Nottinghamshire Area Prescribing Committee Meeting Minutes

APC meeting 19th May 2022: due to the COVID-19 Pandemic the meeting took place as a web conference using Microsoft Teams.

All attendees should be aware that public authorities are legally required to comply with the Freedom of Information Act 2000. The minutes and papers from this meeting could be published on the Publication Scheme or internet with all names included, unless notified to the Chair before the meeting commences, or included in a pre-agreed confidential section due to the sensitive nature of the topic.

Present:

David Kellock (DK)	**SFH Drug and Therapeutics Committee**	**Sherwood Forest Hospitals NHS Foundation Trust**
Laura Catt (LC)	**Prescribing Interface Advisor**	**NHS Nottingham & Nottinghamshire CCG**
Esther Gladman (EG)	**GP - City ICP**	**NHS Nottingham & Nottinghamshire CCG**
Tim Hills (TH)	**Assistant Head of Pharmacy**	**Nottingham University Hospitals NHS Trust**
Claire Nowak (CN)	**Deputy Chief Pharmacist**	**Nottinghamshire Healthcare NHS Foundation Trust**
Susan Hume (SH)	**Advanced Podiatrist and non-medical prescriber**	**Nottinghamshire Healthcare NHS Foundation Trust**
Jennifer Moss Langfield (JML)	**GP**	**LMC representative**
Katie Sanderson (KS)	**Patient representative**	
Ann Whitfield (AW)	**Patient representative**	
Khalid Butt (KB)	**GP and LMC representative**	**Mid Notts ICP, NHS Nottingham & Nottinghamshire CCG**
Steve May (SM) (Chair)	**Chief Pharmacist Sherwood Forest Hospitals**	**NHS Foundation Trust**

In attendance:
Judith Moore, consultant in Obstetrics and Gynaecology NUH, for item 7, Micronised Vaginal Progesterone for Pregnant Women with a Threatened Miscarriage.

Interface support (NHS Nottingham & Nottinghamshire CCG):
Nichola Butcher (NB), Medicines Optimisation and Interface Pharmacist
Hannah Godden (HG), Specialist Mental Health Interface Pharmacist (not in attendance)
Lynne Kennell (LK), Specialist Interface & Formulary Pharmacist for SFH (until 16:00)
Michalina Ogejo (MO), Medicines Optimisation and Pain Clinic Pharmacist (until 16:45)
Karen Robinson (KR), APC Interface & Formulary Pharmacy Technician
Jill Theobald (JT), Specialist Interface Medicines Optimisation Pharmacist
Shary Walker (SW), Specialist Interface & Formulary Pharmacist for NUH

Apologies:

Tanya Behrendt (TB), Senior Medicines Optimisation Pharmacist, NHS Nottingham & Nottinghamshire CCG
David Wicks (DW), GP Mid Notts ICP Nottingham & Nottinghamshire CCG
Ankish Patel (AP), Head of PCN Workforce
Asifa Akhtar (AA) GP, South Notts ICP, Nottingham & Nottinghamshire CCG
Sarah Northeast (SN), Advanced non-medical prescriber, Nottingham CityCare

1. **Welcome and introduction of new members**

2. **Declarations of interest**

One member explained that they had had past involvement with the National Institute for Health and Care Research for End-of-Life Care and that they had also received treatment with rivaroxaban. The committee felt no action was required.

3. **Minutes of the last meeting/matters arising**

The minutes from the previous meeting were reviewed and accepted as an accurate record, subject to minor amendments.

Ibandronic acid

A business case has now been agreed so has been added to the formulary as AMBER 2, as agreed at a previous APC i.e., secondary care initiation and to pass to GP when no further need to be seen by secondary care.

Palforzia NICE TA

Left as unclassified after the previous meeting, due to the NUH Allergy service not having enough capacity. Awaiting guidance and update from NUH.

Amiodarone

SW liaised with Dr Paige, who confirmed that TSH alone can be used as a primary screening to monitor thyroid function in amiodarone-treated patients. If TSH is out of range, T3 and T4 would be tested automatically by the lab (at both NUH and SFHT). This applies even if the TSH is marginally out of range.

ACTION: SW to remove the wording stating "T3 and T4 required".

Sick Day Rule Guidance

This was still awaiting comment from the renal specialists and will be brought to a future meeting.

ACTION: To bring back to APC next time.

4. **FOR DISCUSSION - Hydroxychloroquine serious incident**

LC gave a summary of the serious incident. To prevent further incidents, suggestions had been put forward, including-

Adding links to patient information leaflets in all shared care protocols.

Consideration of Optimise Rx messages where dosing is based on weight.

Add templates to the clinical systems EMIS/Systm1 to ensure patient weight and side effect counselling is up to date.

Community optometrists to receive a copy of the report.

Responsibility for highlighting commissioning gaps and the shared care process were discussed. This has been discussed in the medicine safety group and the incident and ophthalmology requirements included in the MSO bulletin. As there is currently no commissioned ophthalmology service, it has not been possible to undertake a specific audit. City PBP is undertaking a hydroxychloroquine audit as a local audit.
ACTION: Medicines Optimisation technician has been tasked with adding links to patient information leaflets. The City PBP Medicines Optimisation team are developing and implementing a safety audit.

5. FOR DISCUSSION – AMBER 2, definition of 'specialist':

LC explained that some confusion was occurring as to who can be classified as a specialist with regard to recommending AMBER 2 medications.
JML felt that the clinician should not need to be a prescriber as many areas had specialists in their fields such as pain, anticoagulation, and podiatry. This was also agreed by EG.
Overall, it was felt that APC could not police the clinical responsibility and that the definition should remain, with the addition of the wording that the specialist must have "working experience and knowledge within a speciality area".
ACTION: LC to update the wording.

6. Formulary Amendments and Horizon Scanning (SW/LK)

- **Sodium Zirconium Cyclosilicate (Lokelma®)**

SW presented the recent update to NICE TA599 guidance which recommends Lokelma® as an option for treating confirmed persistent hyperkalaemia in adults, when started in specialist care, for people who are not taking an optimised dose of renin-angiotensin-aldosterone system (RAAS) inhibitors because of hyperkalaemia. Eligibility criteria include:

- a confirmed serum potassium level of at least 6mmol/litre, **and**
- not taking an optimised dosage of renin-angiotensin-aldosterone system (RAAS) inhibitor, **and**
- not on dialysis

An AMBER 2 traffic light for Lokelma® will allow the patients to obtain ongoing prescriptions in primary care. No additional monitoring will be required in primary care other than that being currently undertaken. Heart failure nurses will continue to identify eligible patients and monitor patients on Lokelma®. The monitoring results will be available to GPs.

JFG agreed that an AMBER 2 classification would be appropriate but requested that it be added to the Heart Failure Treatment Guidelines. Lokelma is associated with a significant cost of £1,898 per patient per year for a 5g daily dose. The total predicted number that will benefit is 26 patients from both Trusts. This is equivalent to £49,348 per year.

APC recognised the significant cost impact, but this will still be within the mandate.

APC agreed on the traffic light change from RED to AMBER 2, with its addition to the Heart Failure Guideline.
ACTION: SW to update the formulary and update the Heart Failure Guidelines.

Minor amendments:

- Typhoid vaccine (Typhim Vi®) – GREEN (note that Typherix® is discontinued).
- Estradiol pessaries - Vagirux® brand now preferred to Vagifem® (cost-effective and less plastic waste).
- Alprostadil - Viridal Duo® GREY (had been temporarily AMBER 2 due to Caverject® shortage, now resolved).
- Tipranavir (Aptivus®) – capsules discontinued (liquid discontinued in 2019).
- Clonidine - 100microgram tablet added to formulary (25mcg already on formulary).
- Potassium permanganate (Permitabs®) – MHRA safety alert link added to the joint formulary entry. MSOs notified.

Oral Nutritional Supplements:

- Slo Milkshakes – make this and other pre-thickened products Amber 2, on dietitian recommendation (currently unclassified). Agreed.
- Aymes ActaGain 2.4 Complete Maxi – Banana flavour added.
- Aymes ActaGain 600 – AMBER 2, dietitian recommendation only; low volume alternative to ActaGain 2.4.
- Nualtra Altraplen Energy – AMBER 2, dietitian recommendation only.
- Aymes Shake Fibre – AMBER 2, dietitian recommendation only.
- Aymes ActaCal Crème - AMBER 2, dietitian recommendation only.

Other amendments:

- Guanfacine (Intuniv®) – DELAYED AMBER1 (shared care) for paediatrics and adolescents – only if LES- approved. Needs SCP and info sheet.
- Sharps bins – GREEN; information added about prescribing and waste collection.
- Ethyl chloride BP (e.g., Cryogesic® spray) – GREEN, but not to be prescribed on FP10.
- Combodart® brand of dutasteride/tamsulosin capsules - GREY non-formulary.
- Generic dutasteride/tamsulosin capsules - AMBER 3.
- Atorvastatin oral solution – GREY, due to significant alcohol content and to expense (licensed chewable tablets available as an alternative).

Horizon scanning:

Added to formulary as GREY no formal assessment:

- Inpremzia® (insulin) – very similar to Actrapid® (human insulin).
- Truvelog® Mix 30 (insulin) – very similar to NovoMix® (insulin aspart).
- NovoPen® 6 & NovoPen Echo® Plus smart insulin pens – awaiting a decision from DSNs.
- Finerenone tablets (Kerendia®) for CKD associated with T2DM in adults– awaiting NICE TA.
- Morphine sulphate orodispersible tablets (Actimorph®).
- Buprenorphine hydrochloride 74.2mg implant (Sixmo®▼) for opioid dependence.
- Daridorexant (Quviviq®▼) tablets for insomnia.
- Relugolix (Orgovyx®▼) tablets for advanced prostate cancer.
- Rimegepant (Vydura®▼) oral lyophilizate for migraine treatment and prevention.
- Atogepant (Qulipta®▼) tablets for migraine prevention.
- Ubrogepant (Ubrelvy®▼) tablets for migraine treatment.

- Lasmiditan (Reyvow®▼) tablets for migraine treatment.
- Icosapent (Vazkepa®▼) Risk reduction in patients with high CV risk with elevated triglycerides.
- Epinephrine nasal spray (Neffy® and BRYN-NDS1C®) for severe allergic reactions.
- Apomorphine (Kynmobi®) sublingual film for "off" episodes in Parkinson's Disease.
- Relugolix / estradiol / norethisterone / linzagolix (Yselty®▼) for endometriosis.
- Budesonide - oral (Nefecon®▼) for IgA nephropathy.
- Potassium bicarbonate/ potassium citrate (Sibnayal®) prolonged-release formulation for distal renal tubular acidosis.
- Netarsudil (Rhopressa®▼) ophthalmic solution for glaucoma.
- Sibnayal® (potassium bicarbonate/ potassium citrate prolonged-release formulation).
- Yselty®▼ film-coated tablet (relugolix, estradiol, norethisterone, linzagolix 100mg and 200mg).

Added to formulary as GREY non-formulary:

- Liothyronine hard capsules (Roma Pharmaceuticals), in line with other liothyronine preparations.
- Sereflo Ciphaler® DPI (fluticasone/salmeterol) – new initiation of fluticasone/salmeterol not recommended.

New formulations:

- Calcipotriol 50mcg & betamethasone dipropionate 0.5mg cream (Wynzora®) – added as GREEN (gel and ointment already GREEN).
- Testosterone gel in sachets (Testogel®) – added as AMBER 2 (adults) for people who are unable to manage the pump (same price as sachets). Tostran® remains the product of choice for children and adolescents (shared care).
- Calcium polystyrene sulfonate (Calcium Resonium®) 99.75% powder for oral/rectal suspension – AMBER 2 (more effective than Calcium Resonium® brand).
- Cimetidine 200mg/5ml oral solution (Tagamet® syrup) – already on the formulary but add a note that it is more cost-effective than prescribing SF oral solution.

7. New applications:

- **NICE TA773 Empagliflozin for treating Chronic Heart Failure with reduced ejection fraction**

  SW presented the NICE TA773: Empagliflozin for treating chronic heart failure with reduced ejection fraction. The NICE TA was published on 10th March 2022, with implementation required by June 2022. Empagliflozin is recommended as an option for treating symptomatic chronic heart failure with reduced ejection fractions in adults if it is used as an add-on to optimised standard care with:

  • angiotensin-converting enzyme (ACE) inhibitors or angiotensin-2 receptor blockers (ARBs), with beta-blockers, and, if tolerated, mineralocorticoid receptor antagonists (MRAs), **or**
  • sacubitril valsartan, with beta-blockers and, if tolerated, MRAs.

  Treatment of symptomatic heart failure with reduced ejection fraction with empagliflozin should be on the advice of a heart failure specialist. Monitoring should be done by the most appropriate healthcare professional. Dapagliflozin is an alternative and is already

being used for this indication, following a positive NICE TA in 2021. There is no real difference between dapagliflozin and empagliflozin that will impact on current prescribing practice. Patient numbers are expected to be in line with the current use of dapagliflozin. JFG agreed that an AMBER 2 classification should be recommended. It was highlighted that there had been some interest at NUH in the use of empagliflozin for patients with preserved ejection fraction and it was agreed that it should be made clear that the approved use is only in line with the current license and NICE TA.
ACTION: SW to amend formulary entries for empagliflozin and dapagliflozin to highlight that SGLT2 usage for Heart Failure with preserved ejection fraction is GREY: no formal assessment.
AMBER 2: for treating chronic heart failure with reduced ejection fraction

- **NICE TA775 Dapagliflozin for treating Chronic Kidney disease**
  LK presented the NICE TA 775. This was published on 9th March 2022 and compliance is required by 7th June 2022. This TA recommends the following:

  "Dapagliflozin is recommended as an option for treating chronic kidney disease (CKD) in adults. It is recommended only if:
  -it is an add-on to optimised standard care including the highest tolerated licensed dose of angiotensin-converting enzyme (ACE) inhibitors or angiotensin-receptor blockers (ARBs), unless these are contraindicated, and
  -people have an estimated glomerular filtration rate (eGFR) of 25 ml/min/1.73 m2 to 75 ml/min/1.73 m2 at the start of treatment and:
  have type 2 diabetes or have a urine albumin-to-creatinine ratio (uACR) of 22.6 mg/mmol or more."

  It is expected that a significant number of patients locally will meet the criteria outlined in TA775 and the intention is for primary care initiation; many of these patients will not be under the care of renal physicians and it is felt strongly in secondary care that referral for treatment initiation is not appropriate. A regional educational program is in development, but this is unlikely to be available for some time. Some areas have started to produce their own guidelines.

  The JFG had felt that an AMBER 3 classification was most appropriate, and it was agreed that the NICE guidance would be considered as appropriate supporting guidance in the absence of local or regional guidance.

  The APC agreed with the JFG's recommendations.
  ACTION: LK to update the formulary.

- **Micronised Vaginal Progesterone for Pregnant Women with a Threatened Miscarriage**

In November 2021, NICE updated their guidance on the management of miscarriage, to offer vaginal micronised progesterone 400mg twice daily to those women with intrauterine pregnancy confirmed by a scan, who have vaginal bleeding and have previously had miscarriage/s. NICE also recommends that if there is a confirmed foetal heartbeat, micronised vaginal progesterone treatment should continue until 16 completed weeks of pregnancy. This is an off-label indication.

Judith Moore, consultant in Obstetrics and Gynaecology NUH, joined the meeting at 14:05 and presented a summary about micronised progesterone vaginal capsules.

Judith Moore does not think this should be prescribed in primary care at all and felt the prescribing should remain in secondary care, where bleeding can be assessed. The submission asked for GPs to continue prescribing after specialist initiation. Judith Moore's concern was echoed by the APC clinicians. The 16-week supply was also of concern as some women would still miscarry and the prescriber would not be in control of stopping the prescriptions.

Judith Moore explained that at NUH all women with a history of previous miscarriages can ring the early pregnancy unit directly if they are under NUH care.

APC agreed to a GREY classification and recommended that it go to DTC at both Trusts for a decision on RED. SW to check with the submitter that they are happy to administer the full course.
ACTION: SW to make the classification GREY. Feedback to be provided to the submitter for DTC at NUH and at SFHT.

- **Pridinol (Myopridin®).**

A submission for pridinol had been discussed by the JFG. The group had discussed the evidence of efficacy and felt that, although it could potentially be beneficial for this patient group if effective, there was insufficient published evidence currently available to support its use locally. A GREY classification was agreed by JFG.
The APC agreed with the decision made by the JFG.

ACTION: LK to update the formulary and feedback to the submitters.

- **Rivaroxaban (Xarelto®) for the treatment and the prevention of recurrence of venous thromboembolism (VTE) in children**

SW presented the formulary submission for rivaroxaban for paediatric VTE. The British Society for Haematology (BSH) has updated their guideline on the investigation, management, and prevention of venous thrombosis in children, to now offer rivaroxaban for the treatment of venous thrombosis in people of less than 18 years of age, following at least 5 days of parenteral anticoagulation. Rivaroxaban is licensed for this indication and the suspension is the most cost-effective preparation. It has the advantage of being an oral agent that does not require frequent monitoring. It is more attractive to parents, especially of young children, because it improves the quality of life due to there being no requirement for blood test monitoring, unlike the alternatives of warfarin and low molecular weight heparin (LMWH).
It was highlighted that rivaroxaban oral suspension has two sizes of pack formulation, based on the child's weight. The 100mL bottle is for children weighing less than 4kg and contains 2 x 1mL blue syringes with 0.1mL marked graduations. The 250ml bottle is appropriate for children weighing 4kg or more. It contains 2x5mL blue syringes with 0.2mL marked graduations, and 2x10mL blue syringes with 0.5mL marked graduations. The blue syringes included in the packs should be used according to the dose, which is determined based on the body weight.
The appropriateness of prescribing in primary care was discussed. Generally, treatment of VTE is initially for 3 months but can be extended to 12 months in some circumstances. It was suggested that short courses (e.g. 3 months) should be provided by secondary care, but primary care prescribing would be appropriate for children requiring much longer-term therapy.
ACTION: secondary care will supply rivaroxaban for short courses up to 3 months; the GP can continue the extended supply (if over 3 months) as AMBER 2. SW to feedback to the head of service, also to the submitter and to update the formulary.

- **Testosterone for loss of libido in post-menopausal women**

LK presented the submission that had been discussed at the previous JFG meeting. Following several reports of requests for primary care to prescribe testosterone supplementation for post-menopausal women, a formulary application from secondary care clinicians had been requested and received.

Testosterone therapy for loss of libido in post-menopausal women is supported by NICE in NG23, for women in whom HRT is inadequate. Currently, there is not a licensed product for this indication available in the UK and the products suggested for formulary inclusion are Tostran® pump and Testogel® sachets, in line with guidance from the British Menopause Society. Due to the low doses required by women, Testogel® requires some estimation by the patient and counselling on administration is required. Testosterone should be given as a trial for 3 months to determine whether symptomatic benefit is obtained, and women should have been taking HRT for at least 6 months before testosterone is trialled.

Trial evidence supports a value in improving quality of life and the JFG had agreed that an AMBER 2 classification may be appropriate for use, in line with the NICE guidance but requested clarification of potential monitoring requirements and patient numbers. Members felt an information sheet should be provided if the submission was approved.

LK had attempted to seek further opinions on monitoring requirements and potential numbers, but responses had been limited. An endocrinologist had been contacted, as requested at JFG, whose view was in line with recommendations for monitoring to ensure that levels remain within a normal physiological range. Guidance from other areas generally advises monitoring levels from a safety perspective. LK had looked at usage in other areas that have the product available on specialist recommendation and prescribing levels had remained steady and in keeping with usage in Nottinghamshire over many years. Therefore, adding this indication to the formulary locally was not expected to result in significant growth in usage.

The APC agreed that testosterone gel should be made available with an AMBER 2 classification when used for the indication described in NICE guidance and recommended by a Specialist Menopause clinic or Gynaecologist. A prescribing information sheet should be developed to support prescribers before the traffic light change.

ACTION: LK to develop a prescribing information sheet. The formulary will be updated once this has been ratified.

8. FOR RATIFICATION – ANTIMICROBIAL GUIDELINES

- **Acute Sinusitis**

NB presented the Acute Sinusitis guideline update.
This had been updated as it had reached its review date. Main points raised:

- Information stating that the cause in the majority of patients is viral and there is no benefit from antibiotic treatment was retained, along with information on complications.
- Symptoms for ≤ 10 days – do not offer an antibiotic. Advice for patients added, including self-care, link to NHS sinusitis PIL and when to seek medical advice.
- Symptoms for ≥ 10 days – either no antibiotic offered or a delayed antibiotic (considering the evidence that antibiotics make little difference on how long symptoms last).
- Added information about reassessing a patient and when to refer.
- Added antibiotic choices for patients >18 years of age and <18 years of age. Doses checked with BNF and BNF for children. Information added about use in pregnancy.

NB discussed the inclusion of nasal corticosteroid use as it may reduce antibiotic prescribing. This was agreed by the committee.
APC approved.
ACTION: NB to upload to the APC website and make any formulary changes.

- **Chronic Bacterial Sinusitis**

NB presented the Chronic Bacterial Sinusitis guideline update.
This had been updated as it had reached its review date. Main points raised:

- Definition of chronic sinusitis retained and information regarding the duration of symptoms (>12 weeks) added.
- Advice for patients added, including symptom duration, self-care/trigger avoidance measures, link to NHS sinusitis PIL for nasal irrigation, link to CKS allergic rhinitis and APC allergic rhinoconjunctivitis pathway and when to seek medical advice.
- Added information about possible allergic causes and using a corticosteroid nasal spray.
- Added information regarding patients experiencing recurrent acute episodes – link to the APC acute sinusitis guideline added.
- Added information about the referral of patients e.g., persistent symptoms, treatment failure, complications.

No antibiotic prescribing information is included in the guideline, as not recommended without specialist involvement.
NB discussed the inclusion of nasal corticosteroid use and this was agreed by the committee.
APC approved.
ACTION: NB to upload to the APC website and make any formulary changes.

- **Dental Abscess**

NB presented the Dental Abscess guideline update.
This had been updated as it had reached its review date. Main points raised:

- Information regarding the need for dental treatment and input is retained.
- Advice for patients added, including using a soft toothbrush, eating soft food and avoiding hot food and drink, use of analgesia. NHS PIL link added.
- Added information stating that antibiotics should not be prescribed in primary care, unless the patient is systemically unwell, or is at high risk.
- Added information about the considerations when prescribing an antibiotic – alternative diagnoses, do not switch or give repeated courses of antibiotics.
- PHE link for gingivitis treatment updated.
- Added antibiotic choices for patients >18 years of age and <18 years of age. Doses checked with BNF and BNF for children. Information added about use in pregnancy.
- Clindamycin was removed from the guideline as no longer recommended in CKS.

NB to add clarity to the term ‘repeat prescriptions’ and re-enforce the advice that GPs are not specialists in dental treatment and that treatment from a dentist is required.
APC approved.
ACTION: NB to update, upload to the APC website and make any formulary changes.

- **Dermatophyte infection**

Testing for fungal nail specimens had been temporarily suspended due to extreme covid pressures in both SFH and NUH laboratories. There is a plan pending to start accepting community mycology samples again in mid-June, but this will be limited, following updated laboratory guidance to reduce the nail sample laboratory workload.

All specimens from children can be sent; however, nail specimens from adults can only be accepted if:

- there is empirical treatment failure;
- there is Infection from foreign travel;
- there is unusual animal or environmental exposure;
- they are Immunosuppressed or on immunosuppressant medications.

Discussion took place around the monitoring of LFTs. It was also suggested that a link should be included to the patient information leaflet, EG suggested that "empirical" treatment should read "oral". SH the podiatrist explained that athlete's foot should also be checked and treated, as the two infections were linked.

ACTION: SW to contact Viv Weston to clarify if there was any need for LFTs and to confirm when to stop and when to repeat treatment
To be ratified by email.

- **Hidradenitis suppurativa**

Hidradenitis suppurativa (HS) is a new guideline. It was requested due to primary care seeing more and more of these cases, particularly with obesity, and often resulting in repeated antibiotic courses, with variable success. This is also known as acne inversa. It is a debilitating and distressing chronic inflammatory skin disease, requiring a prolonged and repeated course of tetracyclines to reduce bacterial colonisation and inflammation. During flare-ups, an alternative antibiotic is required; this was agreed on locally, in line with the cellulitis guidelines.
The guideline includes definitions, features and stages of hidradenitis suppurativa, general measures for patients, general and medical management, and indications for referral.
The guideline was completed in collaboration with a consultant microbiologist, consultant dermatologists and paediatric dermatologists, with input from a GP with an interest in dermatology.
There were no local guidelines or NICE guidelines available for HS. The information in the guideline was referenced from the British Association of Dermatology guideline for HS and the primary care Dermatology Society.
APC approved and ratified.
ACTION: SW to upload the guideline.

- **Urinary tract infection (UTI)**

SW presented the urinary tract infection update. This had been updated as it had reached its review date.
EG suggested including in the table the safety issues on ciprofloxacin, e.g., rupture of tendons and as per the MHRA guidelines.
APC approved the changes agreed.
ACTION: SW to add the information and upload the update.

9. FOR RATIFICATION – Aminosalicylates in inflammatory bowel disease (IBD)

SW presented and explained that at the last APC the guideline was brought for ratification. It was agreed to make the required changes, apart from some points, and bring it back to the May APC.
One of the changes is the increase in the monitoring schedule from yearly to 6-monthly. A consultant from SFH and some of those from NUH had expressed concerns that this would significantly increase their workload and could be an inconvenience to the patients. The authors of the NUH Aminosalicylates in IBD guideline stated that the increase in monitoring was due to a local incident and was also based on a recommendation from the SPS website. However, the BNF And the British Society of Gastroenterology still recommend annual monitoring.

The author of the SPS drug monitoring was contacted to seek clarification on the monitoring schedule recommendation. They have replied that the information was referenced from the different mesalazine monographs. They have acknowledged that the wordings on the SPCs vary between products and are different in the BSG guideline and the BNF. They also appreciated that there is clearly room for interpretation and local guidelines can be drawn up and agreed upon, so long as safety has been reviewed and considered. They have also clarified that the risk factors include renal impairment, concurrent illness, and duration and severity of the disease.
Another point to clarify with NUH and SFHT was the need for periodic urine dipstick monitoring. Both trusts confirmed that they do not practice routine urine dipstick monitoring and said that it will add a large clinical burden and unnecessary inconvenience to the patient, with no evidence of benefit.
APC felt an agreement needed to be reached and that Bassetlaw also needs to be considered and consulted. There is a plan for NUH to take the guideline to gastro governance again for review.

APC has not approved.
ACTION: Wait for the outcome of the NUH gastro governance review.

10. FOR RATIFICATION – Domperidone for lactation stimulation

JT presented a new prescribing information sheet and updated standard letter to be sent by breastfeeding specialists when requesting that GPs prescribe domperidone for lactation stimulation (off-label indication). JT highlighted that the duration of treatment had been increased from 7 days to 10-14 days, in line with National Infant Feeding Network (NIFN) advice.
The documents were ratified.
ACTION: Ratified: JT to upload to APC website.

11. FOR RATIFICATION – Steroid emergency card – patient information letter (LC)

Item not discussed due to an extensive agenda.

12. FOR RATIFICATION – Emollient formulary

Item not discussed due to an extensive agenda.

13. FOR RATIFICATION – End of Life guideline

JT presented the End of Life guideline which had been updated with the support of palliative care specialists from SFH, NUH and primary care. Anticipatory medicines doses had been updated in line with the Palliative Care Formulary and Nottinghamshire Palliative Care Pocketbook. A new section on the APC website had been created for information about the local palliative care medicines stockist scheme.
The updated guideline was approved.
ACTION: Ratified: JT to upload to the APC website

14. FOR RATIFICATION – Home oxygen pathway for cluster headaches (MO)

Item not discussed due to an extensive agenda.

15. FOR RATIFICATION – Monitoring and Medication after Bariatric Surgery (MO)

Item not discussed due to an extensive agenda.

16. FOR RATIFICATION – Hypothyroidism in Pregnancy Primary Care Guidance (NB)

This one-page guide for primary care has been developed as there are two different pathways in the Trusts. JML confirmed that there is a plan to align the pathways; this is expected imminently but there are currently no definitive timescales. It was agreed that it would be useful to publish this guidance in the interim, to reduce the risk to patients.
JML confirmed that the community midwifery team had been contacted and it has been agreed that community midwives will action the initial TFT blood test during the 'booking bloods' appointment if this has not already been done by the GP. This will be the process whether a patient is under SFH or NUH.
TH requested that mcg be amended to micrograms.
TH queried whether "mU/l" are the units used on the lab reports for all labs. It was agreed that NB would check this.
APC approved, with the changes/clarity added as above.
ACTION: **NB to clarify points raised and amend document. NB to upload to the APC website and make any formulary changes.**

17. FOR RATIFICATION – Male lower urinary tract symptoms guideline

JT presented the updated LUTS guideline. The update was led by Dr Richard Parkinson, urologist at NUH, in consultation with urologists at NUH and SFH. The guideline is in line with NICE guidance (NICE CG97) which has not changed since 2015 (with a surveillance review in Nov 2019).
Main changes:

- Added generic dutasteride/tamsulosin combination product (AMBER 3) and agreed that Combodart® brand remains GREY (costs ten times more than generic).
- Updated age-specific PSA level thresholds in line with NICE CG12.
- Added desmopressin to possible management options, as per APC decision May 2019 (AMBER 2).
- Added statement "We have used the term 'male', but this guidance also applies to people who have changed or are in the process of changing gender and retain the relevant organs".

JML requested that the combination dutasteride/tamsulosin product be highlighted to primary care as a cost-effective option to giving the medicines separately. The updated guideline was ratified.
ACTION: JT to upload guideline to APC website and highlight generic combination product in the APC bulletin and update the presentation.

18. FOR RATIFICATION – Lower carbon salbutamol inhalers position statement (KR)

Item not discussed due to an extensive agenda.

19. FOR RATIFICATION – Alternatives to using an unlicensed "special"

JT presented the updated database of alternatives to using unlicensed "specials". The committee agreed that a new licensed oral solution formulation of atorvastatin oral solution be classified GREY non-formulary, due to a significant alcohol content and the expense (approx. £200 per month for 20mg daily). Licensed chewable tablets are available as an alternative.
The database was ratified.
ACTION: JT to finalise, upload to APC website and make formulary amendment for atorvastatin oral solution.

20. Midodrine information sheet (LC)

Item not discussed due to an extensive agenda.

21. FOR NOTING – Edoxaban switch principles (JT)

Item not discussed due to an extensive agenda; to be sent via email for noting or comments.

22. FOR INFORMATION – APC forward work plan

Item not discussed due to an extensive agenda.

23. AOB

- **Committee update (LC)**

LC, having just completed the annual report, explained that the workload has doubled in the last four years and that the meeting format needs further discussion. This will be discussed via email.
EG is retiring from general practice; her contract finishes at the end of June, but she has kindly agreed to continue to attend APC if needed until a replacement is found.
JT has moved into a new role within the CCG; however. she will continue to attend APC as a deputy for TB.
SM is retiring but will continue to work at SFHT as bank staff and hopes to continue with APC work for at least 3 more months.

24. Date of next meeting: Thursday 21st July 2022 14:00-17:00 (MS Teams)

Meeting closed at 17:00.

Due to the extensive agenda on 19th May, an additional meeting took place on 26th May 2022 from 16:00 – 17:00. A new agenda was circulated.

Present:

David Kellock (DK)	**SFH Drug and Therapeutics Committee**	**Sherwood Forest Hospitals NHS Foundation Trust**
Laura Catt (LC) (Chair)	**Prescribing Interface Advisor**	**NHS Nottingham & Nottinghamshire CCG**
Esther Gladman (EG)	**GP - City ICP**	**NHS Nottingham & Nottinghamshire CCG**
Claire Nowak (CN)	**Deputy Chief Pharmacist**	**Nottinghamshire Healthcare NHS Foundation Trust**
Susan Hume (SH)	**Advanced non-medical prescriber**	**Nottinghamshire Healthcare NHS Foundation Trust**
Jennifer Moss Langfield (JML)	**GP**	**LMC representative**
Katie Sanderson (KS)	**Patient representative**	
Ann Whitfield (AW)	**Patient representative**	
Steve May (SM)	**Chief Pharmacist Sherwood Forest Hospitals**	**NHS Foundation Trust**
Debbie Storer (DS)	**Medicines Information Pharmacist**	**Nottinghamshire United Hospitals**
Asifa Akhtar (AA)	**GP**	**NHS Nottingham and Nottinghamshire CCG**

Interface support in attendance (NHS Nottingham & Nottinghamshire CCG):

Nichola Butcher (NB), Medicines Optimisation and Interface Pharmacist
Karen Robinson (KR), APC Interface & Formulary Pharmacy Technician
Jill Theobald (JT), Specialist Interface Medicines Optimisation Pharmacist

1. FOR RATIFICATION: Steroid emergency card – patient information letter

LC presented the steroid emergency card patient information letter to the group. AW had reviewed and updated the letter to improve readability which included questions and answers sections.

SH had reviewed the card and letter with podiatry and commented that the written letter doesn't fit with the podiatry service and therefore, would need more work to fit. Suggestions were sent to the author and still awaiting feedback. SH had also discussed it with physiotherapists in the MSK clinic. The physiotherapists are not in agreement with distributing the card or the letter; currently, they send their patients back to their GP for discussion and advice regarding steroidal treatment.

JML felt the LMC should be contacted for input and advice regarding this aspect of the patient's journey, CN felt the PGD needed to be updated to include the steroid card and letter information.
ACTION: LC will feed the comments back to the author, Jo Freeman. APC have not approved.

2. FOR RATIFICATION – Emollient formulary

NB presented the Emollient Formulary, which had been updated as it had reached its review date. Main points raised:

• Self-care advice has been enhanced and moved to page 1. NHSE advice and patient information leaflet added.

• Prices were reviewed (April Drug Tariff (DT) and dm+d; any alterations in price were added.

• Product availability and names were checked – Diprobase® is now discontinued (non-formulary), ImuDerm® cream 5% has been discontinued and relaunched as ImuDERM® emollient. which is also a soap substitute. Epimax® range has been renamed but the product specifications remain the same. Eucerin® Intensive 10% lotion has been discontinued and relaunched as Eucerin® UreaRepair Plus 10% lotion.

• A change was proposed to first-line options in the severely dry skin category, due to a significant increase in the price of Emulsifying ointment in the DT. It is no longer listed as generic in the DT and must be prescribed by brand (Ovelle®) in primary care. 50:50 must also be prescribed by brand, Fifty:50® suggested as a commonly known brand.

• The statement on risk of severe burns has been changed to make it clearer that it is applicable to all emollients. Patient and HCP information links were added to page 2.

• Added a statement saying bath emollients should not be prescribed.

• Page 3 – no significant change to content, but the layout has been changed to improve ease of use, with self-care information moved to the start of the formulary.

• References reviewed and updated. Reference to formulary group removed as no longer in existence.

NB discussed the inclusion of a statement saying that oatmeal-based emollients should not be used before the introduction of oats into the diet. NB advised that the comment was added on the advice of Dr Ravenscroft, but NB has been unable to find evidence. This was discussed and it was agreed that further information was required before this statement could be added.
ACTION: NB to seek clarification on oatmeal allergy from Dr Ravenscroft/MI and circulate information via e-mail. To be ratified via e-mail.

3. FOR RATIFICATION – Home oxygen pathway for cluster headaches

LC presented the home oxygen pathway, in MO's absence. The home oxygen pathway was last updated in 2017. The proposed changes reflect what is currently provided by contracted HOS teams.

- Flow chart updated.
- Change from ''PRESCRIBE OXYGEN: PART B HOOF'' to ''Prescribe Oxygen: Part A HOOF''.
- GP is asked to advise patient on what to do if no effect is seen after 20 minutes of high flow oxygen or if oxygen has no effect after 5 episodes of cluster headache. This was originally

assigned to the HOS team, but as they are unable to follow the patient after 3-4 weeks it seems appropriate for GP to advise patient rather than HOS team at six-monthly follow up.
- There is an addition of terms describing episodic and chronic patients and what should be done if the HOS team identify those patients.
- Addition of glossary for abbreviations used in the flow chart.
- Information about the high flow demand valve and its availability on the NHS for identified chronic sufferers only.
- TeamNet listed as a resource platform, where HOS contact details, referral forms and other details can be found.
- Addition of references.

It was intended that the home oxygen pathway for cluster headaches would be included within the overarching pain guidance for use in Primary Care. Clinicians were not aware of any contract changes from Air Liquid to BOC. The clinicians present had not prescribed oxygen for cluster headache and felt that for this indication a specialist should prescribe. JT noted that the fire brigade also needed to be notified of home oxygen but there were no contact details nor explanation of how this is carried out. DK noted a small typing mistake on page 3, parts A and B.
ACTION: LC will feed the comments back to the author, MO. APC have not approved.

4. FOR RATIFICATION – Monitoring and Medication after Bariatric Surgery

LC presented Monitoring and Medication after Bariatric Surgery, in MO's absence. The guidance had been updated in consultation with Mr Idris, Associate Professor in Diabetes and Vascular Medicine at the University of Nottingham.

The amendments to the existing document include:

- Added document version control table.
- The multivitamin replacements should be prescribed on FP10, as per NHS England guidance for CCGs (the previous version advised on purchasing replacements OTC).
- Monitoring fat soluble vitamins might be required in exceptional circumstances.
- References list updated and link added to BOMSS guidance's update from 2020.

APC members questioned why multivitamin replacement was indicated only for bariatric surgery and questioned why for other surgeries patients are expected to buy their own supplements post-surgery. LC to ask MO to clarify the message from NHSE to establish whether the recommendation included other indications.

The guideline shows a number of variations between Derby and Sheffield; clarity over which to follow would need to be provided, along with ensuring whose responsibility it is to monitor and how to differentiate between treatment dose and maintenance dose.

Practices have been receiving letters from Derby post-surgery. The letters received recently by practices were prescriptive, stating that vitamins needed to be supplied.
ACTION: LC will feed the comments back to the author. MO. APC have not approved.

5. FOR RATIFICATION – Lower carbon salbutamol inhalers – position statement

KR presented Nottinghamshire Adult Asthma Treatment Summary position statement, on behalf of the author. The position statement supports the appropriate prescribing of Salbutamol inhalers to reduce the carbon (environmental) impact and was produced in response to practices requesting additional guidance to support the updated Salbutamol entry on the APC joint formulary.

EG suggested incorporating a guideline Dr David Wicks had produced; this document offered a pictorial guide for the carbon impact, which would be better for patients to appreciate during their annual review.

APC members also suggested the following changes:

- Point 6, add the word "consider" as should not be prescriptive;
- Point 7, put DPI before pMDI as it is the first choice;
- Point 10, incorporate Salamol in the bullet point;
- Point 12, if this is for recycling benefit, add "for recycling";
- Incorporate the criteria and characteristics of a DPI;
- Incorporate technique, MDI slow and deep plus first- and second-line choices etc.;
- Incorporate technique, DPI sharp and quick plus first- and second-line choices etc.;
- Summary of a clinical assessment for when a patient would need an MDI rather than a DPI;
- Provide a patient information leaflet to explain the reason for suggesting a change of inhaler.

ACTION: KR to feed the comments back to the author. APC have not approved.

6. FOR RATIFICATION – Midodrine information sheet

LC presented the updated information sheet. The update included additional precautions and interactions. APC members agreed on the following recommendations:

- Need clarification on who does the titration once the patient is initiated on midodrine.
- Clarification needed on response vs risk evaluation before any dose increase
- Once the patient is stable, would they expect to have a review at any point with the specialist or GP to manage, as per the information sheet?

The information sheet needs to be altered to reflect the decisions above.
Agreed to ratify via email.

ACTION: LC will feed the comments back to the author. APC have not approved; this will be completed via email.

7. FOR INFORMATION - APC forward work plan

Forward work plan noted.

8. AOB

LC suggested that in future the JFG meeting becomes an APC meeting with decision-making capability as this would prevent a lot of repetition at APC. Those present agreed to the proposal. LC will look into updating the Terms of Reference (ToR) and ensure both meetings have the correct representation to be quorate.

ACTION: LC to update ToR and ensure the meeting representation provides quoracy.

Meeting closed at 17:00.