These minutes are in draft form until ratified by the committee at the next meeting on 18th January 2024.

Nottinghamshire Area Prescribing Committee Guidelines Meeting Minutes

APC Meeting 16th November 2023: 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**
Tanya Behrendt (TB)	**Senior Medicines Optimisation Pharmacist**	**NHS Nottingham & Nottinghamshire ICB**
David Kellock (DK)	**Consultant in Sexual Health & SFH Drug and Therapeutics Committee Chair**	**Sherwood Forest Hospitals NHS Foundation Trust**
Tim Hills (TH)	**Assistant Head of Pharmacy**	**Nottingham University Hospitals NHS Trust**
Ann Whitfield (AW)	**Patients Representative**	**Representative for the local population**
Asifa Akhtar (AA)	**GP**	**South Notts PBP, Nottingham & Nottinghamshire ICB**
Jennifer Moss Langfield (JML)	**GP**	**LMC Representative**
David Wicks (DW)	**GP**	**Mid Notts PBP, NHS Nottingham & Nottinghamshire ICB**
Mark Clymer (MC)	**Assistant Chief Pharmacist**	**Sherwood Forest Hospitals NHS Foundation Trust**
Kuljit Nandhara (KN)	**Deputy Chief Pharmacist, Head of Pharmacy Mental Health Services**	**Nottinghamshire Healthcare NHS Trust**
Beth Rushton (BR)	**Senior Pharmacist**	**Primary Integrated Community Services (PICS)**
Georgina Dyson (GD)	**Advanced Nurse Practitioner**	**CityCare ICB**
Katie Sanderson (KS)	**Patients Representative**	**Representative for the local population**

In Attendance:
Dr. Manik Arora (MA), Deputy Medical Director, Nottingham and Nottinghamshire ICB.
Lidia Borak (LB), Specialist Medicines Optimisation and Interface Pharmacist, Nottingham and Nottinghamshire ICB.
Dr Bara Erhayiem, Consultant Cardiologist at NUH, present for agenda item 9.

Observing:
Ewura-Adjoa, a 2nd-year University of Nottingham pharmacy student currently on placement with the High-Cost Medicines Optimisation Team at NUH.

Interface Support (NHS Nottingham & Nottinghamshire ICB):
Karen Robinson (KR), APC Interface and Formulary Pharmacy Technician.
Vimbayi Mushayi (VM), Specialist Medicines Optimisation Interface Pharmacist.
Nichola Butcher (NB), Specialist Medicines Optimisation and Interface Pharmacist (in attendance for their agenda items).
Lynne Kennell (LK), Specialist Interface & Formulary Pharmacist for SFH (in attendance for their agenda items)
Shary Walker (SW), Specialist Interface Pharmacist (in attendance for their agenda items).
Irina Varlan (IV), Specialist Medicines Optimisation Interface Pharmacist (in attendance for their agenda items).

1. Welcome and apologies.

APC members were welcomed, and apologies were noted.

2. Declarations of interest.

MA made a declaration of interest for agenda item 9.

3. Minutes of the last meeting & matters arising.

IV to email final AF guidance for ratification.
All other actions were noted as complete.

- NICE TA – Semaglutide to manage overweight and obesity.

LK gave a brief background of the previous APC discussions regarding the current weight management services, and that the ICB remains non-compliant with the NICE TA for semaglutide. These issues have been reiterated to senior ICB commissioners.
On a semi-related issue, LK informed the committee that the team received quite regular queries about orlistat as currently orlistat is not recommended for prescribing in Nottinghamshire and is classified GREY. NICE recommends that orlistat should only be prescribed as part of a comprehensive weight management programme; locally the Tier 2 weight management services are commissioned by Public Health (PH). GPs are therefore recommended not to prescribe orlistat. There is a pilot Tier 3 service led by therapists at NUH specifically for renal patients who are ineligible for renal transplant because of increased BMI. Orlistat is prescribed as part of the management plan, but as the service is led by therapists who are not prescribers, there has been a request for an AMBER 2 classification of orlistat for this this cohort of patients.

APC members felt that as this was a small cohort of patients, prescribing was better placed to remain with the service. In addition, APC felt that allowing prescribing in Primary Care

would also potentially create inequality and confusion as prescribing in Primary Care is not supported for other patients.

ACTION: LK to feed back to NUH.

4. FOR RATIFICATION – Rheumatology shared care protocol (SCP) x 6 Leflunomide, Sulfasalazine, Ciclosporin, Hydroxychloroquine, Methotrexate, Azathioprine

SW and NB presented the six SCPs. SW explained that these have all been standardised and cross-referenced, in line with the Regional Medicines Optimisation Committee (RMOC) templates to improve patient safety, reduce duplication, and reduce inequity of patient access. The current overarching shared care protocol and individual information sheets for the DMARDS were cross-referenced with the RMOC templates, in collaboration with Secondary Care specialists. Minor amendments to the national protocols were made, to reflect locally agreed shared care processes. The current local rheumatology overarching shared care protocol and individual information sheets will be retired after this review.

Key changes made which are applicable to all rheumatology SCPs:

• Following discussions between Primary Care and Secondary Care the transfer of care statement was amended as follows: 'Once the patient is known to be tolerating the medicine, transfer to shared care would normally take place. Before transfer to shared care, the patient is expected to have had at least one specialist review and be stable (no increase in medication dose for at least 6 weeks, together with satisfactory investigation results). On transferring shared care, the specialist will provide at least 4 weeks' medication, to enable the practice to receive and process the shared care agreement and to set up prescribing and ongoing monitoring. Any bloods required within the 4 weeks should be requested/organised and followed up by the specialist.'

• Specialist to prescribe sufficient medication to enable transfer to Primary Care (usually 42 days).

• It was agreed to follow the RMOC's reference values for review and monitoring.

• The appendices will not be included. The national template provides proformas for the specialists to use when requesting shared care and letters of acceptance for Primary Care use. It was agreed with the specialists that the current process works and that adopting this aspect of the RMOC template was unnecessary.

• Shingles information was updated in line with changes to The Green Book September 2023.

• All screening (HIV/Hepatitis etc.) is carried out at the discretion of the specialist.

• Re '9. Ongoing monitoring requirements to be undertaken by Primary Care:' The monitoring of CRP &/or ESR has been removed as it is undertaken by Secondary Care when clinically necessary for individual patients.

All patient information leaflets have been removed other than the Versus Arthritis and Bumps range as these have been approved previously for ease of reading and patient use.

Leflunomide

• Re page 5. 'Initiation and ongoing dose regimen:' The reference to a loading dose of 100mg once a day for three days, and the use of 10mg and 20mg on alternate days was removed as these are not currently practised locally.
• The formulations used locally are 10mg and 20mg only.

Sulfasalazine

• Added an off-label indication of enteropathic arthritis – made the indication explicit (this is classed under spondyloarthropathies).
• On the advice of the specialists, the wording to temporarily stop sulfasalazine during serious infection was removed as this is not local practice.
• Sulfasalazine is safe to take in pregnancy; however further information has been added requesting that the patients contact the rheumatology team 3 months in advance if they are considering trying to conceive.

Ciclosporin

• The off-label indications, Behçet's Disease and Adult Onset Still's Disease, have been added, to reflect current local practice.
• The non-formulary brands of ciclosporin, liquid preparations and generic options have been removed as ciclosporin should be prescribed by the brand.
• HbA1c monitoring is included in the RMOC template and the eMC, therefore it was agreed to retain this monitoring both at baseline and on an ongoing basis.

There was concern over whether the inclusion of unlicensed indications would add another cohort of patients. NB explained that ciclosporin was used with a small group of historic patients and new patients were rarely started.

Hydroxychloroquine

• The following statement included in the RMOC Primary Care section was discussed. 'Remind the specialist when the patient is approaching five years ….' (Page 2). NB explained that the responsibility for ensuring referral to ophthalmology lies with Secondary Care. APC members requested that this assurance is incorporated into the SCP. It was felt it would be useful if Primary Care could also reinforce the requirement and message at annual reviews. A statement is to be added.
• Dose calculation from ACTUAL body weight has been adopted by rheumatology, as per Royal College of Ophthalmologists (RCOphth) guidelines. This is a change from the existing information sheet, where IDEAL body weight was recommended. The dose range has been updated as per the RCOphth guidelines.
• 300mg tablets are non-formulary and have been removed.
• Baseline investigations –a statement has been added that a history of eye symptoms will be taken and that the patient should attend an annual optician review.

Methotrexate and Azathioprine

These were previously approved by APC but have since been adapted, following further consultation with Secondary Care.

• The transfer of care statement from Secondary to Primary Care has been updated as per the other SCPs.
• The shingles vaccination statement has been updated in line with changes to The Green Book.
• The pregnancy statement in the methotrexate SCP has been updated. Patients should inform their specialist at least 3 months beforehand that they intend to try to conceive. Patients who do become pregnant must be initiated on 5mg folic acid and referred to the rheumatologist and early pregnancy unit urgently.
TB stated that one of the Medicines Optimisation Pharmacists, KB, was looking at consistency of breastfeeding and pregnancy advice in all guidelines. NB to contact KB to ensure that the SCPs align with her current work.

ACTION: APC members approved the SCPs. NB to contact KB regarding the pregnancy and breastfeeding sections, make any necessary amendments and formulary changes and upload the SCPs to the APC website.

5. FOR RATIFICATION – Ferric Maltol guidance.

LK presented the ferric maltol prescribing guidance. This had been produced to support the reclassification of ferric maltol from AMBER 2 to AMBER 3, agreed at the October APC meeting, based on the current guidance for ferric maltol in patients with IBD.

ACTION: Members ratified the ferric maltol guidance. LK to make the formulary change to AMBER 3 for ferric maltol and upload the guidance. TH to give feedback on any updates on the NUH IV iron service.

6. FOR TRAFFIC LIGHT CLASSIFICATION – Empagliflozin for treating chronic heart failure with preserved or mildly reduced ejection fraction (NICE TA929).

LK presented the NICE TA929, which had a 30-day implementation period and therefore needed to be discussed at the APC guideline meeting. Empagliflozin is an additional option, as well as apagliflozin, which had previously been approved for this indication with an AMBER 2 classification.
APC members agreed with the AMBER 2 classification of Empagliflozin for treating chronic heart failure with preserved or mildly reduced ejection fraction, in line with the NICE TA 929. It was noted that the heart failure guidelines are currently being updated and, if necessary, further formulary amendments will be made as agreed, in line with the guideline update.

ACTION: LK to update the formulary to AMBER 2 for Empagliflozin to be used in line with the NICE TA for the treatment of chronic heart failure.

7. FOR RATIFICATION – Palliative care pocketbook.

LC presented the updated Palliative care pocketbook. The pocketbook has historically been printed for clinicians in the community who do not have access to records and guidance in patients' homes. There was discussion at a previous meeting whether the pocketbook was needed as there was a full guideline available and printed copies can become outdated, with multiple variations possible in circulation. However, the feedback from clinicians was that it was a very valuable resource, and they felt it should be maintained. The pocketbook has been updated by Dr Christina Sharkey, who has a specialist interest in palliative care, and

the doses and content have been checked by Wai Leong, a Medicines Optimisation Pharmacist.

LC explained that the pocketbook was designed for use by clinicians, although patients and carers could access it via the website. It is not the APC's intention to provide printed copies; however, the uploaded version is formatted in a style allowing for printing into a booklet. MA informed the committee that there was an ICS end- of- life group which includes clinicians with an interest in end- of- life, but this group did not have the governance and authority to sign off prescribing guidelines, hence the need for APC ratification.

ACTION: LC to PDF the Palliative care pocketbook and upload it to the APC website once page numbers have been added.

8. FOR RATIFICATION – Lamotrigine information sheet (NHCT).

KN presented the lamotrigine information sheet for use in bipolar disorder. The information sheet had been reviewed due to reaching its review date. The review had been completed by Anjli Khatri, Senior Clinical Pharmacist, Hannah Godden, Principal Pharmacist, Adult Mental Health Community Teams and John Lawton, Clinical Pharmacy Services Manager. The changes are summarised as follows:

- Information added on lamotrigine plasma level monitoring in pregnancy as per the 2021 MHRA Drug Safety Update on antiepileptics in pregnancy.
- Practical information on lamotrigine plasma levels added as per Maudsley Prescribing Guidelines (timing of level and approximate reference range).
- CSM reference removed as the information on patient and carer counselling on signs of bone marrow failure is now in the BNF.
- References and links checked.

APC members ratified the updated lamotrigine information sheet.

ACTION: KN is to PDF the information sheet and send it to the APC team for uploading onto the APC website.

9. FOR RATIFICATION – Heart Failure Guidance.

IV presented an updated Heart Failure Guideline, explaining that the current version had surpassed its review date in May 2023. The current version is based on NICE NG106 Chronic heart failure in adults: diagnosis and management, published in 2018. However, this is now out of date and will be updated as an exceptional review (publication date TBC). This exceptional review was triggered by members of NICE's cardiovascular disease committee, and other experts in the topic. They highlighted that the recommendations on pharmacological treatments of heart failure with reduced ejection fraction (HFrEF) in the NICE guideline are out of date when compared to 2021 European Society of Cardiology (ESC) guidelines for the diagnosis and treatment of acute and chronic heart failure, and to current UK clinical practice.

The updated Nottinghamshire Heart Failure guidance had been developed in collaboration with the following groups:
a. Entire NUH Heart Failure Multi-Disciplinary Team;
b. Primary Integrated Community Services (PICs);
c. Nottinghamshire Heart Failure transformation group: Primary and Secondary Care interface group;
d. Nottingham Cardiology Department;

e. Representatives from the Integrated Care Systems (ICS) and Integrated Care Board (ICB);
f. Consultant specialist nurse representatives from NUH Nephrology, Renal and Palliative care teams.

GP members attending the meeting confirmed that they diagnose HF regularly in General Practice, therefore Primary Care initiation of some treatments could be possible. Barriers to diagnostic tests were highlighted as an issue, however. It was noted that some of the recommendations within the guideline are becoming standard practice for cardiology teams, but it was very difficult to cost out the impact of adopting the guidance; concerns were expressed that adopting the recommendations in the updated guidance could be beyond the APC's £80K PA threshold for referral to Finance for approval. There was discussion regarding NICE TA's restricting SGLT2 inhibitors and sacubitril valsartan to Specialist initiation.

Sick day rule guidance was questioned. The current APC guidance will be hyperlinked into the HF guidance and the increased risk of UTIs will be highlighted in the SGLT2 summary document that the Interface Team is currently working on.

Dr Bara Erhayiem, Consultant Cardiologist, NUH joined at 15:40.

Dr Erhayiem explained that the Heart failure transformation group is a multi-disciplinary group that is predominantly made up of Primary Care members, Thomas Matthews a Clinical Director for NUH, is also on the group The SFHT involvement was unclear, but contacts and service structure for SFH can be added to the guidance.
Several points were discussed during the meeting, such as the challenges in accessing Echos and HF nurse services and differences in pathways depending on the geographical location, with potential inequity between the services a patient can access according to where they live in Nottinghamshire. Additional clarity was requested regarding diagnosis; for example, more detail about who it is necessary to carry out spirometry and echo in, noting the current issues with access. The committee agreed that there is work required in this regard to improve the services; however, the role of the APC is to review the clinical part of the guideline. #

Points of clinical concern raised included the following:
• The threshold for acceptable eGFR decrease; the value stated was greater than would usually be accepted practice with ACE inhibitors. This requires clarification, with documented evidence to allow Primary Care clinicians to continue, not stop the quadruple therapy. A shorter quick- reference 1–2-page guideline was requested for ease of use when patient facing. Dr Erhayiem requested feedback from GPs regarding desired content. The recommendation to use losartan first line instead of an ACE inhibitor was questioned as this is different to the recommendations in the European guideline; Dr Erhayeim said that this would make the switch to ARNI easier, not needing to have a washout period from an ACEi before initiating sacubitril valsartan.
• The appropriateness of the earlier initiation of sacubitril valsartan and SGLT2 inhibitors in Primary Care was raised as the NICE TAs recommend specialist initiation in those on optimised therapies. Although Primary Care initiation of SGLT2s is now commonplace for other indications, monitoring and dose titration is required for sacubitril valsartan and there will be a cost pressure associated with the new approach.

The importance of trying to estimate a cost impact for medicine spend was emphasised, with an attempt at highlighting the savings in the service costs being needed.

ACTION: IV to work with HF transformation group to attempt to cost out the updated guidance.
IV to give feedback to authors regarding clinical points raised and to request references to support recommendations e.g., acceptable eGFR changes, first line use of losartan.
IV to contact SFH HF nurses and obtain service structure for SFH and include in guidance.
JML to feedback to Dr Bara Erhayiem regarding requirements for the quick reference guide.
Early initiation of sacubitril valsartan to be considered in more detail, from a safety perspective if started in Primary Care, together with cost.
TB to feed back an answer once NICE provide it on the forum.

Post- meeting notes: LC emailed an update about service progress on the 17th, specifically around plans to improve access to Echo at SFH.

10. FOR RATIFICATION – Position statement and leaflet on glucose products for hypoglycaemia.

KR presented the new position statement for the prescribing of glucose products for hypoglycaemia. Oral glucose prescribing has been highlighted to the Cash, Release and Savings Hub (CRASH) and potential saving efficiencies have been identified. To release the potential savings, a position statement has been written to support prescribers in advising diabetic patients to purchase food product(s) to keep with them to treat hypoglycaemia rather than receiving a prescription for glucose products.
An Equality, Quality, and Inequality impact assessment (EQIA) has been completed; this is awaiting feedback from Robbie Naylor, Head of Equality, Diversity and Inclusion for the ICB.
APC members discussed the affordability for some patients; the position statement does not deny the prescribing of oral glucose products but is intended to offer alternatives that can be easily purchased and which patients might find more palatable. APC members felt additional clarity was required within the position statement to prevent prescriptions from being denied to patients.
Treatment options recommended by the Diabetes Specialists and Endocrinologists were discussed and APC members requested that this was explored further.

ACTION: KR to obtain further information about hypoglycaemic treatments from Diabetes Specialists and Endocrinologists. KR to add additional clarity to the position statement, to prevent patients from being denied a prescription.

11. APC Forward Work Programme.

The Dementia information sheet is due for review and NHCT have kindly agreed to update this on behalf of the APC. It had been requested that the expiry be extended by 3 months to January 2024 to allow time for completion.

12. Any Other Business.

None raised.

Date of next APC Formulary meeting: Thursday 14th December 2023 (2pm – 5pm, MS Teams)

Date of next APC Guideline meeting – Thursday 18th January 2024 (2pm – 5pm, MS Teams)

The meeting closed at 17:24.