



Minutes of the Integrated Medicines Optimisation Committee (IMOC)
Held on Wednesday 2nd September 2026 11:30-13:30
Via Microsoft Team

Attendees present:	Time of attendance (if not present for full meeting)	Invited Attendees:	
✓		David Warwicker (DW)	Medical Lead for Medicines Optimisation (chair)
		Heidi Taylor (HT)	SYICB Medicines Optimisation Programme Director (Clinical Effectiveness, Quality and Safety)
		Alex Molyneux (AJM)	NHS SY ICS Chief Pharmacy Officer
✓		Chris Bland (CB)	Chair Community Pharmacy South Yorkshire (CPSY)
✓		Govinder Bhogal (GOVB)	Programme Director for Medicines Optimisation (Pathways Redesign and Population Health)
✓		Charlotte McMurray (CM)	SYICB Medicines Optimisation Programme Director (Pharmacy Integration and Development)
✓		Ashley Hill (AH)	SYICB Senior Medicines Optimisation Technician- Doncaster (IMOC Secretary)
✓		Esoop Bharoocha (EB)	SYICB Deputy Chief Pharmacist – Rotherham Hospital
		Dean Eggitt (DE)	LMC representative – Doncaster

		Rob Wise (RW)	Senior Pharmacist NNICB - Bassetlaw Place Partnership
		Krishna Kasaraneni (KK)	LMC Representative – Sheffield
✓		Lee Wilson (LW)	Consultant Pharmacist DBTHFT
		Sarah Hudson (SH)	Deputy Chief Pharmacist SWYPFT
		Joanne Wragg (JW)	Sheffield Children's NHS FT Chief Pharmacist
		Abiola Allinson (AA)	SYICB Chief Pharmacist- SHSC
		Claire Thomas (CT)	Community Pharmacy Clinical lead- SY ICB
		Graham Marsh (GM)	Sheffield Teaching Hospital Chief Pharmacist
		Mr Veeraraghavan Chidambaram-Nathan (CN)	Transplant and General surgery Consultant - STH
✓		Trish Edney (TE)	Sheffield Healthwatch Representative
✓		Lisa Eccles (formerly Murray) (LE)	Lead Pharmacist (Strategy and Delivery-Rotherham)
✓		Deborah Cooke (DC)	Senior Pharmacist (Strategy and Delivery & Clinical Effectiveness- Barnsley Place)
✓		Gillian Turrell (GT)	SYICB- Hospital Pharmacist- Barnsley
✓	<i>Left 13:00</i>	Sophie Holden (SH)	Rotherham GP MM lead for Rotherham Place
		Jason Page (JP)	Rotherham Place Medical Director
✓		Joanne Howlett (JH)	Medicines Optimisation Lead Pharmacist (Strategy and Delivery – Barnsley Place)
		Paul McManus (PM)	NHSE Specialist commissioning - Senior Pharmacist
		Ewa Gabzdyl (EG)	Senior Pharmacist Strategy & Delivery- Doncaster Place
✓	<i>Left at 12:39</i>	Surinder Ahuja (SA)	Medication Safety Officer & Lead Pharmacist Governance and Formulary- Rotherham Hospital
✓		Shameila Afsar -Baig (SAB)	Senior Pharmacist (Strategy and Delivery)- Sheffield Place
✓	<i>Left at 12:37</i>	Kulsoom Khan (KKh)	Procurement Pharmacist at TRFT
✓		Mallicka Chakrabarty (MC)	GP Prescribing Lead (Bassetlaw)

		Navjit Johal (NJ)	Chief Pharmacist – Rotherham Hospital
✓		Robina Okes-Voysey (ROV)	Senior Pharmacist, Quality Improvement
✓	<i>Left at 12:58</i>	Bipin Chandran (BC)	Rotherham LMC representative
✓		Greg Westley (GW)	Medicines Safety Officer
✓		Kuljit Nandhara (KN)	Chief Pharmacist – RDaSH
✓		Patrick Clearly (PC)	Lead Clinical Pharmacist
✓		Helen Cunningham (HC)	Pharmacy Technician
✓		Leah Murphy (LM)	Senior Pharmacy Technician -Strategic Planning and Commissioning
✓		Joanne Hill (JH)	Chief Technician- Clinical Quality and Strategic Planning & Commissioning
✓		Razwan Saleem (RS)	Strategic Pharmacist
✓	<i>12:05-12:49</i>	Diana Vasile (DV)	Lead Pharmacist

		Action
1	Welcome: Helen Cunningham (HC)-Pharmacy Technician Leah Murphy (LM)-Senior Pharmacy Technician -Strategic Planning and Commissioning Joanne Hill (JH)-Chief Technician- Clinical Quality and Strategic Planning & Commissioning Razwan Saleem (RS) -Strategic Pharmacist Diana Vasile (DV)-Lead Pharmacist	
	Apologies Alex Molyneux, Jason Page, Rob Wise, Mr Nathan, Navjit Johal	
2	Declarations of Interest (DOI) The Chair reminded committee members of their obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of the South Yorkshire Integrated Care Board (ICB). Declarations declared by members 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 None were given	

3	Notification of Any Other Business Community pharmacy hypertension case finding commissioned services- Chris Bland	
4	Minutes of the meeting held on 1st July 2026 & any other items which are not on the agenda The 1 st of July 2026 IMOC minutes were acknowledged as a true reflection and approved. Action: AH to upload ratified minutes to the medicines optimisation website and circulate	AH
5	Action Log & Matters arising Action log 270: Gabapentinoids patient information leaflet (PIL) regarding stopping Gabapentin and Pregabalin documents is still being reviewed by GW, TE asked if any further PIL are being reviewed that she could review then prior to approval at IMOC. AH to add this step onto the application form. Action Log 216: ROV gave an update that further work is required to review CGM devices following the update of the Single National Formulary and the changes to the current traffic light statuses.	
6	ICB Formal Executive Group (FEG) Report GOV updated the committee with the feedback from the executive committee: - Sodium Zirconium Cyclosilicate- The Executive had approved the medicine under the previous Amber-G classification, which would align with the new Specialist Initiation classification framework. It was confirmed that supporting prescribing guidance was required and was being developed by secondary care. This would remain on the action log until the guidance was completed. - Relugolix for prostate cancer – GOV reviewed the NICE TA to use as information and guidance or adopting a local guidance. After a review of the NICE TA GOV agreed that a local Amber G document would be more suitable. This will return to IMOC once completed. - COPD Biologics: Dupilumab and Mepolizumab- Update on the implementation of biologic therapies for COPD, noting that while formulary and classification discussions had largely	

	been concluded, practical implementation remained challenging. Secondary care providers continued to experience difficulties establishing the clinical infrastructure and capacity required to deliver these treatments through dedicated services. RS informed the committee that correspondence from the Prioritisation Panel and Executive discussions had confirmed support for Dupilumab being classified as Red based on the implementation plans submitted by secondary care. He further advised that there had been a clear Executive expectation that Mepolizumab should not delay implementation of COPD biologic pathways and that both medicines should ultimately be managed consistently. The Committee considered whether a decision on the classification of mepolizumab should be deferred to a future meeting. Members noted that further delay could hinder implementation and pathway development. Given the positive NICE Technology Appraisal and previous Executive direction to align COPD biologic classifications, the Committee agreed that mepolizumab should be aligned with dupilumab. Decision: Mepolizumab for COPD was classified as Red, consistent with dupilumab, with implementation subject to the development of appropriate clinical pathways and service arrangements within secondary care.	
7	Updated IMOC Terms of Reference (TOR) The Committee received the updated IMOC Terms of Reference and noted that a full review had been undertaken to reflect current governance arrangements, committee membership, reporting structures and evolving medicines governance terminology. Members were advised that the revised document aligns with the developing Single National Formulary (SNF) framework and introduces updated terminology to support future implementation. In particular: • Access Categories replace the former Traffic Light Classification terminology. • Preferencing Recommendations replace previous formulary designation terminology and describe preferred medicines or brands within a therapeutic class. The revisions had been developed to provide greater clarity and to align locally agreed processes with emerging national arrangements.	

	The Committee noted that the draft Terms of Reference had undergone internal review within the ICB prior to presentation to IMOC. No queries or objections were raised, and the updated TOR were agreed pending final approval from the executive committee.	
8	Updated classification & Traffic Light application The chair & AH presented the proposed transition from the existing South Yorkshire Traffic Light Classification (TLC) framework to the Single National Formulary (SNF) Access Categories. The chair advised that the SNF introduces a broader national categorisation framework intended to standardise prescribing access arrangements across England. Whilst the long-term ambition is for prescribing access categories to be determined nationally, implementation remains in its early stages, and Integrated Care Boards will continue to retain responsibility for local decisions for the foreseeable future. Committee members were advised that the revised framework would require South Yorkshire's existing classifications to be mapped to the new access categories. The proposed mapping was outlined as follows: • Current Red classifications would generally transfer directly to Specialist Only. • Current Amber Shared Care classifications would transfer directly to Shared Care. • Current Green classifications would largely transfer to All Settings. • Current Grey classifications would require subdivision into: • Do Not Prescribe • Self-Care • Current Amber-G classifications would require further review to determine whether medicines are most appropriately classified as: • Specialist Advice, or Specialist Initiation It was noted that that the greatest challenge would be the review of medicines currently classified as Amber-G, as these encompass a range of prescribing arrangements which are more clearly differentiated within the SNF framework. The committee discussed whether future access category	

	decisions would be made nationally or continue to sit within ICB governance arrangements. The chair discussed that the anticipated direction of travel is towards nationally determined access categories. However, this transition is expected to occur gradually over an extended period, potentially several years. During that period IMOC would continue to undertake local classification decisions where required. It was recognised that, even if classification decisions become increasingly standardised nationally, IMOC would continue to have an important role in supporting implementation, local pathway development, formulary management and prescribing preference recommendations. DC highlighted that not all medicines currently classified as Green would automatically meet the definition of All Settings under the SNF framework. Members were reminded that previous amendments to the Green classification had allowed certain medicines to be prescribed in primary care following specialist recommendation without requiring formal specialist initiation or shared care arrangements. The committee therefore agreed that review of existing classifications should not be limited to Amber-G medicines and should also include Green classifications where specialist involvement currently exists. The committee discussed whether the transition to SNF categories should also involve removal of traditional traffic light colour coding. AH advised that prior discussions had suggested retaining traffic light colours during the transition period to support understanding and minimise confusion whilst clinicians become familiar with the new terminology. The updated traffic light status classification document will now become the SNF categorisation and will be available on the Medicines Optimisation website to introduce clinicians to the new SNF terminology. LW strongly supported retaining colour coding, noting that colours continue to provide a useful visual prompt within formularies, prescribing systems and clinical guidance documents. He cautioned against removing a well-established system before clinicians had adapted to the new framework. Members generally agreed that retaining colours alongside the new terminology would help maintain clarity during implementation. The chair acknowledged that whilst Red and Green classifications mapped relatively clearly to the new framework, the previous Amber category encompassed several distinct prescribing arrangements. He suggested that if colour coding remained, consideration may need to be given to different shades or visual distinctions to reflect the new subcategories. RS advised that discussions with OptimiseRx and pilot organisations implementing elements of the SNF indicated that colour coding was likely to remain within prescribing system alerts and decision	
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support tools. This was considered beneficial from a usability perspective and may reduce alert fatigue for clinicians. The committee agreed that colour coding should be retained during the transition period and reflected in future documentation where appropriate. GT sought clarification regarding the implications for local formularies and the potential workload associated with updating local systems to align with the new categorisation framework. AH explained that following the cessation of local Area Prescribing Committee arrangements, formulary-related discussions would increasingly progress through IMOC. Future formulary decisions would be incorporated within horizon scanning processes and prescribing product applications submitted to the committee. JH provided an update on exploratory work currently being undertaken regarding the feasibility of developing a single South Yorkshire formulary. Members were advised that this work remains at an early stage and is currently focused on understanding: • Resource requirements. • Governance implications. • Clinical and operational risks. • Potential technical solutions and hosting platforms. • The scale of formulary standardisation required across the system. JH advised that engagement with partner organisations would be essential as the work progressed. It was noted that this is a big piece of work and require a working group to undertake this task. Members noted the potential benefits of a South Yorkshire-wide formulary and supported further exploratory work. AH presented a revised prescribing product application form which had been developed through the IMOC subgroup. The committee heard that the intention is to convert the application process into an electronic format utilising Microsoft Forms, thereby improving efficiency and consistency of submissions. AH highlighted some key changes such as formatting and adding in additional fields to add further	
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	context to the application form, incorporating the SNF access category terminology and revision of wording relating to formulary positioning and prescribing preference recommendations. A discussion took place regarding the continued use of the term "non-formulary" and formulary. Members recognised that the term remains widely understood by clinicians, although concerns were expressed regarding terminology consistency within the evolving national framework. It was suggested that "not for routine use" could be used instead of non-formulary. LW discussed that the SNF is in its early stages and while there are still local formularies in place that the word "formulary" should be maintained as clinicians are used to the wording. No consensus was made regarding formulary and non-formulary to be included within the application form and this may need to be reviewed later on while the SNF is being established. The committee supported the transition to the Single National Formulary Access Categories and approved the associated governance and application documentation, recognising that further detailed classification review and implementation work will be required over the coming months. Actions: • AH to update the SY Traffic light status classification to the new SNF categories on the MO website • AH to update the MO website with the updated application form Post meeting note: The chair, AJM & CT agreed outside of the meeting that for preferencing recommendation that the wording which should be used instead of formulary and non-formulary is preferred and not preferred. This will be reflected on the application forms and SY Prescribed Product Classification List.	
9	Traffic Light application Ciclosporin eye drops This item was not discussed at the meeting.	
10	SY CKD guidance Diana Vasile (DV) presented the proposed South Yorkshire Primary Care Guideline for the Diagnosis and Management of Chronic Kidney Disease (CKD) in Adults. The guideline was developed from the Sheffield CKD guideline (2023) and subsequently refined through collaboration with clinicians across South Yorkshire. Members noted that the work had been undertaken to	

	establish a single, standardised approach to CKD diagnosis, classification, monitoring and management in primary care, aligned with NICE NG203, local pathways and relevant NICE Technology Appraisals. The CKD guideline incorporated contributions from all four South Yorkshire Places and combined elements of both the Sheffield and Barnsley guidance documents. The resulting document aims to provide a consistent framework for primary care management of CKD across South Yorkshire. DV provided the committee with an overview of the guideline. The chair suggested that the treatment algorithm could be clarified by explicitly distinguishing patients with CKD and Type 2 diabetes from those without Type 2 diabetes. DV agreed to amend the wording accordingly. MC welcomed the guideline and commended the work undertaken, suggesting that the reference to haematuria within the diagnostic section could potentially be interpreted in isolation and recommended additional wording to help distinguish renal causes from haematuria that may require investigation through alternative pathways. Members agreed this was a reasonable clarification. MC also noted that whilst the guideline was comprehensive and clinically useful, implementation could create additional workload within primary care, particularly in relation to optimisation and monitoring of treatment. Diana acknowledged these concerns, noting that the intention was to consolidate existing evidence and guidance into a single accessible document while recognising local capacity constraints. DC suggested the inclusion of a reference to the South Yorkshire SGLT2 inhibitor position statement and recommended that document links should follow the current Medicines Optimisation Team approach. BC asked the committee if the documents had been circulated to LMC members. It was confirmed that it had been with supportive feedback received from Barnsley LMC and no objections raised. Decision: The Committee approved the South Yorkshire CKD Guideline, subject to the minor amendments discussed, including revision of the title to reflect both diagnosis and management of CKD. Members thanked Diana for the significant work undertaken in developing the document. Actions: • DV to make the minor amendments discussed • AH to circulate and upload documents to the MO website	
	Safety updates	

11	<table border="1"> <thead> <tr> <th data-bbox="259 236 674 316">Affected drug</th><th data-bbox="674 236 1167 316">Impact for primary care in South Yorkshire</th><th data-bbox="1167 236 1659 316">Recommended Actions</th></tr> </thead> <tbody> <tr> <td data-bbox="259 316 674 1262"> ACE-inhibitors </td><td data-bbox="674 316 1167 1262"> Advice for Healthcare Professionals: Angioedema is a known uncommon or rare side-effect of ACE inhibitor treatment. This can either be allergic (histamine-mediated) or less commonly non-allergic (bradykinin-mediated). Healthcare professionals should consider bradykinin-mediated mechanisms as a cause when standard anaphylaxis treatment is ineffective. Angioedema can occur at any time during treatment, including after weeks to years of use. Swelling of the tongue, lip, face, or larynx which may cause difficulty in breathing or swallowing may progress and can lead to airway compromise. Other symptoms can include gastrointestinal pain and cramps. Bradykinin-mediated angioedema is unlikely to respond to standard anaphylaxis treatments including adrenaline (epinephrine). Lack of response to standard anaphylaxis treatments should prompt consideration of bradykinin-mediated angioedema, with treatment informed by clinical protocols. If angioedema is suspected in a patient taking an ACE inhibitor, discontinue the ACE inhibitor immediately and do not restart. </td><td data-bbox="1167 316 1659 1262"> Share in Primary Care bulletins </td></tr> </tbody> </table>	Affected drug	Impact for primary care in South Yorkshire	Recommended Actions	ACE-inhibitors	Advice for Healthcare Professionals: Angioedema is a known uncommon or rare side-effect of ACE inhibitor treatment. This can either be allergic (histamine-mediated) or less commonly non-allergic (bradykinin-mediated). Healthcare professionals should consider bradykinin-mediated mechanisms as a cause when standard anaphylaxis treatment is ineffective. Angioedema can occur at any time during treatment, including after weeks to years of use. Swelling of the tongue, lip, face, or larynx which may cause difficulty in breathing or swallowing may progress and can lead to airway compromise. Other symptoms can include gastrointestinal pain and cramps. Bradykinin-mediated angioedema is unlikely to respond to standard anaphylaxis treatments including adrenaline (epinephrine). Lack of response to standard anaphylaxis treatments should prompt consideration of bradykinin-mediated angioedema, with treatment informed by clinical protocols. If angioedema is suspected in a patient taking an ACE inhibitor, discontinue the ACE inhibitor immediately and do not restart.	Share in Primary Care bulletins	
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	Benzylpenicillin benzathine 1.2 Million I.U. powder for suspension for injection	The update was limited to the information intended for healthcare professionals only section, subsection "Special precautions for disposal and other handling" and reflects an update to section 6.6 of the Summary of Product Characteristics (SPC). Additional information was added regarding (1) the potential for benzylpenicillin benzathine formulations to block in the needle if intramuscular injection of the reconstituted product to the patient is not made at a slow, steady rate, and (2) introducing practical guidance to healthcare professionals regarding how to mitigate this issue.	Shared in Primary Care bulletins	
	Gabapentin Relonchem 50mg/ml Oral Solution	Advice for Healthcare Professionals: check the existing stock within your possession and identify if any of the Gabapentin Relonchem 50mg/ml Oral Solution batches listed above are impacted by this issue. The visual check should be done at the point of dispensing or administration. Please note that in addition to dispensaries, this may include clinics, wards and any other relevant locations ensure that the bottles are checked prior to dispensing for any visible crystals and return the bottles through your usual process if crystals are identified. For ease of checking presence of crystals, the bottles may be gently rotated once or twice the product should be stored according to the storage instructions (do not store above 25°C) and ideally the product should not be stored below 15°C if Gabapentin 50 mg/mL Oral Solution is being used for administration via feeding tubes (NG/PEG), alternate formulations should be considered, as there is a potential for obstruction of feeding tubes. Clinical judgement may be required for individual cases. More advice can be sought from Relonchem Limited via the	Emailed CPSY for inclusion in their newsletter	

		contact details in this notification if there are any concerns raised by patients, they should be advised to contact a healthcare professional to obtain a new bottle but should not stop taking the medication unless directed by their physician Healthcare professionals are advised to review the information contained within this notification and take this into account when dispensing this product.		
	Flucloxacillin 500mg capsules	Drug recall: Patients may continue to take the capsules as prescribed by your doctor as the quality of the capsules is not impacted by this defect. No further action is required by patients. This recall is being undertaken as a precautionary measure and applies at Pharmacy and Wholesaler level.	No further action	
	Phenoxymethylpenicillin 250mg/5ml SF oral solution	Advice for Healthcare Professionals: Stop supplying the above batch immediately. Quarantine all remaining stock and return it to your supplier using your supplier's approved process. If batch/product traceability information is available, pharmacy professionals and other healthcare professionals involved in dispensing should identify and immediately contact all patients who have been dispensed the impacted product and ask them to confirm if details on the carton and label and ensure that this matches the dispensing label. If batch/product traceability information is not available, pharmacists should identify all patients dispensed this product from 29 April 2026 onwards. Where appropriate and feasible, contact all patients who have been	Actions for community pharmacy in the alert. No additional actions required	

		dispensed the impacted product with priority given to those who have been dispensed the product most recently and within the last 7 days. If any patients are identified with this product, pharmacy professionals and other healthcare professionals involved in dispensing should contact the patients' GP, or healthcare professional responsible for the care of the patient, to discuss treatment review and whether a new prescription is required for ongoing resupply. Advice for Patients: If you have been prescribed Phenoxymethylpenicillin 250 mg/5ml Sugar free Oral Solution BP and have received impacted product (Batch Number 7124002, Expiry Date 11/2026), please check that the label on the bottle matches the dispensing label. If the label on the bottle does not match the dispensing label contact the pharmacy where your product was dispensed. If you have any concerns, please contact your pharmacy for more information and advice.		
	ChloroPrep 2% w/v / 70% v/v cutaneous solution 1mL applicators	Advice for Healthcare Professionals: Stop supplying the affected batches. Quarantine all remaining stock and return it to your supplier using your supplier's approved process. Advice for Patients: No further action is required by patients as this product is used by healthcare professionals only and they will have taken the action to remove this product from use.	Share in Primary Care bulletins	

	Methylphenidate brand: Neuraxpharm Tuzulby PR chewable tablets	Healthcare professionals are advised to be aware that epistaxis (nosebleed) is a recognised adverse reaction associated with Tuzulby prolonged release chewable tablets and has been added to the Summary of Product Characteristics and Patient Information Leaflet with a frequency of 'not known'. Healthcare professionals should continue to prescribe and dispense Tuzulby prolonged release chewable tablets in accordance with the approved product information. Patients reporting epistaxis should be managed in accordance with routine clinical practice and the individual patient's clinical circumstances. Advice for Patients: The Patient Information Leaflet is being updated to include nosebleed (epistaxis) as a possible side effect. If you experience nosebleeds or have any concerns about your treatment, please speak to your doctor or pharmacist. Patients should continue to take Tuzulby prolonged release chewable tablets as prescribed by their healthcare professional. Do not stop treatment without seeking medical advice. Patients who experience adverse reactions or have any questions about their medication should seek medical attention. Any suspected adverse reactions should also be reported via the MHRA Yellow Card scheme.	No further action.	
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	Methylphenidate brand - Xaggitin XL prolonged release tablets	Advice for Healthcare Professionals: Please physically check the quantity of tablets when receiving the packs and when dispensing these tablets, this may include breaking the tamper evident seal. Please report any affected packs to licensed@ethypharm.com using the reference Ethypharm supply for any reconciliation excursions experienced due to this defect. Be aware that patients may return for their next prescription earlier than expected. Advice for patients: Patients should be aware that some packs of the affected batches may have an incorrect number of tablets in the bottle, leading to missing or additional tablets. Patients may continue to take the tablets prescribed by your doctor as the quality of the tablets is not impacted by this defect.	Shared with SY and NHSE CD leads. Add to Community Pharmacy bulletin	
	Botulinum toxin type A products	If patient is suspected to have botulism, follow the UK Health Security Agency advice on the clinical management of iatrogenic botulism	Share in Primary Care bulletins	

	Domperidone products	Advice for Healthcare Professionals: A small number of reports have been received relating to severe episodes of hypertension in patients with phaeochromocytoma (a rare tumour of the adrenal gland) following administration of domperidone. Domperidone is now contraindicated in patients with confirmed or suspected phaeochromocytoma. Patients with confirmed or suspected phaeochromocytoma should stop taking domperidone immediately and be switched to an alternative treatment. Be aware that administration of domperidone can unmask phaeochromocytomas. If a patient taking domperidone has an episode of severe hypertension, consider further investigations for phaeochromocytoma. Domperidone should be used at the lowest effective dose for the shortest possible duration and maximum treatment duration should not usually exceed 1 week. For patients receiving palliative care, an individual benefit risk decision on treatment should be made in discussion with the patient report suspected adverse drug reactions associated with domperidone via the Yellow Card scheme.	Shared in Primary Care bulletins	
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	VAKU-8 Blood Collection / Infusion / Scalp Vein Set Bipson's Gauze Swab Sterile Technocut Scalpel Romsons Alco Swabs Medi Grip Adhesive Bandage (Antiseptic) Bone Marrow Biopsy Needle Private Ltd Medi Grip Adhesive Bandage (Antiseptic) Precision Coatings (P) Ltd Bone Marrow Biopsy Needle	Advice for Healthcare Professionals: Review whether your organisation holds, uses or supplies any of the devices listed in this Device Safety Information (DSI). Immediately stop using and supplying any identified product(s) and quarantine all remaining stock. Identify and use alternative compliant products. Retain affected devices pending further advice from the MHRA. Alert the MHRA that you are in possession of an affected device via devices.compliance@mhra.gov.uk quoting the DSI reference number (DSI/2026/007). Providers should ensure all relevant members of staff receive DSI and that they understand the problem and actions to be taken report any suspected or actual adverse incidents involving these devices. There are specific reporting arrangements for healthcare professionals to follow in each region. Healthcare professionals should report incidents: in England and Wales to the Yellow Card scheme or via the Yellow Card app	Share in Primary Care bulletins	
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All rectal catheters (gas and colic relievers)	Advice for Healthcare Professionals: Advise parents and caregivers not to use rectal catheters sold for personal use (gas and colic relievers) in infants, including to treat colic, gas, bloating, or constipation and dispose of any unused products The use of these devices may delay diagnosis of serious gastrointestinal conditions, such as bowel obstruction or volvulus, by temporarily alleviating symptoms like gas without addressing the root cause. The risks of rectal trauma, perforation, bleeding or pain associated with the use of these devices in infants are unknown please refer to the NICE Clinical Knowledge Summary for information on the management of colic in infants - https://cks.nice.org.uk/topics/colic-infantile/management/management/ Report any incidents associated with the use of rectal catheters sold for personal use in infants to the MHRA via the Yellow Card Scheme or via local reporting routes. For more detailed reporting instructions please see 'Reporting advice' below.	Share in Primary Care and Community Pharmacy bulletins	
Nifedipine 10mg, 20mg, 30mg and 60mg MR tablets	Supply disruption affecting some preparations of modified-release nifedipine. National guidance provides suitable alternative brands or strengths where appropriate. Prescribers are supported through OptimiseRx alerts in EMIS and SystmOne to help select alternatives safely	No further actions	
Diclofenac (Voltarol® Ophtha) 0.1% eye drops 0.3ml unit dose preservative-free and diclofenac (Voltarol® Ophtha Multidose) 0.1% eye drops	Shortages reported for some ophthalmic diclofenac products. Alternative products and management options are outlined within national supply guidance.	No further actions	

		Prescribing alerts are active to direct clinicians to appropriate alternatives	
	Oxcarbazepine 150mg tablets (Viatris)	Short term issue, now back in stock	No further actions
	Sodium Valproate (Epilim Chronosphere) 50mg, 250mg and 500mg MR granules sachets SF	52 items dispensed in SY in May 2026	No further actions
	Nabilone 1mg caps	0 items dispensed in SY in last 12 months	No further actions
ADHD Prevention of Future Deaths Report GW presented the Regulation 28 Prevention of Future Deaths (PFD) Report and NHS England's response relating to the death of a 23-year-old patient with ADHD. The Committee noted that the coroner had identified concerns regarding communication between a private ADHD provider and NHS primary care, which had resulted in concurrent prescribing of different ADHD medications. While medication was not considered a direct contributory factor in the patient's death, the report highlighted risks associated with poor information sharing, unclear prescribing responsibilities and fragmented shared care arrangements. Members noted that NHS England had accepted the learning from the case and emphasised the importance of robust communication between providers, including independent providers, alongside clear prescribing arrangements and strengthened ADHD pathways. The Committee was advised that the issues identified were particularly relevant to South Yorkshire, where ADHD assessment, treatment and ongoing management involve multiple organisations and care pathways. It was noted that work is already underway across South Yorkshire to address many of these issues through the development of neighbourhood ADHD service models and shared care protocols designed to clarify prescribing responsibilities, monitoring arrangements and provider accountability.			

	During discussion, BC raised concerns regarding existing ADHD shared care arrangements with independent providers. He noted that shared care agreements are often developed with limited primary care involvement and can place significant prescribing, monitoring and communication responsibilities on GP practices. Highlighting the need for a consistent approach to shared care arrangements and advocated for a standardised ADHD shared care protocol with clearly defined expectations for provider communication and clinical responsibilities. He also observed that practices can experience considerable pressure to accept shared care requests, including patient complaints and external escalation where requests are declined. The chair reflected on wider system challenges, including increasing demand for ADHD assessment and treatment and the consequent reliance on Right to Choose providers. He noted that fragmentation of care and communication difficulties can arise within the current model and commented on the importance of developing sustainable service arrangements. He clarified that these observations were not intended as criticism of local providers but reflected broader concerns regarding service planning and investment. KN requested that medicines safety representatives from RDaSH to be involved in future ADHD pathway development work. Highlighting the anticipated growth in ADHD services and stressed the importance of embedding medicines safety considerations within pathway redesign and implementation arrangements. The Committee noted the report and NHS England's response and supported the use of the learning to inform ongoing ADHD service development across South Yorkshire. It was agreed that future updates on pathway development and shared care arrangements would be brought back to IMOC as appropriate. Actions: • Relevant safety updates to be circulated in the primary care bulletins • GW to bring any updates to a future meeting when available	
11	Horizon scanning DC presented the latest Horizon Scanning Report and advised that amendments had been made to align the report with the revised terminology proposed within the updated IMOC Terms of	

	Reference. Members noted that the report now incorporates the new Access Categories and Preferencing Recommendations, with updates made to the relevant classification columns. It was acknowledged that some references to former traffic light terminology remain within the report and would be updated fully in future iterations. All drugs were approved and can be found detailed in the summary at the end. Actions: • AH to update the SY traffic light drug list	AH
13	IMOC subgroup TLDL AH highlighted a small number of amendments required within the Formulary Subgroup recommendations paper following identification of typographical and classification errors. Apixaban- for the prevention of venous thromboembolism (VTE) following hip or knee replacement surgery is traffic lighted Red Atropine- required amendment to ensure the indication includes use within anaesthesia, in addition to the existing indications. Members noted that this would align with classifications already applied in Barnsley and other South Yorkshire Places. Ciclosporin oral formulation - should be revised to reflect local arrangements and reference prescribing in line with relevant Place-based shared care protocols, recognising that these differ across South Yorkshire. Drugs which were approved and can be found detailed in the summary at the end.	
14	NICE summary It was noted that the meeting was not quorate. SAB presented the NICE document. TA694- Bempedoic acid with ezetimibe for treating primary hypercholesterolaemia or mixed dyslipidaemia . Traffic lighted Green in line with SY Lipid guidance TA1172- Atogepant for treating migraine. Traffic Lighted Green (all settings) for the acute treatment of migraines in adults. The committee discussed that there are now multiply “gepants” available and perhaps there is a need for preferencing recommendation.	

TA1169-Mirvetuximab soravtansine for treating folate receptor-alpha-positive platinum-resistant epithelial ovarian, fallopian tube or primary peritoneal cancer. Traffic Lighted Red (Specialist Only) TA1170- Daratumumab with bortezomib, lenalidomide and dexamethasone for untreated multiple myeloma when a stem cell transplant is unsuitable Already traffic lighted Red (Specialist Only) TA1171- Seladelpar for previously treated primary biliary cholangitis. Currently traffic lighted as Grey, re traffic light as Red (Specialist Only) TA1175- Glycopyrronium bromide cream for treating severe primary axillary hyperhidrosis. Traffic lighted as Green (all settings). Glycopyrronium bromide cream can be used but only when lifestyle advice, topical aluminium-based antiperspirants and oral antimuscarinics have not controlled underarm sweating or are contraindicated or not tolerated. TA1176-Teplizumab for delaying the onset of stage 3 type 1 diabetes in people 8 years and over with stage 2 type 1 diabetes. This is a high-cost treatment initiated by the Specialist. There are approximately 11 eligible patients in SY. There are significant implementation requirements including patient identification for which a screening program is required and the development of a specialist treatment pathway. The treatment itself consists of a 30min daily infusion for 14 consecutive days. Concerns were raised regarding absence of an established pathway and substantial financial impact. This will be escalated through FEG reporting process. 11 in total (10 Adults across SY and 1 child) confirmed with specialists List price £10,939.12 x 14 days £183,777 per pt x11 pts = £2.02m (inc VAT) per annum but there is a significant cost reduction because of confidential NHS PAS Screening programme not currently available to identify these pts. Currently traffic lighted Grey(Do not prescribed) pending development of a screening programme and treatment pathway and further consideration through system governance processes.	
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TA1178-Deuruxolitinib for treating severe alopecia areata. Traffic lighted as Red (Specialist Only) Sheffield-5-10 pts Awaiting info from other places Based on NICE figures: 322 eligible pts Yr 1: (20%) 64pts Yr 2: (35%) 113pts Yr 3: (40%) 129pts List Price £949.41 per pk (60x 8mg tabs) £11,551 per pt per annum Yr1: £706K Yr2: £1.27m Yr3: £1.47m but there is a significant cost reduction because of confidential NHS PAS price Genotype testing required pretreatment. Drug company will cover the cost. TA1173-Pirtobrutinib for treating relapsed or refractory chronic lymphocytic leukaemia after a BTK inhibitor. Currently traffic lighted Grey but to be classified as Red (Specialist Only) TA1174-Cemiplimab for treating recurrent or metastatic cervical cancer that has progressed on or after platinum-based chemotherapy. Currently traffic lighted as Red (Specialist Only) TA1177- Pembrolizumab with chemoradiotherapy for untreated locally advanced cervical cancer. Currently traffic lighted as Red (Specialist Only) TA1181- Aficamten for treating symptomatic obstructive hypertrophic cardiomyopathy. Traffic Lighted Red (Specialist Only) TA1179- Lutetium-177 vipivotide tetraxetan for treating PSMA-positive hormone-relapsed metastatic prostate cancer after an anti-androgen but not a taxane. Traffic Lighted Grey (Do not Prescribe)	
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	TA1180- Netarsudil for treating open-angle glaucoma or ocular hypertension. Traffic Lighted Grey (Do not prescribe) TA1182- Finerenone for treating chronic heart failure with preserved or mildly reduced ejection fraction. Traffic Lighted Green (All settings). NICE resource estimate 7750 patients. Heart Failure guidelines to be updated to reflect the new TA. TA1183- Donidalorsen for preventing recurrent attacks of hereditary angioedema in people 12 years and over. Traffic Lighted Red (Specialist Only) TA1184- Acalabrutinib with bendamustine and rituximab for untreated mantle cell lymphoma. Traffic Lighted Red. (Specialist Only) TA1185- Acalabrutinib with venetoclax with or without obinutuzumab for untreated chronic lymphocytic leukaemia. Already traffic lighted Red. (Specialist Only) The committee accepted the recommendations presented, subject to formal ratification due to the meeting not being quorate. Actions: • AH to circulate documents to LMC members • SAB to highlight on the FEG report: ○ TA1176- Teplizumab for delaying the onset of stage 3 type 1 diabetes in people 8 years and over with stage 2 type 1 diabetes ○ TA1178- Deuruxolitinib for treating severe alopecia areata Post meeting note: There was no feedback/ objections raised by the LMC.	AH
15	Updated Documents /Minutes from SY ICB place APCs • Minor amendment to the Barnsley SCG for Entresto in the management of Chronic Heart Failure SY ICB Medicines Optimisation. This was addition of a contact (NMP, Heart Failure Service).	
16	Items for Escalation (e.g. commissioning requirements)	

	• TA1176-Teplizumab for delaying the onset of stage 3 type 1 diabetes in people 8 years and over with stage 2 type 1 diabetes • TA1178-Deuruxolitinib for treating severe alopecia areata to be highlighted on the FEG report. • Approval of the updated TOR	
17	Stock shortages Calcitriol ointment (Silkis) has been discontinued. Supply disruption of Stoboclo (denosumab) 60mg/ml pre filled syringe.	
19	Workplan / Forward Planner/ action log Updated accordingly, as above.	
20	Any other Business CB provided an update on recent changes to the Community Pharmacy Hypertension Case Finding Service. The revised service specification introduces tighter eligibility criteria, including the exclusion of patients with an existing diagnosis of hypertension from ambulatory blood pressure monitoring through the service. A new requirement has also been introduced whereby patients who have had a blood pressure check in any healthcare setting within the previous five years are no longer eligible. GP referrals should now be restricted to patients aged 40 years and over, without a diagnosis of hypertension, and who have not had a blood pressure measurement recorded within the last five years. Members noted the importance of ensuring primary care colleagues are aware of the revised criteria, given the frequent use of community pharmacies for blood pressure case finding and monitoring. Action: Include details of the updated eligibility criteria in the next Primary Care Bulletin for circulation to GP practices. Post meeting note: RS confirmed that this had already been circulated in the primary care bulletins	
21	Date and Time of Next Meeting Wednesday 7 th October 11:30-13:30 via Microsoft teams	

	<u>Approved guidelines/ Shared care guidelines</u> SY CKD guidance	
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September's Traffic Light Drug list

Drug/Product	Brand name	Indication	Categories (previously known as Traffic Light Status)	Preferencing recommendation (First line, Second line, Other, Non- formulary, Hospital only)	Comments	Date Considered	Review date	Agenda Item
Clesrovimab (<i>new medicine</i>)	Enflonsia®	Prevention of respiratory syncytial virus (RSV) lower respiratory tract disease in neonates and infants during their first RSV season.	Specialist only	Formulary -Hospital only		Sep-26		Horizon Scanning
Mpox vaccine (<i>Imvanex® now licensed for Mpox</i>)	Imvanex®	Active immunisation against mpox, smallpox and disease caused by vaccinia virus in adults.	Specialist only	Formulary - Only via sexual health clinics in line with national guidelines (include links to the green book chapter and UKHSA guidance)	Mpox vaccine is available via sexual health clinics.	Sep-26		Horizon Scanning

Progesterone (relaunched product Gestone® - previously discontinued)	Gestone®	Dysfunctional uterine bleeding. Maintenance of early pregnancy in women with a history of ≥3 consecutive unexplained miscarriages, and in selected cases as an adjunct to infertility treatment to facilitate uterine implantation of the fertilised ovum.	Specialist only	Formulary -Hospital only		Sep-26	Horizon Scanning
Tegafur/ gimeracil/ oteracil (relaunched - previously discontinued)	Teysuno®	With cisplatin for advanced gastric cancer. As monotherapy or with oxaliplatin or irinotecan, with or without bevacizumab, for metastatic colorectal cancer where it is not possible to continue treatment with another fluoropyrimidine due to hand- foot syndrome or cardiovascular toxicity that developed in	Specialist only	Formulary -Hospital only	Gestone 50mg/ml solution for injection	Sep-26	Horizon Scanning

		the adjuvant or metastatic setting.						
Brensocatib (<i>new medicine</i>)	Brinsupri®	Indicated for the treatment of non-cystic fibrosis bronchiectasis (NCFB) in patients 12 years of age and older with two or more exacerbations in the prior 12 months.	Do not prescribe	Non-formulary	No NICE TAs	Sep-26		Horizon Scanning
Semaglutide tablets (<i>new formulation</i>)	Wegovy®	As an adjunct to diet and exercise for weight management in adults with a BMI of $\geq 30\text{kg/m}^2$ (obesity), or $\geq 27\text{kg/m}^2$ to	Do not prescribe	Non-formulary	NICE TA in development	Sep-26		Horizon Scanning

		<30kg/m ² (over weight) with at least one weight-related comorbidity.					
Bisoprolol (<i>new orodispersible formulation</i>)	Generic	<u>Orodispersible 1.25mg, 2.5mg and 5mg tablets:</u> Treatment of stable chronic heart failure with reduced systolic left ventricular function in addition to ACE inhibitors, and diuretics, and optionally cardiac glycosides	All settings	Formulary - The first choice beta-blocker is dependant on indication, refer to local guidance where available.	NICE TA for Oral semaglutide for managing overweight and obesity discontinued.	Sep-26	Horizon Scanning
Apixaban		Prevention of VTE after hip or knee replacement	Specialist only	Formulary -Hospital only		Sep-26	IMOC subgroup
		Anticoagulant for stroke and systemic embolism prevention in AF	All settings	Formulary			
Aripiprazole injection		Schizophrenia, rapid control of agitation and disturbed behaviours in patients, when oral therapy is not appropriate.	Specialist only	Formulary -Hospital only- refer to local guidance where available		Sep-26	IMOC subgroup

Atropine injection		Emergency Treatment of Poisoning (Major incidents involving nerve agents. Also for treatment of bradycardia or organophosphate or carbamate insecticides & used as anaesthesia	Specialist only	Formulary -Hospital only- refer to local guidance where available		Sep-26		IMOC subgroup
Ciclosporin oral preparation			Shared Care Protocol	In line with Place shared care protocols		Sep-26		IMOC subgroup
Bempedoic acid with ezetimibe	Nilemdo and Nustendi	for treating primary hypercholesterolaemia or mixed dyslipidaemia	All settings	Formulary	https://www.nice.org.uk/guidance/ta694	Sep-26		IMOC subgroup
Atogepant	Aquipta	for the acute treatment of migraine in adults	All settings	Formulary	Overview Atogepant for treating migraine Guidance NICE	Sep-26		IMOC subgroup
Mirvetuximab soravtansine	Elahere	for treating folate receptor-alpha-positive platinum-resistant epithelial ovarian, fallopian tube or primary peritoneal cancer	Specialist only		Overview Mirvetuximab soravtansine for treating folate receptor-alpha-positive platinum-resistant epithelial ovarian, fallopian tube or primary peritoneal cancer Guidance NICE	Sep-26		IMOC subgroup

Daratumumab with bortezomib, lenalidomide and dexamethasone		for untreated multiple myeloma when a stem cell transplant is unsuitable	Specialist only		Overview Daratumumab with bortezomib, lenalidomide and dexamethasone for untreated multiple myeloma when a stem cell transplant is unsuitable Guidance NICE	Sep-26		NICE TA
Seladelpar	Livdelzi	for previously treated primary biliary cholangitis	Specialist only previously traffic lighted as Grey		Overview Seladelpar for previously treated primary biliary cholangitis Guidance NICE	Sep-26		NICE TA
Glycopyrronium bromide cream	Axhidrox	for treating severe primary axillary hyperhidrosis	All settings		Overview Glycopyrronium bromide cream for treating severe primary axillary hyperhidrosis Guidance NICE	Sep-26		NICE TA
Teplizumab	Tzield	for delaying the onset of stage 3 type 1 diabetes in people 8 years and over with stage 2 type 1 diabetes	Do not prescribe	Keep Grey pending pathway	Overview Teplizumab for delaying the onset of stage 3 type 1 diabetes in people 8 years and over with stage 2 type 1	Sep-26		NICE TA

					diabetes Guidance NICE			
Deuruxolitinib	Leqselvi	for treating severe alopecia areata	Specialist only	-	Overview Deuruxolitinib for treating severe alopecia areata Guidance NICE	Sep-26		NICE TA
Pirtobrutinib		for treating relapsed or refractory chronic lymphocytic leukaemia after a BTK inhibitor	Specialist only previously traffic lighted as Grey		Overview Pirtobrutinib for treating relapsed or refractory chronic lymphocytic leukaemia after a BTK inhibitor Guidance NICE	Sep-26		NICE TA
Cemiplimab	Libtayo	for treating recurrent or metastatic cervical cancer that has progressed on or after platinum-based chemotherapy	Specialist only		Overview Cemiplimab for treating recurrent or metastatic cervical cancer that has progressed on or after platinum-based chemotherapy Guidance NICE	Sep-26		NICE TA

Pembrolizumab with chemoradiotherapy	Keytruda	Pembrolizumab with chemoradiotherapy for untreated locally advanced cervical cancer	Specialist only	Pembrolizumab (including in combination with other drugs) has already been categorised Red	Overview Pembrolizumab with chemoradiotherapy for untreated locally advanced cervical cancer Guidance NICE	Sep-26		NICE TA
Aficamten	Myqorzo	for treating symptomatic obstructive hypertrophic cardiomyopathy	Specialist only	-	Overview Aficamten for treating symptomatic obstructive hypertrophic cardiomyopathy Guidance NICE	Sep-26		NICE TA
Lutetium-177 vipivotide tetraxetan	Pluvicto	for treating PSMA-positive hormone-relapsed metastatic prostate cancer after an anti-androgen but not a taxane (terminated evaluation)	Do not prescribe		Overview Lutetium-177 vipivotide tetraxetan for treating PSMA-positive hormone-relapsed metastatic prostate cancer after an anti-androgen but not a taxane (terminated evaluation) Guidance NICE	Sep-26		NICE TA

Netarsudil	Rhokiinsa	for treating open-angle glaucoma or ocular hypertension (terminated evaluation)	Do not prescribe		Overview Netarsudil for treating open-angle glaucoma or ocular hypertension (terminated evaluation) Guidance NICE	Sep-26		NICE TA
Finerenone	Kerendia	for treating chronic heart failure with preserved or mildly reduced ejection fraction	All settings		Overview Finerenone for treating chronic heart failure with preserved or mildly reduced ejection fraction Guidance NICE	Sep-26		NICE TA
Donidalorsen		for preventing recurrent attacks of hereditary angioedema in people 12 years and over	Specialist only		Overview Donidalorsen for preventing recurrent attacks of hereditary angioedema in people 12 years and over Guidance NICE	Sep-26		NICE TA
Acalabrutinib with bendamustine and rituximab		for untreated mantle cell lymphoma	Specialist only	Acalabrutinib categories (traffic light)(including in combination) in line with positive NICE TA recommendations	Overview Acalabrutinib with bendamustine and rituximab for untreated mantle cell lymphoma Guidance NICE	Sep-26		NICE TA

Acalabrutinib with venetoclax with or without obinutuzumab		for untreated chronic lymphocytic leukaemia	Specialist only	Acalabrutinib categories (traffic light)(including in combination) in line with positive NICE TA recommendations	Overview Acalabrutinib with venetoclax with or without obinutuzumab for untreated chronic lymphocytic leukaemia Guidance NICE	Sep-26		NICE TA
Mepolizumab		maintenance treatment of uncontrolled chronic obstructive pulmonary disease with raised blood eosinophils	Specialist only	was previously traffic lighted as Grey	-	Sep-26		From FEG report