South East London Integrated Medicines Optimisation Committee (SEL IMOC) Meeting
16th July 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 meeting was welcomed by a GP IMOC member on this occasion, who stood in through delegated authority from the Chair of the committee, to oversee the July 2026 meeting due to unforeseen circumstances in the scheduled chairing arrangements. Committee members noted the change in chairing arrangements. 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 use of specific medications used in traumatic brain injury undergoing long-term rehabilitation

The applicants were in attendance to present this item and outlined the role of the specialist traumatic brain injury (TBI) service, which provides multidisciplinary assessment and ongoing management for adults with TBI across SEL. It was explained that the Trust hosts a tertiary neurology and trauma service with a dedicated TBI team and that a significant proportion of medicines used to support recovery following TBI are prescribed outside of their licensed indications.

The committee noted that the formulary request related to medicines used to manage four broad symptom groups (all off-label use):

- Neurostimulants (modafinil, amantadine and methylphenidate)
- Mood stabilisers (carbamazepine and lamotrigine)
- Memory and attention agents (donepezil, rivastigmine and memantine)
- Other agents (bromocriptine, rotigotine and pramipexole)

It was clarified that there is established use of these medicines within the specialist neuro-rehabilitation service to manage common neurobehavioural, cognitive and neurological sequelae following TBI, including disorders of consciousness, fatigue, attention deficits, mood instability, agitation, memory impairment and apathy. The request seeks to formalise formulary inclusion, where treatment is recommended by the specialist TBI team or liaison psychiatry service as part of a neuro-rehabilitation programme. The presenters described how treatment decisions are highly individualised and informed by multidisciplinary assessment, with medicines selected according to a patient's predominant symptoms and rehabilitation goals. In view of this, a set treatment pathway does not exist. It was noted that many of the proposed medicines are already established on the formulary for other indications and are being used where the clinical presentation mirrors recognised conditions such as fatigue, attentional impairment or mood disorders.

An evidence review was presented drawing on evidence primarily from:

- Royal College of Physicians (RCOP) guidance on prolonged disorders of consciousness following sudden onset brain injury
- Published review articles relating to pharmacological management following TBI.

The review highlighted that, although the evidence base is limited for some medicines, many medicines were already established treatments for similar symptom profiles in other clinical conditions and were being applied to equivalent symptom presentations following TBI. Their use is supported by published

reviews, specialist clinical experience and available national and international guidance. Key messages included:

- Amantadine has the strongest evidence among neurostimulants, with studies suggesting improvements in arousal and acceleration of functional recovery.
- Methylphenidate demonstrates benefit for attention, processing speed and cognitive performance.
- Donepezil has some of the strongest evidence for improving memory and attention deficits after TBI.
- Other medicines were supported largely by case series, observational evidence and clinical experience rather than large, randomised trials

It was noted that many of the requested medicines are already included on the SEL formulary for other indications and that the proposed formulary categories broadly align with their existing formulary classification. It was emphasised that the medications are generally low-cost with established safety profiles and no additional monitoring requirements are anticipated beyond those already associated with the medicines' current formulary use. The presenters noted that the limited evidence base for many medicines used in traumatic brain injury rehabilitation reflects the challenges of conducting large clinical studies in a complex and heterogeneous patient population. However, the medicines are established treatments that have been used within specialist neurorehabilitation services for many years. From a cost perspective, within SEL, the request is within the financial threshold delegated to the committee.

A query was raised regarding evidence suggesting carbamazepine may impair cognitive recovery following TBI. The presenters explained that this concern is primarily relevant during the acute recovery phase, whereas the proposed use is predominantly later in rehabilitation when cognitive recovery has stabilised and the focus is management of behavioural and mood-related symptoms. The presenters also confirmed that the specialist TBI service manages adults only. Committee members sought assurance that specialists would initiate treatment, assess effectiveness and monitor patients before any prescribing responsibility transferred to primary care. The presenters confirmed that patients would remain under specialist oversight and medicines would be discontinued when ineffective. In response to a query regarding the rationale for not defining specific first and second line treatment options, the presenters explained that treatment selection is symptom led and highly individualised. In view of this, a standardised treatment algorithm would not be appropriate.

Committee members discussed the proposed formulary categorisation of several medicines. Members considered whether donepezil, rivastigmine, memantine and rotigotine which were proposed as Amber 1 would be more appropriately categorised as Amber 2 to reflect specialist initiation, stabilisation requirements and the off-label use. It was also noted that modafinil and methylphenidate are currently categorised as Amber 3 for other indications and would remain the same in the TBI setting, with shared care agreements in place. Following discussion, committee members agreed the following by consensus:

- Modafinil – neurostimulant in excessive daytime sleepiness – Amber 3 (specialist initiation and stabilisation, prescribed in primary care under a shared care guideline)
- Amantadine - neurostimulant for disorders of consciousness (DOC) – Amber 2 (specialist initiation and stabilisation)
- Methylphenidate - neurostimulant for DOC - Amber 3
- Carbamazepine, lamotrigine – mood stabilisation - Amber 2
- Donepezil, rivastigmine, memantine – for memory disorders (not dementia) - Amber 2
- Bromocriptine - central pyrexia/dysautonomia and improvement of arousal in DOC - Amber 2
- Rotigotine - hemispatial neglect - Amber 2
- Perampanel – apathy - Amber 2

Committee members approved the requests subject to enhanced formulary entries for the medicines/ indications concerned so that clear information is available for primary care. The formulary entries will require detail outlining initiation criteria, monitoring arrangements, outcome measures, circumstances for stopping therapy, follow up arrangements by the specialist teams and details on the point at which prescribing responsibility transfers should be included. If this level of detail for each individual medicine

is not practical, then consideration of generic wording may be appropriate to support primary care colleagues.

The committee also noted that shared care guidelines will need to be developed for modafinil and methylphenidate. The inclusion of these medicines in the SEL Adult JMF will be progressed once the enhanced formulary entries and shared care guidelines have been approved through the committee.

ACTION: Enhanced formulary entries to be developed for medications to be used in TBI and presented at a future IMOC meeting
ACTION: Shared care agreements to be developed for modafinil and methylphenidate use in TBI and brought back to a future IMOC meeting

5. Updated chronic obstructive pulmonary disease (COPD) guideline, outcomes and monitoring framework, and associated cost modelling

The authors and leads were in attendance to present the updated COPD guideline on behalf of the respiratory subgroup. The main update to the guideline is the inclusion of biologic therapies for COPD. This follows publication of technology appraisal (TA) guidance from the National Institute for Health and Care Excellence (NICE) for dupilumab, which is the first biologic therapy in COPD. The presenter outlined the proposed SEL pathway for identifying eligible patients with an eosinophilic phenotype, following assessment by local specialist COPD services before referral to regional multidisciplinary teams. Where biologic treatment is approved, the specialist service would remain responsible for prescribing initiation, administration and monitoring. The guideline has been updated to support clinicians in identifying suitable patients and to provide clarity on referral and treatment pathways across SEL.

The accompanying outcomes and monitoring framework was also presented. The framework aligns with approaches already used in other high-cost drug pathways and is intended to provide assurance that biologic therapies are being prescribed and monitored in line with NICE requirements, with outcome data reported through the respiratory subgroup at agreed intervals. The presenters further noted that much of the required data will also be collected through the National Respiratory Audit Programme (NRAP), which will assist reporting.

The committee reviewed the cost modelling relating to the expected financial impact of introducing dupilumab and cost estimates based on NICE assumptions and local trust estimates. Offset costs including savings from a reduction in hospital admissions and follow up outpatient appointments. From a cost perspective, the costs presented relate to dupilumab only and do not include service delivery related costs. A confidential commercial arrangement is in place, which reduces the price of dupilumab and this has been applied in the cost modelling. As the estimates for dupilumab implementation exceed the financial threshold delegated to the committee, the cost impact will be escalated to the Executive Committee for information only as it relates to a NICE TA.

Members queried the inclusion of mepolizumab in the new biologics section as this medicine has only recently been approved by NICE in a TA. Whilst the respiratory team proposed including both medicines within the pathway, differences between the NICE TAs were highlighted by the committee including variation in eligibility criteria between the NICE TAs for each medicine, which the current pathway did not reflect. It was also noted that the outcomes and monitoring framework would require an update to reflect inclusion of mepolizumab. Following discussion, members agreed that mepolizumab should be removed from the guideline at this stage and brought back to a future meeting once the pathway and monitoring framework had been amended to fully reflect the specific NICE requirements that the ICB commissions against.

Committee members approved by consensus the updated COPD guideline and outcomes and monitoring framework, subject to amendments in line with the meeting discussion.

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

ACTION: Cost modelling for dupilumab to be escalated to the Executive Committee for information

6. Formulary recategorisation of relugolix with estradiol and norethisterone acetate (Ryeqo®) and linzagolix (Yselty®) from Amber 2 to Amber 1 for endometriosis and moderate to severe uterine fibroids

This agenda item was deferred as the main applicant was unable to attend the meeting. Committee members agreed that the proposal should be deferred to a future meeting with clinical representation available to present the case and answer questions.

7. Primary care antimicrobial prescribing guidelines – Eye infections and associated formulary request for chloramphenicol 1% eye ointment for anterior blepharitis as Green (off-label use)

The author presented the primary care antimicrobial prescribing guideline for eye infections to the committee on behalf of the SEL antimicrobial stewardship group. The guideline includes recommendations for the management of conjunctivitis and blepharitis in adults and children and is intended to support consistent prescribing practice and antimicrobial stewardship across primary and secondary care. The guidance will be published on the EOLAS platform (the regional antimicrobial guideline repository) following approval. The guideline aligns local antimicrobial prescribing recommendations with national guidance and local referral pathways.

For conjunctivitis, the guidance promotes self-care and conservative management where appropriate, with antimicrobial treatment reserved for patients who require it. Specific advice is included for contact lens wearers because of their increased risk of complications.
For blepharitis, the guideline recommends eyelid hygiene, warm compresses and lid massage as first-line treatment. For patients with persistent anterior blepharitis, chloramphenicol 1% eye ointment is recommended as a second-line option in line with NICE recommendations (off-label use). Referral to the Minor Eye Conditions (MEC) service is advised for more complex or posterior blepharitis cases.

Alongside the updated guideline, the committee considered a formulary request to include chloramphenicol 1% eye ointment with a “Red, Amber Green” (RAG) category of Green for anterior blepharitis (off-label) where conservative measures have failed. This is supported within NICE Clinical Knowledge Summary (CKS) recommendations and formalises existing SEL prescribing practice. As current prescribing costs are already incurred and no significant increase in use is expected, the cost impact is within the committee’s delegated financial threshold.

Members noted that the NICE CKS recommendation applies to patients aged 12 years and above and requested that this is made explicit within the guideline, which the presenter agreed to amend.

Committee members approved by consensus the primary care antimicrobial prescribing guideline for eye infections and the formulary inclusion of chloramphenicol 1% eye ointment as Green for the treatment of anterior blepharitis (off-label use), subject to the amendment discussed.

ACTION: Guideline to be updated in line with meeting discussion and progressed for approval via IMOC Chair’s action
ACTION: Chloramphenicol 1% eye ointment to be included in the SEL adult formulary as Green for the treatment of anterior blepharitis (off-label use) following approval of the updated guideline

8. Request to change formulary entries for colecalciferol with calcium carbonate from branded to generic

The committee considered a request seeking to amend the SEL Adult JMF entry for colecalciferol with calcium carbonate preparations from branded listings to a generic formulary entry. The change has been prompted by the need to improve prescribing flexibility and support prescribing of lower-cost options where appropriate in primary care. The proposed approach would allow prescribers to use a wider range of suitable calcium and colecalciferol preparations and reduce the need for repeated

formulary updates when new products become available. The review has been discussed with acute Trust representatives who are in support of the proposed changes. It was noted that implementation would be supported through OptimiseRx prompts in primary care to guide prescribers towards cost-effective choices at the point of prescribing. This formulary entry change is not expected to affect the number of patients prescribed colecalciferol with calcium carbonate and no increase in patient numbers or changes to clinical eligibility are anticipated. However, there would be an expected cost reduction over the next 3 years if more cost-effective options are prescribed.

A query was raised regarding clarification on how the proposed generic formulary entry would support prescribers in selecting the most cost-effective preparations and whether this would be supported through existing prescribing optimisation systems. The presenter advised that OptimiseRx prompts would be used to guide prescribing decisions and current prescribing systems already provide alerts suggesting more cost-effective options. A comment was raised regarding the increasing number of available branded products and the challenges associated with maintaining a formulary entry that accurately reflects the market. Members noted that a generic approach may provide greater flexibility and reduce the need for frequent formulary updates.

Committee members approved by consensus the amendment of the SEL Adult JMF entry for colecalciferol with calcium carbonate preparations from branded listings to a generic formulary entry.

ACTION: SEL Adult JMF entry for colecalciferol with calcium carbonate preparations to be updated from branded listings to a generic formulary entry

9. Updated atopic dermatitis treatment pathway

The authors and lead were in attendance to present the updated Atopic Dermatitis (AD) pathway on behalf of the SEL dermatology subgroup. The update focuses on improving usability of the pathway, alignment with current clinical practice and updating monitoring requirements for biologic and Janus Kinase (JAK) inhibitor therapies. Key updates included:

- Changes to reflect current prescribing practice (methotrexate use before azathioprine), improve pathway layout, clarify licensed and unlicensed treatment options, and streamline monitoring and assessment tables.
- New guidance has been added on reducing varicella zoster virus (VZV) reactivation risk, including Shingrix® eligibility for immunocompromised adults.
- Monitoring requirements for biologics have been revised so that further blood tests are undertaken only when clinically indicated, while JAK inhibitor monitoring remains largely unchanged apart from the reintroduction of baseline creatine kinase (CK) testing (as a reference point in case patients later develop symptoms suggestive of muscle toxicity).
- The pathway now also streamlines monitoring and assessment tables, includes a single patient infographic for biologic and JAK inhibitor treatments and adds standardised Epic smart phrases to support consistent clinical documentation and communication across services.

A comment was raised regarding references within the pathway to individual Trust specific guidance, intranet resources and email contacts. Members noted that as this is a SEL-wide pathway, references should not be limited to a single organisation and should support clinicians across all participating Trusts. A request was made to review references to Trust-specific guidance and consider replacing these with more generic wording directing clinicians to local Trust guidance.

Committee members approved by consensus the updated AD pathway, subject to amendments outlined.

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

10. Single national formulary update from the London Early Adopter Group

The Formulary Pharmacist updated the committee on the Single National Formulary (SNF) programme, with SEL participating as an early adopter site alongside a number of other Integrated Care Systems in England. As previously presented in March 2026 and June 2026, the programme will replace existing RAG classifications with nationally standardised terminology, with final national category wording now agreed and regional discussions underway on implementation timelines, actions and communications. A London-wide group has been established to coordinate adoption across London ICBs, chaired by the presenter. The programme also includes content and digital workstreams, although the national digital platform is not expected before 2027. The committee noted the update and welcomed progress towards national standardisation, with further implementation plans and communications to return to future meetings.

In response to questions, the presenter explained that current formulary categories will be mapped to the new national terminology, with all adult formulary entries switching on an agreed go-live date. The categorisation principles remain broadly aligned to current arrangements, with the main change being the move from colour-based classifications to text-based national categories. Supporting communications and guidance will explain the terminology and show how existing RAG categories align with the new classifications, with national materials adapted locally.

Members noted the implementation challenges across adult and paediatric formularies. Separate arrangements will be needed for the SEL paediatric formulary due to its different hosting platform, but work is underway to support a consistent SEL-wide approach.

11. 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. A RAG category of Green was agreed by consensus for atogepant in the treatment of migraine (NICE TA 1172). This is a fast-track TA with a 30-day implementation period. The resource impact, based on NICE, is within the threshold delegated to the committee. It was noted that the primary care migraine treatment pathway is in the process of being updated to include atogepant in this setting.
- For information and noting:
  - Adult Formulary updates, June 2026. This was noted by committee members.
- For noting – items approved via IMOC Chair's action:
  - Guidance for prescribing melatonin for sleep disorders in paediatrics (children and adolescents). This was noted by committee members.

12. AOB

The committee noted that this would be the final IMOC meeting attended by the SEL ICB Associate Chief Pharmacist prior to leaving the organisation. The committee also acknowledged the departure of the Lead SEL Medicines Optimisation support officer. Both members were thanked for their contributions to the committee and members wished them well for the future.

Members were reminded that the August IMOC meeting would be held in a hybrid format.

IMOC dates for next 3 months

Date	Time	Venue
Thursday 20th August 2026	2pm – 4:30pm	Hybrid (MS Teams/in person)
Thursday 17th September 2026	2pm – 4:30pm	MS Teams
Thursday 15th October 2026	2pm – 4:30pm	MS Teams