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DERBYSHIRE JOINT AREA PRESCRIBING COMMITTEE (JAPC)

Minutes of the meeting held on Tuesday 8 July 2014

CONFIRMED MINUTES

Summary Points

Traffic lights

Drug	Decision
Emerade	GREEN
Epipen	GREEN
Alfuzosin	GREEN 3rd line alpha blocker choice for BPH
Balance Activ Rx and other Vaginal PH correction products (e.g Balance Activ BV, Multi-Gyn ActiGel, Relactagel)	BLACK
Canagliflozin	BROWN after specialist initiation as per NICE TA 315
Levonorgestrel 13.5mg intrauterine device (Jaydess)	BROWN 2nd line to Mirena for licensed indications
5 FU (Efudix)	GREEN
Alemtuzumab	RED (NHS England)
Elosulfase alfa	RED (NHS England)
Pixantrone	RED (NHS England)
Posaconazole	RED (NHS England)
Simeprevir	RED (NHS England)
Sorafenib	RED (NHS England)
Tocilizumab	RED (NHS England)
Saxagliptin and metformin (Komboglyze)	BROWN
Sitaglitpin and metformin (Janumet)	BROWN
Vildagliptin and metformin (Eucreas)	BROWN
Linagliptin and metformin (Jentadueto)	BROWN
Alogliptin and metformin (Vipdomet)	BROWN

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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
Dr M Watkins	GP
North Derbyshire CCG	
Dr C Emslie	GP
Dr D Fitzsimons	GP
Mrs K Needham	Head of Medicines Management North (also representing Hardwick CCG)
Hardwick CCG	
Dr T Parkin	GP
Derbyshire County Council	
Mrs S Qureshi	NICE Audit Pharmacist
Derby 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	
Ms C Duffin	Senior Pharmacist
Derbyshire Community Health Services NHS Trust	
Mr M Steward	Chief Pharmacist
In Attendance:	
Mr A Thorpe	Derby City Council (minutes)

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Item		Action
1.	**APOLOGIES**	
	Mr C Newman and Mr M Shepherd.	
2.	**DECLARATIONS OF CONFLICT OF INTEREST**	
	No declarations of interest were made.	
3.	**DECLARATIONS OF ANY OTHER BUSINESS**	
	No declarations of any other business were made.	
4.	**MINUTES OF JAPC MEETING HELD ON 10 JUNE 2014**	
	The minutes of the meeting held on 10th June 2014 were agreed as a correct record after the following amendments: Silk Garments – Amend to 'Agreed: Silk Garments, DermaSilk, DreamSkin and Skinnies) classified as a BROWN specialist initiation medical device and requires assessment. Elastabo Gel – Amend to 'It was listed as an appliance in part IXa of the drug tariff with price of £14.58.' Pivmecillinam - Pivmecillinam classified as a GREEN drug 2nd line for lower UTI (MSU confirmed).	
5.	**MATTERS ARISING**	
a.	**Domperidone** Dr Goddard reported that the position statement indicated that Derby gastro-enterologists would like to continue using long term domperidone as an option in the management of patients with gastroparesis although its use would be limited to: • Definite functional outlet delay evidenced by endoscopy and/or transit study. • Avoid in age > 60. • No significant heart disease, severe hepatic impairment, co-use of CYP3A4 inhibitors or QTc prolongating drugs or on pre-treatment ECG. • Under regular review by clinician. • Maximum dose 10mg tds. • Trial of limited courses with drug "holidays". Mr Dhadli queried whether this had also been accepted by the Chesterfield gastro-enterologists and Ms Duffin confirmed that no comments had been received. It was also queried whether the regular review by clinicians included primary care. Dr Mott stated that there was a large cohort of people currently on domperidone who were not under secondary care and may not need to continue with the drug. A statement was therefore needed for GPs to highlight the safety concerns in the recent MHRA drug alert and to state that patients on long term domperidone for non-specific indications other than gastraparesis needed to be withdrawn and re-assessed. Mrs Needham requested JAPC to also provide a statement for prescribers for prescribing domperidone for increasing lactation in breastfeeding. It was agreed that the UKMI statement on domperidone in breastfeeding would be	

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Item		Action
	considered at the next JAPC meeting. **Action:** The position statement would be amended to reflect that it was Derbyshire wide and the statement about regular reviews by clinicians would be clarified. **Agreed:** JAPC ratified the domperidone position statement with the agreed amendments.	**SD** **WG** **SD**
6.	**NEW DRUG ASSESSMENTS**	
a.	**Adrenaline injection - Emerade** Mr Dhadli reported that Emerade was a new pre-filled adrenaline injection available in three strengths (150/300/500 micrograms). Emerade was the only product currently available with a 500mcg dose and fitted with a 25mm needle (500mcg/300mcg); both of which were recommended by the UK Resuscitation Council. Details were given of the three different types of devices available: Emerade, Epipen and Jext. Emerade had a longer shelf life but the unit costs were slightly cheaper per shelf-life month and therefore could be a potential cost saving. Training was highlighted as a possible issue and Mr Steward advised that Emerade was to be discussed by the DCHS Resuscitation Committee with a recommendation that it should be the preferred product for use and was seen to be cost effective. Ms Duffin commented that Mr Shepherd would prefer not to change product as the nurses and patients would need to be retrained in turn. Dr Mott stated that it would be useful to know what the position of the two Acute Trusts was before recommending the preferred product. Supply problems had been previously been an issue but an assurance had been received from the manufacturer of Emerade that this would not be the case for Emerade. **Agreed:** Emerade 150/300, Emerade 500, Epipen 150/300 and Jext 150/300 all classified as **GREEN** medical devices.	**SD**
b.	**Alfuzosin** Mr Dhadli advised that alfluzosin mr 10mg tablets were listed in the drug formulary chapter as a third line option but had not been assigned a formal traffic light classification. A classification was requested by the guideline group. CKS had recommended once-daily formulations of alfuzosin, doxazosin, tamsulosin and terazosin for the treatment of lower urinary tract symptoms (LUTS) in men. Modified-release alfuzosin did not require dose titration and was well tolerated. NICE in the LUTS guidance does not state a preferred product and suggests a class effect. The recommended classification was green third line alpha blocker but it was highlighted that RDH recommended alfuzosin as a first line treatment. Dr Goddard would check with the consultant urologists why alfuzosin was the preferred treatment in RDH. **Agreed:** Alfluzosin classified as a **GREEN 3rd line** alpha blocker choice drug for BPH	**WG** **SD**

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Item		Action
c.	**Vaginal PH correction products** Mr Dhadli reported that a request had been received from North Derbyshire CCG for traffic light classifications to be assigned for vaginal pH correction products listed in the Drug Tariff. Mr Dhadli highlighted that there was no conclusive evidence for the effectiveness of these products. Ms Duffin added that CRH GUM had indicated that these would not be routinely used and then only for a small number of patients where other products had failed. **Agreed:** All vaginal pH correction products including Balance Activ classified as **BLACK** drugs.	**SD**
d.	**Canagliflozin** Mr Dhadli reported that canagliflozin is an orally administered selective SGLT2 inhibitor and was the second product to be released after dapagliflozin. Positive NICE TAs (TA 315 and TA 288) had been issued for both canagliflozin and dapagliflozin. Mr Dhadli pointed to the differences in the technology appraisals and licensing between the two products. Canagliflozin, but not dapagliflozin, was recommended when used for triple therapy. In terms of renal function it was possible with canagliflozin to go down to a lower eGFR but dapagliflozin was contraindicated in those less than 60ml/minute. There had been a DTB review of SGLT2 inhibitors in November 2013 and most of the studies had been of short duration. However incidences of bladder cancer and breast cancer had been identified together with increase in urinary tract infections and hypertension. Canagliflozin allows doses to be increased if the required reduction in HbA1c levels is not achieved. Mr Dhadli highlighted to JAPC members the increase cost of the 300mg strength, the lack of data of cost effectiveness after dose escalation and uncertainty patient numbers likely to need it. **Agreed:** Canagliflozin classified as a **BROWN specialist initiation** drug as per NICE TA 315. **Action:** The diabetes guidance would be updated to include the use of canagliflozin.	**SD** **SD**
e.	**Jaydess** Mr Dhadli advised that levonorgestrel 13.5mg intrauterine delivery system was a new formulation launched in March 2014. Mr Dhadli commented on the evidence from the NICE review on long-action reversible contraceptives (LARCs) published in June 2014 which had highlighted that the levonorgestrel 19.5 mg intrauterine delivery system used as a comparator in the study was not licensed or available commercially. There was insufficient evidence comparing the levonorgestrel 13.5 mg intrauterine delivery system with existing contraceptives including the levonorgestrel 52 mg intrauterine system (Mirena). In theory, the lower strength and smaller size of the new device could be advantageous to some women but requires more robust data.. This three year LARC is more expensive than the 5 year Mirena (annualised costs).	

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Item		Action
	During discussion Dr Emslie stated that there might be occasions when some patients may benefit from this rather than being referred to sexual health. Mr Steward advised that specialist sexual services would like to use the new product and obtain experience from its use. Dr Parkin commented that there were some issues associated with its use but it was another option. Mrs Needham referred to the lack of public health representation at the meeting to give a view on this which was particularly important now public health commissioned sexual health services. **Agreed:** Jaydess provisionally classified as a **BROWN 2nd line** to Mirena for licensed indications until the views of public health had been obtained.	**SD**
7.	**CLINICAL GUIDELINES**	
a.	**Actinic Keratosis (AK)** Mr Dhadli reported that North Derbyshire currently had an AK clinical pathway and there was an ongoing dermatology education programme for the identification and treatment of AK to differentiate from squamous cell carcinoma (SCC). A number of new products had been released which had led to the development of a Derbyshire-wide guideline. The dermatologists in north and south had worked together in the production of a flowchart which recommended the use of 5-FU and ingenol as treatment options. Mr Dhadli referred to the current traffic light classifications of the AK drugs and highlighted that fluorouracil 0.5% + salicyclic acid (Actikerall) and imiquimod 3.75% (Aldara) had not yet received classifications. Discussion followed on the classification of the AK agents and it was noted that Solaraze (diclofenac 3%) had not been included in the flowchart. In connection with Actikerall, Mr Dhadli stated that there had been a RDTC review which had generally concluded a lack of head to head to comparisons of the AK drugs and that they were all effective. Patient choice and compliance with treatment was a key element. The following actions were agreed: • The flowchart would be updated and re-submitted to JAPC. • Solaraze would continue to be classified as a green consultant/GPSI/dermatology champion initiation drug pending further consultation with the north and south dermatologists to ascertain the reasons and evidence for the exclusion of this drug from the flowchart. This would be further discussed at the next JAPC meeting. • 5-FU classified as a **GREEN** drug. • A traffic light classification for Actikerall would be delayed until further information was available.	**SD** **SD** **SD** **SD**
b.	**Atrial Fibrillation (AF)** Mr Dhadli reported that NICE had recently published CG 180 on AF which presented significant changes to current practice. Most notably it recommended that alongside warfarin the New Oral Anticoagulants (NOACs) of apixaban, dabigatran etexilate and rivaroxaban (all subject of NICE TAs) were made equally available and choice dependent on patient factors.	

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Item		Action
	Mr Dhadli highlighted some of the key points from the NICE CG: • The new NICE AF guidance recommended the use of CHA2DS-VASc scoring to assess stroke risk in people with AF. • There would be a significant increase in the workload for GPs and therefore it would be necessary to determine where warfarin fitted in alongside the NOACs. • The anticipated uptake for anticoagulation had been included in the costing template and it was estimated that currently 58% were diagnosed with AF with a CHADS score greater than 2. The use of a different risk tool would increase this figure to 84%. • The new AF guidance did not recommend the use of aspirin monotherapy and patients currently on aspirin would need to be reviewed and moved on to either a NOAC or warfarin or informed decision of no treatment. • The HAS-BLED score should be used to assess the risk of bleeding in people starting or who had started anticoagulation to enable prescribers to review any modifiable bleeding risk factors. • Patients would need to have a package of care. • There may be changes to the current clinical guideline in terms of INR values. • Rate control should be offered as a first-line strategy. • Anticoagulation should not be withheld solely due to the patient being at risk of falling. • Advice had been given on the use of digoxin monotherapy and amiodarone. • A NICE GP update had been produced which summarised all the key points including the use of CHA2DS2-VASc and HAS-BLED scoring. • A patient decision aid had been included to assist in decision making as to whether treatment should be started or not. During discussion Dr Goddard commented on the complexity of taking patients through a risk/benefit analysis of treatment. Dr Parkin stated that a basic guide for GPs for patients changing from aspirin would be advantageous and anticipated that there would be an increase in demand from patients. Dr Emslie stated that there was a potential risk in stopping aspirin for some patients who could be taking it for other indications. Dr Mott then referred to the annualised adverse drug rates of NOACs document from matters arising t. Mr Dhadli stated that the adverse drug reaction rates for warfarin, rivaroxaban, dabigatran and apixaban, together with the total number of prescription items dispensed had been compiled for the years 2011 to 2013. Shortfalls in the accuracy of the data were stated. The reported fatal outcomes per prescription items dispensed did not look favourable for NOACs compared to warfarin. However NICE had produced a collaborative statement which had concluded that the benefits of NOACs outweighed the risks. Dr Mott commented that it was important to have all the information available in order to make an informed decision and suggested that a time limited working group should be established in order	

Item		Action
	to work on the implications of new AF guidance with appropriate representation from across the health economy. This should include consideration of a preferred drug option and the work already undertaken at RDH on rivaroxaban and the action to be taken if a patient presented with bleeding. It would also be highly important to make it GP friendly particularly in view of the new patient decision making aids. Dr Mott added that the TTR value was currently 50% and suggested that this be changed in the interim to 65% as the local guidance was out of line with NICE – this was agreed by JAPC. **Action:** Mr Dhadli and Mrs Qureshi would produce a scoping document to outline the work which needed to be done in order to produce local AF guidance based on the NICE AF CG. This would include references to aspirin, TTR values, vitamin K antagonists and NOACs together with the recommendation from NICE that all the NOACs should be made available and the circumstances when one might be preferred over another. Consultation to be held with relevant specialists, INR leads and the GP members of JAPC. It was highlighted that a lot of work would be need to be done in connection with those patients who were currently on aspirin and the guidance should therefore reflect that the bulk of the work would be primary care facing. An initial draft of the guidance would be considered by JAPC at the meeting in August and ratified at the meeting in September. **Action**: A holding statement should be included in the newsletter to inform primary care about the work on AF guidance which JAPC had agreed should be completed by September and that this should include a reference to aspirin.	**SD/SQ**
8.	**PATIENT GROUP DIRECTIONS**	
a.	**Meningitis C** JAPC noted that the Meningitis C PGD had been authorised by the NHS England Derbyshire and Nottinghamshire Area Team following NHS England governance systems.	
b.	**Derbyshire Health United (DHU) PGDs** Mr Dhadli advised that the PGDs had gone through the DHU internal governance structures but required legal sign-off by a NHS organisation and, due to the numbers involved, this could result in considerable risk and liability. Mr Dhadli highlighted some of the amendments and additions which would need to be made to these PGDs. Dr Parkin suggested that DHU be requested to check each PGD against the DCHS published guidelines and other local and national resources. Mrs Hunter queried whether the Derby Open Access Centre should have the same range of PGDs. **Agreed:** The PGDs would be extended until October and then re-considered by JAPC once DHU had reviewed and updated them. **Action:** Mrs Needham and Mr Hulme would arrange for sign-off of the PGDs by an individual NHS organisation that commissions their service.	**SD** **KN/SH**

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9.	**SHARED CARE GUIDELINES**	
a.	**Disease Modifying Anti-Rheumatic Drugs (DMARDS)** JAPC had extended the review date of the shared care guidelines for DMARDS to April 2014 but the British Society for Rheumatology (BSR) was still in the process of updating national guidance. It was agreed that March 2015 should be the catch-up point for the review although this could be undertaken at an earlier point if the BSR updated guidance became available.	**SD**
b.	**Sulfasalazine** Mr Dhadli reported that there had been changes to the initial and on-going long-term monitoring to the summary of product characteristics for sulfasalazine. These new monitoring requirements would need to be updated in the current shared care agreements for sulfasalazine and monitoring document.	**SD**
10.	**MONTHLY HORIZON SCAN**	
	Mr Dhadli advised JAPC of the following new drug launches, new drug formulations and drug discontinuations: Alemtuzumab – NHS England red drug. Elosulfase alfa – For the rare disease of Morquio's syndrome and not yet on high cost Pbr excluded list. Red drug. Insulin degludec – Already classified with limitations to prescribing. Liraglutide in combination with insulin–To be left as per local diabetes guideline until a request for its use was received. Pixantrone – NHS England red drug. Posaconazole – NHS England red drug. Simeprevir – NHS England red drug. Sorafenib – NHS England red drug. Toclizumab – Agreement in place for its use in RDH as subcutaneous formulation. Drug discontinuations: Evolve Plus (Lanolin) Macrodantin (nitrofurantoin) Utinor (norfloxacin)	
11.	**MISCELLANEOUS**	
a.	**JAPC Annual Report** The JAPC Annual Report April 2013 to March 2014 was received for information. It was agreed that attendance at all JAPC meetings should be included in the reports. Thanks were expressed to Mrs Qureshi for her work in compiling the Annual Report.	**SQ**
b.	**Gliptin Combination Products** Mrs Qureshi reported that, following the re-classification of the gliptin products at the June JAPC meeting, the combination products of saxagliptin and metformin (Komboglyze); sitagliptin and metformin (Janumet) and	

Item		Action
	vildagliptin and metformin (Eucreas) required traffic light classifications. There were two additional combination products of linagliptin and metformin and alogliptin and metformin which also needed to be classified. **Agreed:** All gliptin combination products classified as **BROWN** drugs only for use for people who had been stabilised, require the individual drugs and where there were compliance issues.	**SD**
c.	**<u>P1NP Testing</u>** Mrs Needham reported that the Sheffield Hospitals were requesting practices in North Derbyshire to carry out serum P1NP testing which was one of a number of biochemical markers of bone turnover that could be measured to monitor compliance and response to drug therapy. However it was noted that did not appear to have gone through commissioning process. CRH did not do the testing but GPs requested the bloods to be sent to Sheffield for interpretation. Mrs Needham added that it would therefore be useful to issue a statement from JAPC to indicate whether the testing was recommended or not. Mr Dhadli advised that in Derby P1NP was used and limited but done within RDH itself. In-patients on teriparatide were monitored. Dr Mott queried whether GPs would be requested to take on this testing and Mr Dhadli stated that there was no national guidance and only a reference to specialist centres. It was agreed that Mrs Needham would write to Sheffield Hospital to convey the recommendation of JAPC that P1NP testing would not be commissioned in Derbyshire.	**KN**
d.	**<u>Terms of Reference</u>** Mr Dhadli referred to the JAPC terms of reference and highlighted: • Healthwatch Derbyshire had now withdrawn as lay representatives but would remain on the circulation list and be sent the minutes and agenda of meetings. • Derby City and Derbyshire County Public Health were not represented. Dr Mott reported that following the last JAPC meeting letters had been sent to the City and County Directors of Public Health. A meeting had subsequently been held with Dr Robyn Dewis, Derby City Consultant in Public Health Medicine. It had been agreed that Dr Dewis would receive the agendas for meetings and attend the JAPC pre-meetings where possible. In addition the agendas would be compiled so that items which required public health input would be scheduled every quarter and Dr Dewis would attend these particular meetings. No response had as yet been received from the County Public Health department who need to ensure that they had capacity and could add value. • Responsibility of the members to consult members of their trust before meetings. • Guidance had been given to JAPC members concerning the legal duty under the Equality Act 2010 (Public Sector Equality Duty) and the Human Rights Act 1988 to give due regard in the decision making process to the needs of the Protected Groups covered by the	

Item		Action
	Act. A one page document had been produced by the Greater East Midlands Commissioning Support Unit on quality inclusion and human rights and this would be included in the member's induction pack. The following amendments were agreed: • Mr C Newman, RDH Chief Pharmacist, to be added to the Derby Hospitals Trust membership. • The reference to JAPC website to be amended to Medicines Management website. The amended terms of reference would be circulated to JAPC.	**SD** **SD** **SD**
e.	**<u>Drugs and Therapeutic Committee – Implementing Drug Safety Updates</u>** JAPC noted this for information.	
f.	**<u>MTRAC – Avanafil Verdict</u>** This was noted for information. Mr Dhadli commented that this supported the decision made by JAPC to classify avanafil as a brown second line drug for those patients who were intolerant to sildenafil.	
g.	**<u>Pharmaceutical Price Regulation Scheme</u>** JAPC noted this for information.	
12.	**JAPC BULLETIN**	
	The June JAPC bulletin was ratified.	
13.	**MHRA DRUG SAFETY UPDATE**	
	The MHRA Drug Safety Update for June 2014 was noted. Mr Dhadli highlighted the following: • New warnings about the combination use of medicines from different classes of renin-angiotensin system blocking agents and risk of hyperkalaemia, hypotension, and impaired renal function. The local hypertension guidelines and BNF chapter had been updated to reflect the changes. This alert would be included in the newsletter and discussed at the September prescribing leads meeting. • There was emerging clinical trial evidence of ivabradine of increased cardiovascular risk and the need to carefully monitor for bradycardia. The local position for ivabradine was that it should only be continued by GPs following a period of four weeks on optimised standard therapy with ACEI, beta-blocker and aldosterone antagonists.	**KN/SD**
14.	**NICE SUMMARY**	
	Mrs Qureshi informed JAPC of the comments for the CCGs which had been made for the following NICE guidance issued in June. TA 314 Implantable cardioverter defibrillators and cardiac resynchronisation	

Item		Action
	therapy for arrhythmias and heart failure. TA 315 Canagliflozin in combination therapy for treating type 2 diabetes.	
15.	**TRAFFIC LIGHTS – ANY CHANGES?**	
	Classifications Emerade – GREEN Epipen – GREEN Alfuzosin – GREEN 3rd line Balance active and Vaginal PH correction products – BLACK Canagliflozin – BROWN as per TA 315 Jaydess – BROWN 5 FU (Efudix) - GREEN Alemtuzumab – RED (NHS England) Elosulfase alfa – RED (NHS England) Pixantrone – RED (NHS England) Posaconazole – RED (NHS England) Simeprevir – RED (NHS England) Sorafenib – RED (NHS England) Tocilizumab – RED (NHS England) Saxagliptin and metformin (Komboglyze) – BROWN Sitaglitpin and metformin (Janumet) – BROWN Vildagliptin and metformin (Eucreas) – BROWN Linagliptin and metformin (Jentadueto) – BROWN Alogliptin and metformin (Vipdomet)- BROWN	
16.	**JAPC ACTION SUMMARY**	
	The action summary was noted by JAPC and amendments made: Shared Care Disulfiram and Acamprosate – Dr Taylor reported that the June DHcFT DTC meeting had been cancelled and this would now be discussed at the July meeting. Actinic Keratosis – To be brought to the August JAPC meeting. Lixisenatide – To be brought to the October JAPC meeting. Domperidone and gastroparesis – To be taken off. Domperidone and breast feeding would be brought to the August JAPC meeting. NOACs – Draft local guidance to be brought to the August JAPC meeting and a final version to the September JAPC meeting. DHU PGDs – To be brought to the October JAPC meeting.	**ST** **SD** **SD** **SD** **SD/SQ** **SD**
17.	**GUIDELINE GROUP**	
	The summary of key messages arising from the meeting held in June 2014 was noted. Mr Dhadli highlighted the following:	

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Item		Action
	• Oxycodone – A UKMI update had been added to the medicines management website. • Emerade auto-injector – This has been discussed by JAPC. • Chapter 1: GI – The formulary chapter had been updated to reflect licensed sulfasalazine (EC or plain) • Chapter 11: Dry eye treatment guideline for primary care – Xaillin night, tear-lac, Xailin gel and Xailin fresh 0.5% had been added to the formulary. • Chapter 6: Endocrine – Strontium had been removed from the formulary chapter. • Osteoporosis Guideline – Etidronate had been removed as it had been discontinued and the MHRA warning for strontium included. • Chapter 7: Combined Hormonal Contraceptives – These had been updated to reflect the most cost effective choices. • Chapter 6: HRT – This was currently being updated.	
18.	**MINUTES OF OTHER PRESCRIBING GROUPS**	
	• Derbyshire Healthcare Foundation Trust Drugs and Therapeutic Committee 22.5.14 • Derby Hospitals NHS Foundation Trust Drugs and Therapeutic Committee 20.5.14 • Sheffield Area Prescribing Group 20.5.14	
19.	**ANY OTHER BUSINESS**	
	There were no other items of business.	
20.	**DATE OF NEXT MEETING**	
	Tuesday, 12th August 2014 at 1.30pm in the Post Mill Centre, South Normanton.	