Nottinghamshire Area Prescribing Committee Guidelines Meeting Minutes 27th March 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**
Tanya Behrendt (TB)	**Senior Medicines Optimisation Pharmacist**	**NHS Nottingham & Nottinghamshire ICB**
Ann Whitfield (AW)	**Patient Representative**	**Nottingham & Nottinghamshire ICB local population**
David Kellock (DK)	**Consultant in Sexual Health and SFHT DTC Chair**	**Sherwood Forest Hospitals NHS Foundation Trust**
Katie Sanderson (KS)	**Patient Representative**	**Nottingham & Nottinghamshire ICB local population**
Jennifer Moss Langfield (JML)	**GP**	**City PBP, Nottingham & Nottinghamshire ICB**
Khalid Butt (KB)	**GP**	**LMC Representative**
Asifa Akhtar (AA)	**GP**	**South Notts PBP, Nottingham & Nottinghamshire ICB**
David Wickes (DW)	**GP**	**Mid Notts PBP, Nottingham & Nottinghamshire ICB**
James Sutton (JS)	**Lead Pharmacist Medicines Finance and Divisional Support**	**Nottingham University Hospitals NHS Trust**
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**
Georgina Dyson (GD)	**Advanced Nurse Practitioner**	**CityCare ICB**
Nicola Graham (NG)	**Senior Transformation Manager**	**NHS Nottingham & Nottinghamshire ICB**

In Attendance:

Prof. Maura Corsetti, Gastroenterology Consultant, NUH, in attendance for agenda item 7.
Sue Haria, Medicines Optimisation Pharmacist, Nottingham and Nottinghamshire ICB, in attendance for agenda item 8.

NHS Nottingham & Nottinghamshire ICB Interface Support in attendance:
Lynne Kennell (LK), Specialist Interface & Formulary Pharmacist for SFH.
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 & action log

The minutes of the previous meeting were accepted as an accurate record, subject to minor amendments, which included JML's role.

IV gave a brief update following the ratification of the Heart Failure (HF) guidance, explaining that Protected Learning Time (PLT) dates are being sought. HF specialists, including consultants, nurses and pharmacists, will collaborate in recording a podcast episode to promote the guidance. NUH will soon upload the long version of the HF guidelines on their website. The intention is to make both documents available for prescribers.

4. FOR INFORMATION – Medicines Optimisation Regional Advisory Group (MORAG) update

Due to the cancellation of the MORAG meeting, no update was provided.

5. FOR RATIFICATION – Amiodarone Specialist Pharmacy Service (SPS) minor update on monitoring

LB presented the minor changes to the amiodarone shared care protocol (SCP) that was ratified in January 2025. Since its ratification, the SPS has published a national update for amiodarone monitoring. On comparing the national and local guidance, the following was noted:

- Thyroid function tests (TFT) – information added within the "initial monitoring" section to consider TFT every 6 weeks until stable for patients with borderline results.
- INR for patients on warfarin – information added within the "baseline investigation" and the "initial monitoring" section to advise to continue weekly INR during the loading regiment for two months or until stable. The two months' time frame is recommended locally, based on specialist advice, and the national recommendation is 7 weeks as agreed by most other regions.
- In case of any adverse respiratory symptoms or suspected pulmonary toxicity, a CT scan is now recommended, alongside pulmonary function tests. CT scans have replaced chest X-rays.

The specialists previously involved have been consulted, and these minor changes have been implemented within the SCP. GP members explained that not all local places are able to request

CT scans for pulmonary toxicity on their clinical systems, while in some areas it is available as a trial. LB will gather further information as to why lung CT scan requests are not available across all Nottingham and Notts practices, and whether this can be enabled. LB will return the amiodarone SCP to the May APC guidelines meeting.

ACTION: LB to gather further information about clinical system requests for CT scans and return the SCP to the May APC guidelines meeting.

6. FOR RATIFICATION – Modafinil information sheet

LK presented the modafinil information sheet. The information sheet was updated, following the agreed formulary submission in February 2025 on its use for fatigue in multiple sclerosis (MS). Clinicians approved the modafinil information sheet, on condition that information about agreeing a pre-pregnancy plan for those of childbearing potential is included.

ACTION: LK to discuss with JML the information to be added about pre-pregnancy planning and ensure its integration into the final document. LK to finalise and upload the information sheet to the APC website.

7. FOR RATIFICATION – IBS Guideline

LB presented the new Management of Irritable Bowel Syndrome (IBS) guideline. This guideline had been developed at the request of the APC to show the place of alverine and simethicone (SimAlvia®) in the management of IBS in Primary Care. A temporary classification of AMBER 2 for symptomatic relief of abdominal pain/discomfort in IBS patients, where symptoms had not responded to therapy with mebeverine, peppermint oil capsules, or hyoscine butylbromide, had been agreed at the July 2024 APC meeting.
The local classification of alverine and simethicone as AMBER 2 was to be reviewed and potentially changed to AMBER 3, following the publication of the new local IBS guideline that had been developed to support IBS management in Primary Care.

APC asked about the local availability of IBS-specific CBT or gut-directed hypnotherapy referrals, and it was clarified that these therapies are not available locally on the NHS. The IBS Management Pathway will be updated to indicate that hypnotherapy is a private service. The flow diagram will undergo slight adjustments to offer increased visual clarity and rifaximin will be removed as it is not used locally. It was also suggested that the pathway should reflect clearly the local traffic light classification for each medicine and at what point in therapy referral should be made from Primary Care to Specialist, to explore other treatment options. It was also requested to include information on when to review treatment and discontinue if not effective.

Final ratification is to be achieved via email, and APC members were requested to acknowledge receipt in a timely fashion.

ACTION: LB to amend the IBS guideline and email to APC members for final ratification and to upload to the APC website and amend the classification of alverine & simethicone to AMBER 3.

8. FOR RATIFICATION - Interim update of the preferred list of Blood Glucose Testing Meters

Sue Haria (SH) attended the APC meeting to provide an update on the Frequency of Blood Glucose Self-Monitoring for adults. The guideline aims to provide clinicians with information regarding the blood glucose and ketone testing requirements of patients with Type 1 and Type 2 Diabetes Mellitus (T1DM & T2DM). This includes the circumstances and frequency of testing that may be required and the quantities of testing strips that patients may need on prescription. Links are provided to the local blood glucose and ketone monitor formulary alongside patient information leaflets regarding sick days, enteral feeding, and driving. Greater clarity of continuous glucose monitoring (CGM) has been made, and out-of-date references have been removed to ensure accuracy and relevance.

Discussions took place regarding the volume of testing strips potentially used by patients with T1DM. It was agreed that the quantity of testing strips offered to patients with T1DM should be increased.
The term “exceptions” is to be changed to “considerations” in both the T1DM and T2DM sections. Eligibility criteria for CGM in the references will be given a more prominent position.

ACTION: SH to make the agreed changes. KR to email the final version to APC members for noting and upload to the APC website.

9. FOR RATIFICATION – ANTIMICROBIAL GUIDELINES

Meningitis

IV presented the meningitis guideline. The guideline was reviewed earlier than its review date of September 2026, due to updated national recommendations in Meningitis by NICE NG 240 (published March 2024) and NICE CKS (published Dec 2024)**.**

IV provided a summary of the changes, which included the following:
- Contact details and the mechanism for reporting meningitis have been updated.
- Cefotaxime was removed as NICE recommends single dose ceftriaxone or benzylpenicillin.
- Maximum daily dose of ceftriaxone in children has been changed to 2g as per NICE.
- Prophylaxis considerations were added as per NICE.

APC members explained that the current dosing in children for Ceftriaxone needs to be calculated and that in an emergency it will increase time for administration. To mitigate this, it was suggested adopting the dose banding for ceftriaxone from the BNFC.
It was also suggested moving up in the table the following instruction, before the treatment recommendations: ‘Do not give IV antibiotics if there is a definite history of anaphylaxis to penicillin or cephalosporins; rash is not a contraindication. Transfer to a hospital immediately.’.

Additionally, the committee wanted to understand the rationale behind the addition of lidocaine to ceftriaxone but not to benzylpenicillin, as both agents have a stinging element when injected. The point was also made that needing lidocaine could potentially delay immediate administration of antibiotics, members questioning whether this was necessary or could be removed.

Clinicians explained that the injections for the emergency treatment of meningitis are infrequently used, and that stock is replaced to be kept in date.

APC members requested final ratification by email.

ACTION: IV to add the paediatric doses from the BNFC and confirm whether the addition of lidocaine is required. IV to email members for final ratification.

Splenectomy

IV presented the splenectomy antimicrobial guideline. This interim review aligns with NUH recommendations for Adults and Children Guidelines for Patients with Absent or Dysfunctional Spleen, updated in December 2024. SFHT are in the process of reviewing its splenectomy guidance, and it will most likely align with NUH updates.

IV provided a summary of the changes, which included the following:

• Lifelong prophylaxis is recommended, but where compliance is an issue, the duration has been changed from 2 years to 1-3 years.
• Children must have prophylaxis up to 5 years of age and for a minimum of 2 years.

APC members requested that greater emphasis should be placed on the life-long prophylaxis as it could be interpreted that only 1-3 years is needed. The committee also asked if there was a 3rd prophylaxis treatment option for patients who have a penicillin allergy and a history of cardiovascular disease and require statin treatment long- term.

APC members requested final ratification by email.

ACTION: IV to enquire about a 3rd treatment option; any findings will be emailed to APC members. IV to make the agreed changes to the guideline for final email ratification.

10. <u>FOR RATIFICATION – Continence formulary update</u>

IV presented the Continence formulary update on behalf of the author, Jill Theobald (JT).
JT had provided on the front sheet a summary of changes, which included the following:

• Added LentisCath Hydrophilic catheter to first- line choices, in addition to BD Ready-to-use and SensaCath – more cost-effective than current product choices.
• Added Actreen Mini to third-line options (specialist recommendation only)
• Catheter Maintenance Solutions (CMS) Pathway – has been updated, and Optiflo is no longer recommended as a first-line option due to concerns over the amount of pressure required to administer it. Uroflush saline 0.9% has been added as first-line saline option – this is also more cost-effective than the existing choices.

• Prices and contact details have also been updated and corrected where required.

APC members enquired whether the Continence Formulary Group had patient representation, also If pads are included in the formulary and whether greener options had been explored, such as washable pads?

IV will direct these questions to the author, and any responses received will be sent to APC members.

APC members ratified the Continence Formulary.

ACTION: IV to email members the response to their questions, finalise and upload the formulary to the APC website.

11. FOR RATIFICATION – VTE management in pregnancy – treatment & prophylaxis

JML presented two new Primary Care guidelines: Thromboprophylaxis in Pregnancy and Management of Acute Thromboembolism in Pregnancy. JML provided a brief background to the proceedings on the guidance development, which had been brought about due to variations.

VTE treatment in pregnancy across the local Trusts.

Areas of concern included:

• Ensuring timely prescribing of enoxaparin for pregnant women at high risk of VTE.

• IT issues and limitations on initiating prescriptions.

• Current guidelines create inconsistency in pathways across hospital trusts and Primary Care, resulting in inconsistency for women presenting at different places.

The two new Primary Care guidelines offer single-page guides, providing information on:

1. Which patients would be at high risk and who assesses this.
2. What treatment/prophylaxis would be required before, after and during each stage of pregnancy.
3. Dose of enoxaparin required (the treatment dose of enoxaparin has been standardised across NUH and SFH).
4. Prescribing information and prescriber responsibilities.

JML explained that hyperlinks to patient information leaflets and training will be added.

APC members requested that the two one-page guidelines are given different colours and if possible uploaded as individual documents rather than as one document, to ensure that users were aware these were two different guidelines.

APC members ratified the guidelines, subject to the minor additions and changes discussed.

ACTION: JML to add hyperlinks and visual clarity to the two guidelines and finalise the final version to be sent to the interface team for uploading.

12. FOR RATIFICATION – Clonidine for tics (NHCT)

KN presented the Clonidine for Tic Disorders in Children and Young People information sheet on behalf of the authors, Joseph Kilgariff – ACP CAMHS Tic Disorder Service, Katie Burton – Lead Pharmacist CAMHS and Susan Doherty – Lead ADHD Specialist Nurse NUH.
KN explained that the information sheet aims to support the prescribing and monitoring of clonidine for tic disorders in children and young people and provided a summary of the changes, which included the following:

- Preferred option in swallowing difficulties added.
- The monitoring section was updated for clarity.
- Guidance was added on how to withdraw clonidine to prevent rebound hypertension if the patient is nonadherent or fails to attend physical health monitoring.
- The pregnancy and breastfeeding section was updated to reflect NHS Medicines A-Z.

In addition, prices, contact details and references have also been updated.

In rare cases, the CAMHS Tic Disorder Service use clonidine oral solution 50microgram/5ml for children with autism who cannot tolerate tablets dispersed in water or soft food. The CAMHS Tic Disorder Service have agreed to contact pharmacy before supplying the clonidine oral solution, due to the high cost. However, on some occasions it is unavoidable and APC members asked if the statement could be changed to include the following: “and use in CAMHS Tic Disorder Service where children/young people are unable to tolerate tablets dispersed in water or crushed and mixed with soft food”. As the liquid would be supplied by the service, this request was deferred to the Trust Medicines Optimisation Group (TMOG).

APC members requested the addition of a pre-pregnancy and breastfeeding plan; subject to this, the information sheet was ratified.

ACTION: KN to feed the pre-pregnancy and breastfeeding plan request back to the authors, finalise and send to APC members for noting and to the interface team for uploading.

13. FOR RATIFICATION – MAOI in patients with periods of Dyskinesia

VM presented the guideline for the Use of Monoamine-oxidase-B Inhibitors in Patients with Off Periods Without Dyskinesia as an Adjunct to Levodopa, which had been reviewed due to reaching its review date.

No changes had been made; however, APC members requested that clarification be provided on the document that these medications were classified as AMBER 2.
APC ratified the guideline, subject to the addition of the traffic light classification.

ACTION: VM to finalise and upload to the APC website.

14. FOR RATIFICATION – ADHD adults SCP

The Adult ADHD Shared Care Protocols (SCP) for methylphenidate, dexamfetamine, lisdexamfetamine and atomoxetine have been updated due to reaching their review dates. Feedback was sought from previous authors and most of the changes made were to bring the advice in line with the children and young people ADHD shared care protocols, where appropriate. VM provided a summary of the changes, which included the following for all adult ADHD SCPs:

- Added a statement specifying that specialists should prescribe medication during initiation and dose stabilisation.
- A statement was added under Primary Care responsibilities to clarify when treatment can be terminated by Primary Care.
- In the event of drug shortages, advice has been added to consult the APC ADHD shortages page or the Nottinghamshire Joint Formulary for up-to-date local guidance and support tools.
- The transfer of care statement following the initiation timeframe remains unchanged. However, an additional statement has been included to address the transfer of care for patients already under shared care: *"For patients already under shared care, when a specialist adjusts the dose or formulation, transfer of monitoring and prescribing to primary care is normally after a minimum of four weeks, provided the patient has demonstrated tolerance or stability with the new dose or formulation."* This recommendation aligns with the guidance in the methylphenidate- switching protocol.
- The wording on baseline investigations, including cardiovascular assessment, has been rephrased in accordance with NICE guidelines and specialist input.
- A comment was added to clarify that the timing for monitoring (e.g., after a dose change) should be determined by the specialist, as no standard timeframe is specified in the literature.
- A general statement / catch- all statement added under adverse effects management: *acute medical concerns to be discussed with on- call medical team.*
- A statement from the SPC has been added regarding the association of stimulants with sudden death, stroke, and myocardial infarction at usual doses. The wording of this advice differs for children and adults. Since dexamfetamine is not licensed for adults, no specific advice is provided for this population. Instead, the dexamfetamine SCP now includes wording from the other three drugs, as the guidance is identical.

Other variations are related to medication specifics, for example, the adverse effects and cautions. Clinicians requested that the interaction section include only medications that interact.

APC members ratified the SCPs.

ACTION: VM to finalise and upload to the APC website.

15. FOR RATIFICATION – Process for developing & ratifying APC guidelines

LC presented the Standards for Developing and Ratifying Guidelines and explained that more robust development guidance was required, due to recent challenges by stakeholders and the LMC.

As the medicines optimisation interface team are often the facilitators of this work, it was felt necessary to outline a set of standards for how guidance is developed and approved.

The standards include when it should be deemed necessary to develop a short- life working group, laying out clearly and concisely what the expectations of that group are.

Links to a template Terms of Reference (ToR) for short- life and the Task and Finish Group (TaF) will be added once approved.

LC explained that not every workstream would require a ToR or TaF, and the interface team would make that decision considering workload, financial implications, service changes or equality considerations.

The previously approved APC ToR Appendix for short- life TaF groups and ToR for such groups will be included in the papers for reference. These will be added to the APC ToR that are to be updated at the May meeting.

ACTION: LC to finalise for the APC Guidelines meeting in May.

16. FOR INFORMATION – APC forward work programme

- APC members noted the APC work programme and agreed to retire Anaemia in IBD pathway.
- Members were urged to respond to the dronedarone ratification email sent by LK.
- NICE COPD biologics - NG explained that an update is expected in April, although it is thought they will not be NICE- approved at the time; approval is expected in 2025.
- Due to team capacity, workload and service review, extended review dates were agreed for:
    - Growth hormone SCP
    - High cost drugs algorithms
    - Dementia - Managing Behaviour and Psychological Problems

17. ANY OTHER BUSINESS

No matters were raised.

18. **APC Formulary meeting**: Thursday 24th April 2025 (2pm to 5pm, Microsoft Teams)

19. **APC Guideline meeting:** Thursday 15th May 2025 (2pm to 5pm, Microsoft Teams)

The meeting closed at 1700hrs.