NHS
South Yorkshire
Integrated Care Board

Minutes of the Meeting of the Sheffield Area Prescribing Group
20th July 2023

Present:

Dr Andrew McGinty.GP and joint Chair of APG, NHS South Yorkshire ICB
Heidi Taylor. Deputy Director, Medicines Optimisation Team. NHS South Yorkshire ICB
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
Andrew Moore. Deputising for STHFT Chief Pharmacist.
Dr Laura Smy. GP and Representative of Local Medical Committee.
Dr Rhona Leadbetter. GP, NHS South Yorkshire ICB
Dr Trish Edney. Lay member. Healthwatch representative
Thomas Bisset. Community Pharmacy South Yorkshire representative

Absent

Dr Zak McMurray. Medical Director and joint Chair of APG, NHS South Yorkshire ICB
Mr Veeraraghavan Chidambaram-Nathan. Consultant representative STHF
Dr Jonathan Mitchell. Consultant representative, Sheffield Health & Social Care FT
Helen Taylor. Clinical Effectiveness Pharmacist, NHS South Yorkshire ICB
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
Dr A Khwaja. Renal Consultant, STHFT
Shameila Afsar-Baig. Pharmacist, NHS South Yorkshire ICB

		ACTION
1.	**Apologies for Absence**	
	The Chair welcomed new member, Thomas Bisset, who will, until Community Pharmacy South Yorkshire (CPSY) appoint a chief officer, represent CPSY at Sheffield APG. Apologies for absence have been received from, Dr Z McMurray, Mr Nathan, Dr Jonathan Mitchell, Helen Taylor, Joanne Wragg and Helen Caley The Chair declared the meeting was quorate.	
2.	**Declarations of Interest**	
	The Chair reminded members of their obligation to declare any interest they may have on matters arising at Area Prescribing Group meetings which might conflict with the business of NHS South Yorkshire Integrated Care Board (ICB). The Chair also reminded members that, in future, not only would any conflicts of interests need to be noted but there would also	

	need to be a note of action taken to manage this. The Chair reminded members that they had been asked to declare any conflicts of interest in agenda items for discussion at today's meeting in advance of the meeting Declarations made by members of the Area Prescribing Group are listed in the ICB Register of Interests. The register is available on the ICB website at the following link: https://southyorkshire.icb.nhs.uk/about-us/our-structure/register-interests No further declarations were made.	
8.	**Protocols and Prescribing Guidelines**	
	Guideline to support Primary Care with the management of Chronic Kidney Disease (CKD) in Adults The decision to produce this guideline was made following the addition of dapagliflozin (Forxiga®) as green on Sheffield Place TLDL for the treatment of chronic kidney disease on the basis of NICE TA775: Dapagliflozin for treating chronic kidney disease. The guideline has been developed with support from clinicians in secondary and primary care. The guideline starts with a flow chart which shows the separate management of patients with and without diabetes. The first section of the flow chart gives information on optimisation of BP and clarifies targets for patient age 80≥. The flow chart gives information on modifying risk of CKD progression, including initiation of a SGLT 2 inhibitor: dapagliflozin being the only SGLT2 inhibitor currently licenced for CKD management. The last section of the flow chart gives information on optimisation of cardiovascular risk. Page 3 of the guideline gives the NICE CKD referral criteria and information on self-management advice for patients. Page 4 takes a flow chart from the STHFT guideline on a stepwise approach to prescribing dapagliflozin. This covers a fluid status assessment, contraindications for SGLT2 inhibitors, dapagliflozin initiation, highlighting that if prescribed concurrently with insulin and/or sulfonylureas, a reduced dose should be considered. The concluding section of this chart is on patient counselling. Page 5 has information on further considerations before initiation a SGLT2 inhibitor, monitoring requirements and sick day rules. LS questioned the advice, on the flow chart on page 2, to repeat the uACR 3 times as NICE advises to repeat twice. AK agreed that to repeat twice is acceptable and the document will be amended to reflect this. LS asked about patients already on canagliflozin and if they should they be changed to dapagliflozin. AK answered that dapagliflozin is, currently, the only SGLT2 inhibitor licensed for CKD, and it does makes sense to use one SGLT2 inhibitor across the board. RL asked for clarity on a sentence in the advice for optimisation of BP	DV

	where it states, *If uACR ≥70mg/mmol: BP<130/80mmHg and refer for nephrology assessment* DV explained that if the patient has a uACR ≥70mg and they are on optimised BP treatment but still uncontrolled, then a referral to nephrology would be appropriate. This sentence will be amended to clarify.	DV
	RL also asked about the fluid status assessment in the flow chart on page 4, and what is the expectation of GPs regarding this. AK explained that as this chart is from the STHFT guideline it was a reminder for secondary care clinicians when SGLT2 inhibitors were new to their practice. The group agreed that this could be removed from the primary care guideline.	DV
	AMcG commented that there is, on page 2, in the modify risk of CKD section, a mistake in this sentence. *Step 1: if uACR ≥70mg/mmol irrespective of BP or CVD, initiate and optimise ACEi **and** ARB.* It should read ACEi **or** ARB.	DV
	LS asked about the optimisation of cardiovascular risk where it states. *If established CVD ensure an antiplatelet is offered,* and questioned if, by definition, that patients with CKD have established CVD. DV agree that this was the case, and the above-mentioned statement is included to reflect NICE guidance. DV will amend that statement to read *Offer antiplatelet for the secondary prevention of CVD but be aware of increased risk of bleeding,* this wording is taken directly from NICE guidance.	DV
	RL raised the issue of reducing insulin dose when initiating dapagliflozin, as stated in the chart on page 4, and asked if GPs could discuss this with the diabetic nurse specialists (DSN's). AMcG added that if initiating dapagliflozin for heart failure, that GPs would refer to the DSN's. HeiT suggested that the wording in the heart failure guidance could be added to this guidance, the wording is, *the GP will be asked by the specialist to prescribe dapagliflozin with the support of the community diabetes specialist nurse (DSN) to titrate doses of insulin/diabetic medication in line with glucose control.*	DV
	HeiT also asked if some of the wording in the guideline could be amended to words that support shared decision making, replacing 'initiate' atorvastatin to 'offer' atorvastatin on page 2 and to 'discuss starting dapagliflozin' with patients rather than to 'initiate'.	DV
	HeiT also questioned that, on page 4, the contraindications noted are mostly cautions and could a caution on eGFR is <15 be included.	DV
	LS asked for final clarification that, if a diabetic patient on insulin and has CKD that the GP can refer to the DSNs to have the SGLT2 inhibitor initiated. HeiT referred back to the statement above, which will be added to the guideline, that the GP will initiate treatment after a detailed conversation and support from the DSNs, which would be an MDT approach.	

	TB asked how sick day guidance are shared with patients and care providers, DV reminded the group that the guidance has a link, on page 4, in the section on patient counselling, to a patient information leaflet, *SGLT2i's Getting the most from your medication,* which has been produced by STHFT. This can be sent to patients by electronic means or printed. **APG approve the guideline with the amendments listed above.** DV and AK left the meeting. **Anticoagulation for Stroke Prevention in Non-Valvular Atrial Fibrillation: Sheffield joint primary and secondary care guidance** SAB presented this third version of the SPAF guideline which has been reviewed and updated in line with local and national guidelines. SAB summarised the main changes. The Orbit tool now replaces HASBLED throughout the guideline, in line with NICE NG196. The Orbit tool is available on both SystmOne and EMIS web. On page 2, the base-line investigations, adding that the repeat clotting screen is not required. For renal function, to minimise confusion with the use of eGFR in the Orbit Tool; Use calculated creatinine clearance (CrCl) to estimate renal function for DOAC dosing. On page 3, the addition of bariatric surgery < 6 months ago to the 1st box of the 2 with heading: Do any of the following apply? With a recommendation to seek specialist advice. The list of interacting drugs has been removed from the 2nd box of the 2 with the heading: Do any of the following apply? Instead, users are referred to the drug interactions page. Also on page 3, a link to NG196 has been added, recommending DOAC in preference to warfarin; and a link to the Sheffield position statement, with edoxaban as the first line DOAC. This may need a minor amendment at a later date, when the position statement is retired. A further addition to page 3 is the advice that any patient who has already been initiated on an anticoagulant, by a consultant cardiologist, should remain on it and not be switched to an alternative. On pages 4 and 5 'drug interactions' have been updated as per SPCs, Stockley and the EHRA practical guide 2021. On page 6, considerations in choosing an anticoagulant, amendment, and additions as follows. • High risk of bleeding (ORBIT ≥4) ensure modifiable risk factors for bleeding are addressed: blood pressure control, drugs, and alcohol • High renal clearance CrCl >95ml/min • Amended 'Extremes of body weight (less than 45kg or greater than 130kg)' see page 6 for new details. This is in line with EHRA DOAC guidelines and local recommendation. • Swallowing difficulties annotation 3 - edoxaban added • Annotation 6 reversal agent updated.	

	Page 7 has updated patient information and resources. Page 8, the anticoagulation referral form has been replaced with ICE and edoxaban has moved to top of the DOACs list, as is now first line. Page 9, has some new guidance on long term monitoring: National guidance, including CKS and SPS now recommend the following for renal function monitoring. CrCl<60ml/min - the frequency of monitoring (in months) can be guided by the CrCl being divided by 10, for example, every 3 months if CrCl is 30 mL/minute. Following discussion at FSG, the previous renal function monitoring, which has been added in blue font, has been kept in the guideline as a pragmatic alternative. Practices can choose which option to use. Page 11, switching warfarin to a DOAC, individual INR thresholds from DOAC SPCs has been replaced with National guidance which gives pragmatic advice. Page 12, dental procedures this has been updated as per the Scottish Dental Clinical Effectiveness Programme (SDCEP), which has been adopted by the British Dental Association for use across the UK. TB commented that although edoxaban has been moved to the top of the list on page 8, it has not been moved in the rest of the document. SAB will amend this. HeiT commented on the advice on page 3, where it states not to change a DOAC if initiated by a consultant cardiologist and asked if it could be clear for primary care clinicians when they could consider a switch to edoxaban if appropriate. SAB shared an example of an incident with the group, where a patient was switched from apixaban to edoxaban to then receive a communication from the arrhythmia clinic asking that the patient is not switched. SAB added that there has been some other cases when practices have been asked not to switch a patients DOAC. SAB will contact cardiology again to ask if they could specify those patients that they do not want switching. AMcG agrees that the specialist should specify those patients that they want to remain on a specific DOAC and has offered to be involved in any conversation SAB has with the arrythmia clinic. **APG approve the updated version, addressing the minor points raised above**. SAB left the meeting.	SAB SAB
3.	**Minutes of the June Area Prescribing Group**	
	The minutes were agreed as an accurate account of the meeting.	
4.	**Matters Arising**	
	Review DOAC Position statement This was in relation to secondary care choice of DOAC, which was raised at the LMPAG meeting and it was discussed how messages are cascaded	

within the STHFT.
LS asked if SHSCFT are also included in those discussions, as there can be issues around antipsychotic prescribing requests. AA assured that SHSCFT are involved in discussions. If GPs are experiencing inappropriate prescribing requests, to inform him of the details.
NFA for APG at this time.

Temporary Care home residents
Following June APG, where the difficulties that the 'temporary' GP has with managing prescriptions due to the limitations of the clinical system. In this scenario the temporary GP cannot prescribe from the patient's routine medication list and prevents cancellation of medication without sending a request to the patients usual GP. This also has potential for medication errors.
HeiT has discussed with members of the MOT to explore if the clinical systems could offer solutions to those problems. Unfortunately, the clinical systems do not offer a workable solution. The only option, as discussed at the June APG meeting, would involve adding workload for the patients usual GP practice. **NFA for APG.**

Repeat Prescriptions: allow 7 days for prescriptions to be processed
Last month, APG were informed that the Community Pharmacy Forum took a paper to the SY Primary Care Provider Alliance about a campaign to reduce pressures on primary care repeat prescribing, an agreement was reached that 7 calendar days should be allowed for repeat prescribing to be processed.

TE had raised the issue that if patients were unable to use electronic means to order their prescription that they can be further inconvenienced. HeiT agreed to share data which shows the percentage of patients that are enabled to access on-line prescription ordering per PCN. The data was shared with the group and reveals that those areas with greater deprivation are as low as 34% where more affluent areas range from 50% to 60%, with the University of Sheffield, Student PCN, at 97%.
NFA for APG.

CNS Chapter.
At the last APG meeting it was agreed, that following some further amendments to the CNS Chapter, it would be sent to HeiT, EP and AM to give final approval. In addition to the discussions at the June APG, HelT has made some additional amendments. For transparency, these have been brought to today's meeting.
The minor changes added to the chapter not previously seen at APG are.

- **Anxiolytics:** Benzodiazepines and opioids: reminder of risk of potentially fatal respiratory depression as per the MHRA Drug Safety Update March 2020.
- **Strong Opioids:** Morphine orodispersible tablets (Actimorph®) are Green on the TLDL only as an option for use in vulnerable patient groups, to reduce the risk of accidental or intentional overdose; or where there are dexterity issues.
  Fentanyl immediate-release (tablets, lozenges, and spray): Black on the TLDL – see Sheffield STOP list for full details and note

circumstances where prescribing may be appropriate. Only licensed for cancer pain – see SPC. Extra information is taken directly from the opioid TD guidance: *If using opioid patches for chronic non-cancer pain and no significant improvement of pain with oral morphine equivalent 60mg/day (fentanyl 25 micrograms/hour or buprenorphine 20 micrograms/hour) refer to pain clinic for further recommendation. Do not increase dose further without specialist advice.*
And a new link to: Brand name prescribing is recommended to reduce the risk of confusion and error in dispensing and administration

- **Migraine:** 4.7.4.1 added: Self-care with over the counter (OTC) preparations is advised for short term use of infrequent migraine. Also added: NICE CG150 Suggests riboflavin at a dose of 400mg daily may be effective in reducing migraine frequency and intensity for some patients. This recommendation refers to self-purchase only.

There was also a discussion at the June APG about clozapine monitoring. Effectively, all monitoring should be under SHSCFT but as there are just 2 clinics that take bloods, with prior agreement, the patient is sometimes given the form to order the bloods. The patient can go to NGH, the drive through phlebotomy clinic or their GP practice. As the form is issued by the specialist, the results go back to the clozapine clinic and there is no requirement for the GP practice to interpret the results. AA agreed that this is the case, emphasising that SHSCFT do not send or recommend patients go to their GP to have their bloods taken for clozapine monitoring.
AMcG added that if paper-based forms, for phlebotomy, are given to the patient, there is less of an issue but if bloods are ordered on ICE and the patient has the bloods taken in practice there is a code change on the label as it is printed in the practice. This means that the results go back to the practice and presumably to the specialist that ordered the bloods. There may be a concern that if a patient attends their GP practice with a paper form that the HCA may transcribe the form on to ICE, and this may result in the specialist not receiving the result.

RL added that she has one patient on clozapine that has had their full blood count taken at practice since 2011 and has not had a specialist review recorded since March 2021. AA has asked that RL share those details for further investigation.

LS asked if the specialist wants to know every time a patient presents with an infection. AA advised that the key risk for patients on clozapine is a risk of neutropenia and a specialist should be contacted.

HeiT shared the sentences relating to this in the CNS Chapter:

Clozapine can cause agranulocytosis and neutropenia. All patients taking clozapine should be managed by the secondary care team. Routine blood tests are needed which may be undertaken by the GP surgery where mutually agreed to support care closer to home, Northern General Hospital phlebotomy service or by the SHSC trust; but responsibility for interpretation and on-going prescribing remains with the specialist.

	If the GP surgery performs an ad hoc blood test and inflammatory markers or immunosuppression is present the treating physician should be contacted immediately. *If any kind of infection begins to develop the GP surgery should perform a blood cell count and contact the treating physician immediately. Particular attention must be paid to flu-like complaints such as fever or sore throat and to other evidence of infection, which may be indicative of neutropenia.* *Particular attention must be paid to flu-like complaints such as fever or sore throat and to other evidence of infection, which may be indicative of neutropenia.* The relevant wording will be shared, after the meeting, with LS, RL and AA, to agree the final wording that will be included in the formulary chapter. LS also asked about the orodispersible morphine and that there are a number of patients who may benefit but, do not necessarily fall into the vulnerable patient groups or where there are dexterity issues. On looking at the Drug Tariff costs, the advice on who to offer the orodispersible medication to, does not seem to be price driven, this will be fed back to HelT. **The CNS Chapter is approved subject to the clozapine wording being finalised.**	HeiT HeiT
5.	**Medicines Management Safety Issues**	
	EP reported that the Medicines Safety Group met yesterday so a full report will be available for the next APG meeting. Since the June APG meeting there has been a National Patient Safety Alert that supports the GLP1 receptor agonist shortage, this requires action to be taken by mid October 2023. **Pregabalin Safety Audit** SK presented this, for information, on behalf of HelT. The group were asked to contact HelT directly if there were any comments, which could be discussed at the next APG meeting.	
6.	**Pharmacy and Prescribing Commissioning Group Feedback**	
	AMcG and HeiT advised that at yesterday's meeting all the APG outputs from June were approved. There were discussions about PQIS and that some practices have appealed the 2022/23 decisions. It was also reported that QIPP is on track. With regard to IMOC, it has been agreed, with ICB finance, that there is no financial ceiling on what IMOC can approve but, the decisions will be noted by finance so that any adjustments can be made to commissioning and/or prescribing budgets. If commissioning arrangement need to be put into place, this could potentially, result in delays.	

7.	**Formulary Sub-group**	
	Draft minutes of the July meeting Were received by the group. MSN 2023/061 - **GLP-1s** Intermittent and limited supply until mid-2024. The MOT are currently asking for some steer from secondary care on risk stratifying patients. AMcG added that patients are being advised to try to obtain their GLP-1 medication from more than one pharmacy as the message is that there should be sufficient supply for patients already being prescribed a GLP-1. There is however inconsistent supply. If a patient cannot obtain their medication, they are being invited back for review and there may be instance where a GLP-1 is no longer indicated; NICE provide stopping criteria. HeiT added that information was sent to the ICB communications team for dissemination but unfortunately there is currently a breakdown in that communication flow. Clinical system searches have been done, in line with the MSN, which indicate those patients that should be prioritised and referred back to secondary care due to a high HbA1c, the Sheffield searches identify approximately 220 patients. There are about 2200 in total, in Sheffield, on GLP-1s. HeiT will share the information, which should have been shared through the communications team, with this group. TC confirmed that community pharmacy is finding that wholesaler stock levels are not reliable. A pharma representative has advised that there is 40% more GLP-1s being produced that last year but, it is suspected that some of this increased production may be being diverted to private weight management clinics. Anecdotally, there are patients still being newly initiated in hospital. Addition of **Somatrogon** to: The treatment of Children with Recombinant Human Growth Hormone SCP – approved at APG in March 2023 who asked FSG to have sight and approve the amendments required to the SCP. **The Amber TLDL proposal is to be presented at IMOC in August/September.** LS asked if the increased monitoring had been incorporated in the protocol. SK assured that this is being addressed. **Matters for APG approval:** **Prescribing guidance in the self-monitoring of blood glucose (SMBG) <u>expected to go to September APG</u>** **Matters approved by FSG under delegated authority (for information)** **Chapter 13 Skin** – Update to replace Ketoconazole 2% shampoo with the more cost effective Nizoral shampoo however, patients are signposted to buy for self-care. Alphosyl 2:1 has been removed as it has been discontinued. **Algorithm for the management of young adults with Type 2 Diabetes**	HeiT

	(18-39 years) a minor update to a link to the low-calorie diet pathway. **Vacuum pumps** – updated wording to Chapter 7 Obstetrics, gynaecology and urinary tract disorders. This wording reflects what is happening in practice. It was previously thought that the specialist service would provide the pumps and be reimbursed but this process did not take place. PPCG agreed to leave what is happening now. The specialist has confirmed that they advise and train the patient on how to use the pump selected for them, then request the GP to prescribe a specific device. The patient is followed up by the service 6 weeks after initially receiving the device and there is also a monthly drop-in clinic, should the patient have any problems. **Freestyle Libre position statement**. This is to advise that the statement is to be updated to incorporate NICE NG17,18 and 28. Medicines Optimisation Team QIPP Plan: Cost Effective Workstreams for 2023/24 – **Alimemazine**. This is being prescribed off label for urticaria and pruritus. It is available as a sugar containing solution which is expensive but, there is a more cost-effective syrup, Alfresed. FSG agreed that a switch to the more cost-effective syrup, where appropriate, ahead of investigating why alimemazine is being initiated. **Stoma accessories preferred prescribing list** – FSG noted the list for use in relation to the Stoma Help Line. LS asked if the stoma help line was to be rolled out across Sheffield, HeiT confirmed that it is. **Matters approved by virtual agreement under delegated authority (for information):** **Testosterone SCP** minor update – this was following MHRA advice about the risk of transferring by physical contact. Some wording has also been added on the HRT pre-payment certificate that does not cover testosterone prescribed for HRT as it only applies to licensed medication for HRT. TB admitted that this may cause some issues for community pharmacies and the difficulties of explaining to patients when it is not covered by the pre-payment certificate. **Matters considered for IMOC** • DEKAs plus liquid TLDL proposal from SCFT	
9.	**Integrated Medicines Optimisation Committee (IMOC)**	
	Minutes June 2023 minutes were received by the group. **IMOC approvals** HeiT commented on the SY ICB TLDL and that the list will be more comprehensive as IMOC have agreed that all new drugs and those associated with NICE TAs will be added. AMcG added that IMOC now has LMC representation from all 4 ICB places.	
10.	**RMOC.**	
	Nothing to report.	

11.	**NICE Guidance**	
	NICE summary for June APG HeiT reiterated that IMOC will now consider all NICE TAs and assign a TLDL status. The NICE guidelines will still be considered locally, at APG. **NICE CG57 (Update): Atopic eczema in under 12s: diagnosis and management**. This now includes *Do not offer emollient bath additives to children with atopic eczema.* Bearing in mind previous discussions and agreements with SCFT, the coming together as an ICB and that other ICB places may have bath emollients as Grey on their TLDLs, this may present additional challenges.	
12.	**APG Mailbox.**	
	Further queries received about specialist weight management service Continue to be received in the APG mailbox. AMcG added that the final analysis of the submissions for the Tier 3 service is continuing this week and hopefully getting closer to appointing a service. **Duplicate discharge summaries** A PCN pharmacist has reported on the difficulties practices face when receiving an electronic discharge summary and later receiving a paper copy as this adds to their workload. This information, along with identifying the directorates responsible, has been shared with colleagues at STHFT. LS added that the LMC are in the process of collecting data on this problem and have identified that STHFT have sent duplicate electronic copies too, SK will share the details received in the APG mailbox and the email exchanges with STHFT, with the LMC. **NFA for APG at this time.**	SK
13.	**Reports from Neighbouring Committees**	
	• MMTG minutes May 2023 • Doncaster & Bassetlaw APC minutes May 2023 • Barnsley APC memo May 2023 LS commented on the article in the Doncaster minutes noting that all their lithium patients are still under secondary care and, as we are moving to joining up services in the ICB, if this is something that can be considered in Sheffield. HeiT added that the principle of agreeing SCPs across SY ICB has been agreed and lithium is going to be part of that process, but it won't reflect commissioning arrangements that are already in place, e.g., Doncaster is the only place that commission a lithium service which prescribes and monitors, Barnsley, Rotherham and Sheffield have an SCP in place where the prescribing and monitoring, after a patient is stable on treatment, is done in primary care with the opportunity to have the support of the specialist if needed. It is not known how far the commissioning or decommissioning of services will go in an attempt to align services across SY ICB. The provider collaborative is looking at all the local commissioned services in addition to those who are looking at the prescribing point of view. LS added that it is those patients on lithium who have been discharged from secondary care that have caused concern and gave a recent example of a	

	pregnant patient where the specialist had written to the GP advising to down titrate and stop medication. AA commented that he would not have expected that response and for LS to contact him with the details. TE commented that Doncaster had raised the issue that there is no official protocol for managing patients on melatonin who are transitioning to adulthood. TE asked if this should be raised by the SY ICB. HeiT commented that patients are supposed to be reviewed in their teenage years, though this is not guaranteed, and acknowledged that, as there is no adult sleep service, it is left to the GP to manage. RL added she had, this week, received a letter from a psychiatrist to request that the GP continues prescribing melatonin. RL agrees it would be beneficial and welcome to have a guideline that the psychiatric team have to work to and discuss with the patient at the point of transitioning. HeiT advised that Jill Rigby is currently working with SCFT on updating the melatonin SCP and APGs conversation will be shared so that these comments can be considered in the update of that SCP. APG would welcome a firm approach to an exit strategy, which describes the end point for melatonin prescribing. This would give GPs something to work with, supported by the specialist, on when the right time has come to stop melatonin prescribing. This conversation is difficult for GPs to initiate when a medication has been started by a specialist if the specialist hasn't had, as part of their conversations with the patient, the discussion that there will be a time when prescribing will no longer be appropriate. SK will inform Jill Rigby.	SK
14.	**Never Events and Sis.**	
	None reported.	
15.	**Any Other Business**	
	Sheffield APG report (for information) Was received by the group. The **link on the PRESS portal to the medicines page** has gone and it would be appreciated if it could be re-instated, AMcG will contact PRESS portal to make this request. LS asked if there has been any progress on **varicella vaccine** for patients who are to become immunosuppressed. SK will take this up with the UK vaccination group and Richard Crosby.	SK
16.	**Date of the next meeting:** **21st September 2023 1:30 via MS Teams**	

Summary Points and Recommendations

July 2023

IMOC approvals	None to report.
IMOC TLDL approvals	June 2023 • Remdesivir- Traffic lighted Red 1,3 • Molnupiravir -Traffic lighted Red 1,3 • Nirmatrelvir plus Ritonavir - Traffic lighted Red 1,3 • Sotrovimab - Traffic lighted Red 1,3 • Tocilizumab - Traffic lighted Red 1,3 • Baricitinib - Traffic lighted Red 1,3 • Casirivimab plus imdevimab - Traffic lighted Grey 1 • Ripretinib Tablet - traffic lighted Grey 2 • Teclistamab 30mg in 3mL and 153mg in 1.7mL vials- Traffic lighted as Grey 6 • Tozinameran + famtozinameran -Traffic lighted as Green • Cholera vaccine- Traffic lighted as Green • Eroxon Stimgel- - Traffic lighted as Grey 7- new rational Evidence not evaluated. To consider change of TLS use SY IMOC TLDL application form. • Hepatitis A – Traffic Lighted as Green • Ranibizumab biosimilar (Byooviz® + Ximluci®)-Traffic lighted as Red 1 • Tezepelumab– Traffic lighted as Red 1,6 • Fludroxycortide 0.0125% cream- Traffic lighted as Grey 4 • Risankizumab Traffic lighted as Red 6
Shared care/Prescribing Guidelines	• The treatment of Children with Recombinant Human Growth Hormone SCP – addition of **Somatrogon**: approved at APG in March 2023 and FSG July 2023. The Amber TLDL proposal is to be presented at IMOC in August/September. • Guideline to support Primary Care with the management of Chronic Kidney Disease (CKD) in Adults - approved • Anticoagulation for Stroke Prevention in Non-Valvular Atrial Fibrillation: Sheffield joint primary and secondary care guidance – approved • Algorithm for the management of young adults with Type 2 Diabetes (18-39 years) minor update to link - approved by FSG under delegate authority of APG • Freestyle Libre position statement, minor update - approved by FSG under delegate authority of APG
Sheffield Formulary Updates	• Chapter 13 Skin – Update to Ketoconazole 2% shampoo prescribing and removal of Alphosyl 2:1 – approved by FSG under delegate authority of APG • Chapter 7: Obstetrics, gynaecology and urinary–tract

	disorders, updated wording re Vacuum pumps –- approved by FSG under delegate authority of APG • Chapter 4: CNS – further minor amendments approved
Other	• Medicines Optimisation Team QIPP Plan Cost Effective Workstreams for 2023/24, addition of alimemazine - approved by FSG under delegate authority of APG • Stoma accessories preferred prescribing list – FSG noted the list for use in relation to the Stoma Help Line.