South East London Integrated Medicines Optimisation Committee (SEL IMOC) Meeting
18th June 2026 (Online via MS Teams)
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. No conflicts were raised.

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 the progress against actions due for this month, these were noted and items closed were agreed.

4. Formulary request for the addition of low dose heparin sodium for line locking of central venous access devices (CVADs) in paediatric patients (Amber 1)

The request relates to a small cohort of paediatric patients, including patients with inherited blood disorders such as sickle cell disease, who have CVADs and require line locking following access/de-access for blood tests, blood products or transfusion-related care. It was explained that, while other settings may use sodium chloride for line locking, the specialist clinical team's preference for this cohort is low dose heparin sodium, due to the increased risk of thrombotic complications. It was clarified that the request related only to low dose heparin sodium preparations and not treatment-dose heparin, which is currently Red-listed on the formulary. The committee heard that community nursing teams may access/de-access these lines in the patient's home or school setting, but that challenges with medicines prescribing and supply arrangements, and internal Trust budgets, impact on the ability of the community teams to administer heparin line locks, unless the product is prescribed for the patient. The request is intended to support continuity of care in the community and avoid unnecessary hospital attendance by enabling supply through primary care repeat prescribing.

A comment was raised that the challenge appeared to be one of prescribing/supply, administration and internal Trust funding, rather than a clinical need for GP prescribing. It was also noted that responsibility for safe management of the CVAD lines routinely falls under the specialist hospital service and the team accessing and managing the line, rather than with primary care, who do not have the expertise. Committee members shared that it would be more appropriate for the specialist or community nursing service involved in line care to manage prescribing, supply and administration arrangements directly. In addition, the appropriate supply and funding route should be established through the community nursing service, rather than transferring prescribing responsibility to primary care, which could add workload and complexity without resolving the underlying issue. In response to a query about potential risks in labelling by community pharmacy, the presenter clarified that the low dose 50 units/5 mL product packaging is already labelled for line locking by the manufacturer. The intention was not to rely on additional labelling instructions from community pharmacy.

Following discussion, committee members did not approve by consensus the request to add low dose heparin sodium for line locking of CVADs in paediatric patients as Amber 1. Members agreed that the operational barriers and financial aspects require escalation by the applicant through internal Trust processes or commissioner discussions rather than through formulary recategorisation. The committee concluded by consensus that the category for the use of low dose heparin sodium in this indication should be Red and continue to be supplied and managed by the appropriate specialist team.

ACTION: Low dose heparin sodium for line locking of central venous access devices in paediatric patients to be included in the SEL paediatric formulary as Red

5. Type 2 Diabetes Mellitus (T2DM) and obesity guidance updates and proposed formulary recategorisation:

- **Updated Clinical Effectiveness South East London (CESEL) Guide for T2DM**
- **Updated glucagon-like peptide-1 (GLP-1) analogue pathway**
- **Recategorisation request for GLP-1 analogues for T2DM and weight management from Amber 2 to Green (Amber 1 for combination use of GLP-1 analogues with insulin in T2DM)**
- **Cost modelling for GLP-1 analogues in T2DM**

The leads were in attendance to present the items on behalf of the diabetes sub-group and a declaration of interest was noted. It was shared that these items were being brought together as updated guidance from the National Institute for Health and Care Excellence (NICE) for the management ofT2DM had significantly changed the position of glucose-lowering therapies, particularly sodium-glucose cotransporter 2 (SGLT2) inhibitors and GLP-1 analogues. The overarching aim of the updates is to align local practice with updated NICE guidance, improve equity of access across SEL, and enable delivery of newer therapies within primary care. The updated T2DM guidance was presented as largely aligned with NICE recommendations, with minimal local modification beyond the inclusion of preferred formulary agents (e.g. dapagliflozin is the preferred SGLT2 inhibitor in SEL).

It was noted that the updated NICE T2DM guidance has expanded the population eligible for GLP-1 analogues which are currently categorised as Amber 2 for T2DM in SEL, requiring specialist initiation. SEL is an outlier compared with other areas and has a relatively low number of GLP-1 analogues prescription items per 1,000 population compared with other areas nationally, and the current formulary status may be a contributing factor for this. The proposal therefore sought to move all licensed GLP-1 analogues to Green status for T2DM, enabling primary care initiation, with the exception of use in combination with insulin, which would have an Amber 1 classification due to higher associated risks and specialist oversight required.

The GLP-1 analogue pathway has been significantly expanded to incorporate both diabetes and obesity management, with clearer eligibility criteria, improved structure around initiation and titration, and additional guidance on when to involve specialist services. Enhancements also include advice on medication adjustments, management of co-prescribing with insulin, and consideration of complications such as diabetic retinopathy. The pathway is designed to support primary care clinicians in safely initiating and managing these therapies, while maintaining appropriate escalation routes.

It was noted that tirzepatide for obesity is now included within national primary care contractual arrangements, including two quality and outcomes framework (QOF) indicators for 2026/27. Additionally, NICE has highlighted primary care initiation for the relevant NHS England weight management cohorts, which are being introduced in a phased way (currently cohort 1 and, from 23rd June 2026, cohort 2). Therefore, a request for the recategorisation of tirzepatide in weight management for NHS England Cohorts 1 and 2 from Amber 2 to Green is also being made to the committee. Semaglutide (Wegovy®) and liraglutide for the management of obesity will remain Red for all patients, and tirzepatide will remain Red for patients meeting the urgent access criteria outlined in the pathway. These treatments will continue to be managed by specialist weight management services (SWMS).

The committee was informed that the cost modelling for implementation of the updated NICE guidance on T2DM had been developed using the NICE resource impact template, with local data used where available. Local population data and prescribing patterns have been used to replace NICE assumptions where these were not considered reflective of SEL practice. It was shared that the NICE template includes an assumption on the proportion of people with T2DM and obesity who may need GLP-1 analogues treatment after optimisation of therapy. NICE had suggested 30% based on optimisation at an HbA1c of 75 mmol/mol; however, in practice, SEL would optimise therapy at a lower HbA1c, therefore the local modelling increased this assumption from 30% to 50%. In addition, NICE suggests a 10% change per year over three years, but as SEL has lower use of both SGLT2 inhibitors and GLP-1 analogues compared with many other areas, the local model uses a 10–20% change per year over three years.

The cost modelling factors in savings from increased use of SGLT2 inhibitors and most GLP-1 analogues, but not for tirzepatide as the relevant clinical outcome data had not been available when NICE developed their resource impact template. It was noted that the actual savings could be higher once tirzepatide-related event savings are considered, and it was highlighted that different GLP-1 analogues may be used depending on the indication.

Within SEL, GLP-1 prescribing already represents a significant financial commitment and the proposed changes are expected to increase both activity and cost over a three-year period. For year one, the model assumes a 25% uptake of all the medication recommendations within the NICE guideline (NG28), in the first year, with the remaining 75% split between years two and three. It was highlighted that costs would increase in years two and three as the assumed proportion of uptake increased. The resulting cost impact per year, estimated over 3 years, is above the financial threshold delegated to the committee. While the financial implications were acknowledged as significant, the committee was asked to consider the cost of implementing the whole guideline rather than viewing each intervention separately.

It was reiterated that the cost modelling presented under this item relates to implementation of NG28 only. The committee was reminded that separate system wide cost modelling for the use of GLP-1 analogues in weight management had previously been presented to the IMOC in 2025. As the cost impact in weight management exceeded the committee's delegated financial threshold, the cost modelling had been escalated to the Executive Committee and had previously already been approved by the Executive Committee in 2025.

Additionally, the committee noted the retirement of the following documents:
- SEL T2DM glycaemic control management pathway for adults
- SEL GLP-1 analogues for glycaemic control in T2DM information sheet
- Mounjaro® (tirzepatide) for managing overweight and obesity – information sheet for SEL

A query was raised by the committee regarding the non-diabetic hyperglycaemia specialist weight management pathway and whether this pathway currently exists. The presenters advised that this is an existing pathway linked to older NICE technology appraisal (TA) guidance and that it has been used previously, although usage reduced during a period of liraglutide shortage and because newer GLP-1 options and NHS England cohort criteria now apply to some patients. In response to a query regarding SWMS referral criteria, the presenters agreed that referral criteria should be checked with the relevant services and updated where needed so that they reflect current eligibility criteria as far as possible.

A comment was raised to request that the pathway should make clear that primary care may initiate GLP-1 analogues for T2DM where appropriate, in the same way that the pathway already describes primary care initiation for obesity cohorts. The presenters agreed to make this change. In addition, a request was made to make the distinction around co-prescription with insulin more prominent, as this remained Amber 1 and could otherwise be missed in its current location in the GLP-1 analogue pathway. It was suggested that the eligibility page should also include a clear cross-reference stating that patients co-prescribed insulin should be referred to, or discussed with, the specialist team.

Further clarification was provided regarding NHS England obesity cohorts 1 and 2 and it was shared that, for primary care prescribing, tirzepatide is the option specified by the relevant NICE TA, whereas SWMS may choose from available treatment options according to the patient's clinical circumstances. It was agreed that an asterisk or explanatory note would be added to the pathway to avoid confusion. A further query was raised regarding urgent access criteria within SWMS and whether patients meeting urgent criteria could face longer waits than patients being managed directly in primary care. The presenters advised that SWMS prioritise urgent access referrals and seek to pull those patients through more quickly, particularly where urgent clinical circumstances apply. Any concerns about specific cases can be escalated through local provider contract review routes.

Clarification was also sought around referral to Behavioural Support for Obesity Prescribing (BSOP) programs. It was confirmed that, under the relevant primary care arrangements, the requirement includes shared decision-making, prescribing of tirzepatide where appropriate, and referral to BSOP. The BSOP provides a structured programme covering advice on health behaviour and safety, protein

intake, hydration, and exercise, with the intention of supporting the wider lifestyle and safety elements outside the prescribing consultation.

A request was made by the committee for education and communication for secondary care clinicians, as some patients are being advised by hospital specialists to ask their GP for GLP-1 therapy despite not meeting eligibility criteria, leading to complaints and pressure on GPs. The presenters acknowledged this issue and advised that the updated guidance should help provide a clear reference point for eligibility. It was noted that updated patient and healthcare professional communications would be developed, and that education for Trust clinicians would be helpful to ensure consistent messaging on eligibility and referral routes. Alongside this, to support education and implementation in primary care, webinars are being planned and this would cover T2DM management rather than focus solely on GLP-1 analogues.

Some reservations were raised by GP colleagues around the move to a Green categorisation, including the complexity of the guidance, the time required for counselling and monitoring, the risk of fragmented care for a chronic condition requiring holistic management, and whether standard GPs would have sufficient systems to ensure ongoing review, weight monitoring and ensuring continuation criteria are applied appropriately. The committee discussed that the current cohort may be more manageable than initially perceived, particularly as many eligible patients are likely to have T2DM and may be managed through existing diabetes arrangements within practices. Emphasis was placed on the importance of maintaining focus on broader diabetes management, particularly optimisation of metformin and increasing the use of SGLT2 inhibitors, to avoid disproportionate attention on GLP-1 therapies. It was also emphasised that, where GPs are not comfortable initiating treatment in particular patients, referral to specialist services remains an option, with additional support available through advice and guidance, Consultant Connect, intermediate care teams and specialist services. The presenters reiterated that the specialist and intermediate care teams recognise this as a major change and would support implementation. It was noted that the aim is to enable patients to access appropriate treatment earlier and safely, with specialist support available where needed.

Committee members approved by consensus the updated CESEL T2DM guidance and GLP-1 pathway pending the amendments requested. The committee also approved by consensus the formulary recategorisation of tirzepatide (Mounjaro®) from Amber 2 to Green for obesity for NHS England (NHSE) cohorts 1 and 2 and semaglutide (Ozempic® and Rybelsus®), tirzepatide, dulaglutide, and liraglutide from Amber 2 to Green for T2DM, except in combination with insulin, where the Amber 1 category was approved by consensus.

It was noted that the T2DM pathway implementation costings were outside the Committee's delegated financial threshold and will be escalated to the Executive Committee for approval.

ACTION: GLP-1 pathway to be updated in line with the discussion and progressed for approval via IMOC Chair's action once financial impact is approved via Executive Committee
ACTION: GLP-1 analogues for the management of T2DM including semaglutide (Ozempic® and Rybelsus®), tirzepatide, dulaglutide, and liraglutide to be recategorised from Amber 2 to Green on the SEL adult JMF once GLP1 pathway approved
ACTION: GLP-1 analogues co-prescribed with insulin for T2DM to be recategorised to Amber 1 on the SEL adult JMF once GLP1 pathway approved
ACTION: Tirzepatide for obesity to be recategorised to Green on the SEL adult JMF following IMOC Chair's action for the GLP-1 pathway
ACTION: Estimated cost impact of the T2DM pathway to be escalated to the Executive Committee for approval

6. Updated CESEL asthma guide in children and young people (CYP) and associated formulary request:

i. Updated CESEL asthma guide in CYP (medicines content only)
ii. Formulary request for Fobumix® Easyhaler® (budesonide/formoterol fumarate) in CYP

The author and lead were in attendance to present this item on behalf of the respiratory sub-group. The request to the committee is to support the addition of Fobumix® Easyhaler® as an additional dry powder

inhaler (DPI) option for maintenance and reliever therapy (MART) in CYP and approve the updated medicines content within the CESEL Guide (which reflects the inclusion of Fobumix® Easyhaler®). The request includes the use of Fobumix® 80/4.5 micrograms Easyhaler® as MART in children aged 6 years and above, noting that this use is off-label in this age group. The request also includes the licensed use of Fobumix® 160/4.5 micrograms Easyhaler® as Anti-Inflammatory Reliever (AIR) therapy and MART in those aged 12 years and above. The "Red, Amber, Green" (RAG) category being requested for Fobumix® Easyhaler® is Green.

The rationale for the formulary request was to provide CYP with an additional inhaler choice. It was noted that the current formulary option for a DPI MART regimen is Symbicort® Turbohaler®, and having an additional device would be helpful where the existing device is not well accepted by some patients. The proposed addition would support implementation of the updated asthma treatment approach for CYP, including alignment with national asthma guidance.

In addition to the new formulary request for Fobumix® Easyhaler®, the committee was asked to note that the application also included a recategorisation request for Symbicort® 100/6 microgram Turbohaler® from Amber 1 to Green. It was highlighted that this recategorisation formed part of the same formulary request and would support the updated CESEL asthma guide and prescribing pathway for CYP.

In terms of the cost impact, as this prescribing cost is already incurred within the system for Symbicort Turbohaler®, the inclusion of Fobumix® Easyhaler® does not represent an additional cost. The committee noted that due to the lower acquisition cost of Fobumix® Easyhaler®, a small saving could be achieved in the first year.

No comments or queries were raised by committee members, who approved by consensus the updated CESEL asthma guide for CYP, the addition of Fobumix® Easyhaler® as an additional DPI option, and the recategorisation of Symbicort® 100/6 microgram Turbohaler® from Amber 1 to Green.

ACTION: Symbicort® Turbohaler® for the management of asthma to be recategorised to Green in the SEL paediatric formulary
ACTION: SEL paediatric formulary to be updated in line with the formulary request to include Fobumix® Easyhaler® for the management of asthma (MART and AIR) as Green

7. Single national formulary update on early adoption and next steps

An update was provided on the development of the Single National Formulary (SNF), including SEL's role as an early adopter site for the new national categorisation system and the expected next steps for local implementation of this. A slide set was shared on screen during the meeting, demonstrating the SNF aims to reduce unwarranted variation, support prescribing across care settings, and enable faster adoption of new therapies, while also supporting system-wide shifts towards community-based care. The nationally standardised formulary will be supported by a digital platform and will focus initially on clinical pathways rather than individual medicines. The programme will be delivered over approximately three years, beginning with priority pathways, such as heart failure.

A key component of the update was the introduction of a new national categorisation framework to replace traditional RAG traffic light system, designed to provide clearer, standardised definitions without reliance on colour coding, which has historically been inconsistent across the country and open to interpretation. The SEL IMOC had previously agreed in March 2026 to be early implementors of the new categorisation framework. The next steps locally will involve mapping existing SEL formulary categories to the new national categorisation framework and beginning implementation, likely from July 2026 onwards. This will be supported by collaboration across London to ensure a consistent approach and engagement with national SNF development groups.

A query was raised regarding whether SEL would automatically align with the SNF where the national category differs from the current local formulary category. It was clarified that national decisions are intended to be the default, with local variation allowed only in limited circumstances, particularly for specialist advice and specialist initiation where local service configuration may affect implementation.

The presenter also advised that local medicines optimisation committees are still expected to have an important role in implementation once the SNF if established, particularly in local pathway alignment, integrating national decisions into local services and managing exceptions.

A concern was raised that allowing local adaptations may limit the extent to which the formulary is truly "single" or national. The presenter clarified that local adaptation is intended to be the exception rather than the rule, and the SNF digital platform is expected to track such variations, enabling national oversight and review where widespread divergence occurs. A further query was raised on whether new formulary applications would be referred to the SNF in the future or continue to be considered locally. The presenter advised that the SNF is not yet designed to review every individual medicine. As such, local formulary processes will continue to operate in parallel, particularly for niche or emerging therapies. In response to a query regarding the national engagement process for the new categories, the presenter explained that a national task and finish group, with representation from different sectors and regions developed the categories by consensus, supported by regional workshops and feedback from local committees including IMOCs.

Committee members noted the update on the SNF and supported progressing local mapping and implementation.

8. Draft London proposal: principles and approach for commissioning shared care for medicines

An overview was presented on the draft London proposal for commissioning shared care for medicines, developed to support a more consistent London-wide approach following local and regional issues with shared care prescribing. The proposal builds on SEL's existing interface work and medicines-specific principles, aligning with SNF definitions of shared care. The proposal is being progressed through all London Integrated Care Boards (ICBs) for approval. No comments or queries were raised and committee members noted the draft London-wide proposal.

9. Guidance on treating tobacco dependency in adults

Includes, for endorsement by the committee:

- **SEL position statement on access to nicotine replacement therapy in primary care (owned by the Tobacco Dependence Oversight Group)**

The leads were in attendance to present this guidance on behalf of the respiratory sub-group. In addition to approval for the guidance, the presenters outlined that endorsement is also being sought from the committee for a SEL position statement on access to nicotine replacement therapy (NRT) in primary care. The latter has been developed and is owned by the SEL Tobacco Dependence Oversight Group (TDOG).

The guidance outlines principles for the medical management and treatment of tobacco dependence and is intended for use by healthcare professionals across SEL. It was noted that local arrangements for tobacco dependence treatment vary depending on commissioning models, and therefore the guidance is intended to be used alongside existing local pathways and guidance rather than replace them. The guidance aims to support clinicians to identify cost-effective, evidence-based treatment options, enable informed discussions with patients and promote shared decision-making. The guidance aligns with SEL ICB priorities which focus on reducing premature mortality and improving population health. It was clarified that commissioning arrangements were outside the scope of the guidance, which is intended to support access for patients and safe prescribing within existing local arrangements.

In addition, the committee were asked to endorse the position statement on access to NRT in primary care, which aims to support a standardised approach across SEL, where clinically appropriate and safe.

A comment was raised by the committee, reflecting that the guidance may not adequately identify dependence on non-tobacco nicotine products, such as vapes or nicotine pouches. This was noted as particularly relevant for inpatients who cannot vape on wards and may otherwise not be offered NRT.

The presenters acknowledged this as an important issue but advised that the current document is focused on tobacco dependence rather than nicotine dependence. This will be considered as part of separate inpatient guidance that is currently in development. In response to a query regarding the ownership of the guidance, the presenters clarified that the guidance is owned by the IMOC's respiratory subgroup, while the accompanying position statement is owned by the TDOG.

A request was made to signpost to the IMOC cytisine formulary recommendation within the guidance and to express the maximum cytisine dose as the maximum number of tablets in 24 hours, to make the dosing clearer for patients. Clarification was also requested regarding the age range for cytisine and to confirm if any age restrictions apply to varenicline. The presenter confirmed that the age ranges reflect the relevant Summary of Product Characteristics wording for each medicine. As the guidance includes references to CYP and pregnancy, a request was made to provide clarity within the document for the adult-only applicability of specific medicines. In addition, the presenters were requested to update and clarify the duration for combination NRT therapy within the document.

Some concern was raised in relation to prescribing for pregnant patients, including the role of NRT compared with behavioural support. The presenter advised that the pregnancy section had been reviewed with maternity colleagues and reflects current practice within maternity services. Further formatting change requests to the document were also raised and agreed to by the authors.

In relation to the accompanying position statement, a request was made to remove a statement that could be considered inappropriate for the document alongside removal of reference to primary care prescribing budgets.

Committee members approved the SEL guidance on treating tobacco dependence in adults by consensus, subject to amendments agreed during the discussion. The committee also endorsed the SEL position statement on access to NRT in primary care, subject to the amendments requested.

ACTION: Guidance on treating tobacco dependence in adults to be updated in line with the discussion and progressed for approval via IMOC Chair's action
ACTION: Position statement on access to NRT in primary care to be updated in line with the discussion and progressed for final endorsement via IMOC Chair's action

10. Potassium binders for hyperkalaemia in heart failure with reduced ejection fraction or chronic kidney disease stages 3b to 5 with albuminuria, including formulary recategorisation:
i. Potassium binders for treating hyperkalaemia guideline
ii. Recategorisation of sodium zirconium cyclosilicate (Lokelma®) and patiromer (Veltassa®) from Red to Amber 2
iii. NICE resource cost impact summary for TA1148

The author and leads were in attendance to present this item on behalf of the cardiovascular medicines sub-group. The guideline is a new resource and has undergone extensive development and consultation, with post consultation updates reflecting updated NICE TA guidance. The item includes the proposed recategorisation of sodium zirconium cyclosilicate and patiromer from Red to Amber 2, and the associated NICE resource cost impact.

The presenters summarised the guideline, including the following key post-consultation updates:
- alignment with updated NICE TA1148 (which supports sodium zirconium cyclosilicate use from a potassium level of 5.5 mmol/L)
- clearer wording on mineralocorticoid receptor antagonists and abbreviations
- broader follow-up wording applicable to both heart failure and chronic kidney disease (CKD) cohorts.
- Additional practical detail has been added, including baseline bicarbonate considerations, clearer correction and maintenance phases, strengthened advice on severe hyperkalaemia management (including escalation to emergency care), and incorporating clearer monitoring and follow-up recommendations.

The intended pathway is specialist initiation and optimisation in secondary care, alongside renin-angiotensin system inhibitor optimisation, with transfer to primary care only once patients are stable for at least 2 months and established on maintenance treatment.

The cost of implementing the updated NICE prescribing related recommendations on the use of sodium zirconium cyclosilicate (NICE TA 1148) over 3 years was included in the agenda pack, based on the NICE modelling. The estimated cost impact is within the financial threshold delegated to the committee. There are also likely to be offset costs from increased prescribing of sodium zirconium cyclosilicate, such as a reduced need for specialist appointments.

A concern was raised by committee members regarding reliability of potassium results in some boroughs due to high rates of haemolysis in blood samples, producing falsely elevated potassium levels. It was suggested that the guideline should recognise the need to repeat levels and confirm hyperkalaemia before changing binder doses where there is concern about sample reliability. The specialist clinician acknowledged the concern but noted that this is primarily a local laboratory systems issue rather than a medicines or guideline issue. It was clarified that initiation, acute monitoring, dose selection and optimisation would take place in secondary care, with primary care asked to continue treatment and undertake periodic monitoring once the patient is stable. The specialist clinician also advised that the expected patient numbers for treatment are likely to be small. A request was made to replace the term “A&E” (Accident & Emergency) with “ED” (Emergency Department) within the guideline, as this is now the accepted terminology. A further query was raised regarding whether sodium zirconium cyclosilicate is intended to be the preferred first-line potassium binder and whether this should be clearly articulated in the guideline. The presenter advised that both medicines had been included because there may be circumstances where either is needed based on the clinical status of the patient. Overall, sodium zirconium cyclosilicate was generally considered preferable due to its monitoring and tolerability profile. It was noted that patiromer may be preferred where oedema is a concern with sodium zirconium cyclosilicate, but patiromer requires additional monitoring including calcium and magnesium. Both are approved and recommended via NICE TAs.

Committee members requested that the guideline distinguishes more clearly between the NICE eligibility serum potassium thresholds for the two medicines, noting that sodium zirconium cyclosilicate is recommended by NICE where the confirmed serum potassium level is at least 5.5 mmol/L (recently updated by NICE), while patiromer is recommended by NICE at a confirmed serum potassium level of at least 6 mmol/L. A comment was also raised that the structure of the guideline could be improved to make it more user friendly, as it was not immediately clear which sections applied to primary care and which applied to secondary care. It was suggested that the pathway/flowchart should be moved earlier in the document, along with the roles and responsibilities so that the requirement for patient stability prior to transfer to primary care are clear at the outset. Members agreed and supported a restructuring of the document.

In response to a query regarding how often patients stabilised on potassium binders require later dose changes, the presenters advised that local experience is limited because relatively few patients have been initiated, but in the small number treated, dose changes after stabilisation have been uncommon. It was noted that some patients may need adjustment if circumstances change, such as worsening renal function or dehydration, but many patients either remain unchanged, reduce dose or stop treatment.

GP members raised concerns that, despite stabilisation before transfer, these medicines may involve nuanced decisions, particularly if kidney function deteriorates or the patient becomes acutely unwell. Concerns were also raised regarding unforeseen primary care workload, additional blood tests, and whether Amber 2 is appropriate across the breadth of CKD stages 3b to 5, particularly stages 4 and 5 where patients may deteriorate rapidly with intercurrent illness. The presenters advised that patients with advanced CKD or heart failure would remain under regular renal or heart failure team follow-up and would not be discharged to primary care as the sole responsible team. It was suggested that where patients deteriorate, primary care should seek specialist advice.
The committee discussed the broader system implications, including alignment with other regions where Amber 2 status is already in place. It was suggested that understanding how other areas have implemented an Amber status safely would be important before making a local decision. Additionally,

there was recognition that moving to Amber 2 without addressing the identified practical challenges could introduce safety risks in primary care.

Committee members acknowledged both the potential clinical benefits of potassium binders and the operational challenges associated with their wider use. Given the range of concerns among primary care representatives, the committee deferred a decision pending additional information and clarifications discussed. The presenters were requested to provide further information and assurance, including benchmarking against other regions and exploring how similar pathways have been safely implemented in other areas nationally, particularly in relation to managing patients with deterioration in kidney function.

ACTION: Leads to provide further information, in line with the meeting discussion, to support the recategorisation request
ACTION: Guidance to be updated in line with amendments discussed, and brought back to a future IMOC meeting

11. Updated SEL Acute Provider Collaborative (APC) urology guideline (medicines content only)

The SEL APC urology guidelines were originally developed and published in November 2023 following a substantial consultation process. The guidelines have been reviewed and updated but in view of the minor changes made, not been re-consulted with IMOC. The changes made for this update have been highlighted in the guideline for the committee's awareness and review. The main change relates to amendments clarifying that generic tadalafil is no longer part of the Selected List Scheme (SLS). The presenter noted that an additional catheter care guideline had been included within the agenda pack, but that the items for IMOC consideration were limited to medicines-related content only.

A request was made by the committee to amend the Selected List Scheme (SLS) criteria section to refer to Cialis® rather than generic tadalafil, as it is the branded product that remains the item covered under SLS criteria. In addition, to add a statement within the incontinence section to consider referral for specialist review where patients are receiving one or more anticholinergic agents and multiple non-pharmacological interventions. A wider comment was shared acknowledging the value of the APC guidelines for primary care and the greater need for awareness and uptake of the guidelines among GPs. It was suggested that targeted outreach and practice meetings could support their original purpose of reducing referrals and improve prescribing practices.

Committee members approved by consensus the updated SEL APC urology guideline (medicines content only), pending amendments in line with the meeting discussion.

ACTION: Updated SEL APC urology guideline to be amended in line with the discussion and progressed for approval via IMOC Chair's action

12. Updated guide for primary care on the off-label use of medicines in oral medicine clinics and associated formulary request:

i. **Updated guide on the off-label use of medicines in oral medicine clinics**
ii. **Formulary inclusion of dexamethasone 2mg/5ml solution for inflammation of the oral mucosa as Amber 2 (off-label). Presented to the committee in April-2026.**

The author was in attendance to re-present this item, following original discussion at the April 2026 IMOC meeting. At the April 2026 meeting, the committee requested clarification on the cohort of patients suitable for dexamethasone solution and to specify the formulation as sugar free. The current submission focuses on these updates to the primary care guide, reflecting the recommended hierarchy in use of steroid mouthwashes and administration instructions, as well as the inclusion of dexamethasone oral sugar-free solution to the formulary.

The presenter explained that topical corticosteroid mouthwashes are generally used before escalation to systemic immunosuppression where appropriate. Dexamethasone sugar-free oral solution was described as an alternative that has worked well in practice, with an internal prescribing review identifying most patients tolerating treatment and remaining stable. The proposed place in therapy was

described as last-line within the topical corticosteroid mouthwash options. Betamethasone soluble tablets remain the usual first-line option, with fluticasone nasules as the second-line option due to cost considerations and established formulary use. Dexamethasone sugar-free oral solution is proposed as a last line option for patients who do not tolerate or cannot practically use betamethasone or fluticasone, including where the device is difficult to use because of dexterity requirements or during interim shortages of fluticasone/betamethasone. It was also noted that the guide had also been updated to reflect the use of tacrolimus 0.03% or 0.1% in oral lichen planus (lip involvement) and exfoliative cheilitis, following approval of the formulary request at the April 2026 IMOC meeting.

A request was made by the committee to amend the wording in the steroid mouthwash section of the guide so that fluticasone is described as the "second-line" corticosteroid mouthwash, rather than the "next" corticosteroid mouthwash, for clarity. In addition, a request was made to replicate wording from the formulary request application within the guide to make the intended patient cohort for dexamethasone clearer. Whilst the patient population was well articulated in the application form, this did not translate across as clearly in the guidance.

From a cost perspective, the formulary inclusion of dexamethasone sugar-free oral solution in this setting is within the delegated financial threshold for the committee.

Committee members approved by consensus the updated guide on the off-label use of medicines in oral medicine clinics, pending amendments discussed, and the formulary inclusion of dexamethasone 2 mg/5 mL sugar-free solution for inflammation of the oral mucosa as Amber 2 (off-label).

ACTION: Guide to be amended in line with the discussion and progressed for approval via IMOC Chair's action
ACTION: Dexamethasone 2mg/5ml sugar-free solution to be categorised to Amber 2 in the SEL adult JMF for inflammation of the oral mucosa (off-label) once the guide is approved

13. Formulary recommendation: Acetazolamide immediate release tablets and topiramate tablets for the management of idiopathic intracranial hypertension in adults

This formulary recommendation has been drafted following the approval of acetazolamide immediate release tablets and topiramate tablets for the management of idiopathic intracranial hypertension as Amber 2 (specialist initiation with maintenance in primary care) at the May 2026 IMOC meeting. A minor comment was received through the Triage Panel review, requesting clarification around topiramate use after an inadequate response to acetazolamide, and this has been actioned. No further comments or queries were raised by committee members. Committee members approved the formulary recommendation (with the proposed amended wording) by consensus.

ACTION: SEL adult JMF to be updated to include acetazolamide immediate-release tablets and topiramate tablets for the management of idiopathic intracranial hypertension

14. Standing items/Items for information only

- Formulary submissions tracker
  - Noted
- NICE 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.
  - This included agreeing a RAG category of green for fezolinetant (TA 1143) by consensus. Committee members noted the higher cost of fezolinetant compared with existing options but recognised that vasomotor symptoms can be debilitating and that alternatives such as clonidine may be limited by side effects and low use in practice. The committee agreed to highlight the NICE TA to the APC menopause pathway leads. Based on cost modelling from NICE, implementation of TA1143 is above the financial threshold delegated to the committee and will therefore need to be escalated to the Executive Committee for information only.
  - The committee also noted the cost modelling based on NICE in relation to implementation of NICE TA 1140 (ruxolitinib) was above the financial threshold delegated to the committee and

will therefore also need to be escalated to the Executive Committee for information only. A RAG category of Red was previously agreed by the committee for the use of ruxolitinib under TA 1140.

- For information and noting only:
  - Adult and Paediatric Formulary updates for May 2026 - noted by committee members.

ACTION: Cost modelling for NICE TAs for ruxolitinib (TA 1140) and fezolinetant (TA 1143) to be escalated to the Executive Committee for information

15. AOB

Committee members noted the Lead Pharmacist for the Committee, who is on maternity leave, had delivered their baby safely and asked that congratulations and best wishes be passed on.

IMOC dates for next 3 months

Date	Time	Venue
Thursday 16th July 2026	2pm – 4:30pm	MS Teams
Thursday 20th August 2026	2pm – 4:30pm	Hybrid (MS Teams/in person)
Thursday 17th September 2026	2pm – 4:30pm	MS Teams