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DERBYSHIRE JOINT AREA PRESCRIBING COMMITTEE (JAPC)

Minutes of the meeting held on Tuesday 12 January 2016

CONFIRMED MINUTES

Summary Points

Traffic lights

Drug	Decision
Nefopam	**BROWN 3rd line** with exceptionalities
Toujeo	**BROWN** after specialist/consultant initiation
Oxybutynin patches	**BROWN** for patients unable to tolerate oral medication
BLI-800 bowel cleansing preparation	**RED**
Carfilzomib	**RED**
Ceftolozane + tazobactam	**RED**
Ciclosporin eye drops	**RED** as per NICE TA369
Bortezomib	**RED** as per NICE TA 370
Trastuzumab emtansine	**BLACK** as per NICE TA 371
Apremilast	**BLACK** as per NICE TA 372
Abatacept, Adalimumab, Etanercept and Tocilizumab	**RED** as per NICE TA 373
Erlotinib	**RED** as per NICE TA 374
Gefitinib	**BLACK** as per NICE TA 374
Elosulfase alfa	**RED** as per NICE HST2
All Homeopathy Treatments	**BLACK**

Clinical Guidelines (Updated)

Dapoxetine position statement
Derbyshire Nebuliser Guidelines for COPD Patients - Assessment and Initiation
Primary Care Management of Overactive Bladder (OAB)
Proton Pump Inhibitors - Advisory Guidance on when to initiate a PPI with a NSAID (or antiplatelet)

Patient Group Directions

Influenza, Fluenz Tetra and Intanza

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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)
Mr J Town	Head of Finance
Hardwick CCG	
Dr T Parkin	GP
Erewash CCG	
Ms H Murch	Lead Pharmacist
Derby City Council	
Dr R Dewis	Consultant in Public Health Medicine
Derbyshire County Council	
Derby Hospitals NHS Foundation Trust	
Derbyshire Healthcare NHS Foundation Trust	
Ms B Thompson	Secretary - Drugs and Therapeutic Committee
Chesterfield Royal Hospital NHS Foundation Trust	
Mr M Shepherd	Chief Pharmacist
Derbyshire Community Health Services NHS Trust	
Mr M Steward	Head of Medicines Management
In Attendance:	
Mr A Thorpe	Derby City Council (minutes)

It was noted that there was no representation from DTHFT because of the Junior Doctor's strike, but it had been agreed that post meeting ratification of the decisions would be made by the members of JAPC from the Trust.

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Item		Action
1.	**APOLOGIES**	
	Ms D Bennett, Dr W Goddard, Dr M Henn and Mr C Newman.	
2.	**DECLARATIONS OF CONFLICT OF INTEREST**	
	No declarations of interest were made.	
3.	**DECLARATIONS OF ANY OTHER BUSINESS**	
	• Diamorphine Shortage. • Winterbourne Update. • Patient Group Directions.	
4.	**MINUTES OF JAPC MEETING HELD ON 8 DECEMBER 2015**	
	The minutes of the meeting held on 8th December 2015 were agreed as a correct record.	
5.	**MATTERS ARISING**	
a.	**Bridging Therapy for Low Weight Molecular Heparin (LWMH)** Mr Dhadli advised that Dr Goddard had agreed to check whether Dr McKernan wished to comment on the draft LMWH bridging guidance. This had been added to the JAPC action tracker.	**WG**
b.	**Promixin** Mr Shepherd commented that the proposed use of Promixin as a second line option to colomycin in the shared care guideline for the treatment of pseudomonas aeruginosa lung infections in adults with bronchiectasis who were non cystic fibrosis patients should remain unchanged.	
c.	**Ulipristal Acetate for Uterine Fibroids** Mr Shepherd reported that a pathway for the use of ulipristal acetate in the treatment of uterine fibroids had been developed and sent to a consultant gynaecologist at DTHFT for comment. This pathway would be brought to the February JAPC meeting for discussion.	**SD**
d.	**Chlamydia Testing and Screening Management** The amended guidelines would now be brought to the February JAPC meeting for further discussion.	**RD/SD**
e.	**Guidance for Blood Glucose Lowering Therapy in Adults with Type 2 Diabetes** Mr Dhadli reported that the diabetes guidance was being updated in light of NICE NG 28. Before presentation to JAPC both the consultants from DTHFT and CRHFT, and the Guideline Group, would need to agree the content.	**SD**
6.	**NEW DRUG ASSESSMENTS/TRAFFIC LIGHT ADDITIONS**	
a.	**Update from DTB and SMC Reviews** Mr Dhadli stated that it had been agreed that JAPC would review the drugs included in the horizon scan in the light of the publication of any peer reviews. Two Drug and Therapeutic Bulletin (DTB) reviews and one review from the Scottish Medicines Consortium (SMC) had been published on catephen for external genital warts, ciclosporin eye drops for dry eyes and naloxegol for opioid induced constipation. **Green tea extract for external anogenital warts (Catephen):**	

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	Mr Dhadli reported that catephen had been highlighted in the December 2015 horizon scan and assigned a traffic light classification of BLACK while a public health review was undertaken. Catephen is a herbal medicinal product consisting predominantly of catechins (sinecatechins) extracted from the green tea leaf formulated as a topical preparation for the treatment of external genital and perianal warts. Current drug treatment options included imiquimod 5% cream and podophyllotoxin 0.15% cream but these had limited efficacy and high recurrence rates and adverse effects. Evidence came from three randomised double-blind placebo-controlled studies which evaluated the efficacy and safety of topical sinecatechins for the treatment of external anogenital warts. The randomised controlled trials showed the licensed topical formulation of green tea extract resulted in complete clearance of external anogenital warts between 34 to 47% of patients compared to approximately 35% treated with placebo. The DTB had concluded that there was currently insufficient evidence to recommend catephen in preference to existing topical therapies. Mr Dhadli referred to the British Association for Sexual Health and HIV (BASHH) guidance on the treatment of external genital warts which included catephens as a treatment option although there was no reference to it in any algorithm of treatment. Podophyllotoxin was an option for initial treatment and there was a NICE Evidence Summary of New Medicines which referred to catephens as the most costly treatment option together with the lack of published comparisons with other active treatments for genital and perianal warts. Mr Dhadli reminded JAPC that referral to specialist genitourinary services is recommended for all people with anogenital warts. **Agreed:** The previously assigned classification of **BLACK** would remain unchanged due to lack of evidence and cost effectiveness compared with standard therapy. **Ciclosporin Eye Drops**: Mr Dhadli advised that NICE had published TA 369 which recommended ciclosporin eye drops (Ikervis) as an option for the treatment of severe keratitis in adult patients with dry eye disease that has not improved despite treatment with tear substitutes. The SMC review referred to the evidence which came from a pivotal phase III double-masked study (SANSIKA) which looked at the modified Oxford scale and the Ocular Surface Disease Index as a marker for improvement using the corneal fluorescent staining technique. Mr Dhadli highlighted that the primary outcomes had not been achieved in the pivotal study and for one co-primary outcome in the supportive study. Evidence of efficacy was derived from secondary outcomes, post-hoc and subgroup analyses. It was noted that the evidence from these types of analyses could be less robust in nature. **Agreed:** This supported the classification of **RED** as per NICE TA 369. **Naloxegol**:	

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	Mr Dhadli advised that naloxegol had a dual classification of BROWN for the treatment of opioid induced constipation in palliative care and RED for other specialities such as pain and gastro-intestinal conditions. Naloxegol was a peripherally acting mu-opioid receptor antagonist licensed for the treatment of opioid-induced constipation in adults who had an inadequate response to laxative treatment. The evidence was obtained from two identical double-blind placebo-controlled studies which evaluated the efficacy of naloxegol. Patients with constipation arising from oral opioid therapy for chronic non-cancer pain had received naloxegol 12.5mg, 25mg or placebo once daily for twelve weeks. The primary end point was response rate during the twelve week trial period with a defined response of three or more spontaneous bowel movements (SBM) per week and at least an increase of at least one SBM over the baseline for nine of the twelve weeks and three of the final four weeks. It was noted that the treatment responses were smaller than anticipated, as the trials expected a 60% response rate for the primary endpoint, but only 35–44% was achieved. The SPC had concluded that there was limited clinical experience with the use of naloxegol in opioid-induced constipation in patients with cancer-related pain and therefore caution should be used when prescribing naloxegol to such patients. Naloxegol was contra-indicated in patients with underlying cancer who were at heightened risk of gastrointestinal perforation. Mr Dhadli added that the American Food and Drugs Administration had not agreed the use of naloxegol in malignant pain due to lack of evidence in this particular group of patients. **Agreed:** The previous classifications of **BROWN** for use in palliative care as per NICE TA 345 and **RED** for use in the pain and gastroenterology clinics would remain unchanged.	
b.	**<u>Nefopam</u>** Mr Dhadli highlighted that the cost of nefopam had increased significantly since the previous classification by JAPC of GREEN 3rd line choice in step two of the non-malignant chronic pain in primary care guidance. Nefopam was licenced for the relief of acute and chronic pain, including post-operative pain, dental pain, musculo-skeletal pain, acute traumatic pain and cancer pain. Due to the price increase it had been decided to look at the evidence and cost effectiveness for the use of nefopam. SIGN guideline 136 concerning the management of chronic pain published in December 2013 had indicated that the evidence identified on the use of nefopam for chronic pain relief was not sufficient to support a recommendation. Two local pain consultants, Dr Faleiro (DTHFT) and Dr Makkison (CRHFT), did not recommend the use of nefopam in primary care. It was noted that DTHFT had classified nefopam as a third line option for patients who were contraindicated or intolerant to NSAIDs or opiates. During discussion Dr Parkin and Dr Watkins highlighted that nefopam was another option for pain relief. However it was considered that nefopam would rarely be used by GPs except in cases of intolerance to other drugs such as morphine. A classification of BROWN would highlight that its general use was not recommended alerting prescribers to the cost and exceptional circumstances. **Agreed:** Nefopam re-classified as a **BROWN** drug (from GREEN) for patients	

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Item		Action
	intolerant to, or contraindicated, to NSAIDs and opiates.	**SD**
c.	**Toujeo** Mr Dhadli reported that Toujeo was a high-strength insulin glargine 300 units/ml for people with type 1 or type 2 diabetes who had large daily insulin requirements to reduce the number and volume of injections. In October 2015 JAPC had classified Toujeo as BLACK in the light of concerns raised by the MHRA (concerning high strength, fixed combination and biosimilar insulin products and the minimisation of the risk of medication error). A view from the consultant diabetologists about the use of Toujeo had therefore been requested and they had now indicated that they would wish to use Toujeo for the following groups: • Patients on insulin degludec. • Patients being considered for insulin pump therapy. • Patients currently on high dose of insulin (>150units/day) who would otherwise have been started with Humulin R U-500 or degludec. The evidence from Toujeo came from two NICE evidence summaries of new medicines in both Type 1 and 2 diabetes which showed non-inferiority to insulin Lantus, similar safety and patient factors and was cost equivalent. It was noted that the percentage of adults with confirmed or severe nocturnal hypoglycaemia was lower with Toujeo than with Lantus in two of three studies. Mrs Needham commented that it may be necessary to change the position of degludec as this was an option for patients on Humulin R. It may also be necessary to determine whether patients on Humulin R would be suitable to switch to Toujeo. These points would be considered further by the Guideline Group. It was also noted that a similar request for the re-classification of Toujeo from BLACK had been made by Dr Robinson, CRHFT Consultant Diabetologist with agreement on similar positioning. **Agreed:** Toujeo re-classified as a **BROWN** drug after specialist initiation for the specific patients who were on insulin degludec or Humulin R; those being considered for insulin pump therapy and those currently on a high dose of insulin.	**SD** **SD**
7.	**CLINICAL GUIDELINES**	
a.	**Dapoxetine** Mr Dhadli stated that JAPC had classified dapoxetine as a BLACK drug for the treatment of premature ejaculation. It was highlighted that the position statement still required updated prices. **Agreed:** JAPC ratified the dapoxetine position statement with a two year extension.	**SD**
b.	**Nebuliser Guidance** Mr Dhadli reported that no changes had been made by the Guideline Group and the DTHFT Lead Respiratory Nurse had suggested a change to indicate that patients who required replacement consumables should contact the clinician who placed the initial order for further supplies.	

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Item		Action
	Agreed: JAPC ratified the Derbyshire Nebuliser Guidelines for COPD patients with the agreed amendment and a two year extension.	**SD**
c.	**<u>Management of Overactive Bladder</u>** Mr Dhadli highlighted some of the changes which had been made to the Primary Care Management of Overactive Bladder (OAB) Guideline: • The Guideline Group had proposed that the assessment sections for men and women be removed to leave conservative management with non-pharmacological treatment and then leading on to the treatment algorithm for OAB. • A section had been included concerning consideration before starting OAB and caution in use of anti-muscarinics in the elderly. • How anti-muscarinics should be initiated to include starting, maximum dose and incremental doses. • Addition of a reference to indicate that there was currently very limited evidence for the use of mirabegron in combination with an antimuscarinic and that more evidence would be required to assess whether combination therapy was appropriate. • Inclusion of a reference to the MHRA safety warning issued in October 2015 about the contraindication of mirabegron in patients with severe uncontrolled hypertension and that blood pressure should be measured before starting treatment and monitored regularly during treatment, particularly in patients with hypertension. Oxybutynin patches were referred to in the pharmacological treatment of overactive bladder section and required a traffic light classification. It was agreed that a traffic light classification of **BROWN** should be assigned for use due to exceptionality for those patients who were unable to take oral medication. Mrs Needham referred to the offer of pads or other containment device in the lifestyle advice section of the flowcharts and suggested that this should be done via the continence service. In addition, the reference in the third line agents section to branded generics should be amended to preferred brand. **Agreed:** JAPC ratified the Primary Care Management of Overactive Bladder Guideline with the inclusion of the agreed changes and amendments.	**SD** **SD** **SD**
d.	**<u>Proton Pump Inhibitor Guidance</u>** Mr Dhadli reported that minor changes had been made to the existing guidance for Proton Pump Inhibitors to include references to rebound hypersecretion, tubulo-interstitial nephritis and the very low risk of subacute cutaneous lupus erythematosus highlighted in the MHRA Drug Safety Update of September 2015. **Agreed:** JAPC ratified the Proton Pump Inhibitors Guidance with the inclusion of the agreed amendments.	**SD**
8.	**MONTHLY HORIZON SCAN**	

Item		Action
	Mr Dhadli advised JAPC of the following new drug launches, new drug formulations and drug discontinuations: New drug launches in the UK: Aviptadil + phentolamine (Invicorp) – CCG commissioned line. To be left unclassified and await clinician request. BLI-800 (Eziclen) – Classified as **RED.** Carfilzomib (Kyprolis) – NHS England commissioned line. NICE TA expected in September 2016. Classified as **RED.** Ceftolozane + tazobactam (Zerbaxa) – CCG commissioned line. Classified as **RED.** New formulation launches in the UK: Fluticasone propionate + salmeterol xinafoate (AirFluSal Forspiro) – Combination inhaler containing a corticosteroid and long-acting beta 2 agonist for chronic obstructive pulmonary disease (COPD) in adults. This was cheaper than Seretide 500 accuhaler, but more expensive than current first line treatments, and would be included in the appendix section of the COPD guideline ahead of Seretide. Licence extensions: Aflibercept (Eylea) – For visual impairment due to myopic choroidal neovascularisation in adults. No NICE TA was expected and was an alternative to ranibizumab (licensed), bevacizumab (off-license) or vertoporfin photodynamic therapy. This is not currently commissioned and would require a business case for consideration of its use. Secukinumab (Cosentyx) Ankylosing Spondylitis (AS)/Psoriatic arthritis (PsA) – NICE TA for AS expected October 2016 and NICE TA for PsA expected in February 2017. This is not currently commissioned.	
9.	**MISCELLANEOUS**	
a.	**Dental Prescribing Letter** Mrs Needham advised that a letter signed by Dr Mott on behalf of JAPC would be 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.	
b.	**Early Access to Medicines (EAMs)** Mr Dhadli reported that an EAMS notification had been received from the MHRA about Osimertinib for the treatment of adult patients with locally advanced or metastatic epidermal growth factor receptor T790M mutation-positive non-small-cell lung cancer who had progressed on or after EGFR TKI therapy. The EAMs notification was noted for information.	
c.	**Gonorrhoea and Antimicrobial Resistance** Mr Dhadli reported that the Department of Health had issued guidance on gonorrhoea and antimicrobial resistance and the recommended therapy of injectable ceftriaxone and oral azithromycin. It was highlighted that suboptimal treatment did not happen and that, in the event that services lacked the facilities to provide injectable drugs, patients were referred to a Genitourinary Medicine (GUM) Clinic or sexual health service for management. Dr Dewis commented that this advice was also included in the chlamydia	

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	guideline and had been circulated via the specialist service.	
d.	**HRT Advice** Mr Dhadli tabled 'NICE Bites' on menopause which summarised the prescribing recommendations from the NICE Clinical Guideline NG 23 which covered the diagnosis and management of menopause including women who had premature ovarian insufficiency. Dr Amanda Smith, a lead doctor from the Derbyshire Integrated Sexual Health Service had further shortened this to the key messages that she felt were important to prescribers Further more Dr Smith had commented that some of the HRT products in the JAPC formulary could not be recommended due to their equine content. It had been decided therefore to send the relevant chapter in the BNF formulary for comment by Dr Smith and any possible changes to be then further discussed by the Guideline Group. Dr Watkins queried the use of testosterone in menopause and it was agreed that this should also be considered by the Guideline Group. It was noted that the use of testosterone had been recommended as a treatment option in the NICE Clinical Guideline. Ms Town also agreed to look into access across the county to the HRT/Menopause service and update at the next meeting.	**SD** **JT**
e.	**Specialised Commissioning** A document from NHS England 'Improving Value for Patients from Specialised Care' was tabled for information and Mr Dhadli highlighted some of the main points: • The commissioning process would be strengthened. • A Strategic Services Review Programme would be published to ensure cost effective treatments from the most capable providers. • The clinically driven change agenda would be centred on working with partners to implement the findings of the national taskforces. • The single operating model to be applied to all contracts in 2016/17. • Contracting for Excluded Drugs and Devices measures introduced in recent years to help ensure that providers and commissioners could jointly deliver best value, including national changes to the tariff excluded high cost devices supply chain, would continue. • The Reforming the Payment System process with providers would continue. • Adult specialised severe and complex obesity services should no longer be commissioned by NHS England and should be reflected in CCG contracts from April 2016. • The following services will no longer be commissioned by CCGs and would be reflected in NHS England contracts from April 2016: - Some highly specialist adult male urological procedures. - Primary ciliary dyskinesia management services for adults. - Some highly specialist adult haematology services. • A mandatory collaborative process for resolving significant local service issues before any service expansion/development plans or service termination notices would be considered by the Commissioner. Mr Dhadli also highlighted the section in this document about contracting for	

Item		Action
	excluded drugs and devices and that there would be a central repository of prices for excluded drugs with specific prices for each one to avoid regional variations. In addition notice would be given on some of the confidential agreements which some providers had with Pharma and the online clinical decision support tool (Blueteq) would subsequently be used for all high cost drugs. The paper based approval process would also be terminated and the online clinical decision support tool used instead by all providers of the identified devices and procedures. Mr Dhadli referred to the NHS England Specialised Commissioning Drugs Briefing for December 2015 and highlighted some points: • The National Commissioning Pharmacists Network had been launched at the end of 2015. • Principles determining the commissioning of drugs. • Clarification that some of the chemotherapy supportive drugs were not considered chemotherapy supportive and therefore GP should prescribe. • Biosimilars to be used if available at a significantly lower price and there is no reason not to. • Alirocumab for hypercholesterolemia and evolocumab for hyperlipidaemia among the drugs to be added to the national excluded drugs list. • Reference to Medicines Optimisation Clinical Reference Group and strengthening the links with CCGs. • Providers should not initiate any specialised services before discussions were held with the CCGs. Mr Dhadli summarised the CCG key learnings and direction of travel for NHS England.	
10.	**JAPC BULLETIN**	
	The following change in the bulletin was noted: NICE Diabetes Guidance – 'NICE has finally published the long awaited type 2 diabetes in adult guideline. The guideline recommends some change in how we could manage diabetes locally. Until then existing local guidelines should be followed for existing and newly diagnosed patients.' The December JAPC bulletin was ratified with the agreed amendment.	
11.	**MHRA DRUG SAFETY UPDATE**	
	The MHRA Drug Safety Update for December 2015 was noted. Mr Dhadli highlighted the following: • Thalidomide: reduced starting dose in patients older than age 75 years. • Mycophenolate mofetil, mycophenolic acid: new pregnancy-prevention advice for women and men. • Bisphosphonates: very rare reports of osteonecrosis of the external auditory canal. This would be highlighted in the osteoporosis guidelines. • Antiretroviral medicines: updated advice on body-fat changes and lactic acidosis.	**SD**
12.	**NICE SUMMARY**	

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	Mrs Qureshi informed JAPC of the comments for the CCGs which had been made for the following NICE guidance issued in December 2015: TA 369 Ciclosporin for treating dry eye disease that has not improved despite treatment with artificial tears - Ciclosporin was recommended as an option, within its marketing authorisation, for treating severe keratitis in adult patients with dry eye disease that had not improved despite treatment with tear substitutes. It is estimated that 2.28% of adults had dry eye disease and 6% of this population had severe dry eye disease and that 75% of this population would use ciclosporin. The number of people treated with optimmune and restasis would decrease and there would be an associated increase in the number of patients treated with ciclosporin eye drops. The total number of people treated would remain the same. Dr Parkin commented that it would be important to highlight in the guidance that this was not just for the treatment of dry eyes and was another treatment option instead of long-term corticosteroids for patients with keratitis due to dry eye disease. Classified as a **RED** drug. TA 370 Bortezomib for previously untreated mantle cell lymphoma – Classified as a **RED** drug (NHS England drug). TA 371 Trastuzumab emtansine for treating HER2-positive, unresectable locally advanced or metastatic breast cancer after treatment with trastuzumab and a taxane – Not recommended by NICE. Classified as a **BLACK** drug (NHS England drug). TA 372 Apremilast for treating active psoriatic arthritis – Not recommended by NICE. Classified as a **BLACK** drug. TA 373 Abatacept, adalimumab, etanercept and tocilizumab for treating juvenile idiopathic arthritis – All classified as **RED** drugs (NHS England drugs). TA 374 Erlotinib and gefitinib for treating non small-cell lung cancer that has progressed after prior chemotherapy - Erlotinib was recommended by NICE as an option for treating locally advanced or metastatic non-small-cell lung cancer. Classified as a **RED** drug (NHS England drug). Gefitinib was not recommended by NICE for the treatment of locally advanced or metastatic non-small-cell lung cancer that had progressed after non-targeted chemotherapy in people with tumours that were EGFR-TK mutation-positive. Gefitinib classified as a **BLACK** drug. HST2 Elosulfase alfa for treating mucopolysaccharidosis type Iva – Classified as a **RED** drug (NHS England drug).	**SD** **SD** **SD** **SD** **SD** **SD** **SD**
13.	**TRAFFIC LIGHTS – ANY CHANGES?**	
	Classifications Nefopam – **BROWN** with exceptionalities Toujeo – **BROWN** after specialist initiation Oxybutynin patches – **BROWN** for patients unable to take oral medication	

Item		Action
	BLI-800 bowel cleansing preparation – **RED** Carfilzomib – **RED** Ceftolozane + tazobactam – **RED** Bortezomib – **RED** as per NICE TA 370 Trastuzumab – **RED** as per NICE TA 371 Apremilast – **BLACK** Abatacept – **RED** as per NICE TA 373 Adalimumab - **RED** as per NICE TA 373 Etanercept – **RED** as per NICE TA 373 Tocilizumab – **RED** as per NICE TA 373 Erlotinib – **RED** as per NICE TA 374 Gefitinib – **BLACK** as per NICE TA 374 Elosulfase alfab – **RED** as NICE HST 2 All Homeopathy – **BLACK**	
14.	**JAPC ACTION SUMMARY**	
	The action summary was noted by JAPC and amendments made: Grazax – Decision to be made as to whether this would be brought to the June 2016 JAPC meeting or via another route. Immunomodulating drugs – Consultant Rheumatologists to be asked for their views on the drugs on a rolling basis. Pain Guidance – To be brought to the February 2016 JAPC meeting. Management of Overactive Bladder – To be taken off the list. Chlamydia Guidance – To be brought to the February 2016 JAPC meeting. LMWH Bridging Guidance – To be brought to the February or March 2016 JAPC meeting. Ulipristal for uterine fibroids – To be brought to the February or March 2016 JAPC meeting. Fluticasone propionate + salmeterol xinafoate – To be brought to the February 2016 JAC meeting.	**SD** **SD** **SD** **SD** **SD** **SD** **SD** **SD**
15.	**GUIDELINE GROUP**	
	The summary of key messages arising from the meeting held in December 2015 was noted. Mr Dhadli highlighted the following: • Carbocisteine sachets had been added to the respiratory formulary as a cost-effective option. • Lactulose sachets – Classified as BLACK as less cost-effective than current standard therapy. • Lucentis – Classified as RED as per NICE TA 155 as not previously classified.	

Item		Action
	• Pegatinib – Classified as RED as per NICE TA 155 as not previously classified.	
16.	**MINUTES OF OTHER PRESCRIBING GROUPS**	
	• Sheffield Area Prescribing Group 15/10/15 • South Staffordshire Area Prescribing Committee 30/10/15 • Chesterfield Drugs and Therapeutic Committee 17/11/15 • Clinical Commissioning Policy Advisory Group 12/11/15 • DTHFT Drugs and Therapeutic Committee 17/11/15 Mr Dhadli highlighted the following: Sheffield Area Prescribing Group: • Toujeo classified as an amber drug. • Paracetamol dosing in low weight adults. South Staffordshire Area Prescribing Committee: • Agreed to adopt Derbyshire JAPC Medical Devices Policy. • Magnaspartate (KoRa) oral powder added to their formulary as the licensed oral magnesium preparation. Chesterfield Drugs and Therapeutic Committee: • Concern expressed about the initiation of NOAC therapy without adequate consideration of the potential place of alternative anticoagulants such as warfarin. • Ongoing discussion about the use of Dymista for a defined cohort of patients.	
17.	**ANY OTHER BUSINESS**	
a.	**<u>Diamorphine</u>** Mrs Needham reported that there was currently a national shortage of diamorphine and regular updates were therefore being received about supplies. CRHFT had decided not to change their current practice but DTHFT had moved to morphine injections apart from syringe drivers who were still given diamorphine. The out-of-hours service had found it difficult to obtain supplies of diamorphine. It was noted that Manor Pharmacy as suppliers of syringe drivers to Erewash had plenty of stock of diamorphine.	
b.	**<u>Learning Difficulties - Winterbourne Medicines Programme</u>** Dr Parkin reported that Hardwick CCG, as the lead commissioner for learning disability services, had taken on the responsibility via the Learning Disabilities Clinical Reference Group to review and reduce the inappropriate use of medicines for this group of people. Three cohorts of patients had been identified within South Derbyshire Learning Disabilities Team, the North Derbyshire Learning Disabilities Team and also those under the care of GPs. It was noted that South Derbyshire Learning Disabilities Team had already undertaken an audit of all patients known to the service. The tool used in the City for the audit would be slightly adapted and rolled out to the North Derbyshire Learning Disabilities Team. In connection with the patients known to GPs, it was agreed that the first stage would involve the use of practice pharmacists to carry out some work to identify those patients who were on antipsychotics and then take them off antipsychotic prescribing.	

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c.	**Patient Group Directions** Mr Dhadli advised that NHS England had added FluMist to the Patient Group direction (PGD) for influenza. JAPC noted that Dr D Harris, Lead Antimicrobial Pharmacist across all the Derbyshire CCGs, had agreed that the Derby Urgent Care Centre should use the following PGDs: • Amoxicillin to treat acute otitis media. • Doxycycline to treat exacerbations of COPD and (doxycycline used along with metronidazole) for cat, dog and human bites in penicillin allergic patients. • Erythromycin to treat acute otitis media and also sore throat/tonsillitis/pharyngitis in penicillin allergic patients. • Nitrofurantoin MR to treat uncomplicated UTIs in women (non-pregnant, aged 16 to 65 years). • Phenoxymethylpenicillin to treat sore throat/tonsillitis/pharyngitis. • Trimethoprim to treat uncomplicated UTIs in women (non-pregnant, aged 16 to 65 years). All the above antibiotics were appropriate agents for the treatment of the above infections and included in the JAPC Antimicrobial Treatment Guidance.	
18.	**DATE OF NEXT MEETING**	
	Tuesday, 9th February 2015 at 1.30pm in the Post Mill Centre, South Normanton.	