NHS
South Yorkshire
Integrated Care Board

Minutes of the Meeting of the Sheffield Area Prescribing Group
18th May 2023

Present:

Dr Andrew McGinty.GP and joint Chair of APG, 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
David Russell. Community Pharmacist and Chair of Community Pharmacy Sheffield.
Andrew Moore. Deputising for STHFT Chief Pharmacist.
Dr Trish Edney. Lay member. Healthwatch representative
Helen Taylor. Clinical Effectiveness Pharmacist, NHS South Yorkshire ICB
Mr Veeraraghavan Chidambaram-Nathan. Consultant representative STHFT
Helen Caley. PCN Pharmacist representative
Dr Lydia Mawer. GP and Representative of Local Medical Committee.

Absent

Dr Zak McMurray. Medical Director and joint Chair of APG, NHS South Yorkshire ICB
Dr Laura Smy. GP and Representative of Local Medical Committee.
Dr Rhona Leadbetter. GP, NHS South Yorkshire ICB
Heidi Taylor. Deputy Director, Medicines Optimisation Team. NHS South Yorkshire ICB
Dr Jonathan Mitchell. Consultant representative, Sheffield Health & Social Care FT
Joanne Wragg. Director of Pharmacy, Sheffield Children's FT

In Attendance:

Deborah Morris. Clinical Effectiveness Technician. NHS South Yorkshire ICB
Dr Elizabeth Dunningham, observing.
Dr Song. Consultant Diabetologist, STHFT
Robina Okes-Voysey. Pharmacist, NHS South Yorkshire ICB
Deb Leese. Pharmacist, NHS South Yorkshire ICB

		ACTION
1.	**Apologies for Absence**	
	Apologies for absence have been received from, Dr Z McMurray, Dr Laura Smy, Dr Rhona Leadbetter, Joanne Wragg and Heidi Taylor 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 Sheffield Clinical Commissioning Group (CCG). 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 CCG's Register of Interests. The Register is available either via the secretary to the meeting or the CCG website at the following link: http://www.sheffieldccg.nhs.uk/about-us/declarations-of-interest.htm No, new declarations were made for the meeting today.	
8.1	**Protocols and Prescribing Guidelines**	
	Management and care pathway for young people with type 2 diabetes in Sheffield. This item was first brought to March APG where certain points were raised. SS and ROV have returned to APG today advising that those points have been addressed. SS advised the group that an update to the Diabetes (type 1 and type 2) in children and young people: diagnosis and management, was published on 11th May 2023 which advocates using GLP-1 receptor agonists after metformin. SS recapped that the aim of this proposal, a guideline for young adults aged between 18 and 39 years, is to have a pathway that focusses on key areas of clinical management particularly obesity, mental health, glycaemic control, CVD risk factors, co-morbidities, and structured patient education. SS responded to a point raised at the March APG meeting regarding CVD risk; if the lifetime risk is high, as stipulated in NG28, the first offer will be an SGLT2 inhibitor. SS informed the group that for patients who are obese, to consider a GLP-1 agonist or SGLT2 inhibitor and that the offer would depend on the lifetime risk and the patient's choice, emphasising that the non-therapeutic support is essential for this cohort. AMcG passed on comments from HeiT, who was unable to attend APG today. Some of the potential expense generated by following the proposed pathway may be offset, this is because many of the patients, in the obesity arm of said pathway, would be eligible, in line with NICE TAs for semaglutide and liraglutide, for a GLP1 if they weren't diabetic. A further comment from HeiT, around semaglutide (Wegovy®), although it is unlikely that (Wegovy®) will be available until early 2024, it is suggested that the pathway could be amended to accommodate this. The final point raised by HeiT was to check that Dr Rajiv Gandhi, clinical director of diabetes and endocrinology and the DSNs have been contacted to ensure there is capacity to accommodate this pathway. SS replied that Dr Gandhi has confirmed his support and SS has forwarded the email from Dr Gandhi to HeiT to confirm this.	

	SS went on to comment on the positive effect, backed by data, of semaglutide (Wegovy®) for weight management. As there is a lack of tier 3 and 4 services and as the criteria for the use of Wegovy® appears less stringent than for liraglutide (Saxenda®), it may not be necessary to have a tier 3/4 service for Wegovy®, as long as there is an MDT, which already exists with a diabetologist, dietician and psychologist, who could work with the weight management services in the community. It is felt that, as HeiT proposed, that for young T2 diabetics with a BMI >35, which equates to about 600 patients in Sheffield, this cohort could potentially be offered Wegovy® with a weight management programme which would improve diabetic control. AA and VN joined the meeting. LM commented/raised questions, on behalf of the LMC. Noting the suggestion that a proportion of the funding could come from the weight management scheme but, as the tier 3 service is not yet operational, the funding would come, in full, from the diabetes service. LM then asked if overweight patients, who are not T2 diabetics, would have to go through the tier 2 scheme before being considered for a GLP-1 agonist, and would this also be the expectation for T2 diabetics? If this is the case, what are the options if they were to refuse engaging with the tier 2 scheme? SS responded, yes, the patient would have to go through the tier 2 service first. If the patient doesn't comply with the tier 2 service, it is difficult but the guideline would be followed, and the GLP-1 agonist would be stopped. SK added that STHFT has been selected, as one of two centres nationally, to receive funding from NHSE for 2 years, for an extra service. This funding will cover various aspects e.g. psychological and dietary modification services. SS added that the pathway will be amended to reflect this funding/extra service for the 18- to 25-year-old patients. **APG approve the pathway**, subject to the amendment above. SK added that it would be appreciated if, in 6 months, to take stock and to receive an audit of prescribing and potential weight reduction relating to the service.	SS/ROV/ Chloe Bullen ROV/ Chloe Bullen
3.	**Minutes of the April Area Prescribing Group**	
	The minutes were agreed as an accurate account of the meeting. See below for comments on the Dapagliflozin▼ and Empagliflozin▼ guidance.	
4.	**Matters Arising**	
	REVIEW DOAC Position statement It has been noted that since this statement was issued in May 2022, the IIF indicators have been retired for 23/24. Another consideration is that it was understood that edoxaban was going to be the most cost effective DOAC until well into 2024 but, there has been an update on apixaban with a possible generic becoming available, though there is an ongoing legal issue with regard to this. SK added that the issue on cost effectiveness and generic availability is	

	being queried with NHSE. **APG will be updated in June.** **Dapagliflozin▼ and Empagliflozin▼ in Heart Failure with Reduced Ejection Fraction (HFrEF) in patients with and without Diabetes Mellitus: guidance for primary care.** LM raised the issue of GPs providing the first prescription and asked why this has not been removed from the guidance. HelT replied that Riz Iqbal was unable to attend todays meeting but, it is understood that this will be looked into further. It is known that secondary care do not always find it easy to issue the first prescription and it has, at the moment, been left in the guidance as some heart failure specialist nurses are not prescribers. LM reminded the group that the LMC have said that when a secondary care service has not been set up to include a prescriber it should not be the problem of primary care to fill that gap and issue the first prescription. The LMC want the line on primary care issuing the first prescription removed from the guidance. HelT added that other wording in the guideline, regarding renal impairment, needs amending and this will also be followed up and so a final version will be coming back to APG and in addition, the LMCs comments will also be taken back to secondary care. **Issue of STHFT OPD prescriptions** This item came about when discussing the Dapagliflozin▼ and Empagliflozin▼ shared care and the issuing of the first prescription. It was asked if there was any progress or news on the potential for electronic prescribing. AM fed back the conversation to Graham Marsh, Chief Pharmacist STHFT, but has not yet been able to give an answer. **APG will be updated when more is known.** **Update to End of life care algorithms regarding the Pink Card** This update does not involve any clinical content and no change to the process for Primary Care. This change is to ensure timely access to end-of-life medication. **APG approve the update.** There has however, in relation to the recently approved **Pink Card Procedure,** been further amendments to the Pink Card which was not seen by APG. HelT advised the group that she will pick this up with Fiona Stephenson, Palliative Care Pharmacist at STHFT, as it is understood that it is ready to go for printing. HelT will obtain the final version and liaise with AMcG who will give Chairs approval. LM asked about adding information on regular sub-cutaneous medication to the Pink Card. HelT confirmed that this is covered in the procedure, with advice to use the Green Drug Administration Card. **Post meeting note:** At the June APG, HelT queried the above and 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. Helen has asked a colleague for a copy of the Pink Card at Barnsley to compare but	HelT/RI HelT/AMcG

	not had a reply yet. HelT has followed up with email to Lydia Mawer and Fiona Stephenson.	
5.	**Medicines Management Safety Issues**	
	Medicines Safety update. An update will be available for the June APG meeting.	
6.	**Pharmacy and Prescribing Commissioning Group Feedback**	
	AMcG gave a summary of items discussed including the • Semaglutide (Wegovy®) – Holding statement to support Sheffield Primary Care • TLDL classification of icosapent ethyl, approved as Amber • IMOC outputs, including the Gluten Free guidance • Ogluo, IMOC approved a TLDL classification as Amber G And reported that PQIS is being progressed for next year.	
7.	**Formulary Sub-group**	
	Draft minutes of the May meeting HelT gave an update of the meeting, advising that a first draft of the **CNS chapter** was discussed and supported. **The commissioning recommendations following the national assessment of blood glucose and ketone meters, testing strips and lancets** was discussed. Sheffield is not in line with one product (TEE 2) and as described in the FSG minutes, secondary care have been contacted to look at the options. It is known that there are drug companies approaching GP surgeries offering to switch patients but, as discussed at the APG learning lunch, the message has gone out to practices to wait until discussions with secondary care on Sheffield choices, are finalised. LM asked about the rosuvastatin item in section 4 of the **FSG minutes and the reference to the Amber TLDL classification**. It was explained that this referred to the **fibrates** and the minutes will be amended to clarify this. LM also commented on the **FSG minutes** (page 9) where it was reported that ***there should be no obligation for primary care clinicians to prescribe outside the licence***. The LMC assumed this referred to ondansetron but with regard to shared care and requesting GPs to prescribe off-label medicines e.g. drugs for gender dysphoria, the question asked is, what is the view of APG regarding that statement in relation to other off-label drugs. AMcG replied that there was a conversation with Dr Alastair Bradley, Chair of Sheffield LMC, around indemnity from CNSGP for shared care guidance and drugs used off-label, not off-licence. AMcG contacted CNSGP who responded that off-label prescribing would be covered by the crown indemnity that it provides. AMcG commented that GPs will, not infrequently, prescribe off-label e.g. amitriptyline. If a GP is asked to prescribe an off-label medicine that they do not feel confident to prescribe, that a conversation with the requestor would be needed, as is covered in the GMC Good Prescribing Guidance.	

	Matters approved by FSG under delegated authority (for information): • Guidance on prescribing Specials • To update Chapter 7 with information on vacuum pumps **Matters approved by virtual agreement under delegated authority (for information):** • Amendment of Chapter 6 section 6.4.1 and 6.4.2 relating to HRT	
9.	**Traffic Light Drug List**	
	None for this month	
10.	**Integrated Medicines Optimisation Committee (IMOC)**	
	Minutes **Ratified minutes of the April meeting** were received. **IMOC approvals** • Efmody® - agreed Amber Shared Care, Sharron Kebell and Dr Debono to be informed (April 23) • Parkinson's Shared care protocol to remain Amber (April 23) • SY Gluten Free Guidelines – agreed Amber G (April 23) • Safe and Effective use of SGLT2i's Proposal Form- Rotherham and Barnsley to review and feedback at next meeting (April 23) • IMOC vs Place document approved (April 23) LM asked about the item 4/23/9 in the IMOC minutes, relating to **oral COVID drugs** and the shift of work moving from secondary to primary care. AMcG responded that it is understood that work is on-going to find a solution to have this delivered in Sheffield via the palliative care pharmacies, it will not be General Practice who will be providing this service. **IMOC TLDL** SK informed the group that it is the aspiration to have one TLDL across SY and IMOC now have the beginnings of a SY TLDL. Whilst in the process of IMOC developing the list, all new additions and amendments will go on that IMOC list and so Sheffield clinicians will be advised to refer to both the Sheffield and the IMOC list. There will be links to the IMOC list, added to the Sheffield TLDL Intranet page soon.	
11.	**RMOC.**	
	No updates.	
12.	**NICE Guidance**	
	NICE summary for April SK highlighted the following: **NICE TA 878 (update) Casirivimab plus imdevimab, nirmatrelvir plus ritonavir, sotrovimab and tocilizumab** for treating COVID-19. **AposHealth for knee osteoarthritis,** a non-invasive device worn on the feet. SK will be looking into this. **NG133 (Update) Hypertension in pregnancy: diagnosis and management.** This useful, visual summary has been added to the	

	medicine's optimisation page of the Sheffield Intranet.	
13.	**APG Mailbox.**	
	Communication on patient discharge from STHFT An email was received from a practice pharmacist who highlighted an incident where a patient, who uses a NOMAD, was discharged without the community pharmacy being made aware. This resulted in the community pharmacy supplying an incorrect NOMAD to the patient. The same pharmacy then experienced the same situation when another patient was discharged without correct notification to the community pharmacy. These incidents took place in December 2022 and February 2023. The practice pharmacist has been in contact with Amanda Plummer STHFT Pharmacy Clinical Services Manager who has investigated and resolved these incidents. EP has recently been sent details of an error by the medicine's safety officer at STHFT, where a community pharmacy had continued to supply a NOMAD without taking into account the drug changes made on discharge. EP has been asked to contact the community pharmacy as it was thought that the error was with the community pharmacy, though this has not been established. EP will liaise with Amanda Plummer. DR added that community pharmacy is often unaware if a patient has been admitted and increasingly, practices are issuing 12 week repeat dispensing prescriptions so this may potentially cause problems. DR asked that if any incidents had arisen due to this, to let him know.	EP
14.	**Reports from Neighbouring Committees**	
	Rotherham MOG minutes, March 2023 **Doncaster & Bassetlaw APC minutes March 2023** The group received the above reports.	
15.	**Never Events and Sis.**	
	None reported.	
8.	**Protocols and Prescribing Guidelines**	
	Sheffield Asthma Guideline DL presented the proposal for the new asthma guideline which covers all age groups. It has been developed in conjunction with SCFT and STHFT and has input from primary care clinicians. This new guideline is longer than the old version but contains extra information to support prescribing choices and has been designed so that the tables and algorithms, within the guideline, can be printed off and laminated for ease of use. The front, contents page offers hyperlinks to the various sections of the guideline and useful links to other guidance e.g. on acute asthma, pregnancy and multilingual videos on asthma, for patients use. On page 2 there are updated sections on diagnosis and, review and management.	

	Page 3 has a new section; Aiming for Complete Control – Good Respiratory Care is Green Respiratory Care, this links to the Asthma Right Care work and highlights that the Global Initiative for Asthma (GINA) advise that for best outcomes, ICS-containing controller treatment should be initiated as soon as possible after diagnosis. The Personalised Asthma Action Plans section has been updated to make it clear at which point patients fall into the amber and red zones. The most significant changes to the guideline are the treatment algorithms. The flexible regimen is the GINA preferred regimen, and it is being put forward as the locally preferred regimen as there is a lot of evidence for both, as needed anti-inflammatory reliever use and MART regimes, in terms of exacerbation reduction and better outcomes. The box at the top of page 4, As needed anti-inflammatory (ICS/formoterol) reliever, was not in the previous guideline. DL explained that in March, Symbicort® received a licence for as needed anti-inflammatory treatment and is also what GINA had been recommending for a while. Now the UK has the licence it has fallen into place for inclusion in this new guideline. As far as DL is aware, Symbicort® will hold that licence exclusively for 12 months. DL explained that Symbicort® can be taken up to 8 puffs daily, and rarely 12 puffs may be needed, for patients who are 12 years and over. The algorithm states, in red writing that *This step is intended for infrequent symptoms – regular use indicates step up is required. Patients using 4 or more puffs/day persistently require review – step up or add on treatment may be required* DL asked the group for comment and opinion on the *4 or more puffs/day persistently* as she has deliberated whether this should read *3 or more puffs.* 4 puffs were considered a medium dose, and as agreed with STHFT, the term ‘persistently’ was agreed in favour of a specific number of days. There is also a warning to *Seek urgent medical advice if you are unwell or needing 8 or more puffs a day.* The algorithm moves on to Low Dose MART, which is where patients with regular symptoms would start. Then Medium Dose MART and then High Dose, (not MART) with referral to specialist care. This treatment algorithm has additional information on add-on therapies e.g. the addition of montelukast at different points. There is a section on SABA and Flexible Regimens, advising that most flexible regimes should be SABA free; ICS/formoterol inhalers can be used for emergency used.	

	Treatment algorithm 2 is the traditional regimen, the key difference is that there is no place for SABA to be used alone. The next page is a table which gives the low carbon footprint DPIs and SMIs Inhaler Choices. New inhalers are included which will be added to the formulary including the ICS/LABA Easyhaler. The high carbon footprint pMDIs are in the next table which has the addition of Kelhale which is a cost-effective version of QVAR fine particle beclomethasone. Combisal pMDI 125mcg and 250mcg join Combisal 50mg, already on the formulary for younger children. In an ideal word, DL explained that it is not the preference to have a salmeterol containing inhaler on an asthma guideline, salmeterol is a partial beta-agonist and often has more systemic effect; there are better options, however, there is a need to have a licensed product for the younger age group and it adds uniformity to the formulary. On page 8 there is information on MART regimes and makes clear that the higher strengths are not licenced for MART. Then there are Cautions and Considerations, which now link to the MHRA, reminding of the risk of neuropsychiatric reactions to montelukast. Finally, there is the children's algorithm, which is similar to previous guidance. DL drew the groups attention to one aspect which is slightly outside of the British Thoracic Society (BTS) guidance. The Sheffield guidance states that a very low dose ICS is stepped up to a low dose ICS/LABA whereas the BTS guidance advises a step up from a very low dose ICS to a very low dose ICS/LABA, before a step up to low dose. DL explained that the problem with this is that there is no licensed combination at appropriate strength i.e. there is no very low dose ICS/LABA. Combination inhalers are being promoted in order to prevent LABA use without ICS for children, which is supported by SCFT. The final table shows licensed inhaler choices for children under 12 years. Although it is clear that a pMDI plus spacer is the preferred delivery method in children under 12 years, DPIs are included as they may be appropriate for some children e.g. for children in the 11/12 year age groups during that transition period from primary to secondary school. Page 11 has a glossary of terms and abbreviations used in the guideline and a table of the active ingredients in inhalers. AMcG asked if, in the section on the flexible regime, that although it is implied, does it need to be explicit that an annual review is required. DL agreed to add this information. AMcG and LM commented on the value of being able to print off and laminate the tables and algorithms within the guideline and asked if the Sheffield place ICB could provide practices with laminated colour copies. General practice won't usually have the facility to colour print those	DL DL

	documents and having them in black and white loses some of the impact. DL will investigate if this can be done. DL informed the group that there will be a number of educational events to promote and support the use of this guideline and has made the offer to attend each PCN to further promote and support the guideline. HelT asked about a link to the GINA website dated 2022, DL will amend as GINA 2023 has just become available. DL asked that APG comment on the question asked earlier on if *4 or more puffs/day persistently* is acceptable. APG agreed that 4 puffs should stand, as also supported by the specialist and there is probably no significant difference in clinical outcomes between 3 and 4 puffs. TE raised the point that it would be useful to give guidance to practice reception staff, who triage patients calls, as this could enable them to identify those patients who have stepped up their inhaler use and need to be seen by a clinician. DL agreed that this is important and may look at producing a short guide for practice staff and perhaps look at offering a tailored education event. AMcG added that although JW was unable to attend the meeting today, she has sent word that she has read the papers for today's meeting and has no objections to any proposal pertinent to SCFT. **APG approve the guideline** with the minor amendments agreed above. DL left the meeting.	DL
16.	**Any Other Business**	
	AMcG informed the group of the following **agreements at the IMOC meeting in May:** • Ogluo- Agreed as Amber G – This is to be discussed at Place, on how it is to be implemented –Jill Rigby will work with SCFT to produce a local guideline to explain when this may get issued (e.g. those at risk of severe hypoglycaemia). With the use of insulin pumps and CGM, it is hoped that the need to prescribe injectable glucagon is reduced. • Cyanocobalamin - Agreed a dual Traffic Light status, Grey (for self-care) and Green (if deficiency) – noting that this is using an oral supplement over and above the licensed product. IMOC noted that IM has the best evidence. • Casirivimab plus imdevimab, nirmatrelvir plus ritonavir, sotrovimab and tocilizumab for treating COVID-19 - Red Traffic Light Status until movement from CMDUs to primary care is in place. DR informed the group that **Community Pharmacy Sheffield will cease to be at the end of June 2023**, there will be a merged Community Pharmacy South Yorkshire committee. DR will pass on the new email address for that new committee so that APG papers can be shared. DR is unsure if who will be attending APG, DR's last APG meeting will be June 2023.	DR
17.	**Date of the next meeting:** 15th June 2023. Virtual meeting1:30 via MS Teams	

Summary Points and Recommendations

May 2023

IMOC approvals	• Efmody®- agreed Amber Shared Care, Sharron Kebell and Dr Debono to be informed and complete (April 23) • Parkinson's Shared care protocol to remain Amber (April 23) • SY Gluten Free Guidelines – agreed Amber G (April 23) • Safe and Effective use of SGLT2i's Proposal Form- Rotherham and Barnsley to review and feedback at next meeting (April 23) • IMOC vs Place document approved (April 23) • SY Gluten Free Guidelines – Agreed changes (May 23)
IMOC TLDL approvals	• 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	• Management and care pathway for young people with type 2 diabetes in Sheffield – Approved • End of life care algorithms - Approved • Guidance on prescribing Specials – Approved by FSG under the delegated authority of APG • Sheffield Asthma Guideline - Approved
Traffic Light Drug List	None for this month
Sheffield Formulary Updates	• Update to Chapter 7: information on vacuum pumps - Approved by FSG under the delegated authority of APG • Amendment of Chapter 6 section 6.4.1 and 6.4.2

	relating to HRT - Approved by FSG under the delegated authority of APG
Other	None for this month