Nottinghamshire Area Prescribing Committee Guideline
Meeting Minutes Thursday 21st May 2026: This meeting was conducted as a Hybrid meeting via MS teams and from Room 6-105, Trent Bridge House, Fox Road, West Bridgford, Nottingham, NG2 6BJ

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 Integrated Care Board (ICB)**
Tanya Behrendt (TB)	**Senior Medicines Optimisation Pharmacist**	**NHS Nottingham & Nottinghamshire ICB**
David Kellock (DK)	**Consultant in Sexual Health and SFHT, Drug and Therapeutics Committee (DTC) Chair**	**Sherwood Forest Hospitals NHS Foundation Trust**
Ann Whitfield (AW)	**Patient Representative**	**Nottingham & Nottinghamshire ICB local population**
Katie Sanderson (KS)	**Patient Representative**	**Nottingham & Nottinghamshire ICB local population**
David Wicks (DW)	**GP**	**Mid 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**
Georgina Dyson (GD)	**Advanced Nurse Practitioner**	**Nottingham CityCare Partnership**
Susan Hume (SH)	**Advanced podiatrist**	**Nottinghamshire Healthcare NHS Trust**
Nicola Jay (NJ) (until 3.30pm)	**Deputy Medical Director**	**NHS Nottingham & Nottinghamshire ICB**
Jacqui Toner Woods, (JTW)	**Advanced Nurse Practitioner**	**Willowbrook Medical Practice, Ashfield North Primary Care Network**
Hannah Sisson (HS)	**Principal Pharmacist – Adult Mental Health Community Teams**	**Nottinghamshire Healthcare NHS Trust**

In Attendance:
Dr Sumeet Singh, Consultant Neurologist, NUH, in attendance for agenda item 4
Peter Richards, Senior Pharmacist, NNICB, in attendance for agenda item 16

NHS Nottingham & Nottinghamshire ICB Interface Support:
Lynne Kennell (LK), Specialist Interface & Formulary Pharmacist for SFHFT.

Vimbayi Mushayi (VM), Specialist Medicines Optimisation Interface Pharmacist.
Lidia Borak (LB), Specialist Medicines Optimisation Interface Pharmacist.
Irina Varlan (IV), Specialist Medicines Optimisation Interface Pharmacist.
Sue Haria (SH), Medicines Optimisation Pharmacist.
Nicola Buxton (NB). Medicines Optimisation Technician.

1. Welcome and apologies.

APC members were welcomed, and apologies were noted.

2. Declarations of interest

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

3. Minutes of the last meeting and matters arising

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

LC provided an update on ICB restructure - The final structure has now been published but recruitment and clarification of roles is not expected to be completed for many months. In the interim, the interface team will be unable to pursue new workstreams such as shared care requests. Work is being escalated for a DLN work programme, but this is unlikely to be actioned until new roles are established and prioritisation will be required. Members were asked to support the team with this, and official supportive communications have been requested from ICB executives.

4. FORMULARY SUBMISSION – Lisdexamfetamine in narcolepsy

Dr Sumeet Singh, Consultant Neurologist, NUH was in attendance for this item.

A formulary submission for lisdexamfetamine for the treatment of narcolepsy was presented. An AMBER 2 classification was requested to support its use alongside dexamfetamine as third line options after methylphenidate and modafinil. Lisdexamfetamine can be given once daily whereas dexamfetamine requires several doses per day as shorter acting. Other advantages include decreased potential for abuse and a more steady release profile. Monitoring is the same as dexamfetamine and lisdexamfetamine is already being used by Specialists at NUH.

Whereas dexamfetamine is licensed for this indication, narcolepsy would be an off-label indication for lisdexamfetamine. However, there is already significant experience of its use for ADHD. There is no national clinical guidance for the treatment of narcolepsy, and lisdexamfetamine is not listed on formularies elsewhere for this indication. There is limited clinical evidence to support effectiveness of lisdexamfetamine in narcolepsy, but its safety is extrapolated from use in ADHD. Patient numbers are expected to be small at approximately 15 patients per year. It is expected to be cost neutral compared to dexamfetamine so no additional cost pressure was expected in primary care.

It was confirmed that dexamfetamine would remain a treatment option as this was licensed and may be preferred by some patients. Patient needs would be taken into account when deciding on the medication used and it was highlighted that the licensing situation should be explained to patients.

APC members requested that monitoring requirements are highlighted when requests to prescribe are made. As there is no additional reimbursement via a LES there may be some

reluctance for Primary care to take this on. If required Neurologists were willing to offer an annual review to support Primary care with prescribing.

APC members supported the use of lisdexamfetamine for narcolepsy with AMBER 2 classification subject to its addition to the Prescribing guidance for narcolepsy. In the absence of a further Nottinghamshire APC meeting it was agreed that this was appropriate to ratify the updated document via trust DTCs. This information should include reference to the off-label use of lisdexamfetamine for narcolepsy.

ACTION: VM to inform the submitter of the APC's decision and update Prescribing information sheet to include lisdexamfetamine. The formulary will be updated once this guidance had been ratified by trust DTCs

5. FOR NOTING – Attention-Deficit/Hyperactivity Disorder (ADHD) Shared Care Protocol (SCP) in Children – updated wording on prescribing responsibilities

An updated SCP to reflect updates to prescribing responsibilities had been circulated and agreed via email.

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

6. FOR RATIFICATION – Antimicrobial Guidelines

The following antimicrobial guidelines presented had been reviewed due to reaching their review dates in consultation with Dr Rodric Francis (RF), Consultant Microbiologist/Community Infection Control Doctor, South Nottinghamshire (NUH).

- ***Clostridioides difficile* Infection (CDI)**

NUH microbiology team were receiving queries regarding oral vancomycin tapering regimens and therefore requested to add more information to the primary care C.difficile infection (CDI) guidance. The advice regarding vancomycin tapering course is aligned across NUH and SFH, and it was considered appropriate to add this information as an appendix. A standard dosing template on the SystmOne formulary could also be created to help clinicians at the point of prescribing.

MC requested that clarification was required about SFH arrangements for dispensing primary care FP10 prescriptions for C difficile treatments and this would be followed up after the meeting.

ACTION: IV to finalise and upload the CDI guideline to the APC website pending clarification regarding SFH arrangements.

- **Pelvic Inflammatory Disease (PID)**

NICE CKS for PID includes ofloxacin as an option, but this had not been adopted in local guidance in line with NUH guidance. However, DK confirmed its use in Sexual Health Services in line with (British Association of Sexual Health & HIV) BASHH guidelines. The decision around including ofloxacin in the PID guideline, will be taken outside of the meeting.

Other changes included updated information about testing kits, updated links, clarification that moxifloxacin should be used alone. It was agreed that a reclassification of moxifloxacin to AMBER3 for this indication was appropriate given its inclusion in guidance.

A comment was made that Public Health England has been disbanded in 2021, and UK Health Security Agency (UKHSA) had taken over PHE's responsibilities. This will be amended in the text.

There was also a discussion that recently updated gonorrhoea guideline did not stipulate a test of cure, and this advice should also be reflected in the PID guidance.

Subject to resolution of these issues the updated guidance was approved.

ACTION: IV to clarify the points raised with DK and RF and once finalised, to upload the PID guideline to the APC website. IV to update classification of moxifloxacin on formulary to AMBER 3

- **Epididymitis and orchitis.**

NICE CKS had recently updated their guideline but there were no changes to treatment recommendations. Updated local guidance involved minor changes only.

Similar to the PID guidance above, advice regarding a test of cure required alignment as did the exclusion of ofloxacin as a treatment option.

A suggestion was made to remove the traffic light colours from the treatment table as this was inconsistent with other antimicrobial guidelines.

Subject to a consensus opinion on the inclusion of ofloxacin being reached, the guideline was approved.

ACTION: IV to finalise and upload the Epididymitis guideline to the APC website.

- **Cellulitis**

There had been no change to treatment recommendations in updated NICE CKS guidance from April 2026 and continue to be in line with local trust recommendations.

Updates included the addition of information about flucloxacillin doses in patients with obesity and stronger encouragement of the use of solid dose forms in children.

ACTION: IV to finalise and upload the Cellulitis guideline to the APC website.

- **Dermatophyte infection of the skin**

A decision was made to retain this local guidance rather than linking directly link to the NICE CKS guidance. Changes were minor and aimed to add clarity and improve the guideline.

- Hydrocortisone 1% cream was added for consideration in addition to antifungal treatment if there is associated marked inflammation. Restricted for a maximum of 7 days.
- The systemic treatment options were separated in a second table, and two more treatment options were added: itraconazole and griseofulvin, in line with NICE CKS recommendations. Both classified Green on the formulary and already listed in our guidelines for Dermatophyte infection of the scalp and nails. Doses are as per BNF and NICE CKS.
- Advice on self-management was added.

ACTION: IV to finalise and upload the Dermatophyte infection of the skin to the APC website.

- **Hidradenitis – proposal to add Octenisan.**

Request from Jeremy Hill, GPSI in dermatology to add Octentisan. It is included in PCDS guideline and more cost-effective than chlorhexidine.

ACTION: IV to finalise and upload the Hidradenitis guideline to the APC website.

- **Scabies**

A request was received to include advice about capping dose of ivermectin following queries from Primary Care. There is limited evidence for use of ivermectin in obesity, but the proposal from microbiology is to dose on actual body weight and to cap dose at 30mg. The APC agreed with this approach, but recommended that a disclaimer be added that this recommendation is based on local specialist opinion.

ACTION: IV to finalise and upload the Scabies guideline to the APC website.

7. FOR RATIFICATION – NICE TA1148 Sodium Zirconium Cyclosilicate for treating Hyperkalaemia

NICE had updated its TA for sodium zirconium cyclosilicate for treating hyperkalaemia (NICE TA1148), lowering the threshold for initiating treatment.

Previously, use was restricted to patients with serum potassium levels above 6.0 mmol/L. The updated recommendation allows use at serum potassium levels over 5.5 mmol/L.

Specialists continue to support the AMBER 2 classification on the local formulary. Heart failure (HF) guidance will need to be updated to reflect this change.

Discussions suggest that, in practice, treatment may already be initiated at lower potassium levels than previously specified by NICE, therefore there was not expected to be a significant impact on prescribing locally.

As this medicine is used by the renal team as well as cardiology, consultation with renal specialists was advised.

ACTION: IV to finalise and update the Joint Formulary and HF guidance. VM to engage with renal specialists.

8. FOR DISCUSSION - APC Documents to retire

LC explained that due to the restructuring and running cost cuts within the ICB, there will be a reduced workforce capacity to maintain the current levels of APC work in terms of document maintenance. Furthermore, as the ICBs cluster there is an expectation that APCs come together and over time amalgamate work such as clinical guidelines. To safeguard team capacity and reduce the risk of hosting out-of-date documents on the APC website, the team have reviewed all guidelines etc which are due to be reviewed at some time during the remainder of 2026 and early 2027. Consideration has been given to what the local guideline offers over national guidance and/or manufacturers information which is available.

The following guidelines were discussed and agreed:

- Inclisiran Prescribing Information Sheet to extend by 6 months.
- Management of Psoriasis (Adult & Children) in Primary Care to extend by 6 months.
- Testosterone Information Sheet (adult male) to extend by 6 months, then consider retiring.
- Testosterone for Postmenopausal Women - Information Sheet to extend by 6 months then consider retiring.
- Colistimethate for Non-CF Bronchiectasis - Information sheet reviewed by ICS respiratory group, no changes were required, rolled over for a further 3 years.
- Information and Guidance on Prescribing in Transgender Health to retain the prescribing check list only and replace the rest with the PrescQIPP bulletin. This had been recently updated and included the content of the local guideline except the checklist for privately initiated treatment. Notts HC to be made aware.
- UTI guidelines due for review since 2025 - set new review date for end 2026. It was raised that there could be a significant cost efficiency opportunity from immediate release nitrofurantoin- this will be considered at the next review.
- Head lice - proposal to retire and link directly to NICE CKS. Self-care advice will be added to the APC website.
- Osteomyelitis - proposal to remove the review date and keep the document on the APC website. The document comprises of general advice regarding referral to Secondary Care. No medicines or doses are included.
- Mould infection of the nail – proposal to retire (consists of 2 paragraphs) and add that information to Dermatophyte Nail Infection and rename it Fungal nail infection.

ACTION: Interface team to update or retire the documents and update the APC website as required. HS to liaise with Transgender service at NottsHC about the planned retiring of local guidance.

9. FOR RATIFICATION – Allergic Rhinoconjunctivities treatment pathway (Adults)

VM presented an updated Allergic rhinoconjunctivitis treatment pathway for adults which had been reviewed due to reaching its review date. Although there is no change to the overall treatment intent; the revisions focused on improving clarity and sequencing. The review and pathway update were undertaken by Kate Hopkinson, Head of Service for Clinical Immunology and Allergy, NUH and Allergy Services MDT.

Fexofenadine was included as an additional treatment option, advice and clarification about IGE testing and referral routes.

Advice has been sought regarding patients obtaining OTC if doses are off label. This is not in line with NHS E guidance so these would need to be prescribed.

The updated pathway was agreed.

ACTION: VM to upload the pathway to the APC website.

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

VM presented the updated guidelines which had been reviewed due to reaching their expiry date. Consultation included PICS, MOSAIC and SFH pain teams. No feedback had yet been received from the NUH pain team.

Main changes involved the osteoarthritis guideline in line with updated NICE guideline. APC agreed the updated guidance subject to there being no conflicting feedback from NUH.

ACTION: VM to ensure NUH have had an opportunity to feedback and upload the guidelines to the APC website. If significant feedback is received this this will require circulation for ratification by email.

11. FOR RATIFICATION – Opioids for persistent non-cancer pain in adults

Opioids for persistent non-cancer pain in adults guidance had been updated to incorporate new advice on oral morphine equivalent (OME) dosing, alongside a MHRA Drug Safety Update. Other changes involved removal of twice weekly buprenorphine resulting in a change from AMBER 3 to AMBER 2 and a review of recommended oxycodone dosing following advice from pain teams.

Feedback had been received from a physiotherapist about the inclusion of information about early referral to pain services for those who were on OME of 50mg/day. APC members felt that GPs were generally able to reduce opioid doses to the recommended oral morphine equivalent (OME) provided that they are aware of the updated recommendations. The main challenge highlighted by members was stopping opioids altogether in more complex cases, so they felt no additional wording around referral was needed. Members did, however, agree that for more difficult patients, clinicians would still refer on if required, as they usually do.

ACTION: VM to ensure NUH have had an opportunity to feedback and upload the guidelines to the APC website. If significant feedback is received this will require circulation for ratification by email.

12. FOR RATIFICATION – Phosphate Binders for the treatment of Hyperphosphatemia in Adults with CKD SCP

VM presented an updated SCP and information sheet, which had been reviewed with Dr Charlotte Bebb, NUH Neurologist and Head of Renal and Transplant Services due to reaching their expiry date.
Main changes involved the removal of Phosex due to its discontinuation. Renalcet remains available as a calcium acetate option. As monitoring is managed by the renal service, all references to monitoring have been removed. APC members also agreed to removing GP responsibility points 6, 8 and 9 in the shared care protocols as monitoring responsibilities are specialists' responsibilities

ACTION: VM to upload the updated SCP to the APC website.

13. FOR RATIFICATION – Buccal Midazolam Guideline for Children

LB presented Buccal Midazolam Guideline for Children which had been reviewed in collaboration with Specialists from both local Trusts due to reaching its expiry date. This guideline has been retained to provide safety information helping to reduce potential prescribing or administration errors associated with high-risk medication like buccal midazolam, and to support community teams.

No major changes to current clinical practice were proposed. Only minor changes to the layout and formatting had been made to highlight Buccolam® as first line licensed product and to emphasise Epistatus® as an unlicensed and non-formulary choice. Dose recommendations were

verified as aligned with the BNFc, a table containing cost and manufacturer information was removed and links were reviewed and updated. The Committee approved the guideline.

ACTION: LB to upload the Buccal Midazolam Guideline for Children to the APC website.

14. FOR RATIFICATION – Adult Headache Pathway

LB presented the Adult Headache Pathway which had been updated due to reaching its expiry date. This guideline has been revised against current NICE and British Association for the Study of Headache (BASH) guidance and developed jointly with Neurology Specialists from NUH and Primary Care representatives.

The origin of this document was to support referral pathways in Secondary Care and was adapted for Primary Care usage. It had been reviewed in 2 parts: secondary care MRI pathways (2ww and headache), which are not relevant for Primary Care but had been amalgamated internally at NUH. Access to MRI from Primary Care remains unchanged but will include links to this guidance to ensure appropriate management has been addressed prior to MRI request. Regarding clinical management of headache, red flags had been simplified to avoid unnecessary MRI. Additional inclusion of red flags that may indicate meningitis, pre-eclampsia or cerebral venous sinus thrombosis were discussed and agreed to be included to aid differential diagnosis. Diagnostic criteria across headache types have been refined, and migraine guidance has been expanded to include menstrual-related migraine and clearer differentiation of chronic migraine to support appropriate treatment choices.

Treatment recommendations remain largely unchanged for acute migraine and tension-type headache; however, prescribing guidance has been strengthened, including advice to avoid opiates, restrict duration of antiemetic use, and highlight cost-effective triptans and key safety considerations. Migraine prophylaxis recommendations have been updated, with propranolol or amitriptyline as preferred first-line options, alongside alternatives like topiramate or pizotifen. Candesartan was introduced as an additional option, albeit as an off-label indication. Recommended dose of amitriptyline was reduced to 80mg based on risk-benefit considerations and pizotifen, although not recommended nationally was retained based on local specialist recommendation. The Committee approved the guideline.

ACTION: LB to upload the Adult Headache Pathway to the APC website.

15. FOR RATIFICATION – Urticaria and angioedema guidelines

LB presented the Urticaria and Angioedema Primary Care Guidelines, which had been revised with specialist input from the NUH Immunology MDT due to reaching its expiry date. Key prescribing changes include removal of fexofenadine 120 mg which is unlicensed for this indication, removal of montelukast as a treatment option, and updated tranexamic acid dosing based on renal guidance with lowered dose-reduction thresholds. Proposed secondary care changes to remove some of the routine monitoring like eye examinations, FBC and eGFR were discussed; however, members noted the need to balance this with safe long-term use in Primary Care. Other key updates include minor adjustment of cetirizine dosing to allow once daily higher dose administration, allowing up to fourfold dose escalation of oral antihistamines if licensed doses are ineffective and addition of pregnancy warnings. Management of ACE inhibitor–related angioedema was discussed; whether C3/C4 testing is to be undertaken prior to discontinuation of ACEi, with agreement to consider withholding the ACE inhibitor and seeking specialist advice where appropriate. The committee approved the guideline.

ACTION: LB to upload the Urticaria and angioedema guidelines to the APC website.

16. FOR RATIFICATION – COPD Exacerbation Rescue Medication Pack

Peter Richards attended to present the updated COPD Exacerbation Rescue Medication Pack guidance.

The updated involved no change to practise, but its format had been simplified. Attention was brought to the need for an accompanying self management plan and other strategies may be appropriate for some patients.

The ICS respiratory meeting had requested more clarity about the encouragement of smoking cessation and advice about referral to Secondary care for consideration of biologics.

It was raised that there may be a requirement for steroid weaning if multiple steroid courses are issued due to a risk of adrenal suppression and more clarity about this was requested to support appropriate management. MC agreed to email suggested wording to PR.

Subject to the inclusion of information about steroid weaning, the updated guidance was agreed.

ACTION: PR to finalise guidance and Interface team to upload the COPD Exacerbation Rescue Medication Pack to the APC website.

17. FOR RATIFICATION – Continence formulary update

This was hosted by APC but approved by the continence advisory service and an updated formulary was included for noting. It was raised that the extent of patient involvement was unclear and the need for adequate patient engagement would be fedback to the service.

ACTION: Interface team to upload the updated continence formulary to the APC website and to feedback to the service about patient consultation.

18. FOR INFORMATION – Post-bariatric surgery guidance – Derby guideline

The APC had previously ratified a Derby guideline, but since then feedback from the bariatric team at Sheffield Teaching Hospitals about management of patients that become pregnant had been incorporated. Consensus opinion was that any patient that becomes pregnant should be referred to a specialist dietician for nutritional screening and blood tests including Vitamin A levels were required during each trimester. It was confirmed that this is a requirement for any patient that becomes pregnant following bariatric surgery irrespective of when the surgery occurred.

It was raised that there may be a lack of awareness of this requirement amongst Primary Care clinicians so communications would be required.

ACTION: LB to upload the updated Post-bariatric surgery – Derby guideline to the APC website and to investigate communication routes.

19. ANY OTHER BUSINESS

APC annual report - this was included in the papers for noting and acknowledged the huge volume of work coordinated through the APC. The report will be escalated via governance reporting routes in the ICB. Thanks were given to all involved in the APC.

Algorithm for PPI choice in children - following discussions at the previous APC meeting about use of products off label, clarity had been added to the guidance about product licensing in different age groups. Information from NICE had also been added regarding reserving pharmacological treatment for proven GORD. Opinion of APC was requested regarding the continued recommendation of MUPs. As this reflected current practise of the acute trusts no changes were felt needed.
ACTION: SHa to finalise guidance and upload to APC website.

NICE TA 1157- this recommends semaglutide (Wegovy) as an option for cardiovascular risk reduction in those with established cardiovascular disease and BMI> 27mg/m2. Whilst local implementation is being considered, a GREY classification had been assigned. This will be escalated to the DLN Cluster APC for consideration once established.

It was noted that LC and TB were leaving the ICB. The APC gave thanks for their tremendous contributions and wished them well for the future.

Meeting closed at 16:50pm

The Cluster DLN APC meeting is scheduled for 11th June 2026, 1-3pm.