Nottinghamshire Area Prescribing Committee Guideline Meeting Minutes 16th January 2025: 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 ICB**
Ann Whitfield (AW)	**Patient Representative**	**Nottingham & Nottinghamshire ICB local population**
Khalid Butt (KB)	**GP**	**LMC Representative**
David Wicks (DW)	**GP**	**Mid Notts PBP, Nottingham & Nottinghamshire ICB**
Tim Hills (TH)	**Assistant Head of Pharmacy**	**Nottingham University Hospitals NHS Trust (NUH)**
Hannah Sisson (HS)	**Principal Pharmacist, Adult Mental Health Community Teams**	**Nottinghamshire Healthcare NHS Trust**
Jo Fleming (JF)	**Specialist Clinical Pharmacist (Pain)**	**Primary Integrated Community Services Ltd**
Georgina Dyson (GD)	**Advanced Nurse Practitioner**	**Nottingham CityCare Partnership**
Susan Hume (SH)	**Advanced podiatrist**	**Nottinghamshire Healthcare NHS Trust**
Nicola Graham (NG)	**Senior Transformation Manager**	**NHS Nottingham & Nottinghamshire ICB**
Jacqui Burke (JB)	**Advanced Nurse Practitioner**	**Willowbrook Medical Practice**
Jennifer Moss Langfield (JML)	**GP**	**City PBP, Nottingham & Nottinghamshire ICB**
Asifa Akhtar (AA)	**GP**	**South Notts PBP, Nottingham & Nottinghamshire ICB**
David Kellock (DK)	**Consultant in Sexual Health and SFHT DTC Chair**	**Sherwood Forest Hospitals NHS Foundation Trust (SFHFT)**
Linnet Talsma (LT)	**Heart Failure Specialist Nurse**	**Nottinghamshire Healthcare NHS Trust**
Patrick Wilson (PW)	**Chief Pharmacist**	**Sherwood Forest Hospitals NHS Foundation Trust (SFHFT)**

NHS Nottingham & Nottinghamshire ICB Interface Support in attendance:

Karen Robinson (KR), Specialist APC Interface and Formulary Pharmacy Technician.
Vimbayi Mushayi (VM), Specialist Medicines Optimisation Interface Pharmacist.
Lidia Borak (LB), Specialist Medicines Optimisation Interface Pharmacist.
Irina Varlan (IV), Specialist Medicines Optimisation Interface Pharmacist.

1. Welcome and apologies.

APC members were welcomed, and apologies were noted.

2. Declarations of interest

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

3. Minutes of the last meeting & matters arising

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

Matters Arising:

- Vitamin B12 Guideline:- LB provided an update and explained to the committee that she had met with AA and JML and, due to the various discussions, significant changes would be made to the guideline and it would be brought back in its entirety to a future APC meeting for ratification.
- Sleep guidelines were discussed in the last meeting. Since then, IV has received a response to an MI enquiry regarding products suitable for vegetarians and will add this to the guideline. In addition, there were further comments regarding promethazine; it has been confirmed that the effects that caused the licence to be changed to 6 years and over are most likely a class effect, not limited to promethazine, and this will be added to the guideline.
- Terms of Reference (ToR) template for short-life task and finish groups: LC explained that this had been ratified by email and the full ToR document will be brought back to the March meeting for final ratification.

*****All other actions were complete or listed on the agenda. *****

4. FOR RATIFICATION - Antimicrobial Guidelines

- **Hidradenitis Suppurativa**

The Hidradenitis Suppurativa antimicrobial guideline has been updated due to reaching its review date, and comments were invited and received from the microbiology and dermatology leads. IV provided a summary of the changes, which included the following:

- Link to Primary Care Dermatology Society removed.
- Patient information section updated.
- Chlorhexidine 4% wash is the first-line topical treatment. This was the recommendation in the original guideline, but there is no specific mention on the Joint Formulary. A minor formulary amendment to the wording is suggested, allowing its use in the treatment of hid radenitis suppurativa.

- Systemic antibiotic treatment:
  - General evidence is not particularly strong for tetracyclines, but some people do benefit from them. No change to initial treatment options.
  - Cefalexin added as an alternative during an acute flare up.
- Added that clindamycin + rifampicin is a combination that may be initiated by dermatology after referral.
- Post-APC meeting, papers sent out: dermatology suggested mentioning the use of spironolactone and metformin for this indication. However, the evidence has not been reviewed by the APC team yet and it was decided to consider this via the formulary submission pathway.

APC members ratified the Hidradenitis Suppurativa antimicrobial guideline, subject to the minor amendments above.

ACTION: IV to make the requested amendments and upload the guideline to the APC website.

- **Dermatophyte of nail**

The Dermatophyte Infection of the Proximal Fingernail or Toenail antimicrobial guideline has been updated due to reaching its review date, and comments were invited and received from the microbiology leads. IV provided a summary of the changes, which included the following:

- Link to CKS added (updated August 2023).
- Patient information added, including that treatment is not always necessary and several self-care measures can be implemented.
- Patient Information Leaflet replaced by British Association of Dermatologists leaflet.
- Further information added about treatment:
  - If infection is confirmed, in certain circumstances topical treatment (amorolfine) can be used in adults and children over 12 years. This treatment should be purchased over the counter.
  - Oral treatment can be offered if a patient has a confirmed fungal nail infection and self/care with or without topical treatment has been unsuccessful or not appropriate.
  - Statement about combination of topical and oral treatment added.
- No change to treatment options other than course length of terbinafine for toenail.

Clinicians asked for children to be removed from the guideline as Amorolfine was not licensed for sale to children. The specialists will be approached to discuss the appropriate treatment options for children; IV will email their comments to APC for information.
Clinicians agreed that complicated terms such as ‘proximal’ should be simplified to ‘nail bed’.

APC members ratified the Dermatophyte Infection of the Proximal Fingernail or Toenail antimicrobial guideline, subject to the minor amendments.

ACTION: IV to make the requested amendments and upload the guideline to the APC website. IV will contact the specialists to ascertain the appropriate treatment for children and email members for information.

5. FOR RATIFICATION – Amiodarone Shared Care Protocol (SPC)

On behalf of a team member, LB presented the Amiodarone SCP, which had been updated due to reaching its review date.

LB provided a full list of changes:

- Wording in section 1 (responsibilities) updated to standard approved wording. This brings the amiodarone SCP in line with other APC SCPs.
- Quantity of medication supplied by Secondary Care at point of transfer to Primary Care updated from 28 days. NUH now provide 8 weeks' supply; SFH continue to provide 4 weeks' supply.
- Note added that amiodarone may be used for post-operative Atrial Fibrillation. These patients are usually able to stop the amiodarone, which will be determined during their follow-up review. Secondary Care will supply sufficient amiodarone until the review date. Shared care will be set up after this review if amiodarone needs to continue.
- Advice for patients taking warfarin updated in line with Summary of Product Characteristics and Stockley's Drug Interactions.
- Wording with regard to ophthalmic symptoms confirmed. Amiodarone can be continued with ongoing monitoring if the patient experiences blueish halos with no blurred or decreased vision. If blurred or decreased vision is experienced, amiodarone must be stopped, and the patient referred urgently.
- No change to overall treatment pathway, baseline, or ongoing monitoring.
- Contact details and telephone numbers for NUH/SFH checked and updated.
- Links and references checked and updated.
- Link to Supporting Document for Primary Care Reviews added. This is to support annual patient reviews and highlight historical patients not yet on shared care. The document has been reviewed by cardiologists and ratified by Medicine Optimisation Governance Group.

APC members suggested changing the wording of supply duration on transfer of care to "each Trust to provide at least 4 weeks' supply", instead of stating the number of days/weeks of supply for each Trust individually.
APC members ratified the amiodarone SCP, subject to the minor amendments.

ACTION: LB to make the requested amendments and upload the Amiodarone SCP and upload to the APC website.

6. FOR RATIFICATION – DOACs for Deep Vein Thrombosis (DVT) & Pulmonary Embolism (PE) Guidance

IV presented the DOACs for DVT & PE guidance which has been updated due to reaching its review date. Comments were invited and received from NUH, SFHFT, Primary Care Network, Bassetlaw and the CRASH (**C**ash **R**elease **A**nd **S**avings **H**ub) Team.

IV provided a full list of changes:

- the brands for Apixaban and Rivaroxaban were removed, following the marketing availability of generics in the past year.
- Note made to choose rivaroxaban tablets vs capsules as they are £45 per 28. The Joint Formulary entry will also be updated.
- The need for changing the wording regarding preferred DOACS due to cost to mirror the AF guidance was considered. NICE doesn't state a preferred DOAC in DVT/PE but recommends apixaban or rivaroxaban as initial treatment, so it was decided against it.
- No further national guidelines were updated since the last update, to call for a change in recommendations.

Clinicians requested that the DOACs were put in first and second-line order, with rivaroxaban as the first-line choice. Brand names will be removed and additional clarity of treatment after post six months will be incorporated.
Bassetlaw also returned comments on this guidance and their observations were similar to the APC committee. They expressed an interest in linking the DOACs for DVT&PE guidance to their local website, once this is ratified and uploaded.

APC members ratified the DOACs for DVT & PE guidance subject to the minor amendments.

ACTION: IV will make the requested changes unless the Secondary Care specialist have reason to request anything different and upload to the APC website.

7. FOR RATIFICATION – Enoxaparin information sheet (interim update)

JML presented the Enoxaparin Information Sheet (interim update) and explained when the information sheet was updated in January 2024 it was highlighted that the dose of enoxaparin used for the treatment of VTE in pregnancy was different at NUH and SFHFT.
This was flagged to the Local Maternity Units the Neonatal Network and the Maternity Guideline Variation Group. Provision and supply of enoxaparin has been discussed at these groups, and these groups included representation from:

- Obstetrics and gynaecology
- Midwifery
- Haematology
- General Practice

SFH updated their guideline 'Thromboprophylaxis and the Management of Venous Thromboembolism in Pregnancy and the Puerperium Guideline' in December 2024, changing the treatment dose from once daily to twice daily in line with NUH, ensuring consistency across the system.

JML will continue to update the APC Committee of any future development(s).

APC members ratified the Enoxaparin Information Sheet.

ACTION: A member of the APC Team will upload the information sheet to the APC website.

8. FOR RATIFICATION – Gastroprotection

VM presented the Gastroprotection (with PPI) for patients on NSAID or antiplatelet (update). Due to queries from primary care about monitoring of magnesium levels in patients prescribed long-term Proton Pump Inhibitors (PPIs) it was agreed with the specialists to undertake a full review of the guideline at the same time (originally due July 2025).
VM full list of changes:

- There have been no changes to national guidance around the use of PPIs and no change to our preferred PPI of choice.
- Hypomagnesaemia section updated:
    - Digoxin does not cause hypomagnesaemia but is potentiated by hypomagnesaemia which in turn increases the risk of digoxin toxicity.
    - Specialists do not recommend routine monitoring of magnesium on patients on long-term PPIs.
    - Symptoms added to clarify when monitoring might be appropriate.
- PPI-induced thrombocytopenia added as a rare risk of long-term PPIs.

Clinicians felt the monitoring requirements needed to be flagged for digoxin and diuretics. VM will consult with the Optimise Team to create an Optimise alert for when PPI is prescribed with digoxin or PPIs with diuretics, furthermore, a link to the omeprazole liquids flow chart will be added to the guidance to hopefully reduce the unnecessary prescribing of high-cost liquids.

APC members ratified the gastroprotection guidance subject to the minor amendments.

ACTION: VM will consult with the Optimise Team to formulate an Optimise message, make the minor amendments to the guidance as discussed and upload to the APC website.
Post meeting: Following discussions with the Optimise team, it was confirmed that Optimise does not generate interaction messages. This is because clinical systems are responsible for highlighting any interaction warnings, ensuring greater accuracy. A test conducted in SystemOne with a sample patient confirmed that the system successfully generates pop-up messages indicating interactions and recommending appropriate monitoring requested above.

9. FOR RATIFICATION – Heart Failure guidelines

IV presented the Heart Failure (HF) guideline which has been produced to summarise the new recommendations for treating HF. The old guidance was no longer considered useful as the current practice had changed following the European HF guidance that was published in 2021. NICE are in the process of reviewing the national HF treatment recommendations, however, this has been a slow process. NICE are expected to publish new guidance by September 2025.

A previous version of the Heart Failure Guidelines was discussed at the November APC meeting in 2023. Due to the estimated cost pressure of some recommendations the guidance ratification was stalled. The current version of the HF guideline is authored by Dr Bara Erhayiem, Heart Failure Consultant and HF lead at NUH. The most recent changes have been agreed by the Heart Failure Task and Finish Group (HF T&F Group) which met in December 2025. The HF T&F Group is formed from representatives from NUH, SFHFT and Bassetlaw, the professions consulted include cardiology consultants, specialist cardiology nurses and specialist cardiology pharmacists, Community HF specialist nurses from across Nottinghamshire, HF Pharmacists from PCN's, GPs with an interest in cardiology/HF, CDA (Clinical Design Authority) representatives and ICB representatives.

IV provided a full list of changes for the APC's consideration and the APC members raised several points for further discussion and clarity.

APC clinicians were not in agreement of prescribing 4 new medications all at once, preferring a staggered initiation over a few weeks to enable the individual assessment of patients and their tolerance to the new medication(s). IV will liaise with the HF T&F Group to create a statement to support the staggered initiation process and offer some narrative around the medications, removing the word 'offer' and replacing it with 'assess' and noting the absence of beta blockers and the clinical reasons why. Clinicians further questioned whether the urgent criterion was comprehensive enough to enable the initiation of 'any' medications while awaiting an echocardiogram referral. In addition, they felt 'RAASi' was not an abbreviation used in general practice and requested it to be detailed in full.
The majority agreed that the bright red colour in the guidance makes it difficult to read and a softer tone should be tried, and some commented that the guideline was wordy, and they believed a more bullet point/flowchart format would be easier to follow in day to day practice.

KB in his capacity as LMC representative requested guideline input from the Local Medical Committee (LMC).
NG provided IV with contact details for clinical directors to check if larger GP consultation is required.
APC members agreed the formatting should be amended to make it more readable to the user, JML and LT agreed to assist IV with this task.

APC members agreed to the monitoring information sheet and the standardised letter. The Interface Team will discuss the changes and decide whether final ratification can be achieved via email or if it needs to be returned to the next APC guidelines meeting in March.

ACTION: KB will submit the Heart Failure Guideline to the LMC for comment and feedback comments to IV.
NG provided IV with the contact details for clinical directors. IV will feed any relevant information from these contacts back to APC.
IV, JML and LT will amend the guideline with the suggested formatting.
IV will discuss the agreed changes with the APC Team and a decision will be made as to how final ratification will be achieved. IV will let APC members know what decision has been made in due course.

10. FOR INFORMATION – APC Forward Work Programme

LC explained that the Ciclosporin Eye Drop and Naltrexone prescribing information sheet were due for review. Following discussions with the APC team and the Medicines Optimisation Team, it had been decided these information sheets were superfluous to requirement and should be retired. APC members agreed this was a suitable action.

ACTION: LC will instruct a member of the APC Team to remove the prescribing information sheets from the APC website.

The remainder of the Forward Work Programme was noted by APC members.

11. Any Other Business

- NB had now taken up a Senior Advisors post within the Medicines Optimisation Team; this was a temporary position to cover maternity leave. APC members wish NB every success for her new position.
- KB notified members of a recent protest that had taken place outside one of the ICB GP practices. AW explained there was a lot of misinformation about the decision-making process within the patient sector and asked if one of the APC Team could attend a meeting to explain the decision making process. LC felt the Communications Team were best to consult for input.

12. Next meeting dates.

APC Formulary meeting: Thursday 27th February 2025 (2pm to 5pm, Microsoft Teams)
APC Guideline meeting: Thursday 27th March 2025 (2pm to 5pm, Microsoft Teams)

Meeting closed at: 16:45