These minutes are in draft form until ratified by the committee at the next meeting on 16th January 2025.

Nottinghamshire Area Prescribing Committee Guideline Meeting Minutes 21st November 2024: 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**
Katie Sanderson (KS)	**Patient Representative**	**Nottingham & Nottinghamshire ICB local population**
Jennifer Moss Langfield (JML)	**GP**	**LMC Representative**
Asifa Akhtar (AA)	**GP**	**South Notts PBP, Nottingham & Nottinghamshire ICB**
David Wicks (DW)	**GP**	**Mid Notts PBP, Nottingham & Nottinghamshire ICB**
Tim Hills (TH)	**Assistant Head of Pharmacy**	**Nottingham University Hospitals NHS Trust**
Kuljit Nandhara (KN)	**Deputy Chief Pharmacist, Head of Pharmacy Mental Health Services**	**Nottinghamshire Healthcare NHS Trust**
Jo Fleming (JF)	**Specialist Clinical Pharmacist (Pain)**	**Primary Integrated Community Services Ltd**
Georgina Dyson (GD)	**Advanced Nurse Practitioner**	**Nottingham CityCare Partnership**
Susan Hume (SH)	**Advanced podiatrist**	**Nottinghamshire Healthcare NHS Trust**
Nicola Graham (NG)	**Senior Transformation Manager**	**NHS Nottingham & Nottinghamshire ICB**

In Attendance:

Dr Rahul Mohan GP – West Bridgford Medical Centre, Clinical Lead, GpwER in diabetes, in attendance for agenda items 7 and 8.

NHS Nottingham & Nottinghamshire ICB Interface Support in attendance:

Lidia Borak (LB), Specialist Medicines Optimisation Interface Pharmacist.
Irina Varlan (IV), Specialist Medicines Optimisation Interface Pharmacist.
Nichola Butcher (NB), Specialist Medicines Optimisation and Interface Pharmacist.
Karen Robinson (KR), Specialist APC Interface and Formulary Pharmacy Technician.
Lynne Kennell (LK), Specialist Interface & Formulary Pharmacist for SFH, was present during the meeting up to agenda item 5.
Vimbayi Mushayi (VM), Specialist Medicines Optimisation Interface Pharmacist, was present during the meeting for agenda items 7 & 8.

1. Welcome and apologies.

APC members were welcomed, and apologies were noted.
The Chair noted that there was no representation from SFHT.

2. Declarations of interest

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

3. 10 Minute learning session – Empathy and walking in other's shoes

Robert Treadwell, Senior OD Business Partner, Nottingham and Nottinghamshire ICB, provided a 10-minute learning session on "Empathy and Walking in other's shoes". The learning session was recorded for future APC member training.

4. Minutes of the last meeting and Matters arising

The minutes of the previous meeting were accepted as an accurate record, subject to minor amendments.

- Naloxone information sheet – At the September APC meeting, additional wording was requested for patients being treated with high-dose opioids. The following text has been added to the information sheet:
  'those being treated with high-dose opioids for chronic pain where there are concerns about a high-risk of opioid overdose. In this situation it would be expected that this would be discussed with Specialist Pain services.'
  Final ratification was via email and APC members were urged to respond.
  ACTION: Awaiting APC members' ratification; once a quorate response has been agreed LK will upload the information sheet to the APC website.

- Transgender Guidance review date has been amended as the temporary legislation date has been extended to end of December 2024.

- APC face-to-face development session: planning is underway for this to be scheduled during February or March 2025.

- Warfarin Prescribing Guideline: LK informed APC members that the Locally Enhanced Service (LES) for warfarin is due for review in 2025/26. All contractual elements have been removed from the prescribing guideline presented at the previous APC and it is planned to keep this as a Prescribing information sheet.
  ACTION: LK to circulate the updated guideline for ratification via email.

- Inflammatory Bowel Disease, Methotrexate Shared Care Protocol (SCP): NB explained that consensus for pregnancy advice for the three SCP's containing methotrexate had not been achieved and would therefore remain different across the three SCPs. Information was requested at the last meeting about stopping methotrexate in immunosuppressed patients. NB advised that this statement was already in the SCPs: 'Stop methotrexate and discuss urgently with the specialist if the patient develops signs of severe infection, liver or respiratory disease, unexplained bleeding or bruising, becomes pregnant, or if immunosuppressed patients are exposed to chickenpox or shingles.'

- IV explained that the Renal Function Calculator Guidance will not be retired as originally planned and the national resources will be linked to the guidance. This decision was made following feedback from the PCN representatives. The review date has been extended to November 2026; however, no further development of this guidance will be made.

Lecanemab / Donanemab

LK explained to APC members that lecanemab and donanemab for Alzheimer's disease are not expected to gain NICE approval; Technical Appraisals (TAs) are expected to be published in early 2025. However, although lecanemab and donanemab are not funded by the NHS, they can be prescribed privately. NHSE has circulated information about potential serious adverse effects and there are interactions to be aware of eg with anticoagulants. This information has been added to the formulary along with information about the NHS position.

ACTION: Lecanemab and donanemab have been added to the Joint Formulary as GREY along with the relevant safety information. LK to update APC with any further information.

*****All other actions were complete or listed on the agenda.*****

5. <u>FOR INFORMATION – Medicines Optimisation Regional Advisory Group (MORAG) update</u>
(previously called The Regional Medicines Optimisation Committees (RMOC)).

LC and TB attended the Medicines Optimisation Regional Advisory Group (MORAG) meeting where several local guidelines from other ICS areas were discussed and shared. Many of the guidelines discussed at the meeting the Nottinghamshire APC/ICB have already produced, and which reflect similar practice. However, there were some guidelines which might be adopted in future, including:

- Penicillin de-labelling.
- Children-specific antimicrobial prescribing guideline.
- Respiratory and asthma in children (the ICB respiratory leads have been made aware of this workstream).
- Repeat prescribing tool kit; a newly appointed ICB pharmacist will be reviewing this as part of the PolyPharmacy workstream.

LC and TB will share the local guidelines the APC have published at a future MORAG meeting.

ACTION: LC and TB will update the APC following MORAG attendance.

6. FOR RATIFICATION – Overarching Chronic Kidney Disease (CKD) guidelines

Dr Rahul Mohan GP - West Bridgford Medical Centre, Clinical Lead, GPwER in diabetes, was in attendance for this agenda item. VM provided a brief update for APC members.

At the September APC meeting, the following actions were requested.

- Increased detail: explanations of Renin-Angiotensin-Aldosterone System (RAAS), examples of medication, dosages, a rapid titration protocol for RAAS blockade have been added, along with clarification of abbreviations.
- Revised Step 2: Step 2 should be reconfigured, as some actions can be done simultaneously. There was also discussion of whether all patients need statins, especially younger patients or those without impaired renal function –adjustments for this have been made to the guideline. Simultaneous actions include starting a statin and ACE inhibitor (ACEi) or angiotensin receptor blocker (ARB). If the patient is less than 40 years old, it is advocated that a Q3 Lifetime risk calculator is used to decide whether the patient needs statins. The link to the risk calculator is provided on page 2. Simultaneous initiation of SGLT2i and ACEI/ARB is not recommended and the reasons for this are explained on page 3.
- Formatting Overhaul: the guidelines need a visual overhaul to be more "guideline- looking." Some graphs on pages 2 and 3 had been flagged as not fitting the overall format and should be reconsidered or removed –the guidelines have been visually reformatted, and some graphs were removed for consistency.
- Consideration of Aspirin: the guideline should expand on when aspirin is appropriate and which patient groups to consider it for – this has been addressed on page 2.
- Clarify abbreviations and medication recommendations: abbreviations like RAAS, ACEi, and ARBs need to be explained, along with recommendations on medicine sequencing and evidence to support these decisions: common abbreviations like RAAS, ACEi, and ARBs have been listed in a glossary, with medication sequencing and supporting evidence linked.
- SGLT2i agents have been listed alphabetically to avoid perceived preferences and a supporting statement explaining this had been included.

In addition, summarising infographics have been developed to facilitate a quick reference guide.

APC members felt a small change was required to allow the chart to flow better. APC members agreed that the appendices should be renamed as summary sheets and a hyperlink was requested within the bulk of the text, allowing prescribers to access the key information quickly. Although the document was described as ‘wordy’ as a whole, it was deemed necessary to support Non-Medical Prescribers (NMP) and Primary Care Network (PCN) colleagues' decision-making.

LC urged members to attend one of Dr Mohan’s training sessions on CKD. More dates will be published soon.
APC members ratified the guideline, subject to the slight changes agreed.

ACTION: VM to make the agreed changes and email the final document to members for information only. VM to upload the Chronic Kidney Disease (CKD) guideline to the APC website.

7. FOR RATIFICATION – Clinical pathway for use of SGLT2i in CKD and Type 2 Diabetes (T2DM)

Dr Rahul Mohan GP - West Bridgford Medical Centre, Clinical Lead, GPwSI in diabetes, was in attendance for this agenda item. VM provided a brief update for APC members.
At the September APC meeting, the following actions were requested, and the pathway was revised in consultation with Catherine Byrne (Renal Consultant, NUH) and Dr Rahul Mohan.
The updates include:

- NICE Guideline Reference: added clarification on ensuring the patient is on the maximum tolerated licensed dose of an ACE inhibitor (ACEi) or angiotensin receptor blocker (ARB).
- Initiation of treatment in T1 Diabetes Mellitus: clarified that for patients with Type 1 Diabetes, initiation and management should only occur in Secondary Care due to the off-license indication.
- eGFR Thresholds: removed specific eGFR cut-offs; advised that SGLT2 inhibitors do not need to be discontinued unless the patient initiates dialysis.
- Patient Education and Temporary Medication Holds: added advice on holding the medication temporarily and provided patient education resources, including links.
- Document Format: updated the document format to align with other APC documents.
- eGFR Values: added units (ml/min) to all eGFR values for clarity.
- Dosing Section: removed minimum eGFR values for canagliflozin in the dosing section to prevent confusion.
- Canagliflozin Guidance: included information specifying that canagliflozin is recommended for Type 2 diabetes with or without Chronic Kidney Disease (CKD), but there is no current recommendation for CKD without diabetes.
- eGFR Values and Licensing: added a statement explaining that different eGFR values in the pathway are based on NICE trial evidence for licensed indications and may differ from SPC.
- Integration with CKD Guidelines: the pathway is now linked within the broader CKD guidelines.

APC members ratified the guideline.

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

8. FOR RATIFICATION – ANTIMICROBIAL GUIDELINES

- **Insect bites and stings**

The Insect bites and stings antimicrobial guideline has been updated due to reaching its review date, and comments were invited and received from the microbiology leads. NB provided a summary of the changes, which included the following:

- Hyperlink to the Clinical Knowledge Summary (CKS) added (last updated July 2023).
- Hyperlink to the APC patient information leaflet added.
- No change had been made to the treatment options or advice, although the following line ‘Most insect bites/stings do not require antibiotics if infection is suspected the cellulitis guideline should be followed’ was highlighted .

- The following statement was added: 'Insect bites are one of the conditions that can be considered via Pharmacy First.'

  APC members ratified the guideline.

  ACTION: NB to upload the guideline to the APC website.

- **<u>Wound Infection</u>**

  The guideline has been updated because it has reached its review date. Comments were invited and received from microbiology and tissue viability leads.

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

- This guideline was, historically, a list of oral antibiotics and doses.
- Feedback from Nottinghamshire Healthcare Trust and microbiology advised that many wounds are treated unnecessarily with oral antibiotics, particularly self-inflicted wounds. Antibiotics are also being prescribed inappropriately, as an antimicrobial dressing is often forgotten or not considered in practice. This is being audited and reviewed by NottsHCT.
- There is no national guidance for the management of self-inflicted wounds.
- The aim of this guideline is to highlight the considerations that should be made before prescribing antibiotics, rather than as a general wound care guideline.
- As advised by Tissue Viability, the 2-step flowchart for the management of wounds was adopted and further information added to Step 1 (page 1):
    - Human or Animal Bite
    - If sepsis is suspected (links to guidance added)
    - Steps and considerations to take if the wound is self-inflicted, with or without soil or faeces contamination.
- Oral antibiotics should only be started if there are: two clinical signs of infection, positive swab microbiology and after treatment with an appropriate antimicrobial dressing.
- If the wound is self-inflicted and contaminated, then oral antibiotics should be started, whether or not there are 2 signs of infection.
- Step 2 (page 2) is the process to undertake if there are two or more signs of infection.
- The link to the NUH microbiology handbook (wound swab section) has been added.
- It was agreed to include a list of generic antimicrobial dressing treatments and add a link to the CityCare and County wound care formularies for details of specific products.
- Surgical wound management was not included in the flowchart, but a separate section generated.
- There were no changes made to the oral antibiotic treatment options; the table was reformatted, and doses were written in words.

  For increased clarity, APC members asked that the term "self-inflicted" be changed to "contaminated" wound. A few additional minor comments were made to add further clarity to the flow chart.

  APC members ratified the guideline.

ACTION: NB will discuss the minor changes with the APC team prior to uploading the guideline to the APC website.

- **Clostridioides Difficile**

The guideline has been updated because it has reached its review date. Comments were invited and received from microbiology leads.

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

- Patient and carer information updated, and information added, including:
    - o Diarrhoea should resolve in 1-2 weeks, and it is not possible to determine if antibiotic treatment has been effective until day 7.
    - o Patients will remain infectious while ill and with symptoms and should not return to work or school until free from diarrhoea for 48 hours. If medication is prescribed, patients should ensure that the full course is completed and there is no further diarrhoea or vomiting for 48 hours afterwards.
- No change to treatment options.
- The list of pharmacies stocking vancomycin has been updated, with a review date of April 2025.
- Contact details for hospital pharmacies checked and updated.

APC members requested that a hyperlink to the sick day rules was added, and that clear directions for obtaining vancomycin from community pharmacies were added.

APC members ratified the guideline, subject to the agreed amendments.

ACTION: NB to make the requested amendments and upload the guideline to the APC website.

9. FOR RATIFICATION – Vitamin B12

LB presented the updated Vitamin B12 guideline; this guideline had been reviewed due to reaching its review date in February 2024 and to the publication of the new NICE guidelines on the management of vitamin B12 deficiency in those over 16 years old.
Because of the major variation between the pre-existing local clinical practice and the newly launched national guidelines, various stakeholders from all local sectors were approached directly and invited to feed back.

LB provided a summary of the major changes to the guideline:

- In general, vitamin B12 testing is now indicated for patients with at least one common symptom and at least one common risk factor (both tabulated within the guideline for easy reference).
- Local labs are using different vitamin B12 assays for each type of test (ie total vitamin B12 assays used at NUH and SFH are different). Following guideline ratification, both laboratory teams have agreed to update test result descriptors to align with the test references in the guideline, as aligned with NICE. NUH is planning to switch all routine B12 testing to the active B12 assay, which DBHT have already done, therefore both tests are included in the guideline to address this local variation.

- The guideline contains 3 separate treatment algorithms: for management of suspected vitamin B12 deficiency in patients presenting without, or with, neurological symptoms, and for patients during pregnancy.
- Treatment choice is guided according to the suspected cause of B12 deficiency, as per NICE guidelines, and this is listed within a separate table, detailing treatment options, duration of replacement therapy and review timescales.

LB explained that, with or without neurological symptoms, some labs use total assays and some use active assays, so the clinicians might see different results. LB had liaised with the laboratories to reach an agreement to include result descriptors aligned to local guidelines, to inform treatment decision.

The committee felt the wordcount could be reduced. Discussions took place around loading dose, and it was felt more clarity was required as to whether or not this was needed. Self-injection was raised, and LB explained that NICE states it is inappropriate for patients to self-inject, due to it being an IM injection.
One of the clinicians commented that they had tried to request a methylmalonic acid (MMA) test on ICE, but it was not listed. LB will raise this with the local laboratories. It was agreed that self–care, where clinically appropriate, should be recommended first line, and this will be made clear. LB will look for a suitable patient information leaflet and hyperlink it to the guideline. Clinicians requested additional clarity around when, after the loading dose, a patient should be tested to ascertain if there was an ongoing clinical deficiency. Due to the practical complexities of guideline implementation by the prescribers in General Practice, it was agreed that LB would liaise with AA and JML to discuss this further and work through the guideline.

Members agreed that the guideline could not be ratified at present and requested that it be returned in January 2025 for further discussion.

ACTION: LB to discuss the availability of MMA testing with the laboratories.
LB to meet with AA and JML to work practically through the guideline. LB to return the guideline to APC in January 2025 for ratification.

10. <u>FOR RATIFICATION – Guideline on the management of sleeping difficulties in children.</u>

IV presented the guideline on the management of sleeping difficulties in childhood, which had been updated due to reaching its review date. Specialists from NUH, SFH and Notts HCT have been consulted on this update.
IV provided a summary of the changes as follows:

- Wording updated to highlight that both licensed and unlicensed melatonin formulations are prescribed within the area. NUH have switched to licensed preparations, but unlicensed capsules are still used at SFHT.
- Information added to stress the importance of sleep hygiene measures in addition to melatonin administration.
- Local formulary choices for melatonin were added to section 7.12.
- Contact details updated for Universal Sleep Services in section 5.2.

- The promethazine section updated to highlight the recent change in license; not recommended in children under 6 years old.
- The chloral hydrate section has been updated to include the MHRA notification from 2021 and its use in movement disorders.

The Joint Formulary has been updated to reflect the change to the promethazine license, highlighting that it is contraindicated for children under 6 years old and should not be prescribed for children under 6 years old without specialist advice. Safety alerts have been published in Australia and New Zealand, which led the manufacturer to change the license; however, nothing has been published by the Medicines and Healthcare Products Regulatory Agency (MHRA) in the UK. The MSO group has been contacted and the practices with patients under 6 years old with promethazine prescriptions have been notified.

The guideline has been updated to reflect the current practice of the local Trusts (NUH, SFHT and NHCT).
The availability of melatonin to buy over the counter (OTC) was discussed by members. In the UK melatonin is classified as a prescription - only medicine (POM). Products containing melatonin can be obtained in the UK from online pharmacies, but they are intended for adult use and are classified as food supplements rather than medicines. It was felt inappropriate to encourage parents and carers to buy OTC melatonin for children.

APC members ratified the guideline, subject to the grammatical amendments made as above.

ACTION: IV to feed back to authors and to upload the guideline to the APC website.

11. FOR RATIFICATION – Osteoporosis guidelines

LB presented the Osteoporosis and Fracture Prevention guideline, which has been reviewed due to reaching its review date. The review has been completed in collaboration with the ICS Bone Health Task and Finish group, following the recommendations of NICE, NOGG, SIGN, Dutch and Canadian national guidelines, and local expert opinion.

LB provided a summary of changes to the guideline as follows:

- Same as in current version, there are two separate flowcharts for management of primary and secondary fracture prevention, which are stratified by the fracture risk or bone mass density (BMD) scores.
- Primary prevention lists wider criteria for the fracture risk assessment, including any postmenopausal women, all men over age of 50, any patient aged 50-89 with a clinical risk factor (not just major risk factor as in previous version).
- Information on management of patients with intermediate risk of fracture for whom a Bone Density Scan (DXA) is not practical.
- Included timeframes and guidance on what should be included in the clinical review and treatment review for each cohort of patients. Separate flow chart on review of oral bisphosphonate (has been updated, aligned, and simplified).
- Alendronic acid 70mg once a week remains 1st- line treatment for primary prevention, with review post- initiation at 3,6 and 12 months (vs 4 months in current guideline).
- Management in secondary fracture prevention is guided by the type of fracture (hip fracture

vs. non-hip fracture divided by existing history of vertebral fractures [vs age of patient in current guideline]).

- Hip fracture is to be managed within Secondary Care- based Specialist services or Community-based Fracture Liaison Services, once established across the ICB (ongoing work), with zoledronic acid as a 1st- line treatment option (vs choice of alendronic acid or zoledronic acid in current guideline).
- 4mg dose of zoledronic acid has been included as a locally recommended treatment option.
- Patients (irrespective of their age) with high risk of fracture or BMD with T value under -2.5 and history of any vertebral fracture are advised a referral to a Specialist (vs managed with alendronic acid in current guidelines).
- Included advice on when to repeat DXA scan.

A "Supporting Information" section has been added; this contains detailed advice, as requested by local clinicians, as follows:

- Guidance on the assessment of risk factors, including the list of recognised and major risk factors.
- Guidance on the diagnosing of osteoporosis, including the clinical assessments with list of investigations, information on interpretation of DXA scans and vertebral fractures (reported by the labs).
- Guidance on osteoporosis prevention in patients on aromatase inhibitors or androgen deprivation therapy.
- Included a link to the NICE guideline on management of people with eating disorders, also covering osteoporosis and fracture prevention.
- Detailed guidance on management and prevention of glucocorticoid-induced osteoporosis, advising immediate initiation of bone protective therapy (without initial FRAX or DXA) for anyone with a prior fragility fracture prescribed steroids at any dose (if not already on bone-sparing treatment), women and men aged >70 years prescribed oral steroids at any dose, anyone commencing high dose corticosteroids (≥7.5mg per day prednisolone or its equivalent for ≥3 months, or ≥30mg per day for >30 day, or cumulative doses ≥5g per year). All other adults aged >40 years, are advised fracture risk assessment when initiating oral or systemic glucocorticoid with ≥2.5mg per day prednisolone or its equivalent for >3 months. Included information on when to review and consider discontinuation of bone therapy.
- Treatment choice summary table matching indication and treatment options.
- Updated information on lifestyle advice, including relevant links.
- Updated advice on calcium and vitamin D and aligned with current local guidelines.
- Updated patient information and clinical resources.
- Appendix 1 – listed all locally used treatment options, with relevant information from NICE, MHRA safety warnings, and treatment duration timeframes.
  Appendix 2 – updated counselling advice
  Appendix 3 – no changes
- Updated referral criteria, as agreed with the local specialists involved in bone health and DXA scanning.

The updated guideline may create additional workload within General Practice and a Task and Finish Group are looking at ways to mitigate the impact. One of the considerations discussed is the re-establishment of the fracture liaison service.

The APC clinicians present wanted additional clarity on the following points:

- Is the guideline for all post-menopausal women or is it only for post-menopausal women over 50 years old? If it is all post-menopausal women, the age at the top of the guideline will need to be removed.
- Can the order of the flow chart for secondary prevention be adjusted to create a better flow?

The clinicians stressed that zoledronic acid needs to be initiated in hospital post-hip fracture; they were seeing several patients who had not been prescribed it on discharge from Secondary Care.

APC members ratified the guideline, subject to the additional clarity.
LB will provide fracture liaison service updates for the APC as and when they become available.

ACTION: LB to feed back the discussions and make the minor amendments. LB to upload the guideline to the APC website.

12. FOR RATIFICATION – Terms of Reference (TOR) – delegated authority to short- life Task & Finish groups appendix

LC presented the new appendix and explained that the recent supply issues had required a short-life Task and Finish groups to be established to facilitate safe and appropriate treatment options for patients.
Examples include Pancreatic Enzyme Replacement Therapy (PERT) and ADHD. On completion of the necessary guidance, it was apparent that there was no clear route for ratification of the documents, generating a gap in the formal governance process. Although such guidance is hosted on the APC website, the APC ratification process itself is often not timely enough. The Task and Finish groups include local specialists from the Trusts in addition to medicines optimisation colleagues, and this appendix aims to formally give delegated authority to the Task and Finish groups for the ratification of guidance production in urgent cases as they arise.
Members suggested creating a prepopulated template TOR for short-life Task and Finish group use; LC will create a template and email it to APC members for comment.

APC members ratified the TOR appendix.

ACTION: APC members ratified the appendix. LC to create an APC template and email it to members for comment.

13. FOR RATIFICATION – Lithium Prescribing.

KN presented the Lithium Prescribing Guideline for Mental Health, which had been reviewed due to reaching its review date.
KN provided a summary of changes to the guideline as follows:

- Additional details regarding the signs, management, and prevention of lithium toxicity, including highlighting the importance of patient education.
- Additional contraindications of personal or family history of Brugada syndrome.
- OTC naproxen added to the interactions section.

- New warnings regarding iodine dressings known to be contraindicated with lithium therapy added to the interactions section.
- New information on how to order the NPSA lithium therapy information pack in Primary Care.
- Updated contact details for the perinatal psychiatry service.

Members requested that the line 'obtain a booklet from your GP' was removed as General Practices rarely keep these booklets. The booklet is available in a downloadable format, and this would be made clear within the guideline as a hyperlink. The booklet is also downloadable in other languages.

Clinicians requested the incorporation of a monitoring table of information.

APC members agreed to ratify the final guideline by email.

ACTION: KN to inform the author of the changes and request the inclusion of a monitoring table. KN will email the final document to members for final ratification.

14. FOR INFORMATION – APC Forward Work Programme

The work plan was noted by APC members.

15. Any Other Business

- Membership to the NUH Primary Care Interface Group discussed.
- Emergency Steroid Card has been reviewed by Medicine safety Officers and there are no changes, so the review date will be updated to 2027.
- Pabrinex IM discontinuation – a licensed thiamine injection is now available, and the alcohol dependence guideline has been updated to include this. A full review of the guideline is due In July 2025. The interim update will be circulated via e-mail for ratification.
- AW highlighted duplication of work within CVD prevention, as well as lack of awareness of workstreams by different organisations, and non- patient- centred decision- making.

16. Next meeting dates

APC Formulary meeting: Thursday 12th December 2024 (2pm to 5pm, Microsoft Teams)
APC Guideline meeting: Thursday 16th January 2025 (2pm to 5pm, Microsoft Teams)

Meeting closed at: 17:15.