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DERBYSHIRE JOINT AREA PRESCRIBING COMMITTEE (JAPC)

Minutes of the meeting held on Tuesday 12 August 2014

Confirmed minutes

Summary Points

Traffic lights

Drug	Decision
Levonorgestrel 13.5mg intrauterine device (Jaydess)	BLACK
Colesevelam	BROWN 2nd line following gastro consultant initiation and assessment for chronic diarrhoea secondary to bile salt malabsorption in those who cannot tolerate colestyramine
Colestyramine	BROWN - after consultant/specialist initiation. For chronic diarrhoea secondary to bile salt malabsorption following gastro consultant initiation and assessment
Pentoxifylline	RED for osteonecrosis of the jaw due to radiation therapy
Sucralfate	BROWN after consultant/specialist recommendation for the management of patients with gastro-oesophageal reflux disease or post-cholecystectomy.
Sucralfate enema	RED
Yohimbine	BLACK for erectile dysfunction
Fluorouracil 0.5% and salicyclic acid 10% (Actikerall)	GREEN - after consultant/specialist initiation (Specialist initiation includes GPSI and GPs who have attended the Derbyshire AK pathway training)
Imiquimod 3.75% (Zyclara)	BLACK
Diclofenac 3% (Solaraze)	GREEN – after consultant/ specialist initiation (Specialist initiation includes GPSI and GPs who have attended the Derbyshire AK pathway training)
Fluorouracil 5% (Efudix)	GREEN – 1st line choice. After consultant/ specialist initiation (Specialist initiation includes GPSI and GPs who have attended the Derbyshire AK pathway training
Enzalutamide	RED as per NICE TA 316
Lubiprostone	Re-classified from BLACK to RED as per NICE TA 318
Ipilimumab	RED as per NICE TA 319
Bedaquiline	RED
Factor VIII and Von Willebrand factor	RED
Vedilizumab	BLACK

Clinical Guidelines

Actinic Keratosis
Antimicrobial Treatment
Lower UTIs in Chronic Kidney Disease

Shared Care Guidelines

Acamprosate and Disulfiram
Low Molecular Weight Heparins

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Present:	
Southern Derbyshire CCG	
Dr A Mott	GP (Chair)
Mr S Dhadli	Specialist Commissioning Pharmacist (Secretary)
Mrs L Hunter	Assistant Chief Finance Officer
Mr S Hulme	Director of Medicines Management
Dr M Watkins	GP
North Derbyshire CCG	
Dr C Emslie	GP
Dr D Fitzsimons	GP
Mrs K Needham	Head of Medicines Management North (also representing Hardwick CCG)
Hardwick CCG	
Dr T Parkin	GP
Erewash CCG	
Dr M Henn	GP
Derby City Council	
Dr R Dewis	Consultant in Public Health Medicine
Derbyshire County Council	
Mrs S Qureshi	NICE Audit Pharmacist
Derby Hospitals NHS Foundation Trust	
Dr W Goddard	Chair- Drugs and Therapeutic Committee
Derbyshire Healthcare NHS Foundation Trust	
Dr S Taylor	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
In Attendance:	
Ms K Stanley	Southern Derbyshire CCG
Mr A Thorpe	Derby City Council (minutes)

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1.	**APOLOGIES**	
	Mr C Newman.	
2.	**DECLARATIONS OF CONFLICT OF INTEREST**	
	Dr Henn declared an interest in the provision of an anti-coagulation service by his practice to neighbouring practices within Erewash CCG. All GPs at the meeting declared that they had the same interest.	
3.	**DECLARATIONS OF ANY OTHER BUSINESS**	
	• Generic sildenafil • Agenda papers for September JAPC meeting	
4.	**MINUTES OF JAPC MEETING HELD ON 9 JULY 2014**	
	The minutes of the meeting held on 9 July 2014 were agreed as a correct record after the following amendments: Monthly Horizon Scan – Amend to 'Liraglutide in combination with insulin'. Amend to 'Tocilizumab – Agreement in place for its use in RDH as subcutaneous formulation'.	
5.	**MATTERS ARISING**	
a.	**Alfuzosin** The action for Dr Goddard to check with the consultant urologists why alfuzosin was the preferred treatment for LUTS in RDH would be added to the action tracker.	**SD/WG**
b.	**Emerade** Dr Mott reported that all the Emerade products had been classified as green medical devices at the last JAPC meeting and RDH had discretion as to how these were used. Ms Needham referred to some supply issues concerning JEXT and Epipen and therefore some practices have had to issue prescriptions for Emerade already.	
c.	**Jaydess** Dr Mott reported that both Derby City and Derbyshire County public health departments had been contacted following the last JAPC meeting to ascertain their views. The two public health directorates had indicated that they had not fully worked out the cost implications and cost effectiveness of Jaydess. It would therefore be necessary to re-classify Jaydess as black as it had not been formally reviewed by public health and should not be used. Dr Dewis advised that the CASH services were commissioned under a block contract. It was agreed that Jaydess would be re-considered by JAPC once a formal view had been obtained from both public health departments.	
d.	**P1NP Testing** Mrs Needham would write to Sheffield Hospital to convey the recommendation of JAPC that P1NP testing would not be commissioned in Derbyshire.	
e.	**Domperidone** Mr Dhadli advised that it had been proposed that the use in children and for	

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	nursing mothers to promote lactation be added to the position statement on domperidone. Mr Dhadli referred to the two position statements which had been issued by UK Drugs in Lactation Service, UKMI and the British Society for paediatric Gastroenterology, Hepatology and Nutrition (BSPGHAN) for the use of domperidone in babies and children with existing congenital heart disease, other children with established reflux or nausea and vomiting and children with newly diagnosed reflux or at risk of nausea and vomiting. It was queried whether domperidone should be prescribed by GPs or consultants and that the position statement did not indicate who should be responsible for prescribing. **Agreed:** A statement would be added to the website to indicate that domperidone could be prescribed off licence for babies and children. JAPC recognised that usually the specialist would prescribe this but that no traffic light classification would be assigned to allow GPs to prescribe where appropriate. A statement for use of domperidone for lactation would also be included.	**SD**
6.	**NEW DRUG ASSESSMENTS**	
a.	**<u>Colesevelam</u>** Mr Shepherd advised that colesevelam had been approved by the CRH Drugs and Therapeutic Committee who had requested JAPC approval for its off-licence use for chronic diarrhoea secondary to bile salt malabsorption in those patients who could not tolerate colestyramine due to primary idiopathic disease and secondary due to terminal ileal disease. RDH had indicated that they supported the CRH proposal. Mr Dhadli advised that the evidence came from two small case series (n=45 and n=5) which found that colesevelam improved diarrhoea and gastrointestinal symptoms in people with bile acid malabsorption. A randomised controlled trial had demonstrated no improvement in outcomes with colesevelam in 24 women with diarrhoea-predominant irritable bowel syndrome, of which four had evidence of bile acid malabsorption. Colesevelam was more expensive than generic colestyramine which was the recognised treatment. Dr Goddard highlighted that colestyramine was the first line treatment in RDH for bile acid malabsorption, if tolerated by the patient. Dr Mott highlighted that colesevelam was not licensed for this indication and had already received a traffic light classification of brown for use in hypercholesterolaemia. Mr Dhadli commented that a clinical assessment for efficacy would be required after the use of colesevelam. **Agreed:** Colesevalam classified as a **BROWN, after gastro consultant initiation and assessment, drug 2nd line to colestyramine.**	**SD**
b.	**<u>Pentoxifylline</u>** JAPC noted that pentoxifylline had already been classified as black for the treatment of intermittent claudication in patients with peripheral vascular disease following a negative NICE technology appraisal. Mr Shepherd reported that the CRH Drugs and Therapeutic Committee had discussed the use of pentoxifylline for osteonecrosis of the jaw induced by radiation or	

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	bisphosphonates and had approved its use for radiation induced osteonecrosis of the jaw. However further information on bisphosphonate induced osteonecrosis was required before recommending it for this indication due to little evidence being available. **Agreed:** Pentoxifylline classified as a **RED** drug for the treatment of osteonecrosis of the jaw induced by radiation.	**SD**
c.	**<u>Sucralfate</u>** Dr Goddard advised JAPC that sucralfate was useful in the treatment of some difficult forms of reflux symptoms and was well tolerated. An audit had revealed a level of inappropriate prescribing of sucralfate. However the gastroenterology department had recently been informed that some GPs in Southern Derbyshire had refused to continue prescribing of sucralfate, initiated by a gastroenterologist because it had not received a traffic light classification. There was some evidence for its use in the empirical management of patients with severe gastro-oesophageal reflux disease (GORD) or post-cholecystectomy, alongside use of PPIs, where there may be bile acid reflux. In addition, there was some evidence to support short-term use of sucralfate granules in suspension to speed the healing of endoscopic variceal sclerotherapy/banding induced ulcers. The department was requesting a traffic light classification for its continued long-term use. During discussion Mr Dhadli stated that the manufacturer had advised that there were supply problems expected until late 2014. Mr Dhadli also advised that new patients should not be initiated on treatment as there was no straightforward alternative to sucralfate and specialist advice should be sought for existing patients. The liquid formulation was available for hospital use only (specialist circumstances e.g. enteral feeding) Mrs Needham commented that the green drug classification list was not comprehensive and there would be anomalies. Mr Dhadli added that a position statement was needed on how further supplies could be obtained. Mr Hulme suggested that a reference should be included to the necessity for a review with the existing cohort of patients about alternatives to sucralfate. **Agreed:** Sucralfate classified as a **BROWN drug on specialist/consultant recommendation** for the empirical management of patients with severe gastro-oesophageal reflux disease (GORD) or post-cholecystectomy, alongside use of PPIs, where there may be bile acid reflux.	**SD**
	Agreed: A reference to the stock issues would be included in the bulletin together with a reference to the need for existing patients to be reviewed by a consultant gastroenterologist if supplies could not be found for them.	**SD**
	Agreed: Sucralfate as an enema classified as a **RED** drug.	**SD**
d.	**<u>Yohimbine</u>** Dr Parkin reported that a traffic light classification was being requested for the use of the herbal remedy yohimbine for erectile dysfunction and suggested	

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	that this should be classified as BLACK. JAPC noted the summaries of the available evidence and the lack of evidence as to its safety and efficacy. **Agreed:** Yohimbine classified as a **BLACK** drug.	 **SD**
7.	**CLINICAL GUIDELINES**	
a.	**Actinic Keratosis (AK)** Dr Mott highlighted two issues associated with the actinic keratosis clinical guideline which included the place of Diclofenac 3% (Solaraze) and to assign a traffic light classification to Actikerall. Mr Dhadli referred to a RDTC review which had compared Actikerall to diclofenac and placebo. The review had concluded that Actikerall did have a beneficial effect and that the AK treatments worked with choice dependent on the area being treated, cost and patient preference. **Agreed:** Actikerall classified as a **GREEN consultant/specialist initiation** drug including GPSIs and those GPs who had attended the Derbyshire AK pathway training. **Agreed:** JAPC ratified the clinical guideline for Actinic Keratosis. **Agreed:** Imiquimod 3.75% classified as a **BLACK** drug due to the significantly higher cost and no evidence of benefit over other therapies that are more cost effective. Dr Watkins queried whether a date had been arranged for the training and Dr Mott advised that the Derby Dermatology Forum would be held on 18 September.	 **SD** **SD** **SD**
b.	**Antimicrobial Treatment Guidelines/Antimicrobial Guidance for the Management of Lower UTI in Chronic Kidney Disease (CKD)** Mr Dhadli advised JAPC that Dr Diane Harris, Southern Derbyshire CCG Lead Antimicrobial Pharmacist, had amended the antimicrobial treatment guidelines which had been submitted to JAPC in June 2014. The amendments included: • Pivmecillinam as a fourth option for the treatment of lower UTIs. • Management of lower UTI in Chronic Kidney Disease. • Lower UTIs caused by ESBL producing organisms. • Some other minor changes. During discussion Dr Fitzsimons highlighted that the Acne Guidelines were different to the North Derbyshire CCG Acne Pathway which had doxycycline 100mg daily or lymecycline 408mg daily as first line, erythromycin 500mg twice daily as second line and trimethoprim 300mg twice daily as third line. Mrs Needham stated that the only difference between the two guidelines was the inclusion of trimethoprim as third line treatment and by that stage patients would probably have been referred to secondary care in the south of the county. Dr Dewis commented that there was now an opportunity to link the	

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	antimicrobial guidelines to the publication of the c.difficile cards which were being issued to all patients who had had a C.*difficile* infection in the past. Dr Dewis also referred to the relevant risk factors in the history section of the care pathway for respiratory tract infections and the desirability of including risks associated with exposure to smoking here. Mr Dhadli would contact Dr Harris concerning the most appropriate place to include a reference to the c.difficile cards and the addition of a reference to smoking exposure risk. Mr Hulme reported that RDH would be releasing the sensitivity testing for pivmecillinam for lower UTIs and CRH would also do this once the necessary equipment had been ordered. Dr Mott highlighted the need to ensure that the most recent version of the guidelines were available. **Agreed:** JAPC ratified the Antimicrobial Guidance for the Management of Lower UTI in Chronic Kidney Disease (CKD)	**SD** **SD**
c.	**<u>Atrial Fibrillation (AF)</u>** Following the last JAPC meeting Mr Dhadli and Mrs Qureshi had developed draft AF guidance for the management of nonvalvular AF. This draft guidance included some key changes from the NICE 2014 guidance: • The CHA_2DS_2-VASc tool should be used to assess stroke risk score in people with symptomatic or asymptomatic paroxysmal, persistent or permanent AF, atrial flutter, or a continuing risk of arrhythmia recurrence after cardioversion back to sinus rhythm. • Patients with a CHA_2DS_2-VASc score of 2 or above for women, or 1 and above for men, taking bleeding risk into account, should be offered anticoagulation. • The new oral anticoagulants (NOACs) should be offered where appropriate. • GPs should not offer aspirin monotherapy solely for stroke prevention to people with AF. Mr Dhadli stated that the CRH and RDH haematologists had been requested to draft a bleeding protocol for all three NOACS and the cardiologists requested to review the sections on dual rate control strategies, referral criteria for transthoracic echocardiography (TTE) and post MI - antiplatelet/ anticoagulation together with a request for comments on the combination treatments (dual and triple antiplatelet therapies). The medicines management team would highlight gaps and any need for clarity and collate feedback from GPs. Mr Dhadli also highlighted the inclusion by NICE of a patient decision aid to help patients to make informed decisions about their treatment and care and that this would require careful consideration. During discussion some points were made as followed: • Need to highlight in the guidance that the content in the blue boxes was for primary care and the red boxes for secondary care. • $CHASD_2$-VASc = 0 should refer to males only. • The list order of NOACs in the guidance should not reflect preferences. • HAS-BLED only measured bleeding risk with warfarin and no bleeding risk assessment for the NOACs.	

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	• The NICE guidance needed to be re-written to make it locally sensitive and it would be important to consider the involvement of patients in their treatment. • A lot of work would be needed by the Prescribing Groups to implement the local guidance. • The NICE guidance incorporated the previous positive appraisals by NICE of apixaban, dabigatran and rivaroxaban, positioning them clearly to enable the GP to support patients in their choice of preventive medication. The choice of NOACs was fundamental to the local guidance and there was currently insufficient clinical evidence at present to recommend one over the other. A recent article in the British Medical Journal had highlighted increased risks of bleeding with dabigatran but there were conflicting reports. • Useful to have a default position for GPs. • What should be done with the existing patients on warfarin and, if patients were stable, should they be switched. • It may be necessary to involve the north and south cardiologists in discussions to obtain a local view. **Action**: Mr Dhadli would send out key questions to the JAPC and request the GP members to ascertain the views of other GPs. A timescale for replies would be included.	**SD**
	Action: Dr Goddard would contact Dr Azeem, RDH Consultant Cardiologist, to obtain his views on NOAC choice.	**WG**
d.	**Dermatology BAD Specials** Mr Dhadli reported that there had been an update to the list of specials produced by the British Association of Dermatologists (BAD). In December 2012 an abridged version of this list was produced in collaboration with Southern Derbyshire dermatologists. The RDH and CRH dermatologists now needed to look at the BAD list and agree a core list of the products to be included for the primary/secondary care interface which could then be included in the drug tariff. Mr Hulme commented that Mr Newman was doing some work on East Midlands procurement of specials and some of the products listed in the BAD list may be included. **Action:** The north and south dermatologists would be requested to look at the BAD list. This would be further discussed by JAPC if a traffic light issue was highlighted.	**SD**
8.	**PATIENT GROUP DIRECTIONS (PGDs)**	
a.	**Gardasil and Meningitis C** JAPC ratified the updated Patient Group Directions and these would be placed on the medicines management website.	**SD**
b.	**Derbyshire Health United (DHU) PGDs** Mrs Needham stated that JAPC had agreed at the July meeting to extend the DHU PGDs until October. However after the meeting it had been found that the PGDs had already expired by 18 months and therefore the CCGs have	

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	not extended the PGDs. The NICE PGD guidance document had been sent to DHU who had been requested to update their PGDs in line with BNF, drug safety updates, local guidelines and SPC guidelines. A shortened list of PGDs had been submitted by DHU for the ones which were urgently required. Mrs Needham highlighted that there were significant omissions in the PGDs including a lack of references to drug safety updates about diclofenac, use of codeine in children and no indication that the PGDs which involved antibiotics had been approved in conjunction with a local specialist in microbiology and documented accordingly. **Action:** Mrs Needham would draft an email to be sent by Dr Mott as JAPC Chair to DHU to express concern at the lack of assurance about the PGDs. Mrs Hunter queried whether organisations should be looked at including Medicare. Mr Hulme would discuss further with Mrs Hunter.	**KN** **SH**
9.	**SHARED CARE GUIDELINES**	
a.	**Acamprosate and Disulfiram** Mr Dhadli stated that the existing shared care agreement for acamprosate had been the subject of minor revision by Addaction and put in the standard JAPC format. In connection with the monitoring requirements for acamprosate Mrs Needham stated that the monitoring requirements should be included at the front of the document and there was also a need to be explicit about the need to monitor at regular intervals if treatment was continued after six months. Dr Parkin highlighted an issue concerning GPs taking on extra work associated with shared care follow up. Dr Taylor referred to the monitoring requirements for disulfiram which specified that patients would be reviewed at six months intervals by the specialist and the decision made to carry on treatment communicated to the GP. **Agreed:** JAPC ratified the Shared Care Agreements for Acamoprosate and Disulfiram. **Action:** Mr Dhadli would check whether the monitoring of acamprosate should mirror disulfiram. (i.e. acamprosate stated GP to monitor monthly for six months whereas disulfiram stated GPs to monitor on a regular basis).	**SD** **SD**
b.	**Low Molecular Weight Heparins (LMWH)** Mrs Qureshi reported that the LWMH Shared Care Agreement (SCA) had been reviewed by the Guideline Group. The SCA had been sent to CRH and RDH for comments and feedback had been received from CRH but not from RDH. Mr Dhadli referred to some queries which had been previously made about some of the indications and length of treatment. For clarity all short duration courses (less than four weeks) had now been taken out of the main body of the guidance and put into the appendix for information. **Agreed:** JAPC provisionally ratified the Low Molecular Weight Heparin Shared Care Guideline on the basis of the comments received back from Chesterfield Royal Hospital.	**SD**

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10.	**MONTHLY HORIZON SCAN**	
	Mr Dhadli advised JAPC of the following new drug launches, new drug formulations and drug discontinuations: Alprostadil cream – Some requests had been received for use. Agreed that that a traffic light classification should be assigned at the next JAPC meeting. Bedaquiline – NHS England red drug. Factor VIII + von Willebrand factor – NHS England red drug. Olodaterol – Await a request for use in Chronic Obstructive Pulmonary Disease. Vedfolizumab – The NICE TA was expected in April 2015. Classified as a black drug awaiting the publication of the NICE TA. Licence extensions: Budesonide 9mg granules (Budenofalk) Crohn's disease – induction of remission in patients with mild to moderate active disease affecting the ileum and/or the ascending colon. Dabigatran etexilate - Deep vein thrombosis and pulmonary embolism – treatment/prevention of recurrence. Defibrotide Hepatic - Veno-occlusive disease in adults and children undergoing haematopoietic stem cell transplant. Delamanid -Tuberculosis, pulmonary multidrug-resistant in adults. Denosumab - Osteoporosis in men. Human papillomavirus vaccine (quadrivalent) (Gardasil) - Prevention of premalignant anal lesions and anal cancers causally related to certain oncogenic HPV types. Leuprorelin (Prostap DCS) - Prostate cancer – neo-adjuvant treatment prior to radiotherapy in patients with high-risk localised or locally advanced disease Paliperidone (Invega) - Schizophrenia in adolescents aged 15 years and older. Drug discontinuations: ACWY Vax (meningitis ACWY vaccine) Emcor (bisoprolol) Emcor LS (bisoprolol) Froben (flurbiprofen) Fru-Co (co-amilofruse) Hay-Crom (sodium cromoglicate) Influvac Desu (influenza vaccine) Menjugate Kit (meningitis C vaccine) Viroflu (influenza vaccine)	**SD**
11.	**MISCELLANEOUS**	
a.	**Silk Garments** Mr Dhadli reported that UK Medicines Information (UKMI) had undertaken a review on silk garments for eczema/atopic dermatitis with 46 children. Some benefit had been observed from the wearing of silk clothing but it had been highlighted by UKMI that NICE had issued guidance in 2007 on the treatment of atopic eczema in children and had made no recommendations about the use of such silk garments in the management of eczema. A systematic review of the use of silk garments in atopic dermatitis in 2012 had concluded	

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	that the evidence of effectiveness was weak and of low quality. A long term trial of silk therapeutic clothing for the management of eczema in children was due to be reported in 2016. To inform future decisions Mr Dhadli reminded JAPC members to the hierarchy of evidence and grading of recommendations, and that expert opinion received the lowest place in the hierarchy.	
b.	**<u>Alcohol Community Detoxification</u>** Dr Taylor stated that the paper on support to primary care from the Derbyshire Substance Misuse Service for prescribed/OTC drug dependence had been considered by the July DHcFT Drugs and Therapeutic Committee. Mr Hulme commented that the paper related to previous discussions as to how the Substance Misuse Service could support General Practice in the management of patients who were prescribed particularly high dose opioids for pain management. It would therefore be helpful to place this on the website. Dr Dewis stated that public health commissioned services for people who were addicted to prescribed drugs. There had been a change to the service this year and then would be included in the re-commissioning of substance misuse services next year. **Agreed:** The Support to Primary Care paper would be sent to the Guideline Group for discussion.	**SD**
c.	**<u>Traffic Lights</u>** Mr Dhadli reported that a query had been raised about the current traffic light classifications to say that they were not explicit enough in terms of initiation and recommendation. A revised list of definitions had therefore been developed as follows: Green Specialist/consultant initiation - Consultant/specialist issues the first prescription usually following a consultation because (a) the patient requires specialist assessment before starting treatment and/or (b) specialist short term assessment of the response to the drug was necessary. GPs would be asked to continue prescribing when the patient was stable or predictably stable. Green Specialist/consultant recommendation - The consultant/specialist requested GPs to prescribe initial and on-going prescriptions, but ensured that (a) there was no immediate need for the treatment and was line with discharge policies and (b) the patient response to the treatment was predictable and safe. Brown statement for combination products - Derbyshire JAPC did not recommend the routine prescribing of oral combination products that were available as the separate constituents the following reasons may apply: • The dose of each individual medicines doses cannot be tailored to the patient's needs, potentially leading to risk of over or under dose. • In the event of an allergic/adverse drug reaction/inefficacy to the combination product then it would be difficult to ascertain the drug	

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	molecule which has caused this reaction. • May not be cost effective. **Agreed:** JAPC ratified the revised traffic light definitions.	**SD**
d.	**Website Copyright** Mr Dhadli reported that requests were often received from external organisations to request permission to use documents from the public facing medicines management website. It would therefore be necessary to agree a position statement and JAPC was requested to approve the use of a statement similar to one which was used by Greater Manchester Medicines Management: 'The material on this site is subject to copyright protection of the Derbyshire CCGs unless otherwise indicated. This material may be freely reproduced for education and not for profit purposes within the UK National Health Service as long as Derbyshire JAPC is acknowledged in any work produced. This is subject to the material being reproduced accurately and not used in a misleading context. No reproduction by or for commercial organisations, for any purpose is permitted without the express written permission of JAPC or its Subgroups.' **Agreed:** JAPC ratified the position statement with the omission of the phrase 'or its subgroups'. Requests for the use of medicines management documents would be considered by the Guideline Group.	**SD**
e.	**Emergency Contraceptives Letter to Healthcare Professionals** JAPC noted the MHRA letter concerning levonorgestrel and ulipristal as suitable emergency contraceptives for all women regardless of bodyweight.	
f.	**Equality Guidance** Mr Dhadli referred to the legal duties arising from the Equality Act 2010 (Public Sector Equality Duty) and the Human Rights Act 1998 for all JAPC members to pay due regard to the nine protected groups covered by the Equality Act in the making of decisions. The nine protected groups were age, disability, sex, race, religion or belief, sexual orientation, gender reassignment, marriage and civil partnership and pregnancy and maternity. Advice had been obtained from Greater East Midlands Commissioning Support Unit (GEM) that this should be included in the general information given to JAPC members and the induction process for new members. The JAPC front cover sheets had been updated to include equality or diversity implications in the consideration of a new drug or guideline. This would ensure that due regard to the nine protected groups was referenced in the JAPC agenda papers and it would be important to ensure that this section on the front cover sheets was properly completed. The engagement of third party organisations would also be necessary in this process although it was currently unclear how this would be achieved. During discussion Dr Dewis commented that public health had recently undertaken a number of Equality Impact Assessments and would therefore be able to provide details of contacts. Mr Dhadli advised that Mr David Fagg from GEM had offered to attend a JAPC meeting in order to provide	

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	clarification about the legislation and answer questions. It was suggested that this could take place before the start of a JAPC meeting and there was also online training which could be completed by members. Mr Dhadli would discuss a future approach with Mr Fagg.	**SD**
f.	**MTRAC Guidance on Gliptins** JAPC noted the commissioning support issued by the Midlands Therapeutics Review and Advisory Committee (MTRAC) on the use of DPP- 4 inhibitors (Gliptins) for type 2 diabetes.	
12.	**JAPC BULLETIN**	
	It was agreed that the decision to re-classify Jaydess as black should be included. The amended JAPC bulletin was ratified.	**SD** **SD**
13.	**MHRA DRUG SAFETY UPDATE**	
	The MHRA Drug Safety Update for July 2014 was noted. Mr Dhadli highlighted the following MHRA advice: • Drugs and driving: Blood concentration limits to be set for certain controlled drugs in a new legal offence. • Intravenous dantrolene: Risk of skin and injection site reactions from undissolved crystals. A filter needle to be used when drawing up reconstituted dantrolene solution and to remain vigilant. • Transdermal fentanyl "patches": Reminder of potential for life-threatening harm from accidental exposure, particularly with children. • Administration errors with drugs for infusion: Need to ensure that appropriate checking procedures were in place. • MHRA Medicines learning modules. It was agreed that the Department of Transport document on drugs and driving be further discussed by the Guideline Group.	**SD**
14.	**NICE SUMMARY**	
	Mrs Qureshi informed JAPC of the comments for the CCGs which had been made for the following NICE guidance issued in July 2014. TA 316 Enzalutamide for metastatic hormone relapsed prostate cancer previously treated with a docetaxel containing regimen. Enzalutamide classified as a **RED** drug. TA 317 Prasugrel with percutaneous coronary intervention for treating acute coronary syndromes. The cardiologists had been contacted to ascertain their views on the use of prasugrel for this indication in the patient pathways. It was anticipated that there would be no significant cost impact. It was agreed that to await the views of the cardiologists and Dr Goddard would contact them about this. TA 318 Lubiprostone for treating chronic idiopathic constipation.	**SD** **WG**

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	The gastroenterologists had been contacted to ascertain their views on the use of lubiprostone for treating chronic idiopathic constipation. It was agreed that Lubiprostine be classified as a **RED** drug. Dr Goddard would obtain the views of the gastroenterologists and develop a protocol. TA 319 Ipilimumab for previously untreated advanced (unresectable or metastatic) melanoma. NHS England **RED** drug. CG181 Lipid modification: Cardiovascular risk assessment and the modification of blood lipids for the primary and secondary prevention of cardiovascular disease. Mrs Qureshi advised that the net cost impact for the CCGs would be: Erewash CCG - Year 1 £18,170, Year 5 £90,851 Hardwick CCG - Year 1 £19,101,Year 5 £95,505 North Derbyshire CCG - Year 1 £55,395, Year 5 £276,976 Southern Derbyshire CCG - Year 1 £95,376, Year 5 £476,895 Dr Mott commented that JAPC would need to consider the NICE lipid modification which included a 10% threshold issue at a future meeting. Mr Dhadli added that it would also be necessary to check that the reporting of HDL cholesterol was in line with the NICE guidance. CG 182 Chronic kidney disease (CKD): Early identification and management of chronic kidney disease in adults in primary and secondary care. Mr Dhadli stated that it would be necessary to discuss the use the CKD Epidemiology Collaboration creatinine equation to estimate GFR creatinine and the use of eGFR cystatinC at initial diagnosis with the laboratory. Frequency of monitoring was another area for further consideration and would be useful information for GPs.	**WG**
15.	**TRAFFIC LIGHTS – ANY CHANGES?**	
	Classifications Levonorgestrel 13.5mg intrauterine device (Jaydess) – BLACK Colesevelam – BROWN 2nd line following gastro consultant initiation and assessment for chronic diarrhoea secondary to bile salt malabsorption in those who cannot tolerate colestyramine. Colestyramine – BROWN after consultant/specialist initiation. For chronic diarrhoea secondary to bile salt malabsorption following gastro consultant initiation and assessment. Pentoxifylline – RED for osteonecrosis of the jaw due to radiation therapy. Sucralfate – BROWN after consultant/specialist recommendation for severe gastro-oesophageal reflux disease or post cholecystectomy. Sucralfate enema - RED Yohimbine – BLACK for erectile dydfunction. Fluorouracil 0.5% and salicyclic acid 10% (Actikerall) – GREEN specialist/GP trained initiation (specialist initiation includes GPSI and GPs who have attended the Derbyshire AK pathway training)	

Item		Action
	Imiquimod 3.75% (Zyclara) – BLACK Dicolfenac 3% (Solaraze) – GREEN after consultant/specialist initiation (specialist initiation includes GPSI and GPs who have attended the Derbyshire AK pathway training). Fluorouacil 5% (Efudix) – GREEN after consultant/specialist initiation (specialist initiation includes GPSI and GPs who have attended the Derbyshire AK pathway training). Enzalutamide – RED as per NICE TA 316 Lubiprostone – Re-classified from black to RED as per NICE TA 318 Ipilimumab – RED as per NICE TA 319 Bedaquiline – RED (NHS England) Factor VIII and Von Willebrand factor– RED (NHS England) Vedolizumab – BLACK	
16.	**JAPC ACTION SUMMARY**	
	The action summary was noted by JAPC and amendments made: Shared Care Disulfiram and Acamprosate – To be removed from the list. Domperidone in breastfeeding – To be removed from the list. Actinic Keratosis – To be removed from the list.	**SD**
17.	**GUIDELINE GROUP**	
	The summary of key messages arising from the Guideline Group meeting held in July 2014 was noted by JAPC.	
18.	**MINUTES OF OTHER PRESCRIBING GROUPS – FOR INFORMATION**	
	• Burton Drugs and Therapeutic Committee 14.7.14 • Chesterfield Drugs and Therapeutic Committee 15.7.14 • Nottinghamshire Area Prescribing Committee 15.5.14 • Sheffield Area Prescribing Group 19.6.14	
19.	**ANY OTHER BUSINESS**	
	(a) Dr Mott referred to the consultation on the place of sildenafil in the Selective List Scheme (SLS) and this was no longer a SLS drug. Generic sildenafil no longer had the restrictions which had been previously placed on it. There was therefore a need to convey this message to primary care that sildenafil generic and apomorphine hydrochloride no longer had restrictions. The quantities which could be prescribed still required clarity and should be included in the message. (b) Members were requested to send any agenda papers to Mr Dhadli for inclusion in the September JAPC agenda as soon as possible.	**SD**
20.	**DATE OF NEXT MEETING**	
	Tuesday, 9 September 2014 at 1.30pm in the Post Mill Centre, South Normanton.	