Area Prescribing Committee Bulletin July 2026

📌 **Quick Overview**

This marks the final Nottinghamshire APC bulletin and summarises decisions from the February, March, April and May 2026 meetings.

As part of the transition to a clustered Derbyshire, Lincolnshire and Nottinghamshire (DLN) APC, future updates will be published through a joint APC bulletin. The first joint edition is expected in August 2026 and will provide a single source of prescribing and formulary updates from across the three areas.

1 - Link to APC website

2 - Link to APC Joint Formulary

Contents

- **New and updated Guidelines and Information Sheets**
- **Retired/ extended documents**
- **Horizon scanning, formulary amendments and traffic light changes**
- **Publications**
- **Feature of the month**
- **Let us know what you think**

Short on time? Click on the grey square bulletin icon, bottom right of your screen, review the thumbnails and jump to the section you want to read first.

New and updated Guidelines and Information Sheets

Antimicrobial Guidelines:

Impetigo

There are no significant changes to treatment recommendations.

Additional information has been added on good hygiene measures and when to refer to secondary care.

Chlamydia

The main changes include:

- Treatment options in pregnancy are now listed in a separate table and include **amoxicillin** as a new treatment option. Two dosing options for erythromycin are included: 500 mg twice a day for 14 days, or 500 mg four times a day for 7 days.
- Information regarding the test of cure was added as per NICE.
- If none of the recommended treatment options are suitable, refer to local Sexual Health Services.

Gonorrhoea

The main changes include:

- Additional information to support differentiation between uncomplicated and complicated infection, including indications for hospital admission.
- Treatment options have been simplified to **one treatment option only:** ceftriaxone 1g IM injection single dose for adults (including pregnant/breastfeeding).
- Other treatment options should only be initiated by Sexual Health Services; ciprofloxacin has therefore been removed.
- Contact details were added to support referral to Sexual Health Services for Nottingham and Nottinghamshire:
- **For appointments,** contact the Call Centre: 0300 131 7010.
- **For clinical advice (9am-6pm)**, contact the relevant Trust switchboard (**SFHT:** 01623 622515 or **NUH City Hospital:** 0115 969 1169) and ask to be put through to Sexual Health.

Vaginal discharge in children

The main changes include:

- Additional information included on potential underlying causes.
- A four-step approach to the management of the condition has been added:

1. Hygiene measures.

2. Treat underlying causes.

3. Treat Group A Streptococcus (GAS) if swab results are positive.

4. Actions if infection persists.

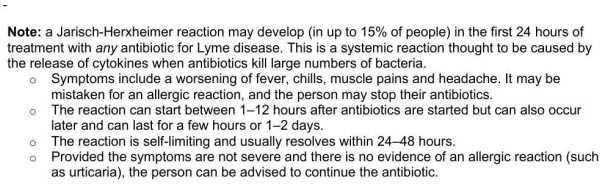
- **Amoxicillin** should only be used for confirmed Group A Streptococcus infection; the recommended course duration is now **10 days.**

- For persistent discharge and/or vulvovaginitis, consider a course of antibiotics guided by sensitivities. If sensitivities are not available, or if empirical treatment is being considered, discuss with the duty microbiologist.

Lymes Disease

No changes to the treatment pathway, additional information was added as follows:

- prevalence information,
- link to Public Health England leaflet 'Enjoy the outdoors but be 'tick aware',
- when to refer,
- possible allergic reactions that may occur once starting treatment for Lymes disease.



Panton-Valentine Leukocidin (PVL)

- More clarity was added to the advice that for PVL treatment, the patient requires oral antibiotics as per cultures, and that only after finishing the course and the wound has healed, the patient should be offered decolonisation treatment.
- Link added to the local Boils guideline for systemic treatment options.

Boils

- Group A Streptococcus was added to the causative microorganisms list and to the scenario where oral antibiotics are required.

Pityriasis Versicolor

The update brought a few changes to the treatment options and included more advice as follows:

- the aspect of the P versicolor rash.
- oral treatment recommendations are now in a table, in line with other guidelines,
- new topical treatment option added as per NICE CKS: terbinafine 1% cream: apply BD for 2 weeks, review after 2 weeks,
- fluconazole was also added as a systemic treatment option, as per CKS. Locally, it was decided to keep only the weekly dose (not the once-daily dose): **300mg once weekly for 2 to 3 weeks**. Relapse rates are lower with weekly fluconazole treatment. Previously, only itraconazole was a systemic option.

- New section added on relapse, referral and taking skin samples as per CKS.

Relapse is common and in most cases, re-treatment of each episode as for the initial presentation is appropriate.
If necessary, consider advising the person to apply ketoconazole shampoo once every 1–4 weeks to the whole body to reduce the risk of recurrence.
Also consider alternative diagnoses such as seborrheic dermatitis, pityriasis rosea, vitiligo.

Topical treatments:

Medication[1]	Dosage	Duration
If an extensive area is involved, prescribe antifungal shampoo.		
Ketoconazole 2% shampoo[2]	**Children and adults ≥12 years:** The preparation should be used as a body wash, lathered and left on affected skin for 3–5 minutes before thoroughly rinsing off. Apply once a day.	Maximum 5 days
If only small areas are involved, consider prescribing an antifungal cream.		
Clotrimazole 1% cream Or Terbinafine 1% cream	Apply twice a day Apply thinly, twice a day	For up to 2-3 weeks For 2 weeks. Review treatment after 2 weeks.

[1] See BNF for appropriate use and dosing in specific populations, e.g., hepatic, or renal impairment, pregnancy, and breastfeeding.
[2]**Note:** ketoconazole 2% shampoo is not licensed for use in children aged under 12 years.

	Adults (non-pregnant):	
Fluconazole or Itraconazole	300mg once weekly 200mg once daily	2 to 3 weeks 7 days
For pregnant or breastfeeding women and children, seek specialist advice.		
[1] See BNF for appropriate use and dosing in specific populations, e.g., hepatic, or renal impairment, pregnancy, and breastfeeding.		

Clostridioides difficile Infection (CDI)

Updates include:

- Oral vancomycin tapering regimen added as appendix.
- Alignment across NUH and SFH.

Pelvic Inflammatory Disease (PID) - due to be uploaded to the APC website shortly

Updates include:

- Information about current testing kits and recommendations.
- Clarification added that moxifloxacin should be used alone as a single agent.
- Moxifloxacin reclassified to **AMBER 3.**

Epididymitis and orchitis - due to be uploaded to the APC website shortly

Minor changes:

- information regarding the new testing kits was added.
- the contacts section and the expired links were updated.

Cellulitis

Updates include:

- Flucloxacillin dosing in patients with obesity.
- Reinforcement of the use of solid dose forms in children over liquid preparations.

Dermatophyte infection of the skin

Updates include:

- Hydrocortisone 1% **(max 7 days)** topical added for inflammation.
- Itraconazole and griseofulvin were added to the guideline as treatment options in line with NICE CKS.
- Further advice added on self-management.

Hidradenitis

- Addition of Octenisan to the topical antiseptic wash section.

Scabies

- There is limited evidence to support the use of ivermectin in patients with obesity. However, microbiology has advised that dosing should be based on actual body weight, with a maximum dose capped at 30 mg.

Guideline updates

Post-bariatric surgery guideline

Originally developed and reviewed in November 2025 by Derby ICB in collaboration with the bariatric tertiary centre at UHDB. The Nottingham APC website will host the guideline, with updates including clarification on annual nutritional blood monitoring and supplementation.

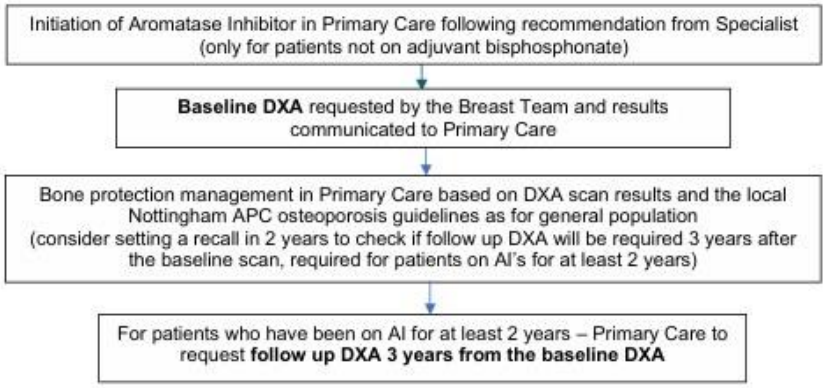
Table 1: Annual monitoring requirements[1]

Blood test	Gastric bands	Sleeve gastrectomy	Roux-en-Y Gastric bypass
U&E, renal function	Yes	Yes	Yes
Liver function test	Yes	Yes	Yes
Full blood count	Yes	Yes	Yes
Ferritin	Yes	Yes	Yes
Folate	Yes	Yes	Yes
Vitamin B12	No	Yes unless patient is having 3 monthly IM hydroxocobalamin	
Calcium	Yes	Yes	Yes
Vitamin D	Yes	Yes	Yes
Parathyroid hormone	Yes	Yes	Yes
Vitamin A	No	No	Measure if concerns regarding steattorrhoea or symptoms of deficiency e.g. Night blindness, and at each trimester during pregnancy
Zinc, copper	No	Yes Also when concerns e.g. Unexplained anaemia, hair loss, pica, neutropaenia	
Selenium	No	Check levels if there is chronic diarrhoea, metabolic bone disease, unexplained anaemia or unexplained cardiomyopathy	Yes and if there is chronic diarrhoea, metabolic bone disease, unexplained anaemia or unexplained cardiomyopathy
HbA1c	Monitor as appropriate in patients with preoperative diabetes		
Lipid profile	Monitor in those with dyslipidaemia		

Osteoporosis prevention in early breast cancer

A new section has been added to the local fracture prevention and osteoporosis management guideline. This aims to guide bone protection management in patients with early breast cancer when treated with aromatase inhibitors. The pathway is to guide all clinicians involved in the patients' care on the appropriate follow-up schedule and to clarify the requirements that need to be undertaken by Primary Care.

Appendix 4. PREVENTION OF OSTEOPOROSIS IN PATIENTS WITH EARLY (NON-METASTATIC) BREAST CANCER TREATED WITH AROMATASE INHIBITORS (AI)



BASELINE DXA SCAN RESULTS – to guide clinical decision on the osteoporosis prevention management based on T scores, as per the local guideline for the general population (primary and secondary prevention applies).

3-YEAR FOLLOW UP DXA SCAN RESULTS – to guide clinical decision on the fracture prevention management based on T scores and the annual rate of bone density loss whichever meets the intervention threshold.

Annual rate of bone density loss	Treatment recommendation	Repeat DXA
4% or more	Initiate bisphosphonate	in 2 years
Less than 4% and stable	Not required if not indicated by the T scores	in 3 years while on AI*

* Patients requiring extended AI therapy (i.e. 7 years), would need DXA scan at baseline, follow up in 3 years, and then 7 years from baseline DXA.

Aromatase inhibitors increase bone turnover causing bone mineral density (BMD) loss. When recommending the initiation of an AI to Primary Care, the Early Breast Cancer clinic will refer patients have a **baseline DXA scan** to measure the baseline BMD. This is to inform Primary Care if bone protection is indicated at that time. The treatment decision should follow the local Nottingham APC osteoporosis and fracture prevention guidelines for the general population.

Please note that patients who are on aromatase inhibitors and who are also eligible to receive 3 years adjuvant therapy with bisphosphonates to improve breast cancer survival (i.e. ibandronic acid or zoledronic acid delivered at the oncology unit) are not required to have any DXA scans.

Over time, AI therapy can lead to a cumulative BMD loss which can significantly increase the risk of fracture or cause osteoporosis. A follow up DXA scan is recommended for all patients who have completed **at least 2 years of therapy with AI**. This is to be requested by the Primary Care **3 years from the baseline DXA**. Patients on extended AI therapy are recommended additional scan 7 years from baseline DXA as above.

Upon completion of AI therapy, for the purpose of osteoporosis prevention, patients are to be manage as per the local guidelines for the general population.

Opioid Deprescribing for Persistent Non-cancer Pain Guideline

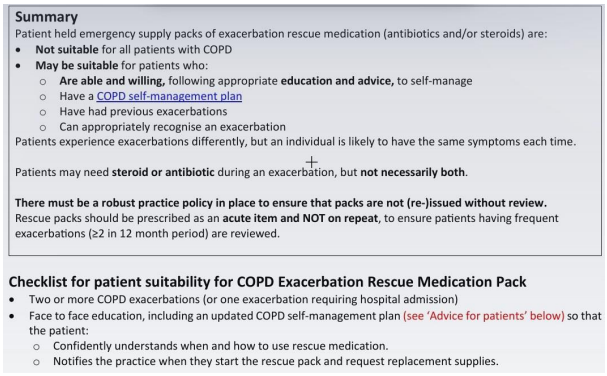
- Statement added that opioid deprescribing is usually appropriate to manage within primary care, with referral to specialist chronic pain services reserved for complex cases.
- Statement added to reflect that the recommended oral morphine equivalent (OME) threshold has been **reduced from 120 mg/day to 90 mg/day, with an ideal target of**

50 mg/day. These thresholds are presented as guidance rather than absolute limits, recognising that exceptions may be clinically appropriate. This change is based on emerging evidence indicating increased harm at higher opioid doses without proportional additional benefit, as reflected in national guidance from the Faculty of Pain Medicine (Opioids Aware). The Opioids For Chronic Non-Cancer Pain In Adults Guidelines has also been updated to reflect the changed in recommended OME threshold.

- The risk of harm increases substantially at doses above an Oral Morphine Equivalent (OME) of 90mg/day (ideal target 50mg/day), but there is no increased benefit. **OME** threshold of **90mg/day**, with an **ideal target of 50mg/day,** is designated as guidance and exceptions may be clinically appropriate. Ref: Faculty of Pain Medicine Key Messages.

COPD Exacerbation Rescue Medication Pack- guidance for prescribers

- Information added on self management plan and other strategies may be appropriate for some patients.
- Information added on the consideration of steroid weaning if multiple steroid courses are issued due to a risk of adrenal suppression.



Summary

Patient held emergency supply packs of exacerbation rescue medication (antibiotics and/or steroids) are:

- **Not suitable** for all patients with COPD
- **May be suitable** for patients who:
  - **Are able and willing,** following appropriate **education and advice,** to self-manage
  - Have a COPD self-management plan
  - Have had previous exacerbations
  - Can appropriately recognise an exacerbation

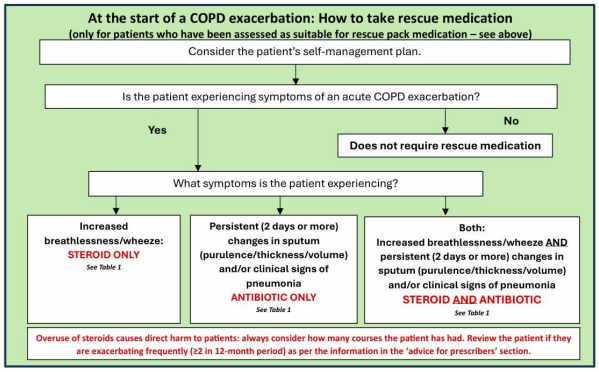
Patients experience exacerbations differently, but an individual is likely to have the same symptoms each time.

Patients may need **steroid or antibiotic** during an exacerbation, but **not necessarily both**.

There must be a robust practice policy in place to ensure that packs are not (re-)issued without review.
Rescue packs should be prescribed as an **acute item and NOT on repeat**, to ensure patients having frequent exacerbations (≥2 in 12 month period) are reviewed.

Checklist for patient suitability for COPD Exacerbation Rescue Medication Pack

- Two or more COPD exacerbations (or one exacerbation requiring hospital admission)
- Face to face education, including an updated COPD self-management plan (see 'Advice for patients' below) so that the patient:
  - Confidently understands when and how to use rescue medication.
  - Notifies the practice when they start the rescue pack and request replacement supplies.



Urticaria and angioedema

- Two treatment options were removed: montelukast which is no longer recommended, and fexofenadine 120 mg which is unlicensed for this indication.
- Tranexamic acid dose in renal impairment was updated to align with updated renal guideline.

- Minor adjustment of cetirizine dosing to allow once daily higher dose administration (up to fourfold of licensed dose).
- Additional safety considerations and information relevant in pregnancy were listed.
- Information added on consideration of withholding the ACE inhibitor and seeking specialist advice where appropriate.

<table>
<tr><th>Medication</th><th>Licensed indication</th><th>Licensed dose</th><th>Doses recommended in urticaria/angioedema</th></tr>
<tr><td>Cetirizine</td><td>The relief of nasal and ocular symptoms of seasonal and perennial allergic rhinitis.
The relief of symptoms of chronic idiopathic urticaria.</td><td>Adults: 10mg once daily (1 tablet).</td><td>10mg to 40mg daily (off-label dose).
Dose reduced in renal impairment:
• if eGFR <50ml/min - use half of normal dose,
• if eGFR 30-50ml/min – use half of normal dose every other day.</td></tr>
<tr><td>Fexofenadine</td><td>The relief of symptoms associated with chronic idiopathic urticaria.</td><td>Adults: 180mg once daily taken before a meal.</td><td>180mg to 540mg daily (off-label dose).</td></tr>
<tr><td>Tranexamic acid</td><td>Hereditary angioneurotic oedema.</td><td>Some patients are aware of the onset of illness; suitable treatment for these patients is intermittently 1g-1.5g two to three times daily for some days.
Other patients are treated continuously at this dosage.</td><td>1g three times daily increased to 1.5g three times daily.
Dose and dose interval reduced if eGFR <50ml/min (Table 1) or if serum creatinine is ≥120micromol/L as per SPC.
Table 1- The Renal Drug Database
<table>
<tr><th>GFR (ml/min)</th><th>Tranexamic acid oral dose</th><th>Dose frequency</th></tr>
<tr><td>20-50</td><td>15 mg/kg</td><td>12 hourly</td></tr>
<tr><td>10-20</td><td>15 mg/kg</td><td>12 to 24 hourly</td></tr>
<tr><td><10</td><td>12.5 mg/kg</td><td>24 hourly</td></tr>
</table></td></tr>
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Adult Headache Pathway

The Adult Headache Pathway has been updated in line with current NICE and BASH guidance, in collaboration with Neurology (NUH) and Primary Care.

- Red flag criteria have been simplified to reduce unnecessary MRI requests, with additional indicators included to support identification of serious conditions (e.g. meningitis, pre-eclampsia, cerebral venous sinus thrombosis). MRI access from Primary Care remains unchanged.
- Diagnostic criteria have been refined, with expanded guidance on migraine (including menstrual-related and chronic migraine).
- Acute treatment recommendations are largely unchanged, but prescribing advice has been strengthened (avoid opioids, limit antiemetics, promote cost-effective triptans).

Migraine prophylaxis guidance has been updated:

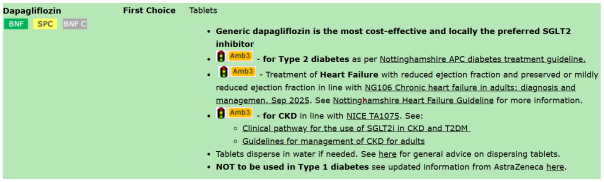
- **First-line:** propranolol or amitriptyline (max dose reduced to 80 mg)
- **Alternatives:** topiramate, pizotifen (local use), candesartan (off-label)

Heart failure guideline (interim update)

- interim update in line with **NICE TA1148 - Sodium zirconium cyclosilicate for treating hyperkalaemia:** The serum potassium threshold for initiating sodium zirconium

cyclosilicate in the treatment of hyperkalaemia has been lowered from 6.0 mmol/L to >5.5 mmol/L, in line with NICE TA 1148. This remains classified as **AMBER 2.**

- **SGLT2 inhibitors traffic light change:** The **AMBER 2** classification for SGLT2 inhibitors in heart failure has led to a high volume of referrals to cardiology for initiation, which the service considers largely unnecessary. SGLT2 inhibitors have been reclassified to **AMBER 3**.
- Generic **dapagliflozin** continues to be the most cost-effective and locally preferred SGLT2 inhibitor.



Buccal Midazolam Guideline for Children

- **Buccolam®** remains the first line as licensed product (Epistatus® as an unlicensed and non-formulary choice).

Management of chronic pain in patient aged 16 years and over – overarching pain guidelines for primary care clinicians

- **Strengthened safety messaging** around dependence, withdrawal and tolerance associated with **gabapentinoids, benzodiazepines and Z-drugs**, with links to the latest MHRA Drug Safety Update.
- **Topical NSAIDs reinforced as first-line pharmacological treatment** for osteoarthritis where appropriate.
- **Paracetamol and weak opioids now have a more limited role**, with guidance clarifying they should only be used **infrequently and for short-term pain relief** when other treatments are unsuitable, ineffective or not tolerated.
- **Strong opioids are not recommended for osteoarthritis**, reflecting their unfavourable risk–benefit profile.
- **Oral NSAID prescribing advice has been strengthened**, with increased emphasis on assessing gastrointestinal, renal and cardiovascular risk and prescribing gastroprotection where appropriate.
- **Weight management recommendations updated** to include information on locally commissioned weight-management services and eligibility criteria for weight-loss injectable therapies.

- **Osteoarthritis imaging advice updated**, emphasising that routine imaging is usually unnecessary and should generally be reserved for situations where more invasive treatment options are being considered.
- **Guidance on intra-articular corticosteroid injections has been revised** to emphasise their use for short-term symptomatic relief only, highlight the limited duration of benefit, and outline the potential risks associated with repeated injections.
- **Recommendations on repeat corticosteroid injections clarified**, advising appropriate spacing between injections and avoidance close to planned joint replacement surgery because of infection risk.

Retired/extended Guidelines

As ICBs begin to cluster, APC workstreams, particularly clinical guidelines are expected to align and merge over time.

To manage capacity and minimise the risk of outdated documents on the APC website, a review of guidance due for update in late 2026 and early 2027 has been undertaken. This included assessing the added value of local guidance compared with national or manufacturer information. Proposals have been made to either retire or extend selected documents.

- Gynaecomastia in Adults- aligned with Association of Breast Surgery (ABS) recommendation - Tamoxifen 10mg daily
- Blood Pressure and Heart Rate Monitoring in Children – it will be hosted via the F12 functionality on SystmOne.
- 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.
- 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.

Other updates

Fezolinetant

- **AMBER 2** classification
- For use on Specialist recommendation for the treatment of moderate to severe vasomotor symptoms associated with menopause when HRT is unsuitable in line with NICE TA1143.
- LFT monitoring required; at baseline then monthly for the first 3 months of treatment- see SPC for further details

Inhaled levodopa (Inbrija) and sublingual apomorphine (Kynmobi)

Both treatments have been approved for formulary use as alternatives to SC apomorphine (**AMBER 2,** specialist initiation).

Sublingual apomorphine (Kynmobi) is **first-line** due to lower cost; inhaled levodopa is **second-line** if unsuitable. Evidence shows both are effective, though each requires manual dexterity and have practical considerations.

Prescribing should remain in secondary care until benefit is confirmed to reduce wastage. A standard handover to primary care will be developed.

Therapy for Hypogonadism and Constitutional Delay in Growth and Puberty in male children and adolescent Shared Care Protocol (SCP) and information sheet

The main updates relate to alignment with the current Summary of Product Characteristics (SPC), particularly within the sections on precautions, adverse effects, and drug interactions.

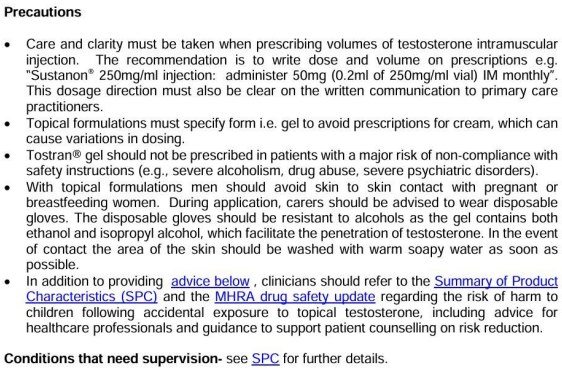
Explicit criteria for review and discontinuation of the medicine

In patients with CDGP, keep under specialist review until testicular volumes are 10mL or more. If during treatment for hypogonadism, an increase in testicular volume is noticed, treatment must be discontinued immediately, and diagnosis reviewed. Treatment can be recommenced once diagnosis of hypogonadism due to testicular failure is reconfirmed.

Contraindications

Sustanon® 250 and Tostran ® 2% gel

- Hypersensitivity to the active substance or to any of the excipients in any of the testosterone formulations i.e. Arachis oil (refined)in Sustanon ® -250. Sustanon ® 250 is therefore contraindicated in patients allergic to peanuts or soya
- Known or suspected carcinoma of the prostate or breast, history of liver tumors
- Hypercalcaemia



Precautions

- Care and clarity must be taken when prescribing volumes of testosterone intramuscular injection. The recommendation is to write dose and volume on prescriptions e.g. "Sustanon® 250mg/ml injection: administer 50mg (0.2ml of 250mg/ml vial) IM monthly". This dosage direction must also be clear on the written communication to primary care practitioners.
- Topical formulations must specify form i.e. gel to avoid prescriptions for cream, which can cause variations in dosing.
- Tostran® gel should not be prescribed in patients with a major risk of non-compliance with safety instructions (e.g., severe alcoholism, drug abuse, severe psychiatric disorders).
- With topical formulations men should avoid skin to skin contact with pregnant or breastfeeding women. During application, carers should be advised to wear disposable gloves. The disposable gloves should be resistant to alcohols as the gel contains both ethanol and isopropyl alcohol, which facilitate the penetration of testosterone. In the event of contact the area of the skin should be washed with warm soapy water as soon as possible.
- In addition to providing advice below , clinicians should refer to the Summary of Product Characteristics (SPC) and the MHRA drug safety update regarding the risk of harm to children following accidental exposure to topical testosterone, including advice for healthcare professionals and guidance to support patient counselling on risk reduction.

Conditions that need supervision- see SPC for further details.

Continence formulary

This formulary continues to be updated on a rolling basis with consultation with the Continence Formulary Group. All of the updated sections have been reviewed to ensure cost efficiency and evidence-based product selection.

Blood Glucose Testing Strips, Lancets and Pen Needles formulary

The formulary sets out the meter options for use in each group of patients:

- Type 2 diabetes (T2DM).
- Type 1 diabetes / Ketosis-prone T2DM.
- Gestational diabetes.
- Other groups, e.g. paediatrics, visually impaired, etc.

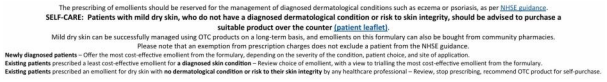
The 2 Acute Trusts are now aligned with the formulary, with the community nursing teams of both Nottingham City and Nottinghamshire County, and with each other, with respect to the meters given to newly diagnosed T2DM patients.

The section on lancets and pen needles has been updated to include additional information to aid clinicians with product selection.

NHSE Category	Patient cohort	Meter	Blood glucose test strips	Ketone test strips	Lancets
1a & 1b	**Type 1 diabetes or Ketosis-prone Type 2 diabetes +/- additional functionality** Any of these meters would be appropriate as a "back-up" meter for patients on CGM who need to test for glucose and ketones	GlucoFix Tech GK^	GlucoFix Tech Sensor	GlucoFix Tech ß-Ketone Sensor	Glucoject PLUS Droplet* Microdot Plus ♯
		4SURE Smart Duo^	4SURE	4SURE ß-Ketone test strips	4SURE Droplet* Microdot Plus ♯
		GlucoRx HCT	GlucoRx HCT Glucose Test Strips	GlucoRx HCT Ketone Test Strips	GlucoRx Droplet * Microdot Plus ♯
	^**Meters with additional functionality** Please see Appendix 1 for details e.g. Paediatrics, Dexterity, Visual impairment				
2	**Type 2 diabetes** Any of these meters would be appropriate as a "back-up" meter for patients on CGM who **do not** need to test for ketones	GlucoRx Q	GlucoRx Q		GlucoRx Droplet* Microdot Plus ♯
		Contour Plus Blue **1st line for patients under the care of community nursing e.g. District Nurses**	Contour Plus		Microlet Droplet* Microdot Plus ♯
		Accu-Chek Instant	Instant		FastClix ONLY
3	**Type 2 diabetes with additional functionality** Please see Appendix 1 for further details.	WaveSense Jazz **Gestational diabetes NUH**	WaveSense Jazz / Duo		AgaMatrix Ultra-Thin Droplet* Microdot Plus♯
		4SURE Smart / Duo **Gestational diabetes SFH**	4SURE	4SURE ß-Ketone test strips	4SURE Droplet* Microdot Plus ♯
		GlucoRx Nexus Voice **Visual impairment**	GlucoRx Nexus		GlucoRx Droplet* Microdot Plus ♯
4	**Type 1 & 2 diabetes** Lancets suitable for most people, including those requiring meters with additional functionality	*Droplet lancets are Type A lancets and considered universal. ♯Microdot Plus lancets are Type A lancets. They are considered universal. Prescribers also have the option to provide patients with a Microdot* lancing device. These are available to order free of charge from Cambridge Sensors Customer Helpline 0800 088 3920			

Emollient formulary

- 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 March 2026 Drug Tariff and DM&D.
- One hyperlink for bath emollients has been removed due to the linked source (low-priority medicines) being retired.
- **Please note Hydromol Intensive has been discontinued. Flexitol 10% urea cream has been added to the formulary as an alternative product.**


The prescribing of emollients should be reserved for the management of diagnosed dermatological conditions such as eczema or psoriasis, as per NHSE guidance.
SELF-CARE: Patients with mild dry skin, who do not have a diagnosed dermatological condition or risk to skin integrity, should be advised to purchase a suitable product over the counter (patient leaflet).
Mild dry skin can be successfully managed using OTC products on a long-term basis, and emollients on this formulary can also be bought from community pharmacies.
Please note that an exemption from prescription charges does not exclude a patient from the NHSE guidance.
Newly diagnosed patients – Offer the most cost-effective emollient from the formulary, depending on the severity of the condition, patient choice, and site of application.
Existing patients prescribed a least cost-effective emollient for **a diagnosed skin condition** – Review choice of emollient, with a view to trialling the most cost-effective emollient from the formulary.
Existing patients prescribed an emollient for dry skin with **no dermatological condition or risk to their skin integrity** by any healthcare professional – Review, stop prescribing, recommend OTC product for self-purchase.

Type 2 Diabetes NICE guidance update – holding statement

NHS Derby and Derbyshire Integrated Care Board

NHS Lincolnshire Integrated Care Board

NHS Nottingham and Nottinghamshire Integrated Care Board

March 2026

Holding Statement: NICE NG28 (Type 2 Diabetes)

Subject: *NICE Type 2 Diabetes Guideline (NG28) – Temporary Pause on Local Implementation*

NHS Derbyshire, Lincolnshire and Nottinghamshire ICBs welcome the publication of the updated **NICE Type 2 Diabetes Guideline (NG28)**, which represents an important and positive development in the management of Type 2 diabetes and improving outcomes for our population. The recommendations available at: https://www.nice.org.uk/guidance/ng28 underscore the ongoing national commitment to strengthening evidence based personalised diabetes care.

At this stage, we ask **all practices and clinicians to pause local implementation of the updated NG28 recommendations**. The three ICB cluster is currently working jointly to:

- review the guideline in full,
- assess the implications for our pathways and workforce, and
- ensure that adoption is feasible **within the available financial envelope** across Derbyshire, Lincolnshire and Nottinghamshire.

This coordinated approach is essential to support equity, sustainability, and consistency across the system.

We anticipate issuing a further update and an agreed implementation plan once this system level work has concluded.

Thank you for your patience and continued commitment to high quality diabetes care.
If you have urgent queries or want to be part of the working group, please contact your local ICB diabetes or medicines optimisation lead.

Proton pump inhibitor choice in children

- Updated information sheet and algorithm support review of long-term omeprazole liquid prescribing in children and young people, aligned with the November 2025 NUH guideline.
- Aims to promote cost-effective prescribing by encouraging use of alternative formulations where appropriate and supporting decisions to reduce or stop PPIs.
- Simplified weight-based dosing information.
- Omeprazole oral suspension is classified as **AMBER 2** and should only be prescribed on specialist advice.
- Highlights concerns around overprescribing in primary care and advises regular review of ongoing treatment.

- Prescribers are reminded to clearly document dosing frequency and off-label use, and to seek specialist advice when prescribing unlicensed or off-label medicines in this population.

Allergic rhinoconjunctivities treatment pathway (Adults)

- Fexofenadine added as an additional treatment option
- Advice and clarification added about IGE testing and referral routes.
- Doses which are off label need to be prescribed and not purchased by patients OTC.

Phosphate Binders for the Treatment of Hyperphosphataemia in Adults with Chronic Kidney Disease

- Phosex removed due to its discontinuation.
- All references to monitoring have been removed as this is the responsibilty of the specialist.

Sativex for spasticity in multiple sclerosis (MS) shared care protocol

Sativex was approved for MS-related spasticity (Aug 2025), subject to a Shared Care Protocol (SCP). Funding for the second month of treatment in secondary care has now been agreed, and the SCP has been developed.

Additional guidance will include:

- expected quantities based on titrated dosing in discharge documentation,
- a product image,
- Controlled Drug classification details,
- and a list of common interactions with corresponding prescribing actions.

Changes to SMA baby milk products

- SMA Althera **Advance** is replacing SMA Althera- stocks are expected to be diminished by end 2026- new patients should be started on SMA Althera Advance
- SMA Alfamino **Advance** is replacing SMA Alfamino- stocks are expected to be diminished by end 2026- new patients should be started on SMA Alfamino Advance.

These are the same cost resulting in no additional cost to the NHS.

Horizon scanning, formulary amendments and traffic light changes

GREY ◯

- Single-ingredient LABA inhalers. Formoterol, olodaterol, and salmeterol have been reclassified as GREY. Current NICE guidelines do not recommend single-ingredient LABA inhaler use.
- Sno Tears® discontinued: Liquifilm® added as an alternative product.
- Nizatidine: Famotidine is to be used preferentially as the formulary choice due to its cost-effectiveness.
- Bisoprolol fumarate 1mg/ml Oral Solution.
- Ozempic (semaglutide) 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 more expensive than 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.

GREEN 🟢

- Tramadol orodispersible: In line with national advice, orodispersible have been added as an option to allow for prescribing during supply problems of soluble tablets.
- Proxor® (beclometasone dipropionate, formoterol fumarate dihydrate): is now recommended as the first-line MDI product.
- Actimorph® orodispersible tablets: where there is concern about overuse/ a need for weaning doses of morphine.
- Domperidone 10 mg orodispersible tablet (Epzit): indicated for the symptoms of nausea and vomiting. More cost effective than suspension.
- PCV20 (pneumococcal vaccine): indicated for the prevention of invasive disease. This is a new addition due to the discontinuation of Pneumovax.
- Tirzepatide (Mounjaro®) for weight management: is currently available only for patients in **NHS England Cohorts 1 and 2** who meet the **national eligibility criteria** and engage with the **mandatory Behavioural Support for Obesity Programme (BSOP)**.As part of the 2026/27 QOF, general practices can prescribe tirzepatide for eligible patients, with referral to BSOP required. Referral forms are embedded within prescribing systems. The community based local commissioned service- Nottingham and Nottinghamshire Weight Management Single Point of Access (WMSPA) will also continue to accept referrals and coordinate access to wraparound support until 14 August 2026, after which remaining patients will be discharged back to their GP.

AMBER 2 🟠

- Vevizye® (ciclosporin) 0.1% eye drops preservative-free 2ml - cost- effective alternative to Ikervis® when used in line with NICE.
- Ipratropium inhaler from GREEN to AMBER 2
- Twice weekly buprenorphine patches (Bupeaze®) have been reclassified as AMBER 2 (weekly patches eg Sevodyne® remain AMBER 3)

AMBER 3 🟠

- SGLT2 inhibitors from AMBER 2 to AMBER 3

Other

- *Buprenorphine (Buvidal®) Restricted to Nottingham City Substance Use Services (Framework/Nottingham Recovery Network (NRN) and Nottinghamshire County Substance Use Services (Change Grow Live (CGL)). Funded via OHID grants.*
- Semaglutide (Rybelsus®): 3mg, 7mg and 14mg strengths are being phased out and will likely become unavailable from early 2026. No new patients are to be started, and existing patients should be reviewed and switched to equivalent dose of new formulation (1.5mg, 4mg, 9mg).
- Adipine MR® & Adipine XL® brands of nifedipine: Discontinued and stocks depleted.

Publications

3 - Link to APC webinars up to April 2025.

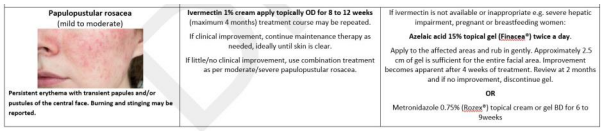
4 - Link to APC podcasts

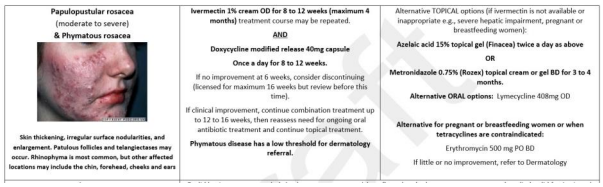
Feature of the month: New Local Rosacea Guideline

A new local guideline has been created for the treatment of **Rosacea**.

- **First-line approach:** Provide lifestyle advice for all patients (trigger avoidance, daily SPF ≥30, gentle skincare) alongside appropriate treatment.
- **Treatment selection:** Base on subtype and severity, using topical therapies first line (e.g. ivermectin, azelaic acid, metronidazole); add oral doxycycline for moderate–severe disease.
- **Review and step up:** Assess response and escalate where required.
- **Referral criteria:** Consider dermatology referral for treatment failure, diagnostic uncertainty, or significant psychosocial impact. Urgent ophthalmology referral if severe ocular involvement suspected.

Doxycycline 40mg MR has been added to the formulary for the treatment of rosacea.





Let us know what you think!

We are the Nottingham Interface team and we can be contacted via:

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Visit: Nottinghamshire APC Website

View: Meeting Minutes, Bulletins, Formularies on Teamnet