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DERBYSHIRE JOINT AREA PRESCRIBING COMMITTEE (JAPC)

Minutes of the meeting held on Tuesday, 14 July 2015

CONFIRMED MINUTES

Summary Points

Traffic lights

Drug	Decision
Budesonide multimatrix (Contiment)	RED
Levosert (levonorgestrel intrauterine system)	BLACK
Omalizumab (for previously treated chronic spontaneous urticaria)	RED (as per NICE TA 339)
Apixaban	GREEN Specialist Initiation (as per NICE TA 341) for the treatment and secondary prevention of DVT and/or PE
Ustekinumab	RED (as per NICE TA 340) for treating psoriatic arthritis
Vedolizumab (as per TA 342)	RED (as per NICE TA 342) for treating moderately to severely active ulcerative colitis
Obinutuzumab in combination with chlorambucil for untreated chronic lymphocytic leukaemia	RED (as per NICE TA 343)
Ofatumumab in combination with chlorambucil for untreated chronic lymphocytic leukaemia	RED (as per NICE TA 344)
Olaparib	RED

Clinical Guidelines

Bronchiectasis - Management of infective exacerbation of bronchiectasis of adults in primary care
Continence appliance guidelines
Management of Recurrent UTIs (RUTIs) in Adult Females

Patient Group Directions

Rotarix (rotavirus vaccine)

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Present:	
Southern Derbyshire CCG	
Dr A Mott	GP (Chair)
Mr S Dhadli	Specialist Commissioning Pharmacist (Secretary)
Mrs L Hunter	Assistant Chief Finance Officer
Mr S Hulme	Director of Medicines Management
Mrs S Qureshi	NICE Audit Pharmacist
Dr M Watkins	GP
North Derbyshire CCG	
Dr C Emslie	GP
Mrs K Needham	Head of Medicines Management North (also representing Hardwick CCG)
Ms J Town	Head of Finance
Hardwick CCG	
Dr T Parkin	GP
Ms M Simpson	Contracting Team Leader
Erewash CCG	
Dr M Henn	GP
Derby City Council	
Ms R Sokal	Acting Consultant in Public Health
Derbyshire County Council	
Derby Teaching Hospitals NHS Foundation Trust	
Dr W Goddard	Chair- Drugs and Therapeutic Committee
Derbyshire Healthcare NHS Foundation Trust	
Ms B Thompson	Pharmacist
Chesterfield Royal Hospital NHS Foundation Trust	
Mr M Shepherd	Chief Pharmacist
Derbyshire Community Health Services NHS Trust	
In Attendance:	
Mr A Thorpe	Derby City Council (minutes)

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Item		Action
1.	**APOLOGIES**	
	Ms S Bassi, Dr D Fitzsimons, Mr C Newman, Ms J Shaw, Mr M Steward and Dr S Taylor.	
2.	**DECLARATIONS OF CONFLICT OF INTEREST**	
	No declarations of interest were made. It was noted that there was no representation from Derbyshire Community Health Services NHS Trust and the meeting therefore not quorate but it was agreed that the meeting should proceed and the DCHS members contacted following the meeting to obtain their views on the decisions made.	
3.	**DECLARATIONS OF ANY OTHER BUSINESS**	
	British Medical Association guidance on duty of care.	
4.	**MINUTES OF JAPC MEETING HELD ON 9 JUNE 2015**	
	The minutes of the meeting held on 9th June 2015 were agreed as a correct record after the following amendment: Use of NOACs for Suspected DVT – Amend to: Dr Watkins queried the use of the NOACs by GPs working in the City in cases of suspected DVT.	
5.	**MATTERS ARISING**	
a.	**Grazax** Mr Dhadli reported that a Grazax referral guidance on patients receiving maximal medication treatment had been discussed by the Guideline Group and that minor changes had been made which would be conveyed to the consultants.	**SD**
b.	**Sildenafil** Mr Dhadli reported that some CCGs in neighbouring counties had been contacted to ascertain their position regarding the use of sildenafil for the treatment of digital ulceration in systemic sclerosis and whether Derbyshire was an outlier. A reply had been received from South Staffordshire CCG to indicate that its use for this unlicensed indication had not been considered but GPs would not be expected to pick up the prescribing. The position in Nottinghamshire CCG was that the decision to use should be based on where the drug was best suited to be prescribed rather than on cost. The GPs of JAPC were satisfied that the classification of RED was correct due to off-licence use, unfamiliar dose, specialist review and ongoing specialist care.	
c.	**Management of Dyspepsia** Mr Dhadli stated that the updated guidance which included new NICE cancer referrals has been sent to the consultant gastroenterologists but no feedback had been received. The updated guidance would be discussed by the Guideline Group in August and, in the event that no further feedback was received, it would be placed on the agenda for JAPC approval. Mr Dhadli would re-send the guidance to the consultant gastroenterologists to ensure that they had opportunity to comment.	**SD**

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Item		Action
6.	**NEW DRUG ASSESSMENTS**	
a.	**Budesonide Multimatrix** Mr Dhadli reported that ulcerative colitis was the most common type of inflammatory bowel disease and usually affected the rectum and a variable extent of the colon proximal to the rectum. The NICE guideline on ulcerative colitis recommended a stepped approach for inducing remission in people with mild to moderate ulcerative colitis and the choice of treatment would be guided by the site of inflammation. Treatments included topical or oral aminosalicylates as first line choice and topical corticosteroids and oral prednisolone as second line treatments. Combination treatments or immunosuppressants could also be chosen as treatment options. Budesonide multimatrix (budesonide MMX) was an oral treatment but worked topically in the colon dissolving when pH≥7 and in theory should minimise systemic absorption. The evidence was from the NICE Evidence Summary: New Medicines and was based on two eight-week, randomised, placebo and active-controlled phase III trials of similar design (CORE I and CORE II). These compared budesonide MMX with placebo in adults with mild to moderate ulcerative colitis. For the primary end point of combined clinical and endoscopic remission at week 8, budesonide MMX was statistically significantly more effective than placebo in both RCTs. The public assessment report for budesonide MMX queried the clinical importance of the 10−13% improvement over placebo. There was no statistically significant difference in clinical improvement at the secondary end point between budesonide MMX and placebo in both RCTs. The report indicated that budesonide MMX may induce remission of ulcerative colitis before systemic corticosteroids were tried which were associated with more severe adverse effects. Mr Dhadli advised JAPC that it may be advantageous to wait for the conclusions of the Contribute study which was comparing budesonide MMX with placebo as add-on therapy to 5-aminosalicyclic acid (5-ASA) in people with ulcerative colitis. Mr Dhadli reported on weaknesses in the study and in particular the uncertainty of the multimatrix budesonide MMX with 5 ASAs or its effectiveness in patients unresponsive to 5-ASAs. Where active comparators were used the study design was not powered to show a difference. During discussion Dr Goddard highlighted that a major advantage of budesonide MMX was the lack of steroid side effects. This was somewhat evidenced by the marginally raised cortisol levels and side effects comparable to placebo. Dr Parkin referred to the fairly large volume of use of steroids in primary care. Mr Hulme commented that it may be worthwhile to wait for the results of the Contribute study and leave unclassified for the time being due to the difficulty in determining the place of budesonide MMX in therapy. Mr Shepherd added that the CRHFT Drugs and Therapeutic Committee had approved the use of budesonide MMX on a concessionary basis for hospital prescribing due to the lack of compelling evidence. **Agreed:** Budesonide MMX classified as a **RED** drug until further evidence was available.	**SD**

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b.	**Levosert** Ms Sokal reported that Levosert was a levonorgestrel intrauterine system which had recently been launched in the UK for contraception and management of heavy menstrual bleeding. Levosert was directly comparable to Mirena and offered no clinical advantage in terms of safety and side-effect profile but was only licensed for three years compared to five years for Mirena. However the use of Levosert would result in an increase cost of £4,281.20 per 100 women over a five year period compared to Mirena. It was anticipated that in the future the license may be extended to five years in line with Mirena. During discussion it was recommended that a black traffic light classification be assigned for Levosert until the licence was extended to five years which would then mean it would be cheaper than Mirena. Ms Sokal advised JAPC that the City and County public health directorates funded the fitting and removal of long-acting reversible contraception (LARC) and that the budget for devices remained with the respective CCGs. Mrs Needham highlighted the need to prescribe by brand name. **Agreed:** Levosert classified as a **BLACK** device. **Agreed:** Primary care should be advised that levonorgestrel intrauterine system should be prescribed as Mirena as the brand to ensure this is the product supplied, fitted and reimbursed.	**SD** **SD**
7.	**CLINICAL GUIDELINES**	
a.	**Management of infective Bronchiectasis in Adults in Primary Care** Mr Dhadli reported that Dr Diane Harris, Lead Antimicrobial Pharmacist, had been requested by a respiratory consultant to develop new guidance on the management of infective exacerbation of bronchiectasis in adults in primary care' and that the NICE Clinical Knowledge Summary (CKS) 2013 on bronchiectasis had been used to assist with this. The guidance included the following: • Diagnosis of an infective exacerbation of bronchiectasis requiring antibiotic therapy. • Management of bronchiectasis and review of the response to treatment. • Other treatments that may be considered for use. • When to admit someone with an acute exacerbation. • Recommended antibiotics for acute infective exacerbations. • Further details and cautions. Mrs Needham suggested that it would be advantageous for the reference to people allergic to penicillin should be placed before the treatment alternatives by clarithromycin 500 mg twice a day or doxycycline (adults only) 200 mg and then 100 mg once a day. **Agreed:** JAPC ratified the management of infective exacerbation of bronchiectasis in adults in primary care.	**SD**

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Item		Action
b.	**Continence Appliance Prescribing Guidelines** Mrs Needham stated that a continence working group regularly reviewed and evaluated new continence products to ensure cost effective and appropriate prescribing of these. Mrs Needham referred to the changes which had been made to the guidance as follows: • Optismooth intermittent catheter is to replace the Speedicath. This could offer significant savings and was being piloted with a group of patients to ascertain the potential for switching. • ProSys support sleeves and catheter valves have been chosen as a replacement for Aquasleeve and Simpla flip flo. • Great Bear leg/night drainage bags have been removed as there are no sterile gloves included to ensure a sterile bag change. • Great bear fix it strap to replace the G strap. • Addition of bladder instillation kit to help with the reduction of incidences of Catheter Associated Urinary Tract Infection through administration of catheter maintenance solutions. • Normasol sachets replaced with ISO-POD. • Patient catheter passport has been rebranded and updated. Dr Parkin highlighted the need to indicate the average length for each of the products in the guidance. Mrs Needham referred to a pilot review of the use of continence products which was being undertaken in some practices in Erewash and North Derbyshire CCGs. As part of this review a reference to the length of the products used would be added to the patient notes. Mrs Needham agreed to the addition of treatment length for all appliances where possible in the guideline. A check would be made to the average length of use for leg bar straps. Dr Mott suggested that it would be useful for feedback about the switching of products when available to be conveyed to the north and south prescribing groups. **Agreed:** JAPC ratified the continence appliance prescribing guideline.	**KN** **SD**
c.	**Management of Recurrent Urinary Tract Infections (RUTIs) in Adult Females** Mr Dhadli reported that the guidance on the management of recurrent urinary tract infections in adult females had been updated by Dr Harris in January 2015. NICE had subsequently released a new UTI CKS on recurrent UTIs in adult females and the guidance had been updated in the light of this. The main changes concerned the addition of 'no visible haematuria' and 'not catheterised' to the title of the guidance and the addition of the categories of patients who require a five to ten day antibiotic course to treat their UTI. Mr Dhadli added that Dr Harris had been informed that one of the DTHFT consultant urologists no longer recommended the use of nitrofurantoin for prophylaxis of a RUTI due to the risk of pulmonary problems. The European Association of Urology (EAU) referred to the use of three antibiotics for prophylaxis which were nitrofurantoin, cephalexin (in pregnancy) and fosfomycin. Dr Harris had subsequently received advice from two consultant microbiologists from Nottingham University hospitals that both nitrofurantoin and trimethoprim for prophylaxis were still used.	

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Item		Action
	In connection with the references included in the document it was agreed that the email address for Dr Harris should be used as a contact point for these. It was also agreed that Dr Harris should be advised that minor changes to guidelines should be referred in the first instance to the Guideline Group. **Agreed:** JAPC ratified the updated guidance for the management of recurrent urinary tract Infections (RUTIs) in adult females.	**SD** **SD**
8.	**PATIENT GROUP DIRECTIONS**	
a.	**Rotavirus** Mr Dhadli advised that the Rotavirus PGD had been authorised by the Medical Director of Derbyshire and Nottinghamshire NHS England (North Midlands), as the commissioner of NHS immunisation programmes, for use across the Derbyshire and Nottinghamshire including primary care. JAPC agreed to the authorisation of the PGD. **Agreed:** JAPC agreed the Patient Group Direction for Rotavirus.	**SD**
b.	**Vitamin K** Mr Dhadli reported that a request for extension of four months for the Vitamin K PGD. This was in line with Vaccination and Immunisation PGDs to October 2015 in line with the other CCG extended PGDs for Hepatitis A, B and typhoid. **Agreed:** JAPC agreed to the four month extension to the Vitamin K Patient Group Direction.	**SD**
9.	**SHARED CARE GUIDELINES**	
a.	**Lofexidine** Ms Thompson reported that the existing shared care guideline which had expired in January 2014 had been updated to include contact details and a reference to further blood pressure monitoring if required. The shared care guideline was aimed at the GPs who were part of the locally enhanced service and GPSIs who worked with specialist services for community delivery. The current traffic light classification was Amber for use by GPSIs only. It would be necessary to extend the shared care guideline until the updated version of 'Drug misuse and dependence: UK guidelines on clinical management' ('Orange Book') was published. JAPC was requested to ratify the updated shared care guideline or advise on the continued need for this in the light of the short duration of treatment of seven days. During discussion the need to ensure that lofexidine was prescribed safely together with the need to understand what the implications would be of a change from shared care were highlighted. **Action:** Mrs Needham and Ms Thompson would look at the current level of prescribing. **Agreed:** Ratification of the shared care guideline would be delayed until enough data had been obtained and the views of City and County Public Health established concerning the commissioning of treatments for substance misuse.	**KN/BT** **SD**

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Item		Action
10.	**HORIZON SCAN**	
a.	**Monthly** Mr Dhadli advised JAPC of the following new drug launches and drug discontinuations: New drug launches in the UK: Ceftobiprole (Zevtera) – IV antibiotics. Leave unclassified until formulary inclusion was requested from Acute Trust providers. Nintedanib (Ofev) - Already classified as **RED (**NHS England but not routinely commissioned). Everolimus (Certican) – Already classified as **BLACK** Olaparib (Lynparza) – Classified as **RED** (NICE TA expected Sept 2015). Drug discontinuations: Anafranil SR (clomipramine) Sonata (zaleplon).	
b.	**NICE** Mr Dhadli advised JAPC of the following NICE clinical guidelines and NICE New Evidence summaries: Clinical guidelines: Asthma - diagnosis and monitoring expected in July 2015. Type 2 diabetes expected in August 2015; although likely to be delayed. New Evidence Summaries: Dulaglutide for type 2 diabetes which will be brought to the August meeting	**SD**
11.	**MISCELLANEOUS**	
a.	**BreatheMOR** Mr Shepherd reported that this was a heart failure study with CRHFT as one of the recruitment sites. The aim of the study was to assess the benefit of modified release morphine on patient reported breathlessness intensity in the management of patients with stable Chronic Heart Failure who are still severely symptomatic despite maximally tolerated medical therapy compared with placebo. A request for funding of the continued prescribing of 10mg twice daily modified release morphine by GPs had been made. Dr Parkin highlighted that Derbyshire JAPC did not consider excess treatment costs but offered advice about drugs included in trials. The four Derbyshire CCGs had delegated responsibility to the Primary Care Research Forum for the funding of excess treatment costs and on-going costs after completion in agreed trials. The costs would be equally split between the four Derbyshire CCGs and the contact for the Primary Care Research Forum was Ms Judy Derricott based at North Derbyshire CCG. JAPC had agreed a process for dealing with excess treatments costs which had been completed in the case of this trial: • Is the drug on the preferred formulary? Yes. • What is the financial risk to the CCGs during and on completion of the trial? For 10-20 annual cost £388.60.	

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	• Will prescribing of this drug influence GP prescribing outside the clinical trial? Highly unlikely. These patients are fragile and most likely seen in secondary care • Are there any clinical concerns that will undermine local prescribing advice? No. • Does the trial conflict with the CCGs strategic position/direction? No.	
b.	**Ezetimibe and IMPROVE-IT** Mr Dhadli advised JAPC of the IMPROVE-IT randomised, active-control, double-blind study of subjects with stabilised high-risk acute coronary syndrome which aimed to evaluate the clinical benefit of ezetimibe/simvastatin combination with statin (simvastatin) monotherapy. The trial had run from 2005 to 2010 and had demonstrated that LDL cholesterol was reduced by approximately 24%, there was a lower risk of cardiovascular events compared to statin monotherapy and there had been significant reductions in the rates of myocardial infarction and ischemic stroke. It was highlighted that the trial showed the clinical benefit of ezetimibe in patients with patient orientated outcome data. Mr Dhadli welcomed patient orientated outcome data for ezetimibe but went on to say that since the study was conducted the management of lipids had moved on to use high intensity statins which would achieve a similar response at a fraction of the cost. JAPC noted the outcome of the IMPROVE-IT trial for information. **Action:** Mr Dhadli would put a reference to the IMPROVE-IT trial in the bulletin.	**SD**
c.	**PBR Excluded Drugs – Free of Charge Scheme** Mr Dhadli reported that there were two schemes involving high cost drugs in secondary care where the manufacturers offered free of charge treatment before the publication of the relevant NICE Technology Appraisal (NICE TA). The normal practice of JAPC and commissioners would be to wait for the publication of a NICE TA and then make a recommendation as to the traffic light status of the drug. This would then be considered by the Trust Drugs and Therapeutic Committees who would decide on the appropriate pathway for treatment. Mr Dhadli discussed the pros and cons of the scheme stating that patients would benefit by gaining access to the particular drug before the publication of the NICE TA drug and therefore not having to wait. The CCGs would gain by not having to fund the drug before publication. The downside included trusts changing practice and in the event of a negative TA could be burdensome in service delivery and re-charging for existing patients remaining on treatment. For new treatments this would also mean a high impact on prescribing budgets not anticipated through horizon scan and part year effects. During discussion Dr Goddard asked whether, in the event that the free of charge scheme had commenced before the NICE Final Appraisal Determination (FAD) and the patient started on treatment as a concession before NICE approval, funding be picked up by the CCGs. Mr Dhadli advised that the historically the CCGs made an amendment to the specification to allow funding if the patient fulfilled the initiation criteria as per the NICE TA.	

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Item		Action
	This was done to enable the Acute Trust to clear the backlog of patients where the commissioning intentions were unclear. Mr Hulme highlighted a possible risk in that the scheme could possibly affect clinical decision making. Mr Dhadli stated that the drug would be free of charge but any associated activity would not. This could for example mean a day case for an IV formulation and ongoing hospital activity costs for patients should NICE not approve the treatment, even if the drug in this instance continued to be provided free of charge. Dr Mott queried the position of NHS England concerning the free of charge scheme. Mr Dhadli stated that NHS England did not have a framework for dealing with these but did consider on an individual basis. NHS England had also confirmed that there was not an equity issue associated with the free of charge scheme. Dr Mott commented that it may be advantageous to model through a previous NICE TA in order to determine the costs of both the drug and activity and ascertain the unintended consequences. It would be necessary to have a clear and consistent process. Mrs Hunter referred to the possible need for legal agreements and the possibility of the free of charge process going through the PrescQIPP process. **Agreed:** Mr Dhadli would convene a group to develop a possible process and criteria for the free of charge scheme and bring this back to JAPC.	**SD**
	Agreed: Mr Dhadli would contact PrescQIPP to ask whether they could consider these schemes in a similar structured way to the rebate process.	**SD**
d.	**<u>Prescribing Specification – Update for Biosimilar Statement</u>** Mr Dhadli advised that an addition to the prescribing specification concerning the use of biosimilars had been proposed and was based on wording which the North of England Specialised Commissioning Team Pharmacy Lead intended to add to their contract as a standard line. The statement read 'For patents expiring within year, Trusts are expected to use generic or biosimilar versions of medicines where these are available for the same licensed indication and where these are significantly (>10%) less costly than the equivalent branded medicines. Trusts should horizon scan and plan for use of such medicines through judicious stock management of branded medicines towards the end of the period of patent protection. Utilisation of generic or biosimilar medicines will be observed by commissioners and fair penalties may be imposed where such medicines are not being used.' Discussion followed during which it was agreed that a better definition of the term fair penalties was required and that there would be more advantage in highlighting gain sharing. It was important that the engagement of providers was secured in connection with this. **Agreed:** JAPC to re-consider an addition concerning biosimilars to the prescribing specification when the specification is updated for 2016/17.	**SD**

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Item		Action
e.	**Insulins MHRA** Mr Dhadli reported that the MHRA had published in April guidance on the minimisation of the risk of medication errors with high strength, fixed combination and biosimilar insulin products already on the market. The European Medicines Agency was also consulting on guidance to minimise the risk of medication error. The views of the consultant diabetologists had been obtained on the issues highlighted by the MHRA. One of these issues concerned the dose step which was a new term to define how patients dialled up the required drug dose on the prefilled pen. Dr Game, DTHFT Consultant Diabetologist, had advised that this was not really an issue as it was the dial up of the units rather than dial up of the volumes. Several new insulin products had become available including three high strength insulins which had concentrations greater than100 units/mL. It would be important that the insulin strength of these products was understood and how they should be used correctly to minimise the risk of medication errors. It was noted that one of these new high strength insulins, Toujeo, was not bioequivalent to Lantus and would be assigned a traffic light classification of Black on launch. Mr Dhadli also advised that the fixed dose combinations would also be classified as Black on launch. The biosimilar insulin Abasaglar was similar to Lantus and the recommended traffic light classification was Green 1st line glargine in all patients if cheaper in price. Switching from Lantus to Abasaglar was not recommended as routine practice currently.	
12.	**JAPC BULLETIN**	
	The June JAPC bulletin was ratified.	**SD**
13.	**MHRA DRUG SAFETY UPDATE**	
	The MHRA Drug Safety Update for June 2015 was noted. Mr Dhadli highlighted the following: • SGLT2 inhibitors (canagliflozin, dapagliflozin, empagliflozin): risk of diabetic ketoacidosis. • High-dose ibuprofen (2400mg/day): small increase in cardiovascular risk. • Intrauterine contraception: uterine perforation and updated information on risk factors.	
14.	**NICE SUMMARY**	
	Mrs Qureshi informed JAPC of the comments for the CCGs which had been made for the following NICE guidance issued in June 2015. TA 339 Omalizumab for previously treated chronic spontaneous urticaria - JAPC had previously classified this drug as RED for persistent allergic asthma. Classified as a **RED** drug for this condition. TA 340 Ustekinumab for treating active psoriatic arthritis – This was a CCG commissioned drug. Current TNF inhibitor treatment options for PSA included Adalimumab, Etanercept, Infliximab and Golimumab. Ustekinumab was recommended as an option, alone or in combination with methotrexate,	**SD**

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	for treating active psoriatic arthritis in adults only when treatment with TNF inhibitor was contra-indicated but would otherwise be considered or the patient had had treatment with one or more TNF inhibitors. The number of eligible patients in the Derbyshire CCGs had been estimated as twenty for Southern Derbyshire, twelve for North Derbyshire, four for Hardwick and four for Erewash. Classified as a **RED** drug.	**SD**
	TA 341 Apixaban for the treatment and secondary prevention of deep vein thrombosis and/or pulmonary embolism - Currently available treatments for treating and preventing DVT and PE included warfarin, LMWH, rivaroxaban and dabigatran. Apixaban provided another option and NICE did not anticipate a significant impact on resources. Rivaroxaban and dabigatran had previously been assigned a traffic light classification of Green after specialist initiation. Classified as a **GREEN** after specialist initiation drug. It was noted that it was similar to rivaroxaban but, unlike dabigatran, no dosing with LMWH was needed. Titration was needed for the dosing of apixaban as 10mg twice daily for seven days, 5mg twice daily for at least three months and 2.5mg for those that had completed six months and for prevention of recurrence.	**SD**
	TA 342 Vedolizumab for treating moderately to severely active ulcerative colitis – This was a CCG commissioned drug. Current treatment options included infliximab, adalimumab and golimumab. Vedolizumab offered an additional treatment option for treating moderately to severely active ulcerative colitis for patients who had had an inadequate response or lost response to or who were intolerant to either conventional therapy or a TNF inhibitor. It was anticipated that there would be increased drug costs for the CCGs. Classified as a **RED** drug.	
	TA 343 Obinutuzumab in combination with chlorambucil for untreated chronic lymphocytic leukaemia – Classified as a **RED** drug (NHS England high cost drug).	**SD**
	TA 344 Ofatumumab in combination with chlorambucil or bendamustine for untreated chronic lymphocytic leukaemia – Classified as a **RED** drug (NHS England high cost drug).	**SD**
	CG 92 Venous thromboembolism in adults admitted to hospital: reducing the risk – This was an update of the current guidance. It was highlighted that do not do recommendations on mechanical prophylaxis for VTE had been included regarding use of foot impulse and neuro-muscular electrical stimulation devices.	**SD**
	CG 97 Lower urinary tract symptoms in men: assessment and management – The do not do recommendation referred to the use of pde-5 inhibitors for lower urinary tract infections unless undertaken as part of a trial.	
	NG8 Anaemia management in people with chronic kidney disease – This offered evidence-based advice on the diagnosis and management of anaemia of chronic kidney disease. Hypochromic red blood cell (HRC) testing was recommended and was anticipated to lead to more accurate diagnosis because of the considerably higher sensitivity and specificity of HRC testing.	

Item		Action
	NG12 Suspected cancer: recognition and referral – This outlined recommendations for the recognition and selection for referral or investigation in primary care of people of all ages, including children and young people who may have cancer. It included the increased use of thresholds and was expected to significantly increase the number of diagnostic tests and referral for suspected cancer.	
15.	**TRAFFIC LIGHTS – ANY CHANGES?**	
	Classifications Budesonide multimatrix – RED Levosert – BLACK Omalizumab for previously treated chronic spontaneous urticaria – RED (as per TA 339) Ustekinumab – RED (as per TA 340) Apixaban – GREEN Specialist Initiation (as per TA 341) Vedolizumab – RED (as per TA 342) Obinutuzumab in combination with chlorambucil for untreated chronic lymphocytic leukaemia – RED (as per TA 343) Ofatumumab – RED (as per TA 344) Olaparib - RED	
16.	**JAPC ACTION SUMMARY**	
	The action summary was noted by JAPC and amendments made: Aripiprazole and pregabalin – To remain on. Lithium monitoring – On the DHcFT workplan. PGDs – To be brought to the October JAPC meeting. NICE CG 28 depression in children and young people – To be brought to the August JAPC meeting. GOR(D) adult new NICE cancer referral criteria – September 2015 Hyperprolactinaemia – Mr Dhadli to contact Dr Stanworth. To be brought to the August JAPC meeting. Biosimilars and Gain Sharing Derbyshire Framework – To be brought to the August JAPC meeting. Grazax – To be agreed at Guideline Group Glaucoma guidance – To be brought to the September JAPC meeting.	**SD** **SD** **SD** **SD** **SD** **SD**
17.	**GUIDELINE GROUP**	
	The summary of key messages arising from the meeting held in June 2015 was noted. Mr Dhadli highlighted that Sukkarto SR (metformin SR), Eppinix XL (ropinirole XL) and Luventa XL (galantamine XL) had been accepted by the Guideline Group as preferred branded modified release products.	

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Item		Action
18.	**MINUTES OF OTHER PRESCRIBING GROUPS**	
	• DHcFT Drugs and Therapeutic Committee 28/05/15 • DTHFT Drugs and Therapeutic Committee 19/05/15 • DCHS Medication Operational Safety Team 20/05/15 • South Staffordshire Area Prescribing Group 10/06/15	
19.	**ANY OTHER BUSINESS**	
	Dr Mott referred JAPC to the recently published guidance from the British Medical Association on clinical good practice concerning prescribing and responsibility for chasing test results. Mr Dhadli would circulate the guidance to members.	**SD**
20.	**DATE OF NEXT MEETING**	
	Tuesday, 11th August 2015 at 1.30pm in the Post Mill Centre, South Normanton.	