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DERBYSHIRE JOINT AREA PRESCRIBING COMMITTEE (JAPC)

Minutes of the meeting held on Tuesday, 11 August 2015

CONFIRMED MINUTES

Summary Points

Traffic lights

Drug	Decision
Lofexidine	RED – Reclassified from Amber
Cabergoline	GREEN after consultant initiation
Quinagolide	GREEN after consultant initiation
Tedizolid phosphate	RED
Lenvatinib	Unclassified pending NHS England review
Nivolumab	Unclassified pending NHS England review
Naloxegol	RED (as per NICE TA 345) for treating opioid induced constipation
Aflibercept	RED (as per NICE TA 346) for treating diabetic macular oedema
Nintedanib	RED (as per NICE TA 347) for previously treated locally advanced, metastatic, or locally recurrent non-small cell lung cancer
Everolimus	BLACK (as per NICE TA 348) for preventing organ rejection in liver transplant. Terminated appraisal.
Dexamethasone	RED (as per NICE TA 349) intravitreal implant for diabetic macular oedema.
Secukinumab	RED (as per NICE TA 350) for treating moderate to severe plaque psoriasis
Cangrelor	BLACK (as per NICE TA 351) for reducing atherothrombotic events in people undergoing percutaneous coronary intervention or awaiting surgery requiring interruption of anti-platelet therapy (terminated appraisal).

Clinical Guidelines

Antipsychotic Physical Health Monitoring – Extended for 12 months only pending a service review
Management of Irritable Bowel Syndrome - New Clinical Guideline
Melatonin
ACS Dual Antiplatelet Policy - STEMI for use in Southern Derbyshire.

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Shared Care Guidelines

Degarelix - Existing shared care guideline extended for two years
Immunomodulating Drugs - Shared care guidelines extended to the end of November 2015.

Patient Group Directions

Meningococcal ACWY (Menvero or Nimenrix)
Shingles (Herpes Zoster) Vaccine (Zostavax)

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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
Ms J Town	Head of Finance
Mr J Vinson	Pharmacist
Hardwick CCG	
Dr T Parkin	GP
Ms M Simpson (MSi)	Contracting Team Leader
Erewash CCG	
Dr M Henn	GP
Derby City Council	
Ms R Sokal	Acting Consultant in Public Health
Derbyshire County Council	
Derby Teaching Hospitals NHS Foundation Trust	
Dr W Goddard	Chair - Drugs and Therapeutic Committee
Derbyshire Healthcare NHS Foundation Trust	
Chesterfield Royal Hospital NHS Foundation Trust	
Mr M Shepherd (MSh)	Chief Pharmacist
Derbyshire Community Health Services NHS Trust	
Ms J Shaw	Pharmacist
In Attendance:	
Mr A Thorpe	Derby City Council (minutes)

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Item		Action
1.	**APOLOGIES**	
	Ms S Bassi, Dr D Fitzsimons, Mrs K Needham, Mr C Newman, Dr S Taylor and Dr M Watkins. It was noted that there was no representation from Derbyshire Healthcare Foundation NHS Trust and the meeting therefore was not quorate but it was agreed that the meeting should proceed and the DHcFT members contacted following the meeting in order to obtain their views on the decisions made.	
2.	**DECLARATIONS OF CONFLICT OF INTEREST**	
	No declarations of interest were made.	
3.	**DECLARATIONS OF ANY OTHER BUSINESS**	
	Bribery Act 2010 – How the NHS is affected.	
4.	**MINUTES OF JAPC MEETING HELD ON 14 JULY 2015**	
	The minutes of the meeting held on 14th July 2015 were agreed as a correct record after the following amendments: Levosert – Amend to 'Primary care should be advised that levonorgestrel intrauterine system should be prescribed as Mirena as the brand to ensure this is the product supplied, fitted and reimbursed.' BreatheMOR – Amend to 'The aim of the study was to assess the benefit of modified release morphine on patient reported breathlessness intensity in the management of patients with stable Chronic Heart Failure who are still severely symptomatic despite maximally tolerated medical therapy compared with placebo.' PBR Excluded Drugs: Free of Charge Scheme – Amend to 'Mr Dhadli advised that historically the CCGs made an amendment to the specification to allow funding if the patient fulfilled the initiation criteria as per the NICE TA which was done to help Foundation Trusts to clear a backlog of patients where commissioning intentions were unclear.'	
5.	**MATTERS ARISING**	
a.	**<u>Confirmation from DCHS on Quoracy</u>** Ms Shaw confirmed that DCHS had expressed agreement to the decisions made at the July JAPC meeting.	
b.	**<u>Lofexidine</u>** Ms Sokal reported that Dr Richard Martin, Derby City Council Head of Substance Misuse and Assistant Director of Public Health, had indicated that Derby City did not have any Substance Misuse GPSIs and therefore lofexidine should not be prescribed in the Derby City community under any shared care arrangements for drug misuse. Dr Mott added that the Medicines Management Team had reviewed ePACT data and this had indicated that there was no prescribing activity of lofexidine outside of Derby City. **Agreed:** Lofexidine classified as a **RED** drug.	**SD**

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Item		Action
6.	**CLINICAL GUIDELINES**	
a.	**Antipsychotic Physical Health Monitoring** Mr Dhadli reported that the DHcFT Antipscychotic Physical Health Monitoring Clinical Guideline expired in July 2015. Dr Mahendra Kumar, Chair of the Physical Care Committee, had prepared a paper for the July meeting of the Trust's Drugs and Therapeutic Committee which outlined options as to how the service could be delivered in future. These options were: • A one-stop shop for the monitoring of physical health for the first twelve months before transferring to primary care. • Initial screening and monitoring is provided by primary care and communicated to secondary care. • Adoption of a system similar to Leicestershire Mental Health where the Trust held a mental health register for physical health maintained by their pharmacy department and patients were sent initial, three monthly and annual investigation slips. • No change to existing shared care. Dr Parkin queried who would carry out the ECG testing and interpretation of the results and referred to the three options for this which were to stay with the psychiatric service; it should become the entire responsibility of general practice or that primary care would carry out the testing but the interpretation would be via a commissioned service in secondary care. Ms Simpson would discuss further with the Hardwick CCG commissioners. **Agreed:** JAPC ratified an extension of the clinical guideline pending a review of the options between DHcFT and the commissioners.	**MSi** **SD**
b.	**Irritable Bowel Syndrome** Mr Dhadli reported that a new clinical guideline for the management of Irritable Bowel Syndrome (IBS) in primary care had been developed and was based on the recommendations in NICE CG 61: Irritable bowel syndrome in adults - diagnosis and management of irritable bowel syndrome which had been published in February 2015. Dr Goddard commented that the clinical guideline concentrated more on ensuring that positive diagnoses were made and that cancers were not missed in the older age group. However he pointed out that there was no reference to faecal calprotectin diagnostic testing in the guideline. Mr Dhadli would check whether faecal calprotectin testing was included in the NICE CG and add this to the JAPC IBS guideline if necessary. The guideline would be sent to Dr Goddard for any further comments. Dr Parkin queried the role of primary care in the use of the clinical guideline and whether this should only extend to the management of treatment after a diagnosis had been made and does not include responsibility for the safety aspects of the guideline. Mr Hulme commented that there could also be risks if the clinical guideline was not aligned to the NICE CG and a pragmatic approach on a case by case was often taken. **Agreed:** JAPC ratified the Irritable Bowel Syndrome clinical guideline.	**SD** **SD**

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c.	**Melatonin** Mr Dhadli reported that this was an update to an existing clinical guideline which would expire in August 2015. JAPC had agreed in March 2013 that, following the declassification of shared care, melatonin should be classified as brown specialist initiation after patients switched to Circadin. Mr Dhadli advised that the shared care had subsequently been re-written as a supporting information document. However the reference to 'unlicensed products should only be used following specialist recommendation' now required amendment to indicate that they should only be prescribed by specialists. **Agreed:** JAPC ratified the melatonin clinical guideline.	**SD**
d.	**Oral Thrush** Mr Dhadli reported that this was a position statement on the use of miconazole for the treatment of surface and ductal thrush in lactating women and off-licence use for oral thrush in children under four months of age. In April 2008 the MHRA had advised that miconazole oral gel should no longer be used with any patient less than four months old and with caution in any pre-term infant less than six months old. Mr Dhadli advised that the position statement had been prepared for community practitioner nurse prescribers and independent prescribers to support them in the use of miconazole and fluconazole off-licence. Amendments had been made by the breast feeding specialist on the basis of advice contained in the NICE Clinical Knowledge Summaries. It was highlighted that there were still some existing queries to be resolved which included the use of swabbing to confirm diagnosis and the use of off-licence/off-label fluconazole in the treatment for ductal thrush. JAPC requested that the guideline group be tasked with making the guideline shorter and practicable. **Action:** The oral thrush position statement would be taken to the Guideline group for further discussion.	**SD** **SD**
e.	**ACS Dual Antiplatelet Policy - STEMI (Southern Derbyshire)** Mr Dhadli reported that Dr Julia Baron, DTHFT Consultant Cardiologist, had requested a further extension to the policy of two years. It was confirmed that the policy was fully compliant with the relevant NICE TAs. **Agreed:** JAPC ratified the ACS Dual Antiplatelet Policy - STEMI for use in Southern Derbyshire.	**SD**
7.	**PATIENT GROUP DIRECTIONS**	
a.	**Meningococcal ACWY** Mr Dhadli advised that the PGD for Meningococcal ACWY had been authorised for use by Derbyshire and Nottinghamshire NHS England (North Midlands) as the commissioner of NHS immunisation programmes for use across Derbyshire and Nottinghamshire including primary care. **Agreed:** JAPC agreed the Patient Group Direction for Meningococcal ACWY.	**SD**

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Item		Action
b.	**Zostavax** Mr Dhadli advised that the PGD for Zostavax (shingles vaccine) had been authorised for use by NHS England (North Midlands) as the commissioner of NHS immunisation programmes for use across Derbyshire and Nottinghamshire including primary care. **Agreed:** JAPC agreed the Patient Group Direction for Zostavax. **Action:** The Patient Group Directions for Meningococcal ACWY and Zostavax would be placed on the Medicines Management website.	**SD** **SD**
8.	**SHARED CARE GUIDELINES**	
a.	**Cabergoline and Quinagolide** Mr Dhadli stated that the shared care agreement for cabergoline and quinagolide for hyperprolactinaemia had previously been discussed by JAPC at its meeting in June 2015 and some queries had been raised concerning the SPC monitoring requirements, especially for the associated risk of pericardial fibrotic reactions with cabergoline. Dr Roger Stanworth, DTHFT Consultant Endocrinologist, had therefore amended the shared care agreement which explained the deviation from SPC requirements. Mr Dhadli outlined some of the changes which had been made to the shared care guideline which included a reference to fibrotic complications with cabergoline and quinagolide baseline testing. Since June 2015 Dr Stanworth had sought consensus from the Derbyshire endocrinologists to issue JAPC with a position statement. This included a favourable safety reference to cabergoline by the Society for Endocrinology sponsoring a National Cross Section study and citing the MHRA warning related to higher doses. Following discussion it was agreed that the on-going prescribing of cabergoline and quinagolide should be undertaken by primary care with the monitoring done by the specialists. In response to a query from Dr Emslie it was highlighted that responsibility for ECHO screening would remain with the consultants. **Action:** Mr Dhadli would develop an information sheet based on the position statement for use by GPs **Agreed:** Cabergoline and quinagolide classified as **GREEN consultant initiation** drugs but this would not be changed until the position statement had been completed.	**SD** **SD**
b.	**Degarelix** Mr Dhadli reported that a request had been made for an extension of the review date for degarelix for prostate cancer by two years. Degarelix had been scoped by NICE in May 2015 and uncertainty remained regarding the cost-effectiveness of degarelix relative to LHRH agonists in subgroups of patients with different risks of spinal cord compression and whether the patients who would benefit most from treatment with degarelix could be reliably identified in clinical practice. Mr Dhadli added that a NICE TA on degarelix was due to be published in October 2015.	

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Item		Action
	Agreed: JAPC ratified the extension of the existing shared care guideline for degarelix for two years. A re-assessment would be undertaken by JAPC in the light of the expected NICE TA.	**SD**
	Action: The issues concerning the use of degarelix would be highlighted to the consultant urologists at the DTHFT Drugs and Therapeutic Committee in view of the higher amount of degarelix use in South Derbyshire.	**SD**
c.	**Immunomodulating Drugs** Mr Dhadli reported that a number of consultants at DTHFT and CRHFT had been contacted in May 2015 to ascertain if they were in need of updating. Some consultants responded that they were happy to extend with no changes pending the BSR update. Mr Dhadli stated that the last active review of these took place as long ago as 2012 and believed some changes were necessary. It was agreed that all the immunomodulating shared care guidelines be tabled at the two Acute Trust Drugs and Therapeutic Committees for discussion. Mr Shepherd commented that the CRHFT consultant rheumatologists wished to add the DMARD mycophenolate and undertook to liaise with them to update the shared care guideline.	**MSh**
	Agreed: JAPC agreed to extend the shared care guidelines to the end of November 2015. A statement would be put on the website to indicate that the shared care guidelines were currently under review and that a check should be made with the SPC in the case of any queries.	**SD**
	Post-meeting note: The Chief Finance Officers are querying one of the principles and will inform JAPC of this.	
10.	**MONTHLY HORIZON SCAN**	
a.	**Monthly** Mr Dhadli advised JAPC of the following new drug launches, new drug formulations and drug discontinuations: New drug launches in the UK: Lenvatinib (Lenvima) – Leave unclassified pending NHS England decision. Nivolumab (Opdivo) – Leave unclassified pending NHS England decision. Tedizolid phosphate (Sivextro) – Classified as **RED.** Licence extensions: Golimumab (Simponi) Methylnaltrexone (Relistor) Perampanel (Fycompa) Prucalopride (Resolor) Ustekinumab (Stelara) – It was highlighted that the NICE TA for ustekinumab published in 2009 was for adults only.	
b.	**NICE** Mr Dhadli advised JAPC of the following NICE New Evidence summaries: Midodrine for orthostatic hypotension – This was now licensed for orthostatic hypotension and had been launched on 29th July 2015.	

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	Currently classified as a **Red** drug. Mr Dhadli stated that primary care over the last few years had received inappropriate requests from consultants to continue to prescribe and asked that the Hospital Trusts submit a paper to JAPC to consider reclassification. High strength insulin glargines for diabetes mellitus – These would be assigned a traffic light classification of **Black** on launch. Insulin glargine biosimilar – This would be adopted on the formulary when launched.	**MSh/WG**
11.	**MISCELLANEOUS**	
a.	**Drugs and Therapeutic Bulletin (DTB) Review - Umeclidinium** Mr Dhadli advised that it had been agreed to look at any high level evidence reviews concerning drugs which had previously been considered by JAPC. Umeclidinium was another long-acting muscarinic antagonist (LAMA) for COPD and the evidence was from two key studies of umeclidinium's efficacy at the licensed dose using outcome measures of lung function, symptom scores and health status. However, neither study was designed to examine treatment effects on COPD exacerbations. The DTB had concluded that, similar to the position of JAPC, there was currently insufficient evidence to recommend umeclidinium over the other long-acting antimuscarinics.	
b.	**Gain Sharing** Mrs Hunter stated that JAPC had discussed gain sharing at the June 2015 meeting. A paper on the principles for sharing the benefits associated with more efficient use of medicines not reimbursed through national tariff prices had subsequently been developed. The paper set out the criteria to be applied for local schemes for high cost drugs that were not reimbursed through national prices, suggested potential areas for greater efficiency and considered how to deal with resourcing issues. It would be the responsibility of the CCG contracting teams to develop specific arrangements with their respective Trusts to include high level principles as to how the benefits should be shared. JAPC agreed the general principles as set out in the paper prepared by Mrs Hunter. The detailed principles would be taken forward by the CCG commissioners to agree with the Acute Trusts. **Post meeting note:** Judith Town highlighted to JAPC members that Mandy Simpson and herself had raised at the August JAPC meeting the need for the paper to be circulated to the Chief Financial Officers of Derbyshire for CCG agreement as the paper posed commissioning implications. JT was asked to make an amendment to the paper following that consultation and circulate to members at a later JAPC meeting.	
c.	**Learning Difficulties – Winterbourne Medicines Programme** Mr Dhadli reported that, in the Department of Health review 'Transforming care: A national response to Winterbourne View Hospital', concerns had been reported about the overuse of medications in people who had learning disabilities and behaviours that could challenge. The Winterbourne Medicines Programme had therefore been developed to	

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	ensure safe, appropriate and optimised use of medication for people with learning disabilities. NHS England had commissioned three pieces of work which aimed to understand the scale and appropriateness of the use of antipsychotic, antidepressant, anxiolytic, hypnotic and antiepileptic medicines: • A detailed examination of data about the use of these medicines in primary care. • An audit of Second Opinion Authorised Doctor decisions about the use of these medicines in patients with learning difficulty detained under the Mental Health Act. • A collaborative improvement programme at local level to obtain an in depth understanding of medicines use and to test new ways of working. During discussion Dr Parkin referred to a trial in Derbyshire looking at the reduction of risperidone prescribing, particularly in adults with learning disabilities, but Dr Mott stated that the scale of work necessary was far more reaching. Ms Shaw stated that DCHS would like to link in with the CCGs concerning future work about learning disabilities and Dr Mott suggested that both North and South Prescribing Groups should discuss further. It was highlighted that a multi-agency response would be needed and that a working group may be the best way to take the work forward. **Action:** Ms Simpson would request an update from the Hardwick CCG Learning Disabilities Commissioning Manager about progress on how a response could be developed for the Winterbourne Medicines Programme and report back to the September JAPC meeting.	**MSi**
12.	**JAPC BULLETIN**	
	The July JAPC bulletin was ratified.	**SD**
13.	**MHRA DRUG SAFETY UPDATE**	
	The MHRA Drug Safety Update for July 2015 was noted. Mr Dhadli highlighted the following: • Denosumab: intravenous bisphosphonates: osteonecrosis of the jaw - further measures to minimise risk and issuing of reminder cards. • Latanoprost prescribed as the brand Xalatan: increased reporting of eye irritation since reformulation. • New Yellow Card smartphone app for reporting suspected side effects.	
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 2015. TA 345 Naloxegol for treating opioid induced constipation - Naloxegol was recommended, within its marketing authorisation, as an option for treating opioid induced constipation in adults whose constipation has not adequately responded to laxatives. Naloxegol was orally administered and could decrease demands on staffing time for providers when used in place of methylnaltrexone which is a subcutaneous injection. It had no additional monitoring requirements and could lead to increased drug	

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	costs for commissioners when used in place of conventional laxative treatments, or cost saving if used as an alternative to methylnaltrexone. Mrs Qureshi referred to the terminated NICE appraisal TA277 for the treatment of opioid-induced bowel dysfunction in people with advanced illness who were receiving palliative care. Methylnaltrexone had been reclassified by JAPC from red to brown after consultant/specialist recommendation in order to allow palliative care patients timely access to this drug. Naloxone-oxycodone had a traffic light classification of BLACK and bisacodyl had a traffic light classification of GREEN. Classified as a **RED** drug. **Action:** Mr Dhadli would consult with the palliative care consultants about the place of naloxegol in therapy. TA 346 Aflibercept for treating diabetic macular oedema – Mrs Qureshi tabled an algorithm which outlined the options for the treatment of diabetic macular oedema (DMO) with aflibercept as an additional 1st line option alongside ranibizumab (Lucentis) and with a Patient Access Scheme. Mrs Qureshi added that the consultant ophthalmologists had been requested to advise on the place for aflibercept, pathways for first and second line options and development of criteria for possible switching. Classified as a **RED** drug. TA 347 Nintedanib for previously treated locally advanced, metastatic, or locally recurrent non-small cell lung cancer - Classified as a **RED** drug (NHS England high cost drug). TA 348 Everolimus for preventing organ rejection in liver transplant – Classified as a BLACK drug for this indication (NHS England high cost drug). TA 349 Dexamethasone intravitreal implant for diabetic macular oedema – This was another second line option in addition to fluocinolone and CCGs were the responsible commissioners for this drug. Mrs Qureshi reported that the annual cost of the implementation of this guidance for the incident population was estimated as £4 million in England. There would also be a non-recurring cost for treating the prevalent population not previously treated with fluocinolone. NICE estimated that this will be implemented over three years at a cost of £17 million in year 1, £17 million in year 2 and £15 million in year 3. It would be necessary to discuss the implications of his guidance with the DTHFT and CRHFT consultant ophthalmologists and highlight to the Drugs and Therapeutic Committee Finance Sub-Group. Classified as **RED** drug. TA 350 Secukinumab for treating moderate to severe plaque psoriasis - Secukinumab was recommended by NICE, within its marketing authorisation, as an additional option for treating adults with plaque psoriasis only when: the disease was severe, as defined by a total Psoriasis Area Severity Index (PASI) of 10 or more and a Dermatology Life Quality Index (DLQI) of more than 10, the disease had failed to respond to standard systemic therapies or these treatments are contraindicated or the person could not tolerate them. Secukinumab was a first-in-class monoclonal anti-human interleukin-17A (IL-17A) antibody of the IgG1/kappa isotype and an alternative to available biologic agents. It was highlighted that further discussions would be needed	**SD** **SD** **SD** **SD**

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	concerning patient pathways. Classified as a **RED** drug. TA 351 Cangrelor for reducing atherothrombotic events in people undergoing PCI or waiting for surgery requiring interruption of anti-platelet therapy – Terminated appraisal. Classified as a **BLACK** drug. NG 14 Melanoma: assessment and management – Mr Dhadli would check for any prescribing implications and bring back to JAPC if necessary.	**SD** **SD** **SD**
15.	**TRAFFIC LIGHTS – ANY CHANGES?**	
	Classifications Lofexidine – RED from Amber Cabergoline – GREEN after consultant recommendation from Amber Quinagolide – GREEN after consultant initiation from Amber Tedizolid – RED Lenvatinib – Unclassified pending NHS England review Nivolumab – Unclassified pending NHS England review Naloxegol – RED as per NICE TA 345 Aflibercept – RED as per NICE TA346 Nintedanib – RED as per NICE TA347 Everolimus – BLACK as per NICE TA348 Dexamethasone – RED as per TA349 Secukinumab – RED as per TA350 Cangrelor – BLACK as per TA351	
16.	**JAPC ACTION SUMMARY**	
	The action summary was noted by JAPC and amendments made: Aripiprazole and pregabalin – To remain on. Lithium monitoring – To be brought to the September meeting. Depression in children and young people – Check to be made with DHcFT about progress in the consideration of NICE CG28 and implications for primary care. GOR(D) adult new NICE cancer referral criteria – To be brought to the September JAPC meeting. Hyperprolactinaemia – To be taken off. Biosimilars and Gain Sharing Derbyshire Framework – To come off from the sharing agreement principles document. Grazax – To be brought to the June 2016 meeting. Glaucoma guidance – Dr Goddard would chase a response from the DTHFT consultant ophthalmologists. Lofexidine shared care – To be taken off Free of charge schemes – To be brought to the November meeting. Immunomodulating Drugs – To be brought to the November meeting. Learning Disabilities – Update to be brought to the September meeting.	 **SD** **SD** **SD** **SD** **SD** **SD** **SD** **WG** **SD** **SD** **SD** **TP/MSi**

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17.	**GUIDELINE GROUP**	
	The summary of key messages arising from the meeting held in July 2015 was noted. Mr Dhadli highlighted the following: • Grazax proposed recommendations as per JAPC request. • Heart failure guideline – No comments had been received from DTHFT and CRH. Dr Goddard and Mr Shepherd would chase responses. • Non-malignant chronic pain in primary care. • Dulaglutide for type 2 diabetes – It was highlighted that JAPC required a drug review	**SD**
18.	**MINUTES OF OTHER PRESCRIBING GROUPS**	
	• Burton Hospitals Drugs and Therapeutic Group 11/05/15 • Nottinghamshire Area Prescribing Committee 21/05/15 • DHcFT Drugs and Therapeutic Committee 25/06/15 • DTHFT Drugs and Therapeutic Committee 16/06/15 • CRHFT Drugs and Therapeutic Committee 21/07/15 • Sheffield Area Prescribing Group 19/03/15 • Sheffield Area Prescribing Group 16/04/15 • Sheffield Area Prescribing Group 25/05/15 • Sheffield Area Prescribing Group 18/06/15 Mr Dhadli highlighted the following items from the minutes: • Burton Hospitals Drugs and Therapeutic Committee –The CCGs would pick up costs for any South Staffordshire patients on fosfomycin. • Nottinghamshire Area Prescribing Committee – Appeal against a formulary submission for Relvar Ellipta and decision that it should now be added to the formulary with a green classification as a 2nd line ICS/LABA option for COPD patients with FEV1< 50% who were unable to use standard devices. • Sheffield Area Prescribing Group – A review of all shared care was being undertaken. • DHcFT Drugs and Therapeutic Committee – Decision that the Drugs and Therapeutic Committee meetings to be alternated with the meetings of the DHcFT Medicines Safety Committee.	
19.	**ANY OTHER BUSINESS**	
	Mr Hulme highlighted that the Bribery Act 2010 created specific criminal offences which carried custodial sentences and potentially unlimited fines. It also introduced a corporate offence with the result that organisations across the public, private and charitable sectors would be exposed to criminal liability for failing to prevent bribery. The Department of Health Legal Service had advised that NHS bodies such as CCGs were deemed to be a relevant corporate body and would become liable unless preventative procedures were put in place for acts of bribery and corruption committed by persons associated with it in the course of their work.	
20.	**DATE OF NEXT MEETING**	
	Tuesday, 8th September 2015 at 1.30pm in the Post Mill Centre, South Normanton.	