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DERBYSHIRE JOINT AREA PRESCRIBING COMMITTEE (JAPC)

Minutes of the meeting held on Tuesday 10th November 2015

CONFIRMED MINUTES

Summary Points

Traffic lights

Drug	Decision
Tizanidine	GREEN specialist initiation following a four month period of dose stabilisation and LFTs.
Glaucoma eye preparations	As per guidelines for the medical treatment of chronic open angle glaucoma and ocular hypertension (GREEN 1st line and BROWN alternative 2nd and 3rd line).
Empagliflozin + metformin (Synjardy)	BROWN
Vortioxetine	RED (awaiting DHcFT review)
Pembrolizumab	RED as per NICE TA 357
Tolvaptan	RED as per NICE TA 358
Idelalisib	RED as per NICE TA 359
Paclitaxel	BLACK as per NICE TA360 and 362
Simeprevir	BLACK as per NICE TA 361
Ceritinib	RED (NHS England)
Netupitant+palonsetron (Akynzeo)	RED (NHS England)

Clinical Guidelines
Antidepressants in moderate and severe unipolar depression
Treatment of chronic open angle glaucoma and ocular hypertension
Oral Anticoagulant Warfarin Monitoring
Falls

Shared Care Guidelines
Liothyronine
Lithium

Local PGD's (For Derbyshire Use Only)
Hepatitis A Adult
Hepatitis A Child
Hepatitis A and Typhoid
Typhoid
Hepatitis B Children and Adults
Vitamin K

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Present:	
Southern Derbyshire CCG	
Dr A Mott	GP (Chair)
Mr S Dhadli	Specialist Commissioning Pharmacist (Secretary)
Mr S Hulme	Director of Medicines Management
Mrs S Qureshi	NICE Audit Pharmacist
Dr M Watkins	GP
North Derbyshire CCG	
Dr C Emslie	GP
Mrs K Needham	Head of Medicines Management North (also representing Hardwick CCG)
Ms J Town	Head of Finance
Hardwick CCG	
Dr T Parkin	GP
Erewash CCG	
	Represented by Dr A Mott
Derby City Council	
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	
Ms S Bassi	Chief Pharmacist
Chesterfield Royal Hospital NHS Foundation Trust	
Mr M Shepherd	Chief Pharmacist
Derbyshire Community Health Services NHS Trust	
Mr M Steward	Head of Medicines Management
In Attendance:	
Mr A Thorpe	Derby City Council (minutes)
Ms G Yates	Care Quality Commission Regional Medicines Management

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Item		Action
1.	**APOLOGIES**	
	Dr R Dewis, Dr D Fitzsimons, Dr M Henn, Mrs L Hunter and Ms M Simpson.	
2.	**DECLARATIONS OF CONFLICT OF INTEREST**	
	No declarations of interest were made.	
3.	**DECLARATIONS OF ANY OTHER BUSINESS**	
	• Haloperidol Injection Position Statement.	
4.	**MINUTES OF JAPC MEETING HELD ON 13 OCTOBER 2015**	
	The minutes of the meeting held on 13th October 2015 agreed as a correct record after the following amendment: Miscellaneous Section 9 (b) to read Excess Treatment Costs.	
5.	**MATTERS ARISING**	
a.	**Prescribing Specification** Mr Dhadli reported that references to the use of biosimilars, controlled drugs, early access to medicines scheme and high cost drugs had now been added to the prescribing specification. This updated version would be circulated to members with a request that any comments be conveyed to Mr Dhadli by 31st October 2015.	**All**
b.	**Guideline Group** Mr Dhadli highlighted the following changes to the schedule of topics for discussion by JAPC: • Non-malignant chronic pain in primary care – New guidance was anticipated from the Faculty of Pain Medicine about the use of opioids in non-cancer pain later in November. Local guideline development has been delayed in the light of this and will be discussed at the December JAPC meeting. • Chlamydia guideline – National guidance had now been published by the Faculty of Sexual Health. The guideline would be updated in the light of the national guidance and discussed at the December meeting. • Management of Overactive Bladder (OAB) – The guidance had now been updated but comments were awaited from the consultant urologists on non-drug management for males and females. The comments received would be incorporated in the guideline and discussed at the December meeting.	**SD** **SD** **SD**
6.	**NEW DRUG ASSESSMENTS**	
a.	**Tizanidine** Mr Dhadli reported that tizanidine had not been assigned a traffic light classification and had been raised as a query by a GP practice. Tizanidine was listed in the BNF for spasticity associated with multiple sclerosis or spinal cord injury or disease. The SPC for tizanidine had highlighted the need for LFTs to be monitored monthly for the first four months in all patients and in those who developed symptoms which indicated liver dysfunction. Mr Dhadli added that the DHcFT formulary indicated that tizanidine tablets were for third-line use for spasticity and hospital specialist initiation only with a shared-care guideline.	

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Item		Action
	Agreed: Tizanidine classified as **GREEN after specialist/consultant initiation** drug following a four month period of dose stabilisation, response assessment and LFT monitoring.	**SD**
7.	**CLINICAL GUIDELINES**	
a.	**Antidepressants** Ms Bassi reported that that the guideline for antidepressants in moderate and severe unipolar depression had been amended and updated as follows: • Lamotrigine augmentation had been removed from Step 3 and remained in Step 4. • Step 4 had been removed (low dose) from atypical antipsychotic augmentation. • MADRS and Hamilton had been removed as these are used more in clinical trials and replaced with PHQ-9. • Gastro-protection advice had been enhanced under 'bleeding risk' to match the JAPC PPI guidance. • A reference had been included to credible medicines in the QTc table. In addition the Guideline Group had queried the definition of recent MI in step 1 of the guidance and advice had been received that this was four weeks in duration. An amendment had also been made to the reference to bleeding risk associated with SSRIs. **Agreed:** JAPC ratified the guideline for the Use of Antidepressants in Moderate and Severe Unipolar Depression.	**SD**
b.	**Falls** Mr Dhadli advised that DCHS had developed guidance for health professionals concerning the drugs which were more likely to be associated with falls in the elderly. The relevant drugs had been graded, using a traffic light system according to their potential to cause a fall, as red for high risk and amber for medium risk. PrescQipp had also produced a comprehensive list of those drugs which were likely to cause falls and this had been used to update the existing guidance for healthcare assistants for falls prevention in care homes. This list assigned classifications of high risk, medium risk and possible risk. It was highlighted that there were some significant differences between the existing DCHS guidance and the new updated version aligned to that produced by PrescQIPP. During discussion Mr Steward commented that the list had been requested by the DCHS Falls Team in order to give advice to care staff as to the main drugs which produce factors such as hypotension and dizziness which contributed to falls. These had been assigned a red classification but the classification of amber also highlighted those other drugs which could cause risk factors. Mrs Needham advised that the opiate analgesics should only be listed as generics and therefore BuTrans (buprenorphine), Matrifen, Oramorph and Zomorph taken out. Mr Newman added that a reference to the falls guideline should also be included.	**SD**

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Item		Action
	Action: The Guideline Group would be requested to develop a definitive list and definition classification for red and amber of those drugs which caused or contributed to falls.	**SD**
c.	**Glaucoma** Mr Dhadli reported that the clinical guideline for the treatment of chronic open angle glaucoma (COAG) and ocular hypertension (OHT) has been updated in collaboration with consultant ophthalmologists from DTHFT and CRHFT who had approved the changes. All the product details and prices had been reviewed and updated as appropriate and a flowchart for the management of open angle glaucoma had been included to provide the most cost effective treatment options. A further flowchart has been included for patients with a known allergy to preservatives and the cost comparison tables had been updated with first line and alternative options. Discussion followed on the suggested traffic light classifications of **GREEN** 1st line after consultant/specialist initiation and **BROWN** 2nd line after consultant/specialist initiation for the commonly prescribed ocular treatments for COAG and OHT as indicated in the appendices to the updated guidance. The importance of a consistent approach to the traffic light classification of drugs from the same group was highlighted. It was also pointed out that brown was an exceptional use category. Mrs Needham highlighted a lack of clarity in the flowchart regarding those patients who required preservative free options. This arose from the indication of latanoprost as the 1st line option although the next step referred to internal ocular pressure controlled but intolerant to preservatives. The flowchart would therefore be amended accordingly.	**SD**
	Agreed: JAPC ratified the clinical guideline for the treatment of chronic open angle glaucoma and ocular hypertension for new patients including the traffic light classifications for the commonly prescribed treatments.	**SD**
d.	**Oral Anticoagulant warfarin monitoring** Mrs Qureshi reported that the existing guideline had been updated and sent to DTHFT and CRHFT for comment. It had been suggested that it would be advantageous for patients who were started on warfarin to have their baseline renal function, LFTs and clotting checked in order to identify those patients who could be sensitive to warfarin and therefore needed additional monitoring. This was in line with both UK Medicines Information drug monitoring in primary care and guidance from the British Committee for Standards in Haematology (BCSH) and had now been included in the updated guidance. An amendment on page 10 of the guidance Discontinuation of Warfarin Therapy would be made to delete the sentence 'Where there are further risks involved 75mg aspirin should be considered' as aspirin is no longer recommended for AF.'	**SD**
	It was reported that Dr Henn had referred to the use of low-molecular-weight heparin (LMWH) in sub-therapeutic patients or in people who had clots while they were in therapeutic range. Mr Dhadli stated that in cases of people who had suffered a deep vein thrombosis (DVT) or pulmonary embolism (PE) on discharge they would be given LWMH and warfarin at the same time.	

Item		Action
	They would continue with LMWH until the International Normalised Ratio (INR) for warfarin was within therapeutic range. A problem would arise when the INR did not achieve the level and GPs would therefore be requested to continue for a few days. However, GPs had refused to do this due to the lack of a shared care agreement and a request had therefore been made that this be extended to include this bridging period. Mr Dhadli highlighted that shared care was not applicable in this situation as the patients were not stable. Dr Emslie queried what action should be undertaken about those patients who were receiving treatment but out of therapeutic range. It would therefore be necessary to include bridging guidance in the guideline. Mr Shepherd referred to the internal bridging guidelines used in CRHFT and would send these to Mrs Needham so that they could be considered for adaption for use in primary care. During discussion Dr Mott commented that there may be other coumarin-type drugs in use in primary care and that it may be necessary to review non-warfarin patients monitored via INR in the community. Mr Hulme referred to Table 1 in the guidance which outlined the indications for warfarin, target INR, therapeutic range and duration of treatment and queried whether other indications which had been revealed arising from the move to INRstar anticoagulation software had been checked for each CCG. Mr Hulme would send Mrs Qureshi a list of the indications in INRstar in order that they can be compared with those in the guidance. **Action:** Additional guidance on bridging would be discussed by the Guideline Group and then added to the guideline. **Agreed:** JAPC ratified the oral anticoagulation with warfarin guideline.	**MSh** **SH/SQ** **SD** **SD**
8.	**PATIENT GROUP DIRECTIONS**	
a.	**<u>Local PGDs</u>** Mr Dhadli reported that the Medicines Management team had updated the PGDs for Hepatitis B, Hepatitis A adult, Hepatitis A child, Hepatitis A and Typhoid, Typhoid and Vitamin K which were specifically for CCG use. It was highlighted that many travel vaccinations were given by practice nurses and therefore a PGD had to be in place in order that prescription only medicines could be supplied by appropriate healthcare professionals without the need for a prescription or other written instruction from a prescriber. JAPC agreed that as a rule occupational health indications were outside NHS commissioned intentions and should be removed from the inclusion criteria. Hepatitis B Vaccine – The following amendments were agreed: • Inmates of custodial institutions to be taken out of the criteria for inclusion. • Pregnancy and breastfeeding, unless there is a clear continuing risk of infection that outweighs the risk of adverse event from the vaccination, to be taken out of the criteria for exclusion. Hepatitis A Vaccine Child – The PGD was agreed without amendment. Hepatitis A Vaccine Adult – The following amendments were agreed: • Frequency of administration – Amend to second booster dose (Vaqta after 18 months) following initial dose.	

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	Hepatitis A and Typhoid Vaccine – The PGD was agreed without amendment. Typhoid Vaccine – The PGD was agreed without amendment. Vitamin K – The following points were highlighted: • Reference in the precautions section that for variable readings >0.5 the practitioner was expected to use their own clinical judgement and refer patients to GP/Out of Hours GP Services/Accident and Emergency/Emergency Services/Minor Injuries Unit/Walk in Centre had been included as best practice. • The Guideline Group had proposed that all health professionals should have appropriate training for resuscitation annually. **Agreed:** JAPC agreed the PGDs for Hepatitis B, Hepatitis A adult, Hepatitis A child, Hepatitis A and Typhoid, Typhoid and Vitamin K with the inclusion of the agreed amendments.	**SD**
9.	**SHARED CARE GUIDELINES**	
a.	**<u>Immunomodulating Shared Care Guidelines</u>** Mr Shepherd advised JAPC that the existing guidelines: for azathioprine, ciclosporin, D penicillamine, leflunomide, 6-mercaptopurine, methotrexate, sodium aurothiomalate (Gold) and sulfasalazine had been updated. Mr Dhadli informed JAPC that the addition of the live vaccination under consultant responsibilities to all the shared cares was not in line with BSR or the green book. : • For azathioprine, mercaptopurine and methotrexate the use of the live herpes vaccine Zostavax should be included in the list of consultant responsibilities. Inclusion of the use of the herpes vaccines in the remaining guidelines would be discussed further. • It was noted that the monitoring requirements and actions to be taken sections were not in line with the recommendations from the British Society for Rheumatology (BSR). The amended guidelines would be brought back to the December JAPC meeting.	**SD** **SD**
b.	**<u>Liothyronine</u>** Ms Bassi reported that the existing shared care agreement for liothyronine for treatment resistant depression had been reviewed and updated. Ms Bassi added that the need for a shared care guideline for liothyronine had been queried by DHcFT and it would be advantageous to know patient numbers. Mr Dhadli referred to the lack of a reference to MHRA reporting and that the Derbyshire JAPC meeting noted in the guideline should be May 2008 not March 2008. **Agreed:** JAPC ratified the shared care guideline for liothyronine with the agreed amendments.	**SD**
c.	**<u>Lithium</u>** Ms Bassi reported that the shared care agreement for lithium has been updated in line with NICE CG 185 Bipolar Disorder: assessment and management with the main update about the frequency of monitoring and that some patients on lithium were out in the community. Ms Bassi added that the advice of JAPC had been requested concerning the continued requirement for a shared care guideline for lithium.	

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	NICE had indicated that, if a patient was stable and well, their care could be managed in primary care. In the event of shared care being discontinued then a detailed and robust individual plan and communication as suggested by NICE would be required in addition to liaison between primary care and secondary care according to patient clinical need. During discussion it was agreed that the following amendments should be made to the guideline: • Referral back to DHcFT criteria would be included. • The requirement to monitor each patient every three months in the first year of treatment and then to be adjusted according to serum lithium levels to be highlighted. • It would be noted that the monitoring in the lithium therapy record book (Purple book) was not aligned to the guideline. **Agreed:** JAPC ratified the shared care guideline for lithium with the agreed amendments. .	**SD** **SD** **SD** **SD**
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: Ceritinib (Zykadia) – NHS England and NICE TA expected in January 2016. New formulation launches in the UK: Empagliflozin + metformin (Synjardy) – CCG commissioned line. Classified as **BROWN.** Netupitant + palonosetron (Akynzeo) – NHS England commissioned line. Classified as **RED.** Vortioxetine (Brintellix) – CCG commissioned line. A NICE Final Appraisal Determination (FAD) had been published in October 2015 which recommended vortioxetine as an option for treating major depressive episodes in adults whose condition had responded inadequately to two antidepressants within the current episode. To be discussed by the DHcFT Drugs and Therapeutic Committee. Classified as **RED.** Drug discontinuations: Advantage Plus test strips Antepsin (sucralfate) Antepsin suspension (sucralfate) Aspirin suppositories Camcolit 250mg (lithium carbonate) - For commercial reasons Camcolit 250mg tablets had been renamed to Lithium carbonate Essential Pharma 250mg tablets and the price increased. Cavi-Care Climagest 1mg (estradiol/norethisterone) Efcortesol (hydrocortisone) Erythrocin injection (erythromycin) Ismo (isosorbide mononitrate) Ismo retard (isosorbide mononitrate) Milupa PKU 3 Advanta PhosLo (calcium acetate) Phytex Sorbisterit Vacuskin	**SD** **SD** **SB** **SD**

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Item		Action
b.	**NICE** Mr Dhadli highlighted the following: Osteoporosis (prevention) – bisphosphonates – NICE TA expected in November 2015. Dry eye disease – ciclosporin (after artificial tears) – NICE TA expected in December 2015. Heart failure – sacubitril valsartan – NICE TA expected in May 2016. Hypercholesterolaemia - ezetimibe – NICE TA expected in February 2016. Hypercholesterolaemia (primary) and dyslipidaemia (mixed) alirocumab – NICE TA expected in June 2016 and significant impact on CCG budgets anticipated.	
11.	**MISCELLANEOUS**	
a.	**Derbyshire Health United (DHU) and Nefopam** Mr Dhadli advised that it had been agreed that JAPC would review and agree any additions to the DHU formulary. DHU had proposed that nefopam, an alternative analgesia option when stepping up from simple pain relief such as paracetamol rather than using stronger opioid based analgesia, be added to their formulary. JAPC was advised that nefopam was currently a 3rd line choice in step 2 of the non-malignant chronic pain in the primary care guidance noting also that the price of nefopam had risen significantly and questioned its cost effectiveness. It was agreed that Mr Dhadli would contact DHU in order to ascertain the reasons why they wished to include nefopam in their formulary.	**SD**
b.	**Free of Charge Schemes** Mr Dhadli advised that JAPC had agreed a process for dealing with free of charge schemes which related to high cost drugs outiside tariff. CRHFT had indicated that they were not interested in looking at any free of charge schemes. Mr Dhadli with input from DTHFT had drafted a framework/template to deal with free of charge drugs. This framework/template included a list of questions and answers which would assist with the consideration of free schemes and/or added value from the pharmaceutical companies and also referred to the risk and benefits associated with the scheme. Ms Town confirmed that North Derbyshire and Hardwick CCGs did not support free of charge schemes. Southern Derbyshire CCG did support having a process of dealing with free of charge schemes and the position of Erewash CCG was unknown. Dr Mott highlighted the necessity of establishing the host CCG for individual patients and that the views of Erewash CCG needed to be ascertained.	**SD**
c.	**Insulin Glargine New Publications** Mr Dhadli reported that the Trent Medicines Information Service had issued a Medicines Management Update which advised that the patent for insulin glargine (Lantus) had now expired and that a biosimilar brand has been launched (Abasaglar) which was 15% cheaper. It was highlighted that the two products had similar actions, but should not be regarded as interchangeable. There was also a risk of unexpected hypoglycaemia if patients were inadvertently switched between brands.	

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	UKMI had also highlighted that Lantus (insulin glargine, 100 units/mL) solution for injection had been the only available insulin glargine product available but Toujeo, a concentrated insulin glargine product of strength 300 units/mL, and Abasaglar, a biosimilar version of insulin glargine of strength 100 units/mL, were now available. The addition of these two new insulin glargine products could cause confusion and the review had summarised the safety considerations associated with their introduction.	
d.	**JAPC Terms of Reference** Mr Dhadli referred to the JAPC terms of reference which were reviewed annually. Mr Dhadli suggested that prescribable medical devices should be added to the JAPC statement of purpose and an additional statement 'Advise the Derbyshire Research Forum on non-commercial trials that relate to drug excess treatment' had been added to the objectives. It was agreed that reference to the Guideline Group as a sub-group of JAPC should be included. Dr Mott raised that the position of JAPC Chair is reviewed annually and indicated that he was happy to carry on in this role if the committee members agreed. **Agreed:** Dr Mott was confirmed as Chair of Derbyshire JAPC for a further year. **Action:** Members were requested to convey any comments on the JAPC terms of reference to Mr Dhadli. **Action**: Dr Mott would write to the Chairs of the Derbyshire CCGs to highlight that JAPC had delegated responsibility from the four CCGs who were committee members of the board.	**All** **AM**
e.	**Rebates** Mrs Qureshi advised JAPC that the following new rebates had been agreed across Derbyshire: • Luventa XL (Galantamine XL cap) • Zaluron XL (Quetiapine XL tabs) • Seretide (fluticasone/salmeterol Evohaler and Accuhaler) It was highlighted that the Nutricia rebates would finish at the end of the 2015/2016 financial year.	
12.	**JAPC BULLETIN**	
	The October JAPC bulletin was ratified.	
13.	**MHRA DRUG SAFETY UPDATE**	
	The MHRA Drug Safety Update for October 2015 was noted. Mr Dhadli highlighted the following: • Mirabegron (Betmiga): risk of severe hypertension and associated cerebrovascular and cardiac events. Mr Dhadli reported that the overactive bladder guidance had been updated accordingly and reference had been included in the BNF chapter and bulletin.	

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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 2015: TA357Pembrolizumab for treating advanced melanoma after disease progression with ipilimumab - Classified as a **RED** drug (NHS England high cost drug).	**SD**
	TA358Tolvaptan for treating autosomal dominant polycystic kidney disease - CCG commissioned line. Tolvaptan is the first treatment for autosomal dominant polycystic kidney disease that targets the disease and delays progression in terms of both total kidney volume growth and rate of kidney function decline. NICE had estimated approximately four people per 100,000 population would be eligible for treatment with tolvaptan. Classified as a **RED** drug.	**SD**
	TA359 Idelalisib for treating chronic lymphocytic leukaemia - Classified as a **RED** drug (NHS England high cost drug).	**SD**
	TA360 Paclitaxel as albumin-bound nanoparticles in combination with gemcitabine for previously untreated metastatic pancreatic cancer – Classified as **a BLACK** drug for this indication.	**SD**
	TA361Simeprevir in combination with sofosbuvir for treating genotype 1 or 4 chronic hepatitis C (terminated appraisal) – Classified as a **BLACK** drug.	**SD**
	TA 362 Paclitaxel as albumin-bound nanoparticles with carboplatin for untreated non-small-cell lung cancer (terminated appraisal) – Classified as a **BLACK** drug.	**SD**
	ESUOM 48 Excessive daytime sleepiness in Parkinson's disease: modafinil – Modafinil had previously been assigned a traffic light classification of **GREEN** following specialist initiation. ESNM 61Orthostatic hypotension due to autonomic dysfunction: midodrine – Midodrine had previously been assigned a traffic light classification of **RED.** ESNM62 Type 1 diabetes mellitus in adults: high-strength insulin glargine 300 units/ml (Toujeo) – Toujeo had previously been assigned a traffic light classification of **BLACK.**	
15.	**TRAFFIC LIGHTS – ANY CHANGES?**	
	<u>Classifications</u> Tizanidine – **GREEN** specialist initiation following a four month period of close stabilisation. Eye preparations – As per Guidelines for the medical treatment of chronic open angle glaucoma and ocular hypertension (**GREEN** 1st line and **BROWN** alternative 2nd and 3rd). Empagliflozin + metformin (Synjardy) – **BROWN.** Vortioxetine – **RED** (awaiting DHcFT review)	

Item		Action
	Brolizumab – **RED** as per NICE TA 357 Tolvaptan – **RED** as per NICE TA 358 Idelalisib – **RED** as per NICE TA 359 Paclitaxel – **BLACK** as per NICE TA360 Simeprevir – **BLACK** as per NICE TA 361 Paclitaxel – **BLACK** as per TA 362 Mr Shepherd queried the classification of promixin as RED for adult patients with non-cystic fibrosis bronchiectasis as a patient at CRHFT had responded well to this drug. It was noted that promixin had been assigned a traffic light classification of RED for use in cystic fibrosis. The use of promixin for non-cystic fibrosis bronchiectasis would be discussed at the December JAPC meeting. **Post meeting note:** Ceritinib classified as **RED** drug (anticipated NHS England line). **Post meeting note:** Netupitant+palonsetron classified as a **RED** drug (anticipated NHS England line).	**SD** **SD** **SD**
16.	**JAPC ACTION SUMMARY**	
	The action summary was noted by JAPC and amendments made: Lithium monitoring – To be taken off the list. Grazax – To be brought to the June 2016 JAPC meeting. Glaucoma guidance - To be taken off the list. Free of charge schemes – To be taken off the list. Immunomodulating drugs - To be brought back to the December 2015 meeting. Midodrine - To be brought to the December 2015 JAPC meeting. Prescribing specification – To be brought to the December 2015 meeting (latest version out for consultation). Nefopam – To be brought to the December 2015 JAPC meeting. Management of Overactive Bladder – To be brought to the December 2015 meeting.	**SD** **SD** **SD** **SD** **SD** **SD** **SD** **SD** **SD**
17.	**GUIDELINE GROUP**	
	The summary of key messages arising from the meeting held in October 2015 was noted. Mr Dhadli highlighted that the Heart Failure Guidance was now a year out of date and no comments had been received from the consultant cardiologists. To be brought to the December 2015 JAPC meeting.	**SD**

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18.	**MINUTES OF OTHER PRESCRIBING GROUPS**	
	• DHcFT Drugs and Therapeutic Committee 23/07/15 • DTHFT Drugs and Therapeutic Committee 15/09/15	
19.	**ANY OTHER BUSINESS**	
	A draft haloperidol injection position statement was tabled for information. Mrs Needham reported that supplies of haloperidol injection were in short supply and the hospitals were therefore sourcing the licensed product from outside the UK. However, dispensing practices and pharmacies were now experiencing difficulties in obtaining the injection and this was likely to be the case for a considerable period of time. It was highlighted that haloperidol injection was used frequently in the palliative care setting for nausea and vomiting and, in the last days of life, agitation and restlessness. Mrs Needham queried how stocks of the haloperidol injection could be obtained or whether levomepromazine could be used instead although this would require the existing guidance to be amended. Mr Dhadli added that the palliative medicine consultants had been contacted to ascertain whether a consensus document could be produced. Dr Maelie Swanwick, Consultant in Palliative Medicine, had provided advice from the palliative medicine consultants in Derbyshire and this had been included in the tabled position statement. **Action:** The palliative care consultants would be contacted in order to achieve consensus about the use of an alternative to the haloperidol injection and this would be circulated once agreed.	**SD**
20.	**DATE OF NEXT MEETING**	
	Tuesday, 8th December 2015 at 1.30pm in the Post Mill Centre, South Normanton.	