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DERBYSHIRE JOINT AREA PRESCRIBING COMMITTEE (JAPC)

Minutes of the meeting held on 11 September 2018

CONFIRMED MINUTES

Summary Points

Traffic lights

Drug	Decision
Insulin Lispro Sanofi® Biosimilar	BLACK
Methylphenidate (including MR)	AMBER 1st line option for ADHD
Lisdexamfetamine	AMBER 2nd line option for ADHD
Dexamfetamine	AMBER 3rd line option for ADHD
Atomoxetine	AMBER 3rd line option for ADHD
Guanfacine	AMBER 3rd line option for ADHD in children aged five years and over
Parathyroid Hormone (Natpar®)	RED
Carbetocin (Pabal®)	RED
Dupilumab	RED (as per NICE TA 534)
Lenvatinib/Sorafenib	RED (NHS England as per NICE TA 535)
Alectinib	RED (NHS England as per NICE TA 536)
Ixekizumab	RED (as per NICE TA 537)
Dinutuximab beta	RED (NHS England as per NICE TA 538)
Lutetium (177Lu) oxodotreotide	RED (NHS England as per NICE TA 539)

Derbyshire Medicines Management Shared Care and Guideline Group Traffic Lights

Drug	Decision
Humalog ® (insulin lispro)	GREEN (100units/ml) BROWN (200units/ml)
Vitamin D preparations (maintenance)	BLACK. 1000 units and below (guidance previously stated 800 units) for maintenance following treatment of deficiency or insufficiency

Patient Group Directions

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 and UK guidelines for the public health management of clusters of serious pneumococcal disease in closed setting.

Administration of intramuscular (or subcutaneous) inactivated influenza vaccine to individuals in accordance with the national immunisation programme for active immunisation against influenza.

Shared Care Guidelines

Management of Attention Deficit Hyperactivity Disorder (ADHD) for Children and Adults

Apomorphine in the treatment of Parkinson's disease

Riluzole for the treatment of the Amyotrophic Lateral Sclerosis form of Motor Neurone Disease (MND)

Somatropin (Synthetic Human Growth Hormone)

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Present:	
Southern Derbyshire CCG	
Dr A Mott	GP (Chair)
Mr S Dhadli	Specialist Commissioning Pharmacist (Professional Secretary)
Mrs L Hunter	Assistant Chief Finance Officer
Mrs S Qureshi	NICE Audit Pharmacist
Dr M Watkins	GP
North Derbyshire CCG	
Dr T Narula	GP
Mrs K Needham	Assistant Chief Quality Officer (Medicines Management) (also representing all four Derbyshire CCGs)
Hardwick CCG	
Dr T Parkin	GP
Erewash CCG	
Dr M Henn	GP
Derby City Council	
Derbyshire County Council	
University Hospitals of Derby and Burton NHS Foundation Trust	
Dr W Goddard	Chair – Drugs and Therapeutic Committee
Mr C Newman	Chief Pharmacist
Derbyshire Healthcare NHS Foundation Trust	
Dr S Taylor	Chair – Drugs and Therapeutic Committee
Chesterfield Royal Hospital NHS Foundation Trust	
Mr M Shepherd	Chief Pharmacist
Derbyshire Community Health Services NHS Foundation Trust	
Ms A Braithwaite	Pharmacist
Derby and Derbyshire Local Medical Committee	
Dr K Markus	Chief Executive
Derbyshire Health United	
Mr D Graham	Pharmacist
In Attendance:	
Mr A Thorpe	Derby City Council (minutes)

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Item		Action
1.	**APOLOGIES**	
	Dr R Dewis, Dr C Emslie, Mr S Hulme, Mr D Moore and Ms J Town.	
2.	**DECLARATIONS OF CONFLICT OF INTEREST**	
	Dr Mott reminded committee members of their obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of JAPC. No conflicts of interest were declared in relation to this agenda; in addition to the existing register of interests.	
3.	**DECLARATIONS OF ANY OTHER BUSINESS**	
	• Low Molecular Weight Heparin	
4.	**MINUTES OF JAPC MEETING HELD ON 14 AUGUST 2018**	
	The minutes of the meeting held on 14th August 2018 were agreed as a correct record after the following amendments: Management of Type 2 Diabetes (Minutes of JAPC meeting held on 10 July 2018) – Amend to: 'Discussion followed and Dr Narula commented that empagliflozin, covered by NICE TAs, had to a large extent replaced usage of the gliptins. However SGLT-2 inhibitors could not be used if the patient's estimated glomerular filtration rate (eGFR) was less than sixty and therefore a gliptin would then be given as second line option. It would seem advantageous that dual therapy of metformin with empagliflozin should move ahead of the dual therapy of metformin with gliptins in the order of drugs to be used in the guideline and, in light of the cardiovascular benefit, as not much cost difference between gliptins and SGLT-2 inhibitors. The combination of metformin + pioglitazone as second line drug should be replaced by metformin + empagliflozin due to the weight of evidence for its efficacy. Dr Narula added that NICE currently recommended the use of GLP-1 agonists after triple therapy but, in the light of the evidence which demonstrated cardiovascular benefit, this could be looked at by the Guideline Group.' ActiPatch® - Amend to 'The second study, which had signed up subjects via the company's website, had not been randomised or had any of the standards required in the hierarchy of trials.'	
5.	**MATTERS ARISING**	
a.	**Branded Prescribing** A check would be made that Mr Moore had taken forward the issue as to whether, in cases where eye drops were out of stock, generic prescriptions would be requested with a second choice if the preferred item was also out of stock.	**WG**
b.	**Derbyshire Recovery Partnership Over the Counter (OTC), Opiate Based Medication and Benzodiazepine Position Statement and Pathway**	

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	Dr Mott reported that an email had been sent to the relevant CCG commissioner, with a copy to the Derbyshire County Council Director of Public Health, concerning the need for clarification about the gaps in the commissioning of the service to deal with OTC opiate prescription medication addiction. However no response had yet been received. Dr Markus added that Derbyshire LMC had proposed a motion to the national conference on the need for guidance on this increasing problem.	
c.	**Pulmonary Rehabilitation in COPD Update** Mrs Needham confirmed that the change in the eligibility criteria for COPD rehabilitation would have no impact on the currently commissioned service in the North of the County.	
d.	**Shared Care Agreements** Mr Dhadli advised that the buprenorphine, methadone and naltrexone shared care agreements would be brought to the October JAPC meeting.	**SD**
e.	**Compression Hosiery** Dr Markus reported that the concerns about the capacity of primary care to undertake the required measurements for class 1 compression hosiery had been conveyed to the Derbyshire Local Pharmaceutical Committee in order to obtain a definitive view - no response had yet been received. Further reports had also been received by Derbyshire LMC that pharmacies in other parts of Derbyshire had also declined to measure made-to-measure stockings. In addition, some community nurses had also declined and indicated that this should be undertaken by primary care. Mrs Needham stated that this issue had been discussed by the North prescribing sub-group and further details would be obtained in order to try and resolve the contractual issues. Mrs Needham would convey the contact details of the person who was taking this work forward to Dr Markus. Dr Markus also highlighted a potential further issue for primary care if community nurses were unable to undertake the measurements for made-to-measure stockings. Mr Dhadli reported that a representative from Boots, the Regional Professional Standards Manager, had contacted a store manager in the relevant area who had confirmed that patients were measured for standard compression hosiery. However for other ulcer compression hosiery repeat prescriptions were received which had measurement forms attached as completed by the practice nurses. It was agreed that any emerging contractual issues could be conveyed to the appropriate commissioner for community pharmacy services for resolution.	**KN**
f.	**Initial Management of Deep Vein Thrombosis (DVT) in Minor Injury Units (MIUs)** Ms Braithwaite reported that a pathway had been developed by DCHSFT staff, in conjunction with staff from all the acute Trusts, to facilitate the initial management of patients who presented at a MIU with the signs and symptoms of a DVT. A Wells score and near patient D-Dimer test would be undertaken on these patients and, in the event that a DVT was suspected, they would receive a first treatment dose of tinzaparin according to their actual body weight and assuming that there were no contraindications to its use.	

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	Patients would then be reviewed and receive an ultrasound scan at an acute hospital on the same day or within a twenty-four hour period. Arrangements would then be made for an assessment via telephone and/or email followed by referral to acute hospital ambulatory care/Medical Assessment Unit. Ms Braithwaite confirmed that the pathway had received the approval of the DCHSFT Clinical Effectiveness Group and it was hoped to commence use with effect from October 2018. It was noted that there was potential for future use by GPs to refer patients with suspected DVTs to MIUs for initial screening to be undertaken, although this has not yet been developed or proposed. Discussion followed and Ms Braithwaite advised that the use of the new oral anticoagulants (NOACs) had not been included in the pathway as they could only be used if a patient's estimated glomerular filtration rate (eGFR) was >30ml/min/1.73m^2. This knowledge may not be available to MIU staff. Their efficacy was also dependent on being taken at regular times. The use of low molecular weight heparin (LMWH), such as tinzaparin, was already established in existing treatment pathways. Dr Markus referred to the basket of services in North Derbyshire which had included point of care testing and D-dimer tests for DVT but subsequently withdrawn due to issues concerning false negatives and variability of the different D-dimer tests. An agreement had been put in place that patients would be sent to the hospitals but the same pathway had now appeared in the MIUs and would be affected by the previous issues which had caused the withdrawal from the basket of services. Ms Braithwaite highlighted that the D-dimer testing would be subject to a quality control process and linked to the UK NEQAS for Blood Coagulation, an international External Quality Assessment (EQA) programme. Dr Mott advised that there would be a need for assurance from UHDBFT and CRHFT that the pathway had been approved via their internal governance processes. The guidance itself was not within the remit of JAPC to check as it related to NHS secondary care providers and a pathway between them, with the proviso that the medication choices were consistent with the JAPC formulary. The guidance had been reviewed by JAPC on the understanding that NOACs would be included in the review. The longstanding issue concerning use of the NOACs by primary care in the management of suspected DVT remains outstanding and would now be addressed by Dr Mott in collaboration with the Guideline Group. Dr Narula also offered his assistance.	**SD/AM**
g.	**<u>Derbyshire Health United (DHU) Out of Hours (OOH) Formulary</u>** Mr Graham was welcomed to the meeting as a regular member on behalf of DHU. Mr Dhadli reported that some discrepancies in the OOH formulary compared to the Derbyshire primary care formulary had been highlighted at the July 2018 JAPC meeting. Comments had now been added to explain these discrepancies as follows: • Dexamethasone 2mg soluble for the management of croup – This had been removed	

Item		Action
	• Prednisolone soluble – This formulation had been amended to indicate use for narrow bore tubes only. • Temazepam 10mg – This had been removed with no alternative. Ms Braithwaite queried the inclusion of dihydrocodeine tablets 30mg in the formulary. Mr Graham advised that a monthly report was compiled on the use of diamorphine, diazepam and codeine. However the use of dihydrocodeine was very limited and, due to the inclusion of codeine in the formulary, it would now be omitted. Dr Taylor referred to the inclusion of diazepam injection 10mg/2ml in the psychiatric emergencies section as NICE guidance for tranquilisation indicated the use of lorazepam. In addition, it would be more appropriate for haloperidol to be relocated within the formulary as its use was widespread in palliative care patients. It was agreed that diazepam in all forms be removed from the formulary and haloperidol placed in the palliative care section. **Agreed:** JAPC accepted the DHU OOH formulary with the agreed amendments.	**DG** **DG** **DG**
h.	**Black Drugs Position Statement** Mr Dhadli reported that comments had been received from JAPC members and the revised guidance uploaded to the website.	
6.	**JAPC ACTION SUMMARY**	
	Suspected DVT-NOAC/D-dimer – Work to be undertaken on the development of a pathway in primary care to treat suspected DVTs with the NOACs. Statins/ezetimibe – The guidelines would be reviewed by the Guideline Group. To be taken off the list. Derbyshire Health United Out of Hours Formulary – To be taken off the list. C.Difficile – Dr Mott would contact Dr D Harris, Lead Antimicrobial Pharmacist, concerning progress with the development of the guidance. Derbyshire Recovery Partnership Over the County Position Statement – This was work in progress.	**AM/Guideline Group** **SD** **SD** **AM** **AM**
7.	**NEW DRUG ASSESSMENTS**	
a.	**Insulin Lispro Sanofi®** Mr Dhadli reported that insulin lispro Sanofi® was a new biosimilar injection for which the reference medicine was Humalog 100 U/ml solution. Laboratory studies had demonstrated that the active substance in insulin lispro Sanofi® was highly similar in terms of structure, purity and biological activity to that of Humalog. The Guideline Group had discussed this new biosimilar and concern had been expressed about its name and the potential risk of confusion with the generic product as the two were not considered to be interchangeable.	

Item		Action
	It had been highlighted that insulin products should be prescribed by brand but in this case even that may cause confusion. Therefore a recommendation had been made for a BLACK classification to be assigned pending receipt of comments from both acute Trusts and the consultant diabetologists. Insulin lispro Sanofi® had been discussed by the UHDBFT Drugs and Therapeutic Committee and the lack of a clear brand name and the consequent risk of inadvertent switching highlighted. **Agreed:** Insulin lispro Sanofi ® classified as a **BLACK** drug as not recommended or commissioned due to patient safety issues.	**SD**
8.	**PATIENT GROUP CLINICAL GUIDELINES**	
	The following PGDs from Public Health England were noted by JAPC: • 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 and UK guidelines for the public health management of clusters of serious pneumococcal disease in closed setting. • Administration of intramuscular (or subcutaneous) inactivated influenza vaccine to individuals in accordance with the national immunisation programme for active immunisation against influenza.	
9.	**SHARED CARE GUIDELINES**	
a.	**Management of Attention Deficit Hyperactivity Disorder (ADHD) for Children and Adults** Dr Taylor reported that NICE had issued Clinical Guideline 87 'Attention Deficit Hyperactivity Disorder – Diagnosis and Management of ADHD in children, young people and adults' in March 2018. The Clinical Guideline had recommended the use of Guanfacine prolonged‑release (Intuniv®) as a third line option for the treatment of ADHD in children aged five years and over and young adults. Guanfacine had a current RED traffic light classification (black triangle drug) by JAPC and it was highlighted that Guanfacine prolonged‑release was not licensed in adults with ADHD. NICE did not recommend its use in adults without advice from a tertiary ADHD service. Dr Taylor referred to the current lack of a commissioned adult diagnostic service in DHcFT and that the current shared care covered both children and adults; although it may be necessary to separate into two agreements. Mr Dhadli advised that the shared care agreement for the management of ADHD for Children and Adults had been updated in line with the NICE Clinical Guideline. It had been recommended that the current position of the ADHD drugs be changed to the following (again in line with the NICE Guidance): • Methylphenidate – 1st line • Lisdexamfetamine – 2nd line • Atomoxetine – 3rd line	

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Item		Action
	• Dexamfetamine – 3rd line • Guanfacine – RED to AMBER 3rd line option for children aged five years and over The clinical evidence for the inclusion of Guanfacine arose from a trial which compared it to atomoxetine and in which similar outcomes had been demonstrated. A traffic light classification of RED had originally been assigned due to the number of non-responders and lack of experience due to it being new to the market. However, Mr Dhadli advised that there was no specific monitoring requirement, other than for symptom based hypertension, and the SPC had not stipulated that it should remain under specialist care. Dr Mott referred to the current specialist nurse service in DHcFT for ADHD in children and the agreement with Sheffield Teaching Hospitals that some adult patients would be diagnosed (if appropriate), initiated and stabilised before being transferred back. The service provided by DHcFT would pick up those patients who did have a diagnosis as part of shared care but this was inconsistent. There is a lack of clarity about the commissioned service for adults from DHcFT, but this is recognised and discussions are due to review this. From the medication perspective it was agreed that it is preferable to have an all age shared care agreement in one place. Dr Markus expressed some concern about the continued prescribing of Guanfacine in primary care for adult patients due to the lack of an adult ADHD service. Mr Dhadli stated that the safety section in the full NICE guidance referred to the lack of studies that directly compared the efficacy and safety of Guanfacine prolonged‑release with other active treatments for ADHD. Dr Watkins requested greater clarity in letters from specialist services about whether patients had the drugs prescribed by the consultant or GP and therefore an indication as to whether a prescription had been issued or not would be advantageous. Dr Markus added that patients should continue to be given a prescription by secondary care until the point that GP practices had given formal agreement to take over the prescribing as part of a shared care agreement. Mr Dhadli stated that all the Derbyshire shared care agreements had generic statements which included advice on this. **Action:** The consultant responsibilities section would be enhanced by the inclusion of a reference to the need to indicate whether a prescription had been issued or not. **Action:** Dr Mott would be part of a wider ongoing discussion with DHcFT and the commissioners about the commissioning and transition arrangements for adults and children with ADHD. **Agreed:** Guanfacine classified as an **AMBER** drug 3rd line option for the treatment of ADHD in children aged five years and over as it required specialist assessment to enable patient selection and initiation of treatment and short or medium term specialist monitoring of toxicity.	**SD** **AM** **SD**

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Item		Action
	Agreed: JAPC approved the revised ADHD guideline with the agreed amendments with a two year review date.	**SD**
b.	**Apomorphine** Mr Dhadli reported that the apomorphine shared care guideline in the treatment of Parkinson's disease was due for review. There had been no significant changes apart from updated contact details for the two Acute Trusts and the inclusion of a link to the newer MHRA advice concerning the minimisation of risk of cardiac events in patients who were taking apomorphine with domperidone. **Agreed:** JAPC approved the shared care guideline for apomorphine (APO-go®) in the treatment of Parkinson's disease with a two year review date.	**SD**
c.	**Riluzole** Mr Dhadli reported that this shared guideline for riluzole for the treatment of the Amyotrophic Lateral Sclerosis form of Motor Neurone Disease (MND) had been discussed by JAPC at the August 2018 meeting. More information had been requested about the use of the licensed riluzole suspension (Teglutik®) which was significantly more expensive than the tablets which could be crushed and mixed with food. Advice had subsequently been obtained from Dr M Knopp, UHDBFT Consultant Neurologist, and Ms S Cole, UHDBFT MND Nurse Specialist, and the guideline had subsequently been amended as follows: • The tablets would be used first line. • For the majority of patients with swallowing difficulties the tablets could be crushed and dispersed. • For severe dysphagia, which caused coughing and aspiration or in patients using gastromy feeding tubing, the suspension could be used as the crushed and dispersed tablets had a risk of tube blockage if they were not adequately dissolved. The use of the suspension could be restricted to use in exceptional circumstances only on MND specialist advice in patients with severe dysphagia or enteral feeding tubes. It was noted that ePACT data had revealed that the twelve month cost across Derbyshire was £4947 with nineteen estimated patients. **Agreed:** JAPC approved the shared care guideline for riluzole for the treatment of the Amyotrophic Lateral Sclerosis form of Motor Neurone Disease (MND) with the agreed amendments and with a two year review date.	**SD**
d.	**Somatropin** Mr Dhadli reported that the Somatropin (Synthetic Human Growth Hormone) shared care guideline was due for review and only the contact details had been updated. **Agreed:** JAPC approved the shared care guideline for Somatropin (Synthetic Human Growth Hormone) with a two year review date.	**SD**

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Item		Action
10.	**MISCELLANEOUS**	
a.	**Dupilumab** Mrs Qureshi reported that NICE TA 534 had been published in August 2018 for Dupilumab (Dupixent®) for the treatment of moderate to severe atopic dermatitis. It was recommended as an option for treating moderate to severe atopic dermatitis in adults. Mrs Quershi highlighted that the NICE TA had not specified any baseline eligibility criteria and had only referred to "moderate to severe" atopic dermatitis. The SPC had indicated that Dupilumab could be used for patients who had an Eczema Area and Severity Index (EASI) score >16 and an Investigator's Global Assessment (IGA) score ≥3. This had been added to the Dupilumab pathway. Mrs Qureshi added that the commissioning responsibilities had now changed from NHS England to CCGs. It was also noted that three patients at UHDBFT were already on the drug and that Dupilumab was part of the early access to medicines scheme (EAMS) which aimed to give patients with life threatening or seriously debilitating conditions access to medicines that did not yet have a marketing authorisation when there was a clear unmet medical need. EAMS, with a NICE approved TA, required a drug to be commissioned within a thirty day period. Dupilumab had been discussed by the earlier meeting of the Biosimilar and HCD Working Group and highlighted as a cost pressure due to being a NICE mandated drug. NICE had also been requested by the JAPC Professional Secretary to provide clarity about their definition of moderate to severe atopic dermatitis. The pathway was ratified by JAPC.	**SD**
b.	**Brexit** Mr Dhadli referred to the government's ongoing preparations, in the event that there was no deal with the European Union in March 2019 about the withdrawal of the United Kingdom, for what the health and social care system needed to consider over the autumn and in the period leading up to this time. Mr Dhadli highlighted the following points: • The United Kingdom to have an additional six weeks supply of medicines in case imports from the European Union through certain routes were affected. • Hospitals, GPs and community pharmacies in the United Kingdom did not need to take any steps to stockpile additional medicines beyond their business as usual stock levels. • Patients should be advised not to store additional medicines at home.	
c.	**Familial Hypercholesterolaemia (FH)** Mr Dhadli reported that Public Health England had produced a document 'Implementing a systems approach to detection and management' in collaboration with NICE, NHS England, HEART UK and the British Heart Foundation. It aimed to set out measures that could be taken to improve the diagnosis and treatment of FH based on the available evidence and expertise. Mr Dhadli highlighted that one of these measures would involve systematic searching of primary care records in order to identify individuals that may have a FH assessment, although there could be resource issues associated with this.	

Item		Action
	The document was noted by JAPC as a useful public health initiative.	
11.	**REGIONAL MEDICINES OPTIMISATION COMMITTEE (RMOC)**	
a.	Mr Dhadli reported that the RMOC (Midlands and East) had expressed their interest to understand the shared care processes currently in place in the Midlands and East in order that awareness could be gained about the specific issues and medicines that created difficulties and problems. JAPC had been requested to comment on this issue via a questionnaire to be completed by 30th September 2018 and this included the following questions: 1. Does the area operate an effective shared care process? Does this include a 'traffic light' system for specific medicines? 2. What are the three main issues that create difficulties at care interfaces? 3. What are the five most common medicines or classes that create most difficulties at care interfaces? Mr Dhadli added that answers to the above questions had been included in the previously circulated information but requested any additional comments or revisions from JAPC members. Following discussion, it was agreed that funding, capacity and inconsistency should be added to the answers provided for question two. In connection with question 3 it was agreed that this should include the dementia, NOAC and ADHD drugs together with the immunomodulating drugs outside rheumatology. Dr Markus also highlighted the issues caused when different traffic light classifications were assigned for the same drug by neighbouring Area Prescribing Committees. There was also some increasing demand for gender dysphoria drugs.	
12.	**JAPC BULLETIN**	
	The bulletin was ratified by JAPC.	
13.	**MHRA DRUG SAFETY UPDATE**	
	The MHRA Drug Safety Alert for August 2018 was noted. Mr Dhadli highlighted the following MHRA advice: • Esmya® (ulipristal acetate) and risk of serious liver injury: new restrictions to use and requirements for liver function monitoring before, during, and after treatment	
14.	**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: • Parathyroid hormone (Natpar®) – Classified as **RED** (NHS England). • Trastuzumab biosimilar (Kanjinti®) – No action. New formulation launches in the UK: • Carbetocin (Pabal®) – Classified as **RED** for review by the Drug and Therapeutic Committees.	

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Item		Action
15.	**NICE SUMMARY**	
	Mrs Qureshi informed JAPC of the comments for the CCGs which had been made for the following NICE guidance issued in August 2018: TA 534 Dupilumab for treating moderate to severe atopic dermatitis – Already classified as **RED**. It was highlighted that patient numbers would need to be determined for the current year in UDBHFT and CRHFT and also in Sheffield Teaching Hospitals. TA 535 Lenvatinib and sorafenib for treating differentiated thyroid cancer after radioactive iodine – Classified as **RED** (NHS England as per NICE TA 535). TA 536 Alectinib for untreated ALKpositive advanced non-small-cell lung Cancer – Classified as **RED** (NHS England as per NICE TA 536). TA 537 Ixekizumab for treating active psoriatic arthritis after inadequate response to DMARDs – Classified as **RED.** TA 538 Dinutuximab beta for treating neuroblastoma – Classified as **RED** (NHS England as per NICE TA 538). TA 539 Lutetium (177Lu) oxodotreotide for treating unresectable or metastatic neuroendocrine tumours – Classified as **RED** (NHS England as per NICE TA 539). NG 102 Community pharmacies: promoting health and wellbeing.	**SD/SQ**
16.	**GUIDELINE GROUP ACTION TRACKER**	
	The summary of key messages from the Derbyshire Medicines Management Guideline Group meeting held in August 2018 was noted. Mr Dhadli highlighted the following: Traffic Lights: • Insulin Lispro – Humalog 100units/ml classified as **GREEN**. Humalog 200units/ml classified as **BROWN**. • Insulin Lispro Sanofi® – Classified as **BLACK** pending local review. • Vitamin D (maintenance) – Classified as **BLACK**. 1000 units and below (the guidance had previously stated 800 units) for maintenance following treatment of deficiency or insufficiency. Guideline Group: • Ciclosporin Shared Care Guidance: Added 'Ciclosporin should be prescribed by brand (to avoid variation in bioavailability) and patients kept on the same brand unless the consultant decided to change.' Guidelines: • C.Difficile – The Guideline Group had formally requested a full review of the document. • Buprenorphine, Methadone and Naltrexone Shared Care Agreements – To be brought to the October JAPC meeting.	**SD**

Item		Action
	• Infant feeding guideline – To be brought to the October JAPC meeting. • Urinary tract infection (UTI) in chronic kidney disease (CKD) – To be brought to the October JAPC meeting. • Atrial Fibrillation (AF) – Awaiting comments from the consultant cardiologists. • Choice of strong opioids for cancer pain – To be brought to the October JAPC meeting.	**SD** **SD** **SD**
17.	**JAPC SUB-GROUPS**	
	Biosimilar and High Cost Drugs Working Group Dr Mott reported that a meeting had been held this morning at which Dupilumab, psoriatic arthritis and the psoriasis algorithm had been discussed. Mrs Qureshi advised that the psoriasis algorithm had been slightly amended to indicate there would now be three commissioned switches for patients; two for intolerance and one for inadequate response. Adalimumab had also been discussed. The paper of the top biosimilar medicines list which gave the target annual savings 2018/2019, cumulative savings and monthly uptakes broken down to UHDBFT, CRHFT and Burton Hospitals NHS Foundation Trust was noted by JAPC. Mr Shepherd had highlighted that the rituximab data was of limited value as it did not account for indication or delivery route and additional assurance would therefore need to be obtained.	
18.	**TRAFFIC LIGHTS – ANY CHANGES?**	
	Classifications Insulin Lispro Sanofi® – **BLACK** Methylphenidate (including MR) – **AMBER** 1st line option for ADHD Lisdexamfetamine – **AMBER** 2nd line option for ADHD Dexamfetamine – **AMBER** 3rd line option for ADHD Atomoxetine – **AMBER** 3rd line option for ADHD Guanfacine – **AMBER** 3rd line option for ADHD in children aged five years and over Parathyroid Hormone (Natpar®) – **RED** Carbetocin (Pabal®) – **RED** Dupilumab – **RED** (as per NICE TA 534) Lenvatinib/Sorafenib – **RED** (NHS England as per NICE TA 535) Alectinib – **RED** (NHS England as per NICE TA 536) Ixekizumab – **RED** (as per NICE TA 537) Dinutuximab beta – **RED** (NHS England as per NICE TA 538) Lutetium (177Lu) oxodotreotide – **RED** (NHS England as per NICE TA 539)	
19.	**MINUTES OF OTHER PRESCRIBING GROUPS**	
	• UHDBFT Drugs and Therapeutic Committee 19/06/2018 • CRHFT Drugs and Therapeutic Committee 17/07/2018	
20.	**ANY OTHER BUSINESS**	
a.	**Low Molecular Weight Heparin (LMWH) – Twice Daily Dosing** Ms Braithwaite referred to a licence change from a once daily to a twice daily enoxaparin injection in 2017 to the LMWH guideline which, although a relatively minor change, had now caused an unintended issue for both DCHSFT and DHU.	

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Item		Action
	The administration of enoxaparin required appropriate minimum time intervals between the morning and evening treatment doses for the high risk patients concerned but, due to the variance in the working patterns of district nurses, difficulties were being encountered in getting the spacings of the second dose correct. In order to try and resolve this issue possible different solutions had been discussed with the UHDBFT consultant haematologists. These included teaching of patients to self-administer and discharge, seeking assurance from consultants as to whether the dosing intervals can be brought closer together and whether an alternative different LMWH could be used. During discussion it was highlighted that there was a risk that these patients may not receive the second dose and consequently would not be adequately anticoagulated. In addition, some patients may lack the necessary skill to self-administer the injection. It was agreed that the discussions with the consultant haematologists should continue in order to try and find a solution. Ms Braithwaite would send information as to the number of patients who were affected to Mr Newman.	**AB**
b.	**<u>Lipid Guidance</u>** Dr Narula queried when NICE was due to publish revised lipid guidance as questions had been raised as to whether atorvastatin 20mg daily was still the correct dose for primary prevention. Dr Narula referred to advice which had been received to downgrade atorvastatin 20mg daily from a high to a low intensity statin and this change would need to be discussed with the cardiologists in the event that new NICE guidance was not published in the near future. Dr Narula would be advised about the NICE forward plan dates.	**AM**
21.	**DATE OF NEXT MEETING**	
	Tuesday, 9th October 2018 at 1.30pm in the Coney Green Business Centre, Clay Cross.	