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

DERBYSHIRE JOINT AREA PRESCRIBING COMMITTEE (JAPC)

Minutes of the meeting held on 12th December 2017

CONFIRMED MINUTES

Summary Points

Traffic lights

Drug	Decision
Tadalafil (once daily)	BLACK
Mefenamic acid	BLACK
Dosulepin	BLACK for new patients (remains BROWN for continuation with existing patients currently)
Gluten Free Products	All BLACK (with implementation to be phased)
Atezolizumab (Tecentriq®)	RED (as per NHS England commissioning intentions)
Patiromer (Veltassa®)	RED
Sarilumab (Kevzara®)	RED (as per NICE TA 485)
Telotristat etiprate (Xermelo®)	RED (as per NHS England commissioning intentions)
Darunavir + cobicistat + emtricitabine + tenofovir alafenamide (Symtuza®)	RED (as per NHS England commissioning intentions)
Nivolumab	RED (as per NICE TAs 483, 484 and 490) as per NHS England commissioning intentions
Aflibercept	RED (as per NICE TA 486)
Venetoclax	RED (NHS England as per NICE TA 487)
Regorafenib	RED (NHS England as per NICE TA 488)
Vismodegib	BLACK (as per NICE TA 489)
Ibutinib	RED (NHS England as per NICE TA 491)

Clinical Guidelines
Emollient Prescribing Guide
Derbyshire Nebuliser Guidelines for COPD patients: assessment and initiation
Management of Neuropathic Pain in Primary Care
Advisory guidance on when to initiate gastroprotection with a NSAID (or antiplatelet)

Patient Group Directions
Ulipristal Acetate 30mgs (EllaOne®) for Sexual Health Patients aged 13 years and older

Shared Care Guidelines
Liothyronine for the treatment resistant depression

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Present:	
Southern Derbyshire CCG	
Dr A Mott	GP (Chair)
Mr S Dhadli	Specialist Commissioning Pharmacist (Professional Secretary)
Mr S Hulme	Director of Medicines Management (also representing Erewash CCG)
Mrs S Qureshi	NICE Audit Pharmacist
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	
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	
Mr M Shepherd	Chief Pharmacist
Derbyshire Community Health Services NHS Foundation Trust	
Ms A Braithwaite	Chief Pharmacist
Derby and Derbyshire Local Medical Committee	
Dr K Markus	Chief Executive
In Attendance:	
Mr D Brown	Commissioning Manager, North Derbyshire CCG
Ms L Swain	Head of Patient Engagement, North Derbyshire CCG
Mr A Thorpe	Derby City Council (minutes)

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Item		Action
1.	**APOLOGIES**	
	Dr M Henn, Mrs L Hunter, Mr C Newman and Dr M Watkins.	
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 conflicts of interest were declared in relation to this agenda; in addition to the existing register of interests.	
3.	**DECLARATIONS OF ANY OTHER BUSINESS**	
	• Shared Care Consultation.	
4.	**MINUTES OF JAPC MEETING HELD ON 14 NOVEMBER 2017**	
	The minutes of the meeting held on 14th November 2017 were agreed as a correct record after the following amendments: Quarterly NICE Updates – Asthma: Amend to 'Advice had been received from a DTHFT respiratory consultant, who had been contacted about the latter, which was seen as a specialist area for secondary care, although a few referrals had been received from GPs. NICE Summary - Metformin in pre-diabetes: Amend to 'Advice from Public Health England had been added to the Derbyshire BNF endocrine chapter.'	
5.	**MATTERS ARISING**	
a.	**Nicotine Replacement Therapy (NRT)** Dr Mott had discussed the issue of re-charging with Dean Wallace, Derbyshire County Council Director of Public Health, and confirmed that re-charging from CCGs to Public Health is still in place. In response to why a wide range of NRT products was necessary the service response had been 'patient choice,' although the list of permanent stock was smaller. It was envisaged that stocks would then be reduced over time. It was noted that an abridged version of the NRT formulary had now been produced for primary care.	
b.	**JAPC Terms of Reference** Dr Mott reported that he had contacted Jayne Stringfellow, Chief Nurse and Director of Quality of the Derbyshire CCGs, about having a Quality Team representative at JAPC. Ms Stringfellow had indicated that a quality representative on JAPC would be desirable but that a decision about who this would be could not be made until the new year due to the current staffing situation.	
c.	**Asthma** Mrs Qureshi reported that draft local asthma guidance had now been developed and would be updated in accordance with the recently published NICE asthma guideline.	

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	It was highlighted that the local guidance would have a focus on management but include a reference to the possible change in the diagnosis pathway, with the use of the forced exhaled nitric oxide test, in line with the NICE guidance. However, this is not routinely available locally. Mr Dhadli referred to the possible cost savings to be made with the increased use of leukotriene receptor antagonists (LTRAs) and consequent reduced use of LABAs. In terms of clinical effectiveness, it was noted that there was little difference between LTRAs and LABAs, although LABAs have a slight advantage, but LRTAs were noted to be cost effective. Local secondary care respiratory clinicians had already raised some concern on the routine use of nitric oxide for asthma diagnosis and Mr Dhadli raised points of implementation that included primary care hubs as suggested by NICE. Mrs Qureshi advised that the draft asthma guidance would be discussed by the guideline group and placed on the action tracker for review by JAPC in February/March 2018. The draft guidance would also be sent to the DTHFT and CRHFT respiratory physicians for comment.	**SQ**
d.	**<u>JAPC Terms of Reference - Membership</u>** Dr Kath Markus was welcomed to JAPC as the representative of the Derby and Derbyshire Local Medical Committee.	
6.	**JAPC ACTION SUMMARY**	
	Use of NOAC for suspected DVT - Mrs Needham reported that a new Public Health F2 doctor would now be taking forward the development of the guidance. Ms Braithwaite advised that DCHSFT were looking to develop a similar local guideline which could be used in the minor injuries units. Advice about this had been obtained from the Acute Trusts including the use of Clexane® (enoxaparin) at DTHFT and tinzaparin at CRHFT. It was likely that DCHSFT would opt for the use of rivaroxaban due to its ease of administration by patients but this was still under consideration. However it was highlighted that a single approach for suspected DVT in Derbyshire was needed. An update would be given to the February 2018 JAPC meeting. Rosuvastatin – On expiry of the patent it would be added to the Familial Hypercholesterolaemia (FH) and non-FH guidance. An update would be given to the January 2018 JAPC meeting.	**KN** **SD**
7.	**NEW DRUG ASSESSMENTS**	
a.	**<u>Mefenamic Acid</u>** Mr Dhadli reported that the Guideline Group had classified mefenamic acid, a non-steroidal anti-inflammatory drug (NSAID), as BROWN for use in patients with dysmenorrhoea and menorrhagia where other NSAID drugs had been ineffective. At the November 2017 meeting JAPC had expressed concern at the high cost of mefenamic acid, through national concessions, which is specifically licensed for menorrhagia.	

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	Mr Dhadli advised that the NICE Guideline 73 (2017) on the diagnosis and management of endometriosis and NICE Guideline 44 (2007) on the assessment and treatment of heavy menstrual bleeding similarly had not recommended a specific NSAID. The NICE Clinical Knowledge Summary (CKS) on dysmenorrhoea had referred to the lack of evidence that mefenamic acid was more effective than the other NSAIDs. Ibuprofen and naproxen are both licensed as well for use in dysmenorrhoea but not for menorrhagia. In addition, the Regional Drug and Therapeutic Centre (RDCT 2014) had indicated in their safer medication use guidance that mefenamic acid should not be used as a first line analgesic, including for dysmenorrhoea, and should be avoided in patients who were at risk of self-harm. It also has a narrow therapeutic window, which increases the risks in overdose, and is more likely than other NSAIDs to cause seizures in overdose. The tariff cost of mefenamic acid 500mg tablets (28) for November 2018 was £13.80, but approximately £50 in tariff concession cost. During discussion Dr Emslie suggested that it would be advantageous to ascertain the current levels of prescribing of mefenamic acid. The prescribing groups would therefore be requested to look at activity levels. **Agreed:** Mefenamic acid classified as a **BLACK** drug due to: • Less cost effective than standard therapy; • Safety concerns due to the narrow therapeutic window; and • Lack of evidence for greater effectiveness for dysmenorrhoea or menorrhagia compared to other NSAIDs. Mr Dhadli advised JAPC that advice had received that an Equality Impact Assessment (EIA) form should be completed prior to any JAPC ratification for a black drug classification or where a decommissioning policy has been produced. This would only be necessary where patients were already on NHS treatment and where there was no suitable alternative treatment. It was highlighted that this was not the case with mefenamic acid when other NSAIDs could be used instead.	**SD** **SD**
8.	**CLINICAL GUIDELINES**	
a.	**<u>Emollient Prescribing</u>** Mr Dhadli reported that the emollient prescribing guideline and formulary had been included in the formulary skin chapter but this had subsequently been replaced with a separate emollient prescribing guide in the Derbyshire Primary Care Formulary. The guide indicated the most cost-effective choices with updated prices. It was highlighted that the annual total spend on emollients by the Derbyshire CCGs was almost £1 million. Mr Dhadli advised that E45 cream had now been replaced with ExoCream and ZeroDouble Gel with MyriBase gel. Mrs Needham referred to the need to check the availability of these new products in order to avoid any potential implementation issues. The availability of Myribase Gel and Exo Cream from the major wholesalers would be checked by the Clinical Effectiveness Team.	**SD**

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	The prescribing sub-groups were requested to look at the opportunity costs from the emollients spreadsheet that had been taken to the Guidelines Group meeting.	**SD**
	Mr Hulme asked whether emollients for relatively minor conditions, such as dry skin which required basic moisturisation, should continue to be prescribed in the light of the current NHS financial situation and competing demands on resources. However it was acknowledged that people with a dry skin condition such as eczema which required more intensive treatment would need a greater quantity of a particular skin emollient product. Dr Emslie highlighted the need for older people to maintain skin integrity in order to avoid more serious complications such as venous ulcers which required more prescribing. Dr Parkin suggested that people should be encouraged to use basic moisturisation as part of their own self-care apart from cases where skin deterioration was a significant risk.	
	Agreed: JAPC approved the Emollient Prescribing Guide with a two year review date.	**SD**
b.	**<u>Nebuliser Guideline</u>** Mr Dhadli reported that the existing Derbyshire Nebuliser Guideline for COPD patients: assessment and initiation was largely unchanged apart from updated contact details for the North Respiratory Team. It was noted that the guideline was for those patients with chronic respiratory conditions, including COPD but not asthma, and provided staff who administered nebulised therapy with a standardised framework of when to use nebulisers and how they could be obtained.	
	Agreed: JAPC approved the Derbyshire Nebuliser Guidelines for COPD patients: assessment and initiation with a review date of two years.	**SD**
c.	**<u>Neuropathic Pain</u>** Mr Dhadli reported that the guideline had been updated with comments received from DTHFT and CRHFT pain management consultants. A reference to the substantial increase in the risk of harm from oral morphine at doses exceeding 120mg/day with no increase in benefit had been included. The remainder of the guideline was largely unchanged with recommendations from the Guideline Group: • No change in the position of duloxetine as third line - noting its tariff price reduction; • No change in the position of pregabalin as second line after amitriptyline; and gabapentin. Although now cheaper, pregabalin is still marginally more expensive than gabapentin, and from a publication by NHSE and PH appears to be more sought after for misuse than gabapentin.	
	Agreed: JAPC approved the Management of Neuropathic Pain in Primary Care guideline with a two year review date.	**SD**

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Item		Action
d.	**Proton Pump Inhibitor (PPI) Guideline for Gastroprotection** The PPI guideline was due for renewal in December 2017 and had been sent out for review and comments. Mr Dhadli reported that a DTB review had been published in October 2017 concerning the long-terms risks of the use of PPIs and the guideline had been amended in the light of this. The evidence had been derived primarily from case studies and observational data. Dr Goddard had recommended that the risks of PPI for pneumonia and cancer should be updated in line with current evidence. However there was retrospective evidence about the risk of B12 deficiency and dementia from studies which had not been designed to reflect this. Dr Mott advised that the title of the guideline should also refer to gastro-protection as there was a difference in use with asymptomatic patients and the H.pylori testing in the GORD guideline. Dr Markus highlighted that the indications for potentially commencing treatment or assessment of the need for a PPI in the flowchart included patients ≥65 years of age receiving short-term or intermittent NSAID but this was also mentioned in the 'does the patient have two or more risk factors' box if the answer was no. It was agreed that an amendment be made to read '> 65 not on a NSAID' in the 'does the patient have two or more risk factors' box so that any potential confusion could be avoided. **Agreed:** JAPC approved the advisory guidance on when to initiate a PPI with a NSAID (or antiplatelet) with the agreed amendments with a two year review date.	**SD** **SD**
9.	**PATIENT GROUP DIRECTIONS**	
a.	**Ulipristal Acetate** The following PGD from DCHSFT was noted by JAPC: • Ulipristal Acetate (EllaOne®) 30mg for sexual health patients aged over thirteen years of age.	
10.	**SHARED CARE GUIDELINES**	
a.	**Liothyronine** Mr Dhadli reported that the existing shared care for the unlicensed use of liothyronine in euthyroid states as an adjunct to any antidepressant in the management of unipolar treatment resistant depression (TRD) had been reviewed by the DHcFT Drugs and Therapeutic Committee (DTC) in November 2017. The DTC had decided that no amendments were needed. **Agreed:** The shared care guideline for liothyronine for the treatment of resistant depression was ratified by JAPC.	**SD**
11.	**MISCELLANEOUS**	
a.	**Shared Care and Guideline Group (SCaGG) Terms of Reference** Dr Mott advised that a deputy for Dr Emslie would be desirable in order to ensure that there was a GP presence at the meetings. It was therefore agreed that, in the event that Dr Emslie was unable to attend a SCaGG meeting, then a request would be circulated to request that one of the other JAPC GP representatives attend in her place.	

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	Mr Dhadli confirmed that there was a wide range of members which included an invitation to providers to undertake the business of SCaGG. **Agreed:** JAPC ratified the terms of reference for the Shared Care and Guideline Group (SCaGG).	**SD**
b.	**Derbyshire Joint Area Prescribing Committee QIPP Working Group Terms of Reference** It was agreed that the reference to the Derbyshire Sustainability and Transformation Proposal (STP) in the paragraph outlining the purpose should be amended to read 'Derbyshire Sustainability and Transformation Partnership'. Mrs Needham advised that a revised version of the terms of reference would be discussed at the next meeting of the QIPP Working Group and these would include frequency of the meetings and a reference to the Chair.	**KN**
c.	**NHS England Items Not Routinely Prescribed in Primary Care** Mr Dhadli reported that NHS Clinical Commissioners and NHS England had finally published proposals on eighteen medicines which should no longer be routinely prescribed in primary care because they were clinically ineffective, unsafe, not cost effective or the NHS could offer a clinically proven alternative for patients. This could achieve savings to the NHS of £141 million a year and the proposals had been included in a public consultation which closed in October 2017. The results of the consultation had now been split into two separate sections in the circulated JAPC paper: the first for discussion by JAPC and the second which indicated that no further action was required in terms of the JAPC decisions/recommendations as these were already in line with those made by NHS England. Exceptional circumstances had also been included and this had been interpreted as: 'Where the prescribing clinician considers no other medicine or intervention was clinically appropriate and available for the individual'. Discussion followed on each drug in the 'for discussion' section and points made: • Dosulepin - NHS England had recommended that prescribers be supported in de-prescribing in all patients and, where appropriate, should ensure the availability of relevant services to facilitate this change. JAPC had assigned a traffic light classification of BROWN continuing use in existing patients only. Dr Mott highlighted the need for a clear implementation plan before any change to a classification of BLACK and this should include numbers on dosulepin over a period of years. Dr Taylor added that there was a small cohort of patients in DHcFT who had previously benefited from the use of this drug and may need to re-start treatment. Mr Hulme suggested that a BLACK classification for new patients be assigned with no routine exceptions. **Agreed:** Dosulepin to remain classified as BROWN continuing use in existing patients only and BLACK: not recommended/commissioned for new patients. Information on the number of patients who had historically been prescribed on dosulepin would be obtained and discussions held with DHcFT consultant psychiatrists about the existing patients.	**SD**

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Item		Action
	• Liothyronine – NHS England had recommended an alignment with the British Thyroid Association (BTA) advice that a small proportion of patients treated with levothyroxine who continued to suffer with symptoms despite adequate biochemical correction should be treated with liothyronine. In these circumstances, where levothyroxine had failed and in line with BTA guidance, endocrinologists providing NHS services may recommend liothyronine for individual patients after a carefully audited trial of at least three months duration of liothyronine. It was noted that the current JAPC classifications for liothyronine were: AMBER for depression; BLACK for hypothyroidism and RED for oncology treatment and for diagnostic purposes in line with the British Thyroid Cancer guidelines. Dr Mott commented that the current classification of BLACK for hypothyroidism did not allow for ongoing prescribing. **Agreed:** Further discussion with the local endocrinologists would be needed about the NHS England recommendations and a possible re-classification to RED.	**AM**
	• Omega-3 fatty acid compounds – NHS England had recommended that primary care should not initiate for any new patients. The CCGs should support prescribers in de-prescribing in all patients and, where appropriate, ensure the availability of relevant services to facilitate this change. No routine exceptions had been identified. JAPC had assigned a traffic light classification of BROWN after consultant lipid specialist recommendation in patients with severe hypertriglyceridaemia (triglycerides >10mmol/L) after trial of fibrates +/- statins. **Agreed:** Further discussion with the secondary care clinicians would be needed to ascertain their views on a re-classification to BLACK.	**AM**
	• Tadalafil (once daily) – NHS England had recommended that primary care should not initiate for any new patients. The CCGs should support prescribers in de-prescribing in all patients and, where appropriate, ensure the availability of relevant services to facilitate this. No routine exceptions had been identified. JAPC had assigned a traffic light BROWN specialist initiation drug after the use of sildenafil first line as a small cohort of patients could benefit from prescribing. Mrs Needham highlighted that a lot of requests for tadalafil (once daily) were received from Sheffield. **Agreed:** Tadalafil (once daily) re-classified as a **BLACK** drug.	**SD**
	Ms Braithwaite referred to the rubefacients section in the list which did not require further action and queried whether this included capsaicin cream. Mr Dhadli would look into this further with a view to its addition as an exception.	**SD**
	Mr Hulme expressed appreciation to the Clinical Effectiveness Team for the production of a very clear and concise report.	
d.	**<u>Vitamin D Equality Impact Assessment</u>** Mr Dhadli reported that in June 2017 JAPC had made a decision to recommend the purchase of vitamin D supplements for maintenance and insufficiency following a recommendation from the JAPC working group.	

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	This decision had been made in the light of NICE PH56: 'Vitamin D: supplement use in specific population groups'. This highlighted that the majority of the population needed vitamin D supplements and almost a fifth of the UK population had a low vitamin D status. For deficiency, which was the clinical diagnosis, all patients were treated the same based on symptoms and vitamin D level. Those people who required supplementation should be encouraged to purchase supplementation over the counter or increase exposure to the sun and dietary advice. Mr Dhadli informed JAPC that at the time of the decision he had liaised with Mr David King (previously Fagg) that an EIA was not necessary. Advice had subsequently been received from Ms Claire Haynes, Clinical Quality Equality Impact Assessment (EIA) Manager, that JAPC should undertake a formal EIA. Mr Dhadli had subsequently met with Ms Haynes to discuss the JAPC decision making process and examples had been given about the assignment of the traffic light classifications of green, red, amber, brown and black together with changes to formulary, restriction of access based on evidence and when an EIA was required. Ms Haynes had advised that an EIA was necessary when something was taken away from patients, i.e. when JAPC assigned a traffic light classification of black and the potential impact this could have on individual patients and patient groups. In addition, impact on the protected characteristics under the Equality Act 2010 of age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership and pregnancy and maternity would need to be taken into consideration. An EIA was therefore required concerning the decisions made about vitamin D and, following a further meeting with an EIA manager, a more detailed and formal EIA had been developed. The EIA form would need to be completed before ratification by JAPC of any decision to assign a black traffic light classification or total decommission of a service when patients were already receiving NHS treatment and where there was no suitable alternative. A template had therefore been developed for due regard (Equality Analysis) to assist in the collation of information and evidence necessary to support the Due Regard process in the making and implementation of JAPC decisions when considering changes to services or functions – this included service redesign/reconfiguration. During discussion it was highlighted that there were several sections which indicated 'to be confirmed'. Mr Dhadli advised that these sections would need to be completed by the medicines management team outside the meeting and indicate those areas which were most likely to be affected and whether mitigation was provided such as patient information leaflets and information in different languages. In addition, the medicines management team should provide an indication of the approximate number of patients' affected using e-PACT data in geographical areas where focused support on implementation may be necessary.	

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	Ms Swain commented that these aspects should be part of the routine process by which JAPC made its decisions and the EIA was a formal means of showing the impact of any decision. Dr Dewis stated that the updated vitamin D guidance now indicated that all people, regardless of diet or sun exposure and without the need for a test, would be vitamin D deficient between September and March unless a supplement was taken - this would be helpful in terms of completing the EIA. Mr Dhadli referred to the need for the inclusion of a standard statement to confirm that an EIA had been completed. The front cover sheets would need to be amended in cases where there was a black traffic light classification or a total de-commissioning policy with patients already receiving NHS treatment and where no suitable alternative. The EIA form must be completed prior to ratification by JAPC. Mr Dhadli added that it was unlikely that there would be many cases where an alternative drug or service was not available. It would be dealt with on a case by case basis and advice from the EIA Manager or Patient Engagement obtained if necessary. Mr Dhadli would produce the final version of the EIA form which would be brought to the January JAPC meeting.	**SD**
e.	**<u>Gluten Free Foods Prescribing Policy</u>** Mr Hulme reported that each governing body of the four Derbyshire CCGs had independently made the same decision to support a no gluten free (GF) foods prescribing policy but to include a statement to highlight GP professional obligations to meet clinical care needs for individual patients. A document had therefore been developed which included this statement and also outlined the necessary guidance, advice and signposting to enable patients to consume a gluten free diet. JAPC was requested to agree the wording for the section on page three 'Prescriber: professional and contractual context'. During discussion Dr Markus advised that it was likely that there would be a cohort of patients who would express concern at this decision and some practices may therefore decide to continue to prescribe GF foods at risk of being reported to the Parliamentary and Health Service Ombudsman. Mr Hulme commented there had been discussion by the governing bodies about the possibility of the existence of cohorts of patients with genuine exceptionality. There was no indication of this in the consultation which had not referred to any specific issues. It would be necessary to clearly record when GF foods were prescribed and this could then be audited in order to determine whether there were groups of people who required additional support. Dr Emslie stated that GPs could potentially face hostility from patients and Dr Parkin suggested that, in order to reinforce the stance of GP in any decision not to prescribe, the first bullet point should be amended to read 'That GPs have clinical freedom to act in an individual patient's best interest where exceptional clinical circumstances exist that warrant deviation from this policy following an Individual Funding Request (IFR) positive approval'. However it was pointed out that this was unlikely to get through the IFR screening system and the stance of GPs would in any case be supported by the existence of the CCG policy.	

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Item		Action
	There would be no prescribing and any complaints concerning clinical based issues would be diverted to the CCG Patient Advice and Liaison Services (PALS) who could in turn signpost to the dietetic services for advice about a gluten free diet using foods naturally free from gluten. Mrs Needham confirmed that there had been discussions with dietitians about the provision of a countywide advice service. Mr Hulme also referred to the introduction of a call back system in connection with this. Dr Markus added that patients were more likely to complain about the practice not prescribers. However it would be the practice and individual GP who would have to answer to the Ombudsman or General Medical Council for not fulfilling their contract for prescribing. There was therefore a need for a national policy on GF prescribing and it would be desirable to know what courses of action had been taken by CCGs in other areas of the country. Mr Hulme referred to the need for a standard EIA statement similar to the one used for other clinical policies and this would be applied in the case of the GF prescribing policy. In addition, work would be undertaken on a support pack which included implementation information and links to relevant sources. Information would also be included as to when a referral to PALS might be made. Mr Hulme advised that work was proceeding with a view to a phased implementation with effect from 1st January 2018. Ms Swain highlighted the importance of giving adequate notice to patients and to define exactly what would happen in terms of prescriptions. Mr Dhadli and Mr Hulme stated that the implementation would begin on 2nd January 2018 and every patient should receive prior notice of this. Dr Mott advised that the implementation should be undertaken on a practice by practice basis and all affected patients would need to receive letters to advise them of this. At the point that these letters were conveyed to patients GF prescribed foods would then become classified as BLACK. It was noted that there would be further discussion about the implementation issues at the next meeting of the JAPC working group. **Agreed:** JAPC noted the Gluten Free Foods Prescribing Policy.	**SD**
	Action: The policy would be placed on the website together with a generic EIA statement. Mr Brown and Mr Dhadli would liaise with the CCG communications department about the publication of the policy.	**DB/SD**
f.	**<u>Self-Care Policy</u>** Mr Hulme reported that the self-care policy has been discussed by JAPC at previous meetings and had now been agreed by all the governing bodies of the four Derbyshire CCGs. Mr Hulme highlighted the section on page four of the policy 'The General Medical Council states that the GP's primary duty is to act in the patient's best interests, but also to make efficient use of the resources available. It is the belief of the Derbyshire CCGs that this policy strikes the right balance between these two duties for most patients most of the time.'	

Item		Action
	JAPC agreed that this should be substituted with the relevant statement previously agreed for the gluten free prescribing policy - this was considered to be more robust and balanced. In connection with implementation, Dr Mott commented that this was difficult as many of the listed products would not involve traffic light changes as many were used for other indications. Dr Emslie stated that it would be essential to highlight to GPs that this policy applied to self-care and self-limiting conditions only and it was not intended to cover use of the products for long-term conditions. Mr Hulme emphasised that the policy concerned the supply of medicines on the NHS and did not restrict access to health professionals for advice. The policy was mainly about public behavioural change and application of the same standards via a policy across all the providers. Ms Braithwaite queried how the policy would operate in Minor Injuries Units (MIUs) where many of the products were supplied on a routine basis. It was highlighted that it should not be the case that patients, who were refused medications under this policy, were then able to obtain these from a MIU. It was noted that a charge was levied in the MIUs for these items but there could potentially be more of a challenging situation concerning those patients who were not eligible for prescription charges. In answer to a question about preparedness in the CRHFT accident and emergency department, Mr Shepherd stated that a version of the policy had been drafted for use and the principles contained in it had been widely accepted. There would be a need for a similar discussion with the DTHFT accident and emergency department. **Agreed:** JAPC noted the Self-Care Prescribing Policy. **Action:** The policy would be placed on the website together with the generic EIA statement. Mr Dhadli and Mr Brown would liaise with the CCG communications department about the publication of the policy.	**SD** **DB/SD**
12.	**REGIONAL MEDICINES OPTIMISATION COMMITTEE (RMOC)**	
	Mr Dhadli outlined some of the points from the Regional Medicines Optimisation Committee (North) meeting: • Dr Keith Ridge, Chief Pharmaceutical Officer for NHS England, had requested, or will be requesting over the coming months, to the RMOCs that they consider how they could support the anti-microbial resistance agenda and national strategy. • Antibiotic use remained a public health concern although there had been a 7% reduction in inappropriate antibiotic use in primary care. However there had been a 1% increase in secondary care. • RMOCs should be looking to deliver its outcomes by working with CCGs on a STP footprint. • Feedback had been given concerning FreeStyle Libre® and a framework developed for the type of patients who could be eligible for use. This was a reactive piece of work and lessons were learned including the feedback that a budget impact assessment would be useful. • Clinical references were also identified as necessary in how RMOC made its decisions.	

Item		Action
	This would be added to its SPS website due to the need for improved communication of these to Area Prescribing Committees. • Across England there were six enhanced health in care home (EHCH) vanguards working to improve the quality of life, healthcare and health planning for people living in care homes. This work had resulted in a 21% reduction in emergency admissions. A Care Homes fund would be available for 2018/2019 and CCGs would be able to apply to this. • A Care Homes Homely Remedies policy was being developed which would need to be endorsed by the Care Quality Commission. • Consideration was being given to the development of a self-care policy and a sharing portal developed. • Support to be given for the biosimilar work via commissioning support units.	
13.	**JAPC BULLETIN**	
	It was agreed that the shared care guideline section be re-worded to read: 'Dronedarone for the maintenance of sinus rhythm after successful cardioversion in clinically stable adult patients with paroxysmal or persistent atrial fibrillation (AF) when alternative treatments are unsuitable. Secondary care is responsible for the patients initial twelve months of treatment and the ongoing six monthly ECGs (arrangement and interpretation). This is a new shared care guideline and GPs will be requested to monitor annual LFTs and Urea and Electrolytes.' The amended bulletin was ratified by JAPC. Dr Narula expressed some views from GP colleagues as to whether it would be safe for them to take on the shared care of six patients in North Derbyshire with dronedarone as they lacked sufficient experience and expertise with its use. Dr Markus commented that some of the shared care agreements were not actually shared in practice and involved the move of workload from secondary care to primary care. In addition, some practices reported that the agreement forms were not being received. Patients had subsequently contacted the practices to say that they had been informed that they could obtain the drug and monitoring from GPs which could place them in an awkward position. Mr Dhadli emphasised that the shared care must be communicated to the GPs who need to indicate agreement. The Department of Health was currently reviewing the shared care templates. Dr Mott commented that JAPC would need to further discuss the issues about shared care, including safety considerations, and referred to a task and finish working group national consultation on shared care.	**SD** **SD (future agenda)**
14.	**MHRA DRUG SAFETY UPDATE**	
	The MHRA Drug Safety Alert for November 2017 was noted. Mr Dhadli highlighted the following MHRA advice: • Quinine: reminder of dose-dependent QT-prolonging effects; updated interactions. • Oral tacrolimus products: reminder to prescribe and dispense by brand name only.	

Item		Action
	A reference had been added to the traffic light classification on the medicines management website concerning the need to prescribe and dispense oral tacrolimus by brand to minimise the risk of inadvertent switching between products which have been associated with reports of toxicity and graft rejection.	
15.	**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: Atezolizumab (Tecentriq®) Atezolizuma (Tecentriq®) – Classified as **RED** as per NHS England commissioning intentions. Imatinib (Imatinib Teva®) – Classified as **RED** as per NHS England commissioning intentions. Patiromer (Veltassa®) – Classified as **RED**. Sarilumab (Kevzara®) – Already classified as **RED** (TA 485). Telotristat etiprate (Xermelo®) - Classified as **RED** as per NHS England commissioning intentions. New formulation launches in the UK: Darunavir + cobicistat + emtricitabine + tenofovir alafenamide (Symtuza®) - Classified as **RED** as per NHS England commissioning intentions. Licence extensions: Icatibant (Firazyr) – Classified as **RED** as per NHS England commissioning intentions.	
16.	**NICE SUMMARY**	
	Mrs Qureshi informed JAPC of the comments for the CCGs which had been made for the following NICE guidance issued in November 2017: TA 483 Nivolumab for previously treated squamous non-small cell lung cancer – Classified as **RED** (NHS England). TA 484 Nivolumab for previously treated non-squamous non-small cell lung cancer – Classified as **RED** (NHS England). TA 485 Sarilumab for moderate to severe rheumatoid arthritis – Classified as **RED** as NICE TA 485. NICE did not anticipate that this would have a significant impact on resources and it would be added to the RA pathway. TA 486 Aflibercept for treating choroidal neovascularisation – Classified as **RED.** TA 487 Venetoclax for treating chronic lymphocytic leukaemia – Classified as **RED** (NHS England). TA 488 Regorafenib for previously treated unresectable or metastatic gastrointestinal stromal tumours – Classified as **RED** (NHS England).	

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

Item		Action
	TA 489 Vismodegib for treating basal cell carcinoma – Re-classified as **BLACK**. TA 490 Nivolumab for treating squamous cell carcinoma of the head and neck after platinum-based chemotherapy – Classified as **RED** (NHS England). TA 491 Ibrutinib for treating Waldenstrom's macroglobulinaemia – Classified as **RED** (NHS England). NG 78 Cystic fibrosis: diagnosis and management – NICE did not expect this guidance to have a significant impact on resources. NG 79 Sinusitis (acute): Dr D Harris, Lead Antimicrobial Pharmacist, was currently reviewing the guidance. It was noted that the guidance aimed to limit antibiotic use and reduce antimicrobial resistance. NG 80 Asthma: diagnosis, monitoring and chronic asthma management – Local work was currently in progress on an asthma guideline. NG 77 Cataracts in adults: management – Mr Dhadli stated that this would need to be discussed by the Clinical Policy Advisory Group in view of the numbers of patients who could be eligible for cataract surgery. NG 81 Glaucoma: diagnosis and management – It was noted that this did not significantly change the local drug treatment pathway as it was based on intraocular pressure and use of either prostaglandin analogues or beta blockers. CG71 (updated from August 2008) Familial hypercholesterolaemia: identification and management – The guidance had been sent to the local lipidologists and comments had been received about the existing availability of DNA testing in North Derbyshire but not in South Derbyshire where assessments were made using the Simon Broome criteria.	
17.	**GUIDELINE GROUP ACTION TRACKER**	
	The summary of key messages from the Derbyshire Medicines Management Guideline Group meeting held in November 2017 was noted. Mr Dhadli highlighted the following: Traffic Lights: Capsaicin 0.025% cream – Classified as **BROWN**. It was noted that it could be considered as an adjunct after NSAIDs (topical or oral) with or without paracetamol in osteoarthritis. Diclofenac (oral) – Classified as **BROWN**. It was highlighted that this should be a third line NSAID due to increased cardiovascular risk. A reference would be placed about this in the newsletter. Gelclair sachets – Classified as **BLACK** pending a submission from the Drugs and Therapeutic Committees.	**SD**

Item		Action
	Caphosol and Episil had already been assigned a BLACK traffic light classification. Tacrolimus (oral) – Classified as **RED.** The drug must be prescribed by brand to minimise the risk of inadvertent switching between products which had been associated with reports of toxicity and graft rejection. Formulary Review: Skin Chapter – A link to the British Association of Dermatologist (BAD) 'specials' list had been added. Respiratory – AirFluSal® MDI had replaced Sirdupia® as a more cost effective fluticasone/salmeterol treatment option for asthma. Central Nervous System – Venlafaxine MR to be prescribed generically and replaced Vensir®. Xaggitin® and Delmosart® had replaced Matoride® and Concerta® as the branded generic drugs of choice for methylphenidate. Guidelines: Osteoporosis – This had been updated to include reference to and need for adherence to the NICE TA 464 on bisphosphonate. The choice of treatment should be made on an individual basis after informed discussion about risk and benefit using the NICE decision tool. NRT Formulary – This had been abridged to include only the most cost effective choices for each product type.	
18.	**TRAFFIC LIGHTS – ANY CHANGES?**	
	Classifications Mefenamic acid – **BLACK** Tadalafil (once daily) – **BLACK** Dosulepin – **BLACK** for new patients. **BROWN** for continuation for existing patients. Gluten Free Products – All **BLACK** with implementation to be phased. Atezolizumab (Tecentriq®) – **RED** (as per NHS England commissioning intentions). Patiromer (Veltassa®) – **RED** Sarilumab (Kevzara®) – **RED** (as per NICE TA 485) Telotristat etiprate (Xermelo®) – **RED** (as per NHS England commissioning intentions) Darunavir + cobicistat + emtricitabine + tenofovir alafenamide (Symtuza®) – **RED** (as per NHS England commissioning intentions) Nivolumab – **RED** (as per NICE TAs 483, 484 and 490) Sarilumab – **RED** (as per NICE TA 485) Aflibercept – **RED** (as per NICE TA 486) Venetoclax – **RED** (NHS England as per NICE TA 487) Regorafenib – **RED** (NHS England as per NICE TA 488) Vismodegib – **BLACK** (as per NICE TA489) Ibutinib – **RED** (NHS England as per NICE TA 491)	

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Item		Action
19.	**MINUTES OF OTHER PRESCRIBING GROUPS**	
	• Burton Drugs and Therapeutic Committee 04/09/2017 • Burton Drugs and Therapeutic committee 13/11/2017 • CRHFT Drugs and Therapeutic Committee 21/11/2017 • Clinical Policy Advisory Group 14/09/2017 • Clinical Policy Advisory Group 12/10/2017 • DTHFT Drugs and Therapeutic Committee 17/10/2017 • Nottinghamshire Area Prescribing Committee 18/05/2017 • Nottinghamshire Area Prescribing Committee 20/07/2017 • Sheffield Area Prescribing Group 20/07/2017 • Sheffield Area Prescribing Group 21/09/2017 Mrs Needham highlighted the following from the minutes of the Sheffield Area Prescribing Group held on 20th July 2017: • It had been decided to remove prednisolone 5mg soluble tablets from the Sheffield Formulary and promote the use of standard or 'plain' tablets, which could be crushed and dispersed in water – this would be 'off label' administration. Mrs Needham proposed that a similar message should be conveyed in Derbyshire by the Guideline Group – this was agreed. Mr Dhadli highlighted the following from the minutes of the Nottinghamshire Area Prescribing Committee held on 20th July 2017: • A defined group of patients had been identified for use of omega 3: only for those with risk of pancreatitis. Mr Dhadli highlighted the following from the minutes of the Burton Drugs and Therapeutic Committee held on 13th November 2017: • Rituximab Fast Infusion – An application had been made for use of the rituximab fast infusion and it had been highlighted that this had been used in Derby for over five years with no problems.	**SD**
20.	**ANY OTHER BUSINESS**	
a.	**New Shared Care Consultation** Dr Mott referred to the task and finish working group on the principles of shared care. This would be circulated to JAPC with an indication of the closing date for comments. It would also be brought to the January 2018 JAPC meeting for discussion.	**SD**
21.	**DATE OF NEXT MEETING**	
	Tuesday 9th January 2018 at 1.30pm, Coney Green Business Centre, Clay Cross	