For agenda items contact Slakahan Dhadli
Tel: 01332 868781
Email: slakahan.dhadli@nhs.net

DERBYSHIRE JOINT AREA PRESCRIBING COMMITTEE (JAPC)

Minutes of the meeting held on 9th January 2018

CONFIRMED MINUTES

Summary Points

Traffic lights

Drug	Decision
Freestyle Libre®	BROWN after diabetic consultant/specialist initiation within a Derbyshire diabetes service (patient numbers to be reviewed in three months and consultant/specialist to complete Association of British Clinical Diabetologists Nationwide FreeStyle Libre® Audit form and to send a copy to the patient's GP)
Levocarnitine	RED as per NHS England commissioning intentions
Prednisolone soluble tablets	BROWN (administration via enteral feeding tubes)
Guselkumab (Tremfya®)	BLACK pending NICE TA
Peginterferon alfa-2a (Pegasys®)	RED as per NHS England commissioning intentions
Atezolizumab	RED (NHS England as per NICE TA 492)
Cladribine	RED (NHS England as per NICE TA 493)
Naltrexone–bupropion	BLACK (as per NICE TA 494)
Palbociclib with an aromatose inhibitor	RED (NHS England as per NICE TA 495)
Ribociclib with an aromatose inhibitor	RED (NHS England as per NICE TA 496)

Clinical Guidelines

Primary Care Management of Overactive Bladder

Ophthalmology commissioning pathways for age related macular degeneration; macular oedema due to BRVO and CRVO; diabetic macular oedema and non-infectious posterior uveitis

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Present:	
Southern Derbyshire CCG	
Dr A Mott	GP (Chair)
Mr S Dhadli	Specialist Commissioning Pharmacist (Professional Secretary)
Mrs L Hunter	Assistant Chief Finance Officer
Ms H Murch	Acting Deputy Director of Medicines Management (also representing Erewash CCG)
Mrs S Qureshi	NICE Audit Pharmacist
Dr M Watkins	GP
North Derbyshire CCG	
Dr C Emslie	GP
Dr T Narula	GP
Mrs K Needham	Assistant Chief Quality Officer (Medicines Management) (also representing Hardwick CCG)
Ms J Town	Head of Finance
Hardwick CCG	
Dr T Parkin	GP
Erewash CCG	
Derby City Council	
Derbyshire County Council	
Derby Teaching Hospitals NHS Foundation Trust	
Dr W Goddard	Chair – Drugs and Therapeutic Committee
Mr D Moore	Lead HCD 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	
Ms J Shaw	Principal Pharmacist
Derby and Derbyshire Local Medical Committee	
Dr K Markus	Chief Executive
In Attendance:	
Mr I McKenzie	Pharmacist
Mr A Thorpe	Derby City Council (minutes)

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Item		Action
1.	**APOLOGIES**	
	Dr R Dewis, Dr M Henn, Mr S Hulme and Mr C Newman.	
2.	**DECLARATIONS OF CONFLICT OF INTEREST**	
	Dr Mott reminded committee members of their obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of JAPC. No conflicts of interest were declared in relation to this agenda; in addition to the existing register of interests.	
3.	**DECLARATIONS OF ANY OTHER BUSINESS**	
	• Use of adjuvanted trivalent flu vaccine for the 2018-19 flu season.	
4.	**MINUTES OF JAPC MEETING HELD ON 12 DECEMBER 2017**	
	The minutes of the meeting held on 12th December 2017 were agreed as a correct record after the following amendments: Mefenamic Acid – Amend to: 'The tariff cost of mefenamic acid 500mg tablets (28) for November 2018 was £13.80, but approximately £50 in tariff concession cost.' Self-Care Policy – Amend to: 'Ms Braithwaite queried how the policy would operate in Minor Injuries Units (MIUs) where many of the products were supplied on a routine basis.' JAPC Bulletin - Amend to: 'Dr Narula expressed some views from GP colleagues as to whether it would be safe for them to take on the shared care of six patients in North Derbyshire with dronedarone as they lacked sufficient experience and expertise with its use' and 'Dr Mott commented that JAPC would need to further discuss the issues about shared care, including safety considerations, and referred to a task and finish working group on shared care. New Shared Care Consultation – Dr Mott referred to the task and finish working group on the principles of shared care'.	
5.	**MATTERS ARISING**	
a.	**<u>Omega 3 and Liothyronine</u>** Omega-3 Fatty Acids - Dr Mott reported that discussions had been held with the secondary care clinicians who had indicated that omega-3 fatty acids could be beneficial to patients with acute pancreatitis. Dr P Masters and Dr R Stanworth had been requested to forward the evidence for this and, in the event that omega-3 fatty acids were not available, they had referred to the alternative but more expensive treatment using PCSK9 inhibitors. Mrs Needham added that there were two patients in Chesterfield who had been started on omega-3 fatty acids by DHcFT although the indication was currently unknown. This would be reviewed via the DHcFT Drugs and Therapeutic Committee.	**ST**

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	Liothyronine – Dr Mott advised that liothyronine currently had a triple traffic classification but the current issue concerned the decision by JAPC to classify this as BLACK for hypothyroidism in the light of the advice and publication by NHS England that it was an effective treatment which could, in appropriate circumstances, contribute to patient wellbeing, quality of life and condition management. NHS England's publication of items not to be routinely prescribed had recommended that all such patients should be reviewed by NHS endocrinologists and Dr Mott had accordingly been in contact with local clinicians. The local endocrinologists had indicated that they did not wish for an additional cohort of patients to be added to their current workload and had suggested that the reviews should instead be managed in the first instance via the NHS e-Referral Service. Dr Mott highlighted the need for JAPC to determine whether the original decision to assign a traffic light classification of BLACK, as not routinely recommended or commissioned, should remain unchanged or be adjusted in line with the national advice. During discussion Mr Dhadli stated that JAPC had originally agreed to its exceptional use due to the views of local endocrinologists that some patients may benefit from the addition of small doses of liothyronine in addition to levothyroxine if their quality of life remained poor despite adequate levothyroxine replacement. However the amount of prescribing and costs of liothyronine for hypothyroidism had significantly increased despite the poor evidence for its efficacy. Mr Dhadli added that the limited evidence reinforced the original decision to assign a traffic light classification of BLACK and it was noted that the paper from the NHS England commissioners was only advisory in nature. There were approximately 150 patients in Derbyshire who were still receiving liothyronine for hypothyroidism and Mrs Needham suggested that the individual funding request (IFR) route was a possible means to obtain the drug. **Agreed:** The current traffic light classification of BLACK for liothyronine for hypothyroidism to remain unchanged. GPs would be advised to use an alternative product for hypothyroidism in the light of this classification but to first obtain the advice of local endocrinologists in cases where patients specifically requested liothyronine.	**SD**
b.	**<u>Rosuvastatin</u>** It was reported that there had been no price reduction for rosuvastatin.	
c.	**<u>New JAPC Front Sheet Template</u>** Mr Dhadli advised that Ms Claire Haynes, Clinical Quality Impact Assessment Manager, had advised that an Equality Impact Assessment (EIA) would be necessary when something was taken away from patients but only in cases where patients were already on NHS treatment and where there was no suitable alternative treatment. However further advice had subsequently been received that a Quality Impact Assessment (QIA) would also be required at the same time as an EIA. The JAPC front sheet template had therefore been amended to reflect both of these requirements. Both the EIA and QIA would need to be completed by the person or group who had developed the proposal and no decision could be made if both had not been completed.	

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d.	**Equality Impact Assessment (EIA) for Vitamin D** Mr Dhadli advised that the vitamin D EIA template had now been completed and the Derbyshire Medicines Management Team were working on the implementation of the recommendations. Further sections had been added by Ms C Haynes who had advised that it was likely that JAPC would not be required to undertake any further action. However the Medicines Management Team would have to confirm that due process had been followed in terms of appropriate communication of the changes to patients, together with details of the resources necessary for implementation of the withdrawal of vitamin D supplements on prescription for those without a diagnosis of deficiency.	
e.	**Dosulepin** Information to be obtained on the historical prescribing of dosulepin and the existing patients – this would be added to the action tracker.	**SD**
f.	**Capsaicin Cream** Mr Dhadli referred to the query raised at the last meeting as to whether capsaicin had been excluded from the rubefacients section in the NHS England 'items not routinely prescribed in primary care' document. The NHS England commissioning document made no specific reference to capsaicin but had cross-referenced PrescQIPP which had excluded capsaicin cream. It was noted that NICE did refer to the use of capsaicin cream in some of their guidelines. Mr Dhadli added that all rubefacients had been assigned a traffic light classification of BLACK by JAPC but this did not include topical NSAIDs or capsaicin cream.	
g.	**FreeStyle Libre®** Mr Moore reported that a paper prepared by Dr E Wilmot, Consultant Diabetologist, on the Freestyle Libre® flash glucose monitoring system which provided readings by scanning a sensor, had been discussed by the DTHFT Drugs and Therapeutic Committee (DTC) in mid-December 2017. The intended place in therapy was as an alternative to routine blood glucose monitoring in people with type 1 and 2 diabetes who used insulin injections. Dr Wilmot had attempted to follow the Regional Medicines Optimisation Committee (RMOC) criteria in the paper presented to the DTC but it had been noted that there was no clear indication of likely patient numbers, particularly in the paediatric group, together with the limited evidence. Mr Dhadli reported that Freestyle Libre® had been added to tariff and a number of patient groups were lobbying CCGs to approve funding for this. A decision had been delayed pending the publication of the RMOC position statement which described when it would be appropriate to consider use of the flash glucose monitoring system. However the cost impact of this had not been included in the review and this was particularly important in view of the fact that a large number of patients could be eligible for this treatment. Both Acute Trusts had therefore been requested to take Freestyle Libre® to their respective DTCs for consideration as to its position and to gain an idea of potential numbers. The endocrinologists in CRHFT and DTHFT had recommended its use in line with the RMOC position statement and an indication of likely patient numbers had been given: 200 adults and 250 four to nineteen year olds in DTHFT and 80 adults and 150 four to nineteen year olds in CRHFT.	

Item		Action
	The DTCs had been requested to indicate the point at which this became cost neutral or cost saving in the light of the current pressures on NHS finances. It had become clear that those patients who required monitoring eight or more times daily were likely to become cost neutral; those patients likely to go on to pump therapy likely to be cost savings and those patients who had more than two admissions per year with diabetic ketoacidosis or hyperglycaemia would be cost savings or cost neutral. It was highlighted that there would be an impact on prescribing costs in primary care due to the use of Freestyle Libre® and the savings, other than the reduced use of blood glucose testing strips, would be offset with savings elsewhere in the healthcare system such as reduced admissions to secondary care. Mr Dhadli commented that the paper prepared by the consultant endocrinologists had referred to existing patients on treatment and advised that those who self-funded should also be eligible for treatment. They had recommended that the Association of British Clinical Diabetologists (ABCD) National Freestyle Libre® audit should be used and this did refer to new patients and those who had already commenced treatment. The patients concerned would have to evidence that they met the criteria although clear guidance would be needed for GPs as to how they dealt with this group of patients. Dr Goddard advised that Dr Wilmot's application to the DTHFT DTC did adhere to the RMOC criteria and that the use of Freestyle Libre® should be supported as a new way of managing insulin type 1 dependent diabetics. It had proved to be of benefit in improving the quality of life of the diabetic patients who had used it. However it would need to be determined how this should be introduced in order to manage expectations. The diabetologists and GPs would be under very considerable pressure to provide this relatively expensive technology. Dr Mott highlighted that the proposal was to provide Freestyle Libre® to 680 patients in Derbyshire who were under specialist care. This did not reflect total expected demand and 680 patients was a cap on numbers which had been proposed by the endocrinologists. It should also be noted that the evidence for Freestyle Libre® came from five studies involving 700 people but this had included only adults whose diabetes was well controlled. Very frequent users would still need to use test strips for activities such as driving and so these costs to prescribing budgets would not be avoided. Dr Mott advised that, as the patients involved were all specialist controlled and the audit was being undertaken by specialists, a case could be made for a traffic light classification of RED. However it should be recognised that the specialists had no budget and would not save any monies by the use of this system. Mr Dhadli referred to the RMOC guidance which recommended a fixed-term collection of audit data on the use of Freestyle Libre® via its use in limited and controlled settings where patients were attending for Type 1 diabetes care. Dr Parkin suggested that there could be an initial appointment with the specialist with a follow up at six months to determine efficacy and prescribing could then be undertaken by GPs. This would involve a classification of GREEN specialist initiation for the limited indications but include an in-built assessment at six months.	

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Item		Action
	Dr Mott highlighted the need for assurance from the specialists about the budgetary implications and what should be done with the existing patients who were already using it. Ms Murch advised that a BROWN specialist initiation may be a more appropriate classification as it would then clearly highlight the criteria for acceptance. It would also be extremely important to have a check on the numbers of patients, particularly in view of the fact that initiation of Freestyle Libre® could come from a different number of sources. Dr Mott stated that the specialists were participating in a national audit and therefore needed to have a clear mechanism for tracking. It would be extremely important for the CCGs to obtain assurances about adherence to the stipulated criteria and the numbers of patients must be logged, perhaps via the DTCs. Mr Dhadli explained that the ABCD Nationwide FreeStyle Libre® Audit used two forms: the pre-FreeStyle Libre® information collection form and the follow up visit data collection form. For existing patients one form would be used to collect data relating to pre Freestyle Libre® use and the other to collect data relating to the time during use. **Agreed:** JAPC agreed that Freestyle Libre® should only be used for exceptional use within a specialist clinical setting and therefore a classification of **BROWN** after diabetic consultant/specialist initiation would be appropriate. Its use would only be for people with type 1 diabetes, aged four and above, who attended specialist type 1 diabetes care using multiple daily injections or insulin pump therapy and who had been assessed by a specialist clinician and met one or more of the RMOC position statement criteria. This must be done within a Derbyshire diabetes service and the consultant/specialist must complete the ABCD nationwide FreeStyle Libre® audit form at initiation and send a copy to the GP of the patient involved. It was agreed that patients currently self-funding this device should only be eligible for treatment on the NHS if evidence of the criteria were met as per RMOC before starting and enrolment into the audit. They must be enrolled via the specialist services, and not GP practices, to ensure consistency and inclusion in the national audit. The suitability of Freestyle Libre® in a patient should only be made during a routine appointment. The decision to commission this device should not encourage increased hospital activity. **Action:** In view of the importance of keeping a close check on the numbers of patients involved a review should be undertaken in three months' time by the Medicines Management Team and JAPC. **Action:** The audit data results would be reviewed by JAPC, in conjunction with the diabetes service, in three, six and twelve months in order to gain assurance that the audit had been effective in its objectives.	**SD** **SD**
6.	**JAPC ACTION SUMMARY**	
	Use of NOAC for suspected DVT – This would be brought to the February 2018 JAPC meeting. Hydroxychloroquine - Guidance from the Royal College of Ophthalmologists was still awaited on optical coherence tomography (OCT) testing and would be brought to a JAPC meeting when available.	**SD** **SD**

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Item		Action
7.	**NEW DRUG ASSESSMENTS**	
a.	**Levocarnitine** Mr Dhadli reported that a consultant paediatrician from Sheffield Children's Hospital had requested a Derbyshire GP to prescribe levocarnitine for a young person in Chesterfield with medium-chain acyl-CoA dehydrogenase (MCAD) deficiency. The Clinical Effectiveness Team had subsequently ascertained that this was a tariff excluded drug funded by NHS England and was covered by two separate policies for adults and children. **Agreed:** Levocarnitine classified as a **RED** drug (NHS England). Dr Narula added that the consultant paediatrician had been advised that this was a NHS England drug and therefore not a GP prescribing responsibility. The consultant paediatrician had indicated that she had always requested the GP to prescribe and had never come across this issue previously but had agreed to prescribe in this instance. Mr Dhadli advised that that Sheffield Area Prescribing Committee had not classified levocarnitine and they would be informed that JAPC had assigned a traffic light classification of RED. Dr Markus highlighted concern about a potential equity issue when JAPC and Sheffield Area Prescribing Committee had assigned different traffic light classifications for the same drug. This created significant confusion and uncertainty for GPs about whether primary care or secondary care had responsibilities for prescribing. Dr Markus undertook to collate examples of this for future discussion.	**SD** **SD** **KM**
b.	**Soluble Prednisolone** Mr Dhadli highlighted the considerable difference in price between plain and soluble prednisolone tablets. The Guideline Group had therefore looked at clinical practice in DTHFT and CRHFT, together with some neighbouring CCGs, regarding the use of prednisolone in a form that was easy to swallow. DTHFT, CRHFT and Sheffield CCG had recommended the use of soluble prednisolone only in a limited number of clinical situations such as those patients with fine-bore enteral feeding tubes. It was noted that the plain tablets could be dispersed in water to form a fine suspension which was off-licence use. **Agreed:** Prednisolone tablets (1mg, 5mg, 25mg) classified as **GREEN** and could be used off-licence when dispersed in water. This would be highlighted in OptimiseRx. **Agreed:** Prednisolone soluble tablets classified as **BROWN** for exceptional use with enteral feeding tubes.	**SD** **SD**
8.	**CLINICAL GUIDELINES**	
a.	**Menopause** Mr Dhadli reported that the menopause management guideline had been updated by Dr A Smith, Clinical Specialist with the Derbyshire Integrated Sexual Health Service.	

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Item		Action
	The main changes were the inclusion of a link to the British Menopause Society advice on the management of perimenopausal women with migraine and an amendment to the testosterone supplementation section. Dr Narula queried the lack of a reference to tibolone in the menopause guideline. In addition, a more user friendly section to indicate which first line and second line drugs should be used for menopausal women with or without a uterus would be useful. It was noted that the formulary did differentiate between the two groups of women but it was agreed that it would be advantageous to include in one section. The Shared Care and Guideline Group (SCaGG) would be requested to consider the points raised by Dr Narula and revise the guideline accordingly. Dr Narula would send examples from guidelines used in other areas to Dr Emslie and Mrs Needham.	**SD** **TN**
b.	**<u>Overactive Bladder</u>** Mr Dhadli reported that the guideline had been updated with comments from DTHFT, CRHFT and DCHSFT. Main changes included: • The need to consider the anticholinergic burden patient in order to reduce central nervous system (CNS) and gastro-intestinal side effects. • If the patient had unmanageable side-effects, or there was lack of efficacy with first/second line agents, a third line medication should be considered taking into account possible advantages of specific agents and cost e.g. trospium in elderly patients for its reduced CNS side effects. • Primary Care Management of Overactive Bladder Initial Assessment - Urinalysis (to exclude infection in patients under 65 years old, haematuria and glycosuria) and, if suspected urinary tract infection (UTI) in over 65 year olds, midstream specimen of urine (MSU) to be obtained and send to microbiology. • Links added to resources for anticholinergic burden although it was noted that registration (free) with the Specialist Pharmacy Service (SPS) and PrescQIPP would be required. • Reference to the anticholinergic risk scale and anticholinergic adverse effects in older persons. However it was noted that there was no single standard anticholinergic burden scale to assist with medication reviews in old or frail patients who were taking multiple medications. Dr Watkins referred to the reference in the initial assessment section to the need to undertake a frequency/volume check and queried how often this would be done in general practice. It was considered advantageous to undertake volume checks before patients came under the care of the continence team and it was acknowledged that the reference to primary care in the document was not just about general practice. In connection with the anticholinergic burden scale it was agreed that SCaGG be requested to consider where this should be situated. It was also agreed that a link to the existing anticholinergic burden scale be included. **Agreed:** JAPC approved the Primary Care Management of Overactive Bladder with agreed amendments with a review date of two years.	**SD**
c.	**<u>Ophthalmology Pathways</u>** Mr Dhadli advised that the ophthalmology pathways were for use in secondary care where the specialists used high cost drugs outside of tariff which were commissioned directly by the CCGs.	**SD**

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Item		Action
	The Derbyshire commissioning ophthalmology pathways covered the following ophthalmic disease areas: • Age related macular degeneration (AMRD) • Macular oedema due to branch retinal vein occlusion (BRVO) and central retinal occlusion (CRVO) • Diabetic macular oedema • Non-infectious posterior uveitis Mr Dhadli advised JAPC that the pathways were compliant with all the relevant NICE TAs and, where appropriate, some locally agreed variations or clarifications to either the SPC or RCO had been included which were highlighted in red. Dr Watkins queried the process for ratification of these highly specialist pathways. Dr Mott stated that all the pathways had been considered by relevant groups in north and south Derbyshire but, in future, the newly established Biosimilar/High Cost Drug Working Group would collate all the relevant information about high cost drugs to be fed into the decision making processes of JAPC. **Agreed:** JAPC approved the ophthalmology commissioning pathways for age related macular degeneration; macular oedema due to BRVO and CRVO; diabetic macular oedema and non-infectious posterior uveitis.	**SD**
10.	**SHARED CARE GUIDELINES**	
a.	**<u>Principles of Shared Care</u>** Dr Mott referred to the circulated letter from the Chief Pharmaceutical Officer (CPO) which outlined the issues about prescribing across the primary and secondary care interface to be addressed by a Task and Finish Group. During discussion Dr Markus stated that concern had been conveyed by some Derbyshire GPs to the Local Medical Committee about the impact caused by the transfer of workload to primary care and how this would be funded. It was considered that the term 'shared care' was a misnomer and was instead deemed to be transfer of care on discharge. It was also important to acknowledge that complex and intensive monitoring was often required and GPs may not have the necessary resources to undertake this. Dr Mott referred to a previous exercise when all the shared care agreements had been scrutinised and the ones which did not fall into the category of shared care were either the responsibility of the hospital or no longer needed. This had resulted in a lower number of shared care agreements than in some other areas but it was still essential that patients under shared care should not be discharged and, if this happened, JAPC and the relevant consultants should be informed accordingly. Dr Markus commented that JAPC made decisions as to whether drugs were suitable for shared care but there was no budget or decision as to how this would be funded. Dr Watkins highlighted that the discharge of patients with chronic diseases also created a significant workload for primary care. Dr Mott stated that there was variation in practice via the commissioning frameworks in some areas of the county and the commissioners should be made aware that certain shared care agreements were not working.	

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Item		Action
	Some resources had been allocated to general practice in the south of the county for adherence to shared care but this was not consistent across Derbyshire. Dr Narula referred to the importance of taking safety issues into consideration when shared care agreements were being developed. Dr Mott stated that it would be important for GPs to indicate if they were uncomfortable in taking on shared care guidelines but ideally these should contain sufficient information and guidance for this to be done successfully and safely. Mr Dhadli commented that JAPC was aware of the importance of giving drugs appropriate classifications and, in cases where there were areas of concern, a red classification would be assigned in order that hospital experience be gained before further development of a shared care. Dr Markus referred to cases when hospitals assumed that primary care would take over the prescribing of a particular drug and patients had already been informed that the prescriptions should now be obtained from a GP. Dr Mott referred to the JAPC Prescribing Specification which made it clear that GPs must be informed first in writing. In addition, all the shared care guidelines required the appropriate agreement form to be completed. Mr Dhadli advised JAPC that all the categories for a shared care guideline, as outlined in table 1 of the national guidance, had been included in the local guidelines. **Action**: The final guidance and annex on shared care would be discussed at a future JAPC meeting, once published.	**SD**
11.	**MISCELLANEOUS**	
a.	**<u>Asthma</u>** Mr Dhadli reported that the Primary Care Respiratory Society (PCRS) had produced a briefing document which compared the NICE guidance with the British Thoracic Society (BTS) SIGN guidance. Thorax, the official journal of the BTS, had also produced a similar document which highlighted the differences between NICE, SIGN and BTS. In view of the existence of three national guidelines Mrs Qureshi, who was developing local asthma guidance, would focus on the therapeutic and treatment aspects of asthma care rather than diagnostics.	
b.	**<u>Prescribing Specification</u>** Mr Dhadli reported that the JAPC Prescribing Specification had been updated to indicate that Provider Trusts would implement and support the recommendations of JAPC on policies that affected the wider healthcare system. These currently included the de-commissioning of gluten free products, self-care and vitamin D supplementation. This amendment to the Prescribing Specification would be put through as a contract variation.	**SD**
c.	**<u>Chief Medical Officer (CMO) Alert – Use of Antiviral Medicines</u>** The CMO Alert issued in December 2017 on the use of antiviral medicines was noted. Dr Markus queried progress on the development of a guideline for the use of antiviral medicines in care homes.	

Item		Action
	Ms Murch stated that this had been discussed today by the Derbyshire CCGs executives and it was possible that there could be a contract variation with DCHSFT although no final decision had yet been made.	
13.	**JAPC BULLETIN**	
	The bulletin was ratified by JAPC.	
14.	**MHRA DRUG SAFETY UPDATE**	
	The MHRA Drug Safety Alert for December 2017 was noted. Mr Dhadli highlighted the following MHRA advice: • Gadolinium-containing contrast agents: removal of Omniscan and iv Magnevist and restrictions to the use of other linear agents. • Cladribine (Litak®, Leustat®) for leukaemia: reports of progressive multifocal encephalopathy (PML) and advice to stop treatment if PML was suspected. • Radium-223 dichloride (Xofigo▼): not to be used in combination with abiraterone and prednisone/prednisolone following clinical trial signal of increased risk of death and fractures. • Eluxadoline (Truberzi ▼): risk of pancreatitis and not to be used in patients who had undergone cholecystectomy or in those with biliary disorders. • Fingolimod (Gilenya▼): new contraindications in relation to cardiac risk. • Fingolimod (Gilenya▼): updated advice about risk of cancers and serious infections. • Buccolam (midazolam) prefilled plastic syringes: potential product defect.	
15.	**HORIZON SCAN**	
	Mr Dhadli advised JAPC of the following new drug launches, new drug formulations, licence extensions and drug discontinuations: New drug launches in the UK: Guselkumab (Tremfya®) – Classified as **BLACK**. NICE TA expected in June 2018. New formulation launches in the UK: Acetylcysteine and Acetylcysteine (NACSYS) – Already classified as **BROWN** (exceptionality for idiopathic pulmonary fibrosis only). Licence extensions: Peginterferon alfa-2a (Pegasys®) – Classified as **RED**. Tenofovir disoproxil + cobicistat + elvitegravir + emtricitabine (Stribild®) – Classified as **RED**. Rivaroxaban (Xarelto®) – It was highlighted that the 10mg dose was a licence change for the prevention of recurrent venous thromboembolism after deep vein thrombosis or pulmonary embolism. An increase in the number of requests had been noted from primary care and this would be further discussed by the Drug and Therapeutic Committees.	
16.	**NICE SUMMARY**	
	Mrs Qureshi informed JAPC of the comments for the CCGs which had been made for the following NICE guidance issued in December 2017:	

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Item		Action
	TA492 Atezolizumab for untreated locally advanced or metastatic urothelial cancer when cisplatin is unsuitable – Classified as **RED** (NHS England as per NICE TA 492). TA493 Cladribine tablets for treating relapsing – remitting multiple sclerosis – Classified as **RED** (NHS England as per NICE TA 493). TA494 Naltrexone – bupropion for managing overweight and obesity – Classified as **BLACK** (as per NICE TA 494). TA495 Palbociclib with an aromatase inhibitor for previously untreated, hormone receptorpositive, HER2-negative, locally advanced or metastatic breast cancer – Classified as **RED** (NHS England as per NICE TA 485). TA496 Ribociclib with an aromatase inhibitor for previously untreated, hormone receptorpositive, HER2-negative, locally advanced or metastatic breast cancer – Classified as **RED** (NHS England as per NICE TA 496). MIB132 Point-of-care and home faecal calprotectin tests for monitoring treatment response in inflammatory bowel disease.	
17.	**GUIDELINE GROUP ACTION TRACKER**	
	The summary of key messages from the Derbyshire Medicines Management Shared Care and Guideline Group (SCaGG) meeting held in December 2017 was noted. Mr Dhadli highlighted the following: Traffic Lights: Eluxadoline – Advice from the MHRA in December 2017 had been added to the BNF chapter that this was not to be used in patients who had undergone cholecystectomy or in those with biliary disorders due to risk of pancreatitis. Formulary Review: GI Chapter – Advice added to: • Use budesonide foam enema if hydrocortisone enema was unavailable; • Prescribe ciclosporin by brand; • Prescribe methotrexate injection by brand (Metoject®) – North Derbyshire only. Guidelines: Clostridium difficile – A note would be added to indicate that the guideline was being updated and a date for review confirmed. Naltrexone Shared Care Guideline – Ms Shaw would check when the guideline was due for review. Chronic Pain (non-malignant) – This guideline would not now be submitted for review. Chlamydia and Allergic Rhinitis – Progress on both guidelines to be checked and review dates confirmed.	**SD** **JS** **SD**
18.	**TRAFFIC LIGHTS – ANY CHANGES?**	
	<u>Classifications</u> Freestyle Libre® - **BROWN** after diabetic consultant/specialist initiation	

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Email: slakahan.dhadli@nhs.net

Item		Action
	(patient numbers to be reviewed in three months and consultant/specialist to complete Association of British Clinical Diabetologists Nationwide FreeStyle Libre Audit form at initiation and to send a copy to the patients GP) Levocarnitine – **RED** Prednisolone tablets – **GREEN** (can be dispersed in water) Prednisolone soluble tablets – **BROWN** for administration via enteral feeding tubes Guselkumab (Tremfya®) – **BLACK** Peginterferon alfa-2a (Pegasys®) – **RED** Atezolizumab – **RED** (NHS England as per NICE TA 492) Cladribine – **RED** (NHS England as per NICE TA 493) Naltrexone/bupropion – **BLACK** (as per NICE TA 494) Palbociclib with an aromatose inhibitor – **RED** (NHS England as per NICE TA 485) Ribociclib with an aromatase inhibitor – **RED** (NHS England as per NICE TA 496)	
19.	**MINUTES OF OTHER PRESCRIBING GROUPS**	
	• Clinical Policy Advisory Group 09/11/2017 • DHcFT Drugs and Therapeutic Committee 27/07/2017 • DHcFT Drugs and Therapeutic Committee 28/09/2017 • JAPC Working Group 11/07/2017 • JAPC Working Group 12/09/2017 • JAPC Working Group 10/10/2017 • JAPC Working Group 14/11/2017 • Nottinghamshire Area Prescribing Committee 21/09/2017	
20.	**ANY OTHER BUSINESS**	
a.	**<u>Adjuvanted Trivalent Flu Vaccine for 2018 to 2019 Flu Season</u>** Dr Mott reported that a letter had been by NHS England to GPs on the use of the adjuvanted trivalent flu vaccine for the 2018 to 2019 flu season. This had referred to the Joint Committee on Vaccination and Immunisation (JCVI) advice that this should be a priority for those people aged 75 years and over. JCVI had also advised that adjuvanted trivalent flu vaccine was more effective and cost effective in people aged over 65 years compared with non-adjuvanted vaccines currently used for this age group. Dr Markus highlighted a potential gap in vaccine cover between the ages of 65 and 75 years. Dr Mott commented that in future it was likely that GP practices would need to have storage facilities for different brands of vaccine for different age groups.	
21.	**DATE OF NEXT MEETING**	
	Tuesday, 13th February 2018 at 1.30pm at Coney Green Business Centre, Clay Cross.	