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DERBYSHIRE JOINT AREA PRESCRIBING COMMITTEE (JAPC)

Minutes of the meeting held on Tuesday 9 July 2013

CONFIRMED MINUTES

Summary Points

Traffic lights

Drug	Decision
Dundee Cream (reflectant sun creams)	BROWN specialist recommendation
Lixisenatide	GREEN (trained specialist) 1st line GLP1for new patients
Modafinil	GREEN specialist initiation for narcolepsy/Parkinson's Disease and BLACK for all other indications
Nalmefene	RED
Ranibizumab	RED as per TA 283
Bevacizumab in combination with paclitaxel and carboplatin for first-line treatment of advanced ovarian cancer	BLACK as per TA 284
Bevacizumab in combination with gemcitabine and carboplatin for treating the first recurrence of platinum-sensitive advanced ovarian cancer	BLACK as per TA 285
Loxapine	BLACK as per TA 286
Dapaglifozin	BROWN specialist initiation (option as per TA 288)
Ruxolitinib	BLACK as per TA 289
Pegloticase	BLACK as per TA 291
Strontium ranelate	GREEN specialist initiation
Fluarix Tetra	BLACK
Fluenz	GREEN for children from 2yrs up to and including 17 yrs

Clinical Guidelines

Management of Clostridium Difficile in Primary Care

Patient Group Directions

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Meningitis C
Rotavirus

Present:	
Derbyshire County Council	
Dr J Bell	Assistant Director of Public Health (Chair)
Mrs S Qureshi	NICE Audit Pharmacist
Southern Derbyshire CCG	
Mr S Dhadli	Specialist Commissioning Pharmacist (Secretary)
Dr A Mott	GP (also representing Hardwick CCG for this meeting)
Dr I Tooley	GP
North Derbyshire CCG	
Dr C Emslie	GP
Dr D Fitzsimons	GP
Mrs K Needham	Head of Medicines Management North (also representing Hardwick CCG)
Erewash CCG	
Dr M Henn	GP
Derby Hospitals NHS Foundation Trust	
Dr F Game	Chair, Drugs and Therapeutic Committee
Mr C Newman	Acting Chief Pharmacist
Derbyshire Healthcare NHS Foundation Trust	
Dr S Taylor	Consultant Psychiatrist, Chair Drugs and Therapeutic Committee
Chesterfield Royal Hospital NHS Foundation Trust	
Mr M Shepherd	Chief Pharmacist
Derbyshire Community Health Services NHS Trust	
Mr M Steward	Chief Pharmacist
Lay Representative	
Dr C Shearer	Healthwatch Derbyshire
In Attendance:	

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Dr D Harris	Specialist Antibiotic Pharmacist, Southern Derbyshire CCG

Item		Action
1.	**APOLOGIES**	
	Mrs L Hunter, Mr S Hulme, Dr T Parkin and Mr A Thorpe.	
2.	**DECLARATIONS OF CONFLICT OF INTEREST**	
	No declarations of interest were made.	
3.	**DECLARATIONS OF ANY OTHER BUSINESS**	
	• UTI Reporting • Strontium Warning • Flu Vaccine Programme Dr Henn stated that the senior physiotherapists at Royal Derby Hospital have requested a review of the decision made by JAPC at the last meeting to classify Flutter Device as black. Dr Bell stated that they would need to submit any new evidence to the Clinical Commissioning Policy Group who had made the original decision. JAPC would not undermine a commissioning decision made elsewhere in the organisation. This would be conveyed to the senior physiotherapists. Dr Henn to submit evidence to the Clinical Commissioning Policy Group.	
4.	**MINUTES OF JAPC MEETING HELD ON 11 JUNE 2013**	
	The minutes of the meeting held on 11 June 2013 were agreed as a correct record with the following amendments: Nicotine Replacement Therapy (NRT) – Amend to: 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. Amend to: 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. Anticoagulation Guideline – Amend to: 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. Guidelines for Chronic Pain Management in Primary Care – Amend to: 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. Travel Vaccines – Amend to: 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 recommended that hepatitis B vaccination was 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.	

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Item		Action
5.	**MATTERS ARISING**	
a.	**Guidelines Sub-Group Terms of Reference** Mr Dhadli advised that revised terms of reference for the Guidelines Sub-Group had now been produced as a result of the recommendation from the JAPC Review. Membership of the Sub-Group would now include a GP representative to represent all the Derbyshire CCGs and it had been recommended that there should be separate representation from both RDH and CRH. Dr Bell highlighted the importance of ensuring that the Sub-Group functioned well in order to assist JAPC in its decision making process. During discussion Mr Shepherd agreed that CRH should be represented on the Sub-Group but suggested that other ways of conducting the meetings should be explored such as teleconferencing. Mr Dhadli stated that the quoracy of the meetings would be achieved with the inclusion of a GP together with one representative from secondary care if there were relevant agenda items which affected that sector. **Agreed:** Dr Tooley would be the GP representative with Dr Emslie as deputy and attendance flexible dependent on the nature of the agenda. **Action:** Mr Newman and Mr Shepherd would nominate representatives from RDH and CRH respectively to join the Sub-Group.	**CN /MS**
b.	**Reflectant Sunscreen Cream (Dundee Cream)** Mr Dhadli stated that Tayside Pharmaceuticals, the manufacturers of Dundee Cream, had been contacted about the supply of Dundee Cream. Tayside Pharmaceuticals had advised that they do not deal directly with wholesalers but only community pharmacies or dispensing doctors who would need to fax an order to them and they were also unable to dispense from a FP10. The price from the supplier of the cream was £19.76p for a 50g tube plus a handling charge of £15 for orders less than £50 in value. Community Pharmacies during endorsing can claim a fixed charge of £20 (specials procurement per item) as per drug tariff. During discussion it was agreed that, due to the small number of patients involved and improving patient access, the use of Dundee Cream would be made available via FP10 and community pharmacies with close monitoring of the costs. **Agreed:** Dundee Cream classified as **BROWN** specialist initiation drug.	**SD**
c.	**Rifaximin for Hepatic Encephalopathy** Mr Dhadli stated that JAPC had previously classified rifaximin as green specialist initiation and since this decision had been made NICE had published a negative FAD for rifaximin in hepatic encephalopathy. The final NICE TA was due to be published in October 2013. Mr Dhadli proposed that we have a holding position and no new patients started on rifaximin in primary care until a final decision on its use had been made by NICE. During discussion Mr Shepherd commented that any change of decision by JAPC should be delayed until a final decision had been made by NICE. Dr Mott stated that it needed to be determined whether new patients should be started on rifaximin	

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	and transferred over when there was a reasonable likelihood that they would be repatriated in three months time. It should therefore be highlighted to patients that the position may change in October and they may need to be repatriated back to secondary care. **Agreed:** Rifaximin would be discussed again by JAPC when the NICE TA is published in October 2013 and that the clinicians should be alerted that patients may need to be repatriated at that time.	**RDH/ CRH** **SD**
6.	**NEW DRUG ASSESSMENTS/TRAFFIC LIGHT ADDITIONS**	
a.	**Epilepsy** Mr Dhadli stated that there were no anti-epileptics currently listed on the local formulary just a statement to follow consultant or specialist recommendation. There had recently been new anti-epileptic drugs launched and it needed to be decided whether these should be approved for use locally or via tertiary centres. Mr Dhadli added that he had contacted some out of area trusts in order to understand the variation in the formulary position. Mr Hulme had also been requested to report back on the place of the newer therapies. Dr Lal, RDH Consultant, had now developed a list of proposed different classifications for a number of anti-epileptic drugs. Dr Bell stated that JAPC would need to agree the principles of how to work with other APCs and accept host classification for drugs from tertiary centres. Mr Dhadli commented that a statement on what constituted a core formulary was needed and suggested that the traffic light classification recommended by the neighbouring APCs be accepted where there was a tertiary centre in line with the guidance on "out of area classification" on the website. **Agreed:** The recommended traffic light classification for perampanel made by Sheffield APC would be followed. **Action:** The list of anti-epileptic drugs prepared by Dr Lal and the list received from Sheffield would be compared in order to decide which drugs could be placed on a local core formulary. A recommendation would be made concerning the drugs which were not on this local list and that the advice of the host APC for the tertiary centre should be followed where a decision had been made, provided the drug had not been classified black in Derbyshire.	**SD** **SD/SH**
b.	**Lixisenatide** Dr Game reported that Lixisenatide was a glucagon-like peptide-1 (GLP-1) mimetic licensed for use in combination with basal insulin or oral antidiabetic drugs for treating type 2 diabetes in adults whose blood glucose was not adequately controlled on these treatments alone. It is administered by injection once daily and cheaper than other GLP-1s. Lixisenatide had also recently been discussed and supported by the RDH Drugs and Therapeutic Committee. Patients should be started on the lower dose of 10mg and increased to 20mg as a maintenance dose. Lixisenatide had been found to be non-inferior to exenatide with no safety implications. It was proposed that it should replace exenatide in the patient pathway	

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	for new starters as first-line treatment. It was not proposed to switch patients who were already on exenatide. Dr Game agreed to update the existing GLP-1 flow charts and develop one for lixisenatide. Mr Dhadli stated that there was a NICE New Medicines Review which had only looked at two fully published studies, GETGOAL-mono and GETGOAL-Asia, but the validity of these had been questioned. Mr Dhadli outlined other more recently published trials (GETGOAL series) which had indicated some weight loss associated with lixisenatide and HBA1c lowering. Mr Dhadli went on to inform JAPC that the triple therapy trial GETGOAL-S would have been of most interest but this had only been available in poster form. A SMC review on lixisenatide was due to be published in September 2013 but there was no indication that NICE would produce an appraisal. Dr Game stated that the same criteria for initiation and ongoing treatment would be used for lixisenatide as for exenatide. There were no competitive trials with liraglutide. Mr Dhadli highlighted concern from the studies about its efficacy for weight loss which may not meet the NICE criteria leading to more discontinuations and that this would require close monitoring. Dr Mott stated that any implementation of lixisenatide would need to be carefully managed. Mr Dhadli then referred to a Derbyshire sample audit of 368 patients in primary care on exenatide from June 2012 to March 2013 which had revealed that 34% did not meet the initiation criteria and 37% did not meet the criteria at six months to continue. Dr Shearer commented on the potential confusion for patients who had the same condition having different treatments. **Agreed:** JAPC endorsed the decision to replace exenatide with lixisenatide for new starters. **Agreed:** Lixisenatide classified as a **GREEN** specialist initiation drug by trained practices. **Agreed:** Exenatide would continue to have a traffic light classification of **GREEN,** Exenatide MR remains a brown classification, and a flowchart and guidelines for type 2 diabetes would be developed. The implementation of lixisenatide and development of the guidelines would be led by the two Prescribing Groups.	FG **SD** **SD**
7.	**CLINICAL GUIDELINES**	
a.	**<u>Management of Clostridium Difficile (CDI) in Primary Care</u>** Dr Harris reported that the guideline had now been updated to reflect the new guidance recently issued by Public Health England and these changes were indicated in the document. Dr Harris outlined the main changes: • Extra details on page 2 from the national guidance concerning mild and severe disease. • Extra details about recurrence and review of treatments. • Some changes on page 4 to ensure that H2 antagonists were not overlooked. • New table on severity of C difficile disease between pages 4 to 5. • Patients with mild disease and decrease in episodes of diarrhoea could be monitored before being given treatment. • Blood test for white blood cell count changes.	

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	• Cross infection risk with C difficile. • Further details added about recurrent infection. • Inclusion of a note about post infective irritable bowel syndrome. Dr Harris referred to a card from RDH for patients to carry which indicated that they had been positively tested for C difficile and, if they needed antibiotics in the future, the health care professional would be aware that an antibiotic should be used with a lower risk of a relapse. This could be done as a Derbyshire-wide initiative. Dr Shearer queried the opinions of patients on the information contained in the card. Dr Harris agreed to check the views of patients about the card and convey these to the infection control meetings. Dr Tooley suggested putting the blood monitoring in the first box on page 1 to ensure that this was done at the beginning. **Agreed:** JAPC ratified the Clinical Guideline for the Management of Clostridium Difficile in primary Care with the agreed amendments.	**DH** **DH** **SD**
b.	**<u>Patient Group Directions (PGDs)</u>** Mr Dhadli reported that the existing Meningitis C PGD had now been updated, in the light of new guidance from Public Health England. There was also a new Rotavirus PGD. It was noted that both PGDs were intended to be used by practice nurses to facilitate vaccinations in GP practices. **Agreed:** JAPC ratified the Meningitis C PGD and Rotavirus PGD.	**SD**
8.	**SHARED CARE GUIDELINES**	
a.	**<u>Modafinil</u>** Mr Dhadli advised JAPC that patients initiated on Modafinil from both RDH and CRH were stabilised on doses and then transferred to primary care. Patients being treated with modafinil that were hypertensive required monitoring of blood pressure and heart rate every six months which could be undertaken by primary care clinicians. It was highlighted that modafinil was only for narcolepsy secondary to Parkinson's disease. **Agreed:** Modafinil classified as **GREEN after specialist initiation** secondary to Parkinson's disease and **BLACK** for all other indications. No shared care required.	**SD**
b.	**<u>Memantine</u>** Dr Taylor highlighted the changes made to the GP and Consultant responsibilities in the shared care guideline for memantine for the treatment of Alzheimer's Disease. Mrs Needham referred to point 2 in section 3 concerning the adjustment of the dose as necessary or as advised by the specialist. It was agreed that this should be changed to the dose to be adjusted as advised by a specialist. **Agreed:** JAPC ratified the memantine shared care guideline	**ST** **SD**
c.	**<u>Acetylcholinesterase Inhibitors</u>** Dr Taylor highlighted a change in the GP responsibilities and it was agreed that point 4 in section 2 be changed to the dose to be adjusted as advised by a	

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	specialist. Dr Fitzsimons referred to the need for advice concerning deterioration in renal function and physical condition in the guidance. **Action:** A statement concerning the action to be undertaken in the event of deterioration in renal function and physical deterioration to be included in the guidance which would be brought back to the JAPC meeting in August.	**ST** **SD** **ST/SD**
9.	**MONTHLY HORIZON SCAN**	
	Mr Dhadli advised JAPC of the following new drug launches and discontinuations: • Nalmefene – Nalmefene classified as a **RED** drug. • Ocriplasmin – Unclassified. • Vagifem 25mg estradiol vaginal tablets – Discontinued.	
10.	**MISCELLANEOUS**	
a.	**<u>JAPC Annual Report</u>** The following amendments were made to the 2012 JAPC Annual Report: • The breastfeeding policies had not been ratified by JAPC to be taken out • Prucalopride reclassified as RED • Repevax (October 2012) to be taken out. • The recommendations section to be amended. The Annual Report would be circulated after the inclusion of the agreed amendments.	**SQ**
b.	**<u>High Cost Drugs</u>** Mr Dhadli advised JAPC that the Department of Health Payment by Results (PbR) Team produced the list of High Cost Drugs excluded from tariff. These drugs were typically used in a relatively small number of specialist centres rather than across all Trusts. In order to ensure fair reimbursement these drugs were excluded from the PbR tariff and additional funding was agreed locally over and above the national mandatory tariff. Mr Dhadli referred to two local shared care agreements that covered the activity of specialised services. These were phosphate binders (lanthanum and sevelemer) and somatostatin analogues for cancer related indications which were commissioned via NHS England. It was anticipated that patients on the above treatments would eventually be repatriated back to the Acute Trust. Mr Dhadli suggested that no new patients should be started on these treatments in primary care under the shared care agreements for these indications for somatostatin and all phosphate binders. During discussion Dr Emslie queried what should be done with the primary care patients who were currently on the shared care agreements and it would be difficult to plan a course of action if there was no date for repatriation to secondary care. Dr Emslie suggested that the current position should continue until a date had been arranged for patients to be repatriated. Mr Newman highlighted the large number of patients in secondary care and the large amount of work that would have to be done concerning homecare, prescribing and governance. Dr Mott commented that it would be useful to obtain details of the amount of prescribing and likely impact on budgets.	

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	Agreed: Mr Newman to provide an update of likely patient numbers and costs to the next JAPC meeting.	**CN**
11.	**JAPC BULLETIN**	
	The JAPC bulletin was ratified by JAPC.	
12.	**MHRA DRUG SAFETY UPDATES**	
	The MHRA Drug Safety Alert for May 2013 was noted. Mr Dhadli highlighted the following MHRA advice: Liothyronine 20 microgram tablets – Continuity of supply and potential increased need for patient monitoring. The MHRA Drug Safety Alert for June 2013 was noted. Mr Dhadli highlighted the following MHRA advice: Diclofenac – New contraindications and warnings after a Europe wide review of cardiovascular safety. Diclofenac now contraindicated for ischaemic heart disease, peripheral heart disease, cerebrovascular disease and congestive heart failure. It was agreed that the current place of diclofenac as third line in the formulary should be discussed by the Guideline Group. Cyprotene acetate with ethinyloestradiol (co-cyprindiol) – Balance of benefits and risks remain positive and updated prescribing advice provided. Oral retinoids pregnancy prevention – Reminder of measures to minimise teratogenic risk. Codeine - Restricted use as analgesic in children and adolescents after European safety review.	**KN**
13.	**NICE SUMMARY**	
	Mrs Qureshi informed JAPC of the comments for the CCGs which had been made for the following NICE guidance issued in May and June: May: TA 283 Ranibizumab for treating visual impairment caused by macular oedema secondary to retinal vein occlusion. Approximate costs for implementation in Southern Derbyshire £500,000 and North Derbyshire £300,000. Ranibizumab classified as a **RED** drug for this indication. TA 284 Bevacizumab in combination with paclitaxel and carboplatin for first-line treatment of advanced ovarian cancer. Bevacizumab classified as a **BLACK** drug for this indication. TA 285 Bevacizumab in combination with gemcitabine and carboplatin for treating the first recurrence of platinum-sensitive advanced ovarian cancer. Bevacizumab	**SD** **SD**

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	classified as a **BLACK** drug for this indication.	**SD**
	TA 286 Loxapine inhalation for treating acute agitation and disturbed behaviours associated with schizophrenia and bipolar disorder. This was a terminated appraisal. Loxapine classified as a **BLACK** drug.	**SD**
	CG 159 Social anxiety disorder: recognition assessment and treatment. It was highlighted that there would be an increase in the number of people who presented with social anxiety disorder and the consequent impact on treatments and costs. Escitalopram was recommended by NICE which was not used locally.	
	June: TA 287 Rivaroxaban for treating pulmonary embolism and preventing recurrent venous thromboembolism. JAPC had previously classified rivaroxaban as green for AF and amber for DVT and substance misuse. It was agreed that the existing group in the north should look at a pathway and determine whether rivaroxaban be included in this. The group would liaise with Dr Mott, Dr McKernan from RDH and a clinician from CRH. Mr Shepherd would advise on the CRH clinician to be involved and an update from the group provided for JAPC at the August meeting.	**MS** **KN**
	TA 288 Dapagliflozin in combination therapy for treating type 2 diabetes. Dapaglifozin classified as a **BROWN specialist recommendation** drug.	**SD**
	TA 289 Ruxolitinib for disease-related splenomegaly or symptoms in adults with myelofibrosis. This was a negative appraisal. Ruxolitinib classified as a **BLACK** drug.	**SD**
	TA 290 Mirabegron for treating symptoms of overactive bladder. JAPC had previously classified this as a red drug. It was agreed that a pathway be developed by the Guideline Group and a traffic light classification assigned at the meeting in August.	**KN**
	TA 291 Pegloticase for treating severe debilitating chronic tophaceous gout. Pegloticase classified as a **BLACK** drug.	**SD**
	CG 164 Familial Breast Cancer. Recommendation to use tamoxifen and raloxifene for five years to postmenopausal women with a uterus and at high risk of breast cancer unless they have a past history or may be at increased risk of thromboembolic disease or endometrial cancer. Prescribing would commence in secondary care and then move out to primary care	
14.	**TRAFFIC LIGHTS – ANY CHANGES?**	
	<u>Classifications</u> Dundee Cream – BROWN specialist recommendation Modafinil – GREEN specialist initiation for narcolepsy secondary to Parkinson's Disease and BLACK for all other indications Nalmefene – RED Ranibizumab – RED as per TA 283 Bevacizumab in combination with paclitaxel and carboplatin for first-line treatment of advanced ovarian cancer – BLACK as per TA 284	

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	Bevacizumab in combination with gemcitabine and carboplatin for treating the first recurrence of platinum-sensitive advanced ovarian cancer – BLACK as per TA 285 Loxapine – BLACK as per TA 286 Dapaglifozin – BROWN specialist initiation as per TA 288 Ruxolitinib – BLACK as per TA 289 Pegloticase – BLACK as per 291	
15.	**JAPC ACTION SUMMARY**	
	The action summary was noted by JAPC and amendments made: Antipsychotics Recommended Physical Monitoring – Mr Dhadli stated that an issue about capacity for on-going ECG monitoring had been highlighted by the DHcFT Drugs and Therapeutic Committee. Transgender Prescribing – Await shared care agreement from Nottingham before agreeing local guideline. Seretide – Children's asthma guidance on cost effective products and devices to be brought to the August JAPC meeting. Apixaban – Comments were still awaited from Dr McKernan on the AF guidance. Dr Game would contact Dr McKernan about this. Pentoxyfilline – Mr Steward reported that discussions had taken place about the possibility of placing pentoxyfilline in the wound care formulary. The view had been expressed that it should not be placed in the wound care formulary due to insufficient evidence but it had been suggested that it could be included in the primary care formulary as a statement similar to that in the BNF. A statement had then been requested as to the point at which GPs could prescribe it or should it only be prescribed on the recommendation of a tissue viability nurse. Mr Dhadli commented that this issue had arisen from a request by a GP to change the traffic light classification of pentoxyfilline to green. There was evidence for its use from Cochrane, Australian and New Zealand guidelines from 2011 and Sign 2010. The vascular consultants had been asked for their views and they had indicated that they did not prescribe and had referred to limited evidence. Mr Steward proposed that pentoxyfilline be classified brown for chronic venous leg ulcer when non-responsive to compression bandaging but it would be a GP decision when to prescribe it. It was agreed that Mr Steward would send Mr Dhadli a summary of the views and recommendations for discussion at the August JAPC meeting. Opioid Pain Guidance/Neuropathic Pain Guidance – Comments were awaited from Burton.	**SQ** **FG** **MS**
16.	**GUIDELINE GROUP**	
	The Guideline Group action tracker was ratified by the JAPC.	
15.	**MINUTES OF OTHER PRESCRIBING GROUPS FOR INFORMATION**	
	• Royal Derby Hospital Drugs and Therapeutic Committee 18/3/13 • Royal Derby Hospital Drugs and Therapeutic Committee 15/4/13 • Royal Derby Hospital Drugs and Therapeutic Committee 20/5/13 • Chesterfield Royal Hospital Drugs and Therapeutic Committee 21/5/13 • Derbyshire Healthcare Foundation Trust Drugs and Therapeutic Committee	

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	23/5/13 • Nottinghamshire Area Prescribing Committee 21/3/13 • Sheffield Area Prescribing Committee 16/4/13 • Sheffield Area Prescribing Committee 21/5/13	
16.	**ANY OTHER BUSINESS**	
a.	**<u>UTI Reporting</u>** Dr Harris reported that communication had been received from a GP in the south who had enquired about sensitivity reporting in Derby. The GP had requested amoxicillin to be an option on the UTI sensitivity report as currently GPs had two main options before they went on to broad spectrum antibiotics. These were trimethoprim and nitrofurantoin. The reason for the removal of amoxicillin from the reporting from Derby was the desire to transfer over to reporting on co-amoxiclav. GPs would like to use amoxicillin as an option if a patient had a problem with nitrofurantoin or trimethoprim. Dr Harris had checked the position in Nottingham as some GPs in the south and Erewash obtained results from there and amoxicillin was an option. Dr Harris had requested RDH microbiology for a decision as to whether amoxicillin could be included and a reply was awaited.	
b.	**<u>Strontium ranelate</u>** Mr Dhadli referred to a recent MHRA warning about increased cardiovascular safety beyond the risk of embolism. The advice for health care professionals was that the treatment should only be initiated by a physician with experience in the treatment of osteoporosis. It was therefore agreed that the traffic light classification of strontium ranelate should be changed to **GREEN** after specialist initiation.	**SD**
c.	**<u>Flu Vaccine</u>** Mr Dhadli stated that Fluenz currently had a black traffic light classification but had now been recommended for use in the national immunisation programme for patients aged two and three years in and in the at risk two to seventeen year olds. It was agreed that Fluenz should have a **GREEN** traffic light classification. In addition it had been recommended that Intanza should be left as black and Fluarix Tetra should also have a black traffic light classification. JAPC ratified this recommendation. Ms Linda Syson-Nibbs, NHS England Derbyshire and Nottinghamshire Area Team Screening and Immunisation Lead, had advised that those children who were being immunised as part of the national campaign would receive Fluenz obtained from the national stock. Ms Syson-Nibbs had also advised that those children who were older than the national campaign should continue to receive Fluenz rather than the other products. Dr Emslie highlighted a major problem for practices who had already ordered vaccines for children based on what had been ordered in previous years. Mr Dhadli referred to a communication from Public Health England which stated that, in the event that practices had already pre-ordered inactivated vaccines for children aged between two to seventeen in the at risk groups, this could be used for other eligible groups in the event of supply problems. Mr Dhadli agreed to convey the concerns expressed by Dr Emslie and other GPs to Ms Syson-Nibbs.	**SD** **SD** **SD**
17.	**DATE OF NEXT MEETING**	

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Item		Action
	Tuesday, 13 August 2013 in the Post Mill Centre, South Normanton.	