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

DERBYSHIRE JOINT AREA PRESCRIBING COMMITTEE (JAPC)

Minutes of the meeting held on 11th February 2020

CONFIRMED MINUTES

Summary Points

Traffic lights

Drug	Decision
UrgoStart	BROWN consultant/specialist initiation under the care of a multidisciplinary foot team (diabetic foot ulcers only)
Vitamin B Compound Strong	BROWN consultant/specialist recommendation
Silver dressing (Atruman Ag, Suprasorb A+Ag, Aquacel Ag+ extra, Acticoat-flex 3, Urgotul silver, Aquacel +ribbon, urgoclean Ag & Urgo clean) All other silver dressing	BROWN restricted formulary choices BLACK
Naldemedine	BLACK
Vernakalant	BLACK
Cladribine	RED (NHS England as per NICE TA616)
Lusutrombopag	RED (as per NICE TA617, CCG commissioned)
Atezolizumab	BLACK (NHS England as per NICE TA618, terminated appraisal)
Palbociclib	RED (NHS England as per NICE TA619)
Olaparib	RED (NHS England as per NICE TA620)
Osimertinib	BLACK (NHS England as per NICE TA621)

Derbyshire Medicines Management Shared Care and Guideline Group Traffic Lights

Drug	Decision
Cimetidine	Declassified
Ranitidine	GREEN (re-classified)
True Results test strips	Declassified
Stalevo (carbidopa, entacapone, levodopa)	Declassified
Nifedipine MR	GREEN for angina and raynaulds phenomenon (unlicensed indication)
Nifedipine IR caps	BROWN restricted for patients with raynaulds phenomenon who do not tolerate MR preparation

Clinical Guidelines

Vitamin B compound/Vitamin B compound strong tablets position statement

Present:	
Derby and Derbyshire CCG	
Dr C Emslie	GP (Chair)
Mr S Dhadli	Assistant Director of Clinical Policies and Decisions (Professional Secretary)
Mr S Hulme	Director of Medicines Management and Clinical Policies

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Mrs K Needham	Assistant Director of Medicine Optimisation and Delivery
Mrs S Qureshi	Head of Medicines Management, Clinical Policies and High Cost Interventions
Dr H Hill	GP Prescribing Lead
Ms J Savoury	Assistant Chief Finance Officer
Ms A Reddish	Clinical Quality Manager – Primary Care
Derby City Council	
Derbyshire County Council	
University Hospitals of Derby and Burton NHS Foundation Trust	
Dr W Goddard	Chair – Drugs and Therapeutic Committee
Ms A Brailey	Deputy Chief Pharmacist
Derbyshire Healthcare NHS Foundation Trust	
Dr S Taylor	Chair – Drugs and Therapeutic Committee
Chesterfield Royal Hospital NHS Foundation Trust	
Mr M Shepherd	Chief Pharmacist
Derbyshire Community Health Services NHS Foundation Trust	
Derby and Derbyshire Local Medical Committee	
Dr K Markus	Chief Executive Officer
Derbyshire Health United	
Staffordshire and Stoke-on-Trent CCG's	
Ms S Bamford	Medicines Optimisation Senior Lead Pharmacist
In Attendance:	
Ms S Boden	Quality and Training Lead Integrated Sexual Health Services Derbyshire Community Health Services NHS Foundation Trust
Ms M Hill	High Cost Interventions Pharmacy Technician Derby and Derbyshire CCG

Item		Action
1.	**APOLOGIES**	
	Dr R Gooch, Ms A Braithwaite, Ms J Derricott, Dr R Dewis	
2.	**DECLARATIONS OF CONFLICTS OF INTEREST**	
	Dr Emslie 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**	
	Prescribing in gender dysphoria	

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Item		Action
4.	**MINUTES OF JAPC MEETING HELD ON 14 JANUARY 2020**	
	The minutes of the meeting held on 14th January 2020 were agreed as a correct record after minor amendments to the following agenda items: Minutes of JAPC meeting held on 10 December 2019 – a post meeting note was added to say that at the January 2020 Derbyshire Medicines Management Shared Care and Guideline Group (MMSCGG) it was noted that there are intermittent supply issues with all H2 Antagonists including cimetidine. Recommendation to JAPC is not to have one preferred option listed.	
5.	**MATTERS ARISING**	
a.	**Chlamydia guidance** Mr Dhadli advised that at the January 2020 JAPC meeting there was a query with regards to where responsibility lies for patients who have received treatment for chlamydia and need to be followed up for re-testing. Dr F Nathani Lead Clinician Integrated Sexual Health Services (ISHS) advised that it is their responsibility within Derbyshire Community Health Services NHS Foundation Trust (DCHSFT) to follow the patients up for re-testing; this will be reflected in the guidance.	**SD**
b.	**Neuropathic pain** Mr Dhadli reported that Derbyshire Healthcare NHS Foundation Trust (DHcFT) would like addition of safety advice for SNRI with Tramadol and serotonin syndrome to be added into the neuropathic pain guideline. Pain consultants were also contacted as SIGN has a different dosing regimen compared to the neuropathic pain guideline, which reflects the advice within the BNF. The pain consultants confirmed that they are happy to follow the BNF recommendations; therefore no further change to the guideline was needed.	
c.	**Cannabis for spasticity** Mrs Qureshi advised that Sheffield have sent their responses through in regards to cannabis based products and they have confirmed that they are currently planning to treat 5 patients from within Derbyshire. Mrs Qureshi has also contacted Derby and Nottingham however she has not yet had a response. The pathway will be tabled at the next JAPC meeting in March 2020.	**SQ**
d.	**Nebuliser guideline for Chronic Obstructive Pulmonary Disease (COPD)** Mr Dhadli reported that at the January 2020 meeting Dr Markus asked if the new referral form from the nebuliser guideline for COPD was embedded into the clinical systems, Dr Emslie confirmed that it is.	
e.	**Shared Care Guidance for consultation** Mr Dhadli informed the committee that Ms Derricott is looking into the Regional Medicines Optimisation Committee (RMOC) shared care agreement 14 day response times, to consider if this is something that should be added into the local shared care agreement templates. Ms Derricott will bring an update to a future JAPC meeting.	**JD**

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Item		Action
f.	**Diamorphine shortage** Mr Dhadli advised that at the January 2020 JAPC meeting, Ms Braithwaite informed the committee that there is a nationwide shortage of lower strength diamorphine which is currently mainly affecting hospitals. Dr Emslie suggested that an investigation into whether there is a shortage of diamorphine within the Derbyshire community should be carried out before a decision is made as to whether DDCCG documents should be updated from diamorphine to morphine. Dr Emslie confirmed that DDCCG documents include both diamorphine and morphine; therefore no further action is necessary.	
6.	**JAPC ACTION SUMMARY**	
a.	**Gastro-Oesophageal Reflux Disease (GORD) guidance** Mr Dhadli reported that the Gastro-Oesophageal Reflux Disease (GORD) guidance currently remains on the JAPC action summary as a review was scheduled to take place to look at whether NICE (CG184)/BNF guidance has updated the clarithromycin dose to be in line with Public Health England (PHE). Mr Dhadli confirmed that NICE have now completed this review and updated the BNF clarithromycin dose. University Hospitals of Derby and Burton NHS Foundation Trust (UHDBFT) and Chesterfield Royal Hospital NHS Foundation Trust (CRHFT) have been notified and CRHFT will be updating their dosing regimen in line with the BNF. Mr Dhadli is still awaiting a response from UHDBFT. The GORD guideline will be updated to reflect the new dosing information.	**SD**
b.	**Continence guidance** Mr Dhadli stated that he has contacted Ms H Greaves Lead Clinical Nurse Specialist DCHSFT who has responded to say that she is in the process of arranging a meeting with UHDBFT, as the continence nurses are not complying with some of the formulary choices.	
c.	**Liothyronine** Mrs Needham advised that this has been discussed at the Derbyshire Prescribing Group meeting and she will be contacting Sheffield hospital to ask if they will accept Derbyshire patients who are not currently under their care for review of liothyronine, now that there is a shared care in place for existing patients.	**KN**
d.	**Questran** At the December 2019 meeting Dr Goddard advised that UHDBFT are receiving a number of letters from GP's in regards to the unavailability of Questran and they have asked for an alternative recommendation. Dr Goddard is currently looking into this, he suggested colesevelam however this would be for off licence use. Mr Dhadli responded to say that he didn't foresee any issues with this as long as 'off licence use' is clearly noted and it is endorsed by a gastroenterologist. Dr Markus advised that there may be some GP's who are not happy to prescribe an unlicensed product.	**WG**

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Item		Action
7.	**NEW DRUG ASSESSMENT/TRAFFIC LIGHT ADDITION**	
a.	**Thealoz Duo for dry eyes** Mr Dhadli informed the committee that a paper for Thealoz Duo has been tabled at the JAPC meeting so that a traffic light classification can be assigned to it, as some GPs have been asked by ophthalmologists to continue prescribing this non-formulary item. Thealoz Duo is a combination product of trehalose and sodium hyaluronate. It is not currently in the Derbyshire Dry Eye guidelines however it has previously been through a Drugs and Therapeutics (D&T) meeting at CRHFT. The two studies quoted at CRHFT D&T meeting were the Chiambaretta F et al. Eur J Ophthalmol 2017 and the Schmidl D et al. Cornea 2015. The Chiambaretta F et al study was a randomized, controlled study of the efficacy and safety of a new eye drop formulation for moderate to severe dry eye syndrome. It took place in France and Tunisia involving 105 patients with moderate to severe dry eye disease for 84 days, comparing hyaluronic acid (HA)-trehalos with HA. The primary outcome was The Oxford 0-15 grading score to assess keratitis severity and severity of conjunctival impairment. Non inferiority demonstrated at day 35- For the HA-trehalose and HA groups, the mean reduction in global Oxford score from day 0 to 35 was -2.5 ± 2.0 and -2.7 ± 1.7, respectively. The Schmidl D et al study looked at tear film thickness (TFT) after treatment with artificial tears in patients with moderate dry eye disease. The increase in TFT remained statistically significant up to 240 minutes after administration of TH-SH. In contrast, the increase in TFT after administration of HA was only statistically significant at 10, 20, and 40 minutes after drop instillation. The consultant ophthalmologist at CRHFT has said that based on feedback from patients with moderate to severe dry eyes, the satisfaction rates in relief of symptoms are far greater with Thealoz-Duo compared to standard Sodium Hyaluronate especially in the first month. UHDBFT do not currently use Thealoz-Duo. There is a cost difference for Thealoz-Duo within primary care and secondary care, with the cost in secondary care being less than in primary care; however current formulary choice items remain more competitive. A discussion took place and the committee agreed that the consultant ophthalmologists at CRHFT should be asked to review the current primary care formulary items for dry eyes to assess whether Thealoz Duo is required and advise on whether products currently within the formulary will meet patients' needs. Mr Dhadli stated that the evidence wasn't strong enough to add to the formulary and that the dry eye formulary had many choices available. **Action:** Mr Shepherd to liaise with Ophthalmology consultants at CRHFT as to place alongside formulary choices.	**MS**
b.	**Pioglitazone** Mr Dhadli stated that pioglitazone was classified from GREEN to BROWN in 2014. A query was raised by a Primary Care Network clinical lead GP to ask if MHRA were reviewing their warning around the use of pioglitazone, as there have been some recent publications. Mr Dhadli reminded JAPC members that NICE in their economic modelling	

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	suggest that this is the most cost effective drug in the treatment of Type 2 Diabetes. However, the uptake of this drug is poor based on the following risks: bladder cancer, heart failure, fractures and weight gain. Mr Dhadli referred to appendix 1 in the tabled paper where NICE NG28 type 2 diabetes in adults (Dec 2015) recommends pioglitazone as monotherapy if metformin is C/I or not tolerated (alongside DPP-4 or sulfonylurea). It is also recommended at first intensification with metformin (alongside DPP-4 or sulfonylurea), or if metformin C/I is not tolerated, with DPP-4 or sulfonylurea (alongside DPP-4+ sulfonylurea). Mr Dhadli advised that he has contacted the MHRA and asked if there has been any change to the MHRA update, which was given some time ago. When asked whether there are any plans to review the MHRA warnings around the use of pioglitazone, the response was that there are no ongoing or planned reviews into the existing warnings around its use. They were also asked if the risks associated with use of pioglitazone remain valid and if so, can this be explained in further detail. They responded to say that in 2012 there was an action taken in parallel to a European review which resulted in the circulation of additional risk minimisation measures, in the form of educational materials and a DHPC concerning the risks of bladder cancer and heart failure. In March 2019 European regulators agreed that there was no longer a need for additional risk minimisation measures for the risks of bladder cancer and heart failure so they were removed. Mr Dhadli then referred to appendix 2 which is based on the full NICE evidence within the diabetes guideline; the areas which are pertinent to pioglitazone are the changes in blood glucose levels. Evidence on the use of pioglitazone and sitagliptin showed similar profiles in terms of change in HbA1c and adverse events. Pioglitazone was associated with a greater reduction in HbA1c at 24 months; sitagliptin was associated with less hypoglycaemia and weight loss at 12 and 24 months. The committee then looked at the health economic analysis and the probability of cost effectiveness. This suggests that for people who could not tolerate metformin, repaglinide was the most cost-effective treatment option, if people were unwilling to take repaglinide at initial therapy, pioglitazone was the treatment option with the lowest lifetime discounted costs. Cost per QALY were higher for repaglinide and pioglitazone. Mr Dhadli then went on to discuss some evidence based publications which have been produced since NICE looked at the safety warnings. One study looked at the association of pioglitazone and bladder cancer. The conclusion was that it is not plausible for a drug to cause bladder cancer in such a short space of time and the numbers versus placebo were also small. This made it difficult to draw any meaningful conclusion about the statistical significance between the two. Other studies also showed that pioglitazone has favourable outcomes in terms of mortality and has beneficial cardiovascular benefits. Risk of fractures is small if the correct recommendations to avoid in at risk patients are followed. Weight gain is also recognised. Mr Dhadli contacted consultants at UHDBFT and CRHFT to seek their views if pioglitazone were to be added back into the Derbyshire formulary. Mr R Robinson consultant at CRHFT was in favour of using this, there have been no comments received as yet from UHDBFT. A discussion took place and the committee agreed that there is a cost benefit	

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	compared with newer antidiabetic agents. Mr Hulme reported that nationally and locally there is generally low prescribing of pioglitazone. The question arose as to whether pioglitazone would have much uptake if it were included onto the formulary. The committee agreed to support a change for pioglitazone to be reclassified from BROWN to GREEN second line, which would potentially be confirmed at the next JAPC meeting. Mr Dhadli would produce a statement to include information for prescribers, the committee also agreed to give further consideration to repaglinide at the March 2020 JAPC meeting. **Action:** Mr Dhadli to produce a statement for pioglitazone and bring to the March 2020 JAPC meeting.	**SD** **SD**

c.	**<u>Urgostart</u>**
	Mr Dhadli reported that UrgoStart was discussed at the UHDBFT D&T meeting in March 2019 following positive NICE MTG, the decision was to support formulary application via JAPC. Following this an MTG business case was submitted proposing inclusion of UrgoStart and UrgoClean Ag dressings onto the wound care formulary to ensure continuity of leg and diabetic foot ulcer pathways from acute to primary care. The business case was reviewed by Clinical Policies Advisory Group (CPAG) in May 2019 and the committee agreed its use in principle.
	NICE MTG42 (January 2019) recommends UrgoStart dressings to treat diabetic foot ulcers in the NHS because they are associated with increased wound healing compared with non-interactive dressings.
	When this went to CPAG the committee found the following:
	• There is insufficient robust evidence supporting the use of UrgoStart in venous leg ulcers
	• There is evidence supporting the use of UrgoStart in diabetic foot ulcers in terms of increased healing rates.
	• Use of UrgoStart must be incorporated within the diabetic foot ulcer pathway to ensure UrgoStart dressings are used appropriately, for example
	  ○ By wound care experts and district nurses
	  ○ For correct indication/wound type (not to be used for infected ulcers)
	Mr Dhadli has emailed different providers in regards to the use of UrgoStart, CRHFT and DCHSFT met on the 26th of November 2019 to discuss how to best integrate UrgoStart use in primary care. Both organisations were in support of UrgoStart use in primary care and will liaise with UHDBFT before finalising a pathway. However they have stated that they do not wish to include it in their clinics.
	Professor F Game Consultant Diabetologist UHDBFT has asked where this will fit in terms of the diabetic ulcer pathway; she has also given a summary guide about how this will be started. The use of this dressing will be limited and it will be used following MDFT (Multi-Disciplinary Foot Team) assessments.
	Dr Markus asked for clarification as to whether patients will receive follow up care in the diabetic foot clinic.
	
	Agreed: JAPC classified UrgoStart as **BROWN specialist initiation following a MDFT assessment for diabetic foot ulcers only.**
		SD
		
		SD

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Item		Action
8.	**CLINICAL GUIDELINES**	
a.	**Vitamin B compound strong** Mr Dhadli stated that he has received feedback from Ms G Dickenson Community Clinical Team Lead Dietitian UHDBFT in regards to vitamin B compound strong and refeeding recommendations. Requests have been made by community dieticians for GP's to prescribe vitamin B co-strong for patients at risk of refeeding syndrome who require timely treatment. Community dieticians are unable to provide prescriptions for patients. The MMSCGG have reviewed this and accepted the recommendation BROWN after consultant/specialist recommendation for refeeding syndrome - short course supplied in hospital or in exceptional circumstances GP's may prescribe following a community dietician request. **Agreed:** JAPC classified vitamin B compound strong as **BROWN after consultant/specialist recommendation** for patients with a medically diagnosed deficiency due to lifelong or chronic condition, or following surgery that results in malabsorption or for refeeding syndrome - short course supplied in hospital or in exceptional circumstances GP may prescribe following community dietician request. This vitamin has multiple classifications and the traffic light classification database should be seen for more information. Position statement has been amended to reflect these changes	
9.	**MISCELLANEOUS**	
a.	**Silver dressings** Mr Dhadli advised that the JAPC paper at January 2020 noted discrepancies between the request for a restricted formulary and the Derbyshire wound care formulary. Mr Dhadli requested clarity from the Tissue Viability nurses at DCHSFT leading on this. An amended paper has now been tabled. Mr Dhadli referred to the wound care products listed in appendix one of the paper. Recommendations have been made as to which silver dressings should be classified as BROWN due to their cost effectiveness and other criteria. A further table of silver dressings to be classified as BLACK was also listed. DCHSFT are aware that there are some slight discrepancies between their wound care guideline and preferred formulary choices; however they are currently working to align them both. Mr Shepherd asked if the Tissue Viability Nurses at CRHFT were consulted with. Mr Dhadli responded to say that this has not been confirmed however Ms S Jones Lower Limb Improvement Lead DCHSFT is aware that the Tissue Viability Nurses at CRHFT were involved with producing the wound care guideline. Mrs Needham advised that the silver dressings listed will need to be included into the Derbyshire formulary and GP clinical systems to alert prescribers. Mr Dhadli went on to discuss a product called Urgo Clean AG. DCHSFT has conducted a review into wound care treatment for biofilm infection. They evaluated using Urgo Clean AG in comparison with current practice, which showed a simpler process and comparative/improved clinical outcomes. It is also a more cost effective treatment choice.	**SD**

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	Agreed: The JAPC committee supported DCHSFT in the use of Urgo Clean AG.	**SD**
b.	**Letter regarding the use of Cannabidiol with clobazam** Mr Dhadli advised that a letter in regards to NICE TA614 and TA615 Cannabidiol with clobazam for treating seizures associated with Lennox–Gastaut syndrome and Dravet syndrome has been tabled for information. The letter looks at who this is recommended for and the clinical criteria. NHS England will commission cannabidiol with clobazam from 6th January 2020 within specialised centres. The specialised centres local to Derbyshire are Nottingham, Sheffield and Leicester.	
10.	**REGIONAL MEDICINES OPTIMISATION COMMITTEE (RMOC)**	
a.	**Free of charge medicines scheme** The RMOC have produced a recommendations paper on free of charge medicines schemes. Mr Dhadli confirmed that DDCCG include a section on this within the Derbyshire prescribing specification document. Both acute providers are aware to notify DDCCG of free of charge schemes and DDCCG would consider the governance arrangements and risk to the organisation. Dr Goddard and Ms Brailey advised that they are planning to review the UHDBFT free of charge medicines policy against the RMOC recommendations. Mr Dhadli advised that DDCCG are required to see any free of charge medicines scheme being offered or considered by the trust, the process would involve this being tabled at a UHDBFT Drugs & Therapeutics meeting with CCG representation.	
b.	**Medicines Prior Approval Forms** Mr Dhadli stated that RMOC have published information in regards to principles for prior approvals. The document suggests that if a prior approval process is to be used and completed then it should be relevant. Mr Dhadli confirmed that the processes outlined by RMOC principles are being followed in Derbyshire.	
c.	**Sequential use of biologic medicines** Mr Dhadli reported that the RMOC document states within the publication a specific line 'A policy adopted by a commissioner that would serve to limit patients' access to appropriate treatments based on a number of prior treatments being attempted would be counter to the provisions of the NHS Constitution. The NHS Constitution pledges that patients have the right to drugs and treatments that have been recommended by NICE subject to being clinically appropriate and patients have the right to expect local decisions on the funding of drugs and treatments to be made rationally and following the proper consideration of evidence. Clinical assessment of the appropriateness of treatments should be the overriding factor rather than the implementation of policies for costs saving reasons'. A discussion took place and committee members agreed that if a clinical decision has been made and it can be demonstrated that it has been through an MDT process and all evidence has been considered, then this should be in line with the advisory statement. The JAPC committee suggested that the	

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	local guidelines for sequential use of biologic medicines be reviewed to ensure it is in line with the RMOC recommendations.	**SD**
11.	**JAPC BULLETIN**	
	The January 2020 bulletin was ratified.	**SD**
12.	**MHRA DRUG SAFETY UPDATE**	
a.	The MHRA Drug Safety Alert for January 2020 was noted. Mr Dhadli highlighted the following MHRA advice: • E-cigarette use or vaping: reporting suspected adverse reactions, including lung injury – authorities in the USA are investigating a multistate outbreak of e-cigarette or vaping associated lung injury. Currently, the volume and pattern of adverse respiratory events reported in association with e-cigarette use or vaping in the UK do not seem to reflect the trends emerging from the USA. This difference of magnitude may be due to difference in regulations. • Ondansetron: small increased risk of oral clefts following use in the first 12 weeks of pregnancy - recent epidemiological studies suggest exposure to ondansetron during the first trimester of pregnancy is associated with a small increased risk of the baby having a cleft lip and/or cleft palate. • Mecasermin (Increlex▼): risk of benign and malignant neoplasia - cases of benign and malignant neoplasms have been observed among children and adolescents who received treatment with mecasermin. The advice is not to use mecasermin in children or adolescents with active or suspected neoplasia or with any condition or medical history that increases the risk of benign or malignant neoplasia. • Letters and drug alerts sent to healthcare professionals in December 2019: o Insuman – permanent discontinuation of 3 presentations o Update – Valproate Pregnancy Prevention Programme o Ranitidine – further recalls • Medical Device Alerts issued in December 2019: o Arrow EZ-IO intraosseous vascular access needle sets – risk of needle stick injury. o Recall of Medicina IV Luer Slip syringe (IVS03) batch number 19040303 (MDA/2019/043) o Spectra Optia apheresis: anticoagulant bags used with ‘Correct Connect’ connectors – risk of unbroken ‘frangible’ connector during use (MDA/2019/041).	
b.	**<u>Novel coronavirus</u>** Mr Dhadli reported that the Department of Health and Social Care have released some advice for clinical staff in regards to the coronavirus. It has been tabled at the JAPC meeting for information; however Mr Dhadli suggested that a statement is added into the JAPC bulletin to raise awareness that there is a link to the latest documents on the Derbyshire Medicines Management website.	**SD**
13.	**HORIZON SCAN**	
a.	**<u>Monthly Horizon Scan</u>** Mr Dhadli advised JAPC of the following new drug launches, new drug	

Item		Action
	formulations, licence extensions and drug discontinuations: • Naldemedine (Rizmoic) – classified as BLACK await clinician request or NICE guidance • Vernakalant (Brinavess) – classified as BLACK await clinician request or NICE guidance Licence extensions: • Insulin glargine (Toujeo) – previously classified as **BROWN after consultant/specialist initiation** • Lenalidomide (Revlimid) – previously classified as **BLACK/RED** • Trastuzumab emtansine (Kadcyla) – previously classified as **RED** • Valsartan (Diovan) – no current traffic light classification Drug discontinuations: December 2019 • Copegus (Ribavirin) • Calmurid • Aptivus Oral Solution (Tipranavir) • Varuby (Rolapitant) • Transvasin (Salicylate) • Serenace (Haloperidol) • Prozac (Fluoxetine) • Prozac liquid (Fluoxetine) • Isotrexin (Erythromycin/isotretinoin) • Duavive (Oestrogen/bazedoxifene) January 2020 • Altacite Plus (Co-simalcite) • Alzhok (Memantine) • Clarelux (Clobetasol) • Dolmatil (Sulpiride) • Uro-Tainer Chlorhexidine (Chlorhexidine) • Xiapex (Collagenase) • Zerit (Stavudine) • Zytram (Tramadol)	
14.	**NICE SUMMARY**	
	Mrs Qureshi informed JAPC of the comments for the CCG which had been made for the following NICE guidance in January 2020: TA616 Cladribine for treating relapsing-remitting multiple sclerosis – to remain classified as **RED** (NHS England as per NICE TA616) TA617 Lusutrombopag for treating thrombocytopenia in people with chronic liver disease needing a planned invasive procedure – classified as **RED** (as per NICE TA617) TA618 Atezolizumab with carboplatin and nabpaclitaxel for untreated advanced non-squamous non-small-cell lung cancer (terminated appraisal) – classified as **BLACK** (NHS England as per NICE TA618) (Terminated	

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	appraisal) TA619 Palbociclib with fulvestrant for treating hormone receptor-positive, HER2-negative, advanced breast cancer – classified as **RED** (as per NICE TA619) TA620 Olaparib for maintenance treatment of relapsed platinum-sensitive ovarian, fallopian tube or peritoneal cancer – to remain as **RED** (as per NICE TA620) TA621 Osimertinib for untreated EGFR mutation-positive non-small-cell lung cancer – classified as **BLACK** (as per NICE TA621)	
15.	**GUIDELINE GROUP ACTION TRACKER**	
	The summary of key messages from the Derbyshire Medicines Management Shared Care and Guideline Group meeting held in January 2020 was noted. Mr Dhadli highlighted the following: Traffic Lights: • Cimetidine – de-classified due to drug shortage • Ranitidine – re-classified as GREEN subject to availability and if it can be sourced from a local pharmacy • True Results test strips – de-classified • Stalevo (carbidopa, entacapone, levodopa) – de-classified removed from traffic lights, whilst awaiting BLACK traffic light review • Nifedipine MR – classified as GREEN for angina and raynaulds phenomenon (unlicensed indication) • Nifedpine IR caps – classified as BROWN restricted for patients with raynaulds phenomenon who do not tolerate MR preparation Formulary Update (Chapter 2 – Cardiovascular System): • Chapter 2: amiodarone SCA link added. Sections 2.5.5.1 Enalapril moved to the bottom of ACEI list. Section 2.5.5.2 – the following wording has been added - when choosing antihypertensive drug treatment for adults of black African or African-Caribbean family origin, consider an angiotensin II receptor blocker (ARB), in preference to an angiotensin-converting enzyme (ACE) inhibitor. See hypertension guideline. Section 2.9 – dipyridamole removed from formulary list and added to the notes below. Flow chart in appendix 3 – felodipine and MR nifedipine removed • Chapter 3: Note added regarding slo-phyllin discontinuation • Chapter 13: Anthelios XL sunscreen removed from the skin chapter, due to out of pocket expenses incurred on prescribing • Chapter 6: GG recognised NICE guidance on starting doses of levothyroxine for patients with primary hypothyroidism; however local endocrinologist advice is to start at low dose and taper the dose up according to biomarkers and QoL markers. Carbimazole – note included to check FBC/LFT prior to initiating carbimazole, but not to recheck unless there is suspicion of agranulocytosis or liver dysfunction (as per UKMI drug monitoring) • Chapter 6: GlucoRx Carepoint Ultra – 4mm/32g included as formulary	

Item		Action
	choice Clinical Guidelines: • T2DM guidance – information added to front page regarding BP and lipid management • Neuropathic pain – extra wording added to gabapentin dosage – "increase in 300mg/day increments every 2-3 days, but dependent on patient factors it can take up to a week" Website Changes/Miscellaneous: • COPD detail aid updated to be in-line with local COPD guidance • ICS stepdown updated with reference to local COPD guidance • Guidance for fosfomycin for the treatment of multi-resistance UTI has been removed from the website due to general availability of fosfomycin through the community pharmacy. A link to local guidance in the traffic lights has also been removed • JUCD recurrent UTI pathway and PIL – GG acknowledge antimicrobials included are as per NICE guidance Guideline Timetable: • The guideline table action summary and progress was noted by JAPC	
16.	**TRAFFIC LIGHTS – ANY CHANGES?**	
	Classifications UrgoStart – BROWN consultant/specialist initiation for use under the care of a multi-disciplinary foot team. To be used for diabetic foot ulcer only (not for venous leg ulcer) Vitamin B Compound Strong – BROWN consultant/specialist recommendation for patients with a medically diagnosed deficiency due to lifelong or chronic condition, or following surgery that results in malabsorption. Also for refeeding syndrome – short course to be supplied in hospital or in exceptional circumstances GPs may prescribe following a community dietician request Silver dressings – BROWN/BLACK: BROWN – Atrauman Ag, Suprasorb A+Ag and Aquacel Ag+ extra - to be used for 2 weeks and then reviewed BROWN – Acticoat-flex 3 - used as part of VAC therapy with Smith and Nephew pump and on TVN recommendation BROWN – Urgotul Silver and Aquacel Ag+ Ribbon - to be used on TVN recommendation only BROWN – UrgoClean Ag & UrgoClean - TVN recommendation only. To be used for 2 weeks then complete treatment with UrgoClean. To treat infections with biofilm in line with DCHSFT guidance All other silver dressings are classified as BLACK Naldemedine – BLACK awaiting NICE guidance Vernakalant – BLACK awaiting NICE guidance or clinician request Cladribine – RED (NHS England as per NICE TA616) Lusutrombopag – RED (as per NICE TA617) Atezolizumab – BLACK (NHS England as per NICE TA618, terminated appraisal) Palbociclib – RED (NHS England as per NICE TA619) Olaparib – RED (NHS England as per NICE TA620)	

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	Osimertinib – BLACK (NHS England as per NICE TA621)	
17.	**MINUTES OF OTHER PRESCRIBING GROUPS**	
	• DHcFT Drugs and Therapeutics Committee 24/10/2019 • DHcFT Drugs and Therapeutics Committee 28/11/2019 • Sheffield Area Prescribing Group 21/11/2019 • UHDBFT Drugs and Therapeutics Group 17/12/2019 • Chesterfield Drugs and Therapeutics Committee 21/01/2020 The following items were highlighted in the Sheffield Area Prescribing Group minutes: • Newly diagnosed patients with a diagnosis of Autistic Spectrum Disorder (ASD) or Smith-Magenis Syndrome (SMS), where sleep hygiene measures had been insufficient would be prescribed Slenyto®. For new patients who do not present with ASD or SMS, Circadin® would continue to be prescribed.	
18.	**ANY OTHER BUSINESS**	
a.	**Prescribing in gender dysphoria** Mr Dhadli stated that he has received an email from Ms J Derricott Head of Primary Care Quality and she has asked if JAPC can discuss areas surrounding prescribing for gender dysphoria patients as some issues have been highlighted. Dr Markus advised that this has been raised because there is currently a gap within the service. When a patient is seen in a gender dysphoria treatment clinic they are advised on what treatment or prescriptions they need and they are then discharged back to the GP to provide these. The prescriptions are unlicensed and the British Medical Association's (BMA's) viewpoint is that GP's should not be involved in monitoring and prescribing of unlicensed medications if they do not have the expertise. There is a national programme for developing through specialised commissioning, extra gender dysphoria community services out of a hospital setting. They are currently being piloted in Manchester and London. Wales have reached a national solution however England has not yet agreed one. Mr Dhadli confirmed that advice should be followed from the General Medical Council and BMA guidance which is detailed on the Derbyshire Medicines Management website.	
b.	**Prescribing Medicines Review** Dr Taylor reported that at the JAPC meeting in December 2019, a publication by Public Health England (Prescribing Medicines Review) was discussed. The document highlights people on antidepressants where prescriptions exceed 3 years; Dr Taylor wanted to add that at the DHcFT meeting in January 2019, members felt that this message was wrong. A third of the people estimated on antidepressants for 3 years do need to be on these due to severe recurrent depression or treatment resistant depression.	
c.	**Vitamin supplements** Dr Goddard advised that the local bariatric team have responded to say that	

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

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	they do not feel that vitamin supplements should be bought over the counter. This will be discussed at a future JAPC meeting.	**WG**
19.	**DATE OF NEXT MEETING**	
	Tuesday, 10th March 2020 at 1.30pm in the Coney Green Business Centre, Clay Cross.	