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DERBYSHIRE JOINT AREA PRESCRIBING COMMITTEE (JAPC)

Minutes of the meeting held on 13th August 2019

CONFIRMED MINUTES

Summary Points

Traffic lights

Drug	Decision
Azithromycin	GREEN specialist recommendation for prophylactic antibiotic therapy for COPD patients
Triple COPD Therapy - Trimbow (Beclometasone 87mcg/Formoterol 5mcg/ glycopyrronium 9 mcg) - Trelegy Ellipta (Fluticasone furoate92 mcg/Vilanterol 22 mcg/ Umeclidinium 65 mcg)	BROWN
GlucoRx safety needles	GREEN, preferred 1st line safety needles.
Mylife Clickfine Autoprotect safety needles	GREEN to be used only by DCHSFT staff, pending release of training material for GlucoRx safety needles.
*All other safety needles (except GlucoRx & Mylife)	BLACK – cost >£20 per 100 GREEN 2nd line – cost <£20 per 100
Melatonin oral solution 1mg/ml	BLACK for short term jet-lag disorder and not licensed/or suitable for children
Nusinersen	RED (NHS England as per NICE TA588)
Blinatumomab	RED (NHS England as per NICE TA589)
Fluocinolone acetonide intravitreal implant	RED (as per NICE TA590)
Letermovir	RED (NHS England as per NICE TA591)
Branded drugs including alphagan, amias, Avodart, bondronat, cialis, cozaar, crestor, cymbalta, ezetrol, femara, fosamax, istin, lustral, movicol, naramig, pariet, procoralan, serc, seroxat, singulair, tylex, travatan, zestril, zyprexa	BLACK
Lacaent and Neurontin	BLACK for non-epilepsy conditions.

***post meeting note**

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Derbyshire Medicines Management Shared Care and Guideline Group Traffic Lights

Drug	Decision
Ethinylestradiol/desogestrel (Cimzt replaces Gedarel 30/150)	GREEN
Ethinylestradiol/drospirenone (Yacelle and Yisnell replace Dretine)	BROWN
Slow K	Removed due to long-standing supply problem and no prescribing
Doxylamine/Pyridoxine (Xonvea)	BLACK (following NICE ESNM review)
Melatonin (Circadin MR)	BROWN Specialist Initiation to include community paediatrics
Desogestrel	GREEN
Oxycodone (OyxPro/Oxeltra)	GREEN modified release preparations 2nd line use only (replacing Longtec)

Clinical Guidelines

- Chronic Obstructive Pulmonary Disease (COPD) Management.
- North Derbyshire OPAT (Outpatient Parenteral Antimicrobial Therapy) Pathway for Primary Care (Step-Up Pathway/Admission Avoidance).

Patient Group Directions

- Administration of inactivated influenza vaccine to individuals in accordance with the national immunisation programme[1] for active immunisation against influenza.
- Supply and administration of live attenuated influenza vaccine nasal spray suspension (Fluenz Tetra), OR supply only in well-defined local circumstances, to children and adolescents from 2 years to under 18 years of age in accordance with the national flu immunisation programme for active immunisation against influenza.

Shared Care Guidelines

- Methotrexate for patients 16+ years
- Sodium Aurothiomalate (Myocrisin)
- Oral sulfasalazine for patients 16+ years

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Present:	
Derby and Derbyshire CCG	
Dr C Emslie	GP (Chair)
Mr S Dhadli	Assistant Director of Clinical Policies and Decisions (Professional Secretary)
Dr M Henn	GP
Mr S Hulme	Director of Medicines Management and Clinical Policies
Dr T Parkin	GP
Mrs S Qureshi	Head of Medicines Management, Clinical Policies and High Cost Interventions
Ms Y Soetan	Head of Medicines Optimisation
Mr Z Azam	Head of Medicines Optimisation
Mr R Coates	Finance Manager
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	
Mr S Jones	Chief Pharmacist
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 Officer
Derbyshire Health United	
Mr D Graham	Pharmacist
Staffordshire CCG's	
Ms Susan Bamford	Senior Pharmacist
In Attendance:	
Ms K Marira	Senior Pharmacist Medicines Pathways
Mrs K Rogers	Derby and Derbyshire CCG Senior Administrator (minutes)

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Item		Action
1.	**APOLOGIES**	
	Dr R Dewis, Mrs K Needham	
2.	**DECLARATIONS OF CONFLICTS OF INTEREST**	
	Dr Emslie 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**	
	There were no declarations of any other business.	
4.	**MINUTES OF JAPC MEETING HELD ON 9 JULY 2019**	
	The minutes of the meeting held on 9th July 2019 were agreed as a correct record after the following amendments: Liothyronine – Dr Goddard expressed his concerns on the delay of the decision to repatriate patients back to primary care after it was reported to JAPC that all patients who had been referred to secondary care for review, have been reviewed. Ibandronate/zoledronic acid for cancer – The use of bisphosphonates is advocated in NICE NG101; NICE guideline is routinely adopted by the CCGs because of the robust clinical and cost effectiveness review undertaken by NICE. The trial evidence supports clinical efficacy and cost effectiveness in the NICE economic modelling. Mr Dhadli pointed out that NICE would have produced a costing template in situations where financial impact is at a reasonable threshold; however they have instead produced a resource impact statement which states “no significant resource impact is anticipated”. Because NICE do not think practice will change substantially as a result of this update to the guideline. A discussion took place around the inequity of access between North Derbyshire who access Sheffield Hospitals and South Derbyshire. Mr Dhadli questioned patient numbers eligible for treatment in Derby Hospitals proposal and the potential budgetary impact, as this has not been reflected in the prescribing in North Derbyshire. Ms Braithwaite expressed her concerns of an inequitable service and the delay and impact for patients, whilst waiting for a decision for commissioners. JAPC clinicians supported the NICE guideline (NG1010), however recognised JAPC as non-budgetary holders. JAPC asked that the topic of this guideline and non-compliance is raised within the CCG.	
5.	**MATTERS ARISING**	
a.	**<u>Plenachol (Vitamin D) availability</u>** Mr Dhadli reported that plenachol is not widely available; therefore it has not been included in the vitamin D guideline.	
b.	**<u>Liothyronine</u>** Mr Dhadli reported that a meeting has been arranged between representatives of JAPC, University Hospitals of Derby and Burton NHS	

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	Foundation Trust (UHDBFT) and Chesterfield Royal Hospital Foundation Trust (CRHFT) for September 2019, to discuss further how to address patients who remain on treatment of liothyronine in secondary care. An update will be bought back to the JAPC meeting in either September or October following this.	**SD**
c.	**<u>Hydroxychloroquine</u>** Mr Dhadli stated that the Clinical and Lay Commissioning Committee (CLCC) have looked at hydroxychloroquine which was presented by Dr R Dewis consultant in Public Health Medicine. The feedback from this is that it must go to the Clinical Policy Advisory Group (CPAG) who will look at the evidence base for this. Planned care will be there and a discussion can take place around how the service will be delivered, whether that is through secondary care or from an outreach service for ocular monitoring.	
d.	**<u>Ibandronic acid</u>** Mr Dhadli advised the committee that he had spoken with Ms C Urquhart Head of Cancer Commissioning within Derby and Derbyshire CCG, the discussion outcome was that Cancer Commissioning does not directly have a budget around this; therefore it may be better placed with JAPC to consider as it is drug related. UHDBFT have been asked to produce a business case for this. Dr Goddard reported that he had contacted oncologists and the oncology chemotherapy group to see if more detailed figures and a breakdown of numbers can be provided. Mr Dhadli expressed his concerns on the delay of a decision, NICE NG101 has published a guideline which looked at the clinical effectiveness of this, if there were to be a recourse impact then NICE would produce a recourse impact tool, which they have not done in this instance. Ms Braithwaite also expressed concerns and she would like it to be minuted that this is a commissioning decision and not a decision of the JAPC committee. JAPC members' support the NICE guideline however as JAPC are non-budgetary holders it is for Derby and Derbyshire CCG to decide if it will be commissioned. Ms Braithwaite also referred to the inequitable service and the quality impact and risk assessment for patients who are not receiving this. Mr Dhadli advised that these comments can be fed back through CLCC and it will be minuted that JAPC feel there is a risk to patients who do not have access to ibandronic acid. A discussion took place over who would review the business case for this. Mr Dhadli advised he felt this would be the Financial Recovery Group (FRG) within Derby and Derbyshire CCG who look to see if there is a resource impact. Committee members questioned why a decision could not be made immediately as ibandronic acid is currently being used in the North of Derbyshire. Dr Emslie reported that Derby and Derbyshire CCG will not commit to anything that requires new funding without looking at this in detail and then giving it the appropriate approval. A business case from UDHBFT would help to show projected costs and the financial impact it would have, as figures from North Derbyshire prescribing do not reflect this.	**SD/SH** **WG**

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6.	**JAPC ACTION SUMMARY**	
a.	**Homely Remedies** Mr Dhadli suggested that this be removed from the action summary as Dr Henn advised that this will be looked at in a different meeting.	
b.	**Liothyronine** It was noted that this should be bought to JAPC in September 2019 or October 2019 following the outcome of the meeting with UHDBFT and CRHFT.	**SD**
c.	**Amiodarone** JAPC to look at Amiodarone in either October 2019 or November 2019 once the new shared care has been developed and been sent out for wider consultation with cardiologists. There is the possibility of a new joint shared care that includes dronedarone.	**SD**
d.	**Ibandronic acid** An update will be bought back to a future JAPC meeting when points can be answered following on from the comments made at today's meeting.	
7.	**CLINICAL GUIDELINES**	
a.	**Chronic Obstructive Pulmonary Disease (COPD) Management** Mrs Qureshi advised the committee that this was an update of the Derbyshire COPD guidance to bring it in line with the recent publication of NICE's COPD guidance (NG115, December 2018) and NICE guidance on triple therapy for COPD, which replaces NICE CG101. Mrs Qureshi gave an outline of the changes, COPD management is based upon whether the patient has asthmatic features or not. Those patients who present with asthmatic features, the guidance recommends considering LABA/ICS combination. Patients without asthmatic features, the guidance recommends offering LABA/LAMA combination. NICE also recommends dual therapy ahead of monotherapy. The evidence shows that compared with other dual therapy combinations and with monotherapy, LABA/LAMA a. Provide the greatest benefit to overall quality of life b. Is better than other inhaled treatments for many individual outcomes (e.g. reducing the risk of moderate to severe exacerbations) c. Is the most cost effective option NICE did not recommend a particular LAMA because they were not convinced that the evidence showed meaningful difference in effectiveness between the drugs in the class. The evidence supported the view that there was probably no meaningful difference between aclidinium, glycopyrronium, tiotropium and umeclidinium for the outcomes of interest. As a result, the committee did not make a recommendation favouring one drug over another, but rather recommended that a number of factors be taken into consideration when making a choice of drug, including patient preference regarding inhaler device and the ability to use it. NICE in collaboration with Cochrane have reviewed the clinical and cost effectiveness of dual therapy. Across the various economic scenarios modelled, the strategy of patients starting with LABA/LAMA was considered cost effective.	

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	Mrs Qureshi then went on to discuss NICE's recommendations for triple therapy. NICE specifically recommend triple therapy based on what dual therapy a patient has had before and based on exacerbations, if they are severe or moderate a patient would be offered triple therapy. In terms of cost effectiveness for triple therapy, Mrs Qureshi reported that results shows that triple therapy is likely to be cost effective compared with both LAMA+LABA and LABA+ICS in patients who continue to exacerbate or remain breathless on dual therapy. The only scenario where triple therapy is not cost effective is when it is delivered as two separate inhalers. This is because delivering triple therapy as two inhalers is more costly than using a single combination inhaler. However when NICE compared the cost of 2 separate inhalers for both triple therapy and dual therapy for comparison, it produced a very high probability that triple therapy is still cost effective (99.1%). NICE recognise the recommendations may result in the number of people who are prescribed triple therapy and an increase in the number of people who need treatment for pneumonia, although this may be mitigated by the relatively widespread current use of triple therapy. Mrs Qureshi went on to say that other new additions to COPD guidance included prophylactic antibiotic therapy, reversibility testing and COPD and asthma overlap. Eosinophil count level is based on local expert advice as there is no national consensus on a reference value. The cost implications for Derbyshire for implementation of NICE guidance would be just under £18,000. Mrs Qureshi then went on to discuss the Derbyshire COPD guidance and pointed out that where it refers to oral prophylactic antibiotics, azithromycin is recommended off label for COPD patients; it was suggested this be GREEN specialist recommendation for prophylactic therapy for COPD. Previous classification of LABA/LAMA's was based on the FLAME study which compared indacaterol/glycopyrronium vs salmeterol/fluticasone. For the current review NICE do not recommend a particular LAMA therefore the suggestion would be for all LABA/LAMA's to be classified the same since they are equally efficacious and have the same cost. Finally both triple therapy combinations are currently BROWN, NICE have said that they are cost effective and there are no differences between them, Mrs Qureshi put forward the suggestion to change the traffic light classification for these. Mr Graham queried whether the suggested traffic light classification for azithromycin would mean that they need to produce a Patient Group Direction for this; Dr Emslie confirmed that this would not be for acute scenarios. Dr Henn felt that some of the guidance could be made clearer in comparison to the flow chart. The flow chart makes it clear that only patients with asthmatic features are considered for triple therapy and this needs to be added to the first bullet point on page 11 where it refers to LABA/ICS offer triple inhaled therapy as this is not clear in the text. Dr Henn also referred to a slight difference in doses and duration of oral corticosteroids during exacerbations between NICE and the COPD guideline, Mr Dhadli confirmed that the duration and dose would be updated to bring this in line with NICE recommendations. Dr Henn then went on to add that the advice of Primary Care Respiratory Society (PCRS) states that triple therapy is not generally beneficial for COPD patients with predominant breathlessness, this might be worth Derbyshire taking into consideration as to when triple therapy should be used, Dr Henn also suggested a clinical review of patients who may be put	**SQ**

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	onto triple therapy. It was also suggested that eosinophil count be mentioned under 'Further investigations for all patients at initial diagnostic evaluation'. Mr Hulme asked if the COPD guidance had been sent to the Right Care Respiratory Steering Group for consultation. He also asked if a microbiologist had been consulted in terms of the potential azithromycin traffic light classification change. Mrs Qureshi confirmed that she had consulted with Dr J Lowery Respiratory Consultant at UHDBFT; however she had not yet contacted a microbiologist. A discussion took place around the traffic light classification of triple therapy. If this were to be made GREEN then it may encourage the use of it more through inappropriate prescribing. The committee felt it best to leave it as BROWN with a view to re-visiting this in the future if they felt it necessary. In regards to the traffic light classification for LABA/LAMA's, Mr Hulme asked if this could be bought back to the next JAPC meeting once patent expiries have been checked. **Agreed:** Azithromycin to be classified as **GREEN specialist recommendation for prophylaxis in COPD** pending consultation with a microbiologist. Triple Therapy to remain classified as **BROWN.** **Agreed:** JAPC ratified the Chronic Obstructive Pulmonary Disease (COPD) Management, with a review date of 3 years, pending consultation with a microbiologist in regards to the azithromycin and patent expiries being checked to decide on the traffic light classification for the LABA/LAMA's.	**SQ** **SQ** **SQ**
b.	**<u>Outpatient Parenteral Antimicrobial Therapy (OPAT)</u>** Mr Dhadli reported that there has been a review and update to the existing OPAT guidance. This was sent out for consultation and comments were received from Ms Booth Senior Pharmacist/Infection Prevention and Control Pharmacist, Derbyshire Community Health Services NHS Foundation Trust (DCHSFT) and Ms Braithwaite. Following the comments, Flucloxacillin Infusion has been removed from page 2 of the guidance; the reference to Intravenous (IVs) at Whitworth Minor Injuries Unit (MIU) has been removed as the Rapid Response service no longer administers this. The teicoplanin dose had been updated to follow the current dose given in the British National Formulary (BNF) and electronic Medicines Compendium (eMC), however Ms Braithwaite asked if this could be amended to follow the Chesterfield guidance as this is where microbiology advice is taken from in North Derbyshire. Mr Dhadli discussed that this would mean having three brackets under 'indication' in the guidance rather than two, Ms Braithwaite agreed with this. Mr Dhadli also discussed teicoplanin levels under 'Monitoring and Escalation' as the timings talk about either 5 days or 72 hours, however this would come under the responsibility of the Rapid Response Team. Mr Dhadli asked if Ms Braithwaite could clarify the timings for this. Dr Parkin raised the question of whether there is an in equitability issue of an OPAT service in North Derbyshire and not one in South Derbyshire. Mr Newman and Dr Goddard clarified that UHDBFT do have an OPAT service, however this is only carried out from within secondary care and DCHSFT do not have any involvement with this. A discussion took place in regards to bringing the two services together to make the process more uniform; Mr	

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	Shepherd reported that a meeting is currently in place to discuss this further. **Action:** Ms Braithwaite to clarify timings for monitoring and escalation for teicoplanin levels and update the committee at a future meeting. **Agreed:** JAPC ratified the guidelines for North Derbyshire OPAT (Outpatient Parenteral Antimicrobial Therapy) Pathway for Primary Care (Step-Up Pathway/Admission Avoidance) with a review date of 3 years.	**AB** **SD**
8.	**PATIENT GROUP DIRECTIONS**	
a.	The following PGDs from Public Health England effective from 1st September 2019 were noted by JAPC: • Administration of inactivated influenza vaccine to individuals in accordance with the national immunisation programme1 for active immunisation against influenza. • Supply and administration of live attenuated influenza vaccine nasal spray suspension (Fluenz Tetra), OR supply only in well-defined local circumstances, to children and adolescents from 2 years to under 18 years of age in accordance with the national flu immunisation programme for active immunisation against influenza.	
9.	**SHARED CARE GUIDELINES**	
a.	**Methotrexate** This is a review and update to the existing methotrexate shared care guideline. Mr Dhadli reported that the update is based on comments from the acute trusts, including Queens Hospital Burton. Mr Dhadli confirmed that going forward all shared cares will also include reference to contact details for Queens Hospital Burton. Following minor comments the IM/IV route has been removed as it is not used, the 'dose and route of administration/duration of treatment' layout has been updated to bring it in line with the British Society for Rheumatology (BSR) guidance. The adverse effects have been updated in line with the Summary of Product Characteristics (SPC) and BNF; the contact details have also been amended. The GPs/patient responsibility for patients on shared care methotrexate via homecare (Healthnet) have been clarified in regards to ancillaries/administrative issues. There was a request from clinicians to use methotrexate for new indications one of them being Neuromyelitis Optica/neuromyelitis Optica Spectrum Disorders (NMOSD), Mr Dhadli advised that the correct process would need to be followed whereby it must be looked at through the hospitals Drugs and Therapeutics meetings, the evidence in support of this must then be reviewed. The live vaccination has been updated to state 'it can be used with caution in patients taking methotrexate up to a dose of 25mg, if not on any other immunosuppressant as per Green book. There is also a statement in regards to males and fathering children which has been left in the guideline. The British Society of Gastroenterology (BSG) Inflammatory Bowel Disease (IBD) guideline states that there is no firm evidence to support the recommendation that men should discontinue methotrexate pre-conception however this is advised in the SPC. Dr Markus queried whether the section on live vaccinations listed under GP responsibilities could be under specialist recommendation rather than the GP	

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	making the decision as to whether they use this vaccine with caution in patients taking methotrexate up to a dose of 25mg, if not on any other immunosuppressant. This information was taken from the Green book, however Mr Dhadli would add a note under consultant responsibilities to say 'advise and respond to GP queries on live vaccination'. Ms Braithwaite commented on the collection and disposal of cytotoxic sharp bins as DCHSFT have received queries from the south as to whether they will accept these. Ms Braithwaite confirmed that they cannot accept used sharps bins; patients are required to take these to the Royal Derby Hospital; however some are unable to travel that far. GP's won't accept them either if they have not prescribed the medication. Mr Dhadli referred to the shared care guideline where it states that collection of cytotoxic waste can be arranged through a home care provider. Mr Newman confirmed that requests for this should go through UHDBFT so that a home care provider can be arranged. **Action:** Mr Dhadli to add a line under consultant responsibilities to say 'advise and respond to GP queries on live vaccination'. **Agreed:** JAPC ratified the shared care agreement for Methotrexate for patients 16+ years, with a review date of 3 years.	**SD** **SD** **SD**
b.	**<u>Sodium Aurothiomalate (Myocrisin)</u>** Mr Dhadli confirmed that the shared care agreement for Myocrisin has been updated to reflect that the manufacturer is discontinuing this. The guideline now states that no new patients are to be commenced on treatment. The shared care agreement will be retired once all existing patients have been reviewed and switched to an alternative treatment. This will be added to the JAPC action tracker and reviewed in three to six months' time. **Agreed:** JAPC ratified the changes to the shared care agreement for Sodium Aurothiomalate (Myocrisin). To be reviewed again in three to six months' time.	**SD** **SD**
c.	**<u>Sulfasalazine</u>** Mr Dhadli advised that the existing shared care agreement contained inconsistent information with regards to the monitoring requirements. To bring this in line with the methotrexate shared care agreement, it was updated to say that in patients following the 6 weeks of dose stability, it will become the GP's responsibility to conduct monthly monitoring for three months followed by three-monthly monitoring thereafter. In regards to the section on live vaccinations, there had been a query from the Derbyshire Medicines Management Shared Care and Guideline Group around the definition of 'standard dose' for sulfasalazine, as it does not give an example of what this should be. Mr Dhadli had been in contact with Dr Badcock Consultant Rheumatologist at UHDBFT and Ms Hardy (Senior Pharmacist Biologics) at CRHFT. Dr Badcock responded to say that the doses used in the shared care under remission and maintenance constitute as standard doses. Ms Hardy also confirmed this in her response and quoted the arthritis UK leaflet which states 'there don't appear to be any factors that mean the vaccine can't be given if you're taking sulfasalazine and hydroxychloroquine, which aren't considered to be immunosuppressive DMARDs.'	

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	Mr Dhadli then continued to say that the contraindications and cautions section had been updated as per the SPC; three additional advices remain which were not from the SPC however this was general advice for DMARDs. Dr Markus referred to the methotrexate shared care agreement under consultant responsibilities where it states 'prescribe methotrexate for the first three months or until medication monitoring is stable'. She asked that this also be conveyed in the sulfasalazine shared care to give a consistent message. Mr Dhadli confirmed he would update this. **Agreed:** JAPC ratified the shared care agreement for Oral sulfasalazine for patients 16+ years, with a review date of 3 years.	**SD** **SD**
10.	**MISCELLANEOUS**	
a.	**Branded drugs for consideration to assign a BLACK traffic light classification** Mr Dhadli advised that there is a recommendation from the JAPC QIPP Working Group to look at classifying some branded products as BLACK. The Derbyshire Medicines Management Shared Care and Guideline Group have split these into three different tables: Mr Dhadli referred to the first table where the brand is clearly more expensive than the generic; the recommendation would be to assign a BLACK traffic light to these brands. The second table contains antiepileptic drugs, where the brand is clearly more expensive than the generic. The recommendation would be to assign a BLACK traffic light for non-epilepsy indications. Table three contains certain strengths of a brand which may or may not be cheaper than the generic, in this instance it has been recommended that the Medicines Management Team include an Optimise Rx message rather than classifying individual strengths. A discussion took place as to some of the challenges that may be faced from patients who cannot take a generic form of a drug. Mr Hulme advised that if a patient were to demonstrate exceptionality then this should go through the Individual Funding Request (IFR) process. Mr Hulme also asked if an Equality Impact Assessment (EIA) and Quality Impact Assessment (QIA) would need to be looked at for each individual drug. Mr Dhadli advised that as there are alternatives available this would not be necessary. Mr Hulme added that the EIA and QIA may affect some processes rather than the decision making and this must be considered.	
b.	**Oxygen** Mr Dhadli reported that there had been a partial update to the Oxygen guideline following the update to the NICE COPD guidance, which recommends against treating smokers/patients living with smokers with oxygen. CRHFT said that they do not recommend any person that smokes is given long term oxygen therapy in their home. Mr Dhadli advised that he had communication with Sue Smith Specialist practitioner for oxygen Advanced Care Lead ImpACT+ Regional Clinical Lead Home Oxygen Contract, who was concerned about the effect of complete cessation of all oxygen for active smokers on bed occupancy and felt this was something that needed to be discussed with the trusts respiratory Guideline Group. The JAPC committee concluded that the local oxygen guideline should acknowledge NICE recommendation however, accept the risk will be	

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	managed by the provider i.e. specialist to continually assess patients on an individual basis at every clinician contact. Mr Dhadli said he would also wait to hear from Sue Smith again once this topic had been discussed at their Guideline Group.	**SD**
c.	**<u>QRISK3</u>** Mr Dhadli advised that QRISK3 has been developed and validated in a prospective open cohort study [Hippisley-Cox, 2017] which used 981 GP practices with 7.89 million patients to develop the risk scores, and 328 practices with 2.67 million patients to validate the scores. Three models were developed; model A contained the same variables as the 2017 version of QRISK2. Models B and C included the additional variables that met the inclusion criteria but differed in that model B did not include the standard deviation of serial systolic blood pressure values, whereas model C did. This has shown that QRISK3 is an appropriate tool and can be used; the QResearch database is something which is used in other prediction tools. QRISK3 does pick up additional risk factors so Mr Dhadli suggested that it be added to the Lipid guidance as an option for those clinicians wanting to use it.	**SD**
	The only comments received back were from Ms R Dewis in regards to the National Healthcheck programme, they are reviewing QRISK3 however for the purpose of the programme it is advised to use QRISK2. Dr Markus asked if the threshold treatment values are still the same, Mr Dhadli confirmed that they are, the only difference is that there are more risk factors added to QRISK3 and more refined. It was noted that this is not available on the GP systems yet, however it is being used externally. The JAPC committee agreed for QRISK3 to be added to the lipid guidance as an option for any clinicians wanting to use it.	
d.	**<u>Safety Needles</u>** The Operational Medicines Optimisation Group (OMOG) asked if JAPC could review the formulary choice for safety needles. Mr Dhadli referred to a paper showing a summary table of the different types of safety needles. Mylife Clickfine is currently the formulary choice, however OMOG have recommended replacing Mylife with GlucoRx safety needles as they are more cost effective. Ms Braithwaite reported that DCHSFT currently use Mylife Clickfine and there doesn't appear to be any training materials on the GlucoRx website to assist with the use of their safety needles. In the past DCHSFT staff who use Mylife safety needles had access to some training, as all safety needles can be slightly different. Dr Emslie agreed that as it is mainly DCHSFT staff who will be administering this product, there is a need for a training package before a complete switch to GlucoRx can be done. It is also necessary for GP's Pharmacists and patients to be able to access a training package on how to use GlucoRx. Dr Emslie suggested that GlucoRx be classified as GREEN and also Mylife Clickfine be classified as GREEN to be used only by DCHSFT staff for home use, until the release of training material for GlucoRx. Ms Braithwaite also asked if this information can be fed back through UHDBFT and CRHFT Drugs and Therapeutics meetings to inform the diabetic team of the changes.	
	Mr Dhadli advised that he will also add this to the JAPC action tracker to	**SD**

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	review in 3 months' time. **Agreed:** GlucoRx safety needles to be classified as **GREEN.** Mylife Clickfine Autoprotect to be classified as **GREEN, to be used only by DCHSFT staff, pending release of training material for GlucoRx safety needles.** **Post meeting note:** JAPC clarified all safety needles with an acquisition cost >£20 per 100 were classified as BLACK and those with a cost of <£20 per 100 were classified as GREEN 2nd line.	**SD**
11.	**REGIONAL MEDICINES OPTIMISATION COMMITTEE (RMOC)**	
	The RMOC Newsletter 2019 Issue 6 was noted. Mr Dhadli highlighted the following: • Biosimilar Insulins – the RMOC is investigating the potential for increasing uptake of biosimilar insulins. • Liothyronine Revised Guidance – the RMOC Guidance 'Prescribing of liothyronine' was updated and published on the SPS website. • Botulinium Toxin – work on unlicensed use for botulinum toxin to be shared. • Prior Approval Blueteq Principles – the RMOC are working to produce a set of principles regarding the use of Blueteq to provide greater clarity and reduce current variation in the system. • Free of Charge/Compassionate use of Medicines – RMOCs currently undertaking this work. • Sequential use of Biologics – the RMOC has been asked to provide advice on the sequential use of biologics. Evidence is lacking in this area and it is a difficult topic to provide general advice. Following the RMOC meeting legal advice has been sought and will form the basis of RMOC advice. • Patient Group Directions – the first two national PGDs were submitted to the RMOC for noting prior to their release, and their implementation to be endorsed as a single source. They are: 'Administration of tranexamic acid injection by registered Paramedics, Nurses and Midwives for treatment of severe haemorrhage'. 'Administration of flumazenil injection by registered Paramedics and Nurses for the complete or partial reversal of the central sedative effects of midazolam used for conscious sedation'.	
12.	**JAPC BULLETIN**	
	The July 2019 bulletin was ratified.	**SD**
13.	**MHRA DRUG SAFETY UPDATE**	
	The MHRA Drug Safety Alert for July 2019 was noted. Mr Dhadli highlighted the following MHRA advice: • Febuxostat (Adenuric): there is increased risk of cardiovascular death and all-cause mortality in clinical trial in patients with a history of major cardiovascular disease. Avoid treatment with febuxostat in patients with pre-existing major cardiovascular disease (for example, myocardial infarction, stroke, or unstable angina); unless no other therapy options are	

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	appropriate. • Tocilizumab (RoActemra): rare risk of serious liver injury including cases requiring transplantation. Serious liver injury has been reported on treatment with tocilizumab from 2 weeks to more than 5 years after initiation. A letter has been sent to healthcare professionals to advise them of this information. • Rivaroxaban (Xarelto.): a reminder that 15 mg and 20 mg tablets should be taken with food. MHRA has received a small number of reports suggesting lack of efficacy (thromboembolic events) in patients taking 15 mg or 20 mg rivaroxaban on an empty stomach; healthcare professionals to remind patients to take 15 mg or 20 mg rivaroxaban tablets with food. • Myocrisin permanent discontinuation: In June 2019, healthcare professionals were informed of the permanent discontinuation of Myocrisin (Sodium aurothiomalate) Solution for Injection. No new patient should commence treatment with Myocrisin injection. Prescribers should complete arrangements to transfer patients on Myocrisin to suitable therapeutic alternatives under medical supervision.	
14.	**HORIZON SCAN**	
a.	**Monthly Horizon Scan** Mr Dhadli advised JAPC of the following new drug launches, new drug formulations, licence extensions and drug discontinuations: New drug launches in the UK: • Nonacog beta pegol (Refixia) – classified as **RED** (as per NHS England commissioning intentions) New formulation launches in the UK: • Insulin glargine + lixisenatide (Suliqua) – to be taken to the Derbyshire Shared Care and Guidelines Group meeting for classification • Melatonin liquid 1mg/ml – classified as **BLACK** • Latanaprost + timolol (Fixapost) – to remain classified as **GREEN after consultant/specialist initiation/BLACK** Licence extensions: • Abatacept (Orencia) – to remain classified as **RED/BLACK** • Atezolizumab (Tecentriq) – to remain classified as **RED** • Botulinum A toxin (Xeomin) – to remain classified as **RED** • Emicizumab (Hemlibra) – to remain classified as **RED** • Olaparib (Lynparza) – to remain classified as **RED**	
b.	**NICE Horizon Scan** Mr Dhadli highlighted the following clinical guidelines which may be of relevance to JAPC: Clinical Guidelines: • Hypertension in adults: diagnosis and management – August 2019 • Cannabis-based medicinal products – November 2019 • Venous thromboembolic diseases: diagnosis, management and thrombophilia testing (2019)	

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	• Thyroid disease: assessment and management – November 2019 • Asthma: diagnosis, monitoring and chronic asthma management – January 2020 • Depression in adults: treatment and management – February 2020 • Acute coronary syndromes – May 2020 • Chronic pain: assessment and management – August 2020 • Atrial fibrillation: management – September 2020 • Acne Vulgaris: Management – January 2021 • Epilepsies in adults: diagnosis and management update – April 2021 • Epilepsies in children: diagnosis and management – April 2021 NICE Technology Appraisals: • Hypertension in adults: diagnosis and management – August 2019 • Dapagliflozin, in combination with insulin, for treating type 1 diabetes [ID1478] – August 2019 • Rivaroxaban for preventing major cardiovascular events in people with coronary or peripheral artery disease [ID1397] – August 2019 NICE New Evidence Summaries: • Lower urinary tract symptoms in men: assessment and management – August 2019	
15.	**NICE SUMMARY**	
	Mrs Qureshi informed JAPC of the comments for the CCG which had been made for the following NICE guidance in July 2019: TA588 Nusinersen for treating spinal muscular atrophy – classified as **RED** (NHS England as per NICE TA588) TA589 Blinatumomab for treating acute lymphoblastic leukaemia in remission with minimal residual disease activity – classified as **RED** (NHS England as per NICE TA589) TA590 Fluocinolone acetonide intravitreal implant for treating recurrent noninfectious uvetitis – classified as **RED** (as per NICE TA590) TA591 Letermovir for preventing cytomegalovirus disease after a stem cell transplant – classified as **RED** (NHS England as per NICE TA591) CG173 Neuropathic pain in adults: pharmacological management in nonspecialist settings – updated guidance	
16.	**GUIDELINE GROUP ACTION TRACKER**	
	The summary of key messages from the Derbyshire Medicines Management Shared Care and Guideline Group meeting held in July 2019 was noted. Mr Dhadli highlighted the following: Traffic Lights: • Ethinylestradiol/desogestrel – classified as **GREEN,** Ethinylestradiol 30 micrograms/Desogestrel 150micrograms – Cimizt has replaced Gedarel	

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	30/150 as preferred brand. • Ethinylestradiol/drospirenone – classified as **BROWN,** not used first line. Yacella and Yisnell replace Dretine as preferred brand. • Slow K – removed due to long-standing supply problem and no prescribing. • Doxylamine/pyridoxine (Xonvea) – NICE ES20 reviewed, to remain classified as **BLACK**, for nausea and vomiting in pregnancy based on limited evidence and cost. • Melatonin (Circain MR) – additional information added to **BROWN** specialist initiation classification, to include the use in community paediatrics patients. • Desogestrel – additional information added to **GREEN** classification, some generics may contain ingredients unsuitable for soya or nut allergy sufferers- these patients should check suitability with pharmacy when product is dispensed. • Oxycodone (OxyPro/Oxeltra) – additional information added to **GREEN** classification, OxyPro/Oxeltra replace Longtec as preferred brand for modified release preparations (2nd line use only). Formulary Update (Chapter 9 – Nutrition and Blood): • Folic acid oral solution removed from 1st line formulary – added as a note 'licensed oral solution available but more expensive' refer to Specials/liquid guideline. • Removed notes on Slow K as long-standing supply problem and no prescribing. • Preferred vitamin D products updated as per recently updated vitamin D guideline – Fultium D3 20,000 unit caps for daily regime, InVita D3 50,000 unit caps for weekly regime. Thorens 10,000 units/ml oral drops for children. Clinical Guidelines: • Prescribing of Stoma Accessories – product description updated as per dictionary of medicines and devices (dm+d) for GP clinical systems. Medi Derma-S replaces Cavilon as per Derbyshire wound care formulary/ prescribing formulary. Specialist contact details also updated. • Infant feeding guideline – SMA Pro high energy renamed SMA high energy. • Lipid modification (non-FH) – added QRISK3 as an option for risk assessment. Website Changes/Miscellaneous: • Website update: a new 'self-care' tab under clinical guidelines has been created. This lists a summary of the conditions and a link to resource that GPs can hand out. • Formulary chapter 7 Obs & Gynae & Urinary-tract – Advice and link to SPS on 'COC in patients taking hepatic enzyme inducing drugs' has been added. • Formulary Chapter 6 Endocrine – Two insulin price tables have been merged. • MHRA advice on febuxostat added to formulary chapter 10 – avoid treatment with febuxostat in patients with pre-existing major cardiovascular	

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	disease. • Edoxaban crushing information added to NOAC detailing aid. • 'Signpost to antimicrobial website' document removed due to lack of use. Guideline Timetable: • The guideline table action summary and progress was noted by JAPC.	
17.	**BIOSIMILAR REPORT**	
	Mr Dhadli reported that a query had been raised to UHDBFT on the use of etanercept, they have responded to say that 147 patients haven't switched however 98 have since consented and are waiting to be switched over which can take approximately 2 months.	**SD**
18.	**TRAFFIC LIGHTS – ANY CHANGES?**	
	Classifications Azithromycin – GREEN specialist recommendation for prophylaxis in COPD Triple Therapy – BROWN GlucoRx safety needles – GREEN Mylife Clickfine Autoprotect – GREEN, to be used only by DCHSFT staff, pending release of training material for GlucoRx safety needles. *All other safety needles (except GlucoRx & Mylife) – BLACK cost >£20 per 100 and GREEN 2nd line <£20 per 100. Melatonin – BLACK Nusinersen – RED (NHS England as per NICE TA588) Blinatumomab – RED (NHS England as per NICE TA589) Fluocinolone acetonide intravitreal implant – RED (as per NICE TA590) Letermovir – RED (NHS England as per NICE TA591) *post meeting note	
19.	**MINUTES OF OTHER PRESCRIBING GROUPS**	
	• Sheffield Area Prescribing Group Minutes 18/04/2019 • Nottingham Area Prescribing Committee Minutes 16/05/2019 • DHcFT Drugs and Therapeutics Minutes 23/05/2019 • DHcFT Drugs and Therapeutics Minutes 27/06/2019 • UHDBFT Drugs and Therapeutics Minutes 19/06/2019 • MOST Minutes 06/06/2019 The following items were highlighted: • Sheffield Area Prescribing Group reviewed the traffic light status of acamprosate and this will remain classified as GREEN, additional advice referring prescribers to the prescribing guideline and to consider psychosocial support will also be added to the Traffic Light Drug List entry. Sheffield has introduced a new shared care guideline template which they will now start to use ahead of comments from Rotherham and Barnsley who still have to discuss the latest feedback at their respective committee meetings. • Nottingham Area Prescribing Committee currently has five different azathioprine information sheets on their website linked to five separate shared care protocols. There has been a proposal to unify the monitoring needed in primary care. Input had been sought from hepatology and gastro-enterology and it was agreed to align monitoring with the other 3	

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	protocols.	
20.	**ANY OTHER BUSINESS**	
	Dr Henn would no longer be attending future JAPC meetings, JAPC expressed their appreciation and thanks to Dr Henn who has been a long standing member of the committee for a number of years.	
21.	**DATE OF NEXT MEETING**	
	Tuesday, 10th September 2019 at 1.30pm in the Coney Green Business Centre, Clay Cross.	