Nottinghamshire Area Prescribing Committee Guideline Meeting Minutes,

19th September 2024: the meeting took place as a hybrid meeting with guests and some members attending online using Microsoft Teams, and some members attending in person in the Boardroom at Sir John Robinson House in Arnold.

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) (left the meeting at 16:30)	**Consultant in Sexual Health and SFHT DTC Chair**	**Sherwood Forest Hospitals NHS Foundation Trust**
Jennifer Moss Langfield (JML)	**GP**	**LMC Representative**
Dr Khalid Butt (KB)	**GP**	**LMC Representative**
Asifa Akhtar (AA)	**GP**	**South Notts PBP, Nottingham & Nottinghamshire ICB**
Tim Hills (TH)	**Assistant Head of Pharmacy**	**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) (left the meeting at 16:30)	**Senior Transformation Manager**	**NHS Nottingham & Nottinghamshire ICB**
Jacqui Burke (JB)	**Advanced Nurse Practitioner**	**Willowbrook Medical Practice, Nottinghamshire**
Jo Fleming (JF)	**Specialist Clinical Pharmacist (Pain)**	**Primary Integrated Community Services Ltd (PICS)**

In Attendance:

Rahul Mohan GP - West Bridgford Medical Centre, Clinical Lead, GPwSI in diabetes, in attendance for item number 4.

NHS Nottingham & Nottinghamshire ICB Interface Support in attendance:

Lynne Kennell (LK), Specialist Interface & Formulary Pharmacist for SFHT (left the meeting at 16:00).
Karen Robinson (KR), Specialist APC Interface and Formulary Pharmacy Technician.
Vimbayi Mushayi (VM), Specialist Medicines Optimisation Interface Pharmacist (left the meeting at 16:00).
Lidia Borak (LB), Specialist Medicines Optimisation Interface Pharmacist.
Irina Varlan (IV), Specialist Medicines Optimisation Interface Pharmacist (left the meeting at 16:30).

1. Welcome and apologies.

Noted.

2. Conflict of interest

Nichola Butcher (NB) had declared a COI for agenda item 8 but was not present in the meeting.
JML declared a COI for agenda item 10; it was felt that no action was required.

3. Minutes of the last meeting

The minutes of the previous meeting were accepted as an accurate record.

Matters arising and action log

3a. Management of Type 2 Diabetes in Young Adults Guideline

This guideline will not include any prescribing elements and will mainly serve as a signposting document. This has been communicated back to the ICS Diabetes steering group and, once agreed, will be incorporated in the Type 2 Diabetes guideline as an appendix.

3b. Daridorexant

No update on daridorexant or CBTi services.

3c. Clozapine information sheet

The clozapine information sheet was ratified by members at the July APC meeting; however, further guidance for managing constipation was requested.

ACTION: Hannah Sissons is writing the guidance and will return it to the APC for ratification.

3d. Parkinson Disease (PD) Information Sheets

VM had contacted the Ophthalmology and Parkinson's Disease Specialists to establish what 'type' of 'visual monitoring' is required when pramipexole is being prescribed. As there were only two published studies, where concern appeared to relate to albino rats only (not albino mice or pigment rats or pigs or primates) and no retinal damage had been shown in humans, both specialities concluded that the 'visual monitoring' could be completed via a community optician or optometrist at an annual or bi-annual vision test or if vision abnormalities occur.

ACTION: VM to add the additional clarity to visual monitoring information in the pramipexole information sheet and re-upload the information sheet to the APC website.

4e. Opioids and Naloxone guidance.

JF explained that discussions had taken place within the PICS Pain Team relating to the prescribing of high-dose opioids and naloxone. A suggestion was made to add more clarity in the guidance about the individual high-risk patients suitable for this treatment and the need to discuss the cases with the Pain clinic. It has the potential for cost pressure and there are separate cohorts of patients. A member of the APC team will contact JF to discuss this further.

ACTION: A member of the APC team will add a line to clarify the use in high-risk patients under the pain clinic and confirm the wording with the original author and JF.

3f. Transgender Guidance

The changes made to the Transgender Guidance were communicated via email in August. TB summarised the updates, which included all the new regulations such as the widespread ban on puberty blockers and advice regarding requests coming from private providers. TB requested that the review date of the guidance is extended to November. TB reiterated that this was for 'guidance only' for GPs and Primary Care prescribers; it was **not** a policy directive.
APC members ratified the updated guidance.

ACTION: KR to accessibility- check and upload the transgender guidance to the APC website.

3g. Training update

LK told members that the **10-minute learning** slots will be reinstated from next meeting and that she is working on a plan for the sessions together with Robert Treadwell. LK also proposed that for some of the learning to be achieved a face-to-face committee development session would be more beneficial. For this, a date in February was proposed and the committee members were generally in agreement.

ACTION: The interface team will propose some dates for the February face-to-face development session.

4. Chronic Kidney Disease (CKD) Guidelines

- **Overarching CKD guidelines** (shared on screen)

Dr Rahul Mohan GP and VM presented the CKD guidelines that had been developed by the Midlands Kidney Network (MKN). These guidelines have been developed to assist Primary Care with the identification of CKD and Dr Mohan explained the rationale behind each of the steps.

APC members asked for the abbreviations to be written in full and for the medication to be listed in the prescribing preference order and for Step 2 to be developed further, as some actions can be done simultaneously. There was also discussion about whether all patients need statins, especially younger ones or those without impaired renal function.

It was agreed that the guideline should be adapted to be more in line with local guideline format.

Dr Mohan explained that the guideline was specific to CKD and that heart failure was not included as the heart failure guidelines are still at developmental stages. In addition, SGLT2i are currently AMBER 2 for heart failure and as this guideline was aimed at Primary Care it could cause confusion.

Members felt that there is room for collaborative work to be carried out within the ICB to support General Practice in early identification of CKD. VM and Dr Mohan to identify what groups to engage to advance this.

ACTION: VM and Dr Mohan will review the comments, update the guideline, and return the guideline to the next APC guideline meeting in November.

- **SGLT2i in CKD pathway for Primary Care**

Dr Mohan and VM presented the SGLT2i in CKD pathway for Primary Care.

The CKD pathway has been developed by the MKN.

Discussion took place around the eGFR cut-off volume and around whether a standard 25ml/min would be less complicated, as opposed to listing different eGFRs. Dr Mohan explained that the NICE guidelines used eGFR cut-off from trials and this could be different from the SPC. It was decided that some lines could be removed from the pathway to aid readability and prevent any confusion.

VM explained that the pathway will be formatted to look like other APC documents; sick day rules and links to patient information materials will also be included. It was suggested that, instead of a separate guideline, the SGLT2i pathway could be integrated with the CKD guidelines.

ACTION: VM will meet with the APC team to discuss the comments made, update the pathway, and return it to the APC meeting in November.

5. FOR RATIFICATION – ANTIMICROBIAL GUIDELINES.

The following antimicrobial guidelines have been updated, due to reaching their review date. Comments were invited and received from microbiology leads.

LK presented the following antimicrobial updates on behalf of NB, who was absent from the meeting.

A general request was made for all the antimicrobial guidelines to be consistent in names of medications and abbreviations.

a) Pharyngitis / Sore Throat / Tonsillitis.

The following key changes were discussed:

- Added that a sore throat is usually self-limiting, normally resolving within two weeks. The order of guidelines has been changed to highlight that prescribing an antibiotic reduces the symptoms by only 16 hours.
- Added that a throat spray (OTC) can be considered for symptom management.
- After reviewing the evidence, the recommended course length has been changed to 5 or10 days' supply of penicillin.
- The following information has been added: 'evidence indicates penicillin treatment for 10 days is more effective at microbiological clearance than 3 or 5-7 days. 5 days may be enough for symptomatic cure (e.g. in young adults with no co-morbidities). A 10-day course may increase the chance of microbiological cure and should always be prescribed for patients with a positive throat swab for Group A Streptococcus'.
- The treatment table has been updated to give the option of 5 or 10 days of penicillin treatment; clinical judgement and assessment of the patient will determine what course length is prescribed.
- CKS link added to the scarlet fever section and information that UKHSA must be notified within 3 days of any cases, including link to paperwork.

Members discussed the prescribing duration of antimicrobials and agreed that additional clarity was required around the number of days antimicrobials needed to be prescribed for and what occurs if a second prescription is required. Clinicians also felt that consideration was needed for high-risk children and should be included.

Subject to the additional clarity being added, the APC members ratified the guideline.

ACTION: APC members ratified the guideline. LK to update the author regarding the comments made. NB to make the required amendments, accessibility-check and upload the antimicrobial guideline to the APC website.

b) Splenectomised Patients and Those with an Afunctional Spleen.

The following key changes were discussed:

• Link to GOV.UK patient information leaflet, alert card and MedicAlert website added.

Clinicians requested the addition of a bullet point line for immunosuppressed patient prescribing. It was noted that the treatment table required a small correction.

ACTION: APC members ratified the guideline. LK to update the author regarding the comments made. NB to make the required amendments, accessibility-check and upload the antimicrobial guideline to the APC website.

c) Varicella Zoster / Chicken Pox / Herpes Zoster / Shingles.

The following key changes were discussed:

• No change to the national or local advice or treatment options.
• Contact details and phone numbers checked and updated.

Members suggested a few minor amendments, along with the addition of a statement requesting that the patient's obstetric team is made aware of exposure/infection. APC members ratified the guideline, subject to the minor amendments.

ACTION: LK to update the author regarding the comments made. NB to make the minor amendments, accessibility- check and upload the antimicrobial guideline to the APC website.

6. FOR RATIFICATION – Warfarin Prescribing Guideline.

LK presented the Warfarin guidance for Primary Care and provided some background information. Warfarin is currently classified as GREEN on the Joint Formulary; however, the dosing is often managed jointly by Primary and Secondary Care; warfarin is prescribed by a patient's GP practice, but monitoring and dosing arrangements vary according to the Locally Enhanced Service (LES) that the practice is signed up to.

The levels of the LES vary as detailed below:

- Level 2, practices perform the blood test and have some responsibility for dose. communication, but the monitoring and dosing is done by the anticoagulant clinic.
- Level 3, warfarin management is by the GP practice, but initiation is by Secondary Care.
- Level 4, the GP practice may also initiate warfarin for AF.

There are approximately 4400 patients prescribed warfarin in Primary Care, with 24 practices signed up to level 4, 35 at level 3 and 116 at level 2. 11 practices are not signed up to the LES.

Previously, there has not been any Primary Care clinical guidance for warfarin, but there were historical CCG Standard Operating Procedures (SOPs) which detailed responsibilities of Primary Care and included copies of hospital guidance. The APC have been asked to review these to support the LES which is in existence for 2024/26. The specification for the LES contains the contractual detail of the historical SOPs but as warfarin is considered a high- risk medication it is felt that there should be local clinical guidance to accompany its use.

For consideration, there is a draft guideline for warfarin that aims to provide some clinical guidance to support prescribers. The proposed guidance is based largely on Derbyshire Primary Care warfarin guidance, with local trust guidance incorporated. It has been shared with Secondary and Primary Care. It was noted that there are some variations in warfarin management between Bassetlaw and the wider ICB. These will be included, once confirmed.

There were discussions around the strength of warfarin used; 3 milligram tablets were preferred across the ICB practices, with the exception of the Bassetlaw practices, and the guidance would make this clear. Clarity was also requested about how warfarin was prescribed in terms of milligrams and numbers of tablets.

A few points were raised about the content of the LES service specification, but it was agreed that discussions about the LES were beyond the remit of the APC; a separate ICB group needed to be involved before the guideline could be approved by the APC

ACTION:
LK to feedback to the ICB contracting team and suggest a working group.
LK to clarify points raised about dosing and arrangements in Bassetlaw.
LK will provide future updates to the APC as they become available.

7. FOR RATIFICATION – Benzodiazepines and Z-hypnotics, Guidance on Prescribing and Deprescribing.

KN presented the Benzodiazepines and Z-hypnotics, Guidance on Prescribing and Deprescribing updated guideline. The Nottinghamshire APC benzodiazepines and z-drugs guideline has been reviewed, due to reaching its 3-year review date.
The following minor changes were proposed:

- Links to NICE patient decision aid throughout the document.
- Updated information on access to local talking therapies (Nottinghamshire Talking Therapies and Step 4).
- Additional information on the use of propranolol in anxiety, with a link to the 2020 Health Services Safety Investigation Body Report highlighting the risk of harm from overdose.
- Appendix Two has been reviewed and references the BNF and the Ashton Manual.
- Clonazepam has been removed from Appendix Two (treatment of anxiety and insomnia are not formulary-approved indications).

KN acknowledged that some comments regarding typographical errors had been made before the meeting and these will be corrected.
Clinicians asked for the key messages to be enhanced to attract prescribers' attention.
A link to daridorexant will be added to the guideline.
MC explained that SFHT were also adding course length to all new benzodiazepines and Z-hypnotics and asked to be included in any workstreams going forward. This was supported by other members, who agreed that a specific duration was required as ‘short-term’ was too vague and open to interpretation.
Members ratified the guidance, subject to the agreed changes.

ACTION: Members ratified the guidance, subject to the agreed changes. KN will make the agreed changes and ensure the accessibility check has been completed before returning the guidance to the APC team for uploading to the APC website.

8. FOR RATIFICATION – Inflammatory Bowel Disease – Methotrexate Shared Care Protocol

LB presented the updated IBD shared care protocol (SCP) on behalf of NB. The SCP has been cross-referenced with the national template and minor changes have been made to reflect the locally agreed shared care process. The existing local overarching SCP and individual methotrexate information sheet will be retired once this SCP has been ratified.
The draft versions have been shared with both NUH and SFH gastroenterology leads, but no comments have been received from SFH, despite many attempts.

Significant points raised:

- Transfer of care – local process aligns with the RMOC guidance. Patients remain under the care of Secondary Care for the first three months and if they are stable at that point they will be transferred to Primary Care for their ongoing monitoring and medication supply.
- RMOC- listed cautions and contraindications have been adopted, as well as the reference values for review and monitoring.

- Pregnancy information updated to reflect current guidance. Men and women should use effective contraception whilst on treatment and for 6 months after treatment stopped. RMOC stated 3 months.
- Shingles information and exposure to VZV guidance updated in line with The Green Book and local practice.
- All patient information leaflets removed, other than the Crohn's and Colitis UK and Bumps ranges, as these have been approved previously for ease of reading and of patient use.

Members felt some of the abbreviations needed further clarification and requested that additional safety information around pregnancy be included. The local protocol recommends effective contraception for both men and women for 6 months after treatment stops but the national protocol suggests 3 months only. The methotrexate SPC suggests 6 months' contraception so further clarity was requested. Clinicians asked for clarity on whether immunosuppressed patients exposed to chickenpox should be continued on methotrexate; the specialist teams will be consulted for an answer.

It was also proposed that when the shared care protocols are next due for a review, an effort should be made to create monitoring sheets for medicines and list the conditions in that document together with the monitoring advice and responsibilities, rather than having a shared care protocol for each condition treated with the same medication. This would make it easier for the clinicians using them and make future reviews less onerous.

Members agreed to ratify, subject to clarifications communicated via email.

ACTION: LB to update NB on the outcome of the discussions. The specialist teams will be contacted to obtain answers to the questions raised. The guideline has been ratified, subject to the clarifications requested. Clinicians asked for the lack of engagement to be raised at SFHT via their Drugs and Therapeutic Committee (DTC).

9. <u>FOR RATIFICATION</u> – Agomelatine

KN presented the updated Aglometatine Information Sheet on behalf of the author, Philippa Cheesman, Senior Clinical Pharmacist NHCT. The Aglometatine Information Sheet has been updated, due to reaching its review date.

A full review of the guideline has been undertaken and minimal changes have been made. The information sheet links and references have been updated accordingly.

ACTION: Members ratified the guideline, subject to a few minor typographical amendments. KN to accessibility-check and send to a member of the APC team to upload to the APC website.

10. <u>FOR RATIFICATION</u> – Hypothyroidism in Pregnancy Primary Care Guidance

LB presented on behalf of NB, with support from JML, the Primary Care guideline that was originally produced in response to concerns raised by GPs after changes to the NUH service pathway meant patients would be managed in Primary Care. Currently, the SFHT pathway remains within the obstetric-endocrine clinic and patients are managed by Secondary Care.

Comments have been requested and received from endocrinology, obstetrics and midwifery leads at both acute Trusts and the guidance/pathway has been discussed at the Local Maternity and Neonatal System (LMNS) group meetings.

Two updated versions were attached to the papers:

Draft 1 Interim guidance reflecting the existing different pathways for the two Trusts:

- The layout has been changed and the differences between NUH and SFHT removed for all steps bar the 'management plan' section. It has been agreed that actions are required at pre-conception, once pregnancy is confirmed and following delivery; this is the same for both acute Trusts.
- More details and advice have been added to each stage, including pre-conception and what to do once pregnancy is confirmed.
- Previously, the recommended dose increases were different for the two Trusts, but these have now been aligned and a dose increase table has been produced and added. This change has been agreed with endocrinologists at both Trusts.

Draft 2 guidance for once pathways are aligned:

- Includes the same information as the interim draft sections for pre-conception once pregnancy is confirmed and following delivery.
- The 'management plan' section has been changed as the process will be the same once the pathway for the acute Trusts has been aligned.

There are ongoing discussions within the system as SFHT would like to adopt the NUH pathway model, but this has not yet been approved. Members were asked to approve the interim guideline update, Draft 1, and consider the appropriateness of Draft 2 for when/if the pathways are aligned. Draft 2 will be reviewed when it is appropriate to do so.

ACTION: Members approved the Draft 1 version of the Hypothyroidism in Pregnancy Guideline. NB to accessibility- check and upload the guideline to the APC website.

11. FOR INFORMATION – Topiramate

Following the Headache Pathway update, a question had been raised regarding contraception advice for topiramate. Specialist advice has been sought and contraception is recommended; this information has been added to the Headache Pathway.

ACTION: No further action is required.

12. FOR INFORMATION – Unlicensed "Specials" Alternatives and Options for Prescribing

PrescQIPP have developed a database of unlicensed specials and a decision had been made by the Senior Pharmacy Management Team to retire the guideline produced by the Medicines Optimisation Team.

Members asked for the PrescQIPP link to be promoted.

ACTION: NB to upload the PrescQIPP Unlicensed Specials Database to the APC website.

13. FOR INFORMATION – Forward work programme

Noted by members; no further action required.

14. AOB

- Dates of future meetings will be sent out via email. Members were asked to review and respond ASAP.
- LC will send out an email poll to establish whether Microsoft Teams meetings or face-to-face meetings are preferred; all members are encouraged to respond ASAP.

15. Date & Time of next APC Formulary meeting: Thursday 17th October 2024 (2pm to 5pm, Microsoft Teams)

16. Date & Time of next APC Guideline meeting: Thursday 21st November 2024 (2pm to 5pm, Microsoft Teams)

Meeting closed at: 16:55