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

DERBYSHIRE JOINT AREA PRESCRIBING COMMITTEE (JAPC)

Minutes of the meeting held on 13th December 2016

CONFIRMED MINUTES

Summary Points

Traffic lights

Drug	Decision
Ciprofloxacin 0.3% / dexamethasone 0.1% ear drops (Cilodex®)	GREEN for use in patients with acute otitis media with tympanostomy tubes or tympanic perforation in adults and children over 6 months of age
Dequalinium vaginal tablets (Fluomizin®)	BROWN 2nd line to metronidazole
Nortriptyline	BROWN 2nd line to amitriptyline
Alimemazine	BLACK
Opicapone (Ongentys®)	BLACK
Resilizumab (Cinqaero®)	RED (NHS England)
Cabazantinib (Cabometyx®)	RED
Factor IX, recombinant (Rixubis®)	RED
Buprenorphine patches	BROWN (use most cost effective brand)
Hydrocortisone and gentamicin ear drops	BROWN
Flumetasone/Clioquinol 0.02%/1% w/v ear drops solution	BROWN
Dapagliflozin	BROWN as per NICE TA 418 and 288
Nivolumab	RED as per NICE TA 417
Apremilast	RED as per NICE TA 419

Clinical Guidelines

Amiodarone monitoring protocol
Bowel cleansing
Clozapine
Use of Compression Hosiery
Management of Emergency Contraception with Ulipristal Acetate 30 mg (ellaOne®)
Management of hypertension using Ambulatory Blood Pressure Monitoring (ABPM)
Topical tacrolimus in primary care
Derbyshire Community Dressing Formulary and Wound Care Guidelines 2016

Patient Group Directions

Administration of Haemophilus influenzae type b and meningococcal C conjugate vaccine (Hib/MenC) to individuals, from their second birthday, with an underlying medical condition.
Triamcinolone Acetonide for the treatment of joint pain, swelling and stiffness associated with rheumatoid or osteo-arthritis, bursitis, tendonopathy and tenosynovitis - Hardwick Federation only

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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
Mrs S Qureshi	NICE Audit Pharmacist
Dr M Watkins	GP
North Derbyshire CCG	
Dr C Emslie	GP
Dr T Narula	GP
Mrs K Needham	Assistant Chief Quality Officer (Medicines Management) (also representing Hardwick CCG)
Mr R Coates	Management Accountant
Hardwick CCG	
Erewash CCG	
Ms H Murch	Pharmacist
Derby City Council	
Derbyshire County Council	
Derby Teaching 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 Foundation Trust	
Ms J Shaw	Principal Pharmacist
In Attendance:	
Ms A Thai	Pharmacist, Southern Derbyshire CCG
Mr A Thorpe	Derby City Council (minutes)

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Item		Action
1.	**APOLOGIES**	
	Dr R Dewis, Dr T Parkin and Ms J Town.	
2.	**DECLARATIONS OF CONFLICT OF INTEREST**	
	Dr Mott reminded committee members of their obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of JAPC. No 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 8 NOVEMBER 2016**	
	The minutes of the meeting held on 8th November 2016 were agreed as a correct record after the following amendments: Nitrofurantoin and renal impairment – Amend to: 'Dr Mott suggested that a reference could be included in the guidance to indicate that nitrofurantoin could occasionally be used but only after microbiologist advice had been obtained. ' PGD for Methylprednisolone Acetate 40 mg/ml for MSK – Amend to: 'Mr Dhadli reported that the PGD had been submitted by Alison Hughes, from Hardwick Federation on behalf of Hardwick CCG, and aimed to improve the outcomes and expenditure relating to the treatment and management of patients with musculoskeletal (MSK) conditions, trauma and injuries in Hardwick CCG.' NICE Horizon Scan – Amend to: 'Mr Dhadli advised that secondary care high cost drugs excluded from tariff were currently being reviewed in conjunction with the DTC finance committee and information on the primary care, secondary care and shared care drugs would be brought to a JAPC meeting together with details of budget impact.'	
5.	**MATTERS ARISING**	
a.	**Sayana Press** Mr Dhadli reported that the protocol for Sayana Press® would be brought to the January or February 2017 JAPC meeting and placed on the action tracker.	**SD**
b.	**Naltrexone** Dr Taylor referred to some confusion about the different shared care arrangements for the use of naltrexone in alcohol dependence and opioid addiction and that this would be resolved during the forthcoming re-alignment of treatment services from April 2017.	
c.	**Somatropin (Resistant Human Growth Hormone) – Choice of Products** Dr Tracy Tinklin, DTHFT Consultant Paediatrician, had acknowledged that there were various preparations for different indications and confirmed that the most effective one was being used in the Trust depending also on patient factors.	

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	A review would be undertaken of the more cost effective versions against the licensed indications - this would be followed through via the guideline group action tracker.	**SD**
d.	**Oxygen** Mr Dhadli reported that the comments made by Dr Henn at the last meeting about the use of oxygen in palliative care had been conveyed to the authors of the oxygen guideline and these would be incorporated into the revised version to be considered by JAPC in January 2017.	
e.	**Patient Group Directions** Mr Dhadli reported that Dr Diane Harris had advised that the monitoring of antibiotic use within Derbyshire Health United was undertaken via the CQUIN scheme.	
f.	**Minimum Data Set** Mr Dhadli stated that, following the November meeting, JAPC members had been emailed with a link to the NHS England minimum data set and also to the specialised services drugs reporting arrangements.	
g.	**Commissioning Medicines in Children** Mr Dhadli reported that a CCG position statement on commissioning for post-pubescent children had been drafted and the outcome of a NHS England consultation would be presented to JAPC in February 2017.	**SD**
h.	**Osteoporosis** Mr Dhadli reported that the osteoporosis guidance had been re-drafted and sent back to Dr Roger Stanworth and Mr Shepherd for comments. Mr Shepherd confirmed that comments from North Derbyshire had been conveyed to Mr Dhadli.	
6.	**PRESCRIBING SPECIFICATION**	
	Mr Dhadli referred to the amendments which had been made to the prescribing specification since it had been originally presented to JAPC and during subsequent discussions. Some of the main amendments were highlighted as follows: • Point 8 - A GP has the right to refuse to enter into a shared care agreement, but to refuse on the grounds of drug cost alone is unacceptable. CCGs must proactively support implementation of agreed shared care protocols to maximise uptake. • High Cost Drugs excluded from Tariff commissioned by CCGs: Point 8 - For audit of high cost drugs excluded from tariff the commissioners require the minimum data set in point 7 to be recorded at patient level to ensure that treatment is in line with NICE or locally agreed guidelines or policies. This will be delivered by appropriate IT software such as Blueteq within a roll-out plan agreed annually with providers. • High Cost Drugs excluded from Tariff commissioned by CCGs: point 14 - Any incentive schemes (financial and non-financial) offered to the Provider Trust from the manufacturers shall be disclosed to the Commissioner, whether they are accepted or not before any agreement.	

Item		Action
	This will include offers by pharmaceutical companies to pay for locally delivered/designed homecare services. Neither the Commissioner nor Provider will be disadvantaged from the acceptance of such schemes. For transparency and fairness any offers to the CCG will be declared to the relevant provider before any decision is made. • High Cost Drugs excluded from Tariff commissioned by CCGs: point 22 - High cost treatments and interventions (unless specified within contracts, not identified in the annual horizon scan or by exceptional circumstances (e.g. cost neutral or cost saving) will be considered low priority for funding in year. Now added to include: 'Additional resources may be considered for treatments that are made available at short notice where there is a strong clinical impact on clinical outcomes supported by high quality study(ies)'. • High Cost Drugs excluded from Tariff commissioned by CCGs: Point 24 - Trusts are expected to plan and discuss with clinicians and medicines management in preparation for the introduction of bio-similars when cheaper than the originator. In order to allow CCGs to continue to invest in new developments this will require a joint improvement programme plan and for all Trusts to use treatments of the lowest acquisition cost to the NHS system in line with product licenses. The plan should aim for all new patients to be initiated on the biosimilar/ generic product within 3 months of them becoming available. All existing patients on treatment will have moved on to the biosimilar/generic product within 12 months of the improvement programme plan agreement. A standard 50% gain share between provider and commissioner will be in operation during this period. This accelerated uptake is to reflect the urgency of efficiency savings needed to be realised within the NHS in Derbyshire. After the 12 month gain share agreement commissioners will only continue to pay at pass through the cost of the cheaper agreed biosimilar. A Derbyshire wide default of 100% will be the standard. This will be revised with input from clinicians and agreed at JAPC for all providers to achieve, there should be no variation of thresholds between providers. JAPC may decide to relax time lines in the event for example of another imminent biosimilar launch or the conclusion of a procurement process. Switching between biosimilars will be in agreement through JAPC with details of opportunity cost, patient safety and resource to switch as considerations. Discussion followed on these amended points in the prescribing specification. In connection with point 8 in the high cost drugs section, Dr Goddard and Mr Shepherd highlighted the need for significant additional resource in order to record the minimum data set in point 7 at patient level to ensure that treatment was in line with NICE or locally agreed guidelines or policies. Mr Shepherd added that this had not been previously provided due to the lack of systems and technical/human resource, together with the large numbers of patients who would be involved. Dr Goddard referred to the IBD clinical management system database which would link to Blueteq but the large volume of patient information prevented this being done during clinical time. Resources would be needed for the existing cohort of patients who were on these treatments. Dr Mott suggested that the wording in this section should be accepted and the concerns expressed highlighted via the contracting process.	

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	Mr Hulme commented that the resources required should be part of the wider contractual negotiations with the Foundation Trusts. Mrs Needham added that the use of Blueteq was one way of providing assurance to the commissioners with the aim of achieving better use of resources in prescribing. Dr Goddard advised that these patients were all discussed at a weekly MDT and all received annual reviews. In connection with point 14 concerning incentives the amended wording in the prescribing specification was agreed by JAPC. In connection with point 24 concerning the introduction of biosimilars and gainsharing, Dr Mott referred to the requirement for all new patients to be initiated on biosimilars or the generic product within three months of availability and that all existing patients on treatment will have moved on to biosimilars or generic products within twelve months of the improvement programme plan agreement. Mr Shepherd agreed with the three month requirement but suggested that an amendment be made to indicate all suitable new patients. Mr Shepherd also highlighted the significant amount of work which would be required to introduce these products, including the reporting of the financial gains, and proposed that a twenty-four month period would be more realistic for the gain share and pass through. Dr Goddard and Mr Newman suggested that the timeline should be three months for the introduction of the product and fifteen months for the swap to give a total of eighteen months. Dr Goddard added that the experience gathered so far in the introduction of the infliximab biosimilars had demonstrated that there was no problem in getting this to new patients but the length of time in achieving the swap to Inflectra® and Remsima® had been significant and this included the identification, recruitment and training of suitable nursing staff. In response to a question as to how other areas had dealt with the introduction of biosimilars Mr Shepherd commented that it had been demonstrated that those Trusts which had made the most progress with these, and the NHS England commissioned medicines, had accepted gain share and adopted a productive and collaborative approach. It was agreed that the wording in point 24 should be amended to indicate a time period of three months for the introduction of the product and fifteen months for the swap to give a total of eighteen months. Mr Newman referred to the Derbyshire wide default of 100% as the standard but that NHS England had adopted a CQUIN of 80% due to advice received from bodies, such as some of the Royal Colleges, that patients should not be automatically switched over to biosimilar products and that clinicians should be fully involved. Mr Dhadli stated that the 100% was a starting point for discussion but it was accepted that this may not be possible to achieve as there could be exceptional criteria. However there should be justifiable reasons for any lower thresholds. Dr Mott highlighted the need for agreement as to an acceptable level for biosimilars and suggested that the current wording in the specification should be clarified – this was agreed by JAPC. The amended wording would be sent to Mr Newman and Mr Shepherd for agreement by the providers and then circulated to JAPC for information.	**SD** **SD** **SD**

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Item		Action
7.	**NEW DRUG ASSESSMENTS**	
a.	**Cilodex** Mr Dhadli reported that Cilodex (Ciprofloxacin 0.3%/dexamethasone 0.1% ear drops) had been requested by a DTHFT Consultant in ENT, Neck and Head Surgery for inclusion in the JAPC formulary for the treatment of acute otitis media (AOM) in patients with tympanostomy tubes (grommets) or tympanic membrane perforation (AOMT) in adults and children aged over six months. In patients with tympanostomy tubes (grommets) the middle ear became accessible to topical therapy and there was evidence that topical aminoglycosides, such as gentamicin or neomycin, were ototoxic and could damage the inner ear. They were therefore contraindicated if the tympanic membrane was perforated. It was also noted that ciprofloxacin was not ototoxic. The evidence came from three studies, multicentre, observer-blind and parallel-group, which had compared Cilodex® for seven days with otic ciprofloxacin for ten days. This had demonstrated greater efficacy of Cilodex® for AOM and the cure rates had been 86% for the Cilodex® group compared to 79% for the controlled group. The median time to cessation of otorrhoea was four days versus six days. Two further studies had revealed mixed results for Cilodex® dependent on the inclusion or exclusion of culture positive patients. Shorter time to resolution of otorrhea than ciprofloxacin, if culture negative patients were excluded, but no significant difference in otorrhea when included. For chronic suppurative otitis media (OM), an unlicensed indication for Cilodex®, topical antibiotics together with ear cleansing would be the usual treatment. It was noted that the use of Cilodex® would be cost neutral. **Agreed:** Cilodex classified as a GREEN drug for acute otitis media in patients with tympanostomy tubes or tympanic perforation in adults and children over 6 months of age and suitable for primary care prescribing.	**SD**
b.	**Dequalinium Chloride Vaginal Tablets** Mr Dhadli stated that dequalinium chloride was a vaginal tablet used to treat bacterial vaginosis. Dequalinium had been highlighted in the horizon scan and subsequently had been the subject of a SMC review in October 2016. The SMC had accepted dequalinium as second line where initial treatment had not been effective or tolerated. Bacterial vaginosis (BV) was a common infection in women of reproductive age and women with BV were more susceptible to sexually transmitted infections and there was a particularly high re-occurrence rate (two thirds within three months). Initial treatment, according to the British Association for Sexual Health and HIV (BASHH), was with oral metronidazole. The evidence for efficacy was from a phase III, single-blind, randomised, non-inferiority study in which patients had been randomised equally to treatment with dequalinium chloride 10mg vaginal tablet daily for six days or clindamycin 2% vaginal cream for seven days. The primary outcome was clinical cure seven days after treatment. A well accepted diagnostic tool, Amsel criteria, was used to identify patient trial inclusion.	

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Item		Action
	The overall safety profile was acceptable and comparable between treatment groups and the economic analysis had been done on cost minimisation versus clindamycin. However clindamycin may not be a second line choice as more cost effective alternatives were available in primary care. Mr Dhadli referred to the cost of relevant comparators and highlighted that dequalinium chloride was significantly cheaper than clindamycin, against which it had been compared. It was noted that the treatment course was one day shorter for dequalinium than for clindamycin vaginal cream and dequalinium did not weaken latex condoms. **Agreed:** Dequalinium chloride classified as a BROWN 2nd line drug after treatment failure with metronidazole (oral and vaginal). **Action:** The Guideline Group was tasked to clarify the messages in the formulary to reflect the positioning agreed.	**SD** **SD**
c.	**<u>Nortriptyline</u>** Mr Dhadli highlighted that, in the light of a very significant increase in the price of nortriptyline and the amount of prescribing, it had been decided to review its place in therapy in primary care. Nortriptyline had not received a traffic light classification and had two indications of depression and neuropathic pain. In August 2014 the local neuropathic guidance had been updated to indicate that the second line tricyclic antidepressant (TCA) was imipramine not nortriptyline in terms of cost effectiveness if intolerable adverse effects developed with the use of amitriptyline. Previous neuropathic pain guidance had listed three TCAs in order of cost as amitriptyline, imipramine and nortriptyline. In the NICE guidance it had been stated that amitriptyline, clomipramine, dosulepin had more sedative properties and imipramine, lofepramine and nortriptyline had less. Dr R Faleiro, DTHFT Pain Consultant, had indicated that nortriptyline was better tolerated than other TCAs and had recommended that it should not be assigned a traffic light classification of BLACK but moved down the list of product choices. **Agreed:** Nortriptyline classified as BROWN as 2nd line to amitriptyline (amitriptyline and imipramine were cost effective choices compared to nortriptyline).	**SD**
d.	**<u>Alimemazine</u>** Mr Dhadli stated that alimemazine was used as a premedication and sedative in children aged two to seven years and also for urticaria and pruritis. The high cost of both the tablets and oral solution was highlighted and it was noted that DHcFT had issued a statement to say that nobody would be initiated on this treatment long term. JAPC had discussed alimemazine at the meeting held in September 2016 and a traffic light classification decision had been delayed pending feedback from community paediatricians. **Agreed:** Alimemazine classified as a BLACK drug as not cost effective and not supported by high quality clinical evidence.	

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Item		Action
8.	**CLINICAL GUIDELINES**	
a.	**Amiodarone** Mr Dhadli stated that the amiodarone monitoring protocol was due for renewal and had therefore been updated. The main changes had been to the drug interactions on page 6 and then to the aligned monitoring checklist in appendix 1. **Action:** JAPC ratified the amiodarone monitoring protocol with a two year review date.	**SD**
b.	**Bowel Cleansing** Mr Dhadli reported that the bowel cleansing guideline for use in patients before operations or procedures was due for renewal in March 2017 and had been reviewed by Dr Andy Cole, DTHFT Consultant Gastroenterologist. Dr Cole had recommended the removal of barium enema from the guideline but it was queried whether this would be replaced by CT colonography. Mr Dhadli would contact Dr Cole to check on this. **Action:** JAPC ratified the bowel cleansing guideline with a two year review date.	**SD**
c.	**Clozapine** Mr Dhadli reported that the clozapine guideline had been updated by DHcFT and gave GPs information about when patients might present with different types of symptoms, what to look out for when patients were taking this drug and how it should be recorded on primary care clinical systems. Dr Mott referred to the important need to highlight to GPs that clozapine was a specialist drug and indicate clearly the links from which information about aspects such as the interactions with other drugs and monitoring could be obtained. It was noted that a reference to all red drugs, including clozapine, was made on the DHcFT patient discharge letter but Dr Emslie advised that it should be highlighted at the top of the discharge letter that clozapine should be added to the electronic patient's medication list. Dr Narula queried what GPs could prescribe to patients who suffered from nausea and vomiting, which was a common side effect of clozapine, in view of the advice to avoid prochlorperazine, metoclopramide and domperidone. Dr Taylor would check the interactions section and advise Mr Dhadli accordingly for inclusion in the guideline. **Agreed:** JAPC ratified the clozapine guidance with the agreed amendments.	**ST** **SD**
d.	**Compression Hosiery** Mr Dhadli reported that the compression hosiery guideline has been reviewed by Ms J Townsend, DCHSFT Tissue Viability Clinical Team Lead, and Dr G Colver, CRHFT Consultant Dermatologist, and minor changes had been made. The guideline highlighted that, in 95% of cases, the measurements for compression hosiery were likely to fall within the manufacturer's standard size garments. **Agreed:** JAPC ratified the Guideline for the Use of Compression Hosiery with a review date of two years.	**SD**

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e.	**EllaOne** Mr Dhadli reported that the ulipristal acetate emergency contraception (EllaOne®) guideline was due for renewal and had therefore been sent to public health sexual health specialists and Dr Nathani for review. Minor changes had been made including a reference to body weight and BMI following MHRA 2014. Advice about enzyme-inducing drugs needed to be included in the light of a MHRA alert issued in 2016. This referred mainly to levonorgestrel but had also included guidance for EllaOne® to indicate that it was not recommended in women who were using enzyme-inducing drugs or who had stopped them in the last four weeks. In the levonorgestrel section it was highlighted that Upostelle® had replaced Levonelle® and in the quick reference flowchart the timelines were now in days rather than hours. **Agreed:** JAPC ratified the Management of Emergency Contraception with Ulipristal Acetate 30 mg (EllaOne®) guideline with a review date of two years.	**SD**
f.	**High Cost Drug Pathways** Mrs Qureshi advised that two clinical pathways for high cost drugs, CCG commissioned and outside tariff had been updated in the light of NICE guidance: • The ankylosing spondylitis pathway now updated to include secukinumab (NICE TA 407). • The rheumatoid arthritis algorithm had been updated and re-formatted in conjunction with DTHFT. The first line biologic agent was etanercept biosimilar and for patients with an inadequate response to abatacept could be considered alongside rituximab. **Agreed:** The ankylosing spondylitis pathway and rheumatoid arthritis algorithm would be ratified virtually if no comments were received from CRHFT clinicians. Any comments received would be discussed by JAPC at a future meeting.	
g.	**Hypertension** Mr Dhadli reported that the management of hypertension using Ambulatory Blood Pressure Monitoring (ABPM) guideline had been updated in accordance with NICE CG127 issued in November 2016 which updated previous NICE guidance. This included recommendations from MHRA drug safety alerts on angiotensin-converting enzyme (ACE) inhibitors during pregnancy and breastfeeding. **Agreed:** JAPC ratified the management of hypertension using Ambulatory Blood Pressure Monitoring (ABPM) guideline with a review date of two years.	**SD**
h.	**Tacrolimus** Mr Dhadli reported that the protocol for use of topical tacrolimus in primary care had been updated due to previous concerns about adverse effects and toxicity. A reference had been made to NICE TA 82 Tacrolimus and Pimecrolimus for atopic eczema published in 2004 which had outlined the circumstances when tacrolimus and pimecrolimus could be used.	

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Item		Action
	Agreed: JAPC ratified the protocol for use of topical tacrolimus in primary care with a review date of two years.	**SD**
i.	**<u>Wound Care</u>** Mr Dhadli referred to the Derbyshire Community Dressing Formulary and Wound Care Guidelines 2016 which had been developed by DCHSFT in collaboration with the East Midlands Tissue Viability Group. The aim had been to provide clinically effective, appropriate and cost effective choices of products to manage the vast majority of wounds in Derbyshire. A cost analysis had been prepared by DCHSFT and savings of between £123K and £161K without prescription had been indicated and FP10 was cost neutral. It was noted that these savings were inclusive of VAT. Mr Dhadli stated that there was also a quick reference guide and it was agreed that it would be advantageous to highlight these to primary care staff. **Agreed:** JAPC ratified the Derbyshire Community Dressing Formulary and Wound Care Guidelines 2016 with a review date of two years.	**SD**
9.	**PATIENT GROUP DIRECTIONS**	
	The Public Health England Patient Group Direction for the following PGD was noted and agreed by JAPC: • Administration of Haemophilus influenzae type b and meningococcal C conjugate vaccine (Hib/MenC) to individuals, from their second birthday, with an underlying medical condition which puts them at increased risk from Haemophilus influenzae type b and Neisseria meningitis capsular group C. The Patient Group Direction for the following PGD for use within North Derbyshire Healthcare Limited was noted and agreed by JAPC: • Triamcinolone Acetonide for the treatment of joint pain, swelling and stiffness associated with rheumatoid or osteo-arthritis, bursitis, tendonopathy and tenosynovitis. A commencement and expiry date would be added to the PGD. **Action:** The Patient Group Directions would be placed on the Medicines Management website.	**KN** **SD**
10.	**MONTHLY HORIZON SCAN**	
	<u>Monthly Horizon Scan</u> Mr Dhadli advised JAPC of the following new drug launches in the UK: Opicapone (Ongentys®) – Classified as **BLACK** due to lack of cost effectiveness. Agreed to wait for request or NICE evidence review expected in February 2017. Resilizumab (Cinqaero®) – NHS England. Classified as **RED.** Mr Dhadli advised JAPC of the following new drug formulation: Certolizumab pegol (Cimzia AutoClicks®) – Already classified as **RED** with a more user friendly device. Factor IX, recombinant (Rixubis®) – Already classified as **RED** as per NHS England commissioning intentions.	**SD** **SD**

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Item		Action
	2017/18 Horizon Scanning Mrs Qureshi referred JAPC to the annual horizon scan for new drugs. This had been developed using the Prescribing Outlook New Medicines from September 2016; Prescribing Outlook National Developments; the new medicines cost calculator and the NICE forward planner. The document had been divided into four sections: • Drugs with primary care implications. • Drugs likely to be initiated by secondary care for continued prescribing in primary care. • Secondary care excluded from tariff drugs. • Secondary care in-tariff drugs. The annual horizon scan for new drugs was noted by JAPC.	
11.	**MISCELLANEOUS**	
a.	**Medication after Bariatric Surgery** Mr Dhadli reported that queries had been received from practice pharmacists about the nutritional supplements and short-term medicines which were indicated on patient discharge letters from DTHFT and Sheffield Teaching Hospitals Foundation Trust following bariatric surgery. The Guideline Group had proposed a Derbyshire wide protocol but it had not been possible to achieve consensus between the two Trusts about this and therefore two documents would be necessary. Mr Dhadli advised that the DTHFT guidance had been developed in conjunction with the best practice guidelines issued by the British Obesity and Metabolic Surgery Society (BOMSS) and in consultation with Mr S Awad, Consultant Surgeon, The East Midlands Bariatric and Metabolic Institute, DTHFT. The BOMSS guidance aimed to deal with the wide variation in practice concerning peri-operative and postoperative biochemical monitoring and micronutrient replacement for patients undergoing bariatric surgery. During discussion Dr Mott highlighted an issue concerning the prescribing of lifelong vitamins such as vitamin D and the discrepancy between the positions of the two Trusts about this. **Agreed:** A decision on the medication after bariatric surgery guidance would be deferred to January or February 2017 when the guidance developed by Sheffield Teaching Hospitals Foundation Trust would be available.	**SD**
b.	**Buprenorphine** Mrs Qureshi advised that there was a wide range of buprenorphine patches with different strengths and frequency of replacement. Reletrans® was the preferred cost effective seven day patch in the North and there were also three higher strength patches which were changed twice weekly or every three days: Hapoctasin®, Transtec® and Bupeaze®. Mr Dhadli added that the UKMI document on the minimisation of risks of medication errors with buprenorphine patches had recommended the use of the most cost effective option and inferred inter-changeability when the correct duration patch is selected.	

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Item		Action
	JAPC agreed that the most cost effective seven day patch should be used however noting also that the North were in the completion of this work for the lower strength patches with the use of Reletrans® over generic and Butrans® **Agreed:** Buprenorphine high strength patches classified as BROWN drugs - most cost effective brand should be used as determined by prescribing subgroups.	**SD**
c.	**Nefopam** Mr Dhadli stated that at the November 2016 meeting JAPC had classified nefopam as a BLACK drug and it had been agreed that the advice of the pain management consultants should be requested about how a review of those patients who were already taking nefopam could be undertaken. Dr Makkinson and Dr Farquharson, CRHFT Consultant Anaesthetist, had advised there may be issues associated with stopping nefopam abruptly and therefore recommended that the dose should be tapered by 30mg per day for those patients who had been prescribed nefopam over a long period of time. Ms Shaw advised that DCHSFT had recently purchased a stock of nefopam and consequently there would be some short-term use although there was ongoing work on alternatives. Dr Mott highlighted the importance of communicating the message about nefopam to primary care and it was agreed that the north and south prescribing groups should discuss further.	
d.	**NHS England Consultation** Mr Dhadli reported that NHS England had started a consultation exercise on four papers which related to the funding of treatment outside of clinical commissioning policy or mandated NICE guidance. The four papers covered in-year service development; individual funding requests; funding for experimental and unproven treatments and continuing funding after clinical trials. The consultation period would end on 15th January 2017.	
e.	**Otitis Externa Products** Mr Dhadli advised that there had been a significant and sustained increase in the unit price of two commonly prescribed ear products: gentamycin/ hydrocortisone and flumetasone/clioquinol. Mr Dhadli added that patients with otitis externa were usually initially treated empirically at first presentation in primary care so choice of product was less important. **Agreed:** Gentamycin hydrocortisone and flumetasone/clioquinol classified as BROWN drugs as less cost-effective than current standard therapy.	**SD**
12.	**JAPC BULLETIN**	
	The bulletin was tabled for information and ratified by JAPC.	**SD**
13.	**PATIENT SAFETY ALERT**	
	The Patient Safety Alert issued on 16 November 2016 on the risk of severe harm and death due to withdrawing insulin from pen devices was noted by JAPC.	

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Tel: 01332 868781
Email: slakahan.dhadli@southernderbyshireccg.nhs.uk

Item		Action
	Ms Shaw advised that the DCHSFT policy for the administration of insulin by District Nurses and other members of staff who visited patients at home in order to administer insulin was being reviewed. A main focus of the review was to train patients and carers to inject their own insulin using the device which the particular individual was familiar with. In addition, there was also ongoing work to limit the current wide variety of pen devices.	
14.	**MHRA DRUG SAFETY UPDATE**	
	The MHRA Drug Safety Alert for November 2016 was noted: Mr Dhadli highlighted the following MHRA advice: • Brimonidine gel (Mirvaso®): risk of exacerbation of rosacea.	
15.	**NICE SUMMARY**	
	Mrs Qureshi informed JAPC of the comments for the CCGs which had been made for the following NICE guidance issued in November 2016: TA 288 (Updated) and TA418 Dapagliflozin in triple therapy for treating type 2 diabetes - Current traffic light classification of **BROWN** as per NICE TA 288. The diabetes guidance would be amended as previously dapagliflozin had not been recommended in triple therapy except as part of a clinical trial. It was now to be included as recommended for triple therapy but only with metformin and a sulfonylurea. TA417 Nivolumab for previously treated advanced renal cell carcinoma – Classified as a **RED** drug. TA419 Apremilast for treating moderate to severe plaque psoriasis – Classified as a **RED** drug.	**SD** **SD** **SD**
16.	**TRAFFIC LIGHTS – ANY CHANGES?**	
	Classifications Cilodex **– GREEN** for use in children with acute otitis media with tympanostomy tubes Dequalinium vaginal tablets – **BROWN** 2nd line to metronidazole Nortriptyline – **BROWN** 2nd line to amitriptyline Alimemazine – **BLACK** Opicapone – **BLACK** Resilizumab – **RED** (NHS England) Cabazantinib – **RED** Factor IX, recombinant (Rixubis®) – **RED** Buprenorphine patches (high strength) – **BROWN** (use most cost effective brand) Gentamicin hydrocortisone – **BROWN** Flumetasone/Clioquinol 0.02%/1% w/v ear drops solution – **BROWN** Dapagliflozin – **BROWN** as per NICE TA 418 Nivolumab – **RED** as per NICE TA 417 Apremilast – **RED** as per NICE TA 419	

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Item		Action
17.	**JAPC ACTION SUMMARY**	
	The action summary was noted by JAPC and amendments made: PCSK9 inhibitors and Lipid/Familial Hypercholesterolaemia guidance – Dr Mott would contact Dr Stanworth and Dr Masters to ascertain progress on the production of the draft lipid guidance. Guanfacine - To be brought to the January 2017 JAPC meeting. Osteoporosis - To be brought to the January 2017 JAPC meeting. Sacubitril/Valsartan – To be brought to the March 2017 JAPC meeting. Alimemazine - To be taken off the list. Nefopam – To be taken off the list.	**AM** **SD** **SD** **SD** **SD** **SD**
18.	**GUIDELINE GROUP ACTION TRACKER**	
	The summary of key messages from the Derbyshire Medicines Management Guideline Group meeting held in November 2016 was noted. Mr Dhadli highlighted the following: • Olive oil ear drops to be prescribed as Arjun® ear drops as most cost effective choice. • Hexetidine to be prescribed first line and then chlorhexidine (as Corsodyl®). • Advised to prescribe Beclometasone Aqueous Spray rather than Beconase® due to cost. • Constipation flow chart updated to use bisacodyl first line rather than senna and include macrogol for faecal impaction and chronic constipation. • Restless Leg Syndrome - ropinirole, pramipexole and rotigotine classified as BROWN for severe RLS in patients with significant impact on quality of life and following self help measures. • Buprenorphine patches classified as BROWN in CKD 4 and 5 when other treatment options have been considered. • Venlafaxine MR Vensir® as recommended treatment but no comment on using it off licence as this agreed clinician/practice level. Dr Taylor reported that the antipsychotics guideline was the subject of internal discussions within DHcFT. Dr Taylor would liaise with Ms B Thompson about an interim update to the guideline until the updated version was ready. Mrs Needham reported that work was in progress on the nicotine replacement therapy. Mr Dhadli advised that the phosphate binders guideline had been updated with the inclusion of minor changes. However the Guideline Group had queried the inclusion of sevelamer as there was a generic alternative.	**ST**

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Item		Action
19.	**MINUTES OF OTHER PRESCRIBING GROUPS**	
	• Burton Drugs and Therapeutic Committee 12/09/16 • DHcFT Drugs and Therapeutic Committee 22/09/16 • Clinical Commissioning Policy Advisory Group 13/10/16 • DTHFT Drugs and Therapeutic Committee 18/10/16	
20.	**ANY OTHER BUSINESS**	
	Dr Narula highlighted an issue concerning SystmOne and the due dates of patient medication reviews. The clinical system was shared by DCHSFT and medication reviews were indicated as having been completed with the result that some medications were re-authorised although these had not been initiated by the Trust. In addition, no known allergies were being recorded every time the patients were seen even though these had already been recorded. Ms Shaw would highlight this within the Trust.	**JS**
21.	**DATE OF NEXT MEETING**	
	Tuesday, 10th January 2017 at 1.30pm in the Post Mill Centre, South Normanton.	