NHS
South Yorkshire
Integrated Care Board

Minutes of the Meeting of the Sheffield Area Prescribing Group
15th June 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
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
Helen Taylor. Clinical Effectiveness Pharmacist, NHS South Yorkshire ICB
Mr Veeraraghavan Chidambaram-Nathan. Consultant representative STHFT

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
Helen Caley. PCN Pharmacist representative
Joanne Wragg. Director of Pharmacy, Sheffield Children's FT
Dr Jonathan Mitchell. Consultant representative, Sheffield Health & Social Care FT
David Russell. Community Pharmacist and Chair of Community Pharmacy Sheffield.
Abiola Allinson. Chief Pharmacist. Sheffield Health & Social Care FT

In Attendance: Deborah Morris. Clinical Effectiveness Technician. NHS South Yorkshire ICB

		ACTION
1.	**Apologies for Absence**	
	Apologies for absence have been received from, Dr Z McMurray, Helen Caley, Dr A McGinty, Joanne Wragg, Abiola Allinson and David Russell 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, new, declarations were made.	
3.	**Minutes of the May Area Prescribing Group**	
	The minutes were agreed as an accurate account of the meeting, with the exception of one point on the **Update to End of life care algorithms regarding the Pink Card** (page 4) and the paragraph where Dr Lydia Mawer GP and Representative of Local Medical Committee, asked about *adding information on regular sub-cutaneous medication to the Pink Card.* and *HelT confirmed that this is covered in the procedure, with advice to use the Green Drug Administration Card.* HelT will clarify with Fiona Stephenson, as the question may have been misinterpreted. When clarified HelT will confirm with Dr Mawer. **Post meeting note:** The May APG have had a post meeting note added to clarify. HelT has confirmed with Fiona Stephenson that there is a place on the Pink Card for regular subcutaneous medication which is prescribed for palliative care (i.e separate to Syringe Pump). Subcutaneous fluids would be prescribed on the green card. HelT has asked a colleague for a copy of the Pink Card at Barnsley to compare but not had a reply yet. HelT has followed up with email to Lydia Mawer and Fiona Stephenson.	HelT
4.	**Matters Arising**	
	Review DOAC Position statement SK reminded the group that at the May APG meeting it was discussed that there was a legal challenge to the roll out of apixaban generics. It was thought that generic apixaban may have offered a cost-effective DOAC. There is an update to this and edoxaban remains the most cost-effective option. The Drug Tariff price for apixaban has not dropped and is not likely to reduce in price in the foreseeable future and, legal challenge may be ongoing. HeiT reminded the group that there is a national rebate on edoxaban and edoxaban is included in the PQIS. If there is any change to the current situation, this will be looked at again. HeiT added that data relating to DOAC selection on OptimiseRx, which flags up to prescribers when they select an alternative DOAC to edoxaban for the indication of AF, asks for the reason that edoxaban was not selected. One of the most frequent rejection reasons is because the DOAC was initiated in secondary care. HeiT will share this data with AM as it may be useful for any further discussions with STHT directorates. AM confirmed that the usage of edoxaban has increased over the last 6 to 12 months though is far behind the uptake in Leeds and Bradford, for example. AM added that the STHFT contract price for apixaban will not change in the next 12 months therefore edoxaban is still more cost effective.	HeiT/AM

	LS joined the meeting. **Issue of STHFT OPD prescriptions** AM has discussed, with Graham Marsh, the possibility of how electronic prescribing solutions could alleviate the problem raised on GPs being requested to issue the first prescription for dapagliflozin, an Amber TLD for HrEF, when a nurse prescriber in unavailable. HeiT added that Graham Marsh is in conversation with relevant bodies at STHFT and their IT department, to start to look at the challenges. The LMPAG meeting, between the LMC and STHFT medical directors, is also due to have discussions on this issue, in July, to address the acknowledged problems caused to GPs. When secondary care does not have robust systems in place, it often results in a shift of work to GPs. This in turn, can cause inconvenience and disruption for the patient/GP relationship when patients expectations are raised; patients will not be aware that GPs do not have the capacity to take this shift of workload and, in some circumstances, the expertise e.g., around Red traffic light drugs. HeiT suggested that, with regard to secondary care specialists requesting GPs to prescribe drugs classified as Red on the TLDL, that it may be useful if AM and VCN could flag to secondary care colleagues the TLDL, and the developing IMOC TLDL, to look to see if the requested drugs are in the Grey/Black or Red sections as GPs will not prescribe and, if in the Amber sections, the guidelines/protocols should be followed. HeiT will discuss this further, outside the meeting, with AM and VCN. **Semaglutide (Wegovy®) Holding Statement to support Sheffield Primary Care - Update** SK reminded the group that there has been further news of an NHSE pilot that will, potentially, involve GP prescribing of semaglutide for obesity and weight management. No further details are yet known about the pilot or where it will be operated from. This information has been added to the existing holding statement. **APG approve the update.**	HeiT/Am/ VCN
5.	**Medicines Management Safety Issues**	
	Medicines with teratogenic potential: what is effective contraception and how often is pregnancy testing needed? Guidance for primary care clinicians New guidance regarding the use of antiepileptic drugs and the risks in pregnancy has been issued by the MHRA. The primary care guidance has been updated to incorporate this. Topiramate has been added to the antiepileptic drugs section and the carbamazepine section has been updated to reflect the 2021 guidance which has shown that it does not affect neurodevelopment. This has been removed and the following wording added, *evidence suggests that the risk of malformation with carbamazepine may be dose dependent.* EP noted that as carbamazepine is an enzyme inducer, this will also be added to this section.	EP

	In the topiramate section the wording on the migraine prophylaxis guidance, about highly effective contraception and what is required as topiramate is an enzyme inducer, has been updated. **APG approve the updates.** **Medicines Safety Update** EP summarised the other items discussed at the medicines safety group (MSG) meeting. Some guidance for **care homes** were approved but not brought to APG as there were no prescribing implications. MSG reviewed the **controlled drugs report,** which sums up activity across the ICB. **National Patient Safety Alert (NPSA): Class 1 Medicines Recall Notification: Recall of Emerade 500 micrograms and Emerade 300 micrograms auto-injectors** and how the ICB handled the recall. Linked to this is the new **Adrenaline Auto-Injectors (AAIs) safety campaign** The MHRA has produced an infographic showing The correct use of your Adrenaline Auto-Injector (AAI). EP proposes to add to the relevant section of the Sheffield formulary and this will be promoted at the APG learning lunch. The **MHRA Drug Safety Update in April.** Reminded of the **nitrofurantoin risks of pulmonary and hepatic adverse drug reactions,** this is not a new risk but as there are rare occurrences, the MHRA remind HCPs to be vigilant for the signs and symptoms in need of further investigation. Part of the alert states that patients should be periodically monitored for signs of hepatitis, guidance on this and appropriate time interval of monitoring is being looked at. This has also gone to the anti-microbial stewardship group for advice. In the **May update**, **Direct-acting oral anticoagulants (DOACs): paediatric formulations; reminder of dose adjustments in patients with renal impairment.** There are two new paediatric formulations, only one is available in England which is the rivaroxaban granules. There are a number of resources available to support it safe use in children. This alert reminds healthcare professionals of the availability of risk minimisation materials, in the form of a prescriber guide and a patient alert card, to support the safe use of all DOACs. The alert also contains a reminder about the importance of assessing and monitoring renal function to ensure adult and paediatric patients receive an appropriate dose of DOAC medicines. Guidance already exists in Sheffield for adults: Calculating renal function for patients prescribed DOACs in primary care. The guidance reflects that issued in the MHRA alert. **Febuxostat: updated advice for the treatment of patients with a history of major cardiovascular disease.** It was previously stated that it shouldn't be used in patients with pre-existing major cardiovascular	

	disease but now states that it can be used, with caution, as second line. **Naseptin Nasal Cream: Caution advised when prescribing and dispensing due to reformulation to remove allergen.** Naseptin has been reformulated to remove the arachis oil so that it can be used for patients with a peanut and/or soya allergy but it has been highlighted that both formulations will be in circulation until November 2025.	
6.	**Pharmacy and Prescribing Commissioning Group Feedback**	
	HeiT informed the group that at the last meeting it was discussed that the **tier 3 weight management service** has attracted some bids, this is now going through the process of reviewing those bids. The **PQIS was also discussed which was agreed and launched**. This year 50% is being measured on the prescribing budget, and 50% on the agreed 6 metrics which are, • edoxaban as a proportion of all DOACs • proportion of broad-spectrum antibiotics of all antibiotics • reducing SABA use in asthma linked to, • optimal prophylaxis treatment with ICS • percentage of OptimiseRx acceptance on cost-effective rules • practices within limits of their ASTRO-PU Practices will be monitored monthly and for each month that the target is achieved, they will be awarded points which will result in proportional financial reward at the end of the financial year. LS asked about the reducing SABA metric and commented that Sheffield's industrial history has resulted in the high numbers of patients on treatment. HeiT confirmed that this was discussed and agreed with the LMC adding that the clinical systems searches for patient numbers exclude COPD. PPCG acknowledged that the **gluten free guideline** may potentially add to the prescribing cost pressure, and this will be monitored throughout the year.	`
7.	**Formulary Sub-group**	
	APG received the **draft minutes of the June FSG meeting.** **Chapter 4: CNS** HelT brought the updates to Chapter 4, summarising the main changes of the full review. All the links in grey boxes on the formulary have been checked and amended where needed. There was discussion, at FSG on the level of content in the grey boxes adding that GP and other representation agreed that the level of content was useful. Although there have been many amendments to the chapter, specific changes to medicines are few and include • Vortioxetine, which is Green on the TLDL, is a newer antidepressant recommended for treating major depressive episodes in adults, whose condition has responded inadequately to 2 antidepressants within the current episode. See NICE TA367 for	

	more information. • Added the Sheffield position statement to the grey box around: Liraglutide (Saxenda®) and semaglutide (Wegovy®) for managing overweight and obesity. • Added two new drugs to the nausea and vomiting section, cyclizine and promethazine • Removed the morphine concentrate 20mg/ml (higher risk with concentrated strength and infrequently used) • Moved the fentanyl patches and buprenorphine 3 and 4 day patches, as not routinely used in chronic pain, to the grey box. • The wording, *pregabalin and duloxetine are alternatives to amitriptyline and gabapentin if either are contraindicated or not tolerated* has been replaced with, *gabapentin (capsules), pregabalin or duloxetine are alternatives to amitriptyline*. HelT shared the updated chapter, pointing out where additional links to useful resources have been added and where some content has been removed. For ease of use of the document a new table of contents, which hyperlinks to the relevant place within the chapter, has been added. LS asked about SystmOne and the order of the picking list when quetiapine is selected. The top of the list offers a brand of modified release preparation. This needs an amendment so that an immediate release formulation appear at the top of the picking list. This will be raised with clinical systems to find a solution. HelT informed the group that a migraine pathway has recently been finalised through CRG and is expected to be published on PRESS portal. The information, currently on the TLDL, on topiramate for migraine prophylaxis, will be amended with a link to the migraine pathway. RL asked about the statement on clozapine, as one patient at her practice attends every month for bloods, presumably on the advice of the specialist. The advice in the CNS chapter reads, *routine blood monitoring will be undertaken by secondary care. If GP surgery performs blood tests and inflammatory markers or immunosuppression is present – specialist prescriber should be contacted immediately.* The group agreed that the GP should not be doing the monitoring. The TLDL advises that: *Patients must be registered with the appropriate clozapine monitoring service. Prescribing physicians must also register themselves and a nominated pharmacist with the monitoring service.* HelT will contact AA and update RL. RL also asked if the migraine pathway can be shared with the group. HelT has asked that any comments are sent to HelT by a deadline of 21st June. (**Post meeting note,** this was shared after the meeting).	HelT HelT

	EP raised queries about safety and suggested the warning on teratogenicity is included, in relation to carbamazepine, in the pain section.	HelT
	EP also raised the MHRA alert from 2021, regarding a small increased risk of post-partum haemorrhage in patients on SSRIs or SMRIs. The obstetrics team at STHFT are aware and incorporate into the monitoring, though concerns were raised that it is sometimes seen that anti-depressants are inappropriately stopped by primary care in patients who become pregnant and asked if a link could be added to the Choices in Medication website which has a range of leaflets, these may be appropriate for signposting. EP also asked if it would be appropriate to add the MHRA link. HelT added that the depression guidelines are in the process of being finalised and HelT will also pass this information to the author, to include similar information to that guideline too.	HelT HelT
	EP asked that, with regard to propranolol and migraine, advising that there was an investigation carried out by the Healthcare Safety Investigation Branch (HSIB) due to the risks of propranolol overdose, as patients with migraine often have depression there are associated risks of self-harm. The NICE guidance, CG150, has a relevant statement, in response to the HSIB report, and should this be considered for adding to the CNS chapter.	HelT
	LS commented on the clozapine monitoring and asked for formal clarification on responsibilities for monitoring and asked if this could be discussed at a later meeting.	HelT
	LS raised the issues around topiramate and the migraine pathway. Many GPs have concerns around initiating topiramate and having referral bounced back from the CASES team. Considering the significant teratogenicity, is there anyway that the CASES team could be liaised with, to accept referrals if a GP is unable to initiate topiramate. HelT responded that this is something that can be discussed with Consultant Neurologist, Fiona McKevitt.	HelT
	LS commented that although it was approved as Green on the TLDL for migraine prophylaxis, it does not change GPs concern about the teratogenicity. There is a potential for patients, who would benefit from topiramate treatment, not being able to access treatment.	
	TE added that the list in Medicines with teratogenic potential, as discuss earlier, is welcomed but asked how often is it reviewed and how is it shared. HeiT responded that many of these will be flagged on clinical systems at the point of prescribing, so there is some in-built protection. EP added that it is publicised when there are changes via APG learning lunch and the Practice Bulletin. EP confirmed that there is an OptimiseRx rule which flags up if topiramate is prescribed for women of childbearing potential age, unless they are read coded as on highly effective contraception.	
	EP added that the MHRA have indicated that there will be further	

	information relating to topiramate in pregnancy. Further comment on the highly effective contraception where, unlike with valproate, due to topiramate being an enzyme inducer, the choice of contraception is limited. HelT added that for treatment of acute migraine attack, there used to be rizatriptan orodispersible on the formulary but in the past, there were problems with stock availability, so it was switched to zolmitriptan. In agreement with Fiona McKevitt and on looking at the Drug Tariff pricing now, it would now be sensible to add rizatriptan orodispersible to the formulary as second line as the stock issues have resolved. HeiT asked that the National Dependence Forming Medicines and the Personalised Care Alert, with recommendations about reviewing patients and having shared decision-making conversations on initiating medicines, to add a grey box with links to these. And then to code as DFM (Dependence Forming Medicines) and link to the appropriate medicine and guidance. **APG agree that, with the above amendments, the final draft will be seen and approved by HeiT, EP and AM.** **Post meeting note:** Patient Decision aid on benzodiazepines and z-drugs from NICE (published 15th June) to be added to CNS chapter 4 update **Post meeting note**: HelT has discussed with Dr Mckevitt (Lead author of Migraine pathway) the concerns from Dr LS re: topiramate and whether referrals can still be made via CASES team if there is a concern re: topiramate initiation in migraine. Dr Mckevitt can't see how the CASES team advice would differ from what is described in the Migraine pathway, which is that topiramate is contraindicated in migraine if the patient declines highly effective contraception. The pathway describes what highly effective contraception is to avoid any ambiguity. Dr Mckevitt advised that the CASES team will be referring clinicians to the Migraine pathway. If there has been a conversation with the patient about topiramate and the patient has declined highly effective contraception that would be useful to include on the referral form. If further advice is required, then a referral can be made. **Matters approved by FSG under delegated authority (for information):** • Advice on Vitamin D Requesting in Adults • Dexcom ONE Position statement **Matters approved by virtual agreement under delegated authority (for information):** • Chapter 6 Endocrine – 6.4.1,6.4.2 minor amendment • Falls risk. Updated the link to the PrescQIPP IMPACT bulletin on the Intranet and the link to that bulletin within the Reducing medication related falls risk in older adults' document. • Palliative care - update to community pharmacy stock list and	HelT HelT HelT

	opening times	
8.	**Protocols and Prescribing Guidelines**	
	None for this month.	
9.	**Traffic Light Drug List**	
	Update on TLDL approvals, discussed below.	
10.	**Integrated Medicines Optimisation Committee (IMOC)**	
	Minutes **May 2023** HeiT went through the approvals for May. The **Gluten Free guidelines** have been updated to add that a read code should be added to the patient record on the annual review date to assure that the patient is aware of the updated guideline. The TLDL approvals were reported. • Ogluo, a glucagon equivalent, agreed as Amber G • Cyanocobalamin, a dual traffic light status of Grey and Green was approved. The nutritional supplement is Grey for self-care and Green for insufficiency as an option where oral treatment is appropriate. It was noted that, for most patients, the IM is more clinically effective. • Covid-19 vaccine (VidPrevtyn Beta®) 10 dose multi-dose vial (VidPrevtyn Beta®) agreed as Green. • Elasomeran + davesomeran (Spikevax® bivalent Original/Omicron BA.4-5) Single dose and 5 dose multi-dose vials (new booster formulation of Spikevax®) agreed as Green • Casirivimab plus imdevimab, nirmatrelvir plus ritonavir, sotrovimab and tocilizumab for treating COVID-19 - Red Traffic Light Status. There is ongoing work around identifying patients but as agreed at the June IMOC, until a pathway is in place it would remain as Red. **Draft June 2023** not available at the time of the meeting. **TLDL.** There is a process in place where a SY TLDL is in development to align all 4 SY places. A start has been made to get a criterion agreed. The broad categories have been agreed. The Black/Grey section is being addressed first and as Sheffield only traffic light a medicine as Black if it was felt that there would be an issue, Doncaster and Barnsley traffic light, all appropriate drugs, in the Grey/Black category. This has resulted in a list of 600 items to review. A small working group are going through that list to find agreement or discuss differences. The plan was that each place was represented by members of that working group so that it would go to IMOC for approval. When the list was presented to IMOC there was, from some members of that group, the insistence that the list should go back to their APG/APC for agreement before IMOC could approve. HeiT shared that list with this group today and asked Sheffield APG if they would like to see the full lists, as they are discussed by the working group, before going to IMOC or, if they would agree the lists going straight to IMOC for approval and only individual items, where there may be contention, be aired at Sheffield APG. Sheffield APG agree that, unless there are specific items where there might	

	be contention, that the lists can go directly to IMOC. The group also agree the colour classification of the list shared today. **HF letter. Doncaster are looking for support to adopt this approach across SY** HeiT shared a letter from Doncaster Consultant, Dr Sara Brett. The letter discusses that an SGLT2i can be initiated for use in chronic heart failure following advice from a heart failure specialist as an add-on to standard optimised care (NICETA 679). In Doncaster there can be significant delay in patients receiving treatment and the cardiologists at Doncaster Royal Infirmary are asking primary care colleagues to consider prescribing either empagliflozin or dapagliflozin, to eligible patients with chronic heart failure, without requesting permission from or referring for a specialist opinion first. When this letter was presented at IMOC, HeiT informed IMOC of the issues Sheffield is facing when secondary care is asking primary care to issue first prescriptions, which is being challenged; hence the letter being brought to APG for Sheffield's response. LS reported that the LMC have responded to that letter and do not support prescribing in the way the letter has requested. LS added that the LMC still have issues about the Amber G classification; acknowledging that there are differences of opinion between the LMC in Doncaster and the other LMCs in SY. RL agreed with the LMC that the request was not acceptable and does not support. HeiT will feed back to IMOC AM left the meeting.	
11.	**RMOC.**	
	Nothing to report	
12.	**NICE Guidance**	
	NICE summary for May APG **Risankizumab for previously treated moderately to severely active Crohn's disease: NICE TA888**, received a Red TLDL status from IMOC **Acne vulgaris: management,** this **update to NG198** is being actioned by the MOT. **Diabetes (type 1 and type 2) in children and young people: diagnosis and management: NG18 (Update).** NICE have amended or made new recommendations, but first line is still metformin, there is now an additional step, before insulin, where adding liraglutide, dulaglutide, or empagliflozin can be considered. It also clarifies the role of continuous glucose monitoring (CGM).	
13.	**APG Mailbox.**	
	Update on number of enquiries SK advised that there is still a stream of enquiries on the tier 3 service. The details of those who have sent enquiries, continue to be added to a log and they will be informed when there is news of a tier 3 service.	

14.	**Reports from Neighbouring Committees**	
	Barnsley APC key points April 2023 Derbyshire JAPC minutes April 2023 Doncaster & Bassetlaw APG minutes April 2023 Rotherham MMC minutes May 2023 The group noted the above.	
15.	**Never Events and Sis.**	
	None reported.	
16.	**Any Other Business**	
	Temporary Care home residents RL reported that there is an increase in the number of patients who are being placed in a care home as S2As, this refers to patients being placed temporarily as 'Somewhere to Assess'. Those patients remain registered with their GP but when entering the care home as S2A, they are also temporarily registered with the GP who will oversee care for the period they are in the care home. This causes difficulties as the 'temp' GP cannot prescribe routine medication from the patient's medication list and cannot cancel medication without sending a request to the patient usual GP. This raises a concern for potential errors. SK added that Robina Okes-Voysey had suggested that the practice 'stops' the repeat template that is owned by another practice with the reason *'temporary resident at xxxxx surgery, please remove repeats from your system until patient is discharged back to your care'.* This will result in a task to be sent to the other practice which, when actioned, will remove the repeat prescription from that practice system. RL agreed that may be a solution but may also create work for the receiving GP, who may not hold the patient for any length of time. LS has a similar problem when their patient enters a temporary facility e.g., Beech Hill, who use SystmOne and set up a duplicate list of prescriptions The usual GP is unable to cancel those prescriptions as they don't 'own' them and this is difficult to manage. RL added that there are added problems for practices who are on EMIS web. HeiT suggests that pharmacist, Greg Westley, may be able to help as he is involved in looking at vulnerable patients and the interface between social care facilities and also to include Robina Okes-Voysey. HeiT will contact Greg and Robina and forward details to LS and RL. **APG will be updated at a later date.** **Blood results on ICE** Since approximately 2018 we have been liaising with STHFT IT dept to enable blood results, when ordered by other providers i.e., the specialists, to be downloaded, rather than manually downloading the results onto the clinical system. This is an enabling function that will give the option to practices to download	HeiT

	the specific test results on to EPR, but GPs can opt not to use it. This system is already in place in Rotherham. In terms of potential benefits: 1. Decreases admin burden of having to manually add the results to EPR from ICE. 2. Improved safety and reduction in potential errors of manually entering blood results. 3. Reduction in duplication of tests – not just for DMARDs, but for anticoagulation, practically all of chronic disease management which require monitoring of bloods. 4. As CQC searches rely on information on EPR rather than ICE (for the specific metrics in relation to medicines monitoring), some practices will see their monitoring data improve significantly. The LMC are very supportive of this and first mentioned this in 2019. Recent correspondence from IT at STHFT has informed that they are unable to progress this, due to the ongoing work STHFT with new systems. SK informed the group that Andrew McGinty is in contact with Dr Krishna Kasaraneni from Sheffield LMC and will be in a position to decide to push forward, if the benefits to patient safety are thought to be significant. **NFA for APG at this time.** **Repeat Prescriptions: allow 7 days for prescriptions to be processed** The SY Community Pharmacy Forum took a paper to the SY Primary Care Provider Alliance about a campaign to reduce pressures on primary care repeat prescribing and reached an agreement that 7 calendar days should be allowed for repeat prescribing to be processed. The alliance will produce some communications for General Practice, Community Pharmacy, and patients on what would be the gold standard. Details on those communications are not known at this time, SK will confirm for next APG. TE commented on the current pressures but that patients can find ordering their repeat medicines challenging, especially those who do not have the facility to order on-line. HeiT advised that data on percentage of patients that order their repeat prescriptions on-line is available and will bring that information to July APG. **Update for July APG.** HeiT advised the group that this was to be David Russell's last meeting, but, unfortunately, had to send apologies. The LPC now have one committee over SY and so David will no longer be representing that committee at APG. APG would like to thank David for the valuable contribution and support he has given to APG over many years. HeiT advised that APG has requested support from SY LPC and Thomas Bisset will be that representative but, it is not clear if he will be available to attend every meeting.	SK HeiT

17.	**Date of the next meeting:** **20th July 2023 1:30 via MS Teams**	

Summary Points and Recommendations

June 2023

IMOC approvals	• SY Gluten Free Guidelines – Agreed with changes (May 23)
IMOC TLDL approvals	<u>May 2023</u> • Ogluo- Agreed Amber G – To be discussed at Place how this is implemented • Cyanocobalamin- Agreed dual Traffic Light status Grey and Green • Covid-19 vaccine (VidPrevtyn Beta®) 10 dose multi-dose vial (VidPrevtyn Beta®)- Covid 19 vaccine agreed as Green Traffic Light Status • Elasomeran + davesomeran (Spikevax® bivalent Original/Omicron BA.4-5) Single dose and 5 dose multi-dose vials (new booster formulation of Spikevax®) – Covid 19 vaccine agreed as Green Traffic Light Status • Casirivimab plus imdevimab, nirmatrelvir plus ritonavir, sotrovimab and tocilizumab for treating COVID-19 - Red Traffic Light Status
Shared care/Prescribing Guidelines	• Semaglutide (Wegovy®) Holding Statement to support Sheffield Primary Care – Update approved • Medicines with teratogenic potential: what is effective contraception and how often is pregnancy testing needed? Guidance for primary care clinicians – Update approved • Advice on Vitamin D Requesting in Adults - approved by FSG under delegated authority of APG • Dexcom ONE Position statement – update approved by FSG under delegated authority of APG • Falls risk. Updated the link to the PrescQIPP IMPACT bulletin on the Intranet and the link to that bulletin within the Reducing medication related falls risk in older adults' document - approved (virtually) by FSG under delegated authority of APG • Palliative care - update to community pharmacy stock list and opening times - approved (virtually) by FSG under delegated authority of APG
Traffic Light Drug List	None for this meeting

Sheffield Formulary Updates	• Chapter 4: CNS - approved • Chapter 6 Endocrine – 6.4.1,6.4.2 – minor amendment approved (virtually) by FSG under delegated authority of APG
Other	