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DERBYSHIRE JOINT AREA PRESCRIBING COMMITTEE (JAPC)

Minutes of the meeting held on 9th February 2016

CONFIRMED MINUTES

Summary Points

Traffic lights

Drug	Decision
Ivermectin cream	GREEN (with review at three months)
Idarucizumab	RED
Isavuconazole	RED (NHS England commissioned drug)
Trametinib	RED (NHS England commissioned drug)
Sacubitril valsartan	UNCLASSIFIED awaiting NICE TA
Adalimumab	RED as per NICE TA 375
Etanercept	RED as per NICE TA 375
Certolizumab	RED as per NICE TA 375
Infliximab (and biosmiliar)	RED as per NICE TA 375
Golimumab	RED as per NICE TA 375
Tocilizumab	RED as per NICE TA 375
Abatacept	RED as per NICE TA 375
Radium - 223 dichloride	RED as per NICE TA 376
Enzalutamibe	RED as per NICE TA 377
Ramucirumab	BLACK as per NICE TA 378
Nintedanib	RED as per NICE TA 379
Panobinostat	RED as per NICE TA 380
Olaparib	RED as per NICE TA 381
Eltrombopag	BLACK as per NICE TA 382

Clinical Guidelines
Chlamydia Testing and Screening Management
Management of Non-malignant Chronic Pain
Management of Neuropathic Pain in Primary Care

Patient Group Directions
Administration of diphtheria, tetanus, acellular pertussis and inactivated poliomyelitis vaccine (DTaP/IPV or dTaP/IPV).
Administration of diphtheria, tetanus, acellular pertussis, inactivated poliomyelitis and Haemophilus influenzae type b conjugate vaccine (Dap/IPV/Hib)
Administration of low dose diphtheria, tetanus, acellular pertussis and inactivated poliomyelitis vaccine (dTaP/IPV).
Extension of Pneumococcal Ploysaccharide Vaccine (PPV)

Shared Care Guidelines
Naltrexone for Alcohol Abstinence

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Present:	
Southern Derbyshire CCG	
Dr A Mott	GP (Chair)
Mr S Dhadli	Specialist Commissioning Pharmacist (Secretary)
Mr S Hulme	Director of Medicines Management **(also representing Erewash CCG)**
Mrs S Qureshi	NICE Audit Pharmacist
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
Derby City Council	
Dr R Dewis	Consultant in Public Health Medicine
Derbyshire County Council	
Derby Teaching Hospitals NHS Foundation Trust	
Dr W Goddard	Chair - Drugs and Therapeutic Committee
Mr C Newman	Chief Pharmacist
Derbyshire Healthcare NHS Foundation Trust	
Dr S Taylor	Chair – Drugs and Therapeutic Committee
Chesterfield Royal Hospital NHS Foundation Trust	
Mr M Shepherd	Chief Pharmacist
Derbyshire Community Health Services NHS Foundation Trust	
Mr M Steward	Head of Medicines Management
In Attendance:	
Mr N Howes	Commissioning Manager, Derbyshire County Council
Mr A Thorpe	Derby City Council (minutes)

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Item		Action
1.	**APOLOGIES**	
	Ms S Bassi, Dr M Henn, Mrs L Hunter, Ms H Murch, Dr T Parkin and Dr M Watkins.	
2.	**DECLARATIONS OF CONFLICT OF INTEREST**	
	No declarations of interest were made.	
3.	**DECLARATIONS OF ANY OTHER BUSINESS**	
	• PGD vaccine PPV - date extension.	
4.	**MINUTES OF JAPC MEETING HELD ON 12 JANUARY 2016**	
	The minutes of the meeting were agreed as a correct record after the following amendments: Addition of Ms J Town to the list of members present. Diamorphine - Amend to: 'It was noted that Manor Pharmacy, as suppliers of syringe drivers to Erewash, had plenty of stock of diamorphine.'	
5.	**MATTERS ARISING**	
a.	**Dental Prescribing Letter** Dr Mott advised that a letter on behalf of JAPC had been sent to the Clinical Director at Charles Clifford Dental Hospital in Sheffield to highlight that Derbyshire GPs should not be requested to prescribe fluoride products for patients. This had subsequently been confirmed in a further email. Mr Steward stated that a request had been made for these products to be assigned a traffic light classification of GREEN specialist initiation so that they could be prescribed by dentists in DCHSFT. It was agreed that JAPC should look further at the evidence before any decision was made concerning a change to the traffic light classification - this would be added to the action tracker.	**SD**
b.	**HRT Advice** Ms Town reported that a county-wide HRT/menopause clinic was located in Buxton operated by DCHSFT. Referrals could be made to the clinic via Choose and Book and the service was block contracted to DCHSFT with costs split between North Derbyshire and Hardwick CCGs, together with a contribution of £5K from Southern Derbyshire CCG. It was noted that no patients had been referred from Erewash CCG.	
c.	**Immunomodulating Drugs** Mr Dhadli reported that the immunomodulating drugs had been sent to the consultants for comment. It was noted that this would inevitably be a time consuming process.	
d.	**Ulipristal** Mr Dhadli reported that NICE were due to issue a clinical guideline on heavy menstrual bleeding. A SMC review had also been published which accepted ulipristal acetate for use within NHS Scotland for the reduction of uterine bleeding in pre-operative women with uterine fibroids and excessive bleeding. A draft guideline with the positioning of ulipristal has been produced by Miss Parratt at CRHFT; comments awaited from DTHFT gynaecologists.	

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Item		Action
6.	**SHARED CARE GUIDELINE**	
a.	**Naltrexone for Alcohol Abstinence** Mr Howes reported that it had been discovered that the Addaction alcohol service were not offering naltrexone which was contrary to NICE guidance. Addaction already had shared care protocols in place for the use of acamprosate and disulfiram but not for naltrexone. Naltrexone was licensed as a treatment adjunct to prevent relapse in formerly alcohol-dependent patients initiated under specialist supervision following detoxification from alcohol. It had been recommended by NICE in CG 115. A shared care guideline for the use of naltrexone in Derbyshire had therefore been developed for use by Addaction with the prescribing to be transferred to primary care after an initial period of treatment. It was noted that naltrexone was already classified as AMBER for substance misuse. Dr Mott clarified that the shared care guideline was for use in the County but not City, and that there was no current prescribing budget in general practice. This service is commissioned by Public Health, not CCGs. Mr Howes stated that some of the people who would have been initiated on acamprosate would now be given naltrexone instead so this would not be a new category of patients and the budget could be re-charged back to County public health as commissioners. It was noted that the financial aspects would require further work in terms of quantifying how many patients were involved and what was being charged for. It was also queried whether naltrexone required a shared care guideline although Dr Emslie advised that some GPs may need the support of a shared care guideline due to the fact that naltrexone was an unfamiliar drug to them. In connection with the specialist responsibilities section in the shared care guideline, Dr Emslie highlighted the need to clarify the nature of the physical assessment to be carried out by the GP and for a mechanism for conveying the results of this to the Addaction Alcohol Team. Dr Mott commented that it was the responsibility of the initial prescriber to check that a patient was physically able and well enough to take the drug. Mr Newman queried the reference in the communication and support section to attendance at Accident and Emergency and that the non-emergency 111 or out of hours GP services should be accessed instead. Dr Dewis explained that an email response had been received from Dr Senthil Mahalingham, lead consultant for the Derby City Alcohol Service, who had indicated that there was very limited prescribing and instead social behavioural work network therapy and motivational enhancement therapy were used for alcohol dependence. GPs in the City would therefore not be requested to prescribe naltrexone. **Agreed:** JAPC ratified the naltrexone shared care guideline for the maintenance of alcohol abstinence with the agreed amendments concerning the physical assessments and conveyance of results.	**SD**

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7.	NEW DRUG ASSESSMENTS/TRAFFIC LIGHT CLASSIFICATIONS	
a.	**Ivermectin** Mr Dhadli advised that some requests for the use of ivermectin cream had now been received for the treatment of rosacea, a chronic relapsing disease of the facial skin which was characterised by recurrent episodes of facial flushing, persistent erythema, telangiectasia, papules and pustules. Current treatment for mild to moderate papulopustular rosacea was with a topical drug such as metronidazole or azelaic acid. For moderate or severe papulopustular rosacea oral tetracycline, erythromycin, doxycycline or lymecycline could be prescribed. A NICE Evidence Summary of New Medicines on ivermectin cream had been published and the evidence came from two randomised controlled trials (RCTs) of identical design which compared ivermectin with placebo and a randomised active-comparator trial which compared ivermectin with metronidazole cream. Information on long-term safety, efficacy and recurrence rates was supplied by one 36 week and two 40 week extension studies. In the two RCTs ivermectin had been statistically significantly more effective than placebo in the improvement of rosacea score, reduction in lesion counts and a Investigator Global Assessment (IGA) score of 0 or 1 (clear or almost clear). From a baseline of approximately 32 lesions people treated with ivermectin had a reduction at twelve weeks of approximately 8.2 fewer inflammatory lesions for ivermectin compared with placebo. There were some patient orientated outcomes and 68% of patients had recorded excellent and 32% good. Dermatology Life Quality Index (DLQI) scores had also been used but these had not been poor so large improvements would not be expected. A further sixteen week randomised, investigator-blinded study had been undertaken to compare the efficacy of ivermectin with metronidazole 0.75% cream which was applied twice daily. IGA scores and lesion clearance rates had been utilised and those people who had used ivermectin had a 83% reduction in inflammatory lesion count as opposed to a reduction of 73.7% in those who had been given metronidazole. It was noted that side effects of ivermectin were common but not severe. Ivermectin had been left unclassified by JAPC in September 2015 and it was noted that, although more expensive than current treatments such as metronidazole cream, it only needed to be applied once-daily. Mrs Needham highlighted that some GPs had advised that ivermectin was a useful drug but should only be used for up to four months and stopped after three months if there was no improvement. Its use could also help to reduce the need for antibiotics. **Agreed:** Ivermectin cream classified as a **GREEN** drug with review of effectiveness at three months and stop the course of treatment at four months.	**SD**
b.	**Vortioxetine** Dr Taylor reported that vortioxetine was a treatment option for those patients who had shown inadequate response to two anti-depressants within the current episode.	

	A traffic light classification of RED had been recommended by the DHcFT Drugs and Therapeutic Committee as a third line antidepressant option in accordance with NICE TAG 367 for specialist use only. **Agreed:** The current traffic light classification of **RED** to continue for vortioxetine.	**SD**
8.	**CLINICAL GUIDELINES**	
a.	**Chlamydia** Dr Dewis reported that the guideline for chlamydia testing and screening management had been discussed by JAPC at the December 2015 meeting and some clarification had been requested on some points. JAPC noted the main changes which had been made to the guideline: • Addition of ceftriaxone in the light of the recent public health guidance on antimicrobial resistance. • Inclusion of advice at the top of the guideline to strongly advise that any patient diagnosed with Chlamydial infection should be referred to the specialist service but also to include advice for the treatment of those patients who would not attend. • Suspected Chlamydial PID - doxycycline 100mg bd to be given for fourteen days and metronidazole 400mg bd for fourteen days but consider seven days if there were significant side effects. • Endocervical or vulvovaginal swabs if having a vaginal examination and self taken vaginal swab or first void urine only to be used if the laboratory used the nucleic acid amplification test. Dr Mott highlighted the need to inform general practice that there was a more sensitive sampling method which should reduce the number of false negatives. • Removal of individual contacts and inclusion of reference to the Integrated Sexual Health Service which can be contacted via the central booking and information line. An issue concerning how calls could be conveyed to an adviser was being resolved by the service. **Agreed:** JAPC ratified the clinical guideline for chlamydia testing and screening management with the agreed changes and a two year extension.	**SD**
b.	**Chronic Pain** Mr Dhadli stated that the local guidance for both the management of non-malignant chronic pain and managing neuropathic pain in primary care had been updated in the light of recommendations from the Faculty of Pain Medicine. The guidance had also been sent to Dr R Faleiro and Dr I Makkison, Derbyshire pain consultants, for comment. The main changes in the non-malignant pain guidance were outlined: • The World Health Organisation (WHO) 3-step 'ladder' approach previously adopted for non-cancer pain management not to be followed. • A trial of opioid therapy to be considered if the clinician and patient agreed that a trial could be effective in the management of the patient's pain. This would include starting the trial; patient assessment; duration of opioid route, formulation and dose and assessment whether the trail had been successful. • Management of opioid-induced adverse effects including the long term association of opioid use with endocrine abnormalities.	

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	During discussion Dr Mott commented that it would be useful for GPs to be aware of endocrine symptoms associated with opioid use during patient medicine reviews. Dr Mott also queried the ceiling dose for the use of oral morphine in primary care as 60mg/day and suggested that, if it was established that the pain was opioid receptive, then the dose could be increased above this level. It was agreed that the dose should not be increased beyond 120mg and referral to the pain clinic should then be considered. Mr Newman queried the bullet point in the first page of the guideline which stated that a medicine should be stopped and the dose not increased if it did not work for the patient. It was agreed that this should be amended to read 'after a suitable trial'. Mr Hulme commented that it would be helpful if medicines management produce a detailing aid to support education and implementation **Agreed**: JAPC ratified the clinical guideline for the management of non-malignant chronic pain with the agreed changes and amendments.	**SD**
c.	**<u>Neuropathic Pain</u>** Mr Dhadli advised that a section on opioid monitoring had been included in appendix one in the guideline. It was highlighted that the chronic pain guideline and neuropathic pain guideline should cross-reference each other. **Agreed:** JAPC ratified the clinical guideline for the management of neuropathic pain with the agreed amendment.	**SD** **SD**
9.	**PATIENT GROUP DIRECTIONS**	
a.	The Public Health England/NHS England Patient Group Directions for the following PGDs were noted and agreed by JAPC: • Administration of diphtheria, tetanus, acellular pertussis and inactivated poliomyelitis vaccine (DTaP/IPV or dTaP/IPV). • Administration of diphtheria, tetanus, acellular pertussis, inactivated poliomyelitis and Haemophilus influenzae type b conjugate vaccine (DTaP/IPV/Hib) • Administration of low dose diphtheria, tetanus, acellular pertussis and inactivated poliomyelitis vaccine (dTaP/IPV). • Pneumococcal Ploysaccharide Vaccine (PPV) **Action:** The Patient Group Directions would be placed on the Medicines Management website.	**SD**
10.	**MONTHLY HORIZON SCAN**	
a.	**<u>Monthly</u>** Mr Dhadli advised JAPC of the following new drug launches, new drug formulations and drug discontinuations: New drug launches in the UK: Idarucizumab (Praxbind) – For the reversal of anticoagulant effect of dabigatran before urgent procedures or in life-threatening or uncontrolled bleeding. The use in hospitals to be determined via the Trust Drug and Therapeutic Committees. CCG commissioned line. Classified as **RED.** Isavuconazole (Cresemba) – NHS England: not routinely commissioned. Classified as **RED.** Sacubitril valsartan (Entresto) – For symptomatic chronic heart failure with reduced ejection fraction in adults. NICE TA expected in May 2016.	**SD** **SD**

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	CCG commissioned line. To remain as unclassified. Trametinib (Mekinist) – NHS England. Classified as **RED.**	**SD**
b.	**NICE** The Clinical Guidelines, NICE Technology Appraisals and NICE New Evidence Summaries were noted for information.	
11.	**MISCELLANEOUS**	
a.	**Derbyshire Health United Drug Request** A request had been made by the Out of Hours Service for the use of clarithromycin 500 mg tablets for the treatment of cellulitis in cases of penicillin allergy. This is in line with JAPC's primary care formulary. **Agreed:** JAPC approved the use of clarithromycin 500 mg tablets for the treatment of cellulitis in cases of penicillin allergy for DHU.	**SD**
b.	**Shingles and Flu Vaccines in People Taking Immunosuppressive Treatments** JAPC noted the Trent Medicines Information Service Rapid Communication for shingles and flu vaccines in people taking immunosuppressive treatments including cancer therapies.	
12.	**JAPC BULLETIN**	
	The following additions and changes in the bulletin were noted: Dental Prescribing – 'JAPC does not support the prescribing of dental products at the request of dentists. Fluoride mouthwashes, oral drops, tablets and toothpastes have previously been classified as BLACK. The Charles Clifford Dental Hospital in the North of Derbyshire is being reminded of the advice which has previously been communicated to Derbyshire community dental practices'. Toujeo (High Strength Insulin Glargine) – 'Toujeo has been reclassified from BLACK to BROWN after specialist/consultant initiation following a proposal by Derbyshire diabetologists for use in a select group of patients. These have been identified as those on either insulin degludec, being considered for an insulin pump or currently on high doses of insulin (>150 units/day) who would otherwise be started on Humulin R U500 or degludec. Patients will be selected and initiated on treatment by secondary clinicians only.' Gonorrhoea and Antimicrobial Resistance – 'The DoH has written to prescribers highlighting a 'resistance alert' related to an outbreak of azithromycin resistant gonorrhoea. Normally under the supervision of a GUM clinic azithromycin should be prescribed with injectable ceftriaxone.' Nefopam – Change to: 'Due to a significant rising cost, availability and a lack of evidence following a review of the evidence base JAPC has restricted the position of nefopam (now BROWN) as a treatment option only in patients with contraindications or intolerance to NSAIDs or opiates. Local pain consultants do not advocate the use of nefopam. Historically nefopam was used as a step change before moving onto toxic NSAIDS and strong opiates.	

	Nefopam is no longer considered to be cost effective. The classification of BROWN will alert prescribers to re-consider its use in new patients and as a reminder to review existing patients to consider alternative treatments.' The January JAPC bulletin was ratified with the agreed amendments.	**SD**
13.	**MHRA DRUG SAFETY UPDATE**	
	The MHRA Drug Safety Update for January 2016 was noted. Mr Dhadli highlighted the following: • Nicorandil (Ikorel) - now second-line treatment for angina; risk of ulcer complications. • Levonorgestrel-releasing intrauterine systems - prescribe by brand name.	
14.	**NICE SUMMARY**	
	Mrs Qureshi informed JAPC of the comments for the CCGs which had been made for the following NICE guidance issued in January 2016: TA 375 Adalimumab, etanercept, infliximab, certolizumab pegol, golimumab, tocilizumab and abatacept for rheumatoid arthritis not previously treated with DMARDs or after conventional DMARDs only have failed - This TA replaced NICE technology appraisal guidance on: • Adalimumab, etanercept and infliximab for the treatment of rheumatoid arthritis (TA130) • Certolizumab pegol for the treatment of rheumatoid arthritis (TA186) • Golimumab for the treatment of methotrexate-naive rheumatoid arthritis (TA224) • Abatacept for treating rheumatoid arthritis after the failure of conventional disease-modifying anti-rheumatic drugs (TA280). The TA also partially updated golimumab for the treatment of rheumatoid arthritis after the failure of previous disease-modifying anti-rheumatic drugs (TA225) and tocilizumab for the treatment of rheumatoid arthritis (TA247). It was noted that whenever a biosimilar product became available it would be covered by the TA. It was noted further that treatment now should only be continued if there was a moderate response measured using the European League Against Rheumatism (EULAR) criteria at six months after starting therapy. It was highlighted that NICE had recommended that EULAR replace the currently used Disease Activity Score (DAS) which was an assessment used by clinicians to measure rheumatoid arthritis disease activity in order to determine whether the signs and symptoms have reduced or stopped and if treatment needs to be adjusted. This was a significant change to current practice of disease assessment and further work would need to be undertaken to project future activity. It was noted that treatment should be started with the least expensive drug and NICE considered that there would be no significant change in resource use for the NHS as a result of the guidance as it was believed that the recommendations covered current clinical practice. Classified as a **RED** drug. TA 376 Radium – 223 dichloride for treating hormone-relapsed prostate cancer with bone metastases. Classified as a **RED** drug (NHS England).	**SD** **SD**

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	TA 377 Enzalutamide for treating metastatic hormone-relapsed prostate cancer before chemotherapy is indicated. Classified as a **RED** drug (NHS England).	**SD**
	TA 378 Ramucirumab for treating advanced gastric cancer or gastro–oesophageal junction adenocarcinoma previously treated with chemotherapy – Not recommended by NICE. Classified as a **BLACK** drug (NHS England).	**SD**
	TA 379 Nintedanib for treating idiopathic pulmonary fibrosis. Classified as a **RED** drug (NHS England).	**SD**
	TA 380 - Panobinostat for treating multiple myeloma after at least 2 previous treatments. Classified as a **RED** drug (NHS England).	**SD**
	TA 381 - Olaparib for maintenance treatment of relapsed, platinum-sensitive, BRCA mutation-positive ovarian, fallopian tube and peritoneal cancer after response to second-line or subsequent platinum based chemotherapy. Classified as a **RED** drug (NHS England).	**SD**
	TA 382 - Eltrombopag for treating severe aplastic anaemia refractory to immunosuppressive therapy (terminated appraisal) – Terminated appraisal. Classified as **BLACK** drug.	**SD**
	NG 33 – Tuberculosis. It was noted that this would be mostly secondary care led.	
15.	**TRAFFIC LIGHTS – ANY CHANGES?**	
	Classifications Ivermectin cream – **GREEN** (with review at three months) Vortioxetine – **RED** Idarucizumab – **RED** Isavuconazole – **RED** Trametinib – **RED** Sacubitril valsartan – **UNCLASSIFIED** Adalimumab – **RED** as per NICE TA 375 Etanercept – **RED** as per NICE TA 375 Infliximab (and biosmiliar) – **RED** as per NICE TA 375 Certolizumab – **RED** as NICE TA 375 Golimumab – **RED** as per NICE TA 375 Tocilizumab – **RED** as per NICE TA 375 Abatacept – **RED** as per NICE TA 375 Radium 223 dichloride - **RED** as per NICE TA 376 Enzalutamibe – **RED** as per NICE TA 377 Ramucirumab – **BLACK** as per NICE TA 378 Nintedanib – **RED** as per NICE TA 379 Panobinostat – **RED** as NICE TA 380 Olaparib – **RED** as per NICE TA 381 Eltrombopag – **BLACK** as per NICE TA 382	

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16.	**JAPC ACTION SUMMARY**	
	The action summary was noted by JAPC and amendments made: Grazax – To be brought to the June 2016 meeting. Immunomodulating drugs – Consultant Rheumatologists to be asked for their views on a rolling basis. Pain – To be taken off the list. Chlamydia Guidance – To be taken off the list. LMWH bridging guidance – To be brought to the March 2016 meeting. Ulipristal for uterine fibroids – To be brought to the March 2016 meeting. Diabetes Guidance – To be brought to the April 2016 meeting.	**SD** **SD** **SD** **SD** **SD** **SD**
17.	**GUIDELINE GROUP**	
	The summary of key messages from the Derbyshire Medicines Management Guideline Group meeting held in January 2016 was noted. Mr Dhadli highlighted the following: • Carbocisteine sachets had been included in the respiratory formulary. • Anticoagulants and dental extractions - A link on the Medicines Management website to the Scottish guidance on anticoagulants and dental extraction had been included.	
18.	**MINUTES OF OTHER PRESCRIBING GROUPS**	
	• DHcFT Drugs and Therapeutic Committee 22/10/15 • DHcFT Medicines Safety Committee 26/11/15 • DTHFT Drugs and Therapeutic Committee 15/12/15 • Burton Hospitals Drugs and Therapeutic Committee 11/01/16 • CRHFT Drugs and Therapeutic Committee 19/01/16 • Clinical Commissioning Policy Advisory Group 14/01/16 Mr Dhadli highlighted the following: DHcFT Medicines Safety Committee: • Physical monitoring of medicines – review of physical monitoring in the first twelve months of antipsychotic treatment. • Net formulary - To provide DHCFT healthcare professionals with clear guidance on which mental health medicines are recommended for use in the DHCFT/Derbyshire with links to useful local guidelines, national documents, Choice and Medication website and the DHCFT Medicines Code. • Summary Care Record – Issues concerning patient consent to enable individual data to be stored in the Shared Care Record database and for health professionals to access the information being taken forward. • Identification of issues concerning antimicrobial resistance via the implementation of an antimicrobial stewardship programme. • Safer use of controlled drugs.	

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19.	**ANY OTHER BUSINESS**	
a.	**Rivaroxaban** Mr Dhadli explained that it had now been revealed that the ROCKET AF rivaroxaban trial had used a faulty point-of-care device to measure INR in its comparator arm of patients taking warfarin and this may have made warfarin results look worse than they otherwise would have been. However the EMA had undertaken a review and concluded that the effect on the study had been marginal and the safety of rivaroxaban (Xarelto) remained unchanged.	
b.	**Zika** Mr Dhadli reported that a letter had been sent by NHS England to all clinicians about the zika virus.	
18.	**DATE OF NEXT MEETING**	
	Tuesday, 8th March 2016 at 1.30pm in the Post Mill Centre, South Normanton.	