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DERBYSHIRE JOINT AREA PRESCRIBING COMMITTEE (JAPC)

Minutes of the meeting held on Tuesday 11th February 2014

CONFIRMED MINUTES

Summary Points

Traffic lights

Drug	Decision
Tramacet	BLACK
Amorolfine	BROWN-exceptional use where treatment is clinically required and systemic medicines are contraindicated or not tolerated. Not to be used for cosmetic purposes
Minocycline	BLACK
Tioconazole	BLACK
Teriflunomide	RED as per NICE TA303

Clinical Guidelines

Bisphosphonate length of treatment guideline in osteoporosis
Advisory guidance – when to initiate a PPI with a NSAID (or antiplatelet)

Shared Care Guidelines

None

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Present:	
Southern Derbyshire CCG	
Dr A Mott	GP (Chair)
Mr S Dhadli	Specialist Commissioning Pharmacist (Professional Secretary)
Mr S Hulme	Director of Medicines Management
Dr I Tooley	GP
Mrs L Hunter	Finance
North Derbyshire CCG	
Dr C Emslie	GP
Mrs K Needham	Head of Medicines Management North (also representing Hardwick CCG)
Hardwick CCG	
Dr T Parkin	GP
Derbyshire County Council	
Mrs S Qureshi	NICE Audit Pharmacist
Derby Hospitals NHS Foundation Trust	
Dr W Goddard	Chair – Drugs and Therapeutics Committee
Mr C Newman	Chief Pharmacist
Derbyshire Healthcare NHS Foundation Trust	
Dr S Taylor	Chair – Drugs and Therapeutic Committee
Chesterfield Royal Hospital NHS Foundation Trust	
Ms C Duffin	Pharmacist
Derbyshire Community Health Services NHS Trust	
Mr M Steward	Chief Pharmacist
Lay Representative	
Dr C Shearer	Healthwatch Derbyshire
In attendance	
Miss P Chera	Medicines Management Interface Technician

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Item		Action
1.	**APOLOGIES**	
	Dr E Rutter, Dr D Fitzsimons, Mr M Shepherd	
2.	**DECLARATIONS OF CONFLICT OF INTEREST**	
	No declarations of conflict 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 14TH JANUARY 2014**	
	The following amendments were made to the minutes of the meeting held on 14th January 2014: Apologies: amend to: *Dr* E Rutter One spelling error on page one: Varenicline Antidepressants in Moderated and severe Unipolar Depression: amend to: *QTC* Metoclopramide: amend to: *Mr Dhadli advised that recommendations came from recent American guidelines on the management of gastro-paresis which note that domperidone and metoclopramide have equivalent efficacy in reducing symptoms* Jext CAS alert: amend to: *Lesley* Carmen Clinical Guidelines: amend to: *It was agreed to pick up at this point an additional agenda item, dapoxetine.* Morphine: amend to: In response to this previous concern the maximum *daily dose* for morphine in the guideline has already been reduced from 200mg to 120mg; this has been standardised for all *non-cancer* pain guidelines. Modafinil: amend to: *Dr Vaithianathar* Subject to amendments stated, JAPC agreed they were happy to accept the minutes of the January 2014 meeting	**SD** **SD** **SD** **SD** **SD** **SD** **SD**
5.	**MATTERS ARISING**	
	Metoclopramide It was agreed to pick this up when representatives from RDH have arrived **CAS alert** Dr Mott informed the group that there has been some discussion between the medicines management team and the area team about cascading appropriate alerts to General Practice. The area team have a plan to get this in place by the end of the financial year, possibly sooner. Mr Hulme added that the area team are in the process of getting distribution lists updated and that a recent national communication from primary care commissioning to area teams stated that processes must be in place for the distribution of CAS alerts by area teams. Mrs Needham suggested that the medicines management teams continue to cascade CAS alerts until March. **Nebuliser guideline** Deferred to the April JAPC meeting **Modafinil** Dr Mott confirmed that he has written to the Chair of the Nottinghamshire Joint Area Prescribing Committee about prescribing requests for modafinil for unlicensed indications. A response has not yet been received.	

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	Mr Hulme informed the group that previously modafinil had been classified as 'black' for all indications except narcolepsy and narcolepsy secondary to Parkinson's disease. An audit completed in the South may not have captured all the other indications that modafinil may be prescribed for in other Derbyshire CCGs. The Senior Prescribing Advisors Team will be having a discussion at their next meeting to clarify these other indications. Ms Duffin informed the group that usage at the Chesterfield Royal Hospital is mainly in palliative care for fatigue in lung cancer patients and that these patients tend to remain under the hospital specialist. RDH actions to be picked up when representative arrive. **Medical devices** Ms Duffin confirmed that Chesterfield Royal Hospital does not have a medical devices committee, and that devices come under the remit of medical engineers. However a discussion has been held about possibly setting up a group if required. Ms Duffin went on to explain that the speech and language therapists would be producing a paper to support the use of the Therabite jaw device. Ms Duffin will speak to the CRH speech and language therapist to ensure that the paper is produced in consultation with RDH & DCHS. Mr Hulme suggested that the paper should include advice about on-going supplies for the replacement pads and how often these should be prescribed. Mr Steward confirmed that DCHS did have a medical devices committee which stopped meeting, however they are due to start meeting again. The groups remit is not to look at devices considered as medicines but devices such as the therabite jaw device would be within their remit. Dr Mott confirmed that if provider Trusts would like GPs to pick up the prescribing of devices in primary care there should be a process in place to determine their use. The group reviewed prescribing data for medical devices; the three areas for further investigation are compression stockings, lymphoedema garments and vacuum pumps. **Agreed:** Produce a list/formulary of compressions stockings for use within primary care **Agreed:** CRH, RDH & Ashgate to check if formulary in place for lymphoedema garments, how this is managed and quantities to be supplied **Agreed:** RDH & CRH to ask within urology departments what their current practice is for issuing vacuum pumps.	**CD** **SH/KN** **CRH/RDH** **CRH/RDH**
6.	**NEW DRUG ASSESSMENTS/TRAFFIC LIGHT ADDITIONS**	
	Minocycline Mr Dhadli informed the group that that the guideline group recognise minocycline as a low priority for the CCGs and want to further restrict prescribing. Although minocycline has various indications, it is used primarily as one of a number of oral antibiotics available for the treatment of acne. Unlike some other drugs in its class it is available as a once-daily treatment and need not be taken on an empty stomach. However there are concerns regarding its place in therapy: • There is no clear evidence that minocycline is more effective or better tolerated than other tetracycline's • There are safety concerns specific to minocycline • Alternative once-daily treatments e.g. doxycycline and lymecycline are available • Minocycline has a relatively high acquisition cost	

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	Mr Dhadli went on to explain that a Cochrane review from 2003 found no evidence to justify the use of minocycline first-line in acne given its cost and concerns over safety. A further systemic review published in 2008 concluded that there was insufficient evidence to support one tetracycline over another in terms of efficacy. A 2006 Drug and Therapeutic Bulletin found no convincing evidence to support the preference of minocycline over other tetracycline's in acne when its association with serious unwanted effects is taken into account. In a 2009 update, DTB stated that they cannot see a place for minocycline in the management of patients with acne and a further DTB review in 2013 "time to say goodbye to minocycline" suggested APCs should review the place of minocycline and remove from formularies. In July 2012 JAPC classified minocycline as brown following RDHs comments to allow usage for specialists in autoimmune bullous disorders and pyoderma gangrenosum. This is supported by guidelines produced by the British Association of Dermatologists; which state doxycycline is mainly used followed by minocycline. Mr Dhadli explained to the group that discussion has taken place with Dr Bleiker, consultant dermatologist, RDH, who has confirmed that the dermatologists will not be using minocycline as other tetracycline's could be used. The dermatologists raised concerns about patients already on treatment; they felt that these patients should not be referred back until they have completed their course of minocycline. Ms Duffin confirmed that CRH have the same stance. Discussion regarding stop dates followed, patients with these conditions should be under specialist care. Mr Hulme questioned whether stop dates should be determined with the specialists. **Agreed:** Minocycline re-classified from a BROWN drug to a BLACK drug **Agreed:** Existing patients initiated by secondary care to continue minocycline until prescribed course is completed. Where a stop date is not clear this should be confirmed with the specialist where relevant. **<u>Topical amorolfine</u>** Mr Dhadli informed the group that topical amorolfine has been recognised by the guideline group and PrescQIPP as a drug of low priority for CCG funding. Amorolfine is a nail lacquer applied once or twice a week for six months in people with fingernail infections, and for nine to twelve months in people with toenail infections. Mr Dhadli went on to explain that evidence is limited and that there are no trials comparing one topical preparation to another. The BNF states antifungal treatment may not be necessary in asymptomatic patients with tinea infection of the nails. If treatment is necessary, a systemic antifungal is more effective than topical therapy. However topical applications of amorolfine or tioconazole may be useful for treating early onychomycosis when involvement is limited to distal disease, or for superficial white onychomycosis, or where there are contraindications to systemic therapy. A DTB review from 2008 stated a lack of evidence for comparison with systemic therapy. The bulletin also states that complications of a fungal infection are uncommon but can include secondary bacterial infections and cellulitis in patients with underlying vascular disease, diabetes and connective disorder. The PrescQIPP bulletin states that children younger than 18 years of age, immuno-compromised patients and patients who have not responded to treatment should be referred to dermatology for confirmation of diagnosis before treatment is initiated. The bulletin goes on to say that systemic treatment is more effective and topical therapy	**SD**

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	should only be considered if the infection is mild. Mr Dhadli noted the evidence that topical treatments are not very effective and systemic therapies should be used first line, however, there may be a small cohort of patients where contra-indication to systemic therapies may benefit from topical therapy. Dr Shearer questioned the side effect risks of systemic therapies; Mr Dhadli confirmed that risks include hepatic or liver impairment. Dr Mott confirmed that £50k has been spent in Derbyshire on amorolfine and a further £20k on Tioconazole in the last 12 months. Mr Dhadli confirmed that tioconazole is another topical treatment option for nail infections which is more costly and appears to have lesser evidence than amorolfine **Agreed:** Amorolfine classified as a BROWN drug for use where treatment is clinically required and systemic medicines are contraindicated. Not to be used for cosmetic purposes **Agreed:** Tioconazole classified as a BLACK drug **<u>Tramacet (combination product of paracetamol and tramadol)</u>** Mr Dhadli informed the group that Tramacet has been recognised by the guideline group as a drug of low priority. Mr Dhadli explained that Tramacet is a fixed dose combination product of 325mg paracetamol and 37.5mg tramadol. £24k has been spent in Derbyshire in the last 12 months. Mr Dhadli asked the group to consider the following points: • Combination products do not allow for titration of individual drugs • Doses appear to be sub-therapeutic • Not cost effective compared to individual components **Agreed:** Tramacet classified as a BLACK drug	**SD** **SD** **SD**
7.	**CLINICAL GUIDELINES**	
	<u>Bisphosphonate length of treatment in osteoporosis guideline</u> Mr Dhadli informed the group that a guideline for length of treatment of bisphosphonates has been produced by the guideline group in consultation with Dr Summers a consultant rheumatologist at RDH and Dr Fairburn a consultant rheumatologist at CRH. Mr Dhadli explained that long term bisphosphonate usage has been associated with safety issues such as atypical femoral fractures, oesophageal irritation, oesophageal ulcers, oesophageal cancer, and osteonecrosis of the jaw. The suggestion of stopping therapy or a drug 'holiday' after 5 years treatment has been made in the literature however no national guidance is available on whether a drug holiday is required, which group of patients would be suitable or for how long the holiday should be. The National Osteoporosis Guideline Group (NOGG) has produced some guidance using FRAX and BMD tools. The guidance allows for stratification of high and low risk patients and where appropriate suggests if patients are suitable to have a bisphosphonate treatment holiday. The local guideline is an adaptation of the NOGG guideline. Mrs Needham suggested the inclusion of calcium and vitamin D into the guidance. Drug treatment should be in order of local formulary choice, i.e. alendronate, risedronate, zolendronate. Mr Newman also suggested adding the word 'holiday'.	

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	Discussion followed about patients being re-assessed in General Practice. Dr Parkin raised a concern about how this would affect QoF however the group concluded that these concerns should not alter the guideline. Guideline accepted pending minor amendments. **Agreed:** add calcium and vitamin D **Agreed:** drugs in bisphosphonate holiday box to be in order of formulary choice and add the word holiday after the length of holiday **<u>Initiation of a PPI with a NSAID (or antiplatelet) advisory guidance</u>** Mr Dhadli informed the group that this guidance has been produced following GP queries about when to initiate a PPI for gastro-protection. This has been produced as an advisory guideline by the guideline group in consultation with Dr Goddard and Dr Austin, Consultant Gastroenterologists at RDH and Dr Braithwaite, Consultant Gastroenterologist at CRH. Mr Dhadli informed the group that the flowchart was adapted from an American consensus document and should be adopted as advisory. Each patient would need to be assessed considering the benefits and the risks associated with long term PPI use. The guideline summarise what the risk factors are and when a PPI may be appropriate to initiate. Dr Mott queried whether another PPI should be recommended in the guidance. The guidance was accepted pending minor amendments. **Agreed:** add in a box stating *'before commencing long term treatment consider risks vs benefits'* **Agreed:** include *'advisory guidance'* into the title **Agreed:** include *'or appropriate other low cost PPI'*	**SQ** **SQ** **SD** **SD** **SD**
8.	**PGDs**	
	None	
9.	**SHARED CARE GUIDELINES**	
	<u>Drugs used in the management of ADHD in children and adults</u> Dr Taylor informed the group that there were separate shared care guidelines in use for adults and children. It was agreed to combine the two guidelines and to also include a new drug, lisdexamfetamine as previously agreed at JAPC. Dr Taylor explained that Beverley Thompson, Chief Pharmacist, DHCFT, has worked on updating the SCG however the only complication with this joint SCG is that in the North the CAMH service is provided through a different provider; Beverley has liaised closely with Dr Walters at CRH. Dr Taylor discussed the changes made to the SCG: • Consultant responsibilities amended to '/specialist service' • Clarification about increasing shared monitoring between primary and secondary care • Contact details updated • The table listing the drugs has been updated, lisdexamfetamine has been added to the table, atomoxetine licensed indication is updated to include adults • A caution regarding seizures has been added to the clinical information section Dr Taylor highlighted that the dosing schedule for dexamfetamine has come from the previous SCG however there are some minor discrepancies between the previous SCG	

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	and the BNF. It was decided to retain the dosing schedule that was previously agreed. Mr Dhadli suggested some minor amendments: • Addition of "MR preparations should be prescribed by brand" so should be listed under GP responsibilities • in the table on page 5 under dexamfetamine the indication for narcolepsy in adults should be removed • under lisdexamfetamine the place in therapy should read *'second line when response to previous atomoxetine is considered clinically inadequate'*, • lisdexamfetamine has been listed as a controlled drug but strictly speaking is not yet, reword CD box to read *'No but treat as CD'* • doses in children section, to include 'for 6 years and over', Methylphenidate is an exception as it is a recognised unlicensed treatment dose in 4-6 years and is recommended in the BNFc Mr Dhadli informed the group that the doses for dexamfetamine in children differ to the current literature and what has been included in the SCG. This has been raised with the community paediatricians to confirm what doses are being used. The dosing in the SCG was from an old SPC for Dexedrine however this drug is no longer listed. Mr Dhadli asked the group to consider whether they would be happy for GPs to take on prescribing responsibility for children aged 3-5 years and also commented that the dose for children aged 6 and over is higher than that listed in the BNFc. The group agreed that due to the age and the unlicensed dosing it may be safer for prescribing for 3-5 year olds to remain under the paediatricians. Mrs Needham suggested adding *'check prescribing intervals'* under GP responsibilities and *'carer'* next to patient responsibilities. Dr Emslie questioned the monitoring frequency outlined in the SCG. Mr Dhadli highlighted that the monitoring would be co-ordinated between the GP and the consultant, patients would be monitored 3 monthly alternating between the GP and specialist service. Discussion followed, Dr Tooley raised concerns about the significant change to the monitoring requirements and the co-ordination between the specialist service and the GPs. Dr Taylor added that the main sticking point appears to be monitoring of blood pressure and pulse in children and the concern that GP practices are not equipped for this as smaller BP cuffs would be required. **Agreed:** JAPC to review shared care guideline pending minor amendments **Agreed:** Implementation to be discussed at the CCG prescribing sub groups **Agreed:** Dr Taylor to clarify off-license use of dexamfetamine and if this can be managed by the specialist service	**SD** **SH/KN** **ST**
10.	**HORIZON SCAN**	
	Monthly horizon scan Nothing to note **Annual horizon scan** Mr Dhadli informed the group that a document called prescribing outlook is produced by UKMi every year. The document outlines new drugs which will become available for use within the NHS. Mr Dhadli shared for information a summary that he has produced of the drugs due to become available in 2014/15 that are not yet marketed that warrant special consideration due to their expected overall impact on the NHS taking account of financial implications, service provision, place in therapy and target population.	

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11.	MISCELLANEOUS	
	Transient ischaemic attack (TIA): clopidogrel Mr Dhadli informed the group that in December 2013 NICE published an off label evidence review for the use of clopidogrel post TIA. The summary identified that that no relevant randomised controlled trials were identified that assessed clopidogrel monotherapy in people who have had a TIA. Due to the impact this may have on primary care prescribing Mr Dhadli asked the opinions of the cardiologists. It was agreed that despite the NICE review cardiologists across Derbyshire are happy to continue using clopidogrel post TIA off -label. This stance is being supported by PRESCQiPP and by the national clinical guidelines for stroke. **Agreed:** Continue to follow local guidance **CQC safer controlled drug use – Preventing harms from fentanyl and buprenorphine transdermal patches** Mr Dhadli informed the group that the safer use of transdermal patches was raised through the Southern Derbyshire CCG prescribing group, with the purpose being to raise awareness of the issues in relation to the prescribing of opioid transdermal patches. The CQC in 2012 stated that suitable systems should be in place to ensure the safe and effective use of transdermal fentanyl patches. This should include on-going education of all staff involved in prescribing, administering and disposing of transdermal fentanyl patches. Mr Newman informed the group that nationally a group was set up to advise on the clinical use of controlled drugs. Two big topics to tackle were opioid patches and safer use of oxycodone. In 2013 the group published advice on the safer use of opiate patches and it was highlighted that more than once a month someone is being severely harmed or killed by using an opiate patch. Mr Newman explained that a couple of incidents relating to the use of fentanyl patches had occurred at the Royal Derby Hospital. Mr Newman questioned if JAPC could produce some advice for clinicians on the safer use of opiate transdermal patches. Discussion followed and Dr Tooley suggested this should be highlighted to prescribers. Mr Hulme informed the group that some work had been done in 2012 and that a newsletter highlighting the CQC statements had been circulated. **Agreed:** Medicines Management Teams to produce a detailing aid to include some prescribing data comparison, local case studies and information from the CQC document **Agreed:** article in the JAPC bulletin **Gain sharing** Mr Dhadli informed the group that NHS England have published a document which outlines the principles of sharing the benefits associated with more efficient use of medicines not reimbursed through national prices with the intention being that CCGs could and should adopt these principles. Mr Dhadli advised that SDCCG have in the past adopted similar principles and suggested other Derbyshire CCGs may want to also consider adopting them. **Agreed**: Minor amendment to the prescribing specification to make reference to this document **Strontium** Mr Dhadli advised the group that the Pharmacovigilance Risk Assessment Committee (PRAC) has recommended that strontium should no longer be used to treat osteoporosis. The committee were due to meet in January to discuss whether	**SH** **SD** **SD**

	strontium should be withdrawn from the market. This recommendation has been made due to previous MHRA warnings about the risk of serious cardiac disorder. Mr Dhadli informed the group that ePACT data suggests there is a significant volume of prescribing within Derbyshire and questioned whether a contingency plan should be put in place. **Agreed:** include advice around no new prescribing of strontium in the JAPC bulletin	**SD**
12.	**JAPC BULLETIN**	
	Modafinil Change refused to *declined* **Medical devices** Mrs Needham referred to the sentence after the word 'red', she felt this was unclear. Mr Dhadli to re-write/remove.	**SD** **SD**
13.	**MHRA DRUG SAFETY UPDATE**	
	Mr Dhadli did not feel there was anything relevant to primary care to raise	
14.	**NICE TEMPLATE**	
	Framework of NICE Guidance Mrs Qureshi informed the group of the comments of the CCGs which had been made for the following NICE guidance issued in January: TA303 Multiple Sclerosis (relapsing) – teriflunomide Mrs Qureshi informed the group that although this will be funded through NHS England teriflunomide still requires a traffic light classification. **Agreed:** Teriflunomide classified as a RED drug Mrs Qureshi informed the group that there are also two clinical guidelines to be published however there are no real prescribing implications. Mr Dhadli did highlight that intermittent hormone therapy is a new recommendation and option in patients experiencing side effects in the prostate cancer guideline.	**SD**
15.	**TRAFFIC LIGHTS – ANY CHANGES?**	
	Tramacet – **BLACK** Amorolofine – **BROWN** Minocycline – **BLACK** Tioconazole – **BLACK** Teriflunomide – **RED**	**SD**
16.	**JAPC ACTION SUMMARY**	
	Rivaroxaban Remove from JAPC action summary **Actinic Keratosis** Dr Goddard has discussed with Dr Bleiker, a proposed pathway has been submitted to the dermatology CIG, to be sent to North Derbyshire for approval. To be sent to Mr Dhadli once pathway agreed **Diabetes guideline** On-going, Mr Dhadli has met with Dr Game to discuss the guideline. Plan to submit to JAPC in April **Lisdexamfetamine** Completed **NSAID & PPI** Completed	**SD** **WG** **SD**

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	To be added to the JAPC action summary: **ADHD SCG implementation** Feedback from CCG prescribing groups on the implementation of the ADHD shared care guideline **Dr Mott picked up matters arising for RDH at this point.** **Metoclopramide in gastroparesis** Dr Goddard confirmed he would draft a position statement for the long term use of metoclopramide in gastroparesis. Dr Goddard will also contact the British Society of Gastroenterology to find out if they have a position statement on this subject. **Agreed:** RDH & CRH to draft a joint position statement in consultation with gastroenterologists and diabetologists. **Agreed:** to be added to the JAPC action summary **Modafinil use in fatigue** Mr Newman has contacted Dr Vaithianathar and is awaiting a response. Mr Newman asked if the results of the audit performed in Southern Derbyshire could be shared with him. **Medical devices** Dr Mott informed Mr Newman of the earlier discussion around medical devices and appropriate prescribing. Mr Newman informed the group that it is unclear where devices are discussed with RDH	**WG** **CN**
17.	**GUIDELINE GROUP ACTION TRACKER**	
	The Guideline Group tracker for information.	
18.	**MINUTES OF OTHER PRESCRIBING GROUPS**	
	• Minutes of the CRH D&T committee – 19/11/2013 • Minutes of the CRH D&T committee – 21/01/2014 • Minutes of the DHCFT D&T committee – 28/11/2013 • Minutes of the medication operational safety team, DCHS – 20/11/2013 • Minutes of the Burton hospitals D&T committee – 20/11/2014	
19.	**ANY OTHER BUSINESS**	
	No other business to discuss	
	DATE OF NEXT MEETING	
	Tuesday, 11th March 2014 at Post Mill, South Normanton.	