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DERBYSHIRE JOINT AREA PRESCRIBING COMMITTEE (JAPC)

Minutes of the meeting held on Tuesday 11 June 2013

CONFIRMED MINUTES

Summary Points

Traffic lights

Drug	Decision
Dymista	BLACK
Flutter Device	BLACK
Sub-cutaneous Depo-medroxyprogesterone	RED
Rifaxamin for hepatic encephalopathy	GREEN specialist initiation

Clinical Guidelines

Oral anti-coagulation
Anti-microbial treatment guidelines
Glaucoma – guidelines for the management
Anti-platelet treatment for STEMI and NSTEMI (Southern Derbyshire RDH)

Shared Care

Rivastigmine

Patient Group Directions

Vitamin K
Hepatitis B vaccine adult
Hepatitis B vaccine child
Hepatitis A vaccine adult
Hepatitis A vaccine child
Hepatitis A with typhoid
Typhoid vaccine

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Present:	
Derbyshire County Council	
Dr J Bell	Assistant Director of Public Health (Chair)
Mrs S Qureshi	NICE Liaison and Audit Pharmacist
Southern Derbyshire CCG	
Mr S Dhadli	Specialist Commissioning Pharmacist (Secretary)
Mr S Hulme	Director of Medicines Management
Dr A Mott	GP
Dr I Tooley	GP
North Derbyshire CCG	
Dr C Emslie	GP
Dr D Fitzsimons	GP
Mrs K Needham	Head of Medicines Management North (and Hardwick CCG)
Hardwick CCG	
Dr T Parkin	GP
Erewash CCG	
Dr M Henn	GP
Derby Hospitals NHS Foundation Trust	
Mr D Anderton	Senior Pharmacist
Dr F Game	Chair, Drugs and Therapeutic Committee
Derbyshire Healthcare NHS Foundation Trust	
Ms B Thompson	Pharmacist
Chesterfield Royal Hospital NHS Foundation Trust	
Mr M Shepherd	Chief Pharmacist
Derbyshire Community Health Services NHS Trust	
Mr M Steward	Chief Pharmacist
In Attendance:	
Dr B Abdalrahman	Public Health Registrar
Dr J Pickard	F2 Public Health Clinical Effectiveness Team
Mr A Thorpe	Derby City Council Public Health (minutes)

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Item		Action
1.	**APOLOGIES**	
	Mrs Linda Hunter.	
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 14 MAY 2013**	
	The minutes of the meeting held on 14 May 2013 were agreed as a correct record with the following amendments: NICE Summary – TA 282 Pirfenidone for treating idiopathic pulmonary disease – Amend to: There were costing implications for NHS England and strict criteria for the patient access scheme. Any Other Business – Amend to: Mr Dhadli then went on to list the study limitations which included no head to head studies with an active comparator and concerns over long term effects with increased electrolyte secretions.	
5.	**MATTERS ARISING**	
a.	**<u>JAPC Review and Terms of Reference</u>** Mr Dhadli reported that a report and revised terms of reference had been produced following the JAPC review on 14 May 2013. These would need to be signed off by JAPC together with the action plan and timescales agreed for the completion of this. The revised terms of reference would then need to be ratified by the Governing Bodies of the four Derbyshire CCGs. Mr Dhadli highlighted the actions to be undertaken in relation to the points in the action plan: • 6.1 The Guidelines Sub-Group revised terms of reference would be brought to the July JAPC meeting. • 6.2 Communications, including the circulation of the minutes of the JAPC meetings, would be strengthened with stakeholders such as the Derbyshire Local Medical Committee and providers commissioned by Local Authorities. • 6.3 The revised JAPC terms of reference would require ratification at this meeting. • 6.4 An induction pack had been developed for new JAPC members. • 6.5 Identified deputies would need to be conveyed to Mr Dhadli. • 6.6 An options paper concerning lay membership of the JAPC to be brought to the July JAPC meeting. • 6.7 Mrs Qureshi and Ms Pardeep Chera would develop a resource to be placed on the website which would form the basis of all communication about the work of the JAPC and enhance its transparency. • 6.8 An audit of the assignment and development of shared care agreements would be incorporated into the work of the Guidelines Group. • 6.9 The costs associated with the operation of the JAPC were currently under discussion. • 6.10 Mr Dhadli would explore the options to improve the sustainability of	**SD** **All JAPC members** **SD** **SD** **SQ/PC** **SD**

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	the JAPC and contact other APCs about this. Dr Fitzsimons to be added to the list of members present at the JAPC Review. **Agreed:** JAPC ratified the JAPC Review and Action Plan. **Agreed:** JAPC ratified the revised JAPC terms of reference. **Action:** The JAPC revised terms of reference would be sent to the CCG Governing Bodies for approval and JAPC informed when these had been approved.	**SD** **SD** **SD**
6.	**NEW DRUG ASSESSMENTS/TRAFFIC LIGHT ADDITIONS**	
a.	**<u>Nicotine Replacement Therapy (NRT)</u>** Ms Tina Jones, Tobacco Control Manager, and Ms Rachel Knebel, Specialist Stop Smoking Adviser, stated that concern had been expressed by Dr Tony Morkane from Derbyshire County Council Public Health about the cost of the use of NRT products and had requested that their use as first, second and third line be re-classified. Discussion followed and Mr Dhadli queried the use of Niquitin CQ 4mg and 1.5mg Mini-lozenges as first line although the Nicorette Gum was the cheaper product. Ms Jones explained that this was due to client preference as gum was not a popular oral product and the mini-lozenge was favoured by clients and had greater usage and compliance which was closely monitored. It was agreed that the Nicorette 2mg and 4mg gum should be moved to first line and the Niquitin CQ 4mg and 1.5mg Mini-lozenges to second line. Mrs Needham stated that the Guidelines Group had amended the reference in the formulary document to add microtabs to Quickmist and the Inhalator as being more expensive than the first-line and second-line products and their consequent status as third line products. Mr Hulme queried whether the formulary was to be shared with GPs and Mrs Needham stated that it would be shared with County GPs only. Mr Hulme also referred to the reference that in Derbyshire County NRT was supplied by requisition and by FP10 in some circumstances. Ms Jones stated that FP10 was used for the first prescription in cases of caution such as stroke or heart attack and this would be highlighted in the paper. Mr Steward queried how updates to the formulary would be communicated to community pharmacists. Ms Jones replied that each pharmacy which had signed up to the LES had a link specialist stop smoking adviser and this person would be responsible for the provision of updates. **Agreed:** JAPC ratified the NRT formulary with the inclusion of the agreed amendments.	**TJ** **TJ** **TJ** **SD**
b.	**<u>Actinic Keratosis (AK)</u>** Mr Dhadli advised that the current products in the formulary for AK had different traffic light classifications. Mr Anderton commented that there was a North Derbyshire guideline which had been shared with the South Derbyshire dermatologists and this guideline did not include the new agents. The South Derbyshire dermatologists had proposed that discussions be held with the North Derbyshire dermatologists which would include the incorporation of the new	

	drugs and this would be co-ordinated by Dr T Bleiker, RDH Consultant Dermatologist. Mr Dhadli stated that there was a possibility of over treatment in primary care for this condition. There were currently discrepancies in the current guidelines so a single guideline was needed to avoid confusion. Dr Emslie added that it would be advantageous to include the GPs with special interest in the discussions between the North and South dermatologists. **Agreed:** JAPC endorsed the decision for a meeting between the North and South dermatologists to produce a single guideline with the new agents and this would be brought to JAPC in three months. **Agreed:** The traffic light classification for current AK products would remain unchanged but add to **GREEN** consultant/specialist initiation GPSIs and dermatology champions	**SD** **SD**
c.	**<u>Reflectant Sunscreen Creams (Dundee Cream)</u>** Mr Anderton reported that Dundee cream was the only sunscreen available in the UK which provided useful UV as well as visible wavelength photoprotection and was manufactured by a NHS Pharmacy Production Unit Tayside Pharmaceuticals. This was the only drug available for patients with genetic disorders or a variety of very serious light sensitive skin disorders such as erythropoietic protoporhyria and solar urticaria and was endorsed in various guidelines produced by the British Association of Dermatologists (BAD) and the BAD Preferred Unlicensed Dermatological Preparations list. The cream was applied twice daily, usually well tolerated and was a tinted reflectant sunscreen available in three colours in 50g tubes. Dundee cream would be continually required by the patient and it would be preferable for them to obtain this directly from primary care. Mr Dhadli commented on possible delays for patient access to Dundee cream due to its unlicensed nature and classification as a special. There would be additional costs to those stated which the community pharmacists would have to include as they may not choose to obtain Dundee cream direct from the manufacturer. Discussion followed on the options by which the small number of patients involved could access the cream. Mr Hulme suggested that one option may be for the hospital to send prescriptions to Tayside Pharmaceuticals who could dispense and post the cream direct to the patients or for this to be obtained from the GP by some route. This would alleviate the need for the patient to go back to the hospital. **Action:** Mr Dhadli would explore the options for patients to be supplied with the cream in conjunction with Mr Anderton and report back to JAPC next month.	
d.	**<u>Dymista</u>** Mr Dhadli reported that Dymista Nasal Spray was listed in the New Product Bulletin as a combination nasal spray of two existing products fluticasone 50mg and azelastine 137mcg for the relief of symptoms of moderate to severe seasonal and perennial allergic rhinitis if monotherapy with either intranasal antihistamine or glucocorticoid is not considered sufficient. The evidence for	**SD**

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	Dymista was considered from UKMI drugs online and from the SPC and had shown an improvement in the nasal symptoms of rhinorrhoea, nasal congestion, sneezing and itching compared to either placebo or azelastine alone or fluticasone alone. On the current formulary beclometasone was first line cortiscosteroid with budesonide as second line. The unit cost of Dymista was £18.91. Mr Dhadli highlighted that Dymista showed some benefit but there were concerns about affordability and that the two components could be used separately more cheaply and effectively. A Drugs and Therapeutic Bulletin review of hayfever had recommended a step wise escalation of therapy based on symptoms and response. This would indicate that a cost effective product would be used and stepped up as required. **Agreed:** Dymista classified as a **BLACK** drug.	
e.	**<u>Flutter Device</u>** Mr Dhadli reported that flutter was a medical device used to assist in the clearance of sputum and was listed in the drug tariff. The device provided positive expiratory pressure (PEP) therapy for patients with mucus producing respiratory conditions including: Atelectasis, Bronchitis, Bronchiectasis, Cystic Fibrosis (CF), Chronic Obstructive Pulmonary Disease (COPD), Asthma or other conditions producing retained secretions. A request had been received from a GP to prescribe the device. It was noted that there was an old NHS Derby City policy for the provision and use of the flutter valve. Dr Bell referred to the Clinical Commissioning Policy Group which supported the CCGs. Requests had been received by this Group for the use of cough assist machines which was similar in function to the flutter valve. The evidence had been considered by this Group but there was insufficient to support the use and this decision had been conveyed to the CCGs. It had been agreed that the consumables would be funded until the machines currently in use were no longer operative. Dr Bell highlighted the need to be consistent in the consideration of these devices and the difficulty in agreeing to the flutter device in isolation. Mr Anderton commented that the national CF guidelines had referred to other techniques being available and that the flutter device may not be the best choice for a given patient. Dr Game added that the usage of the flutter device was unknown and a classification of black would enable an insight to be gained about its use and under which circumstances as it would be up to the provider to request its use. **Agreed:** Flutter Device classified as **BLACK.**	**SD**
f.	**<u>Sub-cutaneous Depo-Provera (DMPA-SC)</u>** Mr Steward reported that DMPA-SC was a new product which had been requested for use in the specialist service and was administered sub-cutaneously every 13 weeks compared to DMPA-IM which was administered by deep IM injection every 12 weeks. It was not licensed for patient self-administration although there had been three studies of self-administration of	**SD**

	DMPA-SC which could reduce the number of clinic visits. Mr Dhadli advised on the costs of two years treatment with DMPA-SC for 1,500 women from the clinics. This was an increase of £1,665 over the two year period. **Agreed:** Sub-cutaneous Depo-Provera classified as a **RED** drug.	
g.	**Epilepsy Treatment** Mr Hulme stated that the current traffic light status of some epilepsy treatments was not clear and may appear to be inconsistent. There was also a lack of a locally agreed pathway to assist primary care clinicians to assess appropriate treatment and or circumstances requiring specialist referral for review. A small working group had been convened to scope the issues that needed to be addressed, provide traffic light status recommendations and advise on the appropriate pathways including available resources. It had been recommended that the 'NICE Bites' January/February 2012 on epilepsy should be signposted as the best available guideline on the website. A summary had also been produced of the current traffic light status of drugs used in epilepsy and this included the newer drugs which did not fit with green specialist initiation. Dr Tooley stated that the 'NICE Bites' was useful as an educational tool but it should be clearly indicated that it was not a recommended guideline. Mr Hulme stated that the working group had suggested that some work could be done about the frequent fliers and an audit template produced which would identify those at-risk patients who required a review or referral. Mr Dhadli commented that a lot of the anti-epileptics did not require specialist monitoring and it would be advantageous to agree a core formulary of anti-epileptic drugs and any new drugs for possible inclusion in the formulary should be considered by the tertiary centres. Dr Mott highlighted that the differences between green specialist recommendation and green specialist initiation needed to be clarified. Green specialist initiation should be the default position. Dr Emslie added that it would be necessary to be clear about the use of some of the drugs as several were used for other conditions. **Agreed:** The 'NICE Bites' document on epilepsy would be signposted on the website to be used as an educational tool. **Action:** Mr Hulme would liaise with Mr Anderton about the RDH position on the place of newer therapies and report back to the July JAPC meeting. **Action:** Mr Dhadli to collate the formulary position for the drugs not otherwise green specialist initiation from out of area Trusts to understand variation.	**SD** **SH** **SD**
h.	**Rifaxamin** Mr Anderton reported that rifaxamin was used at RDH for the treatment and prophylaxis of hepatic encephalopathy (HE) when standard medical care (lactulose, enemas, neomycin, norfloxacin) has been unsuccessful. It had been	

	used at RDH for the last two years utilising an imported product (Xifixanta) which was licensed for traveller's diarrhoea rather than an American licensed product for HE. This was considered a more cost-effective use of resources. It had only just become available in the UK as a licensed product (Targaxan) for HE and RDH planned to use for this patient group. Mr Anderton explained that the advantages were fewer hospital days, it was well tolerated as only active in the gastro-intestinal tract and was cheaper when switched to a licensed product. It was proposed that patients with recurrent episodes of HE over the age of 18, to fit in with the product licence, would be started on rifaxamin and access via the GP. Mr Dhadli stated that that a NICE TA on rifaxamin for the maintenance of HE was expected in October 2013 and that the follow up of these patients had been raised with the RDH gastro-enterologists. The RDH Consultant Gastro-enterologist had advised that patients would be followed up six weekly after the start of treatment to check for efficacy and then three monthly. The CRH Consultant Gastro-Enterologist had stated that their aim was to discharge Patients back to GPs once the patient was stable if not then they would be followed up every three to six months. During discussion JAPC highlighted that the condition required to be monitored rather than the drug. **Agreed:** Rifaxamin classified as a **GREEN** specialist initiation drug.	**SD**
7.	**CLINICAL GUIDELINES**	
a.	**<u>Anticoagulation Guideline</u>** Dr Pickard advised that the current JAPC guideline on oral anti-coagulation, which provided guidance on warfarin prescribing to support the level 4 anti-coagulation management service, now needed to be reviewed. The main changes had been highlighted in the circulated document and mainly involved the appendices which had been rationalised and included in the main body of the text. The patient information leaflet had been removed and a weblink to the patient information leaflet inserted. A clear contents page had been included together with a references section. Dr Pickard highlighted some of the main content changes to the guideline: • Table 1 page 3 target INRs for prosthetic heart valves had changed. • Isolated calf vein DVT duration of six weeks recommended by the British Committee on Standards in Haematology (BCSH). • In connection with the initiation of warfarin therapy the current guidelines recommended daily or alternate day dosing and INR testing. Following feedback it had been decided to leave as previously. • A table had been added to the monitoring section to determine recall periods. • Addition of drug interactions. • Feedback had been received from both RDH and CRH about the management of bleeding and anti-coagulation section. This had led to a revision to the section 'minor bleeding irrespective of INR' to read 'minor bleeding ≥5' and the placement of 'stop warfarin' before 'refer to secondary care'. • The Vitamin K PGD had been updated.	

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	• Oral Vitamin K would only be given in primary care if the INR was >8 and patient not bleeding. Dr Pickard highlighted that Dr McKernan had recommended 2mg oral vitamin K if the INR was >8 and had introduced 4mg oral vitamin K if the INR was >12. This had not been included as the Coagu-Check would only indicate >8. • Contact details and resources had been updated. Discussion followed on the guidance and Mrs Needham queried the reference to the giving of 1-3mg IV vitamin K in the 'minor bleeding irrespective of INR' section and Dr Pickard clarified that this would happen after referral to secondary care. Dr Mott highlighted a gap in the same section to cover those patients INR <5 who had minor bleeding and this would be included in the table. Dr Emslie queried whether a statement was needed at the top of the document as well as the table to highlight that major bleeding, irrespective of INR and minor bleeding >5, should be referred to hospital. Dr Pickard undertook to add this to the guideline. **Agreed:** JAPC ratified the guideline on the management of oral anticoagulation.	**JP** **JP** **SD**
b.	**<u>Vitamin K Patient Group Direction (PGD)</u>** Dr Pickard reported that the Derbyshire JAPC guideline on oral anticoagulation provided reference to the vitamin K PGD as supporting documentation for prescribing vitamin K in over-anticoagulated patients. The original vitamin K PGD was ratified in May 2009 and now required to be updated. The PGD had changed significantly from the previous version and excluded patients with any active bleeding in line with current local practice. The PGD was for use only in patients with INR ≥8.0 with no signs of bleeding. During discussion Mrs Needham queried whether bleeding included bruising and it was agreed that this would not be included. Mr Hulme referred to the INR software as this had just changed over from CleverClogs to INR Star. The software manufacturers had indicated to each CCG that the default clinical settings should be reviewed and this had been delayed pending discussion of the PGD by JAPC. Dr Pickard would discuss this with INR Star on behalf of all the Derbyshire CCGs. **Agreed:** JAPC ratified the Vitamin K Patient Group Direction.	**JP** **SD**
c.	**<u>Antimicrobial Treatment Guidelines for Primary Care</u>** Mr Dhadli referred JAPC to some minor changes made by Dr Diane Harris in the light of the comments made at the previous JAPC meeting: • Insertion of two categories of bites: human and cat or dog. • Addition of information relating to non-truncal involvement. **Agreed:** JAPC ratified the Antimicrobial Treatment Guidelines for Primary Care.	**SD**
d.	**<u>Glaucoma Guidelines</u>** Mr Dhadli stated that the guidelines had been updated to reflect the new formulation of latanoprost preservative free formulation UDV following the JAPC decision at the April 2013 meeting. **Agreed:** JAPC ratified the Glaucoma Guidelines.	

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e.	**<u>Guidelines for Chronic Pain Management in Primary Care</u>** Dr Abdalrahman reported that the guidelines concerned the use of both pharmacological and non-pharmacological methods for the management of chronic pain in primary care. It had been presented to the Guidelines Groups and sent to consultants at both RDH and CRH. The guideline covered pain management in primary care for both cancer and non-cancer patients apart from neuropathic pain which was the subject of a separate document. Discussion followed and some comments made: • Mr Anderton requested that the useful bullet points contained in the British Pain Society (BPS) Guidelines be included. • Use of Tramadol second line – This could be used as a weak or strong opioid dependent on the dose. There were some increased admissions to hospital related to increased tramadol prescriptions. However it had been decided that the benefits outweighed the risks. • Dr Tooley was concerned at the exclusion of nefopam in the guideline as it was useful for patients who got side effects from the use of opioids and had very limited drug interactions. • Dr Abdalarahman explained that the World Health Organisation ladder for pain management had been adopted which was mainly for use in cancer patients but could be used in non-cancer patients as well. • Feedback had been received from the consultants that GPs should not initiate morphine for non-cancer pain and that all patients who needed opioids should be referred to secondary care. • Some concern had been expressed about the prescribing of immediate release preparations. • Mrs Needham requested consistency with the reference to PPIs in the guidelines and a definition of high risk. The following changes to the guidelines were noted: • The BPS guidelines would be included in the guidelines. • Nefopam to be included. • Specific indications for PPIs and definitions of high risk to reflect local guidance. • The reference to palliative care in the anti-emetics section to be taken out. • Take out coxibs throughout. • Haloperidol not first line anti-emetic so need to check in the traffic light classifications which anti-emetics are classified as green. **Action:** Dr Abdalrahman would incorporate the agreed amendments into the guidelines which would be brought back to JAPC for further consideration.	**BA**
f.	**<u>Guidelines for Management of Neuropathic Pain in Primary Care</u>** Dr Abdalrahman reported that this is an update to an already existing guideline with two changes to align these with the Nottingham policy for chronic pain management with the maximum daily dose of morphine to be lowered to 120mg from the previous 200mg per day and to follow the DTB review which recommended carbamazepine to be used specifically for Trigeminal Neuralgia.	

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	Dr Abdalrahman highlighted the concern a RDH consultant about the initiation of strong opioids and the advice given that all patients should be referred to pain services. Dr Abdalrahman referred to NICE Clinical Guideline 96 for neuropathic pain which stated that treatment should not be started with opiates other than tramadol without an assessment by a specialist pain or condition specific service. Mr Anderton queried whether this statement meant that patients should not be started on opiates but referred to the specialists or do not start opiates without also referring to the specialist. Dr Emslie also pointed that a lot of patients with neuropathic pain had a lot of other chronic pain as well. Mr Dhadli referred to page 3 of the guideline and the need to be consistent about initial dosing and include modified release preparations. There was a trigger for a maximum dose of morphine and patients were referred in before the escalation increased. It would be necessary to gain an understanding of the numbers involved and this could be fed into work being done elsewhere on pain relief. Dr Mott stated that morphine for non-neuropathic pain was a routine part of the work of primary care but was a separate issue for neuropathic pain. Mr Shepherd commented on the need to be more specific about the questions to be asked on a particular document such as a guideline. Mr Dhadli referred to the recommendation arising from the JAPC Review that the Guideline Group be strengthened by the addition of RDH and CRH pharmacists who would be the link to the consultants. **Action:** Dr Abdalrahman would amend the guideline and follow up with the RDH consultants. **Action:** The amended guideline to be discussed by JAPC.	**BA** **SD**
g.	**<u>Antiplatelet Treatment for ACS</u>** Mr Dhadli reported that this guideline for the use of anti-platelet therapy following ACS had been agreed with no changes by RDH Consultant Cardiologist. It was highlighted that the guideline related only to RDH. **Agreed:** JAPC ratified the guideline for the use of anti-platelet therapy following ACS.	**SD**
8.	**PATIENT GROUP DIRECTIONS (PGDs)**	
a.	**<u>Travel Vaccines</u>** Mr Dhadli reported that the PGDs for travel vaccines administered in primary care were due to expire in May 2013 and had now been updated to reflect current guidance in the “Green Book” and Summary of Product Characteristics. The Green Book recommends hepatitis B vaccination is not routinely required for travel. These vaccines are not normally provided on the NHS but privately through a travel clinic or private travel service. JAPC are in agreement and so the following PGDs Men ACWY Vax, Rabies, Hepatitis B and combined Hep A and B vaccines be amended to reflect this. Patients with renal insufficiency are now recommended to be vaccinated under a patient specific direction although previously this had been under a PGD	

	The Green Book indications for Hepatitis B still existed in the PGDs but all references to travel had been taken out. The reference to renal defiency had also been removed as this was covered by a Patient Specific Direction rather than a PGD. **Agreed:** JAPC ratified the PGDs for Travel Vaccines.	
9.	**JAPC BULLETIN**	
	The JAPC bulletin was ratified by JAPC.	
10.	**SHARED CARE GUIDELINE**	
a.	**Rivastigmine** Mr Dhadli stated that this was an update of the existing Rivastigmine shared care guideline. **Agreed:** JAPC ratified the updated shared care guideline for Rivastigmine.	
12.	**TRAFFIC LIGHTS – ANY CHANGES**	
	Classifications Dymista - BLACK Flutter Device – BLACK Depo-medroxyprogesterone subcutaneous injection – RED Rifaxamin for hepatic encephalopathy– GREEN specialist initiation	
13.	**JAPC ACTION SUMMARY**	
	The action summary was noted by JAPC.	
14.	**GUIDELINE GROUP**	
	The Guideline Group action tracker was ratified by the JAPC.	
15.	**NICE UNLICENSED REVIEWS**	
	It was agreed that that the NICE unlicensed reviews would be discussed by the Guideline Group who would decide whether they were any local considerations which should come to JAPC.	**SD**
15.	**MINUTES OF OTHER PRESCRIBING GROUPS FOR INFORMATION**	
	• Sheffield Area Prescribing Committee 19/3/13 • STAMP 9/4/13 • Derbyshire Community Health Services 15/5/13	
16.	**ANY OTHER BUSINESS**	
a.	**Prescribing Specification** Mr Dhadhli stated that a minor change had been made concerning five days dressings and there were no resource implications for GPs. The prescribing specification would be sent to Mr Steward.	**SD**
b.	**JAPC Agenda Items** The following agenda items were deferred: • JAPC Annual Report • MHRA Drug Safety Update • NICE Summary	

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17.	**DATE OF NEXT MEETING**	
	Tuesday, 9 July 2013 in the Post Mill Centre, South Normanton.	