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DERBYSHIRE JOINT AREA PRESCRIBING COMMITTEE (JAPC)

Minutes of the meeting held on Tuesday 9 September 2014

CONFIRMED MINUTES

Summary Points

Traffic lights

Drug	Decision
Fluorouracil (Efudix) 5% cream	GREEN specialist initiation 1st line choice. Specialist initiation includes GPSI and GPs who have attended the Derbyshire AK pathway training.
All formulations of alprostadil	BROWN after specialist initiation as per SLS criteria; usually 2nd line to a PDE-5 inhibitor
Fluarix tetra	GREEN: Fluarix Tetra (quadravalent vaccine) 2nd line to nasal preparations, as per national immunisation programme for children aged 3 up to 18 years. Remains BLACK for adults (aged 18 years and over).
Fluticasone propionate nasal drops	GREEN consultant/ specialist initiation for the management of chronic rhinosinusitis with nasal polyps.
Ordansetron	BROWN specialist initiation for treatment of hyperemesis gravidarum (the specialist to specify the dose and length of treatment for the patient).
Dimethyl fumarate	RED as per NICE TA 320 treatment option for adults with active relapsing-remitting multiple sclerosis.

Clinical Guidelines
Atrial Fibrillation

Shared Care Guidelines
Apomorphine
Somatropin

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Present:	
Southern Derbyshire CCG	
Dr A Mott	GP (Chair)
Mr S Dhadli	Specialist Commissioning Pharmacist (Secretary)
Mr S Hulme	Director of Medicines Management
Mrs S Qureshi	NICE Audit Pharmacist
Dr M Watkins	GP
North Derbyshire CCG	
Mrs K Needham	Head of Medicines Management North (also representing Hardwick CCG)
Hardwick CCG	
Dr T Parkin	GP
Derby City Council	
Dr R Dewis	Consultant in Public Health Medicine
Derbyshire County Council	
Derby Hospitals NHS Foundation Trust	
Dr W Goddard	Chair- Drugs and Therapeutic Committee
Mr C Newman	Chief Pharmacist
Derbyshire Healthcare NHS Foundation Trust	
Dr S Taylor	Chair – Drugs and Therapeutic Committee
Chesterfield Royal Hospital NHS Foundation Trust	
Mr M Shepherd	Chief Pharmacist
Derbyshire Community Health Services NHS Trust	
Mr M Steward	Chief Pharmacist
In Attendance:	
Ms S Bassi	Chief Pharmacist (interim) - DHcFT
Dr B Rush	CESR Trainee A and E – DHFT
Mr A Thorpe	Derby City Council (minutes)

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Item		Action
1.	**APOLOGIES**	
	Dr C Emslie and Dr D Fitzsimons.	
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 12 AUGUST 2014**	
	The minutes of the meeting held on 12th August 2014 were agreed as a correct record after the following amendment: Antimicrobial Treatment Guidelines/Antimicrobial Guidance for the Management of Lower UTI in Chronic Kidney Disease (CKD) – Amend to ' Mr Hulme reported that RDH would be releasing the sensitivity testing for pivmecillinam for lower UTIs and CRH would if resistance clinically indicated and then routinely on all samples.	
5.	**MATTERS ARISING**	
a.	**Summary Points - Traffic Lights** Mr Dhadli stated that the Actinic Keratosis (AK) guideline had been ratified at the last JAPC meeting and that a recommendation had been made to change the classification of Fluorouracil 5% (Efudix) cream from green to green specialist initiation so that it was in line with the other AK products. Mr Dhadli added that Dr Bleiker, RDH Consultant Dermatologist, agreed that all the AK products should have the same classification. Mrs Needham commented that Efudix should be the preferred 1st line AK product. **Agreed:** Efudix classified as GREEN 1st line drug after consultant/ specialist initiation (Specialist initiation includes GPSI and GPs who have attended the Derbyshire AK pathway training).	**SD**
b.	**Alfuzosin** Dr Goddard stated that it was unclear why the RDH consultant urologists were using alfuzosin as the preferred treatment for LUTS and that RDH would adhere to the JAPC formulary.	
c.	**Derbyshire Health United (DHU) Patient Group Directions (PGDs)** Dr Mott reported that he had written to DHU, with a copy sent to North Derbyshire CCG, to convey the concern expressed by JAPC at the lack of assurance about the PGDs. Mrs Needham had subsequently met with DHU and had been informed that the PGDs had been withdrawn from use and all services adjusted to ensure that the impact on patients of this was minimised. DHU was now looking for a pharmacist to assist with the development of the PGDs. Dr Mott added that a letter had been received from DHU to confirm that they were not using PGDs in out of hours or at the Walk In Centre and had made alternative arrangements to ensure that a prescriber was always on site to ensure that the treatment of patients would not be affected.	

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d.	**Low Molecular Weight Heparins (LMWH)** Mr Dhadli reported that no response had been received from RDH about the LWMH Shared Care Agreement and it was assumed that they had no comments to make. This had now been placed on the website.	
e.	**Traffic Lights** Mr Dhadli reported that the definitions concerning the consultant/specialist initiation and consultant/specialist recommendation had now been added to the prescribing specification.	
f.	**NICE Summary** Dr Mott commented on the use of the eGFR cystatin C test to assist with Chronic Kidney Disease (CKD) diagnosis which was referred to in the NICE CG 182 guideline on CKD. Dr Mott had understood from the hospital that it could be used but this was not recommended by either the renal team or laboratory. It was therefore anticipated that the NICE guideline would have limited impact.	
6.	**NEW DRUG ASSESSMENTS**	
a.	**Alprostadil Cream** Mr Dhadli reported that alprostadil topical cream was a new product which had been highlighted through the horizon scan last month for the treatment of erectile dysfunction. The evidence cited came from two double-blind placebo controlled studies using the 300mg formulation as this was the only one licensed in the UK. There was also a phase 3 randomised double-blind placebo controlled study which used the different strengths available of 100mg, 200mg and 300mg. Mr Dhadli highlighted that in all the trials patient outcome data had been used and demonstrated that the product, which was another formulation of a currently used drug, was effective. It was recommended that all formulations of alprostadil should be classified as 2nd line brown drugs following specialist initiation using the SLS criteria and that this should also include Caverject and Viridal Duo. Sildenafil tabs 25mg, 50mg and 100mg would continue to be the preferred first line treatment option for erectile dysfunction. **Agreed:** All forms of alprostadil classified as **BROWN specialist initiation** drugs. **Agreed:** Caverject and Viridal Duo classified as **BROWN specialist initiation** drugs.	**SD** **SD**
b.	**Fluarix Tetra** Mrs Needham advised that Fluarix Tetra was currently classified as a black drug but it was now included in the Department of Health's Seasonal Influenza Plan as an option for children who were unable to use a nasal product. In the light of this it had been proposed that Fluarix Tetra be re-classified as green for children/young people aged 3 to 18 according to the national immunisation programme. **Agreed:** Fluarix Tetra classified as a **GREEN 2nd line drug** as per the	

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	national seasonal influenza immunisation programme for children from 3 up to 18 years of age who could not tolerate the nasal spray. **Agreed:** Fluarix Tetra to remain classified as a **BLACK** drug for adults aged 18 years and over.	**SD**
c.	**<u>Fluticasone Nasules</u>** Dr Goddard stated that fluticasone Nasules had been approved by the RDH Drugs and Therapeutic Committee for the treatment of chronic rhinosinusitis (CRS) with nasal polyps. This had been approved on the basis that there was an existing treatment for CRS with beclomethasone drops which were effective but had a high risk of significant cortico-adrenal suppression. Fluticasone was an effective treatment and did reduce symptoms. It was more expensive but had a lack of systemic effects and therefore was a potential long-term treatment. Steroid nasal drops were more concentrated and hence more effective in CRS with polyps. Betamethasone nose drops has been used historically for the treatment of this. Mr Dhadli referred to the Drugs and Therapeutic Committee clinical review and the section on systemic bioavailability and the reference to the Fowler et al study which compared HPA axis suppression for fluticasone versus betamethasone. Mr Dhadli highlighted that only 18 patients had been recruited into the study and had been a volunteer research study of short duration only eight weeks. It had been noted that betamethasone was absorbed systemically leading to significant effects on the HPA axis and that sudden discontinuation can lead to an adrenal crisis. Fluticasone, which was minimally absorbed and did not affect the HPA axis, was available as a Nasule. The UK ENT guidance also included both fluticasone and beclomethasone but did not recommend one product over another. Mr Dhadli highlighted to JAPC that he believed that fluticasone Nasule should not be the preferred product. It was noted that fluticasone Nasule was used in the south of the county but not the north. **Agreed**: Fluticasone Nasules classified as a **GREEN consultant/specialist initiation** drug for the management of chronic rhinosinusitis with nasal polyps. **Action**: More work to be undertaken in order to ascertain patterns of use, existing expenditure and current variations in practice. This would be added to the action tracker. **Action:** Mr Dhadli would send the Fowler et al paper to Dr Goddard and ascertain what the position was at Chesterfield Royal Hospital.	**SD** **SD** **SD**
d.	**<u>Indapamide</u>** Mr Dhadli stated that JAPC had ratified two treatment pathways for the treatment of hypertensive patients: • Newly diagnosed patients with Ambulatory Blood Pressure Monitoring (ABPM) – NICE CG 127. • Newly diagnosed patients or continuation of treatment in stable patients diagnosed using Clinic Blood Pressure Monitoring (CBPM) –	

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	NICE CG 34. At the time of the NICE publication it had been agreed that bendroflumethiazide would stay on the formulary for CBPM and immediate release indapamide for ABPM. Indapamide 2.5mg immediate release had been classified as green in 2011 but the modified release (MR) formulation had been classified as brown in 2013. JAPC reclassified both forms of indapamide as brown due the significant rise in cost. This has now changed again and the August 2014 drug tariff shows a reduced price for the immediate release preparation. JAPC was conscious that prices could continue to fluctuate and had taken a pragmatic step to deal with this. **Agreed:** Bendroflumethiazide would remain first line choice diuretic and the thiazide diuretics, including indapamide 2.5mg and indapamide MR. would be 2nd line and choice based on the lowest acquisition cost.	**SD**
e.	**<u>Nortriptyline</u>** Mr Dhadli advised that the Derbyshire neuropathic pain guideline included nortriptyline as a second line option to amitriptyline where a tricyclic antidepressant (TCA) was being considered. It was noted that the tariff and seen a significant increase in the cost of nortriptyline and advice had therefore been sought from the RDH and CRH consultants about an alternative tricyclic antidepressant. Dr Faleiro, RDH Consultant, following consultation with colleagues at RDH and CRH, had suggested replacing nortriptyline with imipramine as a second line TCA. The guideline group had agreed to update the neuropathic pain guidelines by the removal of nortriptyline and addition of imipramine as a second line TCA to amitriptyline. However the consultants had indicated that they wished to retain nortriptyline as a third line option and it was noted that there were other indications for its use by the maxillofacial and ENT departments for facial neuralgia and neurology for migraine. **Agreed:** Amitriptyline to be the first line TCA. Second line TCA choice to be based on the lowest acquisition cost.	**SD**
f.	**<u>Ondansetron</u>** Dr Goddard stated that this had arisen from an audit of inappropriate requests for prescriptions in primary care and a request from the obstetricians to use ondansetron for hyperemesis gravidarum (HG). It was therefore decided to seek a traffic light classification for ondansetron for this indication as this was referred to in the national guidance for the treatment of HG. All other options for treatment of HG were also unlicensed for use in pregnancy and the evidence suggested that ondanestron was considered safe. Ondansetron is already classified as a BROWN drug for the licensed indications for palliative care and chemotherapy. **Agreed:** Ondansetron classified as a **BROWN specialist initiation** drug for the treatment of HG. Clear advice to be supplied to GPs concerning length of treatment, dose and when to stop treatment.	**SD**

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Item		Action
h.	**<u>Thiamine</u>** Mrs Needham referred to ongoing discussions about vitamin supplementation in alcohol withdrawal syndrome patients and the guideline group had therefore requested clarity and consensus on which supplements should be prescribed post discharge from hospital and on duration of treatment. RDH, CRH and DHcFT all had different guidelines for vitamin supplementation in alcohol withdrawal syndrome. Mr Dhadli referred to a Cochrane review on the evidence for thiamine in alcohol-dependent people which had concluded that thiamine could be recommended for alcohol dependency to prevent the consequences of severe malnutrition, particularly Wernicke–Korsakoff syndrome. There was little evidence from randomized controlled trials (RCTs) on efficacy or optimum dosage of thiamine. However, the NICE Clinical Knowledge Summary (CKS) on alcohol problem drinking recommended the use of thiamine 200–300 mg per day in divided doses for excessive alcohol users and oral thiamine 50 mg per day as a single dose during the maintenance stage following withdrawal. Mr Dhadli advised that this guidance should be adopted locally and that other preparations such as folic acid and pyridoxine should be recommended on a patient by patient basis and this information conveyed to GPs. **Action:** The CKS guidance with the recommended 200-300mg of thiamine daily and 50mg maintenance dose would be circulated to the Trusts for comment and brought back to the December JAPC meeting.	**SD**
i.	**<u>Vigabatrin</u>** Dr Goddard stated that the use of vigabatrin had arisen from an audit of prescriptions for anti-convulsant and anti-epileptic drugs which had revealed a cohort of patients who were on long-term vigabatrin when discharged from neurology follow up. Vigabatrin was recommended for children with tuberous sclerosis (TS) and infantile spasms and the antiepileptic drug of choice. Whilst not commonly used, this medicine was currently initiated under hospital supervision and then prescribed in an ongoing manner by GPs. JAPC had been requested to consider whether GPs should continue to prescribe vigabatrin. Mr Dhadli advised that NICE CG 137 stated that the use of vigabatrin should be discussed with or referred to a tertiary epilepsy specialist. There was therefore a query as to the appropriate place for this treatment. It was suggested that this could be managed by a shared care agreement, although it was highlighted that vigabatrin was associated with visual field defects which required regular visual field testing. It would be necessary to determine who would undertake the tests and the recommended age that these should be done. It was noted that vigabatrin is currently classified as a red drug. During discussion Dr Mott stated that a traffic light classification of amber shared care could be assigned due to the visual field effects, although blood monitoring was not required and GPs would not do the actual eye checks, or it could be green specialist initiation. There is confidence that the eye checks were being undertaken for children, although it was unclear what the position	

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	was for adults. Mr Hulme commented that a shared care agreement was needed and this would address the issue about transition post 18 years of age. Dr Goddard highlighted that there were some patients on monotherapy vigabatrin who were not tuberous sclerotics and these should be included as well – this was agreed. **Action:** Dr Goddard would request Dr Will Carroll, RDH Consultant Paediatrician, to develop a shared care agreement.	**WG**
7.	**CLINICAL GUIDELINES**	
a.	**Atrial Fibrillation (AF)** Mr Dhadli informed JAPC that comments on the draft version of the AF guidance had been received from both RDH and CRH. The CRH cardiologists were generally in agreement with the draft guidance but had requested that amendments be incorporated concerning the wording for routine ECHO and the dual rate control initiation and referral criteria for TTE – these had now been included. Mr Dhadli highlighted the comments which had recently been received from the RDH cardiologists which had been included in an earlier draft AF guideline version. • Use HAS-BLED in all to assess bleeding risk to look for factors that can be addressed. • Do not routinely do an echocardiogram if the decision to initiate anticoagulation has already been made unless there is another indication such as a murmur or suspected heart failure. Atrial fibrillation results in a moderately elevated NT-pro BNP (via atrial stretch) even in the absence of ventricular dysfunction. • Dual rate control to be tried in primary care prior to referral. • Paroxysmal AF – Consultant to assess the need for drug therapy for long term rhythm control only if they have failed to respond to beta-blockers. • Triple therapy (dual antiplatelet and anticoagulant) – This will be initiated under the advice of the cardiologist through a shared management plan. In patients who have received a coronary stent, a thienopyridine (clopidogrel, prasugrel or ticagrelor) is mandated for up to 12 months. In selected patients, aspirin will be discontinued after one month, but this will be on the advice of a consultant cardiologist. Please do not discontinue antiplatelet therapy without discussion with the consultant cardiologist. • LAA closure devices – In selected patients with a high stroke risk due to AF, unsuitable for anticoagulation, left atrial appendage closure may be appropriate. Please refer to cardiology. • Do not routinely offer warfarin in combination with prasugrel or ticagrel or to people who need anticoagulation who have AF except on the advice of a consultant cardiologist. Mrs Needham highlighted the following amendments: • For patients on stroke prevention who are currently stabilised add 'who are on an anticoagulant'. • Amend to 'GRASP-AF which is compatible with clinical systems can be used to identify patients with AF at high risk of stroke'.	

Item		Action
	• Labile INR – need to clarify the use of two scoring thresholds. • Treatment of arrhythmia – Take out 'do not offer amiodarone for long term rate control'. Mr Hulme advised that the Medicines Management Team would be doing some work on the Patient Decision Aids to go alongside the AF guidance. Mr Dhadli stated that a guide had been included in the AF guidance to assist with decision making with the patient about the choice of anticoagulant but that these could be added at a later date with the agreement of the guideline group. Dr Goddard stated that Dr Baron, RDH Consultant Cardiologist, had commented on the use of NOAC to facilitate timely DC cardioversion which would aid its effectiveness. This would be another factor in the use of the NOACs. Dr Goddard confirmed that RDH had bleeding guidelines in place. In connection with advice for primary care about a preferred NOAC it was agreed that it would be very difficult to recommend one NOAC over another. **Action:** JAPC ratified the AF guidance with the agreed amendments. **Action:** The revised and re-formatted version of the AF guidance would be circulated to the JAPC for comments and uploaded onto the website.	**SD** **SD**
8.	**PATIENT GROUP DIRECTIONS (PGDs)**	
a.	**Boostrix, Revaxis, Menitorix, Repevax, MMR, PPV, Zostavax, Influenza PGDs** JAPC noted the PGDs for Boostrix, Revaxis, Menitorix, MMR, PPV, Zostavax and Influenza. **Action:** These will be added and uploaded to the website.	**SD**
9.	**SHARED CARE GUIDELINES**	
a.	**Apomorphine** Mr Dhadli stated that the shared care guideline now included clearer definitions of the responsibilities of the specialists. There had been further amendments to the specialist responsibility section with a reference to the MHRA guidance and a recommendation that, should the dose exceed 100mg, this would be discussed with the GP prior to handover. GPs would also have clear information about the length of treatment with domperidone based on the MHRA review. Mr Hulme queried whether those patients who were opportunistically found by a GP to be anaemic between the six to twelve monthly intervals would be referred to a specialist for a Coombs test. It was agreed that a reference to the need to refer to a specialist if any patient was found to be anaemic during opportunistic testing would be added to the GP responsibilities. **Agreed:** JAPC ratified the apomorphine shared care guideline with the agreed amendments.	**SD**

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b.	**Somatropin** Mr Dhadli stated that the consultant list had now been amended and the adult monitoring requirements section vi had been amended to read 'Patients with GH deficiency are typically commenced on 200-300 micrograms daily. IGF-1 levels are assessed at one month and dose titrated aiming for a mid-range IGF-1 level. Further IGF-1 check one month after each dose change. Annual IGF-1 check is adequate once stable dose is reached.' An addition would be made to the consultant responsibilities to review the patient's condition and monitor response to treatment regularly as per section vi. **Agreed:** JAPC ratified the somatropin shared care guideline with the agreed amendments.	**SD**
c.	**Acamprosate and Disulfiram** Mr Dhadli stated that the acamprosate and disulfiram shared care guidelines had been ratified at the August JAPC meeting. However, it had been agreed that a check should be made to ascertain whether the monitoring of acamprosate should mirror disulfiram. Mr Dhadli highlighted the following changes: • The dosing and monitoring requirements for disulfiram had been further changed to reflect recent changes to the BNF. • The monitoring requirements for acamprosate had been changed to 'monitor alcohol consumption and general health on a regular basis'. • The dose for disulfiram would be 200mg daily with an increase if necessary to the usual maximum of 500mg daily. • During treatment with disulfiram, patients should be monitored at least every two weeks for the first two months, then each month for the following four months and at least every six months thereafter. Following discussion, it was agreed that the monitoring of disulfiram should indicate the importance of correct use and that patients should not ingest any alcohol while taking it. **Agreed:** JAPC ratified the acamprosate and disulfiram shared care guidelines with the agreed amendments.	**SD**
10.	**MONTHLY HORIZON SCAN**	
	Mr Dhadli advised JAPC of the following new drug launches, new drug formulations and drug discontinuations: Launches in the UK: Rituximab (MabThera) Umeclidinium + vilanterol (Anoro) - A once-daily, maintenance bronchodilator treatment to relieve symptoms in adult patients with chronic obstructive pulmonary disease (COPD). Mr Dhadli advised that this had been rejected by SMC in July 2014 and will bring back a paper in October to look at the evidence. Licence extensions: (for information and consideration)	**SD**

Item		Action
	Apixaban (Eliquis) for the treatment of deep vein thrombosis and pulmonary embolism and prevention of their recurrence in adults. Eribulin (Halaven) for breast cancer, locally advanced or metastatic – second-line Ofatumumab (Arzerra) for chronic lymphocytic leukaemia – first-line in combination with chlorambucil or bendamustine, in patients not eligible for fludarabine-based therapy. Drug discontinuations: Betim (timolol) Caloreen Fucithalmic (fusidic acid) Ikorel (nicorandil) Locorten-Vioform (flumetasone/clioquinol) Surmontil (trimipramine)	
11.	**MISCELLANEOUS**	
a.	**Excess Treatment Costs** Mr Dhadli referred to the SANAD II study which was a randomised controlled trial to compare the effectiveness and cost effectiveness of levetiracetam and zonisamide versus standard treatments for epilepsy. This had been previously noted by JAPC. The details of the trial in the original paper included children only but had now been extended to include six adults, three in Arm A and three in Arm B. The attention of JAPC was drawn to the additional costs which would be incurred by the CCGs and also to concerns about the inadequate nature of the study papers supplied. JAPC supported the study and excess treatment costs.	
12.	**JAPC BULLETIN**	
	Mr Dhadli highlighted that the bulletin included a reference to the lifting of restrictions on the prescribing of generic sildenafil following new legislation. The JAPC bulletin was ratified.	
13.	**MHRA DRUG SAFETY UPDATE**	
	The MHRA Drug Safety Update for August 2014 was noted. Dr Mott highlighted the following: • Levonorgestrel and ulipristal acetate to remain suitable emergency contraceptives for all women regardless of body weight or body mass index. • Ofatumumab - Reminder of risk of serious and fatal infusion reactions - always give premedication and monitor patients carefully. • MHRA E-learning module on oral anticoagulants.	
14.	**NICE SUMMARY**	
	Mrs Qureshi informed JAPC of the comments for the CCGs which had been made for the following NICE guidance issued in August. NICE TA 320 Dimethyl fumarate for multiple sclerosis (relapsing-remitting). Dimethyl fumarate classified as a **RED** drug.	**SD**

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Item		Action
15.	**TRAFFIC LIGHTS – ANY CHANGES?**	
	Classifications Fluorouracil 5% (Efudix) cream – GREEN Specialist Initiation 1st line choice. Specialist initiation includes GPSI and GPs who have attended the Derbyshire AK pathway training. All formulations of alprostadil – BROWN Specialist Initiation as per SLS criteria, usually 2nd line to a PDE type 5 inhibitor. Fluarix Tetra – GREEN for administration for children as per national seasonal influenza guidance. 2nd line to nasal preparations, as per national immunisation programme for children aged 3 up to 18 years. Remains BLACK for adults (aged 18 years and over). Fluticasone propionate Nasule – GREEN specialist initiation for the maintenance of chronic rhinosinusitis with nasal polyps. Ondansetron – BROWN specialist initiation for treatment of hyperemesis gravidarum (the specialist to specify the dose and length of treatment for the patient). Vigabatrin – RED until a shared care agreement approved. Apomorphine – AMBER Somatropin – AMBER	
16.	**JAPC ACTION SUMMARY**	
	The action summary was noted by JAPC and amendments made: Lixisenatide – To be taken forward by the north and south prescribing groups. AF Guidance – To be removed from the list. DHU and PGDs – To be brought to the December JAPC meeting. Alfuzosin – To be removed from the list. Jaydess – To be brought to the November JAPC meeting. Lipid Guidance – A verbal update to be given to the November JAPC meeting. Nasal Steroids – To be added to the action summary.	**SD/KN** **SD** **SD** **SD** **RD** **RD/SD** **SD**
17.	**GUIDELINE GROUP**	
	The Guideline Group action progress summary was noted by JAPC.	
18.	**MINUTES OF OTHER PRESCRIBING GROUPS**	
	• Derbyshire Healthcare Foundation Trust Drugs and Therapeutic Committee 24.7.14	
19.	**ANY OTHER BUSINESS**	
	There were no other items of any other business.	
20.	**DATE OF NEXT MEETING**	
	Tuesday, 14th October 2014 at 1.30pm in the Post Mill Centre, South Normanton	