NHS
South Yorkshire
Integrated Care Board

Minutes of the Meeting of the Sheffield Area Prescribing Group
19th October 2023

Present:

Heidi Taylor. Deputy Director, Medicines Optimisation Team. NHS South Yorkshire ICB (Chair)
Sharron Kebell. Specialist Commissioning Pharmacist, NHS South Yorkshire ICB
Emily Parsons. Medicines Governance Pharmacist, NHS South Yorkshire ICB
Abiola Allinson. Chief Pharmacist. Sheffield Health & Social Care FT
Dr Jonathan Mitchell. Consultant representative, Sheffield Health & Social Care FT
Dr Laura Smy. GP and Representative of Local Medical Committee.
Dr Rhona Leadbetter. GP, NHS South Yorkshire ICB
Mr Veeraraghavan Chidambaram-Nathan. Consultant representative STHFT
Thomas Bisset. Community Pharmacy South Yorkshire representative.
Helen Taylor. Clinical Effectiveness Pharmacist, NHS South Yorkshire ICB

Absent

Dr Zak McMurray. Medical Director and joint Chair of APG, NHS South Yorkshire ICB
Dr Andrew McGinty.GP and joint Chair of APG, NHS South Yorkshire ICB
Andrew Moore. Deputising for STHFT Chief Pharmacist
Dr Trish Edney. Lay member. Healthwatch representative
Helen Caley. PCN Pharmacist representative
Joanne Wragg. Director of Pharmacy, Sheffield Children's FT

In Attendance:

Deborah Morris. Clinical Effectiveness Technician. NHS South Yorkshire ICB
Diana Vasile. Pharmacist, NHS South Yorkshire ICB
Augustinas Slucka. Pharmacist, NHS South Yorkshire ICB

		ACTION
1.	**Apologies for Absence**	
	Apologies for absence have been received from, Dr Z McMurray, Dr A McGinty, Helen Caley, Andrew Moore, Joanne Wragg and Dr Trish Edney The Chair declared the meeting was quorate.	
2.	**Declarations of Interest**	
	No addition declarations were made.	
8.	**Protocols and Prescribing Guidelines**	
	Prescribing guidance in the self-monitoring of blood glucose (SMBG) This is an update to the guidance, which reflects DVLA, NICE and current	

	local guidance on when to test, how often to test and how many test strips per month to prescribe. The updated guidance is a merger between the current Prescribing guidance on SMBG and the Algorithm which is available on the Sheffield's place Intranet. The updated guidance has been streamlined in length and relevance of information to make it more user friendly whilst retaining pertinent information for clinicians and HCPs. DV explained that this guideline is separate to the formulary choice guidance for test strips used in Sheffield, the paragraphs on choice of SMBG devices and the local decision of approved SMBG devices has been removed. The formulary will be updated pending NHSE commissioning recommendations following the national assessment of blood and ketone meters, testing strips and lancets. DV described the main updates in the guidance. The front cover is updated to reflect that this is guidance for Sheffield with the addition of, 'adults, children and young people' to clarify who the guidance relates to and now includes a list of the diabetes specialist services contact names, who have contributed to this document. The format of the guideline has been changed, there are 2 main sections: introduction and recommendations. The recommendations give advice on when to consider prescribing, what to do at initiation of therapy and advice on ongoing use and review. On page 2 is a link to the relevant DVLA information. DV added that, for clarity, Continuous Glucose Monitoring (CGM) should only be initiated by clinicians with expertise in CGM use. Still on page 2 and under recommendations, there is a general statement and information on CGM advising that patients will still need to do finger prick testing in certain circumstances which is listed later in the guideline. The recommendations section has separate sections for advice relating to adults, children and young people and pregnancy. The section on children and young people has been expanded and now reflects local guidance and NICE NG18 for children and young people with T2 diabetes. Throughout the recommendation sections, links have been added to the appropriate sections in the tables of recommendations on pages 5 -7, to improve ease of use of the guideline. The section on pregnancy has been updated with support from the diabetes midwives at Jessops, it was considered important to have the following statement in bold:	

	Women with diabetes are more likely to have adverse outcomes including foetal anomaly, macrosomia and neonatal death. Foetal anomaly and still-birth are related to the quality of glucose control in early pregnancy. In the section applicable to all patients, a link to the NICE NG 28 patient decision aid has been included. In the 'At Initiation' section, a link to an STHFT patient information leaflet has been added and a link to the locally recommended Test Strips for Self-Monitoring Blood Glucose (SMBG), which is in the process of being updated. Blood glucose targets; as in the current SMBG guidance, have been removed, advice is now for patients to have individualised targets, as in their care plan/letter from specialists. Pages 5 to 7 have tables with specific information for adults, children and young people, pregnancy and DVLA requirements. The information includes advice on frequency of use of BGTS and quantities to prescribe, plus additional information to support prescribing. DV added that, in the adult's section, it was relevant to consider reviewing treatment for patients on oral antidiabetic treatment who may need to test more often due to increased risk of hyperglycaemia. There has always been debate about many test strips should be prescribed and if they should be on repeat templates for patients on CGM. DV had this discussion with DSNs today, who have advised that 50 test strips should be sufficient for 56 days unless the patient is experiencing events that warrant more testing. In the children and young people's section, which was written with support from SCFT. The section has this advice. *If on monotherapy with metformin: test at least 4 times a day or offer CGM. SMBG frequency may reduce as blood glucose levels stabilise.* There has been a query on this advice, DV clarified that SCFT have advised that they have an aggressive approach to manage this cohort and so initially they would advise children to test 4 times daily. This is to gain a better understanding of the individuals sugar levels across the course of a day this will show if therapy is working or needs to be stepped up. It also gives the patients family/carers a better understanding of the effect of different foods on the patient's sugar levels. TB asked about the annual review, who would be doing that review and, if the patient was initiated by a specialist would it be a specialist review and, if not, how would the review be consistent. DV replied that patients managed in primary care, they would be reviewed by the long-term condition nurses in general practice. Patients being managed by secondary care, and depending on their care plan, would be reviewed by secondary care. There may be certain circumstances where patients are under the DSNs and the DSNs would carry out the review. DV added that if the review is being done by a non-specialist, the DSNs would be available for support if needed e.g., for management plans, as was	

	discussed by DSNs at the PLI last week. HeiT added that this review would be part on the annual medication review. LS agree that it would be part of the diabetes annual review and added that medication would just be reauthorised. LS asked for clarification on the statement on page 5 regarding combined insulin therapy and oral antidiabetic drugs regimen and the advice to give 50 test strips every 2 months. This seems incorrect, if a patient is just on insulin, the advice is to give at least 50 per month. DV replied that this was advised by the DSN but will clarify. LS also asked about initiation of CGM being only by a clinician with expertise; is that 'expertise' going to be defined? DV replied that this is usually secondary care but some primary care clinicians, if confident, could initiate. There is a SY ICB policy that advises this. HeiT added that the wording is taken from NICE and for T1 diabetics it would be the DSNs who would initiate. With the update to the T2 diabetes guidance and expanding the groups for CGM, in the future the thinking may be that a body of growing expertise may become available in primary care. Currently the expertise is in secondary care who will typically be identifying, initiating, and training patients in the use of CGM. LS raised the question that with the number of pre-diabetics and number of patients on metformin who want to monitor sugars with CGM, if the increase would be overwhelming, resulting in significant cost increase. HeiT responded to this advising that this guideline is paused until the policy has been discussed at IMOC, in November. Sheffield has approved Dexcom ONE guidance which is in line with the T2 diabetes guidance, which advises to offer Dexcom ONE to patients who are on multiple injections of insulin and have recurrent hypoglycaemia or severe hypoglycaemia, so eligibility is quite restrictive, and the policy will be in line with this. HeiT acknowledges that the cost to the system will be greater, in Sheffield about 65% – 70% of T1 diabetics are on CGM and for T2, about 5% of those eligible are currently using CGM. Subject to the policy being discussed at IMOC and the clarification on number of test strips for patients on combined insulin therapy and oral antidiabetic drugs regimen, as detailed above, **APG approve the guideline.** DV left the meeting. **Depression in adults - treatment and management protocol (Sheffield)** This guideline has been developed from the Depression (adults) - Guidelines for Primary Care Management of Depression and the Pharmacological Treatment guideline which are currently on the PRESS portal and reflect and aligns with the updated NICE NG222 and the practices and services available in Sheffield. AS summarised the main points.	DV

	The format of the guideline has changed and has more information, merging 2 documents into one. The classification for depression has changed from 4 to 2 groups; chronic depression is included. Treatment options have not changed significantly from the current guideline. There are more links to other resources and services and also patient assessment algorithms. The document is also interlinked for ease of use. The document has also been designed so that sections can be used as stand-alone algorithms. AS highlighted the box, on page 4, referring to chronic depression and debated on how to encapsulate the information included and if it fits within this algorithm. AS added that further consideration can be given to this if the group disagrees with how this is shown within the guideline. The medication choice section has more information to assist decision making at the point of prescribing. The stopping and switching antidepressants section acknowledges that patients have different responses, the treatment withdrawal and cross-tapering algorithm shows a broad approach and gives links to other resources to help with decision making. Section 7 has some advice on preventing relapse and referring to specialist services. JM acknowledged that overall, this is a good document. JM asked that his title is amended to correctly read, Clinical Director, SHSC. JM also advised that the SCHC services referred to in the document are correct now but, the services will be undergoing transformation in the next few months so the document will need updating before it would routinely be reviewed. AS will ensure that an interim review is factored in. JM also commented on NICE moving to ICD11 and DSM5, this is a problem as the NHS is mandated to use ICD10, but NHSD published plans to move to ICD11 by April 2023, which they haven't yet done and don't anticipate a move to ICD11 until 2026. A change of diagnostic criteria requires everyone to understand the difference. JM has raised this with NHSE. AS asked if the document should revert to recommended ICD10, JM responded that this is difficult to know as NHSE have referenced ICD11 in a number of documents and as NICE has added ICD11 it is not incorrect to have it in guidance but, also advised that SCHC are still using ICD10, commenting that it may not have any significant difference for diagnostic criteria on depression. RL agreed that it is a very good document. There are a couple of typos, on page 2 the sentence, *Asses if the person has social support and advice where to seek for help* needs amending and on page 3, *Prior issuing a prescription* also needs amending. On page 6, in terms of initiating pharmaceutical treatment, and after 2 weeks of treatment, unless the patient had an adverse reaction, the	AS AS AS

	treatment would remain until the 4-week review. AS explained that the *Assess weekly for further 1-2 weeks* in the box after starting treatment refers to week 3 and 4 of treatment, this will be amended for clarity.	AS
	Page 8, in the box headed *Initiate treatment withdrawal or cross-tapering* it advises to, *Review after 1 week.* This is unrealistic in practice. AS agreed, that this is a good point, although this is in NICE. RL emphasised that a patient would be advised to contact the GP at any point during the first 4 weeks of withdrawal or tapering, if they were struggling, but would not routinely review the patient after 1 week. AS will remove this from the guideline. JM agreed with RL that a plan would be agreed with the patient with the understanding that if the patient was having problems that they would be seen as soon as possible, to review routinely in 1 week is not practical.	AS
	AA commented on the 4-week discontinuation of treatment, commenting that latest evidence shows that having a longer time frame for discontinuing may be needed. Could consideration be given to those patients that struggle and suggest that some may need 3-4 months; should this be reflected in the guidance. AS agrees and will amend the guideline.	AS
	LS commented on reviewing antidepressants, advising the group that even when cross tapering therapy, a plan is written down for the patient for the 4 weeks before reviewing the patient. The intervals in the guideline are much tighter than can practically be carried out. LS also commented on the talking therapies recommended by NICE and that these are not all available in Sheffield. LS also asked who, in primary care, had been involved in writing the guideline, AS replied that CRG had input which has a number of GPs in the group and the primary care mental health team, who are patient facing. JM added and, though agreed that the time intervals NICE recommend are not practical, the reason for those frequent review intervals are that patients will improve more quickly with more frequent reviews. Regarding the discontinuation of pharmaceutical therapy, it is difficult to judge how much information is included in a guideline, different drugs are more associated with more withdrawal effects and some which can, on low dose, be stopped quickly with little effect and some need more caution. That level of detail may be difficult to include. AS agrees and in considering this point, it may involve a separate project, so some detail has remained in the document. JM agreed that such a project might be more relevant for patients with more complex histories and may sit better with the primary care mental health service rather than being conducted by a GP alone.	
	In conclusion, with regard to review intervals LS asked that the *review weekly interval* is replaced with *based on clinical judgement*. AS will action this. TB asked how easy it is to access talking therapies, AS replied that NHS talking therapies advise that there needs to be an update and some services are more oversubscribed than others. Ideally a talking therapy	AS

	should be first line where appropriate but, if the patient doesn't want or have a talking therapy, to go ahead and prescribe medication. TB added that a new medicines service is being looked at for community pharmacy (CP) to support patients when initiated on medication for depression, it was anticipated that this would be available from April 2023, but it is still being tested. This could be added to the guideline once available. TB also commented on the Daylight Digital Anxiety Therapeutic App, AS confirmed that this had been mentioned via a CP in Rotherham and it would seem that this will be commissioned but no further details are yet known. AS will contact TB for more information. HeiT asked that the guideline includes a request to inform patients, on initiating treatment, that at some point deprescribing will be addressed. Also, to explicitly add that decisions are shared with the patient. And on page 6 in the box headed *Switch to a different antidepressant,* and *Consider vortioxetine if 2 different antidepressants failed for the same episode*, that it is written to make clear that it is for major depression. LS asked what prescribing data has been used regarding vortioxetine as it was not perceived as a medication often initiated in primary care. AS replied that Sally Kirby, who also worked on this guideline, uses vortioxetine for patients who fit the criteria and also experience sexual dysfunction. AA added that vortioxetine is not just for specialist prescribing and there is evidence that shows less likely to show side effects of sexual dysfunction to other SSRIs. JM added that NICE say vortioxetine is not for treatment resistant depression but for people who fail to adequately respond to trials of 2 antidepressants in the same episode, so the patient numbers would be low. The group concluded that, if added to the sentence on page 6, that it is for major depression when 2 different antidepressants have failed for the same episode, its place in therapy would be clear. **APG approve the guideline** with the amendments mentioned above. AS will share the amended document with HeiT, AA and LS for sign off. AS left the meeting.	AS/TB AS
3.	**Minutes of the September Area Prescribing Group**	
	The minutes were agreed as an accurate account of the meeting. It was asked that a post meeting note is added to section 5 to state that morphine 100mcg/ml has been removed from the 'do not prescribe' list on SystmOne as this resulted in the strength appearing at the top of the morphine products picking list. An OptimiseRx alert has been added instead.	

4.	**Matters Arising**	
	Medicines transition (Green bag scheme) The scheme will be developed to enable patients' medication to stay with them as they move wards as an inpatient and to take home when discharged. SK reported that a task and finish group has been set up and to date they have, amended the internal transfer policy to allow for porters to transfer medication without a chaperone and procured 'safe pouches' to transfer the medicines. Data collection has started on patients own drugs, to look at missed doses, and associated savings. A pilot is due to start in November 2023 and if successful it will be rolled out across the trust. The second phase is to promote a campaign to tell patients to take their medicines into hospital with them. It would seem that there have been engagement problems, outside of the hospital pharmacy, so those involved in the pilot will be presenting to the operations director, with the hope for more 'buy in' to the scheme. **APG to be updated in due course.** **Chickenpox vaccine – update** This was taken to IMOC who agreed that due to a lack of clarity for any reimbursement to primary care, that they were not happy to support a move to an Amber TLDL classification and the vaccine would be classified as Red. This issue has been raised nationally and it was suggested that if a national solution wasn't forthcoming that CP could be commissioned, in hubs across SY, to administer. It is understood that it is being looked at to see if the travel clinic could also vaccinate children. LS asked what happens with hepatitis B vaccine, prior to renal replacement therapy. VC-N confirmed that those vaccinations are carried out in the renal assessment unit. **APG to be updated in due course.** **Progesterone (Cyclogest®) pessaries for prevention of threatened miscarriages – update.** This was not supported at the September APG meeting. This issue has been raised at a contract meeting at STHFT who advised that electronic prescribing is a long way off. Following enquiries about community midwives, it has been established that they are not independent prescribers and would perhaps not be readily accessible. Antenatal clinics were also considered but they too lack capacity. The next steps are unclear, VC-N acknowledges that there has not, so far, been any progress on electronic prescribing, further discussions will take place. HeiT added that STHFT have said that the contract is to prescribe for post outpatient appointments for 2 weeks and thereafter, unless there is a clinical reason for the care to continue, prescribing is generally picked up in primary care. APG are asked to consider, taking the commissioning arrangement out of the decision, where the patient would be best served to be prescribed and what would be the safest option. VC-N advised that one proposal was for homecare to be explored and is being looked at.	

	HeiT stated that if homecare was not possible that the patient would have to go to Jessops, but is it the best option for the patient? RL reminded the group that those patients are not being seen by the GP, they are however being seen by the midwife who are happy to ask GPs for prescriptions so could they not instead ask the hospital for a prescription. HeiT replied that unless homecare is an option that would result in the patient having to attend Jessops for the prescription. LS commented that currently, the women are being prescribed for by the consultant, SK added that some GPs were also prescribing. TB asked how prescribing is carried out for the virtual wards. HeiT said that this was via SystmOne, SK added that this has been suggested before for a similar problem, which was refused but this should still be suggested. **APG to be updated in due course.** **PCSK9i proposal that they are moved to an Amber classification.** HeiT advised that the proposal was discussed at IMOC and some feedback from this group as requested last month, has been received. These drugs were quite expensive when first available, were subject to a secondary care discount and were initiated by specialists. Some of those barriers have since been removed and the cost is now the same in both primary and secondary care. These are self-administered drugs and the annual blood tests are the same as for patients on statins. Patient selection is still done by the specialist but once stable, the drug could have an Amber classification and managed in primary care as any other patient on lipid modification therapy. LS replied that the issues were about the amount of monitoring but if it is the same as monitoring a patient on a statin, that is acceptable. Questions are still to be answered on what happens if there are problems and how patients would be referred back into the system. SK added that any adverse effect would be expected to occur during the period of stabilisation and for access back to the specialist with queries, there would be some paperwork made available to support this. HeiT added that there would be some guidance to support GPs including when to stop prescribing. SK added that in Devon they are already operating this model. TB commented that this has started with a small cohort of patients and when passed to primary care, numbers increase without the funding. For CP to obtain supply there will be a significant time lag in receiving payment, which means that CP will be subsiding the NHS for that period. LS added that the effect on independent CP having such a lag in recompense will further put strain on the stability that CP are bearing at this time. HeiT asked TB if this could be fed back nationally. TB added that in the past there were local schemes for advanced payment and maybe that is worth revisiting.	
5.	**Medicines Management Safety Issues**	
	Medicines Safety update October	

	EP reported on the recent MHRA updates. **There have been very infrequent reports of myasthenia gravis with Statins**, PILs and SPCs are being updated. OptimiseRx have produced an alert which has been activated, this will pop-up for anyone prescribed a statin who has myasthenia gravis as a read code. CP have been informed via their newsletter and this will be communicated in the APG learning lunch. **Fluoroquinolone antibiotics: suicidal thoughts and behaviour.** The update on this rare side effect came from a coroner's report. OptimiseRx has edited their alert for all systemic fluoroquinolones to incorporate wording to alert to the risk of psychiatric reactions and to consider supplying the MHRA PIL when prescribing. This alert has been circulated to CP and will be communicated in the APG learning lunch. There has been a **CAS alert about the ADHD medications**. More information below. The request by APG last month, on adding a warning on **ICE for thyroid tests,** is being considered pending checks with the lab, APG will be updated when this has been clarified. HeiT informed the group that information on the issues around the **supply of ADHD drugs** has been developed between colleagues at SCHSC and SCFT to support this problematic situation. There are issues around guanfacine as this has to be titrated down before stopping treatment. Patients have been actively identified to be referred back to the appropriate specialist service. HelT added that stock availability has worsened since last week. JM reported that details of a small number of patients have been received and those details have been sent to specialists with a request to urgently review. Thought will be given to how patients may be managed, should supply be unavailable, to complete a down titration along with guidance. HeiT commented that there should be national advice available, AA confirmed that there is currently no national guidance, but will contact other providers to see what advice may be given elsewhere. HeiT added that a colleague at SCFT, who had been involved in a research study in children reported that the concern about rebound hypertension on stopping guanfacine was not a significant concern, but this may be different for adults. JM added that there is little evidence from adults, the concern comes for use in children and is extrapolated to adults. JM has suggested that specialists consult with cardiology. LS asked if the information that the MOT has produced with SHSC and SCFT could be shared, HelT advised that it has been communicated through the Practice Bulletin and practice pharmacists and in the learning lunch which took place on 12th October.	EP

	RL commented that conversations locally have raised issues about panicking patients and thought it better to wait for patients to raise a query first. HeiT reminded the group that it was a national CAS alert that asked that all patients, on specific medications, were contacted to see how much supply of medication they held. EP confirmed that the CAS alert was issued on 27th September and the bulletin about that alert was issued on 3rd October. TB left the meeting.	
6.	**Pharmacy and Prescribing Commissioning Group Feedback**	
	HeiT comment that the only item to mention here was the **Tier 3 weight management service** where the signing of the contract may be nearing completion.	
7.	**Formulary Sub-group**	
	Draft minutes of the October meeting HelT informed the group that a discussion on **ibandronic acid for post-menopausal women with breast cancer** had taken place and the MOT have been looking at patients who have been on treatment for longer than intended. HelT suggested that a standard letter template, from the specialist to the GP, may be useful, if possible. **Matters approved by FSG under delegated authority (for information):** **Addition of Insupen Original pen needles to Chapter 6: Endocrine System formulary, under 6.1.1.3 Hypodermic equipment.** This was to replace the GlucoRx brand but, as they have not been accepted by patients, who prefer the BD Viva brand, the plan is now to change the GlucoRx with Insupen as first line choice. **Sheffield Specialist Palliative Medicines Management in the Community - A Framework for Shared Care.** This has undergone minor updates. **Edoxaban Quick Reference Guide – minor amendment.** This update was mainly around creatinine clearance and with reference to the national guidance. **Matters approved by virtual agreement under delegated authority (for information):** **Chapter 6: 6.1.1.2 minor amendment re Toujeo®** **Alimemazine – cost effective brand preference (Itzenal® solution).** **Matters for APG approval:** See section 8 above.	
9.	**Integrated Medicines Optimisation Committee (IMOC)**	
	Draft minutes of the October meeting	

	The NICE TAs were classified as Red on the SY TLDL, there were a host of 'Grey' drugs, as noted at the end of the IMOC minutes. A conversation was had about the methotrexate SCP and using the RMOC template across SY ICB. This was not agreed so the RMOC template will be used just for Sheffield. Some other SY ICB places have protocols which are disease rather than medication specific, so a move to the IMOC template was thought to be not appropriate at this time.	
10.	**RMOC.**	
	HeiT stated that it was uncertain that RMOC was still in existence and said this will now be removed as a standing agenda item.	
11.	**NICE Guidance**	
	NICE summary for October APG SK mentioned that the semaglutide confidential price was now available, the remainder of the update was noted. EP left the meeting	
12.	**APG Mailbox.**	
	No communications received this month.	
13.	**Reports from Neighbouring Committees**	
	Barnsley APC memo August 2023 Derbyshire JAPC minutes August 2023 Doncaster & Bassetlaw APC minutes July 2023 RL raised the item in the Doncaster minutes about a patient under the care of Sheffield ophthalmology. Ophthalmology has asked a Doncaster GP to take over the prescribing of melatonin, in an exceptional circumstance; the minutes suggest that the outcome was to advise the GP that it was their decision whether to prescribe or not. RL suggests that APG should take this up as it was to be prescribed off-label. HeiT responded that this unlicensed use would not be on the TLDL and has had a conversation with Doncaster about this as there was a suggestion that IMOC should consider a TLDL classification. To traffic light every unlicensed use would not be possible and it is appropriate to refer to the unlicensed medicines code and to consider on a case by case basis, e.g., has the GP been given sufficient evidence to support the specialists request. HeiT suggested that a log of this request should be kept by STHFT as a request for an unlicensed medicine use and potentially it could come as a SCP in primary care which could then be traffic lighted, but not as a result of a one-off request. RL agreed that it should be documented. HeiT asked that VC-N or AM could look to see if the specific indication is on the unlicensed medicines list, produced by STHFT medicines safety committee. LS commented, as a point of interest, that inclisiran is classified as Red in Derbyshire.	VC-N/AM
14.	**Never Events and Sis.**	
	None reported.	
15.	**Any Other Business**	

	ADHD drugs supply issues - discussed above**.** LS informed the group that there has been a power of 10 morphine dispensing issue at a CP and has been reported to NHSE. LS asks if this needs to be brought to APG, HeiT suggest that this is discussed outside the meeting with EP. **Guanfacine.** HelT has raised a question; are secondary care or CP able to obtain a special to cover the current supply issue. HeiT asked if AA could also ask this question, noting that specials are listed on the SPS supply tool. SPS estimate a re-supply date of the 4mg is 27th November and 4th December for the other strengths. HelT will further investigate the possibility of obtaining a specials product.	AA HelT
16.	**Date of the next meeting:** **16th November 2023 1:30 via MS Teams**	

Summary Points and Recommendations

October 2023

IMOC approvals	• Self-care document approved – will be added to IMOC website. • TLDL criteria – Green clause approved – new version to be added to IMOC website
IMOC TLDL approvals	See appendix 1
Shared care/Prescribing Guidelines	• Sheffield Specialist Palliative Medicines Management in the Community - A Framework for Shared Care. Approved by FSG under delegated authority of APG. • Prescribing guidance in the self-monitoring of blood glucose (SMBG) – Approved but paused subject to IMOC discussions on policy. • Depression in adults - treatment and management protocol (Sheffield) – Approved subject to minor amendments.
Sheffield Formulary Updates	• Chapter 6: 6.1.1.3 - Addition of Insupen Original pen needles. Approved by FSG under delegated authority of APG. • Chapter 6: 6.1.1.2 minor amendment re Toujeo®. Approved by FSG under delegated authority of APG.
Other	• Alimemazine – cost effective brand preference Itzenal®. Approved by FSG under delegated authority of APG.

Appendix 1 IMOC TLDL approvals

Drug/Product	Brand/name	Indication	Agreed TLS
Bosentan		Pulmonary arterial hypertension & Systemic sclerosis with ongoing digital ulcer disease	Red 1
Morphine Sulphate 100 microgram/ml oral solution		Opioid	Red 1
Herbal treatments		Not Recommended	Grey 1
Homeopathic treatments		Not Recommended	Grey 1
Hyaluronic acid Intra-articular injections		Do not offer intra-articular hyaluronan injections to manage osteoarthritis	Grey 2
Ibrutinib		As per NICE TAs's	Red 1,6
Lutein and antioxidants (All dietary antioxidants and supplements to prevent AMD)		Age related macular degeneration (AMD)	Grey 1
Larotrectinib sulphate		In line with positive NICE TA recommendations	Red 1,6
Levofloxacin Tablets		Antibiotic	Amber G
Idelalisib		In line with positive NICE TA recommendations	Red 1
Inositol nicotinate		Intermittent claudication in people with peripheral arterial disease	Grey 2
ITULAZAX 12 SQ-Bet		Moderate-to-severe allergic rhinitis and/or conjunctivitis	Grey 7
Travel Vaccines		cholera diphtheria/tetanus/polio hepatitis A typhoid.	Grey 1
Ketoprofen (topical)		Areas of skin treated with Ketoprofen 2.5 % Gel should not be exposed to direct sunlight, or solarium ultraviolet light, either during treatment or for	Grey 3

		two weeks following treatment discontinuation, in order to avoid phototoxicity reactions and photoallergy.	
Ketoconazole tablets		Cushing's syndrome	Red 1
Liraglutide	Saxenda®	Weight loss	Red 1,6
Lomitapide		An inhibitor of microsomal triglyceride transfer protein (MTP)	Red 1
Loxapine		Mild-to-moderate agitation in patients with schizophrenia or bipolar disorder	Grey 2
Melatonin		As per Place shared care protocols	Amber
Pembrolizumab			Red 1,6
Mavacamten		Treating symptomatic obstructive hypertrophic cardiomyopathy in adults who have a New York Heart Association class of 2 to 3	Red 1,6
Semaglutide	Wegovy	Managing overweight and obesity in adults	Red 1,6
Birch Bark		Treating epidermolysis bullosa	Red 1,6
Riluzole 50mg orodispersible film		Treatment of amyotrophic lateral sclerosis in adults The orodispersible tablet is more cost-effective than the oral suspension.	Amber
Dekas plus liquid		Non- Cystic fibrosis patients	Grey
Dekas plus liquid		Children under 3 years with Cystic fibrosis	Green
Varicella (chickenpox) vaccine	Varilrix®,Varivax®	Vaccine for use Prior to Immunosuppression, in Adults and Children without Immunity	Red 6
Dengue vaccine	Qdenga®	Prevention of dengue disease in individuals aged ≥4 years	Grey 6