NHS
South Yorkshire
Integrated Care Board

Minutes of the Meeting of the Sheffield Area Prescribing Group
21st September 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
Joanne Wragg. Director of Pharmacy, Sheffield Children's 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
Mr Veeraraghavan Chidambaram-Nathan. Consultant representative STHFT

Absent

Dr Zak McMurray. Medical Director and joint Chair of APG, NHS South Yorkshire ICB
Helen Caley. PCN Pharmacist representative
Abiola Allinson. Chief Pharmacist. Sheffield Health & Social Care FT
Helen Taylor. Clinical Effectiveness Pharmacist, NHS South Yorkshire ICB
Dr Jonathan Mitchell. Consultant representative, Sheffield Health & Social Care FT
Thomas Bisset. Community Pharmacy South Yorkshire representative

In Attendance:

Deborah Morris. Clinical Effectiveness Technician. NHS South Yorkshire ICB
Augustinas Slucka. Pharmacist, NHS South Yorkshire ICB
Richard Crosby. Head of Practice Support, NHS South Yorkshire ICB
Elizabeth Webster, Senior CNS Early Pregnancy, STHFT
Emily Udale, Lead Pharmacist for Women's Health, STHFT
Hilde Storkes. Formulary pharmacist, NHS South Yorkshire ICB

		ACTION
1.	**Apologies for Absence**	
	Apologies for absence have been received from, Dr Z McMurray, Helen Caley, Abiola Allinson and Helen Taylor The Chair declared the meeting was quorate.	
2.	**Declarations of Interest**	
	No addition declarations were made.	

7.1	**Formulary subgroup**	
	Chapter 13 Skin and the Abbreviated guide to emollients: Emollient bath additives. This proposal is to amend the Sheffield Skin Formulary and Sheffield Abbreviated Emollient Guide with a change to the position statement on emollient bath additives, this is in response to the update to NICE CG57. NICE have reviewed the evidence on emollient bath additives and updated their recommendations to, *do not offer emollient bath additives to children with atopic eczema*. Following discussions with specialists at STHFT and SCFT, AS explained that an agreement was reached that primary care would not initiate bath emollients or additives but, secondary care specialists would still initiate for those complex cases under their care and ask primary care to continue that prescribing. Treatment initiated in Primary Care would be regular emollients to be used as soap substitutes/bath additives. The wording in both the formulary chapter and the abbreviated guide will be amended to read *Do not prescribe bath emollients or additives unless recommended by specialist dermatology services.* LS asked if there had been discussion with the specialist on the choice of brand of bath emollient or additive, as these products have been removed from the formulary. LS also asked if the specialist could be directed to use the most cost-effective brands as the choice of brand will impact the GP budget though, as mentioned in the proposal, if the STOP list is amended to reflect this proposal, that would be welcomed. LS highlighted that on page 12 of the formulary chapter the advice that Epimax® cream suitable for use in the shower, is duplicated. AS agree to correct this. JW advised that the SCH choice of brand is made as the specialist will use a brand that the GP has already tried and which the patient has not benefitted from. This may not be scientific, and the group acknowledged that AS may, in future communications with specialists, discuss further the selection of cost-effective choices. AS acknowledged that this proposal is a compromise and that the conversation with the specialists will continue. The reason for removing the bath emollients and additives was to discourage prescribing, but if it is thought to be the wrong decision, they can be reinstated. (The group did not explicitly request that they should be reinstated). RL asked that, on page 12, to avoid ambiguity that the sentence *Do not prescribe bath emollients as per Sheffield STOP list.* is amended to read *Do not prescribe bath emollients; as per Sheffield STOP list.* TE commented that it should be acknowledged that some patients will not have the financial ability and therefore choice to purchase bath emollients and additives. TE also asked that in addition to the warnings in the documents that leave-on emollients may make surfaces slippery, it is made clear that when using those preparations on children that the child	AS AS AS

	also becomes slippery and to highlight the associated handling risks. HeiT added that national guidelines state 'do not prescribe' bath emollients and additives, yet specialists say that some severe cases benefit from bath emollients and additives. Sheffield has a STOP list and there is a national 'do not prescribe' list, which predates the NICE CG57 (Update 7th June 2023) but Sheffield is still an outlier in prescribing. HeiT does not think this this proposal will make a difference to who the specialist will prescribe for, and that Sheffield will continue to be an outlier in prescribing bath emollients and additives and NHSE will be asking why. HeiT acknowledged that AS had made significant inroads in engaging with dermatology specialists and the limitations of the BATHE study. HeiT also raised the issue of the TLDL classification and aligning the TLDL across SY ICB. Rotherham, Barnsley and Doncaster have bath emollient and additives as 'do not prescribe' and Sheffield allow prescribing for a specific cohort. HeiT suggests that this proposal is also discussed at IMOC as the specialists will see patients from neighbouring places which will result in inequity. HeiT asked if it is known what the proportion of prescribing of bath emollient and additives in primary care was initiated in secondary care and primary care and, will the prescribing initiated in primary care be stopped and switched to a soap substitute? AS replied that information on the percentage of who initiated treatment is unknown but would look to see if this could be found. With regard to the TLDL, the first stage of the conversation was to get to the compromise reached, as it was judged that this would facilitate further discussions. AMcG reiterated that this proposal is not an end point and that this a compromise enroute to aligning Sheffield with national guidance and comparable prescribing with equally challenged, nearby, populations. **APG approve the proposal.** **Post meeting note.** For clarity, there is currently no plan to stop prescribing of emollient bath additives that have not been initiated by a specialist, as recorded in the September 2023 FSG minutes.	AS
8	**Protocols/Prescribing Guidelines**	
	Generalised Anxiety Disorder (GAD) guideline This proposal has been made as the guideline is due for review, the review has resulted in a few minor amendments and the guideline has been restructured to allow for a better flow of information, although it looks different to the previous version the majority of the content remains the same. AS summarised the main changes which include the links in the guideline have been updated, references to fax machines have been removed and details of how the services prefer to receive referrals have been updated. There is additional information on addiction and withdrawal of benzodiazepines and pregabalin, mainly in the Drug Treatment for GAD section.	

	It has also been added that antipsychotic therapy is no longer recommended in primary care. AS advised APG that the Depression Guidelines will be ready for APGs consideration next month. **APG approve the updated guideline.** AS left the meeting.	
3.	**Minutes of the July Area Prescribing Group**	
	The minutes were agreed as an accurate account of the meeting.	
4.	**Matters Arising**	
	Where can I get help with my medicines? This Patient information leaflet and a tri-fold printable version, previously seen at APG, is now available on the Sheffield place Intranet. The leaflet is also available in hard copy and has been distributed to a number of social care, GP and Community Pharmacy settings where the leaflet has been well received. **NFA for APG.** **Acarizax® SLIT and NICE update.** SK updated APG on how NICE has progressed with its appraisal. SK has contacted clinicians at STHFT and SCFT confirming that there is no news and NICE has still not published. STHFT and SCFT are preparing to audit the treatment success, or otherwise. **An update for APG will follow when more is known.** **Varicella (chicken pox) vaccine.** This proposal first came to APG in January 2023 and today RC is updating the group on the advances made with the proposal. RC commented that there is no doubt around the clinical case for using the vaccine prior to being immunosuppressed. The question of where administration of the vaccine is carried out and the TLDL classification is the issue. The vaccine requires 2 doses, for both adults and children, currently adults are either receiving the vaccination from the Travel Clinic, where 5 patients were seen for this vaccination in a 12-month period, or their GP, where 22 items were prescribed in a similar 12-month period. For children, there is no Travel Clinic option. The GP is being asked to prescribe. RC advised the group that Leeds and York classify the vaccine as Amber. More locally there is less certainty: • Rotherham ICB place: No consistent agreement of prescribing and supply and is without access to a Travel Clinic, like that which is set up in Sheffield. • Doncaster: It is likely that in the main, patients will be commenced on biologics by SCFT but is not sure what arrangements for chicken pox vaccination are in place. • Barnsley: It is likely that in the main that patients will be commenced on biologics by SCFT but not sure what arrangements for chicken pox vaccination are in place.	

	• Derby ICB: Similar situation to Sheffield RC reminded the group that there is clinical risk around confusing the shingles vaccine with the varicella vaccine. Questions on reimbursement have been asked, at very high level, and differing answers have been given. Clarity on some of the information requested on this proposal has been received since this paper was circulated, it now is clear that there is a list of vaccinations, which are part of the global sum, and will attract an item of service (IOS) fee but the varicella vaccine is not on the list and does not attract an IOS fee. The varicella vaccine can be bought in by general practice at a cost of £30 but would be reimbursed less, at £27.37. It can be prescribed on FP10 which would be cost neutral but administering the vaccine would not attract a fee. Abigail Tebbs, Deputy Director of Primary Care, has recently been contacted to ask if a locally commissioned service could be put in place and an answer is awaited. This situation has been escalated to ask if there is a national solution which would be a preferable option. RC concluded that in view of the current situation, and the request for an Amber TLDL classification, that this proposal may not be acceptable to all. LS commented that it would seem sensible that the specialist centres should be commissioned to administer the vaccine. The reasons for this are because the overall numbers requiring the varicella vaccine in this situation is small. It would be a lot of work to ask every surgery to be adequately informed, have the training associated with administering the vaccine, plus the additional administration involved. LS added that the fact that it is not in the global sum, indicates that it is not core contract. JW agreed that SCFT would need to be commissioned to provide the service. HeiT commented that it can be difficult to understand where commissioning of a service sits. Reminding the group that APG aims to keep in mind the best pathway for the patient. If it isn't clear where commissioning falls, that would be picked up by PPCG. There is some work being carried out on shared care, when commissioning may or may not be needed and what is and isn't in core contract and the conversations, as APG have just had, is being replicated at every ICB and, as every workforce is stretched it is a struggle to identify where responsibility lies. In this case there is a situation where some adults are accessing the Travel Clinic but for children it is a case of hoping that primary care will prescribe and administer this vaccine. HeiT added that, as raised by LS, that it is not just about the financial reimbursement it was also about the safety and training to administer. AMcG added that by centralising this service the risk of inadvertently	

	selecting the wrong vaccine would be reduced. LS reiterated that it is understood that secondary care is not commissioned to provide this service and nor is primary care. It appears that this proposal is asking primary care to provide a service that it is not commissioned for which is inappropriate and unfair. SK commented that the greatest risk is for children and there have been mistakes with the varicella vaccine and shingles vaccine being mixed up. SK asked if it could, in the interim, whilst remuneration is being arranged, be looked at to improve the methods of communications between the SCFT clinicians and GPs, if they are continuing to ask GPs to administer the vaccine. RC added that the situation has progressed and at the time of developing this proposal it was not the intention to burden primary care, it was initially advised that the administration of this vaccine attracted an IOS fee. LS asked if there was a possibility of the Travel Clinic seeing under 18s? AMcG concluded that it was not the remit of APG to provide a solution to commission this service, APG are asked to approve the TLDL status of Amber. It is clear from comments today that approval has not been given and this needs to be taken to PPCG, as something needs to be enabled to get the vaccine deployed safely. **APG do not support the proposal to TL as Amber.** The vaccine will remain as Red and APG will be updated of PPCG deliberations in due course. HeiT added that it is IMOC that will approve a TLDL classification, so the proposal should also go to IMOC with the suggestion from Sheffield that, at the moment, subject to an update from PPCG that Sheffield consider this is Red on the TLDL. RC left the meeting.	RC/SK
8.1	**Protocols/Prescribing Guidelines**	
	Progesterone (Cyclogest®) pessaries for prevention of threatened miscarriages in patients at high risk, for up to 16-week gestation. EW and EU joined the group to present this proposal. This proposal follows the NICE NG126 recommendation that patients at high risk of miscarriage have micronised progesterone pessaries, 400mg twice daily for up to 16 weeks gestation. The proposed plan is for Cyclogest® to be initiated by STH and to be used in the following circumstances: • A threatened miscarriage – patient has vaginal bleeding in early pregnancy (up to 13 weeks gestation) AND • a confirmed intrauterine pregnancy AND • has previously had one or more miscarriages.	

	The proposal is that STH will provide a 2 week supply via prescription, written by the on call medical team and notify the GP by post or via ICE, that treatment has commenced. The patient will attend a rescan in 7 to 14 days and if it shows a viable pregnancy, a further 2 weeks supply of progesterone will be given. A discharge letter will then be emailed to the GP, or via ICE, asking the GP to continue to supply until week 16 gestation. LS asked if it would be recommended that the GP issues the prescription at 2 weekly intervals and is the issue why STHFT can't continue to prescribe about drug wastage. EW commented that 2 weekly would be sensible in case the patient miscarries. RL asked how the unit are currently providing prescriptions. KW replied that it is Ad Hoc, and the GP is being asked to continue to prescribe to 16 weeks and to contact the ward with any concerns or issues. HS added that, picking up on the point of frequency of prescriptions, earlier this year when this was discussed at FSG, it was thought that it would be advisable to set up the prescribing as a repeat dispensing (RD) item on a 2-week interval with a limited duration of up to 16 weeks as this would stop the risk of continued, inappropriate, prescribing. HS informed the group that a straw poll of surrounding ICBs and Trusts to see what happens elsewhere it was found that there was a wide variation, some had a Red TLDL classification, some a Green classification. Some ICBs thought it inappropriate to have a SCP, as no monitoring is required by the GP, but some guidance may be helpful for e.g., advising about RD. West Yorkshire gave some helpful advice, as about a year ago they started a system where prescribing is started by the specialist and continued by the GP and there have been no reported concerns from GPs in that area. HS asked EW about the indication beyond NICE, EW confirmed that those patients would be treated as per a consultant decision, as the evidence for use is not currently there. AMcG raised concerns about RD as the items could still be dispensed, unless actively removed from the patient's clinical system record and with regard to the communications to the GP, it would be preferable to have just one option, postal letter or via ICE, not both, as this causes extra work for practices. The communication to GPs would also need to be clear that RD would need to be cancelled when prescribing ceased. HeiT asked about the group of patients that go beyond NICE and for clarification that, for those patients that there will be no request for primary care to prescribe and secondary care will retain that prescribing, EW answered that, at the moment that is the case. HeiT asked about the patient numbers, estimated as 1300-1500 patients per year, EW clarified that this is the number of patients that meet the NICE criteria. HeiT added that this could be a cost pressure and if every patient was to have treatment from week 8 to 16 that cost pressure could be £190,000; this will be raised at	

	PPCG. HeiT asked about the reference in the flow chart to the discharge letter and asked if the patient was discharged from the EPAU; EW confirmed that the patient would be discharged to the maternity pathway. LS asked about the patients who fall outside of the NICE criteria, and if they are issued 2 weekly prescriptions. EW replied that the consultant would decide if progesterone was appropriate and the duration of treatment and the mechanism for receiving that prescription would depend on the patients' circumstance, some are given prescriptions in advance of conception, some through the on-call team, some via the miscarriage consultants directly. The frequency of issuing prescription is patient/consultant specific. LS added that one of the reasons for shifting this work to general practice is due to potential drug wastage if more than 2 weeks are supplied, but that doesn't seem to apply to the cohort that fall outside of NICE, who may get a month or more supply from the consultant. EW responded that, that cohort is fewer than those within NICE. LS further questioned what the general situation currently is for out-patient prescribing at STHFT, as this is essentially a process that is initiated and followed up by EPAU and the request is for the GP to prescribe, and this is the GPs only input into the pathway; why can't this process be contained in STHFT? EW referred to NICE, who say that primary care can pick up prescribing as the patient is being discharged by EPAU and added that in a similar position, the on-call team also have no other input into the pathway. LS asked if this is 'shared care' as the patient is discharged and, questioned if this is the best thing to do, moving the patients care to general practice or is it about a process. AMcG added that patients obtaining a prescription and medication closer to home has benefits. LS asked why the specialist can't send a prescription to the community pharmacy and AMcG explained that the specialists will prescribe in-house, not on an FP10. HeiT added that there is work underway to look at getting prescriptions from secondary care to primary care, and the electronic transfer of prescriptions, Graham Marsh is trying to progress this with the Digital Team at STHFT. HeiT added that this proposal should also be considered at IMOC as this will involve patients from the other SY ICB places. RL commented that no one else across SY ICB have a shared care agreement and feels that this is not a SCP as there is no referring back to the consultant and the document should reflect this. RL asked if midwives should be involved. EW responded that midwives are not authorised to prescribe progesterone. HS added that the use of PGDs was looked at earlier in the year but	

	considering the geographical spread of community midwives, it would make PGDs and pre-packs difficult to manage. HS also agreed with RL that our surrounding areas seem to have an additional classification where the specialist's initiate treatment, but it is not shared care. HS also informed the group that EW has updated the flow cart with contact numbers of clinicians if needed. LS does not support this proposal due to it being a transfer of work to primary care for convenience as a secondary care process is not in place. LS acknowledges that others may be able to support the proposal. RL added that RD is an issue and experience has shown that when RD is stopped, a phone call to the community pharmacy is also needed to say not to dispense, and whether or not collected by the patient, the fee is claimed. The pop-up on the clinical system asking if you want to cancel the prescription and 'yes' is selected, this does not cancel the item. HS added that the pharmacy cannot dispense the item unless the patient requests the RD prescription, but if this is not what is happening and not the preferred way, the prescribing could be done via a regular repeat template. TE commented that many of these patients will probably go on to have a miscarriage and most will only need to have one or two repeat prescriptions and why could they not be issued by the hospital. It does seem to be a lot of work for general practice. AMcG summed up that while APG acknowledges the importance of this treatment, it is the process of how to manage the prescribing that is the issue. AMcG asked that this proposal goes back to STHFT for a detailed description of why STHFTs technical solutions cannot meet this need, inhouse, for these patients. HeiT asked AM and Mr Nathan to link in with EW and Graham Marsh to give this as an example as, mentioned earlier, there is work underway to look at electronic solutions to out-patient prescribing systems. **An update will be given to APG in due course.**	EW/AM/Mr Nathan
7.2	**Formulary Sub-group**	
	Chapter 2 Cardiovascular system APG are asked to approve Chapter 2 which is now due for review, HS is presenting this proposal on behalf of Riz Iqbal (RI), Sheffield place, Pharmacist. HS explained that there few key changes to this review, the changes that have been made bring the formulary chapter in line with existing guidelines and updates that have already been approved at APG, and what is currently in development. HS summarised those key points. Metolazone has been added to the chapter, though will need a TLDL approval by IMOC. There is concern that primary care do not always prescribe by brand following initiation be secondary care and a note has been added to advise of the necessity for brand prescribing.	

	HS explained that there is an exception, in having section 6.1.23 in Chapter 2, this is in order to add the SGLT2s that are used for a cardiovascular indication. HS added that the Dapagliflozin▼ and Empagliflozin▼ in Heart Failure with Reduced Ejection Fraction (HFrEF) in patients with and without Diabetes Mellitus: guidance for primary care, has stalled and once finalised and approved, a link to that guidance will be added to the chapter. The Guideline to support Primary Care with the management of Chronic Kidney Disease (CKD) in Adults, has been approved but not yet published, once done, a link to the formulary chapter will be added. In terms of the oral anticoagulants, the update on DOACs being used in preference to warfarin for SPAF and the national procurement programme, which has edoxaban as first line where clinically appropriate, with rivaroxaban as second line choice, has been added but, the chapter may need changing depending on whether the procurement programme continues beyond January 2024. There have been a number of changes to the lipid regulating sections, which are in line with the guidelines that have already been approved. All the drugs in the pathway, not just those that are Green TLD, are included for completeness. This has been the general theme throughout the update of Chapter 2. AM asked for clarity on metolazone, asking if existing patients in primary care on the unlicensed form, being kept on that product or switched to the licensed formulation. HS replied that this is unknown, and that RI is continuing to look into this. At the time that the MHRA alert was issued, the OptimiseRx warnings were added. There is still some generic prescribing, but it is not known what brand is being dispensed, though it is unlikely that an unlicensed drug is being ordered in by community pharmacy and there may have been patients who have been changed to the licensed preparation without the consequences of the change in bioavailability being considered. EP added that this issue was discussed at Sheffield MSG, and it was agreed that patients at the seven practices, who are prescribing metolazone, will be contacted to establish what is being dispensed and to then add the brand name to the repeat template. Most of the generic prescribing is of the 2.5mg and it is known that half of the licensed 5mg tablet will be given to in-patients at STHFT. HeiT raised a point about the Dapagliflozin▼ and Empagliflozin▼ in Heart Failure with Reduced Ejection Fraction (HFrEF) in patients with and without Diabetes Mellitus: guidance for primary care, adding that the issue was around issuing the first prescription and as there is a NICE TA, there are currently no guidelines to support the implementation of the TA. HeiT asked if that line in the chapter could be removed, until a resolution is reached; this was supported by APG.	

	HS added, for clarity, that the guidelines that are in place are for Dapagliflozin▼ only, there are none, currently, for Empagliflozin▼ and one of the issues are about where the first prescription is written as the HF specialist nurse isn't a prescriber. There was also some concern about the renal monitoring, RI is continuing to look into this. **APG approve the updated Chapter 2.**	
5.	**Medicines Management Safety Issues**	
	Medicines Safety update for September **Fire hazard warning: Emollients.** This document was due for review and as there have been updates to guidance which specifies that there is a fire risk with all emollients, not just those which contain paraffin, the local guidance now reflects this. Because of this change, the previously named, preferred emollients have been removed and links to the toolkit added, that the MHRA has developed, which has videos and information leaflets for patients and HCPs plus a poster that can be displayed. There is also a link on most fire and rescue websites now, where HCPs and patients can self-refer for assessment, for complex cases, where there is a high risk of fire. **APG approve the updated document**, which will be linked to Chapter 13 and the emollient guidance. **Serious incident – infant morphine overdose** A serious incident case study was recently shared via CDLIN. A baby was discharged on morphine 100mcg/ml and in primary care the strength was changed to 10mg/5ml which resulted in the patient receiving a dose 20 times higher than intended. This is not the first instance of a strength change causing an incident and so this is being shared to raise awareness. STHFT and SCFT have seen the case study and have advised that it would be extremely unlikely that a baby would be discharged on morphine in Sheffield however, there are general learning points that can be taken from the case study, some directly linked to morphine. EP confirmed that morphine 100mcg/ml has been added to the 'do not prescribe' list on SystmOne and, OptimiseRx has been asked to add a warning if 10mg/5ml is prescribed to children under 1 year of age. It is also going to be considered at IMOC, to red traffic light the 100mcg/ml strength. Some general learning points: to always communicate any medication strength change to patients. EP added that it is proposed that a safety bulletin is developed on advice about this, for primary care. **Post meeting note:** the morphine 100mcg/ml has been removed from the 'do not prescribe' list on SystmOne as this resulted in the strength appearing at the top of the morphine products picking list. An OptimiseRx alert has been added instead. **National safety alerts**	

	EP highlighted the **CAS alert on the shortage of GLP-1 receptor agonists**, which has been extensively communicated. Also, a **CAS alert on potent synthetic opioids implicated in heroin overdoses and deaths**. Some action for general practice has been issued, relating to risk assessing the patient population and the actions needed, in proportion to the perceived risk. A drug safety alert on **fluoroquinolone antibiotics: reminding of the risk of disabling and potentially long-lasting or irreversible side effects.** And on **methotrexate: to advise patients to take precautions in the sun to avoid photosensitivity reactions,** which is being actioned by SK. **Valproate: re-analysis of study on risks in children of men taking valproate,** the MHRA have issued an update to advise that there may be flaws in their data with regard to the risk in men. LS asked about the warning issued by the British Generic Manufacturers Association that **Biotin may interfere with thyroid immunoassays** and if it was possible to add a warning to ICE. EP was unsure but will look into this.	EP
6.	**Pharmacy and Prescribing Commissioning Group Feedback**	
	HeiT reported that the last PPCG meeting was taken up by looking at the NHSE document concerning 16 workstreams, focussing on medicines optimisation cost efficiencies across secondary and primary care. Of the primary care workstreams, all were on the radar, and all were being addressed. Sheffield benchmark well but there is more that can be done. Once all the data is populated HeiT can share with the group if required.	
7.3	**Formulary Sub-group**	
	Draft minutes of the September FSG meeting was received. SK highlighted the notable items that were discussed: • **Somatrogon (Ngenla) (Growth Hormone) SCP** work is underway and going back to FSG in October. • Issues with **Omeprazole 10mg/5ml and 20mg/5ml** prescribing across SCFT and STHFT, this has been referred to MSG. • **Esketamine TA854** for treatment resistant major depressive disorder; FSG agreed that the proposal, for a Grey classification, should go to IMOC. FSG noted that esketamine is already on the SY TLDL classified as Grey but for major depressive disorder in adults at imminent risk of suicide, referencing NICE TA899. • **Bosentan** Red TLDL proposal for ongoing digital ulcer disease in children, the proposal has gone to IMOC. • **Acromegaly SCP** has now been retired. SK has confirmed with STHFT endocrinology clinicians that patients receive treatment via homecare and the SCP is no longer needed. **Matters approved by FSG under delegated authority (for information):** • **Chapter 13 Skin: Minor updates to sunscreen choice.** The Delph	

	sunscreen preparation is no longer listed in ACBS criteria in the BNF so has been removed and replaced with Anthelios Sunscreen Lotion SPF50+ as a cost effective first choice for patients who fit ACBS criteria. **Matters approved by virtual agreement under delegated authority (for information):** • **Chapter 1: Gastrointestinal System,** minor amendments to links within the chapter have been made. • **Chapter 10: Musculoskeletal & Joint Diseases -** Febuxostat update; new trial data shows that it can be used with caution for patients' with major CV disease. • Annual interim update of pricing to **The Sheffield Integrated Continence Service Adult Formulary**	
9.	**Integrated Medicines Optimisation Committee (IMOC)**	
	Minutes The July 2023 minutes and the draft minutes of the September meeting were received. HeiT reported that progress on the wording relating to the SY TLDL is still being honed and the TLDL is starting to grow. HeiT also informed the group about the paper presented by Ebun Ojo (EO) to IMOC about PCSK9 inhibitors and a proposal that they are moved to an Amber classification on the TLDL. EO has already conducted a lot of engagement with Sheffield place around this, but there seems to have been a gap in communication with other SY ICB places. HeiT asks this group if the IMOC paper could be shared, with this group, so that APG comments can be fed back to IMOC when it considers that paper again; APG agree.	HeiT
10.	**RMOC.**	
	Regional arrangements for medicines optimisation in the NHS. The document was received by the group. AMcG commented that it appeared to describe a function that will relate to ICSs, HeiT added that on page 8 of the document, the governance structure shows how 'National' links down to 'System' as far as ICBs.	
11.	**NICE Guidance**	
	NICE summary for July and August. SK summarised: **Rimegepant for preventing migraine** is recommended as an option for preventing episodic migraine in adults who have at least 4 and fewer than 15 migraine attacks per month, only if at least 3 preventative treatments have not worked. Treatment will be stopped after 12 weeks if the frequency of migraine attacks does not reduce by at least 50%. This has been classified as Red on the SY TLDL; however, the TA says that it is suitable for shared care prescribing. SK reported that work, with the specialists is ongoing, adding that it is a black triangle drug so there is not much data available, and it does require specialist oversight. There is also another TA, for acute migraine, due in October, which may relate to primary care prescribing.	

	Deucravacitinib for treating moderate to severe plaque psoriasis, has been classified as Red on the SY TLDL, SK is producing a Blueteq form. **KardiaMobile for detecting atrial fibrillation,** recommended as an option for detecting atrial fibrillation (AF) for people with suspected paroxysmal AF. This is being looked at by the MOT.	
12.	**APG Mailbox.**	
	SK informed the group that the mailbox continues to receive enquiries about the Tier 3 weight management service and advised the group that a provider has now been agreed. A pathway on how the service will be used will be in development.	
13.	**Reports from Neighbouring Committees**	
	Derbyshire JAPC minutes June 2023 Doncaster & Bassetlaw APC June 2023 Barnsley APC June 2023 Rotherham MMC 28th June 2023 Were noted. For APG information, RS commented on the item in the Rotherham minutes that said it was getting more difficult to differentiate between NHS and private prescription requests; RL added that this is also the case for post bariatric surgery where some private provider requests have got through. AMcG added that Dr David Crichton, Medical Director of SY ICB has raised this issue too. HeiT informed the group about an RTCD document, shared at IMOC, about private prescribing and the interface with the NHS. The suggestion is to adopt that document and a link to the document will be added to the SY Medicines and Prescribing page. It has information that is in line with the Medicines Code and offers sensible advice on interface ethical prescribing issues.	
14.	**Never Events and SIs.**	
	None reported.	
15.	**Any Other Business**	
	Nr Nathan raised the query on **Sodium Zirconium Cyclosilicate prescribing in primary care**, which was raised by Dr William McKane, Consultant Nephrologist last week. SK responded that a discussion had previously taken place with Dr Fotheringham as this was classified as Red on the TLDL, it has a PAS, confidential list price. There was a suggestion that there may be a need for primary care prescribing and SK sent the proposal documentation for secondary care to complete, but there was no response. Recently, HeiT has responded to the email from Dr McKane and sent the proposal documents which SK will offer help in completing. HeiT will forward the email to Nr Nathan and update Mr Nathan outside of this meeting.	HeiT

	HeiT has an email from the **LMC regarding the update, in July, to the SCP for testosterone in post-menopausal women**. The template used was the one previously agreed which has a footnote: *This is guidance on the management of a condition not a commissioning arrangement.* The LMC are asking why GPs are being asked to take on secondary care workload and what indemnity arrangements are being put in place. LS agreed to gather some more information and will discuss with HeiT outside of the meeting.	LS/HeiT
16.	**Date of the next meeting:** **19th October 2023 1:30 via MS Teams** .	

Summary Points and Recommendations

September 2023

IMOC approvals	• Efmody SCP – Barnsley, Doncaster, and Sheffield. Rotherham TBC
IMOC TLDL approvals	See appendix 1
Shared care/Prescribing Guidelines	• Generalised Anxiety Disorder (GAD) guideline – Approved.
Sheffield Formulary Updates	• Chapter 13 Skin: Emollient bath additives – Approved. • Abbreviated guide to emollients: Emollient bath additives – Approved. • Chapter 2 Cardiovascular system: full review - Approved. • Chapter 13 Skin: Minor updates to sunscreen choice – Approved by FSG under delegated authority of APG. • Chapter 1: Gastrointestinal System, minor amendments to links – Approved virtually by FSG under delegated authority of APG. • Chapter 10 - Febuxostat update– Approved virtually by FSG under delegated authority of APG. • Annual interim update of pricing to The Sheffield Integrated Continence Service Adult Formulary - – Approved virtually by FSG under delegated authority of APG
Other	• Fire hazard warning: Emollients – Approved.

Appendix 1 IMOC TLDL Approvals

July 2023

Aceclofenac - Non-steroidal anti-inflammatory- Grey 3
Agomelatine- Major Depression- Grey 3
Aliskiren (Rasilez)- Hypertension-Grey 1
Almotriptan (Almogran)- Treatment of acute migraine- Grey 4
Amantadine- Influenza- Grey 2
Amifampridine (3,4 diaminopyridine phosphate)(Firdapse)- Lambert-Eaton Myasthenic Syndrome (LEMS) in adults- Grey 1
Anakinra (Humira, AMGEVITA, Hyrimoz, Imraldi, Hulio)- Rheumatoid arthritis in adults- Grey 2
Armour thyroid – Hypothyroidism- Grey 1
Atorvastatin 30mg and 60mg tablets (Generic/Lipitor)- Lipid modification- Grey 4
Baloxavir marboxil (Xofluza)- Uncomplicated influenza and post exposure prophylaxis of influenza in patients aged 12 years and above.- Grey 2
Belzutifan (Welireg)- von Hippel-Lindau (VHL) disease- Grey 6
Bemiparin (Zibor)- All licensed indications- Grey 6
Co-Proxamol- All licensed indications- Grey 1
Dosulepin- Depressive illness, particularly where sedation is required-Grey 1
Doxazosin MR preparations- Hypertension- Grey 1
"Self-care medicines - All Conditions for which over the counter
items should not routinely be prescribed in primary care"- Grey 5
Adalimumab (Humira)- As per licenced appropriate NICE TA- Red 1,2,6
Afibercept (Eylea)- "Eye Conditions As per licenced appropriate NICE TA" -Red 1,2
Avelumab (Bavencio)- As per licenced appropriate NICE TA-Red 1,6
Bevacizumab - As per licenced appropriate NICE TA- Red 1,6
Erenumab (Aimovig)- Migraines in adults- Red 1,3
ACARIZAX 12 SQ-HDM(Acarizax)- House dust mite sensitisation- Amber 1,3
Chondroitin (all salts, all strengths)- All indications- Grey 1,2
Cilostazol (Pletal®)-Intermittent claudication in patients without rest pain and no peripheral tissue necrosis- Grey 2
Ciprofibrate -Lipid-regulating drug- Grey 4
Clonidine Oral Solution -The prophylactic management of migraine or recurrent vascular headache.
The management of vasomotor conditions commonly associated with the menopause and characterised by flushing- Grey 4
Cobimetinib (Cotellic®)- Unresectable or metastatic melanoma in adults- Grey 2
Doxepin cream (Xepin® 5% cream)-Pruritus in eczema- Grey 3
Naltrexone/bupropion prolonged-release tablets (Mysimba®)- Weight Management – Grey 2
Pentoxifylline (Trental®)-Intermittent claudication in people with peripheral arterial disease- Grey 2
Rimegepant (Vydura®)-Acute treatment of migraine- Grey 6
Trimipramine-Antidepressant- Grey 1
Co-careldopa intestinal gel (Duodopa®)-Parkinson's Disease – Red 1,6
Relugolix–estradiol–norethisterone acetate (Ryeqo®)- Uterine Fibroids- Red 3
NICE TA878- Casirivimab plus imdevimab, nirmatrelvir plus ritonavir, sotrovimab and tocilizumab for treating COVID-19- Red TLS

NICE TA893- Brexucabtagene autoleucel for treating relapsed or refractory B-cell acute lymphoblastic leukaemia in people 26 years and over- Red TLS
NICE TA894- Axicabtagene ciloleucel for treating relapsed or refractory follicular lymphoma- Grey TLS
NICE TA895- Axicabtagene ciloleucel for treating relapsed or refractory diffuse large B-cell lymphoma after first line chemoimmunotherapy- Red TLS
NICE TA896- Bulevirtide for treating chronic hepatitis D- Red TLS
NICE TA897- Daratumumab with bortezomib and dexamethasone for previously treated multiple myeloma- Red TLS
NICE TA898- Dabrafenib plus trametinib for treating BRAF V600 mutation-positive advanced non-small-cell lung cancer- Red TLS
NICE TA899- Esketamine for treating major depressive disorder in adults at imminent risk of suicide- Grey TLS
NICE TA900- Tixagevimab plus cilgavimab for preventing COVID-19- Grey TLS
NICE TA901- Cemiplimab for treating recurrent or metastatic cervical cancer- Grey TLS
NICE TA902- Dapagliflozin for treating chronic heart failure with preserved or mildly reduced ejection fraction- Amber G TLS- Local guidelines need to be updated.
NICE TA903- Darolutamide with androgen deprivation therapy and docetaxel for treating hormone-sensitive metastatic prostate cancer- Red TLS
NICE TA904- Pembrolizumab with lenvatinib for previously treated advanced or recurrent endometrial cancer- Red TLS
NICE TA905- Upadacitinib for previously treated moderately to severely active Crohn's disease- Red TLS

September 2023

Drug/Product	**Brand/name**	**Indication**	**Agreed TLS**
Capsaicin Patch	Qutenza®	Peripheral neuropathic pain	Red,1
Ciclesonide	Alvesco	Asthma	Grey 4
Co-diovan		Hypertension not adequately controlled by valsartan alone	Grey 4
Daratumumab		As per licenced appropriate NICE TA	Red 1,6
Darifenacin		Urinary frequency,Urinary urgency, Incontinence	Grey, 4
Darvadstrocel		Fistulas (perianal) in adult patients with non-active/mildly active luminal Crohn's disease.	Grey,2

Denosumab		Preventing skeletal-related events (pathological fracture, radiation to bone, spinal cord compression or surgery to bone) in adults with bone metastases from breast cancer and from solid tumours	Red,1
Dequalinium chloride 10mg vaginal tablets		Bacterial vaginosis	Red,1
Dexamethasone and levofloxacin 1mg/5mg in 1mL eye drops		Prevention of infection associated with cataract surgery in adults	Red,1
Dicycloverine Hydrochloride tablets		IBS	Grey,4
Doxepin		Depressive illness (particularly where sedation is required)	Grey,4
Doxylamine / pyridoxine		Nausea and vomiting in pregnancy	Grey,4
Dronedarone		Atrial fibrillation (AF)	Red,1
Duloxetine		Stress Urinary Incontinence	Amber G
Dupilumab		As per licenced appropriate NICE TA	Red,1
Dutasteride 500mcg plus tamsulosin 400microgram		Benign prostatic hyperplasia	Grey,4
Eyelid hygiene Preparations		Examples : wipes, lotions	Grey,3
Bortezomib		As per licenced appropriate NICE TA	Red,1
Bulevirtide		Chronic hepatitis D in adults	Red 1,6
Fampridine		Multiple sclerosis	Grey,2
Eltrombopag olamine		Treating chronic immune thrombocytopenia in adults	Red,1
Enzalutamide		As per licenced appropriate NICE TA	Red,1

Eptinezumab		Migraine	Red,1
Erenumab		Migraine	Red,1
Esketamine Nasal spray		Depression	Grey,2
Erlotinib		As per licenced appropriate NICE TA	Red,1
Everolimus		As per licenced appropriate NICE TA	Red,1
Fludarabine		As per licenced appropriate NICE TA	Red,1
Fluoride tablets		Dental indications	Red,6
Fluoxetine 10mg		licensed indications	Grey,4
Flurbiprofen tablets		licensed indications	Grey,4
Fluvastatin 80mg		licensed indications	Grey,4
Eicosapentaenoic acid 460mg/Docosahexaenoic acid 380mg capsules			Grey,1
Fulvestrant		Red for NICE TA approved indications, grey for all other indications	Red,1
Gamolenic acid (Evening Primrose Oil)			Grey,3
Fremanezumab		As per licenced appropriate NICE TA	Red,1
Gefitinib		Red for NICE TA approved indications, grey for all other indications	Red,1
Gemcitabine		Red for NICE TA approved indications, grey for all other indications	Red,1
Glasdegib		As per licenced appropriate NICE TA	Grey,1
Freestyle Libre Flash Glucose Monitoring System			Amber G
Glucosamine and chondroitin			Grey,1
Insulin needles<£5 per 100 needles			Green
Insulin Needles >£5 per 100 needles			Grey,4

Botulinum toxin type A		As per licenced appropriate NICE TA	Red,1
Dabrafenib		As per licenced appropriate NICE TA	Red,1
Trametinib		As per licenced appropriate NICE TA	Red,1
GRAZAX 75,000 SQ-T oral lyophilisate	Grazax	Grass pollen sensitisation	Amber 1,3
Pembrolizumab		As per licenced appropriate NICE TA	Red,1
lenvatinib		As per licenced appropriate NICE TA	Red,1
Deucravacitinib		Treating moderate to severe plaque psoriasis	Red 1,6
Rimegepant		For preventing migraine	Red 1
Lorlatinib		for untreated ALK-positive advanced non-small-cell lung cancer-	Grey (although Red1,6 for indications where a positive NICE TA
Olaparib		for maintenance treatment of relapsed, platinum-sensitive ovarian, fallopian tube or peritoneal cancer after 2 or more courses of platinum-based chemotherapy	Red 1,6
Semaglutide		for managing overweight and obesity in young people aged 12 to 17 years	Red 1 for indications where a positive NICE TA (note this is terminated TA so not approved for this cohort)

Selpercatinib		for untreated RET fusion-positive advanced non-small-cell lung cancer	Red 1,6
Afamelanotide		for treating erythropoietic protoporphyria	Grey 1
Cipaglucosidase alfa with miglustat - Both Red 1		for treating late-onset Pompe disease	Red 1 for indications where a positive NICE TA for each drug
Finereonone		for treatment of chronic kidney disease stage 3 and 4 (with albuminuria) associated with type 2 diabetes in adults, with certain recommendations	Red,1
Cholera vaccine	(Vaxchora®)	Active immunisation against disease caused by Vibrio cholerae serogroup O1 in adults and children aged ≥2 years	Grey 6
Hepatitis A vaccine	(Avaxim Junior)	Active immunisation against infection caused by hepatitis A virus in children aged 1 to 15 years	Grey 6
Hepatitis B vaccine 10microgram vial	(PreHevbri®)-	Active immunisation against infection caused by all known subtypes of the hepatitis B virus in adults. It can be expected that hepatitis D will also be prevented by immunisation with PreHevbri® as hepatitis D (caused by the delta agent) does not occur in the absence of hepatitis B infection	Grey 6

Lenacapavir	(Sunlenca®)	Use in combination with other antiretroviral(s) for the treatment of adults with multidrug-resistant HIV-1 infection for whom it is otherwise not possible to construct a suppressive anti-viral regimen 300mg tablet	Red 1,6
Lumasiran	(Oxlumo®)	Treatment of primary hyperoxaluria type 1 in all age groups	Red 1,6
Netarsudil + latanoprost 50micrograms/200micrograms in 1mL eye drops TLS	(Roclanda®)-	Reduction of elevated intraocular pressure (IOP) in adults with primary open-angle glaucoma or ocular hypertension for whom monotherapy with a prostaglandin or netarsudil provides insufficient IOP reduction	Grey 6
Vutrisiran	(Amvuttra®)	Treatment of hereditary transthyretin-mediated amyloidosis in adults with stage 1 or stage 2 polyneuropathy	Red 1,6
Efgartigimod	(Vyvgart®)	Use as an add-on to standard therapy for the treatment of adults with generalised myasthenia gravis who are anti-acetylcholine receptor antibody positive	Red 1,6

Ivosidenib	(Tibsovo®)	Monotherapy for the treatment of adults with locally advanced or metastatic cholangiocarcinoma with an isocitrate dehydrogenase-1 R132 mutation who were previously treated by at least one prior line of systemic therapy AND Use in combination with azacitidine for the treatment of adults with newly diagnosed acute myeloid leukaemia with an isocitrate dehydrogenase-1 R132 mutation who are not eligible to receive standard induction chemotherapy	Red 1,3
Mirikizumab	(Omvoh®)	Treatment of adults with moderately to severely active ulcerative colitis who have had an inadequate response with lost response to, or were intolerant to either conventional therapy or a biologic treatment	Red 1,3
Tozinameran 10 dose multi-dose vial	(Comirnaty)	Active immunisation to prevent COVID-19 caused by SARS-CoV-2, in infants and children aged 6 months to 4 years	Green