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DERBYSHIRE JOINT AREA PRESCRIBING COMMITTEE (JAPC)

Minutes of the meeting held on 11th October 2016

CONFIRMED MINUTES

Summary Points

Traffic lights

Drug	Decision
Asparaginase recombinant (Spectrila®)	RED (NHS England)
Lisdexamfetamine	AMBER 2nd line option for the treatment of ADHD within the shared care guideline
Selexipag (Uptravi®)	RED (NHS England)
Susoctocog alfa (Obizur®)	RED (NHS England)
Crizotinib	RED as per NICE TA 406 (NHS England)
Secukinumab	RED as per NICE TA 407
Pegaspargase	RED as NICE TA 408 (NHS England)
Aflibercept	RED as per NICE TA 409
Talimogene laherparepvec	RED as per NICE TA 410
Necitumumab	BLACK as per NICE TA 411(NHS England)
Radium-223 dichloride	RED as per NICE TA 412 (NHS England)

Clinical Guidelines
Management of non-valvular atrial fibrillation
Management of pregnant women and neonates in contact with measles guidance
Management of Lower Urinary Tract Infection (UTI) in Chronic Kidney Disease (CKD)

Patient Group Directions
Pneumococcal Polysaccharide Vaccine (PPV)

Shared Care Guidelines
Attention Deficit Hyperactivity Disorder (ADHD) in Children and Adults
Buprenorphine sublingual 0.4mg, 2mg and 8mg tablets in opioid dependency
Methadone 1mg/ml oral solution in opioid dependency
Naltrexone 50mg tablets for opioid relapse prevention
Somatropin (Synthetic Human Growth Syndrome)

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Present:	
Southern Derbyshire CCG	
Dr A Mott	GP (Chair)
Mr S Dhadli	Specialist Commissioning Pharmacist (Secretary)
Mrs L Hunter	Assistant Chief Finance Officer
Mr S Hulme	Director of Medicines Management
Dr M Watkins	GP
North Derbyshire CCG	
Dr C Emslie	GP
Dr T Narula	GP
Mrs K Needham	Assistant Chief Quality Officer (Medicines Management) - also representing Hardwick CCG
Ms J Town	Head of Finance
Hardwick CCG	
Dr T Parkin	GP
Erewash CCG	
Dr M Henn	GP
Derby City Council	
Dr R Dewis	Consultant in Public Health Medicine
Derbyshire County Council	
Derby Teaching Hospitals NHS Foundation Trust	
Dr W Goddard	Chair - Drugs and Therapeutic Committee
Derbyshire Healthcare NHS Foundation Trust	
Dr S Taylor	Chair – Drugs and Therapeutic Committee
Chesterfield Royal Hospital NHS Foundation Trust	
Ms C Duffin	Principal Pharmacist
Derbyshire Community Health Services NHS Foundation Trust	
Ms A Braithwaite	Head of Medicines Management
In Attendance:	
Mr A Thorpe	Derby City Council (minutes)
Mrs T Taylor	Team Leader, Derby City Council

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Item		Action
1.	**APOLOGIES**	
	Ms S Bassi, Mr C Newman, Mrs S Qureshi and Mr M Shepherd.	
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**	
	• Supply of items for administration by DCHST Nursing Staff. • Supply of insulin to housebound patients by DCHST Nursing Staff.	
4.	**MINUTES OF JAPC MEETING HELD ON 13 SEPTEMBER 2016**	
	The minutes of the meeting held on 13th September 2016 were agreed as a correct record after the following amendments: Management of Type 2 Diabetes in Adults - Amend to: 'Mr Hulme commented that the reply indicated that NICE had considered the safety element. Local clinicians have raised concerns about the risk of bladder cancer associated with the use of pioglitazone'. Bath Emollients/Shower Gels – Amend to' It was suggested that there should be restricted cost effective preferred formulary and it could include one that contained an antibacterial' and 'Dr Henn commented that there were other products available in cases of defined clinical need rather than bath emollients/shower gels; although it would be useful for GPs to have a list of recommended products that can be used as a soap substitute.'	
5.	**MATTERS ARISING**	
a.	**Guidance on the Prevention, Diagnosis and Management of Vitamin D Deficiency in Primary Care** It was reported that North Derbyshire CCG's Prescribing Group would consider how awareness could be raised and access to the Healthy Start Scheme be improved in connection with routine postnatal and baby checks at their meeting next week.	
b.	**Alimemazine** Dr Mott highlighted that JAPC had agreed that alimemazine should be considered for future classification of BROWN or BLACK pending DHcFT feedback on the exceptionality of promethazine. This would be placed on the JAPC action tracker for an update in December 2016.	**SD**
c.	**Medicines Prescribed by other Healthcare Providers** Dr Goddard referred to the list which had now been obtained of the renal patients on the specialist drugs classified as RED and queried whether a letter to inform GPs had been circulated. Dr Mott replied that a letter had been distributed but further action would be undertaken by the North and South Prescribing Groups in conjunction with the providers.	

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d.	**Regional Medicines Optimisation Committee** It was noted that a response from JAPC had now been conveyed concerning the proposed establishment of Regional Medicines Optimisation Committees.	
e.	**Bath Emollients/Shower Gels** Mr Dhadli reported that the emollient prescribing guide had now been updated to include AproDerm® cream as a cost effective emollient. The guidance also now made clear which products within their licensed indications could be used as soap substitute but JAPC accepted that in clinical practice all products listed could be used as soap substitutes. Mr Dhadli highlighted that, in the emollient choice for dry skin, a reference had been made for patients who reported stinging with emollients to consider use of the AproDerm® colloidal oatmeal cream. However there were other products which contained the same sensitiser as AproDerm® and Aveeno® and others which did not contain any sensitisers. It was agreed that the reference to AproDerm® would be taken out and the MIMS Online list of skin emollients with potential skin sensitisers be added, if this was permissible. In the baths section it was also highlighted that the statement about the classification by JAPC of all bath emollients as BLACK should refer to bath and shower emollients – this would be amended. **Agreed:** JAPC ratified the Emollient Prescribing Guide with the agreed amendments.	**SD** **SD**
f.	**Sayana Press** Dr Dewis advised that the protocol for Sayana Press® would be brought to the November JAPC meeting.	**RD**
6.	**CLINICAL GUIDELINES**	
a.	**Atrial Fibrillation** Mr Dhadli advised that the guideline for the management of non-valvular atrial fibrillation had been updated to include edoxaban as an alternative oral anticoagulant drug with details of its licensed indications and contraindications and compliance with NICE TA 355. A query had been raised concerning the reference to weights on page 19 of the guidance about whether ideal or actual body weight should be used. The SPC for each of the anti-coagulant drugs recommended that the Cockcroft Gault formula involving serum creatinine, age, weight and gender should be used for dosing and monitoring. For dabigatran the advice from the manufacturer concerning weight was to use ideal bodyweight in patients who were overweight. A reference would therefore need to be added for actual bodyweight in underweight patients. In the case of edoxaban advice was awaited from the manufacturer but it was likely that actual bodyweight would be used. Mrs Needham referred to the change in the guidance that amiodarone would now be initiated by the hospital only and that the CRHFT Drugs and Therapeutic Committee had recommended that this should be done by a cardiologist only during previous discussions about amiodarone. Dr Emslie commented that a previous recommendation had been made that initiation should not necessarily be done by a cardiologist.	

Item		Action
	Further amendments agreed were the inclusion of a reference to the anticoagulant guidance and the removal of the phrase 'grown up' in the phrase about congenital heart disease. **Agreed:** JAPC ratified the guideline for the management of non-valvular atrial fibrillation for a period of two years.	**SD**
b.	**Pregnant Women and Neonates in Contact with Measles** Mr Dhadli reported that this guidance had been produced by Dr Diane Harris, Lead Antimicrobial Pharmacist, in August 2016 following a query from a GP who had requested advice. Guidance had been provided on the management of pregnant women and neonates in contact with measles and this highlighted the importance of contact with the local hospital microbiology department by the GP or midwife. Public Health England and chapter 21 in the Green Book had been used as references. Dr Henn queried whether there were any contacts with Nottingham due to the significant numbers of patients who accessed the Queen's Medical Centre. Mr Dhadli would query the out of area patients with Dr Harris. **Agreed:** JAPC ratified the management of pregnant women and neonates in contact with measles guidance.	**DH** **SD**
c.	**Management of Lower Urinary Tract Infection (UTI) in Chronic Kidney Disease (CKD) – Review of Existing Guideline** Mr Dhadli reported that there was no change to the existing guidance which was being reviewed by GPs and microbiologists. Dr Henn referred to the prescribing of nitrofurantoin in connection with a national quality target for CCGs to reduce blood borne, particularly e-coli, infections. The target included the ratio between trimethoprim and nitrofurantoin prescribing and the recommendation that nitrofurantoin should not be prescribed below an eGFR of 45. The MHRA had reviewed the evidence for this contraindication, in the light of increasing antibiotic resistance of lower urinary tract pathogens to standard therapy, and produced a statement to indicate that a short course of nitrofurantoin could be used with caution in certain patients with an eGFR of 30 to 44 ml/min/1.73m. Dr Henn queried whether this statement could be included in the guidance. Mr Dhadli undertook to check the MHRA guidance and include in the guidance if pertinent. An update would be given to the November JAPC meeting. **Agreed:** JAPC ratified the Guideline for the Management of Lower Urinary Tract Infection (UTI) in Chronic Kidney Disease (CKD) – Review of Existing Guideline.	**SD** **SD**
7.	**PATIENT GROUP DIRECTIONS**	
a.	**Derbyshire Health United Patient Group Directions for Use in Out of Hours** Dr Mott referred to the PGDs for the following which had been submitted by Derbyshire Health United (DHU) for use in the Out of Hours Service:	

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Item		Action
	• Chlorphenamine 2mg solution • Chlorphenamine 4mg tablet • Clarithromycin • Erythromycin • Flucloxacillin • Prednisolone 5mg tablet • Salbutamol 100mcg inhaler • Salbutamol nebulising solution It was highlighted to JAPC that there was a process issue associated with the production of the PGDs and clarification was therefore about the content in order to ensure that patients received safe and appropriate care and timely access to medicines. Mr Dhadli advised that these PGDs had been submitted by Leslie Harris, DHU Senior Nurse, and developed internally via internal governance and signed off by eight officers. The antimicrobial sign-off had been provided by Dr Diane Harris but it was noted that this did not include checks for validity and accuracy, only the alignment to local formulary choice and indication. Mr Dhadli advised that the remit of JAPC was to approve the PGDs, as DHU was unable to do this due to being a social enterprise and not a designated NHS body, and ensure that the PGDs were aligned with local formularies. There had been recent discussions with Dr Diane Harris and Ms Kara Lindley, SD CCG Lead Pharmacist, when the governance issues concerning the PGDs had been discussed. It had been highlighted that, although the PGD template used by DHU covered most of the required aspects and an internal working group had considered the governance issues, there were still some significant omissions as follows: • Validity dates (from and to); • Quantities; • Recording; and • Access to resources only linked to old not current SPCs; and, in addition, a list of inconsistencies with clinical content was raised. **Action:** Dr Mott would write to DHU and request that the PGDs be fully developed in order that the procedures could be tightened.	**AM**
b.	**<u>Pneumococcal Polysaccharide Vaccine (PPV)</u>** Mr Dhadli reported that Public Health England had developed the PGD template in order to facilitate the delivery of immunisations in the NHS in line with national recommendations. This concerned the administration of 23-valent pneumococcal polysaccharide vaccine (PPV) to individuals from 65 years of age and individuals from 2 years of age in a clinical risk group in accordance with the national immunisation programme for active immunisation against pneumococcal disease. **Agreed:** The pneumococcal polysaccharide vaccine (PPV) PGD was noted and agreed by JAPC.	**SD**

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Item		Action
8.	**SHARED CARE**	
a.	**Attention Deficit Hyperactivity Disorder (ADHD) in Children and Adults** JAPC had agreed an extension to November 2016 for the shared care guideline for ADHD at the September 2016 meeting in order to ensure that an in-date policy was on the medicines management website and used within the Trust while an in-house review of the use of guanfacine and place in therapy of lisdexamfetamine was undertaken. Dr Taylor stated a review had been requested concerning the place of lisdexamfetamine in the management of attention deficit hyperactivity disorder (ADHD) in children and adults shared care guideline. Dr Taylor referred to a study paper to support the efficacy of lisdexamfetamine for second line use for families in crisis and in cases where the medication was not required every day. Mr Dhadli advised that the ADHD shared care was due to expire in November 2016 and included the use of lisdexamfetamine, second line over atomoxetine. JAPC had previously reviewed lisdexamfetamine mesilate as a second line treatment for ADHD in children aged six years of age and over. There had been three controlled trials of lisdexamfetamine, including Coghill et al in 2013, and advice received from the Royal Pharmaceutical Society to indicate that lisdexamfetamine should be treated as though it was a schedule 2 controlled drug. There was a potential for increased adherence with once daily dosing of lisdexamfetamine and the capsules could be dissolved in water or swallowed as a liquid which could not be done with atomoxetine. It was also cost effective when compared to atomoxetine and faster acting. The NICE Evidence Summary in 2013 on attention deficit hyperactivity disorder in children and young people: lisdexamfetamine dimesylate had recommended that, when drug treatment of ADHD was considered appropriate, methylphenidate, atomoxetine and lisdexamfetamine were suitable options within their licensed indications. The SMC had accepted lisdexamfetamine in April 2013 for children and 2015 in adults after a response to methylphenidate had been considered to be inadequate. Safety and efficacy issues with lisdexamfetamine had been highlighted but these were consistent with other amphetamines. However a possible advantage for the use of lisdexamfetamine was the absence of clinically significant psycho-active effects when administered by intra-nasal or IV means which could reduce the possibility of abuse and misuse. During discussion Mr Hulme referred to a possible increase in costs associated with any switch of patients from atomoxetine to lisdexamfetamine but was informed that this was likely to be cost-neutral. Mr Dhadli also referred to the physical monitoring section on page 7 of the shared care guideline and the change for height and weight measurements to take place every six months from three – this was in line with NICE. An amendment would also be made to the section which outlined who had been involved in the preparation of the document. **Agreed:** JAPC ratified the shared care guideline for Attention Deficit Hyperactivity Disorder (ADHD) in Children and Adults with the agreed amendments for a period of two years.	**SD** **SD**

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b.	**Buprenorphine** Dr Taylor stated that the shared care guideline document for the use of buprenorphine in opioid dependency had been reviewed and updated but no significant changes had been made. Effect on ability to drive and operate machinery added. **Agreed:** JAPC ratified the buprenorphine sublingual 0.4mg, 2mg and 8mg tablets shared care guidance for a period of two years.	**SD**
c.	**Methadone** Dr Taylor stated that an update of the shared care document for the use of methadone in opioid dependency had been reviewed. No major changes. Effect on ability to drive and operate machinery added. **Agreed:** JAPC ratified the methadone 1mg/ml oral solution shared care guideline for a period of two years.	**SD**
d.	**Naltrexone** Mr Dhadli highlighted that the only main change was the transfer of responsibilities from GPSIs and GPs working for the enhanced service to GPs, which had been included in the old guidance, to GPs only. Discussion followed and Dr Mott queried whether GPs were aware of this change and, if so, were they happy to prescribe naltrexone. Mr Dhadli had raised this with Dr Senthil Mahalingham, DHcFT Consultant Psychiatrist in Substance Misuse, and had been informed that it had been agreed that GPs could take on the prescribing of naltrexone as it would be beneficial to the relatively few service users in Derby City. Dr Dewis commented that there had been two GPSIs in the City and these had been commissioned via the provider, not the commissioner. However the GPSIs were no longer in post. Concern was expressed that the responsibility had now been passed over to GPs with no consultation and it would also be advantageous to have an idea about the numbers of patients involved. Dr Emslie highlighted that every patient who was on naltrexone should have a drug support worker who would ensure that the patients in their care had the required blood and urine tests done. Dr Taylor agreed to take back the concern of JAPC about the lack of consultation in relation to the transfer of responsibilities from GPSIs to GPs and update at a future meeting. **Agreed:** JAPC ratified the shared care guidance for naltrexone 50mg tablets for opioid relapse prevention for two years with the amendment in the areas of responsibility section to refer to GPSIs.	**ST** **SD**
e.	**Somatropin (Recombinant Human Growth Hormone)** Mr Dhadli reported that this was an update to an existing shared care guidance which had expired in July 2016. The guidance had been sent for consultation with a consultant paediatrician, specialist pharmacist, consultant endocrinologist and endocrine specialist nurses. During discussion Dr Mott queried whether a shared care guideline was needed. Dr Watkins referred to the difficulty caused for patients in those shared care cases when a GP declined to prescribe the appropriate drug(s).	

Item		Action
	Mrs Needham suggested that a traffic light classification of green specialist initiation could resolve this potential problem, although a drug such as somatropin was unusual and not often encountered in primary care and it was unlikely that a GP would see sufficient patients to acquire a detailed knowledge of the drug. Dr Emslie advised that a shared care agreement could be used as a lever to ensure that the drug or drugs in question were prescribed. Mr Dhadli queried whether there were more cost effective versions of the somatropin injections and would discuss this further with Dr Tracy Tinklin, DTHFT Consultant Paediatrician. **Agreed:** JAPC ratified the shared care guideline for somatropin.	**SD** **SD**
9.	**MONTHLY HORIZON SCAN**	
	Mr Dhadli advised JAPC of the following new drug launches, new drug formulations, licence extensions and drug discontinuations: New drug launches in the UK: Asparaginase recombinant (Spectrila®) – NHS England. Awaiting NICE TA in June 2017. Classified as **RED.** Ataluren (Translarna®) – Already classified for duchenne muscular dystrophy. Selexipag (Uptravi®) – NHS England. Classified as **RED.** Susoctocog alfa (Obizur®) – NHS England. Classified as **RED.** Trifluridine + tipiracil (Lonsurf®) – NHS England. Already classified as **RED.**	**SD** **SD** **SD** **SD**
10.	**MISCELLANEOUS**	
a.	**<u>Conflicts of Interest</u>** Mr Dhadli advised JAPC that NHS England had recently published 'Managing Conflicts of Interest: Revised Guidance' in June 2016 and it had therefore been decided to look at the declarations of interest process for JAPC and the Guideline Group in conjunction with colleagues from Information Governance. It had now been decided to develop a form to be completed by JAPC and Guideline Group members every six months. In this form members would need to declare any conflicts of interest and have completed their mandatory training for equality and diversity as per parent organisation. The JAPC and Guideline Group terms of reference would also need to be updated. The cover sheets for both JAPC and the Guideline Group would be streamlined and the conflicts of interest declaration form would now include an appendix with definitions taken from NHS England: • Those with financial interest; • Non-financial interest; • Personal interest; and • Indirect interest. It was also proposed that a register of interests would be tabled as a regular agenda item for JAPC and the Guideline Group meetings and this would list each member and the nature of any interest. The JAPC front sheet had also been updated to align with the conflict of interest declaration forms.	

Item		Action
	In connection with the decisions made at JAPC meetings it was intended that, in order to make this a more transparent and consistent process, the following factors would be considered and recorded in the minutes: • Clinically effectiveness; • Cost effectiveness; • Safety; and • Patient considerations. Mr Dhadli added that anybody outside of JAPC or the Guideline Group would be required to complete a conflict of interest declaration form and this would be included with the front cover sheet. Failure to do this would result in the paper not being submitted to JAPC or the Guideline Group. **Agreed:** The revised Conflict of Interest process for JAPC and Guideline Group meetings was ratified.	**SD**
11.	**JAPC BULLETIN**	
	Dr Narula advised that the term 'non diabetes/hyperglycaemia (non-diabetes) should be used instead of 'non-diabetes' – this would be amended in the bulletin. Dr Narula also referred to the diabetes prevention programme to which people should be referred when it had been fully rolled out across Derbyshire; probably by January 2017 – a reference to this would be included in the bulletin. The revised bulletin was ratified by JAPC.	**SD** **SD** **SD**
12.	**MHRA DRUG SAFETY UPDATE**	
	The MHRA Drug Safety Alert for September 2016 was noted. Mr Dhadli highlighted the following MHRA advice: • Levonorgestrel-containing emergency hormonal contraception: advice on interactions with hepatic enzyme inducers and contraceptive efficacy. • Posaconazole (Noxafil): tablets and oral suspension not directly interchangeable. • Idelalisib (Zydelig▼): updated indications and advice on minimising the risk of infection.	
13.	**NICE SUMMARY**	
	Mr Dhadli informed JAPC of the comments for the CCGs which had been made for the following NICE guidance issued in September 2016. TA 406 Crizotinib for untreated anaplastic lymphoma kinase-positive advanced non-small-cell lung cancer – Classified as a **RED** drug (NHS England). TA 407 Secukinumab for active ankylosing spondylitis after treatment with nonsteroidal anti-inflammatory drugs or TNF-alpha inhibitors - Recommended, within its marketing authorisation, as an option for treating active ankylosing spondylitis in adults whose disease has responded inadequately to conventional therapy (non-steroidal anti-inflammatory drugs or TNF-alpha inhibitors).	**SD**

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	The commissioning algorithm would be updated and circulated to both providers. Classified as a **RED** drug.	**SD**
	TA408 Pegaspargase for treating acute lymphoblastic leukaemia- Classified as a **RED** drug (NHS England).	**SD**
	TA409 Aflibercept for treating visual impairment caused by macular oedema after branch retinal vein occlusion - Classified as a **RED** drug.	**SD**
	TA410 Talimogene laherparepvec for treating unresectable metastatic melanoma - Classified as a **RED** drug (NHS England).	**SD**
	TA411 Necitumumab for untreated advanced or metastatic squamous non-small-cell lung cancer – Necitumumab, in combination with gemcitabine and cisplatin, was not recommended within its marketing authorisation for adults with locally advanced or metastatic epidermal growth factor receptor (EGFR)-expressing squamous non-small-cell lung cancer that has not been treated with chemotherapy. Classified as a **BLACK** drug.	**SD**
	TA412 Radium-223 dichloride for treating hormone-relapsed prostate cancer with bone metastases – Radium-223 dichloride was recommended as an option for treating hormone relapsed prostate cancer, symptomatic bone metastases and no known visceral metastases in adults, only if they have already had docetaxel or docetaxel is contraindicated or is not suitable for them. Classified as a **RED** drug (NHS England).	**SD**
	NG53 Transition between inpatient mental health settings and community or care home settings.	
	NG54 Mental health problems in people with learning disabilities: prevention, assessment and management.	
	NG55 Harmful sexual behaviour among children and young people – This would be circulated to named safeguarding leads, CAMHS, social services, primary care and drug and alcohol services.	
	NG56 Multi-morbidity: clinical assessment and management – Mr Dhadli highlighted the section 'How to identify people who may benefit from an approach to care that takes account of multimorbidity' and the suggested consideration of using validated tool such as eFI, PEONY or QAdmissions, if available in primary care electronic health records, to identify adults with multimorbidity who were at risk of adverse events such as unplanned hospital admission or admission to care homes. There was also a reference to an approach to care that takes account of multimorbidity for adults of any age who are prescribed ten to fourteen regular medicines and who were prescribed fewer than ten regular medicines but were at particular risk of adverse events. Other tools had been referred to including the PRISMA-7 questionnaire, with scores of 3 and above indicating frailty. Mr Dhadli also referred to a recommendation of the need to inform a person who had been taking bisphosphonate for osteoporosis for at least three years that there was no consistent evidence of further benefit from continuing with this for another three years.	

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	Discussion would also include patient choice, fracture risk and life expectancy in the discussion. Mr Dhadli highlighted that this contraindicated guidance from the National Osteoporosis Guideline Group and the National Osteoporosis Society so comments about this had been requested by Dr Roger Stanworth, Consultant Rheumatologist. MIB78 QuikRead go for C-reactive protein testing in primary care. MIB80 FLEXISEQ for osteoarthritis – FLEXISEQ was a topically applied drug-free gel indicated for treating the symptoms of osteoarthritis. This would be discussed by JAPC if it was included in the drug tariff.	**SD**
13.	**TRAFFIC LIGHTS – ANY CHANGES?**	
	Classifications Lisdexamfetamine – **AMBER** 2nd line for the treatment of ADHD within the shared care guideline. Asparaginase recombinant (Spectrila®) – **RED** (NHS England). Ataluren (Translarna®) – Already classified **RED** for duchenne muscular dystrophy. Selexipag (Uptravi®) – **RED** (NHS England). Susoctocog alfa (Obizur®) – **RED** (NHS England). Trifluridine + tipiracil (Lonsurf®) – already **RED** (NHS England). Crizotinib – **RED** as per NICE TA 406. Secukinumab – **RED** as per NICE TA 407. Pegaspargase – **RED** as TA 408. Aflibercept – **RED** as per NICE TA 409. Talimogene laherparepvec – **RED** as per NICE TA 410. Necitumumab – **BLACK** as per NICE TA 411. Radium-223 dichloride – **RED** as per NICE TA 412.	
14.	**JAPC ACTION SUMMARY**	
	The action summary was noted by JAPC and amendments made: PCSK9 Inhibitors – To be brought to the December 2016 JAPC meeting. Guanfacine – To be brought to the January 2017 JAPC meeting. Osteoporosis – To be brought to the January 2017 JAPC meeting. Review of Dequalinium – To be brought to the November 2016 JAPC meeting. Sayana Press® - To be brought to the November 2016 JAPC meeting. Sacubitril/Valsartan – Review in six months. Alimemazine – To be brought to the December 2016 JAPC meeting.	**SD** **SD** **SD** **SD** **SD** **SD** **SD**
15.	**GUIDELINE GROUP ACTION TRACKER**	
	The summary of key messages from the Derbyshire Medicines Management Guideline Group meeting held in August 2016 was noted.	
16.	**MINUTES OF OTHER PRESCRIBING GROUPS**	
	• Nottinghamshire Area Prescribing Committee 19/05/16	

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Item		Action
	• Clinical Commissioning Policy Advisory Group 11/08/16 • CRHFT Drugs and Therapeutic Committee 20/09/16	
17.	**ANY OTHER BUSINESS**	
	Dr Mott advised that the first draft of the prescribing specification would be brought to the November 2016 JAPC meeting for discussion with a view to being signed-off in December 2016. The JAPC terms of reference would be reviewed at the November 2016 JAPC meeting. Ms Braithwaite stated that some issues had been raised by the DCHSFT District and Community nurses in North Derbyshire who went into the homes of patients in order to administer injectables about how these were obtained and labelled. Following work with North Derbyshire CCG and Mrs Needham's team about the legal position and the process which should be followed, it had been agreed that, as it was an annual event, the administration of influenza vaccinations would be undertaken via a patient specific direction (PSD). GPs would produce a list of those people that they authorise to receive the vaccination and who should be assessed. Once the PSD had been provided the District Nurses would collect the unlabelled influenza vaccine and the statutory patient information leaflet for administration in the patient's home. For all other medicines these would need to be dispensed and labelled for that particular patient and stored in their home. GPs would write an FP10 prescription and this would be dispensed and kept in the patient's home and the District Nurse would then administer in the patient's home. A record should be made in the GP practice clinical system of all items administered by DCHSFT staff in case of medicine recall. Ms Braithwaite added that the Care Quality Commission had highlighted in its inspection report a legal issue concerning transportation of ampoules by District and Community Nurses. In connection with the administration of insulin Ms Braithwaite advised that DCHSFT had decided that District Nurses and other members of staff who visited patients at home in order to administer insulin when that patient was unable to self-administer under a prompting system would require a vial to draw the insulin up with a needle rather than using the patient's pen devices. The policy had been introduced in the light of the wide variety of pen devices in existence and the variety of staff who administered the insulin. Ms Braithwaite added that the policy stipulated that the insulin should be drawn from vials rather than pens in order to avoid any mis-administrations. Mr Hulme suggested that this policy should be consulted with by both prescribing groups due to the potential impact on general practice and primary care as GPs would prescribe the insulin. Dr Watkins expressed some concern if GPs were asked to prescribe vials due to the possibility of errors. It was agreed that, due to the implementation and communication implications of the policy, the paper would be sent to Mrs Needham and Mr Hulme for discussion by the North and South Prescribing Sub-Groups.	**SD** **SD** **AB/KN/SH**
18.	**DATE OF NEXT MEETING**	
	Tuesday, 8th November 2016 at 1.30pm in the Post Mill Centre, South Normanton.	