Minutes of the Integrated Medicines Optimisation Committee (IMOC)
Held on Wednesday 1st July 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
✓	*11:43-13:10*	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
✓	*Left at 12:25*	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
		Eloise Summerfield (ES)	Senior Pharmacist (Strategy & Delivery) Rotherham Place Support to High-Cost Drugs (Pathways)
✓		Deborah Cooke (DC)	Senior Pharmacist (Strategy and Delivery & Clinical Effectiveness- Barnsley Place)
		Gillian Turrell (GT)	SYICB- Hospital Pharmacist- Barnsley
✓	*Left 13:00*	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
✓	*Left at 12:39*	Surinder Ahuja (SA)	Medication Safety Officer & Lead Pharmacist Governance and Formulary- Rotherham Hospital
✓		Shameila Afsar -Baig (SAB)	Senior Pharmacist (Strategy and Delivery)- Sheffield Place
✓	*11:51-12:54*	Kulsoom Khan (KKh)	Procurement Pharmacist at TRFT
✓	*Arrived 12:49*	Mallicka Chakrabarty (MC)	GP Prescribing Lead (Bassetlaw)

		Navjit Johal (NJ)	Chief Pharmacist – Rotherham Hospital
✓		Robina Okes-Voysey (ROV)	Senior Pharmacist, Quality Improvement
✓		Bipin Chandran (BC)	Rotherham LMC representative
✓		Greg Westley (GW)	Medicines Safety Officer
✓		Kuljit Nandhara (KN)	Chief Pharmacist – RDaSH
✓		Tracey White (TW)	Pharmacy Technician – Strategy and delivery (Doncaster)
✓	*11:30-12:00*	Richard Crosby (RC)	Strategic Pharmacist – Integration (Primary care, Public health and Local Authority
✓	*11:59-12:12*	Jessica Tay (JT)	Consultant Clinical Oncologist- Sheffield Teaching Hospital
✓	*12:39-13:13*	Arif Khwaja (AK)	Consultant Nephrologist and Clinical Director- Sheffield Teaching Hospital
✓		Jill Rigby (JRig)	Senior Pharmacist (Strategy and Delivery)
✓	*13:00-13:13*	William McKane (WMc)	Consultant Nephrologist- Sheffield Teaching Hospital

		Action
1	**Welcome:** Welcome to: Tracey White Pharmacy Technician – Strategy and delivery (Doncaster) Richard Crosby Strategic Pharmacist – Integration (Primary care, Public health and Local Authority Jessica Tay Consultant Clinical Oncologist- Sheffield Teaching Hospital Jill Rigby Senior Pharmacist (Strategy and Delivery) Arif Khwaja Consultant Nephrologist and Clinical Director- Sheffield Teaching Hospital William McKane Consultant Nephrologist- Sheffield Teaching Hospital	
	Apologies Heidi Taylor & Charlotte McMurray	
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** Any other Business: Prescribing in metabolic disorders – Deborah Cooke	
4	**Minutes of the meeting held on 3rd June 2026 & any other items which are not on the agenda** The 3rd June 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 TE commented on the effectiveness of the PIL's, that while the document is comprehensive and clinically informative, the key messages are not sufficiently prominent. She emphasised that the primary purpose of the leaflet is to support patients in safely discontinuing gabapentin and that the critical instructions—namely to reduce the dose gradually, not stop the medication suddenly, and follow the tapering schedule provided—should be presented clearly at the beginning of the document.	

	Members acknowledged that the leaflet contains a substantial amount of information and agreed that patients may not read beyond the opening sections. There was broad support for restructuring the leaflet so that the essential safety messages and dose-reduction guidance are placed more prominently, while retaining the supporting information elsewhere in the document. SH supported these concerns and suggested that some currently highlighted information, such as advice to contact the prescriber with questions, could be repositioned to avoid detracting from the leaflet's primary purpose. The committee agreed that the PIL's should be updated and would be an action for the IMOC sub group to review. It was also confirmed that the current leaflets would remain available on the website pending any revisions, as the content itself is not clinically incorrect. TE noted that this issue may extend to other patient information leaflets and encouraged a more patient-centred approach to future leaflet development, ensuring that the key message and required action are clearly communicated within the opening section of the document. **Action**: Review the PIL's through the IMOC Subgroup, with consideration given to restructuring the document to prominently display the key safety messages and tapering guidance at the outset. The chair and TE to review updated PIL's Action log 277: AJM gave the committee an update on the Action log 277: AJM gave the committee an update on the Place based meetings. AJM advised that the Sheffield meeting arrangements are being stepped down, with alternative arrangements being considered to ensure stakeholders continue to receive relevant information and updates. This is expected to include the circulation of information via email to previous attendees, with reports from relevant groups being shared as appropriate. AJM will be attending Barnsley's meeting next week, following which a decision will be made regarding future arrangements. Doncaster is continuing to consider its	

	future approach and whether meetings will continue to be held across the provider community. SH confirmed that current meetings are continuing at present. However, discussions are underway regarding future arrangements, including the possibility of moving from the current frequency to monthly meetings and work is ongoing to determine the most appropriate structure and membership going forward. AJM concluded by explaining that responsibility for the leadership and structure of these meetings is moving away from the Medicines Optimisation Team. Decisions regarding future meeting arrangements will therefore sit with providers within each locality. He emphasised that the Medicines Optimisation Team will continue to support these arrangements by providing a collaborative communication pathway between the ICB, in its commissioning role, and providers responsible for service delivery and implementation.	
6	**Tirzepatide Weight management updated position statement** Richard Crosby (RC) -Strategic Pharmacist, NHS South Yorkshire ICB presented a proposal to update the traffic light classification from cohort two patients from red to green and update the SY position statement. He explained that the amendments were intended to align the existing position statement and proposal form with current NICE guidance, NHS England interim commissioning guidance, and recent developments relating to obesity management pathways. The current traffic light position supports prescribing for patients within Cohort 1 and that the proposed update would extend this to include Cohort 2, in line with national guidance. It was noted that this alignment would ensure consistency between SY ICB prescribing arrangements and national eligibility criteria. RC also highlighted the importance of the update in supporting implementation of the obesity management pathway and ensuring that prescribing restrictions do not inadvertently create barriers for eligible patients. There is work underway to update the Tirzepatide weight management prescribing guidance which will come to a future IMOC meeting for approval. DE challenged the suggestion that prescribing tirzepatide formed part of the requirements for achieving QOF-	

	related obesity indicators. That it was his understanding that QOF requires practices to undertake shared decision-making and referral activity, rather than prescribing medication, and therefore questioned whether any financial implications would arise from not prescribing tirzepatide. That the QOF rules did not explicitly require prescribing within general practice.BT discussed that QOF should not be regarded as a commissioned service, it is a quality improvement service and raised concerns of the withdrawal of a previously approved local commissioned service should not be considered equivalent to support the obesity QOF indicators. ROV provided clarification regarding the obesity-related QOF indicator. She advised that her understanding, based on guidance received from NHS England and information shared through Primary Care IT channels, was that achievement of the indicator required: • Shared decision-making with the patient. • Referral to an appropriate weight management or behavioural support service. • Recording that pharmacotherapy for obesity had been prescribed. ROV acknowledged that confusion had arisen during recent NHS England webinars and advised that she had sought clarification from the presenters. She reported that subsequent clarification indicated that pharmacotherapy formed part of the intended pathway. She emphasised that her comments related solely to interpretation of the business rules and not to the wider debate regarding commissioning arrangements. The chair summarised the discussion, noting the concerns raised by the LMC representatives regarding commissioning arrangements and the QOF requirements. The concerns will be captured and escalated through the FEG report. The committee approved the position statement and the change in traffic light status to classify cohort two patients from red to green. The chair thanked RC for presenting and attending IMOC.	

	Actions: • AH to update tirzepatide weight management traffic light status for cohort two patients from red to green • AH to replace the tirzepatide weight management position statement	**AH** **AH**
7	**Relugolix traffic light proposal** Jessica Tay (JT)- clinical oncologists based at Western Park Hospital. Has returned to ask the committee to support the traffic light status of Relugolix from Red to Amber G in line with other ICB's. The application previously came to IMOC in March 2026 where the specialists were asked to look at surrounding areas traffic light status to see whether an Amber shared care or Amber G status would be suitable. Previously at IMOC the committee discussed that there were no clinical concerns regarding moving Relugolix from Red to Amber G. JT advised that patients receiving Relugolix would generally remain under specialist follow-up, with PSA monitoring routinely undertaken by oncology or urology services. No additional routine monitoring requirements were identified beyond standard clinical management. AH discussed that a review of classifications across other NHS systems demonstrated that the majority of ICBs had assigned Relugolix an Amber G status. It was further noted that whilst some areas had developed local prescribing guidance, others relied upon national guidance and NICE documentation to support prescribing. DC proposed classification would align with current arrangements for other androgen deprivation therapies prescribed in primary care and would bring South Yorkshire into line with the majority of other NHS systems. BC highlighted concerns raised by Sheffield LMC representative regarding the impact on locally commissioned service payments where patients move from injectable androgen deprivation therapies to oral treatment. However, it was acknowledged that Relugolix may reduce demand on practice nurse appointments associated with administering	

	injections. This will be flagged up on the exec report. JT further outlined the clinical benefits of Relugolix, including improved convenience for patients, avoidance of injection-site reactions, and potential cardiovascular advantages in selected patient groups. AJM provided clarity that PSA monitoring every 6 months would not be particularly out of line with minimum monitoring. Therefore it wouldn't be added to any shared care payment service. In response to a query regarding monitoring requirements, JT advised that routine liver function monitoring is not generally required for Relugolix. She clarified that liver function monitoring is more commonly associated with other prostate cancer treatments, such as bicalutamide. The committee approved the traffic light status from Red to Amber G. GOV will review available national and regional prescribing guidance, including NICE linked resources and identify an appropriate supporting guidance document to accompany the Amber G classification. The chair thanked JT for attending IMOC. **Actions:** • AH to update Traffic light status from Red to Amber G • GOV to review guidance documents to support the Amber G status	**AH** **GOV**
8	**Prescribing Improvement Scheme** Jill Rigby (JRig) Senior Pharmacist (Strategy and Delivery) presented the proposed Medicines Optimisation QIPP opportunities for endorsement by the Committee. It was noted that the majority of the opportunities were established workstreams that had featured in previous QIPP programmes and had been undertaken by the Practice Support Team. The proposed list is intended to support delivery of the 2026/27 Prescribing Incentive Scheme. BC raised	

	concerns regarding several proposed switches, particularly those involving changes between formulations of the same medicine. Highlighting previous safety considerations that had driven prescribing towards certain formulations and expressed concern that some of the proposed switches could create confusion for prescribers in busy general practice settings. He also questioned whether the practical benefits of some opportunities would justify the workload required to identify and implement them. DC acknowledged these concerns and advised that appropriate prescribing support would be provided through OptimiseRx alerts and prescribing data to assist practices in identifying suitable patients. She noted that many of the opportunities had previously been implemented successfully and that, whilst not all patients would be suitable for switching, the potential cost savings remained significant enough to warrant inclusion. LW echoed concerns regarding recommendations involving different formulations of the same medicine, noting that changes in availability and pricing may require frequent review. SH sought clarification regarding the recommendation related to Slenyto® and melatonin prescribing. She queried the wording referring to “even doses” and requested clarification regarding its intended meaning and application in practice. In response, JRig outlined previous work undertaken with Sheffield Children’s Hospital Sleep Service and explained that Slenyto® remains appropriate for certain patients, particularly where a smaller modified-release tablet is required. However, for suitable patients, alternative melatonin formulations may offer a more cost-effective option. She confirmed that supporting resources would be made available to assist clinicians in making prescribing decisions. Committee members agreed that the wording related to melatonin dosing could be misunderstood. It was proposed that the wording be revised to more clearly describe doses that can be achieved using 2 mg modified-release tablets. The Committee endorsed the Medicines Optimisation QIPP Opportunities List for inclusion within the 2026/27 Prescribing Incentive Scheme, subject to a minor amendment to the wording relating to melatonin dosing.	

	The chair thanked JRig for attending IMOC. **Actions:** • JRig & DC to revise the wording within the melatonin section to improve clarity	**JRig/DC**
9	**Safety updates** **Becton Dickinson UK Ltd are recalling batches of ChloraPrep 2% w/v / 70% v/v cutaneous solution 1mL applicators and ChloraPrep Frepp 2% w/v / 70% v/v cutaneous solution 1.5 mL applicators due to a potential breach of sterility in the packaging process. The recall applies to all batches with an expiry date up to and including 02/2028. Batches with an expiry date after 02/2028 are not impacted.** - 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 Healthcare Professionals to Provide to 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. **Recommended actions**: Sent to Practice bulletin to share this information **Teva UK Limited is reporting a labelling error on the carton for Ponlimsi (Denosumab) 60mg Solution for injection in Pre-filled Syringe. The carton states "For application to the skin" when the product is licensed for subcutaneous use.** - This notification contains batches that have commenced distribution from 21/01/2026 onwards. All 3 batches have been manufactured and packed with	

	the erroneous carton, however as the product administration should be performed by an individual who has been adequately trained in injection techniques, these batches will not be repackaged and continue to be distributed. Teva UK Limited have confirmed that all future deliveries will be supplied with a copy of this notification to help remind healthcare professionals and patients that this product is for subcutaneous use. **Recommend actions**: Sent to Practice bulletin to share this information **Infant death (4 months) where carer had taken sedating medication; co-sleeping contributed. Existing safer sleep advice had not included medication-related risks**. - Need to link sedating medicine counselling with safer sleep advice for parents/carers of infants. BNF updated to include "Patients who are parents or carers of babies aged up to 12 months should be counselled on the risks of co-sleeping (sleeping with a baby on a bed, sofa, chair, etc.); for further information on safer sleeping and co-sleeping, see the Lullaby Trust at https://www.lullabytrust.org.uk/baby-safety/safer-sleep-information/co-sleeping/". **Recommended actions**: Promote awareness; incorporate safer sleep messaging into medicines discussions; engage community pharmacy, GP and HV teams. Support rollout of safer sleep training offer (currently Sheffield) and explore expansion across South Yorkshire. KN discussed work previously undertaken across the Nottinghamshire system which utilised statistical reporting to support service improvement, particularly within mental health services and physical health monitoring. She highlighted the value of data-driven approaches in identifying opportunities for improvement and measuring outcomes, including medicines-related indicators. KN offered to explore whether the Nottinghamshire methodology and reporting could be shared for consideration.GW welcomed the offer and any information available could help inform the development of a similar approach across SY.	

	Actions: • Place Committee members to discuss/ implement at Place meetings	
10	**Recording medicines prescribed somewhere else on clinical systems guide** GW presented the Guide to Recording Medicines Prescribed Elsewhere on Clinical Systems for approval. He acknowledged the significant contribution of Laura Fillingham (Medicines Safety Pharmacy Technician), who had undertaken the majority of the development work prior to leaving the ICB, noting that he had completed the final stages of the document's preparation. Tthe guidance document developed to provide a standardised approach across South Yorkshire for recording medicines prescribed by organisations other than a patient's registered GP practice. The guidance aims to improve patient safety, support medicines reconciliation, maintain accurate Summary Care Records, and clarify prescribing responsibilities. The document includes a one-page summary with links to detailed EMIS Web and SystemOne instructions, alongside background information and examples of patient safety incidents that informed its development. Feedback from pilot sites and pharmacy teams had been positive, with the process considered practical and easy to follow. AJM sought clarification regarding drug interaction alerts. GW confirmed that interaction checking remains available when licensed medicines are recorded using recognised medication entries. However, this functionality is not available for some unlicensed or clinical trial medicines that cannot be added to the prescribing system in the same way. SH noted that the proposed approach differs from current practice in some areas and raised concerns regarding visibility of medicines prescribed elsewhere. GW confirmed that these medicines remain visible via the Summary Care Record. BC welcomed the document and supported its implementation.	

	The committee approved the guidance document. **Actions:** • AH to upload onto the Medicines Optimisation website and circulate	**AH**
11	**Horizon scanning** DC summarised the horizon scanning document following on from last month's IMOC meeting. Under the revised process, new medicines, new chemical entities and clinically significant new formulations will continue to be presented to IMOC. However, new brands of existing medicines will not routinely be brought forward unless they present a significant cost saving, a substantial cost pressure, or have the potential to reduce health inequalities. Similarly, where medicines have already been classified by IMOC at chemical substance level, subsequent products within that classification will not routinely be presented unless there is additional information requiring consideration. 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**
12	**Sodium Zirconium pathway proposal** Dr Arif Khwaja (AK) presented an application requesting that sodium zirconium cyclosilicate (SZC) be reclassified from Red to Amber G. Using the Bristol pathway as a protype to support the Amber G status. He noted that many other ICB's have classified the medicine as Green or Amber and that current Red classification could create barriers to patient access. AK advised that patients would be initiated and stabilised in secondary care before transfer to primary care. He stated that, once a stable dose had been established, monitoring requirements would not exceed routine monitoring already undertaken for the patient's underlying condition. BC& SH expressed	

	concerns regarding the proposed Amber G classification. They noted that the Bristol pathway referenced ongoing monitoring and repeat blood testing following dose changes, which appeared inconsistent with the definition of SY Amber G. BC concerns were also raised regarding the lack of clarity around ongoing monitoring responsibilities and the potential risk of patients being missed without a formal monitoring framework, that the Bristol's pathway only has monitoring information and suggested that an amber shared care would be in line with the safety and monitoring requirements. AJM commented that the Bristol pathway appeared to place ongoing management within primary care without a requirement for routine specialist input and therefore could be consistent with an Amber G classification. However, acknowledged that the principal concern appeared to relate to the potential monitoring and workload implications associated with an Amber classification. A suggestion that clarification within the guidance that any monitoring recommendations were intended as supportive information rather than mandatory additional requirements may help address concerns from primary care and reassure LMC representatives that the proposal would not create a significant additional workload burden. The committee agreed, where possible, existing external guidance should be adopted rather than developing entirely new local documentation. Although it was noted that concerns were raised regarding the references within the pathway to other Bristol- specific documents and medicines not currently under consideration within SY including Patiromer. It was felt that some amendments would likely be required before the document could be adopted. AK advised that patients continue to be reviewed according to the underlying severity of their CKD or heart failure rather than because they were prescribed SZC. Routine monitoring of SZC in secondary care is unnecessary and not in patients' best interests once treatment had been stabilised. Despite broad support for improving access to SZC, concerns remained regarding the proposed classification, monitoring arrangements and supporting guidance. As consensus could not be reached, the Committee was	

	unable to make a unanimous recommendation. It was agreed that currently the traffic light status would remain Red. The Committee agreed that the discussion and differing views should be reflected within the report to the ICB Executive for consideration and to provide a steer on the proposed change in traffic light status. BC would take further discussion to Rotherham's LMC meeting **Actions:** • ICB Executive to consider the proposal and provide further direction regarding the requested traffic light classification**.** • Sheffield Consultants to await the outcome of Executive consideration before progressing revisions to supporting guidance. • BC to discuss IMOC discussion at next Rotherham's LMC meeting • Item to remain on the IMOC Action Log pending further discussion and feedback from the ICB Executive.	
13	**IMOC subgroup TLDL** All drugs were approved and can be found detailed in the summary at the end.	
14	**NICE summary** TA1155- Rozanolixizumab for treating antibody-positive generalised myasthenia gravis**.** Currently traffic lighted as Grey and will be reclassified as Red TA1156- Osimertinib for treating EGFR mutation-positive unresectable locally advanced non-small-cell lung cancer after platinum-based chemoradiotherapy Already traffic lighted Red TA1157-Givinostat for treating Duchenne muscular dystrophy in people 6 years and over. Currently traffic lighted as Grey and will be reclassified as Red	

	TA1158- Amivantamab with carboplatin and pemetrexed for untreated EGFR exon 20 insertion mutation-positive advanced non-small-cell lung cancer. Already traffic lighted Red TA1159-Lisocabtagene maraleucel for treating relapsed or refractory large B-cell lymphoma after 2 or more lines of systemic treatment. Already traffic lighted Red TA1160-Durvalumab with chemotherapy for neoadjuvant and adjuvant treatment then alone for adjuvant treatment of resectable gastric or gastro-oesophageal junction adenocarcinoma. Already traffic lighted Red TA1161-Sotatercept for treating pulmonary arterial hypertension. Currently traffic lighted as Grey and will be reclassified as Red TA1162-Nusinersen and risdiplam for treating spinal muscular atrophy. Already traffic lighted as Red TA1164-Tisotumab vedotin for treating recurrent or metastatic cervical cancer that has progressed on or after systemic treatment. Traffic lighted Red TA1165- Cemiplimab with platinum-based chemotherapy for untreated advanced non-small-cell lung cancer. Already traffic lighted Red TA1167- Serplulimab with carboplatin and etoposide for untreated extensive-stage small-cell lung cancer. Currently traffic lighted as Grey and will be reclassified as Red TA1163- Nogapendekin alfa inbakicept with BCG for non-muscle-invasive bladder cancer with carcinoma in situ that is unresponsive to BCG. Terminated Appraisal traffic lighted Grey TA1168-Imlunestrant for treating oestrogen receptor-positive HER2-negative advanced breast cancer after endocrine therapy Terminated Appraisal traffic lighted Grey	

	TA1166- Mepolizumab for maintenance treatment of uncontrolled chronic obstructive pulmonary disease with raised blood eosinophils. NICE resource impact estimates the following: 49 (5%) in Yr 1 108 (15%) in Yr 2 218 (31%) in Yr 3 £11k per pt per annum (£840.00 x 13) i.e. £11 k x 49 = £535k per annum but there is a significant cost reduction because of confidential NHS PAS It was noted that there are no direct comparative studies between mepolizumab and dupilumab in COPD. Whilst indirect comparisons are associated with significant uncertainty, they may suggest that mepolizumab is less effective than dupilumab at reducing exacerbations. However, mepolizumab is approximately 40% less expensive than dupilumab based on PAS pricing. SK advised that discussions were ongoing regarding the COPD pathway and that both mepolizumab and dupilumab should be considered together to ensure a consistent approach. Further discussions with providers were planned to agree the pathway and Blueteq arrangements. The Committee discussed the existing Traffic Light classification of mepolizumab, which is currently classified as Red for asthma. It was agreed to classify mepolizumab as Red for asthma and Grey for COPD, mirroring the approach taken for dupilumab and supporting alignment of both medicines within the developing COPD pathway, pending further Executive Committee review.	
15	**ICB Formal Executive Group (FEG) Report**	

	Dupilumab has been taken to the prioritisation panel and will then go to the executive board.	
16	**Minutes from SY ICB place APCs** None were discussed	
17	**Stock shortages** None were discussed	
18	**Items for Escalation (e.g. commissioning requirements)** • Tirzepatide Weight management updated position statement- noting the concerns raised by the LMC representatives regarding commissioning arrangements and the QOF requirements • Relugolix traffic light proposal- payments for PSA(injections) monitoring Sodium Zirconium pathway- Could not met a consensus on change of traffic light status from Red to Amber G • Mepolizumab awaiting COPD pathway TL as GREY	
19	**Workplan / Forward Planner/ action log** Ongoing collective action to be added to the planner	
20	**Any other Business** <u>Prescribing in metabolic disorders</u> DC discussed that there was a recent query received from a GP practice regarding the prescribing and managing high cost protein substitute for phenylketonuria (PKU) with an estimated annual cost of approximately £16,000. The request had been initiated by a specialist dietitian within the Adult Inherited Metabolic Disease Service. DC reported that a review of NHS England service documentation had identified some uncertainty regarding prescribing responsibilities. Whilst an older service specification appeared to indicate that prescribing should remain with specialist services, the current NHS England Manual for Prescribed Specialised Services (2023) states that responsibility for ongoing prescribing of nutritional products rests with ICBs	

	through primary care. Clarification was being sought; however, the 2023 document was considered to represent the current commissioning position.PM confirmed that NHS England commissions the Adult Inherited Metabolic Disease Service in Sheffield and advised that the current specialised services manual places responsibility for ongoing provision of nutritional products with ICBs. He reported that national work had previously commenced to review pathways and commissioning arrangements, including engagement with patient groups, although progress had slowed following NHS organisational changes. Members discussed the distinction between nutritional products and medicines, noting that nutritional products are not routinely subject to standard medicines governance processes. Concerns were raised regarding potential discrepancies between national inherited metabolic disease guidance and existing South Yorkshire Traffic Light classifications, as well as the financial implications for providers where prescribing is initiated in secondary care. HT has contacted PrescQipp to see if there is any cost-effective information on PKU products. AJM noted that the issues raised extend beyond the individual case and should be considered as part of wider strategic commissioning work, particularly in light of future developments relating to the national formulary and the implications for local formulary governance. **Actions:** • DC, HT, AJM & PM to undertake further work to review prescribing responsibilities, commissioning arrangements and formulary implications relating to PKU nutritional products and inherited metabolic disease therapies.	
21	**Date and Time of Next Meeting** TBC	

	Approved guidelines/ Shared care guidelines • Tirzepatide Weight management updated position statement • Recording medicines prescribed somewhere else on clinical systems guide • Relugolix – Amber G	

July's Traffic Light Drug list

Drug/Product Traffic Light Status	Brand name	Rationale / criteria	Indication	Date Considered	Review date	Comments	Agenda Item
Toripalimab *(NICE TA in development)*	Loqtorzi®	6	In combination with cisplatin and gemcitabine, is indicated for the first-line treatment of adult patients with recurrent, not amenable to surgery or radiotherapy, or metastatic nasopharyngeal carcinoma. In combination with cisplatin and paclitaxel, is indicated for the first-line treatment of adult patients with unresectable advanced, recurrent, or metastatic oesophageal squamous cell carcinoma.			NICE TA in development	**Horizon Scanning**

Elinzanetant *(new medicine)*	Lynkuet®	6	Indicated for the treatment of moderate to severe vasomotor symptoms (VMS) associated with menopause			NICE TAs in development	**Horizon Scanning**
Potassium Chloride Syrup 7.5% (equivalent to 1 mmol K+ per ml) *(new licensed generic alternative to discontinued product)*	Generic		For the treatment of hypokalaemia and potassium deficiency of renal and extrarenal origin.			Available in 500ml, according to MIMS, and 150ml/500ml according to SPC. This is a licensed generic alternative to Kay-Cee-L Syrup which is discontinued. In Barnsley potassium chloride 1mmol/ml syrup is formulary green with a note: Kay-Cee-L® syrup will be discontinued from late November 2024 due to manufacturing and commercial issues (Barnsley Formulary includes links to using potassium effervescent tablets as an alternative). Doncaster and Sheffield do not have this traffic lighted. Cannot access Rotherham TLDL. Other surrounding ICBs: Nottingham - formulary green (a licensed 1mmol/mL potassium oral liquid product is now available in the UK, meaning that the need to use part of an effervescent potassium tablet is rare, but this may be required if the liquid is unavailable/unsuitable), Cheshire and Merseyside - formulary green (specialist initiation and stabilisation in paediatrics), North Yorkshire and York - green, Open Prescribing: potassium chloride 375mg/5ml (7.5%w/v) (Apr25-Mar26): 16 items across SY (9 Barnsley, 6 Sheffield, 1 Rotherham, 0 Doncaster)	**Horizon Scanning**

Imlunestrant *(new medicine)*	Inluriyo®	6	Inluriyo is indicated as monotherapy for the treatment of adult patients with oestrogen receptor (ER)-positive, HER2-negative, locally advanced or metastatic breast cancer with an activating ESR1-mutation, who have disease progression following prior treatment with an endocrine based regimen (for biomarker-based patient selection, see section 4.2). In pre- or perimenopausal women, or men, Inluriyo should be combined with a luteinising hormone-releasing hormone (LHRH) agonist.			NICE TA in development	**Horizon Scanning**

Amlodipine *(new orodispersible tablet formulation - Amdelta®)*	Amdelta®		Hypertension Chronic stable angina pectoris Vasospastic (Prinzmetal's) angina.			Barnsley and Doncaster: Amlodipine is formulary green, Sheffield - amlodipine is listed in cardiovascular system formulary chapter. Costs amlodipine standard tablets (Drug Tariff June 26): 1 x 28 5mg tablets = £0.55, 1 x 28 10mg tablets = £0.58. Costs amlodipine orodispersible tablets (Amdelta®) (MIMS June 2026): 1 x 28 5mg tablets = £8.86, 1 x 28 10mg tablets = £9.93. Consider adding information to ScriptSwitch/OptimiseRx regarding the higher cost of amlodipine orodispersible tablets in comparison to standard tablets.	**Horizon Scanning**
Levetiracetam *(new 500mg orodispersible tablet formulation - Zolvum®)* Amber	Zolvum®		Levetiracetam is indicated as monotherapy in the treatment of partial onset seizures with or without secondary generalisation in adults and adolescents from 16 years of age with newly diagnosed epilepsy. Levetiracetam is indicated as adjunctive therapy • in the treatment of partial onset seizures with or without secondary			*Levetiracetam is already classified Amber on the SY TLDL in line with the SY Epilepsy SCP* *Costs (Drug Tariff June 26): levetiracetam 500mg tablets x 60 = £2.93, levetiracetam 250mg tablets x 60 = £1.27, levetiracetam 500mg granules for oral solution sachets sugar free x 60 = £39.46. Costs (MIMS June 26): Zolvum (levetiracetam) 500mg orodispersible tablet x 60 = £23.68.* *Consider adding information to ScriptSwitch/OptimiseRx regarding the higher cost of levetiracetam orodispersible tablets in comparison to standard tablets.*	**Horizon Scanning**

			generalisation in adults, adolescents, children and infants from 1 month of age with epilepsy. • in the treatment of myoclonic seizures in adults and adolescents from 12 years of age with Juvenile Myoclonic Epilepsy. • in the treatment of primary generalised tonic-clonic seizures in adults and adolescents from 12 years of age with Idiopathic Generalised Epilepsy.				
Linezolid **Traffic lighted Green only in Rotherham** (Traffic Lighted Red for all other Places)			Arrangements for the access to antimicrobials for Rotherham Community-based Patients with Infections in whom Linezolid are the only treatment options on advice from microbiology	Jul-26		Rotherham Place Information	**IMOC subgroup**

Linezolid **Traffic Lighted Red only in Barnsley,Doncaster & Sheffield** (Traffic Lighted Green in Rotherham)			oxazolidinone antibacterial	Jul-26			**IMOC subgroup**
Dienogest			Endometriosis	Jul-26			**IMOC subgroup**
Temozolomide		1,6	In line with positive NICE TA's	Jul-26		Temozolomide NICE Information	**IMOC subgroup**
Plasma-Lyte		1	Infusion - for use in adults, older patients and adolescents (age 12 years and over) for fluid replacement, as intraoperative fluid replacement, in haemorrhagic shock and clinical conditions requiring rapid blood transfusions, and in mild to moderate metabolic acidosis, also in case of lactate metabolism impairment.	Jul-26		Intravenous fluid therapy in adults in hospital	**IMOC subgroup**
Nelarabine		1,6	T-cell acute lymphoblastic leukaemia, T-cell lymphoblastic lymphoma	Jul-26		https://bnf.nice.org.uk/drugs/nelarabine-specialist-drug/	**IMOC subgroup**

Metaraminol		1	Acute hypotension	Jul-26		metaraminol Information	**IMOC subgroup**
Methoxypsoralen (Also known as methoxsalen)		1	Dermatology specialist only	Jul-26			**IMOC subgroup**
Methyl-5-Aminolevulinate	Metvix®	1	Actinic keratoses, basal cell carcinoma, squamous cell carcinoma in situ (Bowen´s disease)	Jul-26		photodamage NICE Information	**IMOC subgroup**
Rozanolixizumab		1,6	treating antibody-positive generalised myasthenia gravis	Jul-26		NICE TA 1155 was traffic lighted Grey	**IMOC subgroup**
Osimertinib		1,6	treating EGFR mutation-positive unresectable locally advanced non-small-cell lung cancer after platinum-based chemoradiotherapy	Jul-26		In Line with positive NICE TA's	**IMOC subgroup**
Givinostat		1,6	treating Duchenne muscular dystrophy in people 6 years and over	Jul-26		NICE TA 1157	**NICE TA**
Amivantamab		1,6	untreated EGFR exon 20 insertion mutation-positive advanced non-small-cell lung cancer	Jul-26		Traffic lighted as Amivantamab (in combination with other drugs) in line with positive NICE TA's	**NICE TA**

Mepolizumab		8	maintenance treatment of uncontrolled chronic obstructive pulmonary disease with raised blood eosinophils Grey classification will be reviewed when a plan to support implementation has been agreed.	Jul-26		NICE TA 1166	**NICE TA**
Lisocabtagene maraleucel		1,6	treating relapsed or refractory large B-cell lymphoma after 2 or more lines of systemic treatment	Jul-26		NICE TA1159	**NICE TA**
Durvalumab		1,6	Durvalumab with chemotherapy for neoadjuvant and adjuvant treatment then alone for adjuvant treatment of resectable gastric or gastro-oesophageal junction adenocarcinoma	Jul-26		In line with positive NICE TA's	**NICE TA**
Sotatercept		1,6	treating pulmonary arterial hypertension	Jul-26		NICE TA 1161	**NICE TA**

Nusinersen and risdiplam		1,6	treating spinal muscular atrophy	Jul-26		NICE TA1162	**NICE TA**
Tisotumab vedotin		1,6	treating recurrent or metastatic cervical cancer that has progressed on or after systemic treatment	Jul-26		NICE TA1164	**NICE TA**
Cemiplimab		1,6	Cemiplimab with platinum-based chemotherapy for untreated advanced non-small-cell lung cancer	Jul-26		In line with positive NICE TA's	**NICE TA**
Serplulimab		1,6	Serplulimab with carboplatin and etoposide for untreated extensive-stage small-cell lung cancer	Jul-26		NICE TA1167	**NICE TA**
Nogapendekin alfa inbakicept		7	Nogapendekin alfa inbakicept with BCG for non-muscle-invasive bladder cancer with carcinoma in situ that is unresponsive to BCG (terminated evaluation)	Jul-26		NICE TA 1163	**NICE TA**

Imlunestrant		7	Imlunestrant for treating oestrogen receptor-positive HER2-negative advanced breast cancer after endocrine therapy (terminated evaluation)	Jul-26		NICE TA 1168	**NICE TA**
Relugolix (Amber G)	Orgovyx®	1,2b	Treating hormone-sensitive prostate cancer	Jul-26		NICE TA995 Awaiting to see whether additional guidance is required	**IMOC Application**
Tirzepatide (cohort **ONE & TWO** weight management patients only) [Multiple traffic light classifications]			Traffic Lighted as Green for **cohort ONE & TWO** weight management patients only (refer to local clinical guidance for further information).	Jul-26		Awaiting updated Tirzepatide weight management statement	**IMOC Application**