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DERBYSHIRE JOINT AREA PRESCRIBING COMMITTEE (JAPC)

Minutes of the meeting held on Tuesday 9 April 2013

CONFIRMED MINUTES

Summary Points

Traffic lights

Drug	Decision
Mirabegron	RED
Ingenol Mebutate Gel	GREEN specialist recommendation
Latanoprost preservative free eye drops UDV	GREEN specialist initiation
Tafluprost preservative free eye drops UDV	BROWN
Bimatoprost preservative free eye drops UDV	BROWN
Colistimethate sodium dry powder inhaler	RED
Tobramycin dry powder inhaler	RED

Guidelines

Diagnosis and Management of Lower UTI
Appropriate Antimicrobial Prescribing
Guidance on the management of Clostridium Difficile in primary care

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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	
Dr I Tooley	GP
North Derbyshire CCG	
Dr C Emslie	GP
Hardwick CCG	
Mrs K Needham	Head of Medicines Management
Dr T Parkin	GP
Derbyshire Community Health Services NHS Trust	
Mr M Steward	Head of Medicines Management
Derby Hospitals NHS Foundation Trust	
Dr F Game	Chair- Drugs and Therapeutic Committee
Mr D McLean	Principal Pharmacist
Derbyshire Healthcare NHS Foundation Trust	
Dr S Taylor	Consultant Psychiatrist, Chair – Drugs and Therapeutic Committee
Chesterfield Royal Hospital NHS Foundation Trust	
Ms C Lawson	Principal Pharmacist
In Attendance:	
Mrs S Agboola	Specialty Registrar Public Health
Dr D Harris	Specialist Antibiotic Pharmacist
Dr R Rabindranathnambi	Consultant Dermatologist, RDH
Dr J Pickard	F2 Public Health
Mr A Thorpe	Derby City Council Public Health (minutes)

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Item		Action
1.	**APOLOGIES**	
	Mrs L Hunter, Dr D Fitzsimons, Dr A Mott and Mr M Shepherd.	
2.	**DECLARATIONS OF CONFLICT OF INTEREST**	
	No declarations of interest were made.	
3.	**DECLARATIONS OF ANY OTHER BUSINESS**	
	JAPC Review – Core business meeting.	
4.	**MINUTES OF JAPC MEETING HELD ON 12 MARCH 2013**	
	The minutes of the meeting held on 12th March 2013 were agreed as a correct record with the following amendments: Summary Points: Circadin – Add Melatonin 2mg MR NOACs (Apixaban) – Amend to 'Dr McKernan stated that it had been decided to look at poorest controlled patients first and those with less than 50% time in therapeutic range over the previous six months.' Action: Add 'It was agreed to amend CHADS to greater or equal to 1 so this would be compliant with NICE Guidance'. Rivaroxaban for DVT/PE – RDH - Amend to 'The duration of treatment for PE was approximately six months and distal DVT approximately three months.' Agreed: Amend to 'JAPC agreed the use of rivaroxaban for patients on long-term treatment dose low weight molecular heparin with very poor control and at high risk of thrombosis.' Hypomagnesaemia and Unlicensed/Off Label Use of Oral Treatments: Amend to 'there was no national guidance for the treatment and there were no published trials for placebo versus active treatment.' Any other business – Amend to 'It was agreed that Mr Shepherd would nominate a representative from CRH and the CCGs would nominate a GP representative and inform Mr Dhadli accordingly.'	
5.	**MATTERS ARISING**	
a.	**Fosfomycin** Mr McLean reported that fosfomycin would be made available at RDH and had been discussed by the RDH Drugs and Therapeutic Committee. An implementation plan was awaited for a pro-forma which patients would take to the pharmacy. Mr Dhadli stated that the implementation plan would need to be agreed by either JAPC or the Southern Derbyshire Prescribing Group.	
b.	**Pentoxyfilline for Venous Leg Ulcers** The revised wound care guideline would be brought back to the June JAPC meeting when a traffic light classification would be assigned.	**DCHS**
c.	**Shared Care Pathology Group** Mr McLean reported that the governance arrangements around guidelines issued by the Shared Care Care Pathology Group had been discussed and these would be reviewed by the RDH Drugs and Therapeutic Committee to ensure that only approved guidelines were circulated. The Group did not deal with guidelines which involved drugs.	
d.	**Disulfiram Shared Care**	

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	Dr Taylor reported that Ms Caroline Jones was currently revising the shared care and this would be included in the Action Tracker for discussion at the June JAPC meeting.	**DHcFT**
6.	**NEW DRUG ASSESSMENT**	
a.	**Mirabegron** Mr Dhadli reported that mirabegron was a new drug launched for the symptomatic treatment of urgency, increased micturition frequency and/or urgency incontinence as may occur in adult patients with overactive bladder (OAB). The treatment was not curative and therefore patients would require long term therapy. The evidence came from patients with symptomatic OAB in two phase III, double-blind, parallel group placebo controlled 12 week study carried out in Europe/Australia and North America and an active-controlled 12 month study. Participants were recruited aged 18 years of age and over with symptoms of OAB for three or more months and were excluded from the study if they showed significant stress incontinence or stress predominant mixed incontinence at screening or an average total daily urine volume >3000mls during run-in assessment. The primary endpoints assessed were change from baseline to final visit in the mean number of incontinence episodes/24 hours and micturitions/24 hours based on a three-day micturition diary. Key secondary endpoints included changes in the mean volume voided per micturition, and changes in the mean number of incontinence episodes/micturitions/24 hours at week four, based on a three day micturition diary. Mr Dhadli informed JAPC that the studies had revealed that mirabegron was more effective than placebo in reducing the mean number of incontinence and micturition episodes in 24 hours. . Mr Dhadli referred to the trial limitations and highlighted that mirabegron had not been directly with other OAB drugs in appropriately designed trials, that the intention to treat population were not used for the assessment of efficacy, trials included a 100mg treatment group (not licensed) and of short duration. Mirabegron for adults with symptoms of overactive bladder would be the subject of a NICE TA due to be issued in June 2013 and the preliminary recommendation was for mirabegron to be an option for treating overactive bladder symptoms only for those people for whom antimuscarinic drugs were contraindicated or clinically ineffective or had unacceptable side effects. **Agreed:** Mirabegron classified as a **RED** drug pending the release of the NICE TA guidance when this decision would be reviewed.	**SD**
b.	**Ingenol Mebutate Gel** Mr Dhadli stated that ingenol was a new licensed preparation for the cutaneous treatment of non-hyperkeratonic, non-hypertrophic actinic keratosis (AK) in adults. There had been a NICE evidence summary review in March 2013 and a SMC review in February 2013. Two strengths were licensed: 150 micrograms/gram (0.015%) for treating lesions of the face or scalp and 500 micrograms/gram (0.05%) for treatment of the trunk or extremities. The duration of treatment was two consecutive days for the trunk or extremities	

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	and once daily for three consecutive days for the face or scalp which was a shorter duration than other patient-applied, topical medicines licensed for AK. Mr Dhadli stated that a four-arm study had shown that compared to placebo ingenol was clinically effective. The most common adverse event was skin response at site of application, but most side effects occurred after the conclusion of treatment. The study limitations were lack of head-to-head studies with other treatments for AK and a Cochrane 2012 systematic review had compared interventions and concluded that diclofenac, 5-FU, imiquimod and ingenol mebutate had similar efficacy but with different adverse events and cosmetic outcomes. Mr Dhadli then commented on trial limitations. There as a lack of evidence about repeated use of ingenol on recurrent lesions, on areas greater than 25cm^2 and limited long term data. It was noted that the cost of 5-FU was £33 per course and for ingenol £65 per course. Details were also given of the incremental costs per QALY by the SMC conducted by an indirect comparison which indicated a significant increase in ICER when compared to 5-FU During discussion Dr Game commented that ingenol was a useful agent as patients finished their course of treatment before they got any side effects. Dr Tooley highlighted that ingenol offered an advantage with patient compliance and may save money in the long term as it was a single course treatment. It was queried whether there was a need for specialist guidance for GPs as to the use of 5-FU or ingenol. Mrs Needham stated that each practice in North Derbyshire CCG had a GP who had received dermatology training. Mr Dhadli referred to the NICE CG which stated that patients should only be referred if there was diagnostic uncertainty or in more severe cases suspected squamous cell carcinoma. **Agreed:** Ingenol Mebutate Gel classified as a **GREEN** specialist recommendation drug.	**SD**
c.	**<u>Glaucoma Preservative Free Eye Drops</u>** Mr Dhadli informed JAPC that this was a new drug formulation for preservative free prostaglandin eye drops. The current local guideline for the medical treatment of glaucoma for those patients who could not tolerate benzalkonium (BAK) was to offer travoprost, which had a different non-BAK preservative, and bimatoprost which had a quarter of the preservative of Xalatan which contained BAK. Tafluprost preservative free eye drops were the current preferred option in the event of patients being intolerant to BAK. Mr Dhadli stated that this strategy is no longer necessary as latanoprost preservative free eye drops is a cost effective option Mrs Needham highlighted that it should made clear in the traffic light classification that these were Unit Dose Vials (UDV). **Agreed:** Latanoprost preservative free eye drops unit dose vials – **GREEN** specialist initiation. 1st line preservative free prostaglandin formulation.	

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	Tafluprost preservative free formulation UDV- **BROWN** Bimatoprost preservative free formulation UDV – **BROWN** **Action:** Mr Dhadli to amend the glaucoma guidelines to reflect the change in the pathway.	**SD**
7.	**CLINICAL GUIDELINES**	
a.	Dr Rabindranathnambi presented an outline business case for the use of biologic agents in patients with severe or very severe psoriasis. Patients with psoriasis were assessed and if they met the NICE technology appraisals criteria for a biological agent they were offered one of these. However if they failed on this selected biologic agent a second agent was not offered to them and required separate approval as sequential use of biologics in Dermatology has not been agreed. Derby was stated by Dr Rabindranathnambi as an outlier with other neighbouring Trusts, it did allow second and third biologics. The latest NICE Clinical Guidelines specifically recommended a second biologic agent when one agent had not been successful. The numbers of patients anticipated was between seven to ten in the first year and five patients year on year after the first failure. There was a risk that these patients may need to be admitted to hospital with renal or cardiac failure associated with severe psoriasis. Dr Bell highlighted that JAPC was being requested to amend a local pathway of commissioning high cost drugs. The terms of reference did not allow JAPC to make investment decisions but there would be a need to discuss the proposal and the governance. Mr Dhadli stated that biologics were currently commissioned according to the NICE Technology Appraisals (TA). The current TA's currently recommended one biologic agent but patients who failed on this were not allowed to proceed to a second or third agent. A subsequent clinical guideline had been issued which recommended a second or possibly third biologic but this did not necessarily need to be commissioned. Mr Dhadli highlighted the high cost of treatment as expensive, estimated at around £9,500 per patient per year, also that although sequential use of biologics appeared to be common practice from neighbouring trusts evidenced by Dr Nambi's survey to clinicians. Mr Dhadli stated that the commissioners in other treatment centres were unaware of the use of second and third biologics. Mr Dhadli went on to summarise findings from the full NICE clinical guideline. The NICE Clinical Guideline had noted a wide variation across England. NICE estimated cost increase from CG implementation of more potent corticosteroids, use of a second biologic as an alternative to best supportive care and earlier identification of co-morbidities. In the event of failure with a biologic patients were treated with best supportive care which included combination of therapies, monitoring and regular attendance at day case centre. Savings were predominantly identified	

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	from reduced inpatient stays. Mr Dhadli stated that the NICE Clinical Guideline noted that their literature review identified no relevant economic evidence. The strategy of second biologics is associated with very high cost to the NHS and there was no cost effectiveness analysis identified in the published literature. NICE undertook an analysis broadly similar to technology appraisals but had revised the costs to best supported care to £10,700 (almost twice that used in the technology appraisals) with costs mainly attributable to inpatient stays and had also assumed a class effect for all biologics. It had also been highlighted by NICE that care should be taken in the choice of a second biologic, switching to infliximab for example may not be a cost effective option. Clarity was also needed between primary and secondary failure and audit results would be advantageous. Mr Dhadli advised JAPC not to agree the policy in terms as presented but to acknowledge that there was a good business case to look at individual cases. Identifying appropriate patients is key to allow sequential biologic use. Cost effectiveness of switching is likely if it reduces high need patients, the number of hospitalisations and other types of best supportive care are removed and targeting patients with worst Dermatology Life Quality Index (DLQI) at baseline. Dr Bell referred to the efficacy of the prior approvals process and the desirability of defining the sub-group of patients in terms of cost utilisation. It would be important to note that the CCGs would be responsible for paying for the treatments. Mr Dhadli commented that the prior approvals process for this small number of patients could be managed and that Mrs Qureshi was picking up the data from the Trust. There were also a very small number of patients who went to Sheffield from CRH and these would need to be included. **Agreed:** Dr Nambi and Mr Dhadli would develop a set of criteria for the cases which would have to be met in future. This would be agreed outside of JAPC	**RR/SD**
b.	**<u>Antimicrobial Guidelines</u>** Diagnosis and Management of Lower UTI – Dr Harris advised that the guidance had been reviewed and updated in line with the new Health Protection Agency (HPA) Management of Infection Guidance in Primary Care 2013 and HPA guidance 'Diagnosis of UTI Quick reference Guide for Primary Care 2011 and highlighted the key changes: • Catheter in situ – Antibiotics will not eradicate asymptomatic bacteriuria; only treat if systemically unwell or pyelonephritis likely. • Catheter in situ - Do not use prophylactic antibiotics for catheter. changes – unless history of catheter-change-associated UTI/trauma. • Lab test – Culture and sensitivity should be done in suspected UTI in men: consider prostatitis. • Lab test – Failed antibiotic treatment or persistent symptoms or recurrent UTI. • Empirical treatment of UTIs in pregnancy - Dr Harris highlighted the antibiotics for 1st line nitrofurantoin for seven days except at term in	

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	pregnancy or if G6PD deficient/2nd line trimethoprim except in first trimester pregnancy/3rd line cefalexin. • Acute uncomplicated UTI in adult symptomatic women (non-pregnant) • New percentage of 90% culture positive for severe or 3 or more typical • UTI symptoms; change to 97% NPV if urine is not cloudy and mild symptoms; and 92% PPV if positive nitrite and blood and leucocytes or positive nitrite alone. • Sampling and how to interpret a culture result. Mrs Needham advised that the reference to fosfomycin should include 'microbiologist advice only' in in section community multi-resistant *E.coli.* **Agreed:** JAPC ratified the Diagnosis and Management of Lower UTI guidance. Antimicrobial Treatment Guides – Dr Harris advised that the guidance had been reviewed and updated in conjunction with the new HPA Management of Infection Guidance in Primary Care 2013 and other guidance as appropriate. The key changes were highlighted: • More key messages included at the start of the guidelines. • Access to further details on children's doses of medications. • Clarithromycin doses have been included, as appropriate, as when prescribed generically they are now of similar costs to Erythromycin tablets. • Ciprofloxacin has been included (in addition to ofloxacin) as a treatment option for acute pyelonephritis and acute prostatitis. Ciprofloxacin is included in the HPA guidance and is more cost effective than ofloxacin. Ofloxacin is the only quinolone included as treatment for Pelvic Inflammatory Disease, as per HPA guidance. • Emergency treatment of suspected meningococcal disease has been updated, in line with BNF and new HPA guidance, including changed details on hypersensitivity. • More details have been included on diabetic foot ulcer guidance (in consultation with Royal Derby Hospital and liaison with Chesterfield Royal Hospital • More details have been included on dental abscess, as per latest HPA guidance. Discussion followed on the guidance: First infections section – Dr Parkin queried the section to low dose of penicillins being likely to select out resistance. Dr Harris agreed to change this to 'increase the risk of resistance'. Dr Tooley referred to the section of bites and the recommendation to review the patient after 24/48 hours. Dr Harris stated that this was new guidance on the HPA website to indicate that it was advised to review at 24/48 hours in cases of penicillin allergy. Bites - It was also agreed that the section on bites should be split into human bites and animal bites. Dr Harris added that the RDH microbiologists had recommended the dose of Co-amoxiclav 625mg and indicated that clarithromycin 250-500 bd was low for human bites. Dr Tooley suggested that this should be a matter of clinical judgement by the clinicians.	**DH** **DH**

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	Diabetic foot ulcer infected section - Dr Tooley queried the section which stated that patients should be referred to multidisciplinary foot care clinic within 24 hours. Dr Game confirmed that this was within NICE guidance and NHS diabetes guidance. It was agreed that the contact telephone number needed to be added. Dental abscess – Dr Tooley highlighted that guidance from the Local Medical Committee that GPs should not treat dental patients and patients should be referred to dentists. It was agreed that an amendment be made that antibiotics should be prescribed by a dentist. Shingles – Dr Harris would amend this section to highlight the people who needed treatment. **Action:** Dr Harris would incorporate the agreed amendments in the guidance and bring back for ratification by JAPC together with the HPA guidelines for information.	**DH** **DH** **DH**
c.	**<u>Appropriate Antimicrobial Prescribing</u>** Dr Harris highlighted the key changes: • Risk of association with C difficile – Quinolones, cephalosporins, co-amoxiclav and clindamycin have higher risk/Macrolides and amoxicillin have moderate risk. • RTIs – All quinolones (including levofloxacin) should be reserved for proven resistant organisms and thus recommended by microbiology. • Erythromycin – Prescribe as EC 250mg tablets. If clarithromycin tablets are used, prescribe generically. The references to PCTs would be replaced by CCGs and a cross reference to this document would be inserted in the Antimicrobial Guidelines. **Agreed:** The Appropriate Antimicrobial Prescribing Guideline was ratified by JAPC.	**DH**
d.	**<u>Management of Clostridium difficile Infection Guidelines</u>** Dr Harris reported that the changes agreed by JAPC at the last meeting had been saved and highlighted the key changes: • Details on pages 4 to 7 and two attachments added of a patient/carer information leaflet on CDI and Infection Prevention & Control requirements for Patients with C.difficile Infection in their Own Home. • Details added on: table of indicators of severe disease on page 4; brief explanation of leaflets on page 5; signs of deterioration on page 5; definition of relapses after 28 days and simplified details on page 7 regarding treatment of first recurrence • A minor change on the use of ranitidine was made by Sue D on p 4. • It was agreed at the March JAPC meeting that an initial GP visit would be done on day 1 with a further visit done from days 4 to 6 (to allow for weekends). • Ms Dakin had updated the monitoring section keeping the initial visit on diagnosis and had amended further details to include either a visit or	

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	telephone monitoring to assess response to treatment on days 3 and 7. Dr Harris had amended this to 'on days 3 and 7, or as soon as practical afterwards' – this was done to allow for weekends. Ms Dakin had also added an assessment, by telephone or in person, to be done on completion of treatment. • The flow diagram on page 2 and details on page 3 are to be amended to state GDH antigen rather than stating CD antigen. • The definition of new case of C.difficile on page 7 will be changed to: 'If a relapse of CDAD occurs more than 28 days after the date of the specimen collection (for the first toxin positive result) then it is classed as a new case of infection.' During discussion Dr Tooley referred the section on monitoring and concern that GPs were expected to undertake four assessments: one face to face assessment on diagnosis, telephone or face to face reviews on day 3 and day 7 and a further review on completion of treatment. Dr Tooley highlighted that it had been agreed that GPs should assess at day 1 and a further assessment between days 4 to 6. Agreement was reached as below: A face to face assessment on day 1 (or as soon afterwards as possible). A further assessment (face to face or telephone - as is clinically appropriate) between days 4 and 6. A final assessment to be done 3 days after completion of treatment. Further assessments may be needed if clinically indicated by the patient's condition It was agreed that a reference should be added to indicate that further assessments may be needed if clinically indicated Dr Tooley also queried the lack of guidance as to what should happen out of hours. Dr Harris would contact Derbyshire Health United to ascertain its role in this in advance of the next meeting.	**DH** **DH**
e.	**<u>Nicotine Replacement Therapy and Smoking Cessation</u>** This would be discussed at the June JAPC meeting and a front sheet included.	**SD**
8.	**MONTHLY HORIZON SCAN**	
a.	Mr Dhadli advised JAPC of the following new drug launches: • Insulin Degludec-unclassified • Mirabegron- reviewed • Ingenol mebutate gel, 150 and 500 micrograms/g- reviewed • Imiquimod cream 3.75% - This was unclassified • Rifaximin – This was unclassified until any request for its use as received from secondary or primary care. • Latanoprost preservative free eye drops-reviewed • Bimatoprost preservative free eye drops-reviewed	

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9.	**MISCELLANEOUS**	
a.	**JAPC Contracts with Providers – Formularies** JAPC noted that the NHS Commissioning Board (NHSCB) had released the NHS standard contract for 2013/14 and a clause of this required providers to publish their formularies and ensure that these reflected all positive NICE TAs and were available on patient-facing websites.	
b.	**NICE Unlicensed Reviews – PolyCystic Ovary Syndrome** Mr Dhadli stated that this was a NICE evidence summary of an unlicensed off-label use of metformin in polycystic ovary syndrome (POCS) in women not planning pregnancy. The summary stated that there was no good evidence that regimes containing metformin were statistically different with co-cyprindiol in controlling hirsutism in women with POCS. Two small studies found no statistically significant difference between metformin and co-cyprindiol in effects on acne but the assessment methods were unclear. Metformin was less effective at improving menstrual regularity than co-cyprindiol. Co-cyprindiol was noted as being cheaper than metformin. Information about the summary would be included in the newsletter.	**SD**
10.	**NICE SUMMARY**	
	Mrs Qureshi informed JAPC of the comments for the CCGs which had been made for the following NICE guidance: TA 276 Colistimethate sodium and tobramycin dry powders for inhalation for treating pseudomonas lung infection in cystic fibrosis (CF) – The dry powder inhalers should displace the nebulised formulation. It had been estimated that 40% of patients who were using colistimethate would change to the dry powder inhaler and 20% would change to the tobramycin dry powder. It was noted that colistimethate sodium dry powder was not currently available. Both dry powders came with a patient access scheme. Mr Dhadli commented that the full guidance indicated that tobramycin when used should be used for 28 days of treatment followed by 28 days off. Some clinicians did not like this on and off prescribing and recommend during the off period either half-dose tobramycin/colistemethate or alternating treatments. Neither of which are supported by the evidence. Mrs Qureshi would look further at the evidence base and cost effectiveness of using tobramycin for 28 days and then 28 days off and contact relevant trusts. Tobramycin dry powder inhaler classified as a **RED** drug. Colistimethate dry powder inhaler classified as a **RED** drug. TA 277 Methylnaltrexone for treating opioid-induced bowel dysfunction in people with advanced illness receiving palliative care. This was a terminated appraisal due to the lack of submission of an economic appraisal by the pharmaceutical company. Mr Dhadli stated that this had been re-classified from red to brown specialist initiation to enable quick access for palliative care patients and had received a positive SMC review in 2008.	**SQ** **SD**

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	It was agreed that methylnaltrexone should continue to be classified as BROWN specialist initiation drug and re-visited should the situation about the lack of an economic appraisal change.	
11.	**JAPC BULLETIN**	
	The following changes to the JAPC bulletin were noted: Rivaroxaban - Change to: Following the advice of a consultant haematologist the NOAC atrial fibrillation guidance relating to rivaroxaban now requires the use of the Cockcroft Gault formula to more accurately calculate the patient's creatinine clearance to determine the correct dose.' The amended JAPC bulletin was ratified by the JAPC.	
12.	**GUIDELINE GROUP**	
	The Guideline Group action tracker was ratified by the JAPC.	
13.	**TRAFFIC LIGHTS – ANY CHANGES?**	
	Classifications Mirabegron – RED Ingenol – GREEN specialist recommendation Latanoprost preservative free eye drops UDV – GREEN specialist initiation Tafluprost preservative free eye drops UDV– BROWN Bimatoprost preservative free eye drops UDV– BROWN Colistimethate sodium dry powder inhaler– RED Tobramycin dry powder inhaler– RED Mrs Needham commented that Q10 should read Co-enzyme Q10. It was agreed that the traffic light list be re-formatted to highlight the list of black drugs.	**SD** **SD**
14.	**ACTION SUMMARY**	
	The action summary was noted by JAPC.	
15.	**MHRA DRUGS SAFETY UPDATE**	
	The MHRA Drug Safety Alert for March 2013 was noted. Mr Dhadli highlighted that dabigatran was now contraindicated in patients with prosthetic heart valves requiring anti-coagulant treatment related to their valve surgery because of the risk of thromboembolic and bleeding events. The NOAC guidance had been updated to reflect this. Mr Dhadli also highlighted that aqueous cream may be associated with skin reactions, particularly in children with atopic eczema. This had been included in the formulary chapter.	
16.	**MINUTES OF OTHER PRESCRIBING GROUPS FOR INFORMATION**	
	• Nottinghamshire Area Prescribing Committee 17/1/13 • Sheffield Area Prescribing Committee 22/1/13	

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	• DHFT Drugs and Therapeutic Committee 18/2/13 • Sheffield Area Prescribing Committee 19/2/13 • DCHS Medication Operational Safety Team 13/3/13 • CRH Drugs and Therapeutic Committee 19/3/13	
17.	**ANY OTHER BUSINESS**	
	It was agreed that a business meeting be held from 3.30 pm to 4.30 pm after the JAPC review.	
18.	**DATE OF NEXT MEETING**	
	Tuesday, 14 May 2013 in the Rangewood Room, Post Mill Centre, South Normanton (JAPC Review). Details and timings to be circulated to members.	