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DERBYSHIRE JOINT AREA PRESCRIBING COMMITTEE (JAPC)

Minutes of the meeting held on Tuesday 11 November 2014

CONFIRMED MINUTES

Summary Points

Traffic lights

Drug	Decision
Debrisoft	BROWN second line after consultant/ specialist recommendation (re-classified from Red) from Tissue Viability Nurses for chronic sloughy wounds and hyperkeratotic skin around acute or chronic wounds. Not cost effective if more than 10 applications are needed
Jaydess	GREEN for contraception only as commissioned by public health (re-classified from Black)
Lurasidone	RED
Phosphate Binders	GREEN specialist initiation for DHFT (re-classified from Amber)
Cabozantinib	RED
Daclatasvir	RED
Idelalisib	RED
Teduglutide	RED
Pentosan Polysulfate	RED
Dabrafenib	RED as per NICE TA321
Travel Vaccines : Hepatitis B Meningitis Yellow Fever Japanese B encephalitis Tick borne encephalitis Rabies	BLACK when used for travel. These immunisations should not be given as part of an NHS service.

Clinical Guidelines

Atrial Fibrillation (updated with advice from cardiologists)
Clozapine
Thiamine

Patient Group Directions acknowledged for use in the Out of Hours Service and Walk in Centre (under DHU)

Ibuprofen
Paracetamol
Amoxicillin capsules and suspension
Codeine 30mg
Doxycycline capsules
Erythromycin tablets and suspension
Nitrofurantoin MR capsules Phenoxymethyl penicillin tablets and suspension
Trimethoprim tablets and suspension

Shared Care Guidelines

Somatostatin
Phosphate binders reclassified from Amber to Green after consultant/specialist initiation

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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
Mrs S Qureshi	NICE Audit Pharmacist
North Derbyshire CCG	
Dr C Emslie	GP
Dr D Fitzsimons	GP
Mrs K Needham	Head of Medicines Management North (also representing Hardwick CCG)
Ms J Town	Head of Finance Commissioning
Hardwick CCG	
Dr T Parkin	GP
Erewash CCG	
Ms H Murch	Lead Pharmacist
Derby City Council	
Dr R Dewis	Consultant in Public Health Medicine
Derbyshire County Council	
Derby Hospitals NHS Foundation Trust	
Dr W Goddard	Chair - Drugs and Therapeutic 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	
Mr M Shepherd	Chief Pharmacist
Derbyshire Community Health Services NHS Foundation Trust	
Mr M Steward	Chief Pharmacist
In Attendance:	
Ms K Stanley	Medicines Management, Southern Derbyshire CCG
Mr A Thorpe	Derby City Council (minutes)

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Item		Action
1.	**APOLOGIES**	
	Dr M Henn (Ms H Murch deputising) and Dr M Watkins.	
2.	**DECLARATIONS OF CONFLICT OF INTEREST**	
	No declarations of conflict of interest were made.	
3.	**DECLARATIONS OF ANY OTHER BUSINESS**	
	• Gender re-assignment	
4.	**MINUTES OF JAPC MEETING HELD ON 14 OCTOBER 2014**	
	The minutes of the meeting held on 14 October 2014 were agreed as a correct record after the following amendments: Summary Points: Traffic Lights – Umeclidinium/Vilanterol (Anoro) Patient Group Directions – DTaPIPVHIB Pediacel or Infanrix IPV HIB Matters Arising – 5 (a) to read Vigabatrin 5 (b) to read 'Dr Goddard would check with Dr Julia Baron. Clinical Guidelines – 7 (a) Rheumatoid Arthritis Commissioning Algorithm - To read 'Mr Dhadli highlighted that an addition should be made to the commissioning algorithm to indicate that tocilizumab subcutaneous injection would only continue to be commissioned with the proviso that the patient access scheme was still available. NICE Summary CG 184 Dyspepsia and gastro oesophageal reflux disease: Investigation and management of dyspepsia, symptoms suggestive of gastro oesophageal reflux disease, or both. To read 'Mrs Qureshi reported that the local clinical guideline was being updated in line with the NICE guidance.'	
5.	**MATTERS ARISING**	
a.	**Umeclidinium/Vilanterol (Anoro)** Dr Mott commented that it would be advantageous to highlight the reasons of JAPC for the classification of BLACK drugs and to do this for all BLACK classifications in future.	
b.	**Rheumatoid Arthritis Commissioning Algorithm** Mrs Qureshi would check whether the three IV patients at RDH, who they wanted to give tocilizumab as a subcutaneous injection at an estimated additional annual cost of £10,000 each, are existing or new patients. Mrs Qureshi would inform Dr Mott and Mr Hulme accordingly.	**SQ**
c.	**Insujet** Dr Dewis reported that there had been ongoing discussions about the future of the IFR Panel and who would be taking this forward. Eleanor Rutter, Derbyshire County Council Consultant in Public Health, would be going to the next CCG 4 + 4 meeting who would set the remit for the review of the IFR process. Dr Mott commented that the review would be led by the CCGs but Public Health and JAPC would both need to be involved in some way with this.	

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d.	**NICE DG 14 Atrial fibrillation and heart valve disease: self- monitoring coagulation status using point of care coagulometers (the CoaguChek XS system and the INRatio2 PT/INR monitor).** Mrs Qureshi had contacted Ann Hayes to request a position statement from the Clinical Commissioning Policy Group but not had a reply.	
e.	**Nitrofurantoin for Urinary-tract Infections** Mr Dhadli referred to the action requiring an update to the antimicrobial guidance in the light of the MHRA advice about nitrofurantoin use in renal disease. The JAPC bulletin had been re-worded on the advice of the Derbyshire antimicrobial specialist and local guidance has not been updated until the specialist pharmacist had spoken to the antimicrobial microbiologists Dr Goddard advised that discussions had taken place at RDH about the NICE dyspepsia guidance in relation to helicobacter pylori treatment and it had now been decided to follow the NICE guidance.	
f.	**Debrisoft** Mr Dhadli advised that NICE had published a framework which included a medical technologies guidance for Debrisoft for use in acute or chronic wounds. It had been highlighted in a previous discussion that there was not a strong evidence base to support use, mainly based on case series reports and cost effectiveness relied on the number of home visits. A classification of black had been assigned based on the evidence but a request had been received from some Tissue Viability Nurses (TVNs) to use Debrisoft in limited patient numbers. JAPC had classified Debrisoft as RED based on this and the available evidence in April 2014 but requests had now been received from pharmacists for this decision to be re-considered. Mr Steward added that the request had been made to change the classification from red to green specialist recommendation to allow access at primary care practice level. During discussion Mrs Needham queried how long would patients stay on Debrisoft and Dr Mott advised that an audit on its use by the TVNs would be a useful way of monitoring use and any potential increase in costs. Mrs Needham added that if Debrisoft was used as a very occasional dressing the TVNs would have the capacity to check whether the patients had benefited from its use and discontinued if necessary. Mr Steward would request the TVNs to undertake this audit. Mr Dhadli made reference to the NICE review recalling that cost effectiveness was demonstrated in up to ten applications in clinical practice and in a home. **Agreed:** Debrisoft re-classified as **BROWN** specialist recommendation from RED for use by TVNs for the specified wounds to include guidance on treatment length. Not cost effective if more than 10 applications are needed. **Action:** Mr Steward would inform the TVNs about the audit and request them to liaise with the Medicines Management team about how this would be undertaken.	**MS** **SD** **MS**
6.	**NEW DRUG ASSESSMENTS**	
a.	**Estring** Mr Dhadli stated that Estring was a vaginal delivery system of HRT to alleviate	

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	the symptoms of menopause. Estring was recommended by the British Menopause Society. The DCHS continence service is currently advising its use in elderly women with memory or dexterity problems. Some JAPC GPs have experience of recommending and prescribing this device. **Agreed:** Estring classified as a **GREEN** drug.	**SD**
b.	**<u>Jaydess</u>** Dr Dewis reported that JAPC had assigned a provisional classification of Green at the meeting in July. This was subsequently amended to Black following consultation with Public Health Commissioners while work was undertaken to understand the potential financial impact of this device. Dr Dewis advised that the additional cost over five years for each of the Public Health commissioners was estimated to be up to £2420 for Derbyshire County Council and £854 for Derby City Council. The views of the clinical leads for the specialist contraceptive services had been obtained and they had advised that there would be small numbers of individuals who would be suitable for this device and support a traffic light classification of Green. Dr Dewis added that a version of the information supplied by the clinical leads would be circulated as a letter to the fitters – this would also be included in the formulary or added to the medicines management website. It would also be highlighted that Jaydess was only licensed for contraceptive use and not for heavy menstrual bleeding. **Agreed:** Jaydess classified as a **GREEN** drug for contraception only.	**SD**
c.	**<u>Lurasidone</u>** Dr Taylor stated that lurasidone was a new antipsychotic drug which was efficacious but less cost effective than current standard therapy and had been classified as Red by JAPC at the October meeting pending review by the DHcFT Drugs and Therapeutic Committee. Dr Taylor advised that the DHcFT Drugs and Therapeutic Committee had agreed not to approve initiation but allow continuation if patients moved to Derbyshire that were already stabilised on this treatment. Mr Dhadli referred to a SMC review which had accepted lurasidone for limited use and that the evidence had come from placebo controlled studies and was non-inferior to quetiapine. The annual cost of lurasidone was only comparable to aripiprazole. Lurasidone has a low risk of weight gain although it does have a higher incidence of akathisia and carries a higher risk of other EPSEs – in many respects its side effect profile is similar to haloperidol. **Agreed:** Lurasidone to continue to be classified as a **RED** drug.	**SD**
7.	**CLINICAL GUIDELINES**	
a.	**<u>Atrial Fibrillation (AF)</u>** Mr Dhadli stated that the AF guidance had been written and aligned to NICE recommendations but further advice of the consultant cardiologists had been sought on some key points in the guidance. Dr Julia Baron, RDH Consultant Cardiologist, had supplied comments and the guidance had been updated accordingly to include: • Reference to antiplatelets with anticoagulants • Warfarin should not be routinely offered in combination with prasugrel or ticagrelor to people who need anticoagulation and who have had an MI	

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	except on the advice of a consultant cardiologist. • Stroke/TIA patients with newly diagnosed atrial fibrillation. • Pill in the pocket strategy to be decided after cardiologist assessment and communicated to primary care clinicians. **Agreed:** JAPC ratified the updated Atrial Fibrillation Guidance.	**SD**
b.	**<u>Clozapine</u>** Dr Taylor reported that the existing guidance had been updated and the references re-visited in order to raise awareness of the potentially significant side effects and promote the recording on practice prescribing systems to facilitate alerts. Dr Mott advised that, as a CCG representative on the DHcFT DTC Group, he has asked that details of patients on clozapine which would be conveyed to the relevant GP practices. Dr Taylor added that DHcFT would write to each GP practice to highlight the need to add clozapine to their electronic patient medicines list. Dr Dewis highlighted the need for the smoking cessation service to liaise with DHcFT for their clients quit attempts where they were on clozapine. **Agreed:** JAPC ratified the updated clozapine guidance.	**ST** **SD**
c.	**<u>Thiamine</u>** Mr Dhadli stated that the guideline group had requested clarity on vitamin supplementation for use post-discharge for alcohol withdrawal syndrome and the duration of this. Mr Dhadli added that DHcFT, RDH and CRH had their own individual agreements about this and a position statement had therefore been produced to outline the drug treatments initiated by each Trust. This also provided GPs with information about any on-going prescribing that might be required. Mr Newman suggested that the reference to admitting a person who was in poor health with signs of severe malnutrition for intramuscular or intravenous administration of thiamine should be amended to consideration of referral – this was agreed. JAPC was advised that the medicines management teams would be reviewing those patients who were on high dose thiamine and other high dose vitamin B supplementation. **Agreed:** JAPC ratified the thiamine guideline with the agreed amendments.	**SD** **SD**
8.	**PATIENT GROUP DIRECTIONS (PGDs)**	
a.	Mrs Needham stated that JAPC needed to have assurance that there was a rigorous process for the production of PGDs for use within the Out Of Hours Service and Walk in Centres by Derbyshire Health United (DHU) staff. Dr Mott referred to some minor issues identified by Dr Diane Harris concerning the antimicrobial PGDs. During discussion Mr Steward queried the process by which DHU updated the PGDs as these were based on the ones used by DCHS which were constantly updated. Mrs Needham stated that they had been developed by a PGD working group within Derbyshire Health United and their work was supported by two pharmacists. However this working group operated as a task and finish group and did not have a monitoring role. Mr Newman highlighted that it was a specific requirement of antimicrobial PGDs that they were regularly reviewed and monitored. Mrs Needham would check this with Ms Lesley Harris, Senior	

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	Nurse Manager and Medicines Lead. Dr Mott added that the PGDs would need to be signed by both North Derbyshire and Southern Derbyshire CCGs as both CCGs commission services that will use these PGDs. **Agreed:** JAPC agreed the Derbyshire Health United Patient Group Directions with the highlighted changes.	**KN/SD** **SD**
9.	**SHARED CARE GUIDELINES**	
a.	**Phosphate Binders** Mr Dhadli stated that this was an update of an existing shared care guideline for phosphate binders in the treatment of hyperphosphataemia in patients on dialysis. It was noted that the shared care agreement applied only to RDH. It was highlighted that there was no specific monitoring requirement by GPs for phosphate binders and that a shared care was not necessary although guidance as to their use would be useful. **Agreed:** Phosphate binders (Calcium Carbonate, Calcium Acetate, Aluminium Hydroxide, Sevelamer and Lanthanum) no longer to be the subject of a shared care agreement and classified as **GREEN after specialist initiation** drugs and guidance on use to be produced.	**SD**
b.	**Somatostatin** Mr Dhadli stated that the shared care guideline had been updated and that the indication now had a third extension to include treatment of individuals with low grade neuroendocrine tumours of bowel or pancreas to control tumour growth. Mr Dhadli highlighted a commissioning and financial issue associated with this as currently commissioned by NHSE. It was noted that the two existing indications were for the treatment of individuals with acromegaly and treatment of symptoms associated with neuroendocrine tumours. **Agreed:** JAPC ratified the updated shared care guideline for somatostatin without the third indication which would need to be discussed outside JAPC.	**SD**
10.	**MONTHLY HORIZON SCAN**	
	Mr Dhadli advised JAPC of the following new drug launches, new drug formulations and drug discontinuations: **Horizon Scan Monthly Action Plan New Drug Launches in the UK:** Cabozantinib (Cometriq) – Classified as **RED** Daclatasvir (Daklinza) – Classified as **RED** Idelalisib (Zydelig) – Classified as **RED** Teduglutide (Revestive) – Classified as **RED** Telavancin (Vibativ) - left unclassified **New Formulations:** Brinzolamide + brimonidine (Simbrinza) Budesonide + formoterol (DuoResp Spiromax) **Licence Extensions:** Denosumab (Xgeva) Dexamethasone (Ozudex) Tiotropium bromide (Spiriva Respimat) Tocilizumab	

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	Annual Horizon Scan: Mr Dhadli stated that three lists had been compiled of the drugs that were most likely to impact on primary care drugs budget including those high cost drugs commissioned by CCGs that are PBR excluded. Mr Dhadli then gave a commentary on the impact of the drug lines.	
11.	**MISCELLANEOUS**	
a.	**Black Traffic Light Status** Mr Dhadli referred JAPC to the recommendations which had been proposed to the traffic light status classification. There is currently little distinction between BLACK and BROWN status and there is a need for advice in managing patients already on BLACK drugs : • To add the following in BLACK traffic light status 'People currently receiving treatment for a BLACK drug designation prior to JAPC decision should be able to continue treatment until their NHS clinician considers it appropriate to switch or stop at the next available medication review.' Amend 'Not recommended or commissioned' to 'Not routinely recommended or commissioned.' • Add to BROWN status exceptionality where a small cohort of patients may benefit from prescribing can be identified. • Replace PCTs with CCGs and remove reference to Local Operation Plans. During discussion Mrs Needham suggested that a similar statement should be applied to the BROWN classification for those patients who did not meet the exceptionality cohort. Mrs Needham also queried the use of the term 'not routinely'. Dr Dewis commented that this could refer to applications in exceptional circumstances which went through the IFR process. It was also agreed that the word 'small' should deleted be in the reference to the cohort of patients and the negative NICE appraisals classified as BLACK. Dr Mott also highlighted the need to make more of a difference between the black and brown classifications. Mr Dhadli referred to the new definitions of affordability and exceptionality. Dr Mott highlighted the importance of how this was documented in order that decisions about traffic light classifications could be explained and, if necessary, defended. Dr Mott pointed out that the list of black drugs should be re-visited, particularly those about which the decision had been made on affordability grounds where for example prices may have altered when drugs had come off patent. Dr Mott added that it was essential to be clear why the classification had been assigned. In the case of lack of evidence they would not need to be re-visited unless new evidence became available but if the decision was based on affordability or priority then they would need to reviewed periodically. Dr Mott suggested that it would be useful to divide the list into categories to enable the tariff prices to be looked at, any new evidence to be taken into consideration and those which would not be re-looked at. The need for clarity was paramount in order to make the list relevant and robust. **Action:** The Guideline Group would review the black drug list.	**SD**
b.	**Molloscum Contagiosum** Mr Dhadli stated that JAPC had discussed the new product Molludab (5% Potassium Hydroxide Solution) for the treatment of molluscum contagiosum in	

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	October 2013. Mr Dhadli added that since that decision a DTB review on potassium hydroxide 5% for the treatment of molloscum hydroxide had been published which had concluded similarly there was limited clinical evidence for its use.	
c.	**NHS England Commissioning Intentions** Mr Dhadli referred JAPC to the NHS England (NHSE) Commissioning Intentions document for prescribed services 2015/16. Mr Dhadli highlighted some of the key points in the document which CCG commissioners should be aware of and its potential impact • Excluded devices and drugs amounted to 25% of acute spend which was a large financial risk. • The actual price of drugs which were being charged would be confirmed and made subject to audit. • Providers would need to submit the national standard minimum data set for drugs and devices expenditure set out in the Schedule 6 of the NHS Standard Contract. • New drugs would not be funded in year unless NICE approved or identified through horizon scan. • National procurement of drugs. • Updated risk and reward sharing arrangements. • NHSE had suggested that renal dialysis (excluding encapsulating sclerosing peritonitis surgery) and surgery for morbid obesity may in future be commissioned by CCGs. • NHSE and CQUINs including the wider use of the Blueteq system (2015/16) to support usage decisions. • Arrangements for the individual funding requests and the cancer drug fund would continue in 2015/16. • Annual horizon scan including challenge and confirm and a review of outliers of growth. • Where drugs and devices are used outside of commissioned services, as defined as nationally commissioned by NHS England, any consequential costs that were incurred will not be funded. This included the costs associated with the entire treatment. • Non-excluded drugs prescribed concurrently with the excluded drugs are not chargeable as these are covered within national tariff. No additional charges above cost will be accepted unless specifically identified in 2015/16 national tariff guidelines, explicitly agreed with NHS England and specifically in advance within the contract. • NICE TAs excluded from tariff would be automatically funded from day 90 of publication. Some approved drugs and devices may be funded before this time at the discretion of NHS England. • Trusts are expected to meet the requirements of NICE TAs and be able to demonstrate compliance through completion of innovation scorecard returns. • Post-transplant immunosuppressants. • The programme of planned change from primary care to secondary care prescribing of post-transplant immunosuppressants and inhaled antibiotics for cystic fibrosis will continue in 2015/16 once NHS England was assured there is a stable homecare market. • National chemotherapy algorithms would be published for 2015/16.	

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	• A review of gender pathways, including access to treatment, would be undertaken to identify area how existing pathways can be strengthened and improve services for patients. Mr Dhadli advised that the following could be adopted as CCG principles into the prescribing specification for its high cost drugs: • A reference as to reporting and transparency could be improved. • Where drugs and devices are used outside of commissioned services, as defined as nationally commissioned by NHS England, any consequential costs that are incurred would not be funded. This includes the costs associated with the entire treatment. • Non-excluded drugs prescribed concurrently with the excluded drugs are not chargeable as these are covered within national tariff. No additional charges above cost will be accepted unless explicitly agreed by the CCGs. The above inclusions to the prescribing specification were agreed by JAPC. Mr Shepherd highlighted that there would be occasions when pricing arrangements were confidential and this was the subject of national discussions. In addition there should be recognition that, if additional data was requested to provide assurance to the commissioners that drugs were being used appropriately, there would be a cost implication associated with this.	**SD**
d.	**<u>Pentosan Polysulfate</u>** Mrs Needham stated a request had been made by a GP in North Derbyshire to prescribe Elmiron (pentosan polysulfate) for the treatment of painful bladder/interstitial cystitis. The product was not licensed in the UK, was not included in the BNF and had very little evidence as to efficacy. Mr Dhadli added that three CCGs in the south of England had classified this drug as red for specialist use only. Dr Goddard advised that a concession request had been received from a RDH consultant urologist for one patient with post-radiotherapy bladder bleeding. The RDH Drugs and Therapeutic Committee had approved this request for this very severe indication in order to reduce the need for clinical interventions. The representatives from the Acute Trusts were not aware of a need to include it into their formulary and would manage requests through their concessions process. It was highlighted that GPs would not be familiar with the drug or the monitoring required. **Agreed:** Pentosan Polysulfate classified as a **RED** drug because of the need for specialist assessment.	**SD**
e.	**<u>Prescribing Specification</u>** Mr Dhadli reported that the prescribing specification had been updated in the light of feedback received and amendments made at the October JAPC meeting. Mr Dhadli highlighted the amendments: • Private providers contracted to treat NHS patients now required to follow the commissioning intentions of this specification. • Compliance with JAPC Traffic Light Classification for Prescribing – addition of appliances/medical devices. • Initiation is when a consultant/specialist issues the first prescription because the patient requires assessment before starting treatment and/or short term assessment of the response to the drug is necessary and GPs will only be	

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	asked to continue prescribing when the patient is stable or predictably stable. • Recommendation is when a consultant/ specialist asks GPs to prescribe the initial and on-going prescriptions, but ensures that there is no immediate need for the treatment and is in line with the out-patient discharge policy and the patient's response to treatment is predictable and safe. • On-going monitoring e.g. blood test or ECGs until requesting the primary care clinicians takes responsibility for this as per JAPC traffic light classification • In-patients on discharge or transfer shall receive a minimum of 14 days treatment for all drugs and appliances unless otherwise indicated clinically (e.g. short courses). Mr Newman advised that RDH, in conjunction with GPs and CCGs, had developed a formal short-stay model which would focus on treating patients quickly and look at an average stay of less than 48 hours. The patients treated within this model would only be supplied with new medicines or those where the dosages had been changed. Mrs Needham highlighted concern that some patients may go home with insufficient medicines if they had needed a repeat prescription during that 48 hour period and subsequently it could lead for the patient to be re-admitted because they did not have their medication, or it could cause logistical issues for patients/carers/practices to sort out additional prescriptions at very short notice. Mrs Needham stated that the North Derbyshire audits had shown that the majority of patients now brought in their medication to hospital, and therefore the need to re-supply existing medicines should have decreased in many cases. Mr Hulme requested that an assurance about adequate supply be included and urgent medicines such as antibiotics and pain relief be made available. Mrs Needham added that some patients may be discharged to a care home or community hospital and therefore consideration was needed to ensure that they had all the necessary medicines for this discharge. Mr Shepherd and Mr Newman suggested that the wording in section 10 of the specification be re-worded to read 'This 14 day treatment (or adequate supply) can be a reconciliation of medicines supplied by the trust and where appropriate medicines in possession by the patient, reducing unnecessary waste.' It was agreed that Mrs Needham, Mr Hulme, Mr Newman and Mr Shepherd would develop a form of words for this part of section 10. • Medication required for planned hospital procedure before hospital dialysis) medication will be supplied the hospital/provider. • Clarity on high cost drugs commissioned by CCGs. • Appendix 2 – It was agreed that a statement concerning patient support would be developed as part of the discussions about section 10. **Agreed:** JAPC ratified the amended prescribing specification subject to agreement on section 10 and appendix 2.	**KN/SH/ CN/MS** **SD** **SD**
f.	**<u>Travel Vaccinations</u>** Mr Dhadli stated that PrescQIPP had made recommendations concerning the prescribing of vaccinations for travel purposes in order to address the concern that £5.3 million was spent nationally on vaccines that were potentially not suitable to be prescribed on the NHS as they are mainly used for travel. The recommendations made by PrescQIPP were to classify as Black the following vaccines when used for travel:	

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	• Hepatitis B (single agent). • Meningitis ACWY (quadrivalent meningococcal meningitis vaccine; A, C, Y and W135) (ACWY Vax). • Yellow fever. • Japanese B encephalitis. • Tick borne encephalitis. • Rabies. Dr Mott referred to the point suggesting discussion with the Local Medical Committee (LMC) concerning the availability of hepatitis A vaccine but not hepatitis B and the uncertain position of the combined vaccine. This was down to local negotiation or decision making. Mr Dhadli would contact the Secretary of Derbyshire LMC to obtain their view and ensure that this was included in the updated vaccines formulary. Mr Dhadli would also contact PresQIPP about the exception for meningitis ACWY. **Agreed:** Travel vaccinations classified as **BLACK when used for the purpose of travel.**	**SD**
12.	**JAPC BULLETIN**	
	An amendment to the section on denosumab and also an amendment to the nitrofurantoin section had been made to read ' Shorter courses (3-7 days) can be prescribed with caution where eGFR is between 30 to 44ml/min in patients with proven multi-resistant pathogens and where the benefits outweigh the risks of side effects. The amended JAPC bulletin was ratified.	**SD**
13.	**MHRA DRUG SAFETY UPDATE**	
	The MHRA Drug Safety Update for October 2014 was noted. Mr Dhadli highlighted the following: • Interferon beta: risk of thrombotic microangiopathy and risk of nephrotic syndrome. This would be included in the newsletter. • Dexamethasone 4 mg/ml injection: Reformulation with changes in name, concentration, storage conditions and presentation. Mrs Needham and Mr Hulme would contact the relevant practices to alert them to this.	**SD** **KN/SH**
14.	**NICE SUMMARY**	
	Mrs Qureshi informed JAPC of the comments for the CCGs which had been made for the following NICE guidance issued in October. TA 321 Dabrafenib for treating unresectable or metastatic BRAF V600 mutation-positive melanoma. This was a NHS England commissioned drug and classified as a **RED** drug. CG 186 Multiple sclerosis: management of multiple sclerosis in primary and secondary care. It was highlighted that patients with acute relapse of MS with steroids should be offered treatment for relapse of MS with oral methylprednisolone 0.5 g daily for 5 days. CG 187 Acute heart failure: Diagnosing and managing acute heart failure in adults.	**SD**

Item		Action
15.	**TRAFFIC LIGHTS – ANY CHANGES?**	
	Classifications Debrisoft – BROWN second line after consultant/specialist recommendation (re-classified from Red) from Tissue Viability Nurses for chronic sloughy wounds and hyperkeratotic skin around acute or chronic wounds Estring – GREEN Jaydess – GREEN where commissioned Lurasidone – RED (unchanged) Phosphate Binders – GREEN specialist initiation (from Amber) Cabozantinib – RED Daclatasvir – RED Idelasip – RED Teduglutide – RED Pentosan Polysulfate – RED Dafrafenib – RED as per NICE TA321 Travel vaccines for Hepatitis B (single agent), Meningitis ACWY (quadrivalent meningococcal meningitis vaccine; A, C, Y and W135) (ACWY Vax), Yellow fever, Japanese B encephalitis, tick borne encephalitis and rabies.	
16.	**JAPC ACTION SUMMARY**	
	The action summary was noted by JAPC and amendments made: DHU and PGDs – To be removed from the list. Jaydess – To be removed from the list. Lipid guidance – To be brought to the December JAPC meeting. Fluticasone propionate nasal drops (nasules) – To be brought to the December JAPC meeting. Vigabatrin – To be brought to the December JAPC meeting. Thiamine – To be removed from the list. Nitrofurantoin – To be brought to the December JAPC meeting.	**SD** **SD** **SD** **SD** **SD** **SD** **SD**
17.	**GUIDELINE GROUP**	
	Mr Dhadli highlighted the following actions by the Guideline Group: • Three detail aids for epilepsy, PPI and CKD. • New formulation of Fostair Nexthaler available and included in local guidelines. • Amiodarone classified as GREEN in the traffic light database but according to amiodarone monitoring protocol this should be GREEN after consultant/specialist initiation – the traffic light database had been updated to reflect this. • Leuprorelin, goserelin and triptorelin previously formed shared care but when the service specifications were agreed the classifications were changed to GREEN after consultant/specialist initiation. The Guideline Group Action Tracker was noted by JAPC.	

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Item		Action
18.	**MINUTES OF OTHER PRESCRIBING GROUPS**	
	• DHFT Drugs and Therapeutic Committee – 16/9/14 • DHcFT Drugs and Therapeutic Committee – 25/9/14 • DHcFT Drugs and Therapeutic Committee – 23/10/14 • Sheffield Area Prescribing Group – 17/7/14	
19.	**ANY OTHER BUSINESS**	
	(a) Mr Dhadli reported that three requests for different hormonal treatments had recently been received by the Medicines Management team. A shared care gender pathway was to be developed nationally or by Nottingham as host commissioners but this had not yet been received. A letter should therefore be sent to Nottingham APC to request the development of a shared care if Derbyshire GPs were expected to prescribe these treatments off-licence. Mr Dhadli would draft a letter for Dr Mott to sign. (b) Mr Newman referred to the concern expressed by Dr Henn at the last JAPC meeting about the lack of an out-patient pharmacy at London Road Community Hospital in Derby. Mr Newman explained that, since the move of the main site from London Road to Royal Derby Hospital, clinics based at London Road Community Hospital were served remotely by the Trust's Boots out-sourcing partnership. The out-patients who attended the London Road Clinic were offered a choice of eighteen different locations around the city and county where they could pick up their medicines the next day. Nearly 90% of patients chose this option and the remaining 10% opted to go to the main RDH site to collect their medicines. This applied to medicines which not need to be started the same day. Urgent medicines which needed to be started straight away were supplied in a pre-pack. Drugs such as antibiotics were available in the dermatology clinic at London Road Community Hospital and it had been confirmed that this facility was being used appropriately.	**SD**
20.	**DATE OF NEXT MEETING**	
	Tuesday, 9th December 2014 at 1.30pm in the Post Mill Centre, South Normanton.	