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DERBYSHIRE JOINT AREA PRESCRIBING COMMITTEE (JAPC)

Minutes of the meeting held on Tuesday 8 September 2015

CONFIRMED MINUTES

Summary Points

Traffic lights

Drug	Decision
Naloxegol	BROWN after consultant/specialist recommendation
Demeclocycline	BROWN specialist initiation
Meningococcal Group B Vaccine (Bexsero)	BLACK (not recommended or commissioned outside of the national immunisation programme where stock is obtained free of charge to practices)
Tolvaptan	RED (NHS England commissioned drug)
Raltegravir	RED (NHS England commissioned drug)
Ivermectin	Unclassified
Tiotropium + olodaterol	Unclassified
Tafluprost + timolol	Unclassified
Vedolizumab	RED as per NICE TA352
Bevacizumab	BLACK as per NICE TA 353
Edoxaban	GREEN after specialist initiation as per NICE TA354 for DVT/PE
Edoxaban	Unclassified for stroke prevention in adults with AF

Clinical Guidelines

Treatment of refractory symptomatic chronic constipation in men and women.
Management of Dyspepsia and Gastro-Oesophageal Reflux Disease (GORD).
Management of C.difficile infection in primary care - Extended to September 2016.

Patient Group Directions

Meningococcal B Vaccine (Bexsero)

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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 (also representing Erewash CCG)
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)
Ms J Town	Head of Finance
Hardwick CCG	
Dr T Parkin	GP
Erewash CCG	
Represented by Mr S Hulme	
Derby City Council	
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	
Ms S Bassi	Chief Pharmacist
Chesterfield Royal Hospital NHS Foundation Trust	
Mr M Shepherd	Chief Pharmacist
Derbyshire Community Health Services NHS Trust	
Mr M Steward	Head of Medicines Management
In Attendance:	
Ms Y Soetan	Lead Pharmacist, Southern Derbyshire CCG
Mr A Thorpe	Derby City Council (minutes)

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Item		Action
1.	**APOLOGIES**	
	Dr C Emslie, Dr M Henn, Dr D Fitzsimons, Mrs L Hunter, Ms H Murch and Dr R Sokal.	
2.	**DECLARATIONS OF CONFLICT OF INTEREST**	
	No declarations of conflict of interest were made.	
3.	**DECLARATIONS OF ANY OTHER BUSINESS**	
	• NHS England PGD for addition to website.	
4.	**MINUTES OF JAPC MEETING HELD ON 11 AUGUST 2015**	
	The minutes of the meeting held on 11th August 2015 were agreed as a correct record after the following amendments: Traffic Lights quinagolide and cabergoline - Amend to GREEN after consultant initiation from GREEN after specialist initiation. NICE TA 346 Aflibercept for treating diabetic macular oedema – Mrs Qureshi tabled an algorithm which outlined the options for the treatment of diabetic macular oedema (DMO) with aflibercept as an additional 1st line option alongside ranibizumab (Lucentis) and with a Patient Access Scheme. Mrs Qureshi added that the consultant ophthalmologists had been requested to advise on the place for aflibercept, pathways for first and second line options and development of criteria for possible switching. Classified as a RED drug.	
5.	**MATTERS ARISING**	
a.	**Gain Sharing** **Post meeting note**: Judith Town highlighted to JAPC members that Mandy Simpson and herself had raised at the August JAPC meeting the need for the paper to be circulated to the Chief Financial Officers of Derbyshire for CCG agreement as the paper posed commissioning implications. JT had been asked to make an amendment to the paper following that consultation and circulate to members at a later JAPC meeting.	**JT**
b.	**Learning Difficulties – Winterbourne Medicines Programme** Mrs Needham undertook to update JAPC after the working group had held a meeting to develop a multi-agency response to the Winterbourne Medicines Programme. It was highlighted that the Winterbourne review would remain on the action tracker.	**KN**
c.	**Quoracy** It was noted that the DHcFT members had indicated that they were satisfied with the decisions made by JAPC at the August 2015 meeting.	
d.	**Cabergoline and Quinagolide** Mr Dhadli reported that, following discussion with Dr R Stanworth, it had been agreed that cabergoline and quinagolide should have a traffic light classification of GREEN after consultant initiation for the treatment of hyperprolactinaemia. The information sheet based on the position statement for use by GPs had now been agreed via the Guidelines Group and placed on the website.	

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	Mr Dhadli added that the ePACT data run at Derbyshire CCG level had revealed that 2mg doses of cabergoline were being prescribed although the usual dosing regimen for hyperprolactinaemia was between 0.25mg and 1mg weekly. Mr Dhadli queried whether the 2mg dose was being prescribed for Parkinson's Disease from where the MHRA warnings and extra monitoring originated. It was agreed that Mrs Needham and Mr Hulme would look further at this prescribing.	**KN/SH**
e.	**Irritable Bowel Syndrome (IBS)** Mr Dhadli reported that faecal calprotectin was not specifically mentioned in the NICE recommendations on IBS but had been referred to in terms of differential diagnosis with IBS. Calprotectin had therefore been included in the IBS guideline, as per clinical advice.	
f.	**Naloxegol** Mr Dhadli stated that Naloxegol was recommended by NICE, within its marketing authorisation, as an option for treating opioid induced constipation in adults whose constipation has not adequately responded to laxatives. The Trusts had therefore been requested to give their views on whether oral naloxegol could be used as an alternative to subcutaneous methylnaltrexone for patients with opioid induced constipation. The following responses had been received: DCHS - Staff would prescribe if a specialist had already prescribed it for a patient but would not be the primary initiator. CRHFT - It should be prescribed under specialist initiation but with GPs supplying repeat prescribing where required. Ashgate Hospice - Methylnaltrexone was rarely used for patients repeatedly. DTHFT – No prescribing currently from palliative care or other speciality. Dr Goddard advised that the palliative care team had recently discussed this and felt that use would be very low. No response had been received from the chronic pain clinic. During discussion Mr Dhadli advised that methylnaltrexone had previously been re-classified to Brown after consultant/specialist recommendation in order to allow palliative care patients timely access to the drug. Dr Mott commented that it was unlikely that GPs would use either methylnaltrexone or naloxegol without some form of specialist input and support. **Agreed:** Naloxegol and methylnaltrexone classified as **BROWN after consultant/specialist recommendation** drugs.	**SD**
6.	**NEW DRUG ASSESSMENTS**	
a.	**Demeclocycline** Mr Dhadli stated that a request had been received for a traffic light classification to be assigned to demeclocycline, a tetracyline drug used in the treatment of chronic hyponatraemia associated with the syndrome of inappropriate secretion of antidiuretic hormone (SIADH) secondary to malignant disease where water restriction was ineffective and the patient did not have concomitant cirrhosis.	

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	It was highlighted that, although the drug would not need any monitoring, the condition of chronic hyponatraemia would have monitoring requirements by GPs and that the cause and treatment of the patients SIADH would need to be followed up and reviewed by hospital specialists. The NICE Clinical Knowledge Summary (CKS) on the monitoring of demeclocycline had indicated that a rapidly decreasing serum sodium concentration could be life-threatening. Repeating the serum sodium measurement would help detect at risk people needing admission and the time frame for repeating the serum sodium should be based on clinical judgement. Mr Dhadli advised that Leeds Hospital had a shared care agreement which included regular repeated monitoring requirement But also included a statement on tailoring to the specific patient. Mr Dhadli advised JAPC of the current traffic light classifications which had been assigned to demeclocycline by the Trusts and neighbouring Area Prescribing Committees: Derbyshire JAPC - Not listed. CRHFT - Red consultant initiation only. DTHFT - This tetracycline was included to enable it to be used in the treatment of syndrome of inappropriate ADH secretion (SIADH). Recommended dosage for this indication is 900-1200mg daily in divided doses, reducing to 600-900mg daily in divided doses for maintenance therapy Nottinghamshire APC - Amber 2 after specialist/consultant recommendation. Sheffield APC - Not listed. South Staffordshire APC - Non-formulary. Leicestershire APC - Not listed. Mr Dhadli highlighted that the cost of demeclocyline had significantly increased and the licensed product was currently out of stock. An interim arrangement had been made by the manufacturer to import unlicensed demeclocycline tablets and these could be ordered by hospitals and community pharmacies. **Agreed:** Demeclocyline classified as a **BROWN specialist initiation drug** on the grounds of exceptionality where a small cohort of patients could benefit from prescribing. It would be expected that monitoring requirements would be specified by the initiating specialist.	**SD**
b.	**<u>Dulaglutide</u>** Mr Dhadli stated that dulaglutide was a long acting once weekly Glucagon-like peptide-1 (GLP1) agonist which had been launched for the management of type 2 diabetes and was given once weekly by subcutaneous injection. Dulaglutide had not received a NICE TA and NICE had not included it in their guideline which was shortly to be published. There were two licensed doses of 0.75mg as monotherapy (outside local guidance) and 1.5mg as add on therapy in combination with other glucose-lowering medicinal products including insulin. Dulaglutide was not recommended for use in patients with severe renal impairment or dialysis – this was similar to other GLP1s.	

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	The evidence for use arose from six PIII RCTs (AWARD studies) and an EPAR (European Public Assessment Report). The NICE Evidence Summary New Medicine had only considered three RCTs (AWARD 1, 5 & 6) which had been published in full. The primary outcome in all the studies was HBA1c, a change from baseline to the primary time point. Mr Dhadli advised that, in comparison to exenatide, dulaglutide 1.5mg or 0.75mg once weekly was statistically superior to placebo; sitagliptin once daily and non-inferior to liraglutide 1.8 mg once daily. The most common adverse events were hypoglycaemia, renal hepatic disease and heart failure. It was noted that the overall effect of dulaglutide on weight was modest across the AWARD trials and that the clinical relevance of the observed effect size with the 1.5 mg dose was uncertain. The Award 1 trial appeared to demonstrate dulaglutide potency was greater than exenatide BD dosing. Mr Dhadli highlighted that dulaglutide was significantly more expensive that the other GLPI drugs currently used and the current traffic light classifications of these were: Lixisenatide - GREEN 1st line Liraglutide - GREEN 2nd line Exenatide – GREEN 3rd line Exenatide prolonged release - GREEN 3rd line In terms of safety it was noted that the NICE Evidence Summary on dulaglutide referred to small mean increase in PR interval and a 2.4% incidence of first-degree atrioventricular block had been observed with dulaglutide 1.5 mg in people with normal conduction at baseline. An event-driven cardiovascular outcome study is currently being undertaken and results would be reported in 2019. The consultant diabetologists had been contacted to ascertain their views on dulaglutide and Dr Robinson from CRHFT had indicated that it could have some benefit. A response had also been requested from Dr F Game, DTHFT Consultant Diabetologist, but none had been received to date. Discussion followed and Dr Watkins highlighted that the once-weekly administration device of dulaglutide compared to the other GLP1 agonists could increase patient compliance. Mr Hulme queried whether another GLP1 drug was needed in the formulary and advised caution about class effect in terms of similar therapeutic effects and similar adverse effects. **Agreed:** A decision on the traffic light classification on dulaglutide would be deferred for one month. **Action:** Mr Dhadli would contact Dr Game to query whether there was a specific cohort of patients who would benefit from the use of dulaglutide. **Action:** Mr Dhadli would look at cost-effectiveness data for liraglutide in the NICE technology appraisal and ascertain the position of dulaglutide in other neighbouring CCGs.	**SD** **SD** **SD**

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Item		Action
7.	**CLINICAL GUIDELINES**	
a.	**Constipation Charts** Dr Goddard referred to the separate and amalgamated algorithms for the treatment of refractory symptomatic chronic constipation in men and women and the update of the existing guideline for the use of prucalopride in women. Dr Goddard added that prucalopride was used in DTHFT on a concessionary basis for men and that the algorithm now included the use of lubiprostone as an option for hospital clinicians to initiate and continue to prescribe in cases where treatment with prucalopride has failed. An algorithm for the use of lubiprostone in men has also been produced. It was confirmed that the guideline was compliant with the NICE TAs. Mrs Needham queried the reference in the algorithm to the box which indicated that there should be a trial of two laxatives from different classes at the highest tolerated dose for six months and the box concerning the need to check whether the patient had improved after four weeks. It was agreed that the box which referred to the four week check should be amended to read six months and placed before the box which referred to the trial of two laxatives. It was also agreed that the algorithm should be presented on one page. **Agreed:** JAPC ratified the guideline for the treatment of refractory symptomatic chronic constipation in men and women with the agreed amendment.	**WG** **SD**
b.	**Management of Dyspepsia and Gastro-Oesophageal Reflux Disease (GORD)** Mr Dhadli reported that this guidance replaced the existing guideline on the Management of Dyspepsia which had been developed in March 2010 and reviewed in June 2012. The guidance was based on NICE CG 184 'Dyspepsia and gastro-oesophageal reflux disease' issued in November 2014 and NICE NG12 'Suspected cancer: recognition and referral' issued in June 2015. Mrs Needham commented that there should be a reference to long term care emphasising patient empowerment by the promotion of 'on demand' use of the lowest effective dose in the key points on the front page of the guidance. In addition, a cross reference to C.difficile and PPIs should also be included in the key points. **Agreed:** JAPC ratified the guidance for the Management of Dyspepsia and Gastro-Oesophageal Reflux Disease (GORD) with the agreed amendments.	**SD**
c.	**Management of C.difficile Infection in Primary Care** Mr Dhadli reported that Dr D Harris, Lead Antimicrobial Pharmacist, had updated the guidance on C.difficile infection in primary care in May 2015 and this had subsequently been ratified by JAPC. Dr Harris had now requested that this guidance be extended to September 2016 whilst awaiting national guidance publication. **Agreed:** JAPC agreed to extend the guidance on the management of C.difficile infection in primary care to September 2016.	**SD**

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Item		Action
8.	**PATIENT GROUP DIRECTIONS**	
a.	**Meningitis B Vaccine** Mr Dhadli reported that NHS England and Public Health England had advised that immunisation against meningococcal B disease (Meningitis B) was to be added to the childhood immunisation programme as part of the routine schedule in England from 1st September 2015. The Meningitis B vaccine was recommended for babies aged two months, followed by a second dose at four months and a booster at twelve months. There was also a temporary catch-up programme for babies who were due their three and four month vaccinations in September 2015. In view of the fact that babies given the Meningitis B vaccine alongside their other routine vaccinations at two and four months were likely to develop fever within the first 24 hours after vaccination, NHS England and Public Health England had stipulated that babies should be given liquid paracetamol as prophylaxis following vaccination at two and four months in order to reduce the increased risk of fever from this particular vaccine. Parents of infants about to receive these vaccinations would be advised to purchase a supply of liquid paracetamol in advance. Mr Dhadli added that GP practices would be able to order paracetamol for the first dose only via ImmForm and for subsequent supplies parents were being signposted to purchase over the counter. Mr Dhadli advised that Public Health England had prepared a protocol on the prophylactic use of paracetamol post Meningitis B immunisation and this advised the administration of three 2.5ml (60mg) prophylactic doses to infants post MenB vaccination and that infants developing a fever may be treated with paracetamol for up to 48 hours post immunisation. It was highlighted that the licence for paracetamol covered the treatment of pain and fever and not prophylaxis so would need to be given off-licence. Dr Mott referred to a potential issue concerning the supply of paracetamol to parents who were unable or unwilling to purchase this. **Agreed:** JAPC ratified the Patient Group Direction for Meningitis B Immunisation. **Action:** Meningitis B vaccination to be assigned a BLACK classification outside of the national childhood immunisation programme as it would not be routinely recommended or commissioned. GP Practices would be made aware of this decision and advised that supplies of the first dose of paracetamol could be ordered via the national ImmForm website and to signpost parents or carers to purchase doses thereafter.	**SD** **SD**
9.	**MONTHLY HORIZON SCAN**	
a.	**Monthly** Mr Dhadli advised JAPC of the following new drug launches, new drug formulations and drug discontinuations: New drug launches in the UK: Edoxaban (Lixiana) - To be classified as GREEN specialist initiation in line with the other NOACs as per NICE TA 354 for the treatment of DVT/PE. It was not anticipated to be used much locally due to the need to load the patient with low molecular-weight heparin alongside the Edoxaban.	

Item		Action
	Midodrine (Bramox) – The Acute Trusts had been asked to review if the current Red classification was the correct traffic light classification. Tolvaptan (Jinarc) – Classified as **RED** (NHS England) given that a licensed formulation is now available. New formulation launches in the UK: Glatiramer acetate (Copaxone) – Already classified as **RED** (NHS England). Ivermectin (Soolantra) – Leave unclassified and await clinician request. Lisdexamfetamine dimesylate (Elvanse Adult) – Shared care to be updated to reflect the change to the licence for use in newly-diagnosed adults. Raltegravir (Isentress) – Classified as **RED** (NHS England), Tafluprost + timolol (Taptiqom) – Leave unclassified and await clinician request. Tiotropium + olodaterol (Spiolto Respimat) - Leave unclassified and await clinician request. Licence extensions: Febuxostat (Adenuric) Ibrutinib (Imbruvica) Insulin degludec + liraglutide (Xultophy) Lanreotide (Somatuline Autogel) Pertuzumab (Perjeta) Sapropterin (Kuvan) Drug discontinuations Lopresor (metoprolol), Suprax Paediatric Suspension (cefixime) and System 4	
b.	**NICE** The Clinical Guidelines, NICE Technology Appraisals and NICE New Evidence Summaries were noted for information.	
10.	**MISCELLANEOUS**	
a.	**Anticholinergics and Dementia** Mr Dhadli reported that two consultant urogynaecologists from CRHFT and DTHFT, on behalf of the East Midlands Midlands Pelvic Function Group, had requested the advice of JAPC regarding the continued use of oxybutynin for the elderly, in the light of emerging evidence of the onset of dementia being linked in some situations to long term use of anti-cholinergics especially oxybutynin. It had also been queried whether all anti-cholinergics should be stopped and mirabegron used instead as a first line treatment. Mr Dhadli advised that mirabegron was currently on the formulary as a Green 3rd line choice after a trial of oxybutynin and tolterodine. Dr Goddard and Mrs Needham highlighted that the data on anti-cholinergic use and increased risk of dementia was observational and did not prove cause. Mr Dhadli then updated JAPC that he could find no evidence nationally where guidance had changed following this study. It was agreed that the recommendations outlined in the 'guideline of urinary incontinence' written by the European Association of Urology be included in the formulary and overactive bladder guidance update.	**SD**

Item		Action
b.	**Orphenadrine Discontinuation** Ms Bassi reported that orphenadrine 50mg tablets would be discontinued on 1st December 2015 and therefore no new patients would be started on it. This is due to the manufacturer of the active ingredient discontinuing production together with decreased demand for this preparation. The DHcFT Drugs and Therapeutic Committee had produced guidance about the alternative treatments for patient care. Ms Bassi added that three patients had been initiated on orphenadrine in 2014. Mr Dhadli reported that he had asked a few pharmacists to check indication of use and that there was some use by neurology and pain consultants. **Action:** Information about the discontinuation of orphenadrine and guidance as to alternatives would be put in the bulletin and distributed to practices.	**SD**
c.	**Patient Safety Alert – Antimicrobial Resistance** Mr Dhadli referred to the joint National Patient Safety Alert issued to all providers of NHS care in England by NHS England, Health Education England and Public Health England to highlight the challenge of antimicrobial resistance and the need for antimicrobial stewardship. Dr D Harris, Lead Antimicrobial Pharmacist, had indicated that this alert had been circulated to all GP practices, together with the update on the local antimicrobial treatment guidelines that have recently been updated, and had referred to the need to establish an Antimicrobial Stewardship Programme across the Derbyshire Health Economy. Mr Dhadli added that the north and south prescribing leads would need to consider how to address the recommendations in the Patient Safety Alert and a task group would be established to take the work forward.	
11.	**JAPC BULLETIN**	
	The August JAPC bulletin was ratified.	
12.	**MHRA DRUG SAFETY UPDATE**	
	The MHRA Drug Safety Update for August 2015 was noted. Mr Dhadli highlighted the following: • Simeprevir with sofosbuvir: risk of severe bradycardia and heart block when taken with amiodarone. The amiodarone prescribing protocol had been amended to reflect this. • US Food and Drink Administration (FDA) Drug Safety Communication: The FDA had warned that DPP-4 inhibitors for type 2 diabetes could cause severe joint pain. The formulary and diabetes guidance had been amended to reflect this. The warning would also be included in the bulletin to alert GP practices about this. Mr Shepherd queried whether JAPC should report on FDA alerts or alerts outside the MHRA and UK as routine. JAPC decided that advice following each alert should be assessed individually.	**SD**
13.	**NICE SUMMARY**	
	Mrs Qureshi informed JAPC of the comments for the CCGs which had been made for the following NICE guidance issued in August 2015:	

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Item		Action
	TA352 Vedolizumab for treating moderately to severely active Crohn's disease after prior therapy - Vedolizumab was recommended as an option for treating moderately to severely active Crohn's disease only if: a tumour necrosis factor-alpha inhibitor has failed or a tumour necrosis factor-alpha inhibitor cannot be tolerated or is contraindicated. Vedolizumab was recommended only if the company provided it with the discount agreed in the patient access scheme. The population eligible for treatment had been calculated based on the number of people with moderate and severe Crohn's disease when a TNF inhibitor was ineffective, contraindicated or not tolerated. Mrs Qureshi stated that the costing template from NICE was currently unavailable but when this was issued the DHTFT and CRHFT Finance departments would be informed accordingly. The algorithm would be updated and brought back to JAPC. Classified as a **RED** drug.	**SQ**
	TA353 Bevacizumab for treating relapsed, platinum-resistant epithelial ovarian, fallopian tube or primary peritoneal cancer (terminated appraisal). Classified as a **BLACK** drug.	**SD**
	TA354 Edoxaban for treating and for preventing deep vein thrombosis and pulmonary embolism – This provided another option for the treatment and prevention of deep vein thrombosis and pulmonary embolism in adults. NICE did not anticipate a significant impact on resources as it was an alternative New Oral Anticoagulant (NOAC) and the four drugs together were similarly priced. It was highlighted that edoxaban required a five day lead-in with heparin treatment but was taken once a day. Classified as a **GREEN specialist initiation** drug in line with the other NOACs for DVT and PE.	**SD**
	NG14 Melanoma: Assessment and management.	
	NG15 Antimicrobial stewardship: systems and processes for effective antimicrobial medicine use – This had previously been discussed by JAPC.	
	NG17 Type 1 diabetes in adults: diagnosis and management – It was recommended that type 1 diabetic patients should test their blood glucose at least four times a day and up to ten times if the desired target was not met; hypoglycaemic episodes increased; during illness, before, during and after sport and when planning pregnancy. Mrs Qureshi referred to the costs of the blood glucose testing strips and the cost impact of an increase in the number of blood glucose tests which could have financial implication for primary care. There could also be further cost implications arising from the increase to the target for people with diabetes to obtain an HbA1c value of under 6.5%, although savings would be realised by the consequent reduction in diabetic complications.	
	NG18 Diabetes (type 1 and type 2) in children and young people: diagnosis and management – Advice had been given for children and young people with type 1 diabetes to routinely undertake at least five capillary blood glucose tests per day. In addition children and young people with type 1 diabetes should be offered blood ketone testing strips and a meter and advice to test for ketonaemia if they were ill or had hyperglycaemia. It was highlighted that this was a significant change in practice arising from the use of blood ketone testing strips instead of urine ketone testing strips.	

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Item		Action
14.	**TRAFFIC LIGHTS – ANY CHANGES?**	
	Classifications Naloxegol – BROWN after consultant/specialist recommendation Demeclocycline – BROWN specialist initiation Bexsero – BLACK outside of national immunisation guidance Tolvaptan – RED (NHS England commissioned drug) Raltegravir – RED (NHS England commissioned drug) Ivermectin – Unclassified Tiotropium + olodaterol – Unclassified Tafluprost + timolol – Unclassified Vedolizumab – RED as per NICE TA352 Bevacizumab – BLACK as per NICE TA 353 Edoxaban – GREEN after specialist initiation as per NICE TA354 for DVT/PE Edoxaban – Unclassified for stroke prevention in adults with AF	
15.	**JAPC ACTION SUMMARY**	
	The action summary was noted by JAPC and amendments made: Aripiprazole and pregabalin – To remain on. Lithium monitoring – Shared care currently being updated and to be brought to the November meeting. NICE CG 28 depression in children and young people – To be taken off. GOR(D) adult new NICE cancer referral criteria – To be taken off. Grazax – To be brought to the June 2016 meeting. Glaucoma guidance – To be brought to the October meeting. Free of charge schemes- To be brought to the November meeting. Immunomodulating drugs – To be brought to the November meeting. Winterbourne review – Await feedback within two months. Oral thrush – To be brought to the November meeting.	**SD** **SD** **SD** **SD** **SD** **SD** **SD** **SD** **SD** **SD**
16.	**GUIDELINE GROUP**	
	The summary of key messages arising from the meeting held in August 2015 was noted. Mr Dhadli highlighted the following: • Care Homes and Social Care - New section to be added to the Medicines Management website under other useful guidelines. Confirmation of medication directions and covert administration of medicines had been agreed for inclusion. • Heart failure guideline - Dr Ahmed from DTHFT had agreed to update the guidance and a response was awaited. • Non-malignant chronic pain in primary care – It was noted that comments were awaited from CRHFT.	

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17.	**MINUTES OF OTHER PRESCRIBING GROUPS**	
	• Burton Hospitals Drugs and Therapeutic Committee 13/07/15 • DTHFT Drugs and Therapeutic Committee 21/07/15 • Nottinghamshire Area Prescribing Committee 16/07/15	
18.	**ANY OTHER BUSINESS**	
a.	**PGD Sign-Off for NHS England** Mr Dhadli referred to the process for circulation of the Patient Group Directions following sign-off by the NHS England Medical Director. It was agreed that on receipt the Clinical Effectiveness Team would upload on to the website and they would then be noted by JAPC at the following meeting.	
b.	**Atrovent Inhaler** Mr Steward queried whether there had been any experience of the use of atrovent inhaler for the use of hyper-salivation which was outside the product licence. Mr Steward was advised to check in the palliative care formulary.	
19.	**DATE OF NEXT MEETING**	
	Tuesday, 13th October 2015 at 1.30pm in the Post Mill Centre, South Normanton.	