOC meeting for approval

12. Standing items/Items for information only

- 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:
  - Updated IMOC documents approved via IMOC Chair's approval

13. Update on the management cost reduction for SEL Integrated Care Board

The presenter was unable to attend the meeting; therefore, this item will be deferred to the next IMOC meeting in May.

14. AOB

IMOC workplan for 2025/26

The author noted given the ongoing NHS organisational changes, the IMOC workplan for 2025/26 will be a simplified workplan with focused areas. One focus area will include a review of existing guidelines to determine their continued relevance and to assess whether alternative national guidance is available that can be signposted to instead. A second area will outline a process for developing local guidelines, with the aim of limiting the number of guidelines that are being generated through the committee.

The draft workplan will be presented at the next IMOC meeting in May 2025.

IMOC dates for next 3 months

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