South East London Integrated Medicines Optimisation Committee (SEL IMOC) Meeting
19th March 2026 (Hybrid Meeting)
Final Minutes

Microsoft Copilot (artificial intelligence) was used to support the initial drafting of these meeting notes. The accuracy and content have been reviewed, edited and finalised by the meeting leads.

1. Welcome, introductions and apologies

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

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. Members were provided with an update on the progress against actions due for this month, these were noted, and items closed were agreed.

4. SEL ophthalmology treatment pathways and associated costings

- **Treatment pathway for macular oedema secondary to retinal vein occlusion (RVO)**
- **Treatment pathway for centre-involving diabetic macular oedema (DMO) with visual impairment**
- **Formulary request for dexamethasone intravitreal implant (off-label)**
- **Updated outcomes and monitoring framework**

- **Treatment pathway for RVO and DMO**

The authors and leads were in attendance to present this item on behalf of the Medical Retinal Therapies sub-group. The SEL Treatment pathways for RVO and DMO have been adapted from NHS England's (NHSE) national treatment pathways for these conditions and have been through IMOC consultation. Following consultation, they have been amended in line with comments and approved via the sub-group. The national pathways aim to support a consistent approach to the management of DMO and RVO and support the use of either intravitreal biosimilar aflibercept 2mg or biosimilar ranibizumab as first line treatment options. Second line options are outlined within the pathways.

The presenter highlighted the key updates made to the locally adapted versions of the pathways. The updates include making clear where recommendations made in the national pathways have been accepted for local commissioning in SEL. This involves selected treatments being recommended outside of the relevant National Institute for Health and Care Excellence (NICE) technology appraisal (TA) or outside of their licensed indication but in line with the relevant NHSE treatment pathways. The recommendations made in the national pathways reflect established clinical practice nationally and cover:

- the use of biosimilar ranibizumab or dexamethasone implant before laser treatment in RVO (outside of NICE TA 283 and NICE TA 229)
- biosimilar aflibercept 2mg or biosimilar ranibizumab in DMO where central retinal thickness (CRT) is less than 400 microns (outside of NICE TA 274 but in line with NICE guideline NG 242 – diabetic retinopathy: management and monitoring)
- Four monthly dexamethasone implant (off-label, DMO and RVO)
- Repeated administration of dexamethasone beyond 7 implants in DMO (off-label)
- Fluocinolone up to 2 implants per eye (recommended to be commissioned by NHSE and in line with licensed indication)

- **Formulary request for dexamethasone intravitreal implant (off-label)**

To support the off-label use of four monthly dexamethasone implants in DMO and RVO, committee members considered a formulary request for the use of dexamethasone implants in this setting.

Dexamethasone (Ozurdex®) implants are licensed to be used every 6 months, however clinics and real-world data support usage of 4 monthly dexamethasone implants. The use of four monthly dexamethasone implants is also supported by the national NHSE pathways for DMO and RVO. In line with the licensed indication, the "Red Amber Green" (RAG) category for this request would be Red. From a cost perspective, the use of four monthly dexamethasone implants in this setting is within the financial threshold delegated to the committee.

- **Updated outcomes and monitoring framework**

The outcomes and monitoring framework, updated and approved through the medical retinal therapies subgroup, was presented. The outcomes and monitoring framework has been updated to include the monitoring of treatments used to manage DMO and RVO in line with the pathway and was included as part of the IMOC pathway consultation. This includes the use of best value anti-VEGFs and a review of patients receiving off-label dexamethasone intravitreal implant 4 monthly.

Committee members approved the following by consensus:

- SEL DMO and RVO treatment pathway and the associated locally commissioned elements and use of treatments outside of NICE TAs (but in line with the national pathways)
- Formulary request for dexamethasone intravitreal implant (off-label) for DMO and RVO (Red RAG category)
- Updated outcomes and monitoring framework

ACTION: Off-label use of dexamethasone intravitreal implant in DMO and RVO to be added to the SEL JMF

5. SEL Acute Provider Collaborative (APC) orthopaedic guidelines:

- **Guideline for hip pain in adults (medicines content only)**
- **Guideline for knee pain in adults (medicines content only)**

The authors were in attendance to present this item, seeking approval for the medicines content of the guidelines concerned. The presenters outlined the work to develop the guideline which supports the diagnosis and management of hip and knee pain. The guidelines were circulated for consultation with the IMOC as well as a broader consultation across primary care including the Local Medical Committee (LMC). The guidelines aim to support consistent, evidence-based management of hip and knee pain across SEL. In addition the guidelines aim to support an improvement in the quality and appropriateness of referrals into secondary care and set realistic expectations for both clinicians and patients regarding management. The medicines content of the guidelines are very limited with reference to the Clinical Knowledge Summaries (CKS) topic on analgesia, local pain guidelines and the use of intra-articular steroid injections.

A comment was raised regarding the early stages of management and whether patients would be advised to purchase simple analgesia over the counter. The presenter clarified where medicines can be safely purchased over the counter, patients should be encouraged to do so. Analgesia such as opioids and neuropathic pain agents which require a prescription should be reserved for situations where pain becomes limiting or where stronger analgesia is required, recognising that not all patients with chronic hip or knee pain will require prescribed analgesia. A question was also raised regarding the administration of intra-articular steroid injections in primary care for knee pain and if this is common practice. The presenter confirmed the administration of intra-articular steroid injections are a widely held skill within primary care, delivered by GPs, First Contact Practitioners, and other appropriately trained clinicians, depending on local skill mix. Additionally, the inclusion of intra-articular steroid injections within the guideline supports timely symptom relief and is consistent with current practice.

Committee members approved by consensus the medicines content of the SEL APC hip pain and knee pain guidelines pending amendments in line with the meeting discussion.

ACTION: Guidelines to be updated in line with the discussion and progressed for approval via IMOC Chair's action

6. Formulary recommendation - pyridostigmine for the treatment of Orthostatic Hypotension (OH) in adults

This formulary recommendation has been drafted following the approval of pyridostigmine in this setting as Amber 3 (shared care) at the February 2026 IMOC meeting. The formulary recommendation was shared with the IMOC triage panel for comments, minor comments were noted, including clarification of the place in therapy and positioning of the off-label statement earlier in the recommendation.

Committee members approved the formulary recommendation by consensus.

7. Clinical Effectiveness South East London (CESEL): multiple long-term condition (mLTC) resource pack (medicines content only)

The author was in attendance to present this item which has undergone consultation with the IMOC for the medicines content. The resource has been developed in response to system-wide feedback that existing CESEL guidance remains largely single-condition focused and that clinicians require practical support to manage patients with multiple co-existing long-term conditions. This is particularly in the context of integrated neighbourhood teams. The author explained the resource pack has been designed as a prompt sheet and is intended for clinicians familiar with the individual condition management. The clinical content synthesises previous CESEL approved guides for hypertension, type 2 diabetes (T2DM), chronic kidney disease (CKD) and the SEL IMOC lipid management pathways. The pack is structured into five sections with section one – clinical mLTC care containing the medicines-related content.

A query was raised in relation to the rationale of including both the NICE and Quality and Outcomes Framework (QOF) HbA1c targets, given that they differ. The presenter explained that NICE targets are evidence-based and clinically aspirational, whereas QOF targets remain operationally important in general practice. Including both reflects real-world clinical and contractual realities, while allowing clinicians to individualise care. GP committee members also noted including both targets is also useful in practice. A query was also raised in relation to whether the resource pack had been piloted with clinicians in primary care and if any feedback had been received. The presenter confirmed that formal piloting had not been carried out however the resource pack will be used as part of a project underway by the Health Innovation Network (HIN) and will be evaluated as part of this project.

Committee members approved the medicines content within the Clinical Effectiveness South East London (CESEL): multiple long-term condition resource pack by consensus, pending amendments in line with the meeting discussion.

ACTION: Resource pack to be updated in line with the discussion and progressed for approval via IMOC Chair's action

8. Intranasal adrenaline (EURneffy®) for emergency treatment of severe allergic reactions (anaphylaxis) in adults and children with a body weight ≥ 30 kg

This formulary submission originates from acute Trust adult and paediatric allergy clinicians and requests the use of the intranasal formulation of adrenaline (epinephrine, (EURneffy®)) for emergency treatment of severe allergic reactions (anaphylaxis), in line with its licensed indication. Treatment is indicated for adults and children with a body weight ≥ 30 kg. The application requests an Amber 1 or Amber 2 "Red Amber Green" (RAG) category for the use of EURneffy® in this setting, noting if approved, ideally GPs will issue repeat prescriptions once EURneffy® has been initiated or recommended by secondary care, mirroring current prescribing arrangements for adrenaline auto-injector (AAI).

- **Evidence Review**

The Formulary Pharmacist provided an overview of the evidence base, background to the condition and its management. The IMOC Triage Panel agreed, on this occasion, to the use of the Drug and Therapeutics Bulletin (DTB, January 2026) for the evidence review alongside a local evidence briefing. This is because, owing to ethical reasons, clinical studies of epinephrine nasal spray were not conducted in people experiencing a severe allergic reaction and this limits the evidence identified for the evidence review. The studies (as summarised in the DTB review) are pharmacokinetic and pharmacodynamic studies. The information presented also included the estimated resource impact for use of EURneffy®. The resource impact of the submission is within the financial threshold delegated to the committee.

The committee heard that around 90% of anaphylaxis events respond to a single dose of adrenaline. Intramuscular (IM) adrenaline commonly administered using an AAI is the first line treatment for anaphylaxis. Most anaphylaxis reactions respond to one or two IM adrenaline doses. NICE guidance on anaphylaxis assessment and referral after emergency treatment (CG134) advises that patients at risk of anaphylaxis are prescribed two adrenaline injectors and advised to carry them at all times. EURneffy® is an intranasal adrenaline spray licensed for the emergency treatment of anaphylaxis in adults and children weighing ≥30 kg. It is not intended to replace AAIs but provides an alternative route of administration to improve accessibility, acceptability and timely use in selected patient groups. EURneffy® has a longer shelf life than most AAIs and greater storage flexibility.
In October 2025, the British Society for Allergy and Clinical Immunology (BSACI) welcomed the Medicines and Healthcare products Regulatory Agency (MHRA) approval of EURneffy® and recommended shared decision-making when considering its use. However, BSACI advised that EURneffy® should not be used as the sole rescue treatment in:

- people who have previously needed more than 1 dose of adrenaline to treat anaphylaxis
- people with a previous severe anaphylaxis with hypotension, something which is more common in those with allergy to insect venom

Randomised controlled trials in acute anaphylaxis are neither feasible nor ethical due to the unacceptable risk of deliberate induction of anaphylaxis. Regulatory approval was therefore based on a pharmacological equivalence approach, consistent with established practice for emergency medicines. Pharmacokinetic (PK) studies demonstrated that intranasal EURneffy® achieves systemic adrenaline concentrations comparable to AAIs. An integrated PK analysis including adults and paediatrics demonstrated that Epipen® reached maximum concentration most rapidly, followed by EURneffy® and then IM needle-and-syringe injection; however, these differences were considered clinically insignificant, as therapeutic benefit occurs at plasma concentrations well below peak levels. A paediatric study involving children ≥ 30kg undergoing controlled food-challenge testing was presented as supportive evidence. Participants were given a single dose of EURneffy® after allergy symptoms that were induced by an oral food challenge. The median time to symptom resolution was approximately 16 minutes with no participants requiring a second dose within 15 minutes.

From a safety perspective, there is a theoretical concern regarding a higher risk of hypertensive crisis (a rare unwanted effect of adrenaline) with nasal administration in comparison to IM administration, especially among people who are older or have pre-existing cardiovascular disease. However, it was highlighted that increases in BP is more likely with accidental injection of adrenaline into blood vessels than with nasal administration.

- **Applicants' presentation**

The applicants were in attendance to present the submission and field any questions. The applicant's declaration of interests was noted.

Clarity was requested regarding the place in therapy of EURneffy® in relation to existing AAIs available on the formulary and how clinicians will decide between the initiation of EURneffy® or an AAI. The applicants explained that in adults, EURneffy® is intended as an alternative in young adults for whom the intranasal route offers practical or behavioural advantages and in patients with needle phobia. For paediatric patients, EURneffy® will be particularly useful in adolescents who find it difficult to carry AAIs

and will be used first line for food challenges carried out in clinics to support the on-going evaluation of EURneffy® with the BSCAI.

A query was raised regarding whether switching existing patients from AAIs to EURneffy®, will be done opportunistically in clinic and if GPs will be requested to undertake switches. The applicants confirmed for adults there is no plans or intention for routine/blanket or programme-driven switching and any switches will be patient-led, rather than mandated. For paediatrics there are also no plans for an active switch programme, other than for the identified patient cohort for whom EURneffy® is considered appropriate.

A question was raised relating to the delivery of training for patients, carers, and school settings on the use of *EURneffy®*. The applicants advised that training would be provided by specialist hospital teams, supported by trainer devices and educational materials. They also noted that national work via the BSACI is underway to update standardised allergy action plans which schools follow for the management of anaphylaxis and this will include EURneffy® alongside other adrenaline devices. Wider school-based training initiatives linked to national policy developments will also support implementation.

A question was raised regarding the expected quantities of EURneffy® to be prescribed per patient. Concerns were raised regarding the current demand for additional AAI devices at multiple locations for paediatrics in particular. The applicants advised that the introduction of EURneffy® is not expected to alter the existing demand for multiple devices, noting that this reflects a broader issue associated with AAIs rather than a product-specific concern. Where appropriate, particularly for older or more independent children, patients are expected to carry two doses in line with national guidance from the MHRA and NICE. However, they acknowledged that requirements may vary depending on the child's age and school arrangements. The applicants confirmed that routine prescribing of multiple packs is not proposed, although the longer shelf life of EURneffy® may offer a practical advantage where additional devices are required. A follow-up comment was raised regarding the estimated costs for the application, with a request to review the costings to factor in the potential need to prescribe additional EURneffy® devices.

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

Committee members discussed the application and members confirmed support of the application and acknowledged there is a patient cohort who could benefit from EURneffy® as an alternative route of administration for adrenaline in the management of anaphylaxis whilst acknowledging further support and training is crucial for primary care and local schools to support the safe and timely administration of EURneffy®.

After balancing ease of initiation with safety oversight, and noting AAIs are Amber 1 in paediatrics, committee members approved by consensus intranasal adrenaline (EURneffy®) for the emergency treatment of anaphylaxis in adults and children with a body weight ≥ 30 kg as Amber 1 *(initiation in primary care on specialist advice).*

ACTION: Revised estimated costings for the use of EURneffy® to be provided in line with the meeting discussion
ACTION: Formulary recommendation to be drafted and presented at a future meeting
ACTION: Intranasal adrenaline (EURneffy®) to be added to the SEL JMF following approval of the formulary recommendation

8. **SEL Acute Provider Collaborative (APC) primary and secondary care gynaecology guidelines and associated formulary request:**
   - **Recurrent first trimester miscarriage and/or one or more second trimester miscarriage (medicines content only)**
   - **Formulary request for vaginal micronised progesterone for women with vaginal bleeding in early pregnancy, and history of miscarriage (off-label)**

The authors were in attendance to present this item which covers the remaining two SEL APC guidelines that support the diagnosis and management of gynaecological sub-conditions. The guidelines were circulated for consultation with the IMOC as well as a broader consultation including the Local Medical Committee (LMC). Following IMOC consultation, twenty one guidelines were discussed and reviewed across the December 2025 – February 2026 IMOC meetings, of which twelve guidelines included medicines content. The twelve guidelines were presented with associated formulary requests and were approved, subject to amendments.

Committee members noted the guideline on asymptomatic increase in endometrial thickness guideline is included within the agenda pack for information only. It does not contain medicines and therefore does not require IMOC approval.

The recurrent first trimester miscarriage and/or one or more second trimester miscarriage guideline is being re-presented alongside the formulary request for vaginal micronised progesterone for women with vaginal bleeding in early pregnancy, and history of miscarriage (off-label). The use of vaginal micronised progesterone in this setting is in line with guidance from the Royal College of Obstetricians and Gynaecologists (RCOG) and NICE guidance - ectopic pregnancy and miscarriage (NG126). The proposed RAG category is Amber 2 *(specialist initiation).* From a cost perspective, the formulary request is within the financial threshold delegated to the committee.

A comment was raised to note the use of vaginal progesterone in this setting within the guideline as per the wording in the NICE guideline and include the treatment duration of up to 16 weeks' of gestation. A comment was also raised requesting the addition of a statement within the guideline which clarifies the RAG category for enoxaparin is Red.

Committee members approved by consensus the recurrent first trimester miscarriage and/or one or more second trimester miscarriage guideline pending amendments in line with the meeting discussion and the formulary inclusion of vaginal micronised vaginal progesterone in this setting (off-label) as Amber 2.

ACTION: Authors to return amended guideline in line with discussions to be progressed for approval via IMOC Chair's action
ACTION: SEL adult JMF to be updated in line with the formulary request for micronised vaginal progesterone in women with vaginal bleeding in early pregnancy, and history of miscarriage (off-label).

9. **Paediatric formulary requests - switch from unlicensed to licensed oral preparations:**
   - **Spironolactone 50mg/5ml oral suspension (Qaialdo®)**
   - **Flecainide 25mg/5ml oral solution**

The paediatric formulary leads presented this item. In line with MHRA guidance and medicines optimisation principles, a switch from unlicensed to licensed products is preferred where available and clinically appropriate. Licensed spironolactone and flecainide oral liquid preparations have recently become available, which has simultaneously led to the supply discontinuation of the unlicensed oral liquid preparations.

Due to the supply discontinuation of the unlicensed preparations, the paediatric joint formulary has been updated to include the licensed spironolactone (Qaialdo®) and flecainide oral liquid preparations to enable continued supply within the Trusts. A risk assessment was carried out for the licensed preparations to ensure all liquid preparations are being assessed against the same. In line with this, the formulary requests for licensed spironolactone (Qaialdo®) and flecainide oral liquid preparations are retrospective in nature, ensuring IMOC oversight and formal approval.

A licensed oral suspension of spironolactone (Qaialdo®) is now available at an equivalent concentration to the previously used unlicensed formulation, reducing the risk of dosing errors. Qaialdo® was selected locally due to its suitability for administration via enteral feeding tubes, which is common in the paediatric population. For flecainide, the majority of patients have been switched to the licensed oral solution, supported by a clinical memo and patient and GP information letters. Licensed spironolactone

and flecainide liquid formulations are less cost-effective than unlicensed alternatives. This has highlighted the need to consider weight-banded dosing for licensed liquids and to encourage tablet use where appropriate, including referral to pill-swallowing training (pill school).

From a cost perspective the use of licensed spironolactone and flecainide oral liquid preparations is within the financial threshold delegated to the committee.

A request was made to present the associated cost impact for licensed spironolactone and flecainide oral liquid as system-wide additional costs, using the cost difference in comparison to the unlicensed specials. The applicants agreed to update the costings as discussed. A query was also raised in relation to the RAG category for spironolactone (Amber 1), noting that GPs would not normally initiate spironolactone in paediatrics. The presenter clarified that in practice, initiation of spironolactone in paediatrics is usually specialist-led and agreed to feed this back to the specialist team for review of the Amber 1 category.

Committee members approved by consensus the retrospective formulary inclusion of licensed spironolactone 50mg/5ml oral suspension (Qaialdo®) and flecainide 25mg/5ml oral solution.

ACTION: Revised estimated costings for the use of licensed spironolactone suspension and flecainide be provided in line with the meeting discussion

10. Updated guidance on alternatives to prescribing unlicensed specials in primary care (summary of changes included)

The same presenters as for the previous item presented this updated guidance; the guideline has undergone a minor update to reflect changes in prescribing patterns for unlicensed specials locally and availability of new licensed formulations. This includes the addition of cyanocobalamin 100mcg tablets and flecainide liquid and updated recommendation for magnesium oral preparations.

The Committee approved the updated guidance by consensus.

11. Medicines Optimisation and Pharmacy Strategic Commissioning 5-year plan

The author presented the Medicines Optimisation and Pharmacy Strategic Commissioning 5-year plan, which forms part of the overarching ICB five-year strategic commissioning plan. This plan supersedes the previous Medicines and Pharmacy 5 year Forward Plan. The Medicines Optimisation and Pharmacy Strategic Commissioning 5 year plan is structured around four main priorities:

- Workforce, digital innovation and sustainability
- Community Pharmacy integration and transformation
- Medicines value, antimicrobial stewardship and safety
- Optimisation of medicines use in long-term conditions, including reducing over-prescribing

Committee members were also provided an update on the ICB Change Programme. The draft ICB staff consultation for the Change Programme has been launched and is being consulted across the ICB for 45 days.

Committee members noted the Medicines Optimisation and Pharmacy Strategic Commissioning 5-year Plan and update on the ICB Change Programme.

12. Terms of reference for London Medicines Commissioning Network (LMCN)

The lead for this item presented that the London Medicines Commissioning Network has been established through collaboration of the London ICB Chief Pharmacists and the London Regional Chief Pharmacist. The network will identify areas of strategic commissioning which benefit from a single approach across London region to release capacity, deliver efficiency or reduce inequalities and variation. The LMCN have produced Terms of Reference (ToR) to which the network will work to.

A verbal update on the development of the Single National Formulary (SNF) was also provided. The SNF is progressing and will require local formularies to adopt a standardised national categorisation model, intended to replace traditional "traffic light" categorisation systems. This will result in a move away from colour-coded RAG categories towards descriptive text-based categories, providing clearer definitions of prescribing responsibilities. Committee members were informed that SEL may be requested to act as an early adopter for implementing the revised classification framework, and the presenter queried if there would be any objections or concerns with this. Committee members indicated their support for being early implementers.

Committee members noted the ToR for the LMCN and updates regarding the SNF.

13. Standing items/Items for information only

- Formulary submissions tracker
  - Noted.
- NICE Technology Appraisal (TA) Guidance Summary - Integrated Care Board and NHSE attributed medicines:
  - The summary was noted, and RAG categories were approved by consensus, where it was possible to confirm the RAG status.
- For information and noting:
  - Adult and paediatric formulary update February 2026 – noted by committee members.

14. Any other business

Committee members noted the appointment of the new IMOC Chair. Members shared congratulations, welcoming the new IMOC Chair to their role.

Committee members noted that this meeting marked the last meeting chaired by the outgoing IMOC Chair. Members expressed their appreciation for their leadership, highlighting their composed and methodical approach, clarity in decision-making, and sustained guidance of the Committee over several years. The Chair was thanked for their valuable contributions to SEL IMOC. The outgoing Chair thanked members warmly and reflected that they had greatly valued the professionalism, dedication, and collaborative spirit of committee members. They noted how important the IMOC's work is within the broader SEL medicines system and expressed full confidence in the committee's continued effectiveness.

IMOC dates for next 3 months

Date	Time	Venue
Thursday 16th April 2026	2pm – 4:30pm	MS Teams
Thursday 21st May 2026	2pm – 4:30pm	MS Teams
Thursday 18th June 2026	2pm – 4:30pm	MS Teams