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 11th April 2017

CONFIRMED MINUTES

Summary Points

Traffic lights

Drug	Decision
Safinamide	BLACK
Idebenone (Raxone®)	RED (NHS England)
Fibrinogen concentrate (FibCLOT®)	RED (NHS England)
Elotuzumab	BLACK (as per NICE TA 434)
Tenofovir alafenamide	BLACK (as per NICE TA 435)
Bevacizumab	BLACK (as per NICE TA 436)
Ibrutinib with bendamustine and rituximab	BLACK (as per NICE TA 437)

Clinical Guidelines

Management of Infective Exacerbation of Bronchiectasis in Adults in Primary Care.
Gastro-oesophageal Reflux Disease: Recognition, Diagnosis and Management in Children and Young People.
NSTEMI Guidance – North Derbyshire.
Management of Recurrent Urinary Tract Infections (RUTIs) in Adult Females.

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Present:	
Southern Derbyshire CCG	
Dr A Mott	GP (Chair)
Mrs L Hunter	Assistant Chief Finance Officer
Ms H Murch	Acting Deputy 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)
Hardwick CCG	
Dr T Parkin	GP
Erewash CCG	
Dr M Henn	GP
Derby City Council	
Derbyshire County Council	
Derby Teaching Hospitals NHS Foundation Trust	
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 J Achiampong	Clinical Pharmacist, Hardwick CCG
Mr A Thorpe	Derby City Council (minutes)

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Item		Action
1.	**APOLOGIES**	
	Dr R Dewis, Mr S Dhadli, Dr W Goddard and Mr S Hulme.	
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 additional conflicts of interest were declared in respect to this agenda.	
3.	**DECLARATIONS OF ANY OTHER BUSINESS**	
	There were no declarations of any other business.	
4.	**MINUTES OF JAPC MEETING HELD ON 14 MARCH 2017**	
	The minutes of the meeting held on 14th March 2017 were agreed as a correct record after the following amendments: Addition of Dr C Emslie to the list of members present. Monthly Horizon Scan – Amend to read: 'dapagliflozin + saxagliptin (Qtern®) – This was not a combination recommended in the NICE diabetes guidance. Classified as BLACK.'	
5.	**MATTERS ARISING**	
a.	**Glycopyrronium Bromide** An update would be given on the numbers involved and use of glycopyrronium to the May JAPC meeting.	**SD**
b.	**Juxta CURES** Mr Newman advised that referrals for the use of the Juxta CURES system were being received from the DTHFT vascular surgical nurse specialist and that an application would be made to the Drugs and Therapeutic Committee meeting in May 2017. The JAPC action tracker would be amended accordingly to indicate June 2017.	**SD**
c.	**Osteoporosis** An update on the inclusion of hyperprolactinemia as a risk factor would be given to the May JAPC meeting.	**SD**
d.	**DMARDS/Immunomodulating Drugs** Mrs Qureshi reported that the methotrexate shared care guideline had been sent for comment to Dr A Austin, DTHFT Consultant in Hepatology and Gastroenterology. The remaining shared care guidelines had now been prepared in anticipation of consultation with the specialists and consultants. Mr Newman agreed to contact Dr Austin to request that his comments be conveyed to Medicines Management as soon as possible.	**CN**
e.	**Monthly Horizon Scan** Mrs Qureshi advised that the Guideline Group would be looking at insulin aspart (Fiasp®) in April and would not be reviewing dapagliflozin + saxagliptin (Qtern®) as indicated.	

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f.	**Management of Dementia in Primary Care** It was confirmed that the dementia guideline had been amended to include a reference to the type of patients to de-prescribe and how to do so.	
6.	**NEW DRUG ASSESSMENTS**	
a.	**Safinamide** Mrs Qureshi reported that safinamide was licensed for the treatment of mild to late stage idiopathic Parkinson's Disease as an add-on therapy to levodopa, alone or in combination with other Parkinson's Disease medications. Safinamide was a highly selective and reversible Monoamine oxidase (MAO-B) inhibitor and the dosage started at 50mg daily and then increased to 100mg daily based on clinical need. Other MAO-B inhibitors included rasagiline and selegiline but these were irreversible whereas safinamide was reversible. Rasagiline had a traffic light classification of GREEN after consultant recommendation and selegiline was unclassified. The evidence for safinamide was based on two RCTs when it was evaluated as add-on therapy to levodopa with or without concomitant Parkinson's Disease medications in people with mid to late stage disease. Study 016 had been a twenty-four week RCT double-blind placebo controlled trial which evaluated safinamide 100mg or 50mg daily in patients with mid to late Parkinson's Disease. Patients in study 016 were eligible to continue in an eighteen month placebo controlled extension trial which was study 018. The SETTLE trial was a twenty-four week study and the dosing schedule had ranged from 50mg to 100mg daily. The primary outcomes for both RCTs were a change in mean daily on time without troublesome dyskinesia over eighteen hours. In study 016 and the SETTLE study safinamide increased on time without troublesome dyskinesia by approximately thirty to sixty minutes daily at twenty-four weeks compared with placebo. This improvement was considered clinically relevant in a population of people with advanced Parkinson's disease with motor fluctuations. However safinamide did not improve dyskinesia in the three RCTs compared with placebo which was the primary outcome for study 018. There were statistically significant improvements in motor symptoms with safinamide measured by the UPDRS-III score and clinical global impression (CGI-C). Safinamide had not been compared with active comparators in the head to head study and a post-hoc analysis of study 016 and the SETTLE study had presented results of several sub-group analyses. The sub-groups were differentiated on whether or not participants were taking levodopa alone or also using a dopamine agonist, COMT inhibitor or amantadine. There was also a high usage of anti-cholinergics which was not likely to reflect UK practice and safinamide had not been investigated in people with severe disabling peak dose or diphasic dyskinesia with unpredictable or wide fluctuations. It was noted that two of the studies had 80% Asian populations, which was not reflective of the UK population, and there was no data on long-term use or in people who were more than 75 years of age. In terms of safety safinamide used as an adjunct to levodopa could potentiate the adverse effects of levodopa and exacerbate pre-existing dyskinesia. Safinamide was licensed for adjuvant therapy and rasagiline and selegiline were both licensed for use as monotherapy and adjuvant therapy to levodopa.	

Item		Action
	It was also highlighted that safinamide 50mg or 100mg was significantly more expensive than rasagiline and selegiline for which generic versions were available. Mr Newman stated that an application for the use of safinamide was to be made to either the May or June meeting of the DTHFT Drugs and Therapeutic Committee. Dr Rob Skelly, DTHFT Consultant in Medicine for the Elderly, had advised that there could be a limited place for safinamide as an alternative to rasagiline and selegiline although the lack of evidence was acknowledged. **Agreed:** Safinamide classified as a **BLACK** drug as not routinely recommended or commissioned.	**SD/SQ**
7.	**CLINICAL GUIDELINES**	
a.	**Medication after Bariatric Surgery** Mrs Qureshi advised that there were currently two guidelines for bariatric surgery; one from Sheffield Teaching Hospitals NHS Foundation Trust (STHFT) and the other from DTHFT. The reason for this had arisen in the absence of national guidance and different centre approaches. However it had not been possible at the time to resolve the differences in the guidance between Sheffield and DTHFT and two protocols had therefore been developed. It was highlighted that the main differences between the two guidelines concerned blood monitoring, supplementation and liquid formulation. The Guideline Group had recommended that the draft DTHFT guidance be amended in order to align this with the STHFT guidance and also to reflect the national promotion for self-care. It would therefore be advantageous to have a single Derbyshire guideline for use in primary care. In connection with self-care Mrs Qureshi highlighted that, for vitamin D maintenance therapy, patients should be encouraged to purchase multi-vitamins over the counter. In cases of vitamin D deficiency they would be prescribed. Mr Newman added that it would be desirable for the DTHFT position on the switching of medicines required in liquid to the standard formulation at six weeks following surgery be adopted. **Action:** The Guideline Group would be requested to pull together the principles from the two guidelines. Dr Mott would then contact the Sheffield Area Prescribing Committee and the two bariatric surgery departments to give the JAPC perspective that the differences should be reconciled in order that one single guideline could be produced.	**SD/SQ AM**
b.	**Management of Infective Exacerbation of Bronchiectasis in Adults in Primary Care** Mrs Qureshi reported that the existing guideline for the management of infective exacerbation of bronchiectasis in adults in primary care had been updated by Dr D Harris, Lead Antimicrobial Pharmacist, using the NICE Clinical Knowledge Summary on bronchiectasis and following consultation with respiratory consultants. It was highlighted that linezolid had not been recommended for use in primary care as it had a traffic light classification of RED and required long term monitoring of toxicity.	

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Item		Action
	Dr Henn queried the recommendation in the guidance that longer term use of a short-acting inhaled beta²-agonist such as salbutamol should be reviewed in secondary care and whether this was an excessive requirement. Mrs Qureshi would contact Dr Harris about this together with the suggestion that an amendment be made that a referral to secondary care be considered.	**SQ**
	Dr Narula commented that some antibiotics were given via the Outpatient and Parental Antimicrobial Therapy (OPAT) service in North Derbyshire but there was no mention of this in the guidance. However it was highlighted that bronchiectasis was not one of the conditions covered by the OPAT service so it was agreed that there was no need to refer to this in the guidance.	
	Agreed: JAPC ratified the management of infective exacerbation of bronchiectasis in adults in primary care guideline with a two year review date.	**SD/SQ**
c.	**<u>Gastro-oesophageal Reflux Disease: Recognition, Diagnosis and Management in Children and Young People</u>** This guidance was based on NICE NG1 published in January 2015 on diagnosing and managing gastro-oesophageal reflux disease (GORD) in children and young people. During discussion Dr Mott referred to a recommendation in the guidance from a local expert to consider a trial of carobel as paste or added to expressed breast milk. It was noted that carobel was the first line recommended product for thickened feeds. Due to lack of clarity about the paste it was agreed that the reference to this should be removed.	**SQ**
	In connection with the recommended powdered 'anti-regurgitation' formulas it was agreed that the reference to these all being available to purchase over the counter by parents should be made more prominent and the prices removed. It was also agreed that both the GORD guidance and Infant Feeding guidance should be cascaded to all Derbyshire health visitors via both relevant providers (DCHSFT and DHcFT).	**SD/SQ**
	Agreed: JAPC ratified the Gastro-oesophageal Reflux Disease: Recognition, Diagnosis and Management in Children and Young People Guideline with the agreed amendments.	**SD/SQ**
d.	**<u>Luteinising Hormone-Releasing Hormone (LHRH) Agonists in Prostate Cancer</u>** Mrs Qureshi highlighted that there was a significant spend in Derbyshire on LHRH agonists and that there were three LHRH agonists on the JAPC formulary: goserelin, leuprorelin and triptorelin. The price differences with the reducing rebate of leuporelin between them was minimal. All three drugs had been assigned a traffic light classification of GREEN after consultant/specialist initiation and were available as one or three monthly injections. It was noted that triptorelin was also available as a six monthly injection and that leuprorelin was the current preferred choice. The guidance had been based on the NICE guidelines which stratified the risk of prostate cancer in men as low, intermediate and high.	

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Item		Action
	It had also been proposed to use intermittent therapy for long-term but there was limited evidence for this and therefore advice from the urologists would be needed. It would now be necessary to determine which of the LHRH agonists would be the preferred choice. The PrescQIPP document on LHRH agonists in prostate cancer stated that there was no conclusive evidence to suggest that one drug was better than the other or had fewer side effects. Choice of drug should therefore be dictated by licensing indications, side effect profile, type of administration and cost. The costs were very similar so the triptorelin injection could be the preferred choice due to the need for fewer patient visits to primary care. Discussion followed during which the amount of work needed to facilitate a switch of drugs was highlighted together with the fact that any potential gain would be dependent on a change to the current primary care Local Enhanced Services across the four CCGs. It was agreed that the views of the urologists be obtained on the preferred formulary choices but that an exercise to swap patients from one drug to another would not be beneficial. The views of the urologists would also be obtained concerning the suggestion that intermittent therapy for men having long-term androgen deprivation therapy be considered in view of the limited evidence about possible reduction in side effects and effect on the progression of prostate cancer.	**CN**
e.	**<u>NSTEMI Guidance – North Derbyshire</u>** JAPC was advised that the NSTEMI guidance for North Derbyshire has been reviewed by CRHFT clinicians and no changes had been made. However the ACS guidelines were now being reviewed and this could lead to a change of loading dose to ticagrelor instead of clopidogrel. Mr Shepherd queried the necessity of the guidance as the treatment information would be included in the discharge summary or outpatient letter. Dr Mott commented that the guidelines had originally been developed following the publication of the NICE TAGs and had been necessary to determine the order and duration of treatment with the drugs. In the event of a change to ticagrelor the guidelines may no longer be needed. **Agreed:** JAPC ratified the NSTEMI guidance for North Derbyshire with a two year review date.	**SQ/SD**
f.	**<u>Management of Recurrent Urinary Tract Infections (RUTIs) in Adult Females</u>** Mrs Qureshi reported that the existing guideline for the management of recurrent urinary tract infections (RUTIs) in adult females had been sent to the DTHFT and CRHFT urologists and microbiologists for comment. The NICE Clinical Knowledge Summaries (CKS) for Recurrent UTIs had also been checked in order to ensure that the guideline conformed to the national recommendations. Mrs Qureshi highlighted some of the main amendments: • Nitrofurantoin as first line and trimethoprim as second line options for antibiotic treatment had been highlighted. • A section on preventative measures, such as adequate hydration and regular emptying of the bladder, in order to reduce the risk of recurrent UTIs had been added.	

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	• Due to the fact that long term use of nitrofurantoin could lead to pulmonary symptoms/side effects an addition to discontinue usage if deterioration in lung function occurred has been included to the monitoring and cautions section. • A hyperlink to the NICE CKS recurrent UTI guidance had been added to the flow diagram on page 4. Mrs Qureshi referred to Public Health England (PHE) guidance which indicated that for prophylactic antibiotic treatment of recurrent UTIs nitrofurantoin should be used first line (100mg at night or post-coital STAT dose) and pivmecillinam as second line (200mg at night or post-coital STAT dose). However local microbiologists had given their opinion that pivmecillinamm should not be used empirically and only when guided by cultures and sensitivities. Pivmecillinam should therefore continue to be used in line with the NICE CKS guidance. Discussion followed and it was highlighted that, due to the very detailed nature of the document, it was not always easy to read. It was also suggested that the document updates section should be moved from the front of the guideline to the back to encourage the reading of the whole document. Dr Narula queried whether every patient on prophylactic antibiotics which proved to be ineffective and then subsequently developed a UTI should be referred to a urologist after six months. It was agreed that this be amended to indicate that a referral to an urologist could be considered.	**SD/SQ**
	Agreed: JAPC ratified the Management of Recurrent Urinary Tract Infections (RUTIs) in Adult Females guideline with the agreed amendments.	**SD/SQ**
g.	**<u>Vitamin D Maintenance Therapy</u>** Mrs Qureshi reported that the JAPC Working Group and Guideline Group had both recommended that patients who required maintenance therapy with Vitamin D should be encouraged to purchase vitamin D supplementation 400iu and maintenance doses 800iu over the counter – this had been included throughout the guideline. The recommended daily intake of vitamin D from the Public Health England publication in 2016 on vitamin D had also been included throughout the document. Mrs Qureshi referred to table 3 concerning the treatment/maintenance dosing for Vitamin D which had been divided into adults and children (>6 months). This included the advice to purchase daily supplements from local pharmacies, health food shops or supermarkets. However it was highlighted that pregnant women, who were eligible for free vitamins via the Healthy Start scheme, would continue to receive vitamin supplements from this national scheme. Pregnant women who were not entitled to vitamin supplement from this scheme would be advised to purchase a supplement. Children up to the age of four years entitled via the Healthy Start scheme would continue to receive vitamin supplements. The parents of children over four years of age, and those children not entitled through the Healthy Start scheme, were advised to purchase a vitamin D containing supplement for maintenance treatment.	

Item		Action
	In addition a message would be added at the beginning of the guideline to highlight the JAPC recommendation that vitamin D for maintenance therapy would no longer be prescribed and patients therefore advised to purchase supplementation over the counter (OTC). During discussion Dr Mott commented that it would be important to convey the message that vitamin D should not be routinely prescribed and this could be preferable than attempting to define exclusions. Dr Emslie referred to a discrepancy between the 400iu recommended dose for the whole of the general population and 800iu for the maintenance dose after treatment of deficiency or insufficiency. Dr Emslie also suggested that it would be advantageous to take out the prevention of vitamin D deficiency section and instead include a position statement about prevention. This could have a reference to the Public Health England recommendation that everyone should take a 400iu dose but also to highlight that particular groups were at particular risk. **Action:** A separate position statement for the general population would be developed by the Guideline Group for the prevention of vitamin D deficiency which would refer to the Public Health England advice that everyone should take a supplementation dose of 400iu vitamin D during the winter months and certain at risk groups to take supplementation throughout the year. The Guideline Group would also be requested to develop a revised guideline to cover treatment and maintenance. This would refer to the treatment of patients with an initial loading regimen of 20,000 iu vitamin D daily for fifteen days to be followed by a maintenance dose of 800iu daily to be purchased OTC.	**SD/SQ**
8.	**MONTHLY HORIZON SCAN**	
	Mrs Qureshi advised JAPC of the following new drug launches, new drug formulations, licence extensions and drug discontinuations: New drug launches in the UK: Idebenone (Raxone®) – NHS England. Classified as **RED**. Migalastat (Galafold®) – Previously classified as **RED**. New formulation launches in the UK: Fibrinogen concentrate (human) (FibCLOT®) – NHS England. Classified as **RED** Glycopyrronium (Sialanar®) – Already classified by JAPC. Licence extensions: Lenalidomide (Revlimid®) – NHS England. Already classified as **RED**. Pembrolizumab (Keytruda®) – NHS England. Already classified as **RED**. Discontinuations: Isotretinoin gel (Isotrex®) – Now removed from the SKIN formulary chapter.	

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Item		Action
9.	**MISCELLANEOUS**	
a.	**High Cost Drugs Pathways** JAPC was advised that the two commissioning pathways for the treatment of severe psoriasis and biologic drugs for the treatment of rheumatoid arthritis had been updated in line with NICE TAs. The pathways were now aligned for both DTHFT and CRHFT and had been approved by both Drugs and Therapeutic Committees.	
b.	**Substance Misuse and Alcohol Services Update** It was reported that DHcFT had sent a letter to every GP practice in Derbyshire from Mr David Hurn, Service Manager of the new Derbyshire Recovery Partnership. The letter outlined the significant change to the provision of adult drug and alcohol treatment in Derbyshire to take effect from 1st April 2017. From this date Derbyshire Recovery Partnership, which was a formal collaboration between DHcFT, Derbyshire Alcohol Advice Service, Phoenix Futures and Intuitive Thinking Skills, would deliver an integrated drug and alcohol treatment system across Derbyshire. In order to ensure that the information about the new service was widely circulated to primary care Dr Taylor agreed to check the circulation of the letter from Mr Hurn. Information about the new service would also be included in the JAPC bulletin.	**ST** **SD/SQ**
10.	**JAPC BULLETIN**	
	The bulletin was noted for information and ratified by JAPC. Mrs Needham advised that obtaining supplies of Molita, which had replaced asasantin retard, was difficult and there was a risk that patients would run out. It would therefore be advantageous to indicate in the bulletin that patients would be moved to clopidogrel where possible rather than to a product which was difficult to obtain – this was agreed. Mrs Qureshi would check that asasantin retard/Molita had been removed from the Chapter formulary and flowchart.	**SD/SQ** **SQ**
11.	**MHRA DRUG SAFETY UPDATE**	
	The MHRA Drug Safety Alert for March 2017 was noted. Mrs Qureshi highlighted the following MHRA advice: SGLT2 inhibitors: updated advice on increased risk of lower-limb amputation (mainly toes). Canagliflozin could increase the risk of lower-limb amputation in patients with type 2 diabetes. The evidence did not show an increased risk for dapagliflozin and empagliflozin, but the risk may be a class effect. This warning had already been included in the diabetes guidance.	
12.	**NICE SUMMARY**	
	Mrs Qureshi informed JAPC of the comments for the CCGs which had been made for the following NICE guidance issued in March 2017. TA434 Elotuzumab for previously treated multiple myeloma (terminated appraisal). Classified as **BLACK.** TA435 Tenofovir alafenamide for treating chronic hepatitis B (terminated appraisal). Classified as **BLACK.**	**SD/SQ** **SD/SQ**

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	TA436 Bevacizumab for treating EGFR mutation-positive non-small cell lung cancer (terminated appraisal). Classified as **BLACK.** TA437 Ibrutinib with bendamustine and rituximab for treating relapsed or refractory chronic lymphocytic leukaemia after systemic therapy (terminated appraisal). Classified as **BLACK.** TA180 (updated from Sept 2009) Ustekinumab for the treatment of adults with moderate to severe psoriasis. No change. TA340 (updated from June 2015) Ustekinumab for treating active psoriatic arthritis. No change. NG65 Spondyloarthritis in over 16s: diagnosis and management – The pharmacological management of spondyloarthritis did mention the use of biologics and the need to refer these patients into secondary care faster. Mrs Qureshi would check with Dr Sheila O'Reilly, DFHFT Consultant Rheumatologist, whether a high cost algorithm was needed and whether it would come under ankylosing spondylitis.	**SD/SQ** **SD/SQ** **SQ**
13.	**TRAFFIC LIGHTS – ANY CHANGES?**	
	Classifications Safinamide - **BLACK** Idebenone (Raxone®) – **RED** (NHS England) Fibrinogen concentrate (FibCLOT®) – **RED** (NHS England) Elotuzumab – **BLACK** (as per NICE TA 434) Tenofovir alafenamide – **BLACK** (as per NICE TA 435) Bevacizumab – **BLACK** (as per NICE TA 436) Ibrutinib with bendamustine and rituximab– **BLACK** (as per NICE TA 437)	
14.	**JAPC ACTION SUMMARY**	
	The action summary was noted by JAPC and amendments made: PCSK9 inhibitors and Lipid/Familial Hypercholesterolaemia guidance – To be brought to the May JAPC meeting. Sacubitril/Valsartan – To be brought to the May JAPC meeting. Juxta CURES – To be brought to the June JAPC meeting. DMARDS/Immunomodulating drugs – To be brought to the June JAPC meeting. Osteoporosis - An update on the inclusion of hyperprolactinemia as a risk factor would be given to the May JAPC meeting. Glycopyrronium Bromide - An update would be given on the numbers involved and use of glycopyrronium to the May JAPC meeting.	**SD** **SD** **SD** **SD** **SD** **SD**

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15.	**GUIDELINE GROUP ACTION TRACKER**	
	The summary of key messages from the Derbyshire Medicines Management Guideline Group meeting held in February and March 2017 was noted. Mrs Qureshi highlighted the following: February 2017: • Cinacalcet for the treatment of secondary hyperparathyroidism (HPT) in patients with end-stage renal disease (ESRD) on maintenance dialysis therapy shared care guideline which had expired in December 2016. This had been sent out for comment to Dr R Stanworth, DTHFT Consultant in Diabetes and Endocrinology but none had been received to date. • Colomycin for the management of chronic pulmonary infections due to *Pseudomonas aeruginosa* which had expired in February 2017. This had been sent out for comment to Dr I Wahedna, DTHFT Respiratory Consultant, Ms E Stevenson, DTHFT Specialist Respiratory Nurse, and Ms H Stroud, CRHFT Clinical Nurse Specialist, but none had been received. Mrs Qureshi would contact the consultees in order to expedite the responses. It was also agreed that Mr Newman and Mr Shepherd would be copied into all the requests for comments from clinicians. • Prempak C had been discontinued. Sequential combined therapy updated to include Elleste Duet, Cyclo-Progynova and Femoston. • Travoprost/Bimatoprost to be prescribed generically (pending patent expiry) and the glaucoma guideline updated accordingly. March 2017: • CNS Chapter - All drugs for dementia had now been assigned a traffic light classification of GREEN. • Skin Chapter - Isotretinoin (isotrex®) gel discontinued and replaced with tretinoin/erythromycin solution (Aknemycin Plus®) as an option for moderate acne. • Guidelines - For antipsychotics the recommended physical monitoring guideline now included the specific HBA1c test when it referred to a blood glucose testing. • Following the re-classification by JAPC of rubefacients as BLACK the BNF chapter for MSK and the guideline on non-malignant pain had been updated to include this information. • Lipid modification guideline – This was due to be discussed by JAPC in May 2017. • Oxygen guideline – Some comments had been received and now due to be discussed by the Guideline Group in April 2017. • ACS-NSTEMI (South) Guideline – Comments were awaited from Dr J Baron, DTHFT Consultant Cardiologist. • Management of C.difficile - Dr D Harris had requested a formal extension. Mrs Qureshi would check that the revised guidelines were placed on the website and JAPC updated accordingly via the action tracker.	**SD/SQ** **SQ**

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16.	**MINUTES OF OTHER PRESCRIBING GROUPS**	
	• Burton Hospitals Drugs and Therapeutic Committee 09/01/2017 • JAPC Working Group 10/01/2017 • Clinical Commissioning Policy Group 09/02/2017 • DTHFT Drugs and Therapeutic Committee 21/02/2017 • Chesterfield Drugs and Therapeutic Committee 21/03/2017 Dr Parkin advised that many of the initiatives agreed by the JAPC Working Group were currently on hold pending the publication of national policy statements.	
17.	**ANY OTHER BUSINESS**	
	There were no items of any other business.	
18.	**DATE OF NEXT MEETING**	
	Tuesday, 9th May 2017 at 1.30pm in the Post Mill Centre, South Normanton.	