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DERBYSHIRE JOINT AREA PRESCRIBING COMMITTEE (JAPC)

Minutes of the meeting held on 10th October 2017

CONFIRMED MINUTES

Summary Points

Traffic lights

Drug	Decision
Azithromycin 1% eye drops	GREEN 2nd line for purulent bacterial conjunctivitis if chloramphenicol and gentamicin is contraindicated (e.g. pregnancy) or not tolerated
Fusidic acid 1% eye drops	BROWN no longer cost effective
FreeStyle Libre®	BLACK
Prednisolone foam enema	BLACK
Trimbow® (beclometasone + formoterol + glycopyrronium)	BROWN reserved for exceptional use
Cetuximab	RED (NHS England as per NICE TA 473)
Sorafenib	RED (NHS England as per NICE TA 474)
Dimethyl fumarate	RED (as per NICE TA 475) for plaque psoriasis
Paclitaxel	RED (NHS England as per NICE TA 476)
Sodium Chloride 7% nebules	BROWN after specialist initiation for use with patients with bronchiectasis
Capsaicin cream 0.025%	BROWN
Maviret® (glecaprevir + pibrentasvir)	BLACK
Kisqali® (ribociclib)	BLACK

Clinical Guidelines
Monitoring and Medication following Bariatric Surgery
Requesting Prescriptions for and Managing Patients using Varenicline

Patient Group Directions
Administration of intramuscular (or subcutaneous) inactivated influenza vaccine
Supply and administration of live attenuated influenza vaccine nasal spray suspension (Fluenz Tetra®▼)
Hepatitis A Vaccine – Adult
Hepatitis A Vaccine – Children
Typhoid Vaccine for Children and Adults
Hepatitis A and Typhoid Vaccine
Hepatitis B
Vitamin K

Shared Care Guidelines
D-penicillamine
Riluzole for the treatment of the Amyotrophic Lateral Sclerosis form of Motor Neurone Disease

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Present:	
Southern Derbyshire CCG	
Dr A Mott	GP (Chair)
Mr S Dhadli	Specialist Commissioning Pharmacist (Professional Secretary)
Mrs L Hunter	Assistant Chief Finance Officer
Ms H Murch	Pharmacist
Mrs S Qureshi	NICE Audit Pharmacist
North Derbyshire CCG	
Dr C Emslie	GP
Dr T Narula	GP
Mrs K Needham	Assistant Chief Quality Officer (Medicines Management) (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
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	
Ms A Braithwaite	Pharmacist
In Attendance:	
Ms L Swain	Head of Patient Engagement, North Derbyshire CCG
Mr A Thorpe	Derby City Council (minutes)

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Item		Action
1.	**APOLOGIES**	
	Dr R Dewis, Mr S Hulme, Mr C Newman and Dr M Watkins.	
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 conflicts of interest were declared in relation to this agenda, in addition to the existing register of interests.	
3.	**DECLARATIONS OF ANY OTHER BUSINESS**	
	• Public Health England advice concerning PPV23 vaccine. • Bisphosphonate use in osteoporosis.	
4.	**MINUTES OF JAPC MEETING HELD ON 12 SEPTEMBER 2017**	
	The minutes of the meeting held on 12th September 2017 were agreed as a correct record.	
5.	**MATTERS ARISING**	
a.	**Patient Group Direction - Salbutamol for Derbyshire Health United (DHU)** Mr Dhadli referred to an inconsistency in the indication section concerning the relief of acute severe/life threatening bronchospasm in patients over four years of age and a further reference to children aged one to five years. Mr Dhadli added that DHU had advised that the PGD was for the treatment of severe bronchospasm in patients over four years of age and not for COPD. Ms Braithwaite stated that salbutamol nebules could not be administered to children under the age of two years and the indicated dosage for children over this age of 2.5mg/2.5ml was in line with advice from the DTHFT consultant paediatricians and in the NICE Clinical Knowledge Summary. Mr Dhadli would confirm that this was consistent with the other PGDs.	**SD**
b.	**Dronedarone** Mr Dhadli reported that the CRHFT consultant cardiologists had been contacted and had indicated that they would wish to use dronedarone as an option for the maintenance of sinus rhythm after successful cardioversion in people with paroxysmal or persistent atrial fibrillation (AF). It had been queried whether GPs should be responsible for the provision and interpretation of the required ECGs. Mrs Needham advised that this had been discussed at meetings of the Prescribing Sub-Group and the Prescribing Leads meetings. The GP representatives had clearly indicated that there was no desire to provide or interpret ECG results on a six-monthly basis for dronedarone patients. Dr Mott stated that there had been similar discussions in the south during which it had been queried whether this proposal was for a full shared care or more of a transfer of patients with the prescribing and monitoring to be picked up by primary care. The south Prescribing Group had suggested that the ECGs be undertaken and interpreted by secondary care. Dr Emslie and Dr Henn commented that the main issue was the interpretation of the ECG results by GPs. Dr Goddard referred to a letter received from Dr R McIntosh, DTHFT Consultant Cardiologist, which proposed that patients should be discharged back to primary care with a standard dronedarone letter.	

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Item		Action
	DTHFT would feed the patient into a newly established dronedarone pathway with scheduled ECGs to take place automatically and a review to be undertaken by the initiating consultant cardiologist. **Action:** The proposed shared care would be updated and sent to the CRHFT and DTHFT consultant cardiologists for comment. These would be brought back for further discussion and decision at the November JAPC meeting.	**SD**
c.	**Immediate-release Fentanyl** Mr Dhadli highlighted the issue in the north of the county concerning access to immediate release fentanyl and that an analysis of prescribing had revealed that there had been no rapid growth. Mrs Needham referred to the low value medicines consultation and that the results of this would need to be fed into discussions between the CCG and palliative care consultants depending on the outcome of the national consultation.	
d.	**Matters arising from the Action Tracker** NRT and Service Provision: Mr Dhadli reported that Michelle Halfpenny from Derbyshire County Council Public Health had advised that with effect from 1st December 2017 the Live Life Better Derbyshire, a health and wellbeing service which offered help and support on stopping smoking, weight management and healthy lifestyles, would transfer to the County Council from DCHSFT. Once the service was in place there would need to be a discussion about the most cost effective formulary choices of NRT products. To be brought to the December JAPC meeting.	**SD**
	ADHD Monitoring in Adults: Dr Taylor referred to the current gap in service which concerned both diagnosis and the ad hoc sharing of care for adult patients. Dr Mott added that both the BNF and SPC had indicated that shared care guidelines should be in place for the drugs used in the treatment of ADHD. The lack of a diagnostic service was highlighted as a significant gap in current service provision and the concern of JAPC about this would be conveyed to the commissioners.	**AM**
	Dosulepin: Mr Dhadli reported that the NHS Clinical Commissioners had published a consultation on guidance for CCGs for items which should not routinely be prescribed in primary care and one of the included products was dosulepin for depression. Dosulepin had been discussed by the DHcFT Drugs and Therapeutic Committee and concern had been expressed about the effect on the patients who were on the drug if it was stopped following a suggested traffic light re-classification from BROWN to BLACK. It was noted that the drug was associated with a high level of risk but it could be difficult to withdraw its use. It was agreed to leave dosulepin as it was currently classified.	
	Suspected DVT – NOAC/D-dimer – To be brought to the November JAPC meeting.	**SD**

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Item		Action
	Prescribing Specification – To be brought to the November JAPC meeting. Comments should be conveyed to Mr Dhadli.	**All**
6.	**NEW DRUG ASSESSMENTS**	
a.	**Azithromycin Eye Drops** Mr Dhadli reported that azithromycin eye drops for the treatment of purulent bacterial conjunctivitis or trachomatous conjunctivitis had been assigned a traffic light classification of RED by JAPC. However CRHFT had recently considered azithromycin eye drops and added it to their formulary. Therefore, JAPC had been requested to consider a re-classification of azithromycin eye drops to GREEN 3rd line after chloramphenicol and gentamicin eye drops. Their use would be restricted as a third line option, when chloramphenicol and gentamycin eye drops were found to be ineffective and for treatment of moderate to severe purulent conjunctivitis. The use of azithromycin eye drops in pregnancy would replace fusidic acid 1% eye drops due to a very significant cost increase. **Agreed:** Azithromycin eye drops classified as **GREEN** 3rd line for bacterial conjunctivitis if chloramphenicol and gentamicin is contraindicated (e.g. pregnancy) or not tolerated, as suitable for primary care prescribing. **Agreed:** Fusidic acid eye drops classified as **BROWN** as significantly more expensive than other treatment options.	**SD** **SD**
b.	**FreeStyle Libre®** Mr Dhadli reported a number of requests had been received to prescribe FreeStyle Libre® which measured glucose levels using interstitial fluid levels from a sensor applied to the skin as an alternative to routine finger-prick blood glucose testing in people with type 1 and 2 diabetes. It would be necessary to formally classify FreeStyle Libre® products whilst awaiting national guidance or receipt of a business proposal. NICE had published a Medtech innovation briefing in July 2017, subsequently updated in September 2017, which referred to the evidence mainly from five studies involving 700 people. These include two randomised controlled trials; one including people with type 1 diabetes and the other including people with type 2 diabetes. The evidence suggested that using FreeStyle Libre® for up to twelve months reduced time spent in hypoglycaemia compared with self-monitoring of blood glucose using finger-prick tests and reduced the average number of finger-prick blood glucose tests needed. Diabetes UK had also indicated that FreeStyle Libre® might be useful for certain groups of people where continuous glucose monitoring was appropriate such as pregnant women. Mr Dhadli highlighted the following caveats: • Finger-prick blood glucose measurements were sometimes still needed e.g. when people were ill or driving. • The randomised controlled trial of people with type 1 diabetes had included only those adults whose diabetes was well controlled. • The resource impact of FreeStyle Libre® was uncertain. • Support and training from diabetes specialist was needed. • Blood glucose meters were currently provided free for patients.	

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	• Two MHRA safety notices had recently been issued. • The East of England Priorities Advisory Committee, which was a function of PrescQIPP, did not recommend routine use of FreeStyle Libre® in primary care as cost-effectiveness had not been demonstrated. • The Derbyshire Diabetes Network had indicated that they wanted FreeStyle Libre® to be widely available for patients with type 1 diabetes although cognisant of the current financial position of the NHS. During discussion Dr Mott advised that FreeStyle Libre® could be prescribed on a FP10 with effect from 1st November 2017 and that its greater impact may be for the less well controlled patients with diabetes. The current proposal was for FreeStyle Libre® to be given a traffic light classification of BLACK pending the submission of a business case. A decision on usage should be made by the wider health economy and it would also be sensible for it to be discussed by the Regional Medicines Optimisation Committee (RMOC). Dr Henn commented that there was very little clinical evidence that it delivered any significant advantages over standard treatment other than convenience and patient choice. In addition, the training costs had not been taken into consideration as patients would need tuition to be able to use it. Mr Dhadli added that the cohort of patients that could benefit from use needed to be clearly defined and supported by existing evidence. **Agreed:** FreeStyle Libre® classified as **BLACK** as not yet commissioned. **Action:** The diabetologists would be contacted by Dr Mott to request that a business case be made and this should include an indication of possible savings such as the reduced use of glucose testing strips.	**SD** **AM**
c.	**<u>Prednisolone Foam</u>** The QIPP working group had requested that prednisolone 20mg/application foam enema should be re-classified as BLACK as other equivalent rectal corticosteroid preparations were available with lower comparative prescribing costs. The proposal was supported by secondary care gastroenterology consultants at both acute Trusts. **Agreed:** Prednisolone foam enemas classified as **BLACK** as less cost-effective than current standard therapy. Hydrocortisone 10% foam enema was the preferred choice.	**SD**
d.	**<u>Trimbow®</u>** Mr Dhadli reported that Trimbow® was a combination of beclometasone + formoterol + glycopyrronium pressured metered dose inhaler (pMDI). The indication was for maintenance treatment in adult patients with moderate to severe chronic obstructive pulmonary disease who were not adequately treated by a combination of an inhaled corticosteroid and a long-acting beta2-agonist. There had been two fifty-two week active-controlled studies which compared beclometasone/formoterol/glycopyrronium to beclometasone/formoterol (the Trilogy Study) and evaluated the superiority of beclometasone/formoterol/glycopyrronium to tiotropium (the Trinity Study).	

Item		Action
	The Trilogy Study had demonstrated that, after twenty-six weeks treatment, Trimbow® had demonstrated statistically significant increases in pulmonary function and quality of life scores compared with ICS/LABA dual therapy. The Trinity study had showed that Trimbow® reduced the incidence of moderate and severe exacerbations by 20% and significantly increased lung function compared with tiotropium monotherapy. The Guideline Group had recommended that a BROWN classification be assigned to Trimbow® as the cost per QALY for triple therapy was more than the recommended NICE thresholds. Dr Henn advised that Trimbow® was now the most cost effective triple therapy and offered the advantage of being a pMDI inhaler which made administration easier for both patients and carers. **Agreed:** Trimbow® classified as BROWN for exceptional use where a small cohort of patients may benefit from prescribing as it could be more cost effective than the individual components.	**SD**
7.	**CLINICAL GUIDELINES**	
a.	**<u>Bariatric Surgery</u>** Mr Dhadli reported that monitoring and medication following bariatric surgery had previously been discussed by JAPC but it had not been possible to fully reconcile the significant differences in the guidelines used by the two centres of Derby and Sheffield. Consequently guidance had been produced which combined the two guidelines used by Derby and Sheffield. Mr Dhadli referred to some of the main areas of consensus and change: • Following all types of bariatric surgery patients would be recommended to self-care where appropriate. • Some differences in monitoring requirements. • Treatment for nutritional deficiency to follow local formularies. • Derby centre recommended omeprazole 20mg capsules daily for twelve months duration and ursodeoxycholic acid 500mg tablets twice daily for six months duration. Sheffield centre recommended lansoprazole capsules for three months post-surgery. The following changes were agreed: • Table 2 'Treatment recommended following detection of deficiency'. Ferritin and calcium - add 'see local formulary'. Folate – amend to 'to be purchased over the counter only'. Vitamin D - amend to 'maintenance dose should be continued and purchased over the counter.' • Amend to: Discuss with patient a referral back to the bariatric service if patient is pregnant or there are any concerns about surgery or nutritional status as a result of surgery. Dr Henn queried the quality of information given to patients after surgery. Mr Dhadli would check this with the Derby and Sheffield centres and add any resources to the guidance. **Agreed:** JAPC ratified the Monitoring and Medication following Bariatric Surgery with the agreed amendments with a two year review date.	**SD** **SD** **SD** **SD**

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b.	**<u>Varenicline</u>** Mr Dhadli reported that varenicline was available as a first line option for smoking cessation, with behavioural support, following discussion with client and clinician. This was an update to the existing guideline and now included the Derby City Public Health Smoking Cessation Service. **Agreed:** JAPC ratified the Requesting Prescriptions for and Managing Patients using Varenicline guideline with a two year review date.	**SD**
8.	**PATIENT GROUP DIRECTIONS**	
	The following PGDs from Public Health England were noted by JAPC: • Administration of intramuscular (or subcutaneous) inactivated influenza vaccine to individuals in accordance with the national immunisation programme for active immunisation against influenza. • Supply and administration of live attenuated influenza vaccine nasal spray suspension (Fluenz Tetra®▼) or supply only in well-defined local circumstances, to children and adolescents from two years to under eighteen years of age in accordance with the national flu immunisation programme for active immunisation against influenza. The following local PGDs for Hepatitis A and Typhoid had been updated to allow nurses and other registered healthcare professionals to administer vaccinations in line with NHS and Public Health England recommendations: • Hepatitis A Vaccine – Adult • Hepatitis A Vaccine – Children • Typhoid Vaccine for Children and Adults • Hepatitis A and Typhoid Vaccine **Agreed:** JAPC agreed the updated PGDs for Hepatitis A Vaccine – Adults; Hepatitis A Vaccine – Children; Typhoid Vaccine for Children and Adults and Hepatitis + Typhoid Vaccine. The following local PGD had been updated: • Hepatitis B Mr Dhadli reported that there was a local Hepatitis B PGD for pre-exposure immunisation which would expire in October 2017 but no current Hepatitis B PGD for renal patients. Two national Hepatitis B templates had been approved to support the provision of Hepatitis B vaccine pre and post exposure to hepatitis and to support the provision of Hepatitis B vaccine to renal patients. Dr Henn queried whether the triple combination vaccine should be referenced in the exclusion criteria – this was agreed. **Agreed:** JAPC agreed the updated PGD for Hepatitis B Vaccine for Children and Adults. The following local PGD had been updated with no material changes: • Vitamin K **Agreed:** JAPC agreed the updated PGD for Vitamin K.	**SD** **SD** **SD** **SD**

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Item		Action
9.	**SHARED CARE GUIDELINES**	
a.	**Penicillamine** Mr Dhadli reported that the D-penicillamine shared care guideline had been updated. It was noted that the 2017 guidance issued by the British Society of Rheumatology (BSR) had not included or made any recommendation on the monitoring of penicillamine. Mr Dhadli added that Dr L Badcock, DTHFT Consultant Rheumatologist, had requested that the values aligned to that in the updated BSR be added to the actions to be taken table in the guideline. **Agreed:** JAPC ratified the D-penicillamine shared care guideline for a period of two years.	**SD** **SD**
b.	**Riluzole** Mr Dhadli reported that the shared care guideline for riluzole for the treatment of the Amyotrophic Lateral Sclerosis form of Motor Neurone Disease was due for review but no changes had been made. **Agreed:** JAPC ratified the shared care guideline for riluzole.	**SD**
10.	**MISCELLANEOUS**	
a.	**Drugs and Therapeutic Bulletin Review - Vortioxetine for Acute Depression in Adults** Mr Dhadli advised that vortioxetine had previously been classified as RED by JAPC following the publication of NICE TA 367 'Treating major depressive episodes' in 2015. Dr Taylor advised that there had been eight prescriptions issued within DHcFT. JAPC noted the DTB Review.	
b.	**Gluten Free Food Prescribing in Erewash CCG, Hardwick CCG, North Derbyshire CCG and Southern Derbyshire CCG** JAPC was presented with feedback of the Consultation on the Prescribing of Gluten-free Foods along with a summary of its findings and commissioning options. Mrs Needham advised JAPC that the options for the future of gluten free food prescribing for coeliac disease across Derbyshire needed to be discussed and a viewpoint made to go to the governing bodies of each of the Derbyshire CCGs for a final decision. The total spend on gluten free products in Derbyshire was around £750,000 per annum. Gluten free foods had been available on prescription for more than forty years and during that time the cost of GF foods to purchase has significantly reduced. They were also now widely available in shops and supermarkets. In the light of the current financial situation in the NHS it was necessary for all CCGs to ensure that budgets were spent for the benefit of the whole population as well as ensuring that services met the needs of individuals. The Derbyshire CCGs had therefore undertaken a public consultation on the future of gluten free prescribing in Derbyshire which had given details of four possible options as a way forward: • Stop providing gluten-free foods on prescription altogether. • Change the gluten-free allowance to eight units per month for everyone eligible for gluten-free food on prescription and have much more limited products available on prescription. • Continue to follow the Coeliac Society's recommendations for number of units (ten to eighteen units depending on the age and sex of the patients) but have much more limited products available. • Do nothing.	

Item		Action
	A report had been prepared for JAPC which included the position taken by other CCGs on the future of gluten free prescribing. It was noted that the majority of CCGs had restricted prescribing in different ways and some had stopped this altogether. It had been noted that, in cases where the CCGs had adopted a more restrictive approach, the greater the reduction in expenditure had been. The report also referred to an article in 'The Times' newspaper about gluten free foods which had highlighted the cost to the NHS of £19 million and that Derbyshire GPs were amongst the heaviest prescribers. Mrs Needham added that the outcome of a national consultation on gluten free prescribing, which had now closed, was also awaited but an exact time for this was currently unknown. Ms Swain highlighted the importance of ensuring that all the views expressed during the local consultation were taken into account before any decision was made and factors such as low income and social circumstances were taken into consideration. During the discussion the difficult financial positions of the CCGs was expressed. Clinicians of the group then expressed their concern on limited patient access to gluten free products either through residence in rurality or financial reasons and patients on low income. Evidence presented to JAPC did not support that prescribing of gluten-free products enhanced compliance with diet. Dr Goddard commented that the landscape of the NHS had now changed, with increased awareness of the prevalence of coeliac disease, greater access to gluten free foods, and the thresholds for diagnosis of coeliac disease had significantly increased. The availability and quality of gluten free products had improved and gluten free meals were included in menu choices at many restaurants. Dr Mott queried whether there had been any feedback from gastro-enterologists across the country in the light of local decisions to stop prescribing altogether. Dr Goddard was not aware of any significant feedback but, in a recent article in the British Medical Journal published in January 2017, two contributors had presented the case for ensuring ongoing access to gluten-free staple foods and highlighted that removing prescriptions unfairly discriminated against people with coeliac disease. Dr Henn stated that a restriction to four units would guarantee a basic supply of baseline products. In connection with addressing the equality issue, Dr Emslie stated that it would be desirable for everyone to be given the same amount of units but the difference in the amount needed to meet the requirements should either be made up by the purchase of gluten free products or non-gluten containing foods. Dr Henn advised that where a final decision would either be a total restriction or limit in units and, in either case, it would be important to provide people with the maximum amount of information to enable them to manage the change. **Agreed:** JAPC agreed that the recommendation from JAPC to the governing bodies of Southern Derbyshire CCG, North Derbyshire CCG, Erewash CCG and Hardwick CCG based on the presented papers should be to reduce the number of units and reduced formulary for gluten free. That the rationale for its decision be clearly communicated with a view that number of units should be limited to four units per month for adults and children together with a reduced formulary given the concerns raised.	

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Item		Action
	The affected patients in any final decision that resulted in a change should be provided with the maximum amount of information to enable them to manage the change.	**SD**
c.	**NHS England and Bisphosphonates** Mr Dhadli referred to a letter from the NHS England Acting Director of Specialised Commissioning concerning the availability of bisphosphonates for the prevention of secondary breast cancer. The letter confirmed that CCGs were responsible for the commissioning and funding of breast cancer surgery and this included bisphosphonates.	
d.	**Adrenaline Auto-Injectors in Schools** Dr Mott advised that schools were now allowed to obtain, without a prescription, adrenaline auto-injector (AAI) devices for use in emergencies. This was similar to existing practice to allow the supply of salbutamol asthma inhalers to be kept in schools. The amended guidance concerning AAI devices in schools was noted by JAPC.	
11.	**REGIONAL MEDICINES OPITIMISATION COMMITTEE (RMOC)**	
	Biosimilar Framework/Biosimilar Working Group Mr Dhadli reported that NHS England, NHS Improvement and NHS Clinical Commissioners had published the Commissioning Framework for Biological Medicines including Biosimilar Medicines. This would be used to inform the Derbyshire Biosimilar Task and Finish Group to be established. Dr Mott referred to the terms of reference for the Group which needed to be finalised once decisions had been made about membership. A date for the inaugural meeting would be arranged and the Midlands and East Regional Pharmacy Lead, Mr Richard Seal, would be invited to attend this.	**SD**
12.	**JAPC BULLETIN**	
	The bulletin was noted for information and ratified by JAPC.	
13.	**MHRA DRUG SAFETY UPDATE**	
	The MHRA Drug Safety Alert for September 2017 was noted. Mr Dhadli highlighted the following: • Miconazole (Daktarin®): over-the-counter oral gel contraindicated in patients taking warfarin. • Loperamide (Imodium®): reports of serious cardiac adverse reactions with high doses of loperamide associated with abuse or misuse.	
14.	**HORIZON SCAN**	
	Mr Dhadli advised JAPC of the following new drug launches and new drug formulations: New drug launches in the UK; Alectinib (Alecensa®) - Already classified as BLACK (TA 438) for previously treated anaplastic lymphoma kinasepositive advanced non-small-cell lung cancer (terminated appraisal). Beclometasone + formoterol + glycopyrronium (Trimbow®) – Classified by JAPC as **BROWN** at today's meeting.	

Item		Action
	Eluxadoline (Truberzi®) – No action as JAPC had already classified this as RED. Enoxaparin biosimilar (Inhixa®) – Biosimilar working group to review. Glecaprevir + pibrentasvir (Maviret®) – Classified as **BLACK** pending NICE TA. Ribociclib (Kisqali®) – Classified as **BLACK** pending NICE TA. New formulation launches in the UK: Irinotecan (Onivyde®) – No action. Midazolam (Epistatus®) – No action. Sufentanil (Zalviso®) – Await clinician request.	
15.	**NICE SUMMARY**	
	Mrs Qureshi informed JAPC of the comments for the CCGs which had been made for the following NICE guidance issued in September 2017. TA473 Cetuximab for treating recurrent or metastatic squamous cell cancer of the head and neck – Classified as **RED** (NHS England). Replaces TA172. TA474 Sorafenib for treating advanced hepatocellular carcinoma – Classified as **RED** (NHS England). Replaces TA189. TA475 Dimethyl fumarate for treating moderate to severe plaque psoriasis – The commissioner was CCG. NICE did not anticipate a significant impact on resources. Classified as **RED**. TA476 Paclitaxel as albumin-bound nanoparticles with gemcitabine for untreated metastatic pancreatic cancer - Currently classified as BLACK but now recommended. Classified as **RED** (NHS England). Replaces TA360. TA357 Pembrolizumab for treating advanced melanoma after disease progression with ipilimumab - Currently classified as RED (NHS England) as per TA357. No change needed. TA366 Pembrolizumab for advanced melanoma not previously treated with ipilimumab - Currently classified as RED (NHS England) as per TA366. No change needed. TA428 Pembrolizumab for treating PDL1 - positive non-smallcell lung cancer - Currently classified as RED (NHS England) as per TA428. No change needed. TA439 Cetuximab and panitumumab for previously untreated metastatic colorectal cancer - Currently classified as RED (NHS England) as per TA439. No change needed. CG54 Urinary tract infection in under 16s: diagnosis and management – This was being reviewed by Dr D Harris, Lead Antimicrobial Pharmacist. PH38 Type 2 diabetes: prevention in people at high risk – NICE had now recommended that metformin could be offered if lifestyle interventions had not been successful.	

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	It was noted that at the time of publication one modified-release metformin product, Glucophage SR, had recently extended its marketing authorisation to include reducing the risk or delaying the onset of type 2 diabetes. Other products would be used outside of the licence. Dr Dewis, Derby City Consultant in Public Health Medicine, would be requested to review this public health guideline.	**RD/SQ**
16.	**GUIDELINE GROUP ACTION TRACKER**	
	The summary of key messages from the Derbyshire Medicines Management Guideline Group meeting held in September 2017 was noted. Mr Dhadli highlighted the following: Sodium Chloride 7% nebules – Classified as **BROWN** after specialist initiation for use with patients with bronchiectasis. Capsaicin cream 0.025% - Classified as **BROWN** in line with NICE CG177 for use after self-care, rubifacients and oral analgesia**.** Eye bags/eye compress – Specific eyebag preparations listed (Clinitas®, Meibopatch®, MGDRx®, Optase®) classified as **BLACK.** Vitamin D (Colecalciferol®) 800 units (e.g. Fultium®; Desunin®) – For maintenance, following treatment of deficiency, or insufficiency, JAPC had recommended that patients should be encouraged to make lifestyle changes and to purchase a supplement over the counter. Classified as **BLACK.** Eye chapter - Now updated. Gentamicin 0.3% eye drops added as an alternative, if chloramphenicol was not suitable. Appendix 1 dry eye treatment updated with cost-effective choices. Falls guidance - Now updated to align with the PrescQIPP 'Medication and Falls' advice. NSTEMI South – To be discussed by the Guideline Group. It would be highlighted that the existing guidance was still current.	**SD**
17.	**TRAFFIC LIGHTS – ANY CHANGES?**	
	<u>Classifications</u> Azithromycin eye drops - **GREEN** 3rd line for purulent bacterial conjunctivitis after chloramphenicol and gentamicin eye drops Fusidic acid 1% eye drops - **BROWN** FreeStyle Libre® - **BLACK** Prednisolone foam enema – **BLACK** Trimbow® (Beclometasone + formoterol + glycopyrronium) - **BROWN** reserved for exceptional use Cetuximab – **RED** (NHS England as per NICE TA473) Sorafenib – **RED** (NHS England as per NICE TA474) Dimethyl fumarate – **RED** (as per NICE TA475) Paclitaxel – **RED** (NHS England as per NICE TA476) Sodium Chloride 7% nebules – **BROWN** after specialist initiation for use with patients with bronchiectasis	

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Item		Action
	Capsaicin cream 0.025% - **BROWN** Maviret® (Glecaprevir + pibrentasvir) - **BLACK** Kisqali® (Ribociclib) – **BLACK**	
18.	**MINUTES OF OTHER PRESCRIBING GROUPS**	
	• DHcFT Drugs and Therapeutic Committee 25/05/2017 • DTHFT Drugs and Therapeutic Committee 15/08/2017 • Medication Optimisation Safety Team 03/08/2017 • Medication Optimisation Safety Team 07/09/2017 • Clinical Policy Advisory Group 13/07/2017	
19.	**ANY OTHER BUSINESS**	
a.	Mr Dhadli reported that Public Health England had sent out a letter to all General Practitioners concerning the current shortage of the polysaccharide vaccine (PPV23). However it was highlighted that there was no national shortage of the pneumococcal conjugate vaccine (PCV13). Their advice was to stagger the administration use in the elderly rather than link to the annual flu immunisation programme.	
b.	Mr Dhadli referred to the NICE TA464 'Bisphosphonates for treating osteoporosis' and the recommendation that these be considered as options for the treatment of osteoporosis in adults only if the ten year probability of osteoporotic fragility fracture was at least 1%. There had been concern that every patient who was risk assessed by means of the FRAX risk tool would end up on treatment. The recommendations in the TA would be further discussed with the consultant endocrinologists.	**SD**
20.	**DATE OF NEXT MEETING**	
	Tuesday, 14th November 2017 at 1.30pm in the Post Mill Centre, South Normanton.	