For agenda items contact Slakahan Dhadli
Tel: 01332 868781
Email: slakahan.dhadli@southernderbyshireccg.nhs.uk

DERBYSHIRE JOINT AREA PRESCRIBING COMMITTEE (JAPC)

Minutes of the meeting held on Tuesday 9 June 2015

CONFIRMED MINUTES

Summary Points

Traffic lights

Drug	Decision
Brinzolamide 1%/ brimonidine 0.2% eye drops (Simbrinza)	GREEN after specialist initiation
Grazax	RED for use in DTHFT specialist paediatric allergy clinic only
Sildenafil	RED for the treatment of digital ulceration in systemic sclerosis
Indacaterol/glycopyrronium (Ultibro)	BROWN
Formoterol	GREEN
Glycopyrronium (Seebri Breezhaler)	BROWN 2nd line LAMA after tiotropium
Aclidinium (Eklira Genuair)	BROWN 2nd line LAMA after tiotropium
Umeclidinium (Incruse Ellipta)	BROWN 2nd line LAMA after tiotropium
Symbicort	GREEN 3rd line
Seretide	GREEN 3rd line

Clinical Guidelines

Management of COPD

For agenda items contact Slakahan Dhadli
Tel: 01332 868781
Email: slakahan.dhadli@southernderbyshireccg.nhs.uk

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 (also representing Erewash CCG)
Mrs S Qureshi	NICE Audit Pharmacist
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)
Ms J Town	Head of Finance
Hardwick CCG	
Mrs K Needham	Representing
Erewash CCG	
Mr S Hulme	Representing
Derby City Council	
Derbyshire County Council	
Derby Teaching Hospitals NHS Foundation Trust	
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	Head of Medicines Management
In Attendance:	
Dr K Reddington	GP Registrar
Mr A Thorpe	Derby City Council (minutes)

For agenda items contact Slakahan Dhadli
Tel: 01332 868781
Email: slakahan.dhadli@southernderbyshireccg.nhs.uk

Item		Action
1.	**APOLOGIES**	
	Ms S Bassi, Dr W Goddard, Dr M Henn, Dr T Parkin and Ms R Sokal.	
2.	**DECLARATIONS OF CONFLICT OF INTEREST**	
	No declarations of interest were made.	
3.	**DECLARATIONS OF ANY OTHER BUSINESS**	
	• Rivaroxaban post ACS • MHRA biosimilars and high strength insulins	
4.	**MINUTES OF JAPC MEETING HELD ON 12 MAY 2015**	
	The minutes of the meeting held on 12th May 2015 were agreed as a correct record after the following amendments: Minutes of the meeting held on 14th April 2015 - Dementia: Amend to: ' Ms Bassi advised JAPC that the shared care agreements acetylcholinesterase inhibitors donepezil, rivastigmine and galantamine were due to expire in June 2015 and memantine for Alzheimer's disease was due to expire in May 2015.' Aclidinium + Formoterol (Duaklir Genuair) – Amend to: ' It was highlighted that significant savings could be made by the use of a combination product over prescribing individual inhalers, where both LAMA and LABA are beneficial to the individual patient.' Adult Asthma Guidance – Amend to: 'Dr Henn highlighted that there was a sub-group of patients who would achieve better control from the use of QVAR (beclomethasone) inhaler and also requested that a clearer indication of maximum doses be given in the section concerning the flexible dosing regimens of Fostair MART and Symbicort SMART.' GORD Diagnosis and Management in Children and Young People – Amend to: 'The guidance had been produced in liaison with Dr Julia Surridge, Paediatric Emergency Department Consultant, and Dr Aiwyne Foo, Consultant Paediatrician and had been sent out for consultation and comment.'	
5.	**MATTERS ARISING**	
a.	**Children's Asthma Guidance** A copy of the guidance would be sent to the Local Pharmaceutical Committee.	**KN**
b.	**GORD Diagnosis and Management in Children and Young People** It was reported that Carobel had been removed from the breast-feeding section of the guidance and was the preferred cost effective option over anti-regurgitation' formulas. The guidance would be placed on the website.	**SD**
c.	**Bowel Cleansing Guidance** Mr Dhadli reported that home self administered phosphate enemas had now been included in the bowel products section.	

Item		Action
d.	**ACS Dual Antiplatelet (DAPT) Guideline NSTEMI** Mr Dhadli reported that the CRHFT and DTHFT NSTEMI pathways differed significantly. The DTHFT guideline had gone back to the consultant cardiologists with a request that they develop a different pathway should they wish for the more wider use of ticagrelor. In the meantime CRHFT guidance was accepted.	
e.	**Management of Dyspepsia** Mr Dhadli advised that the new referral criteria from the forthcoming NICE cancer referral guidance were significantly different to the most recently updated draft GORD guidance which had gone out for consultation. Mr Dhadli advised JAPC members that the guideline should be deferred.	
6.	**NEW DRUG ASSESSMENTS**	
a.	**Brinzolamide/brimonidine combination eye drops** Mr Newman stated that Simbrinza was a combination of brinzolamide and brimonidine tartrate in an eye drop suspension and was licensed for treating chronic open angle glaucoma in adults in whom monotherapy had not sufficiently reduced intra-ocular pressure. The DTHFT ophthalmologists were looking to use these eye drops as either a third or fourth option in the glaucoma treatment pathway with prostaglandins and beta-blockers as first and second line choices. Mr Newman highlighted that the use of a combination product reduced the exposure to preservatives and improved patient compliance due to the reduced number of drops which were needed to be administered. Mr Dhadli advised that the evidence came from two randomised controlled trials in people with glaucoma with brinzolamide/brimonidine which had demonstrated that combination eye drops were statistically significantly superior to either constituent drug administered alone as monotherapy in reducing intraocular pressure at three months. The adverse effects were surprisingly higher in the combination products compared with the individual constituent drugs. There was no safety data for use of the combination eye drops beyond six months but there was longer term data available for brinzolamide and brimonidine monotherapies. The product is more or less cost neutral but as a combination may improve patient compliance. It was also noted that this is the first combination treatment eye drop without timolol. Mr Dhadli highlighted that the treatments for glaucoma and ocular hypertension with suspected glaucoma were different with the first line treatment for the former being prostaglandin analogues and the latter topical beta-blockers or prostaglandin analogues. The Guideline Group had therefore been requested to develop a treatment algorithm which would indicate: • which product should be used first line • information about when beta-blockers, carbonic anhydrase inhibitors and alpha-2 would be used • choice of prostaglandin analogues The draft glaucoma and raised intra-ocular pressure guideline would be brought to the September JAPC meeting.	**SD**

Item		Action
	Agreed: Simbrinza eye drops classified as a **GREEN drug** after specialist initiation in place of the individual components.	**SD**
b.	**Grazax** Mr Newman reported that Grazax, a grass pollen extract from Timothy grass, had previously been assigned a traffic light classification of BLACK for the treatment of seasonal allergic rhinitis. A very small cohort of children had been identified by the Trust who may derive particular benefit from the use of Grazax sub-lingual therapy which could reduce the use of current subcutaneous immunotherapy with Pollinex and consequently the number of hospital visits required. Six patients had been identified by the Trust for the use of Grazax sub-lingual therapy. Mr Dhadli advised that Grazax was a once-daily oral treatment used for three years and there was a manufacturer's risk share scheme which reimbursed therapy costs in treatment failure provided the treatment had started four months prior to the start of the hay fever season. The evidence was from a DTB review in 2008 which had not recommended its use and there had been a further DTB review in 2010 in response to licensing changes and the extension of one of the studies. The licensing change related to its re-classification as a disease modifying agent and that it was now licensed in children over five years of age. The review had queried the benefit in year four and whether it really was a disease modifying agent. The evidence for children came from one double-blind RCT which involved 253 children and the DTB had concluded that the effects of Grazax were modest and that other treatments would still need to be used. The use of Grazax was not recommended for the vast majority of patients with hayfever and this had been reinforced by a 2011 Cochrane review on sub-lingual immunotherapy for allergic rhinitis. A recent Cochrane review of immunotherapy use in children had found a significant reduction in symptoms and medication requirements in participants who received sublingual immunotherapy compared to placebo. The World Health Organisation had included Grazax in a 2009 paper but the SMC had rejected its use on two occasions. There were no published comparisons versus conventional treatments; the added benefit was modest and existing treatment options were likely to continue. During discussion Dr Mott commented that the evidence was weak but the consultants had indicated that they could define a very tight cohort of children who may benefit from Grazax and there would be a need to determine whether there was a place in the formulary for this. The position of Derbyshire JAPC concerning Grazax was at variance with other Area Prescribing Committees. Mr Hulme queried why this cohort of patients had been chosen and whether a precedent would be set if this drug was approved for use. In the event that Grazax was given a traffic light classification of Red would this have the potential to increase the number of referrals and therefore increase the defined cohort of patients. There may also be additional costs caused by the need for follow ups and the position after the three year period would need to be determined.	

For agenda items contact Slakahan Dhadli
Tel: 01332 868781
Email: slakahan.dhadli@southernderbyshireccg.nhs.uk

Item		Action
	Mrs Hunter highlighted an issue concerning costs of supply and out-patient appointments. Dr Mott queried whether a sub-set of patients could be identified in the cohort on which the drug could be tested and, in the event that no benefit was found, the costs would be reimbursed by the drug company in the first year. **Agreed:** Grazax classified as a **RED** drug for use in the DTHFT specialist paediatric allergy clinic only. **Action:** Mrs Hunter would raise the finance issues concerning out-patient appointments at the Drugs and Therapeutic Finance Sub-Committee. **Action:** Dr Mott would update the guidance on the use of anti-histamines in conjunction with Dr Traves, DTHFT Consultant Paediatrician, and bring this to the Guideline Group. **Action:** The transition of teenagers into the adult service would be clarified. **Action:** Mr Dhadli to request Dr Traves and Dr Carroll to produce an annual report for JAPC on the efficacy of Grazax.	**SD** **LH** **AM** **SD**
c.	**<u>Sildenafil and Digital Ulcers</u>** Mr Newman reported that NHS England had produced a clinical commissioning policy on the use of sildenafil and bosentan for the treatment of digital ulceration in systemic sclerosis/severe Raynaud's disease. NHS England considered this to be a cost-effective option compared to regular courses of iloprost. Sildenafil is a phosphodiesterase type 5 inhibitor (PDE5i) and its cost had recently significantly reduced. Sildenafil was not currently licensed for the treatment of Raynaud's disease or digital ulcers in patients with systemic sclerosis. Bosentan, which reduced the formation of new digital ulcers, was also commissioned by NHS England. The NHS England policy indicated a change in order of treatment with a six week trial of sildenafil to be used in the event of failure with standard therapy but before iloprost which needed a period of hospitalisation. In the event of a lack of success with sildenafil and iloprost, patients would be considered for bosentan. Dr Mott queried whether GPs would be happy to prescribe sildenafil for this unlicensed indication. The GPs present expressed the opinion that they and colleagues would probably not be happy to do this. It was estimated that 30 patients would be involved although this had been queried as the NHS England Commissioning Policy document had estimated that 10% of patients may satisfy the criteria for treatment with bosentan and the number of patients in England who were likely to require initiation or ongoing treatment was 140 annually. There were also issues associated with specialised commissioning and local commissioning and these would need to be resolved before any firm decision was made as to a traffic light classification for sildenafil to enable GPs to continue therapy after initiation by a rheumatologist. **Agreed:** Sildenafil classified as a **RED** drug for this indication.	**SD**

For agenda items contact Slakahan Dhadli
Tel: 01332 868781
Email: slakahan.dhadli@southernderbyshireccg.nhs.uk

Item		Action
	Action: Mr Dhadli would ascertain the position regarding the use of sildenafil for the treatment of digital ulceration in systemic sclerosis in other Clinical Commissioning Groups.	**SD**
7.	**CLINICAL GUIDELINES**	
a.	**COPD Management** Mrs Qureshi reported that the existing guideline had been updated and preliminary feedback received from the Guideline Group in March 2015, Further comments had been received back from the DTHFT and CRHFT respiratory consultants which had been included in the guideline. The updated guideline also included the new drugs and formulations which had become available since the publication of the original guidance. JAPC noted that the DTHFT respiratory consultants had queried the medicine management of stable COPD algorithm in the guideline as follows: • For FEV1≥50% LABAs were placed before LAMAs. There was no difference between a LAMA and LABA with regards to prevention of exacerbation or hospitalisation according to the NICE guidance and therefore LABAs were considered the most cost-effective option for this cohort of patients. • For FEV1<50% it had been advised to weigh the risk against the benefits when prescribing LAMAs or LABA/ICS. There was an increased risk of pneumonia when using LABA/ICS combination. • The issue of LABA/LAMA combinations and their place in therapy. There was limited evidence for efficacy, but could potentially be a cost effective option in patients who used the individual components. JAPC agreed that, due to the guidelines being primary care facing and numbers of COPD cases, the cost differences between the LABAs and the LAMAs had to be taken into consideration particularly for poorly controlled patients. The feedback from CRHFT respiratory consultants had requested a link with spirometry training and this would be included in the finalised guidance. The Guideline Group had highlighted that there were currently three LABA/LAMA combinations inhalers available: • Formoterol/aclidinium (Duaklir Genuair) - BROWN • Indacaterol/glycopyrronium (Ultibro Breezhaler) – BLACK • Vilanterol/umeclidinium (Anoro Ellipta) - BLACK It had been recommended that indacaterol/glycopyrronium be re-classified to BROWN from BLACK due to the combination product being a cost-effective option over the individual components. Mrs Needham stated that the left hand arrows in the medicines management of stable COPD algorithm should be highlighted in bold in order to indicate that for FEV1 ≥50% LABA Formoterol Easyhaler was the preferred choice and for FEV1 < 50% LAMA Tiotropium was the preferred choice.	**SQ** **SQ** **SQ**

Item		Action
	In addition an arrow going both ways would be inserted between the left and right hand sides. Mr Dhadli reported that two amendments which had been supplied by Dr Henn: • Bullet point 2 diagnosis: diagnosis to be made proving airflow obstruction on post bronchodilator spirometry • Page 4 respiratory services. Add contact details of Primary Care Facing Community Respiratory Nurse Specialist. Mrs Qureshi referred to the LAMA pathway in the document which indicated that Tiotropium (Handihaler or Respimat) remained the preferred LAMA. In cases where tiotropium was contra-indicated or not tolerated then glycopyrronium, Seebri Breezhaler, Eklira Genuair or Umeclidinium Incruse Ellipta could be tried. **Agreed:** Indacaterol/glycopyrronium (Ultibro Breezhaler) re-classified to **BROWN** from BLACK. The following drugs in appendix 4 were assigned traffic light classifications: Formoterol turbohaler – **GREEN** Glycopyrronium – **BROWN 2nd line** Aclidinium **– BROWN 2nd line** Umeclidinium **– BROWN 2nd line** Symbicort 200/6/Symbicort 400/12 **– GREEN 3rd line** Seretide **– GREEN 3rd line** **Agreed:** The management of COPD guideline was ratified with the agreed amendments and traffic light classifications.	**SD** **SD**
8.	**SHARED CARE GUIDELINES**	
a.	**<u>Cabergoline and Quinagolide</u>** Mr Dhadli stated that the shared care agreement for cabergoline and quinagolide for hyperprolactinaemia had previously been discussed by JAPC and some queries had been raised concerning the SPC monitoring requirements for the associated risk of pericardial fibrotic reactions. Dr Roger Stanworth, DTHFT endocrinologist, had therefore amended the shared care agreement which included an explanation as to why some of the monitoring requirements in the updated guidance went outside the Summary of Product Characteristics (SPC) monitoring requirements. Discussion followed and Dr Mott queried whether GPs would be prepared to continue prescribing outside shared care with follow up specialist appointments. Dr Fitzsimons highlighted a potential risk that some patients may be lost to follow up. Dr Emslie stated that it would be important to obtain the support of other endocrinologists for the position taken by Dr Stanworth as many GPs would initially refer to the British National Formulary where fibrotic reactions were highlighted in the section about bromocriptine and other dopaminergic drugs.	

Item		Action
	Agreed: Dr Stanworth would be requested to supply an information sheet for the next JAPC meeting which would answer some of the questions raised. The views of some other consultant endocrinologists would also be obtained. The traffic light classification would remain unchanged until JAPC had discussed this again at the meeting in July.	**SD**
9.	**MONTHLY HORIZON SCAN**	
a.	Mr Dhadli advised JAPC of the following new drug launches, new drug formulations and licence extensions: New drug launches: Secukinumab (Cosentyx) - Await NICE guidance expected in July 2015. New formulation launches: Cholic acid (Orphacol) Levonorgestrel (Levosert) – This would need to be considered by public health as well as the CCGs who commissioned the service for heavy menstrual bleeding. To be left unclassified. Licence extensions: Adalimumab (Humira) Aripiprazole (Abilify Maintena) Bevacizumab (Avastin) Budesonide (Budenofalk) Panitumumab (Vectibix)	
10.	**MISCELLANEOUS**	
a.	**Gain Sharing** Mr Dhadli reported that Healthcare Improvement Scotland had developed a national prescribing framework to support the introduction of biosimilar medicines. The framework gave information about the differences between biosimilar medicines and generic medicines and also highlighted the amount of work which would be needed in connection with the introduction of biosimilars in hospitals. Mr Dhadli also referred to the NHS England document which set out principles for sharing the benefits associated with more efficient use of high cost drugs not reimbursed through national prices set out in the National Tariff and directly commissioned by NHS England It was reported that Mrs Hunter had developed a local framework for 'gain sharing' and this could be used as starting point for discussions and agreement about the benefits to be achieved by the introduction of biosimilars. However this document was now out of date and therefore needed to be updated in the light of the new guidance and developments around biosimilars. The importance of having a transparent and open process for gain sharing was highlighted. **Action:** Mrs Hunter and Mr Dhadli would liaise with both Trusts and bring back an updated local framework to the August JAPC meeting.	**LH/SD**
b.	**MTRAC Reviews** Mr Dhadli highlighted the main points from recent Midlands Therapeutic Review and Advisory Committee (MTRAC) reviews:	

Item		Action
	Fixed Dose LABA/ICS Inhalers (COPD) – Seretide and Symbicort have a large evidence base for efficacy. Fostair was also recommended and non-inferior to other products and low acquisition costs. The evidence was weak for Relvar Ellipta and there was no comparative data for exacerbation rate against placebo or other LABA/ICS inhalers. Fixed Dose LABA/LAMA Inhalers (COPD) – Currently insufficient patient-orientated evidence to draw distinction between different products or make comparisons with LABA/ICS inhalers. Saving in drug acquisition costs associated with the use of fixed-dose LAMA/LABA inhalers in place of the individual constituents. Relvar Ellipta (Asthma) – Cost effective option but the evidence is relatively weak. Relvar Ellipta has a low place in therapy in view of the lack of comparative evidence with other ICS/LABA inhalers. Relvar Ellipta (COPD) – Relvar Ellipta may be an option for patients with adherence problems taking current twice-daily alternatives and the simplicity of the device may be advantageous for patients with poor inhaler technique. Tiotropium - The evidence for efficacy for tiotropium was considered to be relatively weak based on three RCTs that evaluated tiotropium within its licensed indications and reported patient-oriented outcomes. The use of leukotriene antagonists had been referred to in the review.	
c.	**FDA Alert** Mr Dhadli reported that the US Food and Drug Administration (FDA) had issued a warning that SGLT2 inhibitors for diabetes may result in ketoacidosis. Mr Dhadli added that the three NICE TAs relating to SGLT2 inhibitors had been added to the formulary and all had been assigned a traffic light classification of BROWN. Mr Dhadli would include a reference to the FDA alert in the formulary chapter, newsletter and diabetes guidance.	**SD**
d.	**JAPC Annual Report** Mrs Qureshi stated that amendments received following the last JAPC meeting had been incorporated in the Annual Report and that Dr Mott had circulated an introduction. Members were requested to convey any further comments to Dr Mott who would then circulate the final version to the JAPC, the CCG Governing Bodies and the Trust Drugs and Therapeutic Committees. Mr Newman highlighted an omission in the Annual Report concerning patient outcomes and would email Dr Mott so that a reference to this could be included.	**AM** **CN/AM**
11.	**JAPC BULLETIN**	
	The May JAPC bulletin was ratified.	**SD**
12.	**MHRA DRUG SAFETY UPDATE**	
	The MHRA Drug Safety Update for May 2015 was noted. Mr Dhadli highlighted the following: Sofosbuvir with daclatasvir; sofosbuvir and ledipasvir: risks of severe bradycardia and heart block when taken with amiodarone.	

Item		Action
	Mr Dhadli commented that there were an increasing number of high cost drugs which were outside tariff and often prescribed by the hospital. It was important that information about patients who were on these treatments be communicated to primary care and drug interactions recorded on clinical systems. Dr Mott stated that it was very important that GPs were made aware of drug interactions as it was often difficult to pick these out from patient notes. Dr Mott would feedback via the Drugs and Therapeutic Committee.	**AM**
14.	**NICE SUMMARY**	
	Mrs Qureshi informed JAPC of the comments for the CCGs which had been made for the following NICE guidance issued in May 2015: NG9 Bronchiolitis in Children – Mrs Qureshi highlighted the recommendation that oxygen saturation was measured in every child who presented with suspected bronchiolitis, including those who presented to primary care if a pulse oximetry machine was available. There would be a possible cost implication to primary care caused by the need to purchase additional pulse oximeters, although this would be offset by the avoidance of unnecessary referrals to hospital.	
15.	**TRAFFIC LIGHTS – ANY CHANGES?**	
	Classifications Brinzolamide/brimonidine (Simbrinza)– GREEN specialist initiation Grazax – RED for use in specialist paediatric allergy clinic only Sildenafil – RED (specialist provided) for the treatment of digital ulceration in systemic sclerosis Indacaterol/glycopyrronium (Ultibro) – BROWN Formoterol turbohaler – GREEN Glycopyrronium (Seebri Breezhaler) – BROWN 2nd line Aclidinium (Eklira Genuair)– BROWN 2nd line Umeclidinium (Incruse Ellipta) – BROWN 2nd line Symbicort – GREEN 3rd line Seretide – GREEN 3rd line	
16.	**JAPC ACTION SUMMARY**	
	The action summary was noted by JAPC and amendments made: Hyperprolactinaemia – Position statement to be brought to the July JAPC meeting. Lithium monitoring – To be brought to the August JAPC meeting. PGDs – Updates to be brought to the July JAPC meeting. NICE CG 28 depression in children and young people - DHcFT to consider NICE guideline and feedback to JAPC if primary care was affected by any changes in July. JAPC Annual Report – To be taken off. Rivaroxaban in ACS with DAPT – To be taken off.	**SD** **SD** **SD** **ST** **SD** **SD**

For agenda items contact Slakahan Dhadli
Tel: 01332 868781
Email: slakahan.dhadli@southernderbyshireccg.nhs.uk

Item		Action
17.	**GUIDELINE GROUP**	
	Mr Dhadli highlighted the following: Gastrocate had been removed from the formulary. Aciclovir was currently unavailable and was not expected to be back in stock until quarter 1 in 2016/17. The eye formulary and traffic light database had been updated to enable ongoing prescribing of ganciclovir 2nd line treatment if aciclovir was unable to be prescribed. The reference to carbodome had been removed from the BNF and psoriasis guidance. Heart Failure Guidelines – Mr Dhadli reported that there had been no response to the emails sent to the Heart Failure Nurses. This would be followed up.	**SD**
18.	**MINUTES OF OTHER PRESCRIBING GROUPS**	
	• Burton Drugs and Therapeutic Committee 9/4/15 • Nottinghamshire Area Prescribing Committee 19/3/15 • DHcFT Drugs and Therapeutic Committee 23/4/15 • DTHFT Drugs and Therapeutic Committee 21/4/15 • CRHFT Drugs and Therapeutic Committee 19/5/15 • Clinical Commissioning Policy Advisory Group 14/5/15	
19.	**ANY OTHER BUSINESS**	
a.	**Rivaroxaban in ACS with DAPT** Mr Dhadli advised that the CRHFT cardiologists had indicated that there was no immediate need to start prescribing rivaroxaban with dual anti-platelet treatment for ACS. An email had been received from Dr Damien Kelly, DTHFT Consultant Cardiologist, who had given the opinion that there was a place for this treatment including consideration of the benefits versus the risk of bleeding. JAPC left the traffic light classification as RED for this indication until a clear pathway is submitted by the cardiologists.	
b.	**MHRA Alert Biosimilars – High Intensity Insulins and Combination Insulins** Mr Dhadli reported that Dr Game, DTHFT Consultant Diabetologist, had indicated that this was to be discussed by the Trust Diabetes Group in order that a statement could be developed. Dr Mott commented that the concentrations may be different between devices but, as long as these were used properly, the risks would be minimised.	
c.	**Use of NOACs for Suspected DVT** Dr Watkins queried the use of the NOACs by GPs working in the City in cases of suspected DVT. Mr Dhadli stated that this work was being led by Mrs Ann Hayes in the County Public Health Directorate and a meeting would be held in July to discuss the development of a policy about this.	
20.	**DATE OF NEXT MEETING**	
	Tuesday, 14th July 2015 at 1.30pm in the Post Mill Centre, South Normanton.	