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DERBYSHIRE JOINT AREA PRESCRIBING COMMITTEE (JAPC)

Minutes of the meeting held on Tuesday 12 February 2013

CONFIRMED MINUTES

Summary Points

Traffic lights

Drug	Decision
Ivacaftor	RED (correction from previous minutes)
Co-codamol 8/500 mg & Co-dydramol 10/500 mg	UNCLASSIFIED
Degarelix	RED
Cerelle	GREEN first line desogestrel preparation
Fosfomycin	BROWN on recommendation of a Consultant Microbiologist
Fluocinolone	BLACK for NICE TA 271
Vinflunine	BLACK for NICE TA 272
Tadalafil	BLACK for NICE TA 273

Clinical Guidelines

Clozapine

Shared Care Guidelines

Nebulised Colomycin
Updated Shared Care Template

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Present:	
NHS Derbyshire County	
Dr J Bell	Assistant Director of Public Health (Chair)
Dr C Emslie	GP – North Derbyshire CCG
Dr D Fitzsimons	GP – North Derbyshire CCG
Mr S Hulme	Head of Prescribing – Southern Derbyshire CCG
Dr A Mott	GP – Southern Derbyshire CCG
Mrs K Needham	Head of Medicines Management North – North Derbyshire CCG
Dr T Parkin	GP – Hardwick CCG
Mrs S Qureshi	NICE Liaison and Audit Pharmacist
Dr I Tooley	GP – Southern Derbyshire CCG
Derbyshire Community Health Services NHS Trust	
Ms C Curry	Principal Pharmacist
NHS Derby City	
Mr S Dhadli	Specialist Commissioning Pharmacist
Derby Hospitals NHS Foundation Trust	
Mr T Gray	Chief Pharmacist
Derbyshire Healthcare NHS Foundation Trust	
Mr D Branford	Pharmacist
Dr S Taylor	Consultant Psychiatrist, Chair – Drugs and Therapeutic Committee
Chesterfield Royal Hospital NHS Foundation Trust	
Mr M Shepherd	Chief Pharmacist
In Attendance:	
Mr A Thorpe	NHS Derby City (minutes)

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1.	**APOLOGIES**	
	Dr F Game, Mrs L Hunter and Mr M Steward.	
2.	**DECLARATIONS OF CONFLICT OF INTEREST**	
	No declarations of interest were made.	
3.	**DECLARATIONS OF ANY OTHER BUSINESS**	
	No declarations of any other business were made.	
4.	**MINUTES OF JAPC MEETING HELD ON 8 JANUARY 2013**	
	The minutes of the meeting held on 8 January 2013 were agreed as a correct record with the following amendments: Summary Points: Ivacaftor – Amend to: RED. TTR Values for the New NOACs - Amend to 'Dr Ashcroft advised that Dr McKernan, Consultant Haematologist, had now indicated that she would prefer a higher time in therapeutic range threshold and was keen that this be re-looked at again.' Degarelix – Amend to 'The drug caused a rapid reduction in PSA without androgen surge and consequently would be used for a very small sub-group of patients'. Lipid and Familial HypercholesterolaemIa – Amend to: 'A sub-group would be established to review the Familial Hyperlipidaemia guideline and statin policy with the following representatives suggested.'	
5.	**MATTERS ARISING**	
a.	**Co-codamol 8/500 mg and Co-dydramol 10/500 mg** Mr Hulme reminded JAPC that these treatments had previously not received a traffic light classification and this had been queried by pharmacists in the South of Derbyshire. A paper was tabled which outlined potential traffic light options for co-codamol (8/500mg) and co-dydramol (10/500mg). Mr Hulme highlighted some points in his paper: • The BNF classified these drugs as less suitable for prescribing but there may be some justifiable use in certain circumstances. • The appendix contained some extracts of a comprehensive review undertaken by MeRec in 2006 on the withdrawal of co-proxamol: alternative analgesics for mild to moderate pain. • The MPC and Clinical Knowledge Summaries did not recommend low dose (opioid) combination analgesics. • Lower dose opioid treatments may be appropriate in elderly patients who were more susceptible to side-effects. • Side effects and cautions relevant to low dose opioid as well as high dose e.g. constipation and dependence/tolerance. • Low cost of separate components although the cost of the effervescent tablets was high. • Patient factors where the placebo effect was strong and was another step before moving to stronger opioids and NSAIDs. • Benefits and risks of assigning a traffic light classification of green, brown, black or unclassified. • Recommendation that a traffic light classification of brown be assigned but	

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	a managed approach would be needed together with exceptionality defined. Dr Tooley expressed concern that a brown classification for co-codamol and co-dydramol would give the message that the drug should be avoided and whether this would be taken into account by GPs. Dr Mott commented that the prescribing of 75,000 packs of co-codamol and co-dydramol did not imply exceptional use and that they were going to be used with or without evidence as patients derived benefits from them. Mr Gray suggested that, in the event of an unclassified status being given, there could be some merit in conveying key messages to patients such as maximising the use of paracetamol and being able to purchase over the counter. **Agreed:** Co-codamol 8/500 and Co-dyramol 10/500 would remain unclassified. **Action:** The guidance section in the formulary on the use of Co-codamol and Co-dydramol would be highlighted in the bulletin.	**SD** **SD**
b.	**<u>Degarelix</u>** Mr Shepherd stated that discussions had been held with the CRH urologists. Mr Shepherd added that feedback had been that there had been no reported adverse reactions from patients who had gone back to a LHRH from his consultants. Mr Gray reported that feedback had been received from Dr Simon Williams, RDH Consultant Urologist, who had discussed this with Mr James from CRH. Both consultants were clear that there was no evidence to support a switch and Dr Williams had also undertaken a detailed review of the costing in relation to the SMC decisions including the rebate scheme. This had concluded that the differential was not that great between degarelix and leuprorelin. There was evidence for a switch from leuprorelin to degarelix but none for degarelix to leuprorelin. Therefore the clinicians were looking to restrict its use for a select group of patients who were at highest risk of coming into hospital with spinal chord compression or who required severe surgical intervention. Dr Mott referred to the need to tightly define the small number of patients who should have degarelix and how this could be implemented in general practice as this was not covered by the current LES. Mrs Needham queried how easy it would be for practices to monitor their patients if the numbers were very small. The cohort of patients was well defined in the original paper and it would be necessary to demonstrate admission avoidance and the necessity of spinal surgery and associated morbidity. Mr Dhadli commented that it should be determined whether the small group of patients concerned were best treated in primary care or secondary care. Mr Dhadli added that Nottingham APC had left degarelix unclassified but Leicestershire APC had a shared care guideline in place by which the first two injections were done in hospital. Mrs Needham stated that the current traffic light classification of degarelix was red and Dr Bell commented that RDH clinicians could therefore prescribe if approved by their Drugs and Therapeutic Committee. Mr Gray added that it had	

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	been decided to bring this to JAPC in order to manage the use across the local health community and in particular to address the disparity between Chesterfield and Derby. Dr Parkin suggested that in the interim the following two options on the recommendation of a consultant: • For patients to be switched over to leuprorelin and GPs to take over or to continue prescribing in primary care • Otherwise for patients who needed on-going degarelix then this would continue to be obtained and administered from hospital. Mr Shepherd commented that it would be useful for JAPC to see the Leicester shared care and ascertain whether consensus could be obtained between the Chesterfield and Derby urologists. **Agreed:** Degarelix classified as a **RED** drug. **Agreed:** Patients who wanted to continue to have their degarelix from the hospital urologists could carry on with this otherwise they could obtain their LHRH from their GP. **Action:** Mr Dhadli would obtain details of the Leicestershire shared care guideline and share this with RDH and CRH.	**SD** **SD** **SD**
c.	**Lipid and FH Policies** Mr Dhadli referred JAPC to the membership of the working group which had been put together to update the local guidance. A meeting of the working group would be held on 8th March 2013 at Babington Hospital. **Agreed:** JAPC noted the agenda for the working group meeting and evidence papers for review.	**SD**
d.	**Breastfeeding Policies** Dr Bell reported that the relevant people who had developed the guidelines had been contacted to explain that JAPC was only able to discuss the prescribing elements in these but nothing further had been heard.	
e.	**Shared Care Disulfiram/Acamprosate** Mr Branford stated that some changes had been made and the final version would be brought back to the March JAPC meeting.	**DB**
f.	**Antipsychotics ECG Monitoring** JAPC was informed that ECG monitoring had been sent to the four CCGs in Derbyshire in order for them to make a decision. Dr Parkin reported that this had been discussed by Hardwick CCG as lead for mental health but no decision had been possible. A paper had previously been produced which looked at the different levels of need and options for provision, but the final decision would need to be made by the Derbyshire CCGs at one of their 4 + 4 meetings. Dr Taylor highlighted that there were an increasing number of drugs which	

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	required ECG monitoring and a decision on this was important. Dr Parkin and Dr Emslie referred to the funding issues associated with ECG monitoring in primary care.	
g.	**Prescribing Specification** Mr Dhadli stated that the prescribing specification had been updated based on the new QIPP indicators and sent to all the providers.	
6.	**NEW DRUG ASSESSMENTS/FORMULARY ADDITIONS**	
a.	**Cerelle** Mr Dhadli stated that Cerelle was an oral progesterone only contraceptive and was a cheaper version of Cerazette. Mr Dhadli highlighted that cost savings of £135,194 could be obtained in Derbyshire by a 100% switch to Cerelle. Derbyshire Community Health Services and the sexual health clinics had indicated that they supported the use of Cerelle as first line choice over Cerazette. Dr Emslie highlighted that there would be a need to prescribe as cerelle in order to achieve the cost savings. **Agreed:** Cerelle classified as a **GREEN** first line drug desogestrel preparation.	
b.	**Fosfomycin** Mr Shepherd stated that he had not previously seen the circulated paper which had been prepared by a locum consultant microbiologist and advised that fosfomycin had occasionally been recommended to GPs. The use of fosfomycin was accepted practice at CRH and occasionally used for in-patients. Mrs Needham advised that it would be helpful to assign a traffic light classification as this would give GPs assurance to prescribe it and would be for exceptional use. However it was noted that, as this was an unlicensed product and special, there may be difficulties with timely access particularly for those patients who did not live close to the hospital. Mr Gray stated that fosfomycin was not currently used at RDH but would check whether it could be made available with a GP prescription. **Agreed:** Fosfomycin classified as a **BROWN** drug on microbiologist recommendation. **Action:** A reference would be placed in the interactive traffic light list to highlight that fosfomycin was a special drug and therefore difficult to obtain. **Action:** Mr Dhadli would highlight in the bulletin that fosfomycin was an unlicensed product and therefore not listed in the BNF.	**TG** **SD** **SD** **SD**
7.	**CLINICAL GUIDELINES**	
a.	**Opioids in Cancer Pain and Non-Cancer Pain** Mr Dhadli presented two opioid papers: an update to an existing expired guideline and a new non-cancer opioid guideline adopted from the one used in Nottingham. Dr Mott highlighted that in the existing guideline in the transdermal fentanyl Matrifen patches should be given as an example of fentanyl and note the use of oramorph solution/morphine for breakthrough pain.	

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	In connection with the paper on opioids for persistent non-cancer pain Mr Dhadli stated that this was a local version of the Nottingham guidance and highlighted that PRN dosing was not recommended for use in chronic pain and also that dosing thresholds had been included. A RDH consultant had fedback that some patients had been found to have been prescribed very high doses of morphine which was more suitable for cancer pain rather than non-cancer pain. During discussion Mr Dhadli queried whether GPs would find the chart useful and the possible over-promotion of transdermal patches. Mr Gray commented that it would be useful to have more information about immediate and modified release preparations and this could be included as an appendix in both cancer and non-cancer pain. It was queried whether a reference to buprenorphine not being recommended should be added to the chart together with the maximum doses of strong opioids. **Agreed:** JAPC agreed that there should be just one paper for cancer and non-cancer pain which should include maximum doses and safety information. This would be brought back to the March JAPC meeting.	**SD**
b.	**<u>Neuropathic Pain</u>** Mr Dhadli highlighted to JAPC the changes made to the guideline for the management of neuropathic pain: • Review date extended to August 2013 when NICE guidance would be released. • Carbamazepine added to anti-convulsants as first line treatment for trigeminal neuralgia. • Morphine dosing changed from 200mg maximum dose to 120mg daily with titration initially 5-10mg every 4 hours. • Initial dosage of morphine to be 5-10mg. • Costings chart updated. Discussion followed and the following additional changes were agreed: • Capsaicin cream 0.075% cream should be used for post herpetic lesions. • Use of modified release preparations for non-cancer pain needed to be consistent with the non-cancer pain guidance. • Titration needed to be consistent across the three guidelines. **Agreed:** The dose of morphine would be changed on the website. **Action:** The cancer, non-cancer and neuropathic guidelines would be incorporated into one document and brought back to the March JAPC meeting.	**SD** **SD**
c.	**<u>Clozapine</u>** Mr Branford stated that this was an update of the existing guidance for GPs and other health professionals for the use of clozapine for schizophrenia and psychosis in Parkinson's Disease. The guidance aimed to enable GPs to add clozapine onto patient records which would then trigger a set of tests associated with the use of anti-psychotic drugs. GPs would need to add patients on clozapine to the mental health register and undertake an annual physical health check. One change had been made on page 5 to highlight the necessity of	

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	recording medicines prescribed by other healthcare providers in order to minimise risk. Dr Fitzsimons commented that any medicine being taken by a patient which had not been prescribed by a GP should be included on the medical repeat list in order that any potential interactions could be monitored. Dr Mott stated that it would be important to correlate the patients who DHcFT considered to be on clozapine and the patients which the GP practices had recorded on their systems. Mr Branford would look into the feasibility of informing GPs of this. Mr Dhadli advised that the final page of the paper relating to the recording of medicines prescribed by other healthcare providers in order to minimise risks would be issued as separate guidance. **Agreed:** JAPC ratified the clinical guideline for clozapine	**DB** **SD**
8.	**PATIENT GROUP DIRECTIONS**	
a.	Mr Hulme advised JAPC that after 1st April 2013 there would be no organisations authorised to sign off Patient Group Directions (PGDs) some of which had now expired. Legislation was awaited on this but there was no indication when this would be implemented. Interim advice concerning the expiry dates of PGDs indicated that they could be extended for a maximum period of one year to allow for the transition although it would be necessary to check that the PGD had not significantly changed since the last review. Mr Hulme added that further advice had been issued to highlight that successor organisations should have appropriate governance arrangements in place. Discussion followed and Dr Bell commented that, if JAPC agreed to an extension of the PGDs which had expired, then a process for their re-consideration would need to be determined. It would be preferable in the absence of legislation to put a fairly short timescale in order that the reviews could be completed to allow sign-off in May 2013 or carry out the review process for all the PGDs by the end of March 2013. Mr Dhadli highlighted that PGDs were a priority for the CCGs to get them updated as soon as possible. Mr Gray commented that it was illegal to administer or supply a drug under a PGD that had expired and it may be advantageous to do the review and extend the expiry date to a year from now so that they could be transferred to the new organisations. Mr Hulme pointed out that an extension of expiry date to May 2013 would allow more time to carry out a proper review but there may be no authority at that stage to sign-off. Dr Mott advised that the expiry date of the PGDs be extended to May 2013 by which time they should have all been reviewed. In the event of a lack of clarity about who should sign-off the PGDs then the Chairs of the CCGs and National Commissioning Board Area Team should be requested to do this in the absence of any legislation. **Agreed:** The expiry dates of the PGDs which required review would be extended to the beginning of May 2013 and then considered at the May JAPC meeting. The dates of the expired PGDs would be extended to May 2013 and this would be made clear in the bulletin.	**SD**
9.	**SHARED CARE GUIDELINES**	
a.	**Nebulised Colomycin**	

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	Mr Shepherd and Mr Gray stated that the existing Shared Care Guideline (SCG) had been reviewed by RDH and CRH clinicians and subsequently updated. It was agreed that the title of the SCG should be changed to Nebulised Colomycin Injection (Colistin) in Adults with bronchiectasis in non CF patients. Dr Tooley advised that a reference be included in the bulletin about the GP responsibility to ensure that the patient gave a sputum sample every month. **Agreed:** JAPC ratified the Nebulised Colomycin Shared Care Guideline.	**SD** **SD**
b.	**<u>Update to Shared Care Templates</u>** JAPC noted that the shared template had been updated to include a generic transfer letter template. JAPC noted the updated Shared Care Template for information.	
10.	**MONTHLY HORIZON SCAN**	
	Mr Dhadli advised that a horizon scan monthly action plan would be a standing JAPC agenda item. The action plan would be produced to highlight all new drug launches and to agree the necessary action. It would also inform JAPC about those drugs which impacted directly on primary care and required a rapid review and the others which required an interim formulary classification until a request from a GP or clinician for its use had been received. Mr Dhadli referred to the new drug dapagliflozin for the treatment of type 2 diabetes for which NICE guidance was expected. It would be necessary to determine what the process to deal with this should be which could be to wait for the NICE publication timeframe, update the local diabetes guidance, undertake a full review or act on a request received for its use from a clinician. Discussion followed and the role of the Guidelines Group was queried in terms of widening its remit. Mrs Needham suggested that a holding statement could be given and formulary implications included in order indicating whether NICE guidance was awaited or a request from a clinician. Mr Gray referred to the East Midlands Formulary Support Group which had developed a formulary database which would include reviews of newly launched drugs. These reviews could be used as part of the horizon scanning process. **Agreed:** The horizon scan would be received by JAPC every month. **Agreed:** Dapaglifozin would be considered further once the NICE diabetes guidance had been received or the local diabetes guidance updated. **Action:** Mr Dhadli would look further at the development of an interactive database/formulary to enable its use as a reference guide and report back to a future JAPC meeting. **Action:** Mr Dhadli would include drugs which had been discontinued.	**SD** **SD** **SD** **SD**

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11.	**MISCELLANEOUS**	
a.	**JAPC/Guideline Group Terms of Reference – Developing and Updating Local Formularies** Dr Bell referred to the internal review of the JAPC terms of reference which had already taken place and the possible need for an external review of the decision making process of the JAPC. Mr Dhadli had highlighted some areas which required further work by JAPC arising from the NPC 'Developing and Updating Local Formularies' document. **Agreed:** JAPC agreed that an external review should be undertaken and a day to commit.	**SD**
b.	**Innovation for Health and Wealth – Scorecards for TAs** Mr Dhadli stated that 'NICE Technology Appraisals in the NHS in England 2011: Experimental Statistics – Innovation Scorecard' had been issued in January 2013. An action identified by Innovation for Health and Wealth aimed to drive compliance with NICE and NICE TAs and reduce variation by publishing information that related to levels of compliance with NICE TAs. The Innovation Scorecard was an indicative measure to stimulate the monitoring of NHS compliance with NICE TAs. The purpose of the work was to drive compliance with TAs by the publication of information relating to levels of compliance and variation at local level. Mr Gray outlined that work had been done across the East Midlands to look at the current status of NICE approved agents within the formularies by looking at 2011/12 and 2012/13 TAs.	
c.	**High Cost Drugs Excluded from Tariff** Mrs Qureshi advised JAPC that a list of drugs excluded from tariff had been issued by the Department of Health. The drugs which would be commissioned by the National Commissioning Board (NCB) had been taken out and the resulting list had been circulated to JAPC. It would be important to highlight to the CCGs the significant financial impact of the drugs which remained on the list. Mr Dhadli also referred to insulin consumables, apomorphine and collagenase which would need to be added to the list.	
10.	**NICE SUMMARY**	
	Mr Dhadli informed JAPC of the comments for the CCGs which had been made for the following NICE guidance: **TA271 Fluocinolone acetonide intravitreal implant for the treatment of chronic diabetic macular oedema after an inadequate response to prior therapy** Flucinolone classified as a **BLACK** drug. **TA272 Vinflunine for the treatment of advanced or metastatic transitional cell carcinoma of the urothelial tract** Vinflunine classified as a **BLACK** drug. **TA273 Tadalafil for the treatment of symptoms associated with benign**	

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	prostatic hyperplasia Mr Dhadli highlighted to JAPC that this was a terminated appraisal. Tadalafil classified as a **BLACK** drug. **CG155 Psychosis and schizophrenia in children and young people: Recognition and management** Mr Dhadli queried who would follow up the patients and undertake the monitoring. Dr Taylor and Mr Branford would ensure that this considered at the DHcFT Drugs and Therapeutic Committee and an action plan developed. **MTG13 WatchBP Home A for opportunistically detecting atrial fibrillation during diagnosis and monitoring of hypertension** Mr Dhadli stated that this was a device used in primary care to look at blood pressure and pulse rate for atrial fibrillation. NICE had indicated that this could be potentially cost saving if used in the over 65 years age group compared with normal blood pressure monitors.	**ST/DB**
11.	**JAPC BULLETIN**	
	The amended JAPC bulletin was ratified by JAPC.	
12.	**GUIDELINE GROUP**	
	The Guideline Group action tracker was ratified by the JAPC.	
13.	**TRAFFIC LIGHTS – ANY CHANGES?**	
	Classifications Ivacaftor – RED (correction from previous minutes) Co-codamol 8/500mg and Co-dydramol 10/500mg – UNCLASSIFIED Degarelix – RED Cerelle – GREEN first line Fosfomycin – BROWN on recommendation of a Consultant Microbiologist Fluocinolone – BLACK for NICE TA 271 Vinflunine – BLACK for NICE TA 272 Tadalafil – BLACK for NICE TA 273	
14.	**ACTION SUMMARY**	
	The action summary was noted by JAPC.and amendments made: Vitamin D Deficiency and Treatment with ProD3 – CRH to ask consultants for anecdotal feedback on success/failure. Q10 – This would be going back to Sheffield APC which would be looking to classify red for Friedreich's Ataxia and black for all other indications. Transgender Prescribing – This service would be commissioned by the NCB and a shared care agreement from Nottingham was awaited. Seretide – This would be brought to the April JAPC meeting.	**MS** **SD** **SD** **SQ**

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15.	**MHRA DRUGS SAFETY UPDATE**	
	The MHRA Drug Safety Alert for January 2013 was noted. Mr Dhadli highlighted that the European Medicines Agency had recommended that the licence for Tredaptive should be suspended after a review showed that the benefits of this product no longer outweighed the risks. Tredaptive had been recalled from 18 January 2013. Patients currently taking tredaptive should be reviewed at a non-urgent appointment in order to consider the need for alternative treatment options.	
16.	**MINUTES OF OTHER PRESCRIBING GROUPS FOR INFORMATION**	
	• DCHS – Medication Operational Safety Meeting 21/11/2012 • DHCFT - Drugs & Therapeutics Meeting 22/12/12 • Burton Hospital – Drug & Therapeutics Meeting 19/11/12 • Burton Hospital – Drug & Therapeutics Meeting 14/01/13 • STAMP 08/01/13 • Chesterfield Royal – Drug & Therapeutics Committee 15/01/13 • Nottinghamshire APC – 15/11/12 • Stockport Area Medicines Management Panel 08/01/13	
17.	**ANY OTHER BUSINESS**	
	No other items of any other business were transacted.	
18.	**DATE OF NEXT MEETING**	
	Tuesday, 12 March 2013 at 1.30 pm in **The Parkhouse Room, Coney Green Business Centre, Clay Cross.**	