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DERBYSHIRE JOINT AREA PRESCRIBING COMMITTEE (JAPC)

Minutes of the meeting held on 13th September 2016

CONFIRMED MINUTES

Summary Points

Traffic lights

Drug	Decision
Shower Gels /Bath Emollients	BLACK
Oscillating PEP Devices (e.g Flutter®/Acapella®)	RED for specialist physiotherapist use only
Ulipristal Acetate (Esmya®)	Green after specialist/ consultation 1st course as per local guideline for treatment of uterine fibroids
Alipogene tiparrovec (Glybera®)	RED (NHS England)
Sofosbuvir + velpatasvir (Epclusa®)	RED (NHS England)
Eftrenonacog alfa (Alprolix®)	RED (NHS England)
Brentuximab vedotin (Adcetris®)	RED (NHS England)
Decitabine (Dacogen®)	RED (NHS England)
Teduglutide (Revestive®)	RED (NHS England)
Cabazitaxel	RED as per NICE TA 391 (no change)
Bosutinib	RED(NHS England) as per NICE TA 401
Pemetrexed	RED (NHS England) as per NICE TA 402
Ramucirumab	BLACK as per NICE TA 403
Degarelix	AMBER as per NICE TA 404 (no change)
Trifluridine–tipiracil	RED (NHS England) as per NICE TA 405

Clinical Guidelines

Appropriate use and prescribing of infant formula in primary care.
Heart failure with reduced ejection fraction- updated to include positioning of sacubitril/valsartan.
Guideline for the Management of Clostridium Difficile Infection in Primary Care – Extension for six months.
Nicotine replacement therapy – Extension for two months.

Patient Group Directions

Administration of intradermal inactivated influenza vaccine (Intanza®) to individuals from 60 years of age in accordance with the national immunisation programme for active immunisation against influenza.

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Administration of intramuscular (or subcutaneous) inactivated influenza vaccine to individuals in accordance with the national immunisation programme for active immunisation against influenza.
Administration of *Haemophilus influenzae* type b and meningococcal C conjugate vaccine (Hib/MenC) to individuals from their first birthday to under 10 years of age in accordance with the national immunisation programme for active immunisation against *Haemophilus influenzae* type b and *Neisseria meningitidis* capsular group C.
Administration of shingles (herpes zoster, live) vaccine to individuals who are eligible for the national shingles immunisation programme for the prevention of herpes zoster ("zoster" or shingles) and herpes zoster-related post-herpetic neuralgia (PHN).

Shared Care Guidelines
Acamprosate and Disulfiram – Extension to April 2017.
Attention Deficit Hyperactivity Disorder (ADHD) in Children and Adults – Extension to November 2016.
Memantine and Actetycholinesterase Inhibitors for the Treatment of Alzheimer's Disease.
Apomorphine in the Treatment of Parkinson's Disease.

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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
Dr M Watkins	GP
North Derbyshire CCG	
Mrs K Needham	Assistant Chief Quality Officer (also representing Hardwick CCG)
Ms J Town	Head of Finance
Hardwick CCG	
Dr T Parkin	GP
Erewash CCG	
Dr M Henn	GP
Derby City Council	
Derbyshire County Council	
Derby Teaching Hospitals NHS Foundation Trust	
Dr W Goddard	Chair - Drugs and Therapeutic Committee
Mr C Newman	Chief Pharmacist
Derbyshire Healthcare NHS Foundation Trust	
Ms B Thompson	Deputy Chief Pharmacist
Chesterfield Royal Hospital NHS Foundation Trust	
Mr M Shepherd	Chief Pharmacist
Derbyshire Community Health Services NHS Foundation Trust	
Ms A Braithwaite	Head of Medicines Management
In Attendance:	
Mr A Thorpe	Derby City Council (minutes)

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Item		Action
1.	**APOLOGIES**	
	Dr R Dewis, Dr C Emslie and Dr T Narula. Ms Braithwaite was welcomed to JAPC as the representative from Derbyshire Community Health Services NHS Foundation Trust.	
2.	**DECLARATIONS OF CONFLICT OF INTEREST**	
	Dr Mott reminded committee members of their obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of JAPC. No declarations of interest were made.	
3.	**DECLARATIONS OF ANY OTHER BUSINESS**	
	• Derbyshire-wide working group to support work on increasing self-care, prescribing only for clinical need and consideration of difficult decisions.	
4.	**MINUTES OF JAPC MEETING HELD ON 9 AUGUST 2016**	
	The minutes of the meeting held on 9th August 2016 were agreed as a correct record.	
5.	**MATTERS ARISING**	
a.	**Sayana Press** It was noted that Ms Bernadette Brown, Derby City Public Health Manager, was working with the clinical lead from DCHSFT to develop a protocol for Sayana Press®.	
b.	**Management of Type 2 Diabetes in Adults** Mr Dhadli advised that a response had now been received to the query to NICE about the safety issue associated with pioglitazone and cost effective choice. The risks of hypoglycaemia and weight gain were a known difference between the different types of treatment and modelled by NICE economics. NICE acknowledged that rare but potentially serious side effects are a concern. But gave two reasons for non-inclusion in NICE modelling exercises: they were rare due to the small numbers and not necessarily conclusive and secondly it would not affect the economic analysis as it was done on a population level and therefore would still be cost effective. Mr Hulme commented that the reply indicated that NICE had considered the safety element. Local clinicians have raised concerns about the risk of bladder cancer associated with the use of pioglitazone. The traffic light classification of BROWN assigned at the last JAPC meeting would indicate the need for its use to be carefully considered. In addition, there may also be a need to review the decision making process. Dr Mott and Mr Dhadli would further discuss outside the meeting.	**AM/SD**
c.	**Oral Nutrition Support Guidelines** Mr Dhadli reported that the need for any changes to the MUST score level for dietitian referral would need to be agreed Derbyshire-wide and had been conveyed to the dietitians.	

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Item		Action
d.	**Guidance on the Prevention, Diagnosis and Management of Vitamin D Deficiency in Primary Care** Dr Mott requested that the North and South CCG Prescribing Groups consider how awareness could be raised and access to the Healthy Start Scheme be improved in connection with routine postnatal and baby checks.	**SD/KN**
e.	**Bath Emollients/Shower Gels** Mr Dhadli reported there had been a full discussion about the use of bath emollients/shower gels at the August JAPC meeting and their use had been identified as part of a review of drugs of limited clinical value and limited or no evidence of cost effectiveness. JAPC had considered the DTB, BMJ and CKS reviews on bath emollients/shower gels and it had been agreed that a wider consultation should be undertaken to include the views of dermatologists and GPSIs. A response had been received from Dr T Bleiker, Clinical Vice-President of the British Association of Dermatologists (BAD), who had referred to the BAD position statement on the place of bath emollients in the treatment of atopic dermatitis – this had been circulated as a late paper ahead of JAPC with further copies made available on the day. The position statement referred to emollient creams which could be used as a soap substitute or as an alternative to bath emollients/shower gels and patients being given a choice as to which product they would prefer to use. The statement concluded with 'A wide range should be readily available on the NHS to facilitate this'. Mr Dhadli added that the BATHE trial (Bath Additives in the Treatment of cHildhood Eczema) would produce a report at the end of 2017. It was noted that the Nottinghamshire Area Prescribing Committee had not included bath additives on their formulary due to the lack of evidence of efficacy and North West Nottinghamshire CCG had consciously excluded bath emollients from their formulary some years ago. During discussion it was highlighted that there had been broad consensus at the last JAPC meeting that bath emollients/shower gels should all be classified as BLACK with exceptionality in cases where patients might benefit from the short-term use of emollients with antimicrobials. BAD had indicated that people with confirmed atopic dermatitis should have access to all products. Dr Henn stated that the NICE guidance on atopic eczema only mentioned emollients and those which could be used for washing. There was a lack of evidence as to the efficacy of bath emollients compared to other products which could be used. Dr Parkin commented that all the decisions made by JAPC were based on the presence rather than absence of evidence and there was clearly very little in this case. The products were also readily available from supermarkets and stores. Mrs Needham referred to the Nottingham guideline where the products which could be used as soap substitutes were clearly indicated. Dr Mott queried whether there should be any exceptions and whether the advice from dermatologists should be the determining factor. Mr Dhadli advised that, in the event that bath/shower emollients were included in the formulary, it should be highlighted that bath/shower emollients had a very limited place in the Derbyshire formulary and may occasionally be used as an alternative to soap after an emollient had been considered or shampoos in a small number of cases only.	

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Item		Action
	It was suggested that there should be restricted cost effective preferred formulary and it could include one that contained an antibacterial. Mr Hulme referred to the decisions made by the CCGs in Nottingham asking whether the removal from formulary had affected prescribing levels. Mr Hulme added that any decision to classify all bath emollients and shower gels as BLACK as not recommended or commissioned would apply to new patients and that patients currently using these products would continue until this was reviewed by the prescriber, usually a GP. Dr Henn commented that there were other products available in cases of defined clinical need rather than bath emollients/shower gels; although it would be useful for GPs to have a list of recommended products that can be used as a soap substitute. **Agreed:** All bath emollients and shower gels classified as **BLACK** as not recommended for prescribing. It was agreed that the emollient formulary should be clearly annotated to highlight products that can be used as a soap substitute.	**SD**
f.	**<u>Non- Diabetes/Hyperglycaemia (Pre-Diabetes)</u>** Mr Dhadli reported that Dr Narula had queried at the last JAPC meeting whether the use of metformin should be included in the non-diabetes/hyperglycaemia (pre-diabetes) stage as indicated in the NICE Type 2 diabetes guidance. A literature search had been undertaken and reference made to the NICE public health guidance. Mr Dhadli outlined differences between the World Health Organisation, American Diabetes Association, NICE and a UK expert group in defining non-diabetes/hyperglycaemia (pre-diabetes) using HbA1c, impaired fasting glucose and impaired glucose tolerance. There was a risk of labelling patients with this diagnosis and committing patients to long term drug treatment and monitoring. The review included progression rates of non-diabetes/hyperglycaemia (pre-diabetes) to diabetes and the effect of metformin in prevention. Affordability to treat this population was also considered. Dr Goddard commented that there should be greater emphasis on identification and referral in to the emerging lifestyle changing services rather than the use of medication. Dr Mott referred to the DHcFT information sheet about the use of metformin to help reduce weight gain from medicines and queried which patients would be involved. Ms Thompson stated that the Trust subscribed to 'Choice and Medication' which was a national website to improve access to good quality information for service users and carers about medicines used in mental health. The website enabled service user involvement in discussions with clinicians about medicines and the metformin information sheet was included there. Ms Thompson highlighted that DHcFT would aim to improve the rates of monitoring and lifestyle interventions before using drugs. **Agreed:** JAPC agreed that, in view of the evidence which had been reviewed, there was no need for pharmacological treatment for non-diabetes/hyperglycaemia (pre-diabetes) and lifestyle interventions should be used instead via emerging lifestyle services.	

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Item		Action
6.	**NEW DRUG ASSESSMENTS**	
a.	**Alimemazine** Ms Thompson referred to a query received about the significant expenditure in primary care associated with the prescribing of alimemazine at the request of community paediatricians. The DHcFT Drugs Safety Officer had subsequently highlighted concerns about the safety of alimemazine which community paediatricians had been using for some time. The community paediatricians had been alerted to the significant increasing cost of alimemazine and there had been some discussion about alternative medicines for supporting sleeping in children with complex needs. The community paediatricians had also indicated that their preferred method of promoting sleep management would be to work intensively with behavioural management and non-drug treatment. However the resources needed to encourage parents and carers to go down this route and sustain this in a way which continued to show benefits was challenging. It was noted that the community paediatricians were no longer initiating alimemazine and, in appropriate cases, promethazine would be used instead although it was less effective. Ms Thompson stated that there were ongoing discussions about the criteria for selecting patients for promethazine and the further work needed on risks and benefits and what should happen to the cohort of patients currently on alimemazine. JAPC noted that promethazine currently had a traffic light classification of BROWN for nausea and vomiting, vertigo and allergy. Ms Thompson advised that the DHcFT Drugs and Therapeutic Committee was looking at promethazine more widely as it had been placed by NICE in the rapid tranquillisation in mental health settings guidelines for use in IM and there was increasing oral use. **Agreed:** Alimemazine would be considered for future classification of BROWN or BLACK pending DHcFT feedback on the exceptionality of promethazine	**SD**
b.	**Flutter® and Acapella® Devices** Mr Dhadli reported that Anil Ramineni, Clinical Specialist Respiratory Physiotherapist based at St Mary's Court, Chesterfield, had requested that JAPC re-consider the decision made in June 2013 to classify Flutter®, a medical device used to assist in the clearance of sputum, as BLACK. There was also an Acapella® device and both were known as oscillatory Positive Expiratory Pressure (PEP) devices used to mobilize secretions. PEP devices had been found to give independence to patients with chronic respiratory diseases as the therapy could be done when convenient for the patient and without the need for an assistant. The submission cited that Acapella® and Flutter® devices have similar actions to PEP therapy. PEP was included in NICE COPD 2010 COPD guidance. Mr Dhadli explained that the appeal was based on the guidelines for the physiotherapy management of the adult, medical, spontaneously breathing patient from the British Thoracic Society/Association of Chartered Physiotherapists in Respiratory Care (2009).	

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Item		Action
	Reference had also been made to the background to the JAPC decision in 2013 and the NICE COPD Guidelines (2010) which advised that physiotherapy using positive expiratory pressure (PEP) masks should be considered for selected patients with exacerbations of COPD to help with the clearance of sputum. The usual treatment for mobilisation and removal of airway secretions in many types of respiratory dysfunction especially in chronic lung disease was chest physiotherapy (CPT) with bronchial drainage. However, standard CPT such as postural drainage, percussion techniques and Active Cycle of Breathing technique (ACBT) were very labour intensive and time-consuming both for hospitalised and non-hospitalised patients with impaired airway clearance. In addition, some patients may not be suitable to have postural drainage due to complex co-morbidities. It was noted that the Community Respiratory Team had indicated that they were unable to fund the cost of the two devices and that access to an FP10 prescription under a traffic light classification of AMBER or RED would be beneficial for a selected number of patients. Dr Mott queried whether the current traffic light classification should be changed in the light of the available evidence and that the devices should be used after normal physiotherapy and other steps had been undertaken. Dr Henn highlighted the need for initiation training and re-assessment with the use of the devices although comments had been received from the specialist therapists in Erewash to indicate that they had been found to be of clinical benefit for some patients. Mrs Needham queried how often the devices would need to be replaced and was informed that this would be every two years for Acapella®. **Agreed:** Flutter® and Acapella® oscillatory positive expiratory devices classified as **RED** for specialist physiotherapist use only due to the requirement for specialist assessment to enable patient selection, initiation and on-going treatment.	**SD**
7.	**CLINICAL GUIDELINES**	
a.	**Infant Feeding Guidelines** Mr Dhadli reported that the guidance on the appropriate use and prescribing of infant formula in primary care had been updated with some minor changes. Mrs Needham commented that an amendment should be made on page 10 of the guidance to indicate that the powder should ordinarily be used in preference to the high cost ready to feed cartons. **Agreed:** JAPC ratified the guideline on the appropriate use and prescribing of infant formula in primary care with the agreed amendment for a period of two years.	**SD**
b.	**Nicotine Replacement Therapy – Derbyshire County** Mr Dhadli reported that a two month extension had been requested for the Nicotine Replacement therapy formulary in order to review the formulary and ensure the formulary was consistent with the new protocols which were currently being developed.	

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Item		Action
	Agreed: JAPC approved a two month extension to the nicotine replacement therapy formulary to October 2016.	**SD**
c.	**<u>Management of Clostridium Difficile Infection in Primary Care</u>** Dr Diane Harris, Lead Antimicrobial Pharmacist, had requested an extension of six months to the local C difficile infection guidance pending the publication of national guidance by Professor Wilcox. **Agreed:** JAPC approved a six month extension to the Guideline for the Management of Clostridium Difficile Infection in Primary Care.	**SD**
d.	**<u>Heart Failure Management (including Sacubitril/Valsartan)</u>** Mr Dhadli reported that the heart failure guidance had been updated to include NICE TA 388 for sacubitril/valsartan and, following wide consultation, a whole section on sacubitril/valsartan had now been included and the algorithm for the treatment of heart failure updated. There was also a checklist to ensure that the patients treated met the NICE criteria and a draft shared care agreement for sacubutril/valsartan use in the management of heart failure with Reduced Ejection Fraction had accordingly been developed. Dr Mott highlighted that this was a new drug with limited knowledge of use and experience. It would therefore be advisable to delay the move to shared care while experience, familiarity and confidence was assured by secondary care and specialist colleagues -- a traffic light classification of RED would therefore remain appropriate. Mr Dhadli highlighted that there were likely to be high numbers of patients concerned and a shared care was likely to increase the number further. **Agreed:** Sacubitril/valsartan would continue to be classified as a **RED** drug and a review undertaken in six months to include the numbers of patients involved.	**SD**
e.	**<u>Heavy Menstrual Bleeding</u>** Mr Dhadli reported that this guideline based on the use of ulipristal for uterine fibroids had previously been discussed by JAPC but it had been decided to await the publication of the NICE guidance before a decision on its place in treatment was made. The NICE Clinical Guidance 44 'Heavy Menstrual Bleeding: Assessment and Management' had now been published and an amendment had now been made to indicate the maximum number of courses is four and fibroids greater than 3cm. Dr Jennifer Parratt, Consultant Gynaecologist, had developed two pathways: one for the use of ulipristal acetate for young women who wished to pursue fertility treatment – this would be managed in secondary care. The other pathway had been developed for older patients with symptomatic fibroids who were keen to avoid surgery and had received a diagnosis via an ultrasound scan. They would be given an individualised clinical treatment plan and ulipristal would be initiated in secondary care and subsequent courses, if successful, would be supplied by primary care. JAPC noted that ulipristal acetate was currently classified as RED for this indication.	

Item		Action
	Agreed: Ulipristal acetate classified as **GREEN** specialist initiation for uterine fibroids in agreement with clinical guideline with an individualised management plan.	**SD**
8.	**PATIENT GROUP DIRECTIONS**	
	The following PGDs were noted and agreed by JAPC: • Administration of intradermal inactivated influenza vaccine (Intanza®) to individuals from 60 years of age in accordance with the national immunisation programme for active immunisation against influenza. • Administration of intramuscular (or subcutaneous) inactivated influenza vaccine to individuals in accordance with the national immunisation programme for active immunisation against influenza. • Administration of *Haemophilus influenzae* type b and meningococcal C conjugate vaccine (Hib/MenC) to individuals from their first birthday to under 10 years of age in accordance with the national immunisation programme for active immunisation against *Haemophilus influenzae* type b and *Neisseria meningitidis* capsular group C. • Administration of shingles (herpes zoster, live) vaccine to individuals who are eligible for the national shingles immunisation programme for the prevention of herpes zoster ("zoster" or shingles) and herpes zoster-related post-herpetic neuralgia (PHN).	
9.	**SHARED CARE**	
a.	**<u>Acamprosate and Disulfiram</u>** Ms Thompson reported that the Substance Misuse Service had requested the DHcFT Drugs and Therapeutic Committee to extend the review date for the shared care for acamprosate and disulfiram to April 2017. Ms Thompson added that, although DHcFT was not responsible for the commissioning of any alcohol services at present, the Trust would have the new contract for the new commissioned service from April 2017. The current shared care was unchanged pending service development and review. **Agreed:** JAPC agreed an extension to April 2017 for the shared care agreement for acamprosate and disulfiram.	**SD**
b.	**<u>Attention Deficit Hyperactivity Disorder (ADHD) in Children and Adults</u>** Ms Thompson advised that DHcFT had requested an extension for the review date to November 2016 in order to ensure that an in-date policy was on the medicines management website and used within the Trust while an in-house review of the use of guanfacine and place in therapy of lisdexamfetamine was undertaken. **Agreed:** JAPC agreed an extension to November 2016 for the shared care guideline for ADHD.	**SD**
c.	**<u>Alzheimer's – Memantine and Actetycholinesterase Inhibitors</u>** Ms Thompson advised that DHcFT had requested an extension on the review dates of the shared care agreements for memantine and donepezil, rivatigmine and galantamine to enable a review and reconfiguration of the dementia service.	

Item		Action
	JAPC noted that the following statement had been included on the front sheet of each shared care agreement: "This shared care agreement is retained for the purpose of outlining the currently agreed operational framework for providing treatment with Acetylcholinesterase Inhibitors, pending on-going discussions with Commissioners. For up to date clinical information please refer to the BNF or SPC.' **Agreed:** JAPC agreed the shared care agreements for memantine and donepezil, rivatigmine and galantamine.	**SD**
d.	**Apomorphine** Mr Dhadli reported that some minor amendments to the supply of ancillary equipment had been made to the shared care agreement for apomorphine which had been sent out for consultation. **Agreed:** JAPC ratified the shared care agreement for apomorphine in the treatment of Parkinson's disease.	**SD**
10.	**MONTHLY HORIZON SCAN**	
	Mr Dhadli advised JAPC of the following new drug launches, new drug formulations and licence extensions: New drug launches in the UK: Alipogene tiparvovec (Glybera) – NHS England. Classified as **RED.** Sofosbuvir + velpatasvir (Epclusa) NHS England. Classified as **RED.** Bazedoxifene + conjugated estrogens (Duavive) – Unclassified. Await clinician request New drug formulation launches in the UK: Eftrenonacog alfa (Alprolix) – NHS England. Classified as **RED.** Licence extensions: Brentuximab vedotin (Adcetris) – NHS England. Classified as **RED.** Decitabine (Dacogen) – NHS England. Classified as **RED.** Teduglutide (Revestive) – NHS England. Classified as **RED.**	**SD** **SD** **SD** **SD** **SD** **SD**
11.	**MISCELLANEOUS**	
a.	**Conflict of Interest** Mr Dhadli reported that NHS England had published 'Managing Conflicts of Interest: Revised Guidance' in June 2016 and highlighted annex A 'Template for Declaration of Interests for CCG members and annex E: 'Template Declarations of Interest Checklist' as being of particular relevance for both JAPC and the Guideline Group. **Action:** JAPC's current processes around declaring and managing conflicts of interests to be reviewed by the Chair and Secretary. Proposals included the development of a revised draft conflict of interest form for use by members of JAPC and the Guideline Group by Dr Mott and Mr Dhadli and this would be brought back to the next meeting for discussion and approval.	**AM/SD**

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Item		Action
b.	**Liothyronine** Mr Dhadli reported that a long standing position statement had been devised in conjunction with Dr R Stanworth, Consultant Endocrinologist, and that liothyronine was not recommended for use outside of specialist initiation for very specific indications. It had been determined that a limited number of patients could benefit from the addition of small doses of liothyronine in addition to levothyroxine and this should be of three months duration in order to establish whether a patient's quality of life had improved. Liothyronine had featured on the PrescQIPP DROP - List as a drug considered to be poor value for money and with limited clinical value. PrescQIPP had recommended that CCG Medicines Management Teams should liaise with local endocrinologists to ensure that prescribing was consistent across the interface between primary and secondary care. Mr Dhadli highlighted that there had been some reports from practice pharmacists and audit that there had been prescribing of liothyronine in monotherapy outside of current recommendations and exception of shared care for resistant depression. Dr Stanworth had subsequently confirmed that liothyronine should only be used on specialist endocrine advice and/or initiation and then only in exceptional cases. Monotherapy was not recommended unless for resistant depression and levothyroxine should be used for thyroid deficiency. A combination treatment was recommended for a small group of patients who were symptomatic. Mr Dhadli highlighted the significant difference in cost between liothyronine-containing products and levothyroxine and it was agreed that this should be picked up by the prescribing groups.	**SD/KN**
c.	**Medicines Prescribed by other Healthcare Providers** Dr Mott stated that an audit had been undertaken on RED drug prescribing for renal indications at Derby Hospitals on a small cohort of patients and it had been discovered that the patient's Summary Care Records (SCR) often had no record of tacrolimus or equivalent drugs. It was highlighted that there were many medications which were prescribed and/or supplied directly to patients by healthcare providers outside of the GP practice and these include all specialist drugs which had been classified as RED by JAPC. It is particularly important to avoid any adverse interactions and incidents of toxicity and therefore essential that GP practices maintained records of these drugs on their clinical systems. It had been discovered that hospitals could not add directly on to the SCR directly and that, even if the hospital-only medications had been added to the GP systems correctly, they would need to be regularly updated as entries more than a year old disappeared from the SCR. A letter had been sent out to the north and south prescribing groups to highlight the importance of recording and keeping this information up-to-date on the PSCR and this issue would be escalated across the East Midlands as it was not just a Derby-centric issue. Dr Mott referred to the letter which he had prepared to outline the actions to be undertaken by JAPC, Provider Trusts, Medicines Management Teams and GP Practices to resolve this key safety issue.	

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	This included guidance for the addition of medicines prescribed and issued by other Health Care Providers to the GP clinical systems of SystmOne and EMIS Web. Mrs Needham commented that the north prescribing group had suggested that section 4 (c) in the EMIS web guidance be amended to show that the drugs added should be repeat and not acute as currently indicated. This amendment would be discussed by the south prescribing group meeting to be held next week. Mr Newman advised that a list had been obtained from DTHFT of all the renal patients on immuno-suppressants and this would be further discussed at the south Prescribing Group. JAPC noted the guidance on recording medicines prescribed and issued by other Healthcare Providers on GP clinical systems and supports the ongoing work to address this issue.	**SD**
d.	**<u>Regional Medicines Optimisation Committees</u>** Mr Dhadli reported that NHS England had issued a proposal to establish four Regional Medicines Optimisation Committees (RMOCs) to help eliminate unnecessary duplication of effort and instead refocus scarce resources towards implementation activities and the achievement of best value and patient outcomes from all medicines via the implementation of medicines optimisation. A paper outlining the proposals had been published by NHS England on 16th August 2016 and feedback and comments had been requested on this by 19th September 2016. Responses to the suggested functions of the RMOCs had been prepared and it was agreed that members should convey any further comments to Mr Dhadli before this deadline in order that a single response on the proposals from JAPC could be conveyed to NHS England.	**All members**
e.	**<u>NHS England Drugs</u>** JAPC noted the letters from NHS England Specialised Commissioning Midlands and East concerning the NICE Technology Final Appraisal Determinations for the following cancer drugs: • Crizotinib for untreated anaplastic lymphoma kinase-positive advanced non-small-cell lung cancer. • Pemetrexed maintenance treatment for nonsquamous non-small-cell lung cancer after pemetrexed and cisplatin.	
12.	**JAPC BULLETIN**	
	The bulletin was ratified by JAPC.	**SD**
13.	**MHRA DRUG SAFETY UPDATE**	
	The MHRA Drug Safety Alert for August 2016 was noted. Mr Dhadli highlighted the following MHRA advice: • Riociguat (Adempas): Not for use in patients with pulmonary hypertension associated with idiopathic interstitial pneumonias.	

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Item		Action
14.	**NICE SUMMARY**	
	Mrs Qureshi informed JAPC of the comments for the CCGs which had been made for the following NICE guidance issued in August 2016. TA391 Re-issued: Cabazitaxel for hormone-relapsed metastatic prostate cancer treated with docetaxel - This guidance replaces TA 255 and had been available via the Cancer Drugs Fund but from August 2016 cabazitaxel would be available via routine commissioning – Already classified as a **RED** drug (NHS England). TA401 Bosutinib for previously treated chronic myeloid leukaemia - This guidance replaced TA 299 and had been available via the Cancer Drugs Fund but from August 2016 bosutinib would be available via routine commissioning – Was previously classified as BLACK. Re-classified from BLACK as a **RED** drug (NHS England). TA402 Pemetrexed maintenance treatment for nonsquamous nonsmall-cell lung cancer after pemetrexed and cisplatin - This guidance replaced TA309 and had been available via the Cancer Drugs Fund but from August 2016 it would be available via routine commissioning – Was previously classified as BLACK. Re-classified as a **RED** drug (NHS England). TA403 Ramucirumab for previously treated locally advanced or metastatic nonsmallcell lung cancer – Not recommended. Classified as a **BLACK** drug. TA404 Degarelix for treating advanced hormone-dependent prostate cancer – Currently classified as **AMBER** for the treatment of adult male patients with advanced hormone-dependent Prostate Cancer. TA405 Trifluridine–tipiracil for previously treated metastatic colorectal cancer – Classified as a **RED** drug (NHS England).	**SD** **SD** **SD** **SD** **SD**
15.	**TRAFFIC LIGHTS – ANY CHANGES?**	
	Classifications Shower/Bath Emollients – **BLACK** Oscillating PEP Devices (e.g Flutter/Acapella®) – **RED** for specialist physiotherapist use Sacubitril/Valsartan – To remain **RED** pending review in six months Alipogene tiparrovec (Glybera®) – **RED** (NHS England) Sofosbuvir + velpatasvir (Epclusa®) – **RED** (NHS England) Eftrenonacog alfa (Alprolix®) – **RED** (NHS England) Brentuximab vedotin (Adcetris®) – **RED** (NHS England) Decitabine (Dacogen®) – **RED** (NHS England) Teduglutide (Revestive®) – **RED** (NHS England) Cabazitaxel – To remain **RED** as per NICE TA 391 Bosutinib **– RED** as per NICE TA 401 Pemetrexed **– RED** as per NICE TA 402 Ramucirumab **– BLACK** as per NICE TA 403 Degarelix **–** Remains as **AMBER** as per NICE TA 404 and local shared care Trifluridine–tipiracil – **RED** as per NICE TA 405	

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Item		Action
16.	**JAPC ACTION SUMMARY**	
	The action summary was noted by JAPC and amendments made: PCSK9 Inhibitors – To be brought to the October 2016 JAPC meeting. Guanfacine – To be brought to the January 2017 JAPC meeting. Osteoporosis – To be brought to either the January 2017 JAPC meeting. Review of Dequalinium – To be brought to the November 2016 JAPC meeting. Sayana Press® – To be brought to the October 2016 JAPC meeting. Bath Emollients/Shower Gels – To be taken off the list. Diabetes prevention – To be taken off the list. Sacubitril/Vasartan – Review in 6 months.	**SD** **SD** **SD** **SD** **SD** **SD** **SD** **SD**
17.	**GUIDELINE GROUP ACTION TRACKER**	
	The summary of key messages from the Derbyshire Medicines Management Guideline Group meeting held in August 2016 was noted. Mr Dhadli highlighted the following: • Update of existing specials guideline - Donepezil licensed orodispersible tablets available cheaper than the liquid formulation. • Naproxen dispersible 250mg tablets available and considerably less expensive than liquid. • Betamethasone dip + calciprotol (enstilar) foam classified as GREEN (and included in the psoriasis guidance). • Tamoxifen classified as GREEN specialist initiation in women for licensed indications. • Sun cream/Sun screen (Anthelios®, Sunsense ultra®, Uvistat®) classified as BROWN.	
18.	**MINUTES OF OTHER PRESCRIBING GROUPS**	
	• Sheffield Area Prescribing Group 19/05/16 • Burton Hospitals Drugs and Therapeutic Committee 11/07/16 • CRHFT Drugs and Therapeutic Committee 10/07/16 • Clinical Commissioning Policy Advisory Group 14/07/16 • DTHFT Drugs and Therapeutic Committee 19/07/16 Mr Dhadli highlighted that Sheffield Area Prescribing Group had approved the proposed removal of BuTrans® buprenorphine patches and replacement with Butec® transdermal patches.	

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Item		Action
19.	**ANY OTHER BUSINESS**	
	Mrs Needham stated that it had been proposed to establish a Derbyshire-wide working group to undertake work on behalf of the four CCGs to support work on increasing self-care, prescribing only for clinical need and consideration of difficult decisions and that this would report to JAPC. It was suggested that providers should be included in the membership. **Agreed:** JAPC approved the establishment of a Derbyshire-wide working group.	**KN**
20.	**DATE OF NEXT MEETING**	
	Tuesday, 11th October 2016 at 1.30pm in the Post Mill Centre, South Normanton.	