

**Nottinghamshire Area Prescribing Committee Meeting Minutes Thursday 30th April 2026:
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: -

Laura Catt (LC) (Chair)	Prescribing Interface Advisor	NHS Nottingham & Nottinghamshire Integrated Care Board (ICB)
Tanya Behrendt (TB)	Senior Medicines Optimisation Pharmacist	NHS Nottingham & Nottinghamshire ICB
Katie Sanderson (KS)	Patient Representative	Nottingham & Nottinghamshire ICB local population
Jennifer Moss Langfield (JML)	GP	City Place-Based Partnership (PBP), Nottingham & Nottinghamshire ICB
Dr Shan Hussain (SHU) representing on behalf of Dr Khalid Butt	GP	Local Medical Committee (LMC) Representative, Nottinghamshire.
David Wicks (DW)	GP	Mid Notts PBP, Nottingham & Nottinghamshire ICB
Deborah Storer (DS)	Medicines Information Manager and Drug and Therapeutics Committee (DTC) Pharmacist	Nottingham University Hospitals NHS Trust
Mark Clymer (MC)	Assistant Chief Pharmacist	Sherwood Forest Hospitals NHS Foundation Trust
Steve Haigh (SH)	Medicines Information and Formulary Pharmacist	Sherwood Forest Hospitals NHS Foundation Trust
Gladys Maponese (GM)	Deputy Chief Pharmacist and Head of Community Health Services and Forensic Health	Nottinghamshire Healthcare NHS Trust
Fatima Malik (FM)	Practice-based pharmacist	Nottinghamshire locality
Georgina Dyson (GD)	Advanced Nurse Practitioner	Nottingham CityCare Partnership
Nicola Jay (NJ)	Deputy Medical Director	NHS Nottingham & Nottinghamshire ICB
Shelly Herbert (SHe)	Practice Nurse	Musters Medical Practice, Rushcliffe PCN
Jacqui Toner Woods, (JTW)	Advanced Nurse Practitioner	Willowbrook Medical Practice, Ashfield North Primary Care Network

NHS Nottingham & Nottinghamshire ICB Interface Support in attendance:

Lynne Kennell (LK), Specialist Interface & Formulary Pharmacist for SFHT.

Karen Robinson (KR), Specialist APC Interface and Formulary Pharmacy Technician.

Lidia Borak (LB) – Specialist Medicines Optimisation Interface Pharmacist.

Irina Varlan (IV), Specialist Medicines Optimisation Interface Pharmacist.

Sue Haria (SHa), Medicines Optimisation Pharmacist.

1. Welcome and apologies.

APC members were welcomed, and apologies were noted.

2. Declarations of interest

APC members, attendees and the APC support team made no declarations of interest.

3. Minutes of the last meeting

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

4. Matters arising & action log

- Weight Management - From April 2026, the responsibility for referral to wraparound services and prescribing of injectable medications for weight management is moving from the ICB-funded centralised service to individual Primary Care practices. LMC questioned whether an Enhanced Service had been developed. As this is a nationally commissioned service through Quality and Outcomes Framework (QOF) LC explained that funding for this work would be via that route. LC explained that the Commissioning Team were due to send out communications to practices regarding this change of service and explained that there would be an interim period where it is likely that a mixture of both referral into the centralised service and practice prescribing under QOF takes place before the service is decommissioned in September 2026. To support prescribing via both routes of service delivery, on the Joint Formulary (JF), the classification will be changed from RED to GREEN, with cohort restrictions as defined by NHS England. The Behavioural Support for Obesity (BSOP) service will remain available. It was requested that the JF should not be changed until supporting information is available to avoid confusion and potential inequity.
- Blood test results - Some clinicians previously raised concerns about the visibility of blood test results from the various Trusts in the Integrated Clinical Environment (ICE) platform. JML had raised this as a concern with the Interface groups at NUH and SFHT.
- Icosapent ethyl – This had been discussed briefly at the ICB Cardiovascular Disease Board meeting, but it was questioned whether this was the correct committee to support the discussion and authorisation. This will be escalated for cluster-wide consideration via the Derbyshire, Lincolnshire, Nottinghamshire (DLN) clustered APC.
- Penicillin information leaflet– The Medicines Safety Officers (MSOs) addressed the comments made by members, and this is available on the Medicine Optimisation section of the APC website.
- A new formulation of Kay-Cee L had previously been identified via horizon scanning, where it was noted that there had been a significant cost increase for the new sugar-free product. Data taken from Open-Prescribing showed that 31 items had been prescribed between January 22

and January 23. Based on the low prescribing volume and recommendations in the [Neonatal and Paediatric Pharmacy Group \(NPPG\) Position Statement for: Enteral Calcium, Phosphate, Potassium and Zinc Supplementation in Neonates and Children](#), APC members approved its inclusion in the formulary.

ACTION: KR to update the Joint Formulary.

a) Update on ICB structures

LC appealed to members to respond to the survey regarding attendance at the June DLN APC meeting, noting that the meeting would aim to discuss clustered arrangements, Terms of Reference (ToR), quoracy, and the appointment of a Chair. In addition, a process would be required to ensure that mandated Technical Appraisals (TA's) are implemented appropriately during the summer whilst the DLN processes are developed.

b) Heylo – stoma leakage sensor prescribing data

LB gave an update on the Heylo audit provided by the Nottinghamshire Appliance Management Service (NAMS). Heylo had been approved by APC in February 2025 with a temporary classification, which was to be reviewed following a six-month audit to demonstrate neutral financial impact by generating savings with reduced use of ancillary stoma items following initiation of Heylo. Currently, there are 24 patients, with 9 having recently been initiated, representing a significant spike in prescribing. These initiations have been linked back to clinical staff funded by the company manufacturing Heylo, and NAMS have agreed to mitigate this conflict of interest to ensure that prescribing protocols have been followed by all stoma staff. The committee requested NAMS provide reassurance that this will be managed effectively. Patients' feedback had been positive.

APC members questioned the longer-term use of these appliances, noting that their approved place in therapy was to allow patients to gain confidence to go about their daily routine.

APC requested that the calculated savings be reviewed and recommended that prescribing be restricted to a very specific cohort identified as per the agreed local protocols, for its use as a training aid, to help build confidence for people with a stoma; it should not become an additional cost.

The audit will be returned to a future clustered DLN APC meeting.

ACTION: LB to liaise with NAMS to produce the requested information and return the item to a DLN cluster APC meeting.

c) Enoxaparin – update on potential change of brand in Secondary Care

DS confirmed that NUH will change its low-molecular-weight heparin (LMWH) brand to Clexane, but the date of this change had not been finalised. SFHT were considering their product choice of enoxaparin. It was noted that Inhixa was the most cost-effective brand for Primary Care. As there are some differences between devices for the LMWH, it is generally advised that patients continue with the brand prescribed in Secondary Care due to the training requirements. LC noted that, although there is a cost impact from Clexane in Primary care, there will be a saving to the ICS overall.

Additionally, it was noted that VTE in pregnancy is currently under discussion as part of the Better Birth Bundle of Care. JML will return anything significant to APC for discussion as it arises.

ACTION: Interface team to liaise with NUH re updating enoxaparin guidance.

d) Update on the Single National Formulary (SNF).

LK provided a brief update about the SNF and explained that the first step was likely to be the implementation of a nationally agreed RED, AMBER, GREEN (RAG) rating for medicines. This will move away from the current colour coding to a verbal descriptor. It is expected that this will not include an equivalent to an AMBER 3 classification. Consideration had been given to becoming a pilot site for its implementation.

However, due to the ongoing uncertainty around roles within the new DLN structure, this had not been pursued. The first stage for implementation of the SNF is expected in early 2027.

e) Rosacea guidelines

The Rosacea guideline was returned to the APC for further discussion. Previous reservations were around concerns over the inclusion of doxycycline 40mg MR (Efracea), which was more expensive than alternatives. This preparation was, however, included in the NICE Clinical Knowledge Summary (CKS) for the treatment of inflammation in papulopustular rosacea and was supported by Microbiologists at NUH due to its adherence to principles of antimicrobial stewardship.

After discussion, it was agreed to ratify the guidance with the inclusion of doxycycline 40mg MR. However, due to uncertainty regarding its cost-benefit, it was requested that usage and cost-effectiveness be reviewed in two years. This will be added for the DLN APC cluster to review.

ACTION: IV to review guidance and ensure previously agreed changes have been adopted, uploaded to the APC website, and update the JF. IV to escalate for DLN cluster APC for review in two years.

Action Log

- Xonvea (doxylamine/ pyridoxine) - approved summer 2025 for nausea and vomiting in pregnancy. Usage had been reviewed and was less than anticipated in the submission. Prescribing will continue to be monitored.
- Bupivacaine and adrenaline were added to the formulary due to lidocaine and adrenaline supply issues that had since resolved. APC clinicians had asked if it could remain on the JF, as the cost difference between the two products is negligible; it was agreed to keep both products on the JF.

ACTION: LK to update the action log and JF.

All other actions were either complete or on the agenda for further discussion.

5. NEW APPLICATIONS – Fezolinetant (Veoza)-NICE TA1143

NICE TA1143 was published on the 31st March 2026, with implementation required by 29th June 2026. Recommends fezolinetant to be used as an option to treat moderate to severe vasomotor symptoms (VMS) associated with menopause, when hormone replacement therapy is unsuitable. Fezolinetant-associated hepatic adverse effects have been highlighted by the Medicines and Healthcare products Regulatory Agency (MHRA), and Liver Function Tests (LFT's) must be performed before treatment initiation, then monthly for the first three months of treatment, and thereafter performed based on clinical judgement.

Fezolinetant is a neurokinin 3 (NK3) receptor antagonist licensed for the treatment of moderate to severe vasomotor symptoms (VMS) associated with menopause. An alternative to fezolinetant is elinzanetant, which has recently been launched. This medication does not require ongoing LFT monitoring, but costs approximately £100 PA more per patient. This would also be subject to NICE TA guidance, but its publication was not expected imminently. Fezolinetant is also not recommended by the manufacturer for use in women taking endocrine therapies for oestrogen-dependent cancers due to a lack of published data. However, elinzanetant has published evidence that supports its use in this cohort. Local Menopause Specialists supported the availability of both treatment options.

The NICE appraisal anticipated that the prescribing of fezolinetant would be mainly through Primary care, with Secondary Care Specialists being involved in its recommendation via the Advice and

Guidance route. The opinion of local Menopause Specialists was to support an AMBER. This pathway would require LFT monitoring to be performed in Primary Care if fezolinetant was used. No Primary Care concerns regarding this were raised, but it had already been highlighted to commissioning colleagues within the ICB.

It was highlighted that financial approval would be required as the predicted cost impact exceeded the APC's delegated authority for approval. It was expected that a DLN-level decision would be required to ensure consistency across the cluster. However, due to implementation timescales, it had been requested that individual APCs agree on a recommendation for consideration at the inaugural DLN Cluster APC.

APC Clinicians requested a defined initiation criteria due to a potentially large cohort and high cost in comparison to hormone replacement therapy (HRT) and alternative off-license treatment options such as Selective Serotonin Reuptake Inhibitors (SSRIs). It was highlighted that the existence of a TA recommendation precluded further restrictions, but these treatments should only be considered for those unsuitable for treatment with HRT. It was noted that approving elinzanetant for use before the publication of the NICE TA gave an element of risk if the TA then received a negative appraisal. From a clinical perspective, APC members approved the addition of fezolinetant and elinzanetant for use in line with the criteria outlined in NICE TA1143 with an AMBER 2, Specialist recommendation classification.

ACTION: LK to take the recommended Amber 2, Specialist recommendation classification to the DLN APC for a cluster level decision and to seek financial approval.

6. FORMULARY AMENDMENTS

FOR INFORMATION – Log of minor amendments carried out:

- Viridal duo – Now available only as a starter pack (injector +cartridges) as the continuation pack had been discontinued.
- Mesalazine suppositories - Pentasa suppositories had been debranded and are no longer available as branded Pentasa suppositories.

FOR DECISION - Suggested amendments:

- SGLT2 inhibitors in Heart Failure (HF) – the current AMBER 2 classification has resulted in cardiology receiving large numbers of referrals for initiation, which was felt to be unnecessary by the service. Members discussed a range of options and scenarios and agreed a reclassification to AMBER 3 in line with classifications of SGLT2s for other indications (T2D and CKD). Although the Amber 3 classification was likely to be reviewed as part of the of SNF work, as discussed in item 4d, this was felt to be the most appropriate option in the interim. It was requested that preferential use of generic dapagliflozin be promoted as the most cost-effective SGLT2.

ACTION: IV to inform cardiology of the decision and update the JF with the AMBER 3 classification.

7. HORIZON SCANNING

GREY no formal assessment:

- Oczyesa 20 mg Prolonged-release solution for injection in pre-filled pen (Octreotide subcutaneous depot). Indicated for maintenance treatment in adult patients with acromegaly who have responded to and tolerated treatment with somatostatin analogues.
- Leuprorelin (Eligard) 7.5mg, 22.5mg and 45mg prefilled syringes (with solvent). Treatment of hormone dependent advanced prostate cancer and for the treatment of high-risk localised and locally advanced hormone-dependent prostate cancer in combination with radiotherapy [new depot formulation, given up to 6-monthly].
- Levodopa and carbidopa (Onerji). Indicated for Parkinson's disease.
- Evorel Gel 500 microgram Transdermal gel. Estradiol 0.5 mg. HRT for estrogen deficiency symptoms in postmenopausal women.
- Amlodipine orodispersible tablets (5 & 10mg) Amdelta. Indicated for hypertension, chronic stable angina pectoris and Prinzmetal's angina.
- Zolvum (Levetiracetam) 500 mg Orodispersible Tablets. Indicated for Epilepsy.

GREY:

- Ozempic 2mg pen. Indicated for Type 2 diabetes. The 2mg dose had previously been classified GREY prior to existence of the 2mg pen. The 2mg dose is double the cost of lower doses and NICE guidance recommends a dose of up to 1mg
- Apixaban 1 mg/ml Oral Suspension. Apixaban tablets are licensed for dispersion in water. Suspension is less cost-effective than tablets and carries a higher risk of error.

New NICE guidelines:

- NG28: Updates include new recommendations on metformin, SGLT-2 inhibitors, GLP-1 RAs, DPP-4 inhibitors, sulfonylureas and pioglitazone. Changes to recommendations on insulin have also been made in the context of the withdrawal of insulin products and known insulin brand shortages. The implementation of updated NG28 is being considered on a DLN wide basis and a holding statement has been published.
- TA 1143: Fezolinetant for treating moderate to severe vasomotor symptoms associated with menopause. Discussed as agenda item 5.

ACTION: KR to update the JF with the agreed actions.

8. APC Documents due for review; proposals to retire or extend

Due to the restructuring within the ICB there will be a reduced workforce with limited capacity to maintain the current levels of APC work in terms of document maintenance. Furthermore, as the ICBs cluster, there is an expectation that APCs come together and over time, there will be an amalgamation of workstreams, such as clinical guidelines. To safeguard team capacity and reduce the risk of hosting expired documents on the APC website, the team had reviewed documents that would require review during the remainder of 2026 and early 2027. Consideration had been given to the value that the local guideline offers over national guidance and/or manufacturers' information. Documents were presented with a proposal to retire or extend them.

The following actions were agreed:

- Blood Pressure and Heart Rate Monitoring in Children – this was not felt to be an APC-relevant document, the expiry date will be removed, and it will be hosted via the F12 functionality on SystemOne.
- Cinacalcet Prescribing Information Sheet - to be retired, with the relevant information added to the Joint Formulary.
- Anaemia- Ferric Maltol Treatment Algorithm – to be retired.
- High-cost medicines treatment algorithms - to extend the review date to December 2026.
- Dementia medicines information sheets (donepezil, galantamine, rivastigmine) – to be retired.
- Lamotrigine in bipolar disorder - to extend to November 2027 and then consider retiring.
- Drospirenone Prescribing Information Sheet - to be retired.
- Prescribing and Supply of Unlicensed and Off-label Medication Policy – APC members felt this was still required. LC will discuss this further with the Medicines Governance and Community Pharmacy lead and raise as a piece of work for the DLN cluster APC.
- Renal Function Calculation and Drug Dosing/Monitoring - to retire and add links to the national online calculators.
- Narcolepsy information sheets (methylphenidate, modafinil and dexamphetamine) – to extend to December 2026.

As a number of APC guidelines had been developed to support an AMBER 3 classification, to enable the use of an APC-endorsed alternative guideline, the following amendment to the AMBER 3 definition was agreed:

From:

AMB 3

Primary care/ non specialist may initiate as per APC guideline.

The supporting prescribing guideline must have been agreed by the relevant secondary care trust D&TC(s) and approved by the Nottinghamshire APC.

To-

AMB 3

Primary care/ non specialist may initiate as per APC endorsed guideline.

The supporting prescribing guideline must have been agreed and recognised as clinically appropriate by the Nottinghamshire APC. Such guidelines will be linked to the specific medication entry of the joint formulary

It was confirmed that, as guidelines are retired, any clinically relevant information will be added to the JF entry of the medication.

TB explained that PrescQIPP had recently published a bulletin on transgender and gender dysphoria and suggested obtaining the analytics to see how often the APC guidelines were viewed. Depending upon these findings, the PrescQIPP version could be adopted, allowing the local version to be retired. LC will add this item to the document for review.

ACTION: LC to update the work log for future cluster consideration and retire or extend the documents as agreed by APC members.

9. FOR RATIFICATION – EMOLLIENT FORMULARY

KR presented the updated Emollient Formulary, which had been reviewed in response to product discontinuations. The previous authors of the Emollient Formulary had been contacted and informed, and the following amendments had been implemented:

- QV 5% had been removed from the Drug Tariff and is no longer available on prescription.
- ImuDERM cream had undergone a name change to ImuDERM Emollient.
- Prices had been updated in line with the Drug Tariff and DM&D [online, accessed March 2026].
- Reference sources and hyperlinks had been checked and updated where required.
- One hyperlink for bath emollients has been removed due to the linked source (low-priority medicines) being retired.

KR noted that Hydromol Intensive had also been discontinued, and the authors had been contacted regarding this.

** Post-meeting note: Flexitol 10% urea cream will be added to the formulary as an alternative product to Hydromol Intensive. APC members were informed of this addition via email.*

*** Wording regarding the supply of spatulas and spoons by community pharmacies has been removed as these items are not consistently provided due to self-funding arrangements. The wording now states: 'Emollients in pots should be applied using a clean spoon/spatula to prevent cross-contamination'.*

ACTION: KR to make the emollient JF changes, inform the authors, and add the formulary to the APC website.

10. FOR RATIFICATION – SATIVEX FOR SPASTICITY IN MULTIPLE SCLEROSIS (MS) SHARED CARE PROTOCOL (SCP)

Sativex was approved for use for spasticity in MS in August 2025, subject to the development of a SCP. There had been some uncertainty regarding available funding in Secondary Care for prescribing after the initial trial period funded by the manufacturer; however, funding for the second month's supply via Secondary Care has subsequently been agreed, and the SCP has been developed.

To aid prescribers, it was requested that the expected quantities based on the prescribed number of titrated sprays be included in the discharge letter and the SCP. A product image of Sativex (showing it is a spray), along with a definition of the Controlled Drug (CD) classification, will be included. APC clinicians requested the inclusion of an interaction list to highlight the most common interactions and the actions needed to be taken by the prescriber.

Subject to these additions, APC members approved the SCP.

ACTION: SHa to liaise with Secondary Care and incorporate the agreed changes to the SCP. Once finalised SHa will upload the SCP to the APC website and reclassify Sativex to AMBER 1 on the JF.

11. FOR RATIFICATION – PROTON PUMP INHIBITOR CHOICE IN CHILDREN AND YOUNG PEOPLE – INFORMATION SHEET

An updated information sheet and algorithm for the review of children and young people taking Omeprazole liquid long-term were presented. The original document was intended to prompt a review of prescribing omeprazole liquid due to the high cost of the liquid formulation and the potential benefits of changing to other formulations where possible. The update had been developed to take into account the updated NUH guideline: Proton Pump Inhibitor Choice in Children, November 2025, and was intended to support the prescribing of enteral (both oral and NG, PEG, etc.) Proton Pump Inhibitors (PPIs) in Primary Care, including advice on selecting the most suitable formulation and when to consider stopping or reducing the dose.

Oral suspension sugar-free is the only medication that is licensed in children between 1 month and 1 year of age; the use of other products in this cohort is off-license. It was explained that although the cost of the suspension is a consideration, there are also theoretical concerns regarding the lack of enteric coating in the omeprazole suspension form and how this affects its effectiveness. Over-prescribing of omeprazole for children in Primary Care is a recognised issue, and this guideline aims to support the review of ongoing prescribing.

APC members asked for the frequency to be added to the dose, the classification to be made clear, and to make it clear that the product was being used off-license. NJ noted there were inconsistencies in local unlicensed and off-label medicines use and expressed the view that prescribers should seek specialist advice before prescribing an unlicensed or off-label medicine in this patient group. It was noted that Omeprazole oral suspension is classified as AMBER 2 and therefore should only be prescribed on the advice of a specialist.

ACTION: SHa will make the requested changes and upload to the APC website.

12. ANY OTHER BUSINESS

Actinic Keratosis Primary Care pathway- Supply issues with fluorouracil 5% have resulted in the use of 4% cream as an alternative, and it has been noted that this was not included in the pathway. The pathway was due for review next month; however, it was agreed to retire the document and direct prescribers to the Primary Care Dermatology Society. Fluorouracil 4% and 5% creams will both be listed on the JF with an AMBER 3 classification.

ACTION: SHa to retire the pathway guideline and update the JF with the local messages.

13. DATE & TIME OF NEXT MEETINGS

APC Guideline meeting – Thursday 21st May 2026 (2pm - 5pm, MS Teams)

The meeting closed at: 16:50