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DERBYSHIRE JOINT AREA PRESCRIBING COMMITTEE (JAPC)

Minutes of the meeting held on 14th January 2020

CONFIRMED MINUTES

Summary Points

Traffic lights

Drug	Decision
Buprenorphine (Buvidal) SC	RED new formulation of a long acting injection. Available for use within substance misuse service
Moxifloxacin	RED for use in line with PHE/NICE and BASHH guidance within sexual health services
5-fluorouracil 5% cream (Efudix)	GREEN in line with the Managing Actinic Keratosis pathway (re-classified from GREEN consultant/specialist initiation)
Ingenol	BROWN specialist recommendation
Duloxetine	GREEN re-classified to second line treatment for neuropathic pain alongside gabapentin and pregabalin
Vitamin B compound strong	BROWN for medically diagnosed deficiency due to lifelong or chronic condition, or following surgery that results in malabsorption. This vitamin has multiple classifications and the TLC database should be seen for more information.
Gilteritinib (Xospata)	RED (as per NHS England commissioning intentions)
Meropenem + vaborbactam (Vaborem)	BLACK await national guidance or clinician request
Talazoparib (Talzenna)	RED (as per NHS England commissioning intentions)
Nicotine (Voke)	BLACK await national guidance
Zanamivir (Dectova)	BLACK pending clinician request
Cannabidiol with clobazam	RED as per NICE TA614 for treating seizures associated with Dravet syndrome
Cannabidiol with clobazam	RED as per NICE TA615 for treating seizures associated with Lennox–Gastaut syndrome

Derbyshire Medicines Management Shared Care and Guideline Group Traffic Lights

Drug	Decision
~~Cimetidine~~	~~GREEN~~ (see post meeting note for JAPC)
Sucralfate liquid	BROWN consultant/specialist recommendation for empirical management of patients with severe GORD or post-cholecystectomy, alongside use of PPIs
Calcipotriol and beclomethasone	BROWN Dovobet and Enstilar. Do not add as repeat prescription. See skin formulary appendix 2 for guidance on use in psoriasis
Hyoscine hydrobromide patch	BLACK for use in the treatment of travel sickness

Clinical Guidelines

Managing Actinic Keratoses
Chlamydia Testing and Management guideline

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Medication and falls prevention in the older person
Nebuliser guideline for Chronic Obstructive Pulmonary Disease (COPD) assessment and initiation
Managing Neuropathic Pain in Primary Care
Derbyshire Formulary for Nicotine Replacement Therapy (NRT)
Proton Pump Inhibitors (PPI)
Gluten Free Foods Prescribing Policy

Present:	
Derby and Derbyshire CCG	
Dr C Emslie	GP (Chair)
Mr S Dhadli	Assistant Director of Clinical Policies and Decisions (Professional Secretary)
Mrs K Needham	Assistant Director of Medicine Optimisation and Delivery
Dr H Hill	GP Prescribing Lead
Ms J Savoury	Assistant Chief Finance Officer
Ms J Derricott	Head of Primary Care Quality
Derby City Council	
Derbyshire County Council	
University Hospitals of Derby and Burton NHS Foundation Trust	
Dr W Goddard	Chair – Drugs and Therapeutic Committee
Mr R Sutton	High Cost Drugs/Commissioning 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	Chief Pharmacist
Derby and Derbyshire Local Medical Committee	
Dr K Markus	Chief Executive Officer
Derbyshire Health United	
Mr D Graham	Lead Clinical Pharmacist
Staffordshire CCG's	
Ms S Bamford	Medicines Optimisation Senior Lead Pharmacist
In Attendance:	
Mrs K Rogers	Derby and Derbyshire CCG Senior Administrator (minutes)

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Item		Action
1.	**APOLOGIES**	
	Mr S Hulme, Mrs S Qureshi, Dr R Dewis, Dr R Gooch, Ms A Reddish, Ms A Brailey.	
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**	
	• Hospital shortage of diamorphine.	
4.	**MINUTES OF JAPC MEETING HELD ON 10 DECEMBER 2019**	
	The minutes of the meeting held on 10th December 2019 were agreed as a correct record after minor amendments to the following agenda items: • New emollients listed in the Emollient Prescribing Guide were added to the traffic light classifications and summary section. • Matters arising item 5a added: Agreed: JAPC classified ibandronate 50mg tablets GREEN consultant/specialist initiation, for use in post-menopausal women with breast cancer as per NICE NG101. • Miscellaneous item 11a reads '*SIGN are now recommending a dose of 60mg for annual review and >90mg before referring to pain centres'* amended to say '*SIGN are now recommending a dose of >50mg for annual review and >90mg before referring to pain centres'.* For quoracy purposes Mr Dhadli informed the committee that Derbyshire Healthcare NHS Foundation Trust (DHcFT) have confirmed that they agree with the decisions of the minutes of the JAPC meeting held on 10th December 2019 where there was no DHcFT representation present. **Post Note for JAPC**. At the January 2020 Derbyshire Medicines Management Shared Care and Guideline Group (MMSCGG) it was noted that there are intermittent supply issues with all H2 Anatgonists including cimetidine. Recommendation to JAPC is not to have one preferred option listed.	
5.	**MATTERS ARISING**	
a.	**Cannabis for spasticity** Mr Dhadli reported that Mrs Qureshi has emailed both provider trusts along with Nottingham and Sheffield, who were sent a questionnaire devised on cannabis use in spasticity with multiple sclerosis. Sheffield will be raising this at their Drugs and Therapeutics meeting; there has been no further response as yet. Information is needed in regards to scoping when Sativex would be used, what treatments are being used prior to this and the number of existing and projected patient numbers. To scope also whether a clinical pathway and a shared care will be necessary for use within tertiary centres and primary/secondary care.	

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	Dr Goddard advised that this has been raised at the University Hospital of Derby and Burton NHS Foundation Trust (UHDBFT) Drugs and Therapeutics meeting. A discussion took place and it is likely that Derby would use this; however they felt that patient numbers would be small. Mr Dhadli confirmed that Chesterfield would not be using this.	
b.	**Homely remedies** Dr Markus stated that she has been in contact with Derby City Council in regards to homely remedies in care homes. She has advised them of decisions that need to be made and is waiting for a response. The council did not seem to be aware of the Homely Remedies policy which had previously been jointly issued by the Derbyshire CCG's and Derby City/County Council.	
c.	**Questran** At the December 2019 meeting Dr Goddard advised that UHDBFT are receiving a number of letters from GP's in regards to the unavailability of Questran and they had asked for an alternative recommendation. Dr Goddard suggested colesevelam however he would confirm this with Mr Dhadli following the meeting. Mrs Needham suggested recommending an alternative for all three current products. **Action:** Dr Goddard to give some advice on alternative recommendations due to the ongoing stock issue of Questran.	**WG**
d.	**Hydroxychloroquine** Mr Dhadli reported that Hydroxychloroquine was discussed at the December 2019 JAPC meeting and queries were raised in regards to the progress of this. Mr Dhadli confirmed that Dr R Dewis Consultant in Public Health Medicine has met with both the Derby and Chesterfield Ophthalmology Clinical Improvement Group's (CIG's), feedback suggested that they would both prefer to follow the Royal College of Ophthalmology guidelines however they would accept a modified approach. For baseline, Derby CIG's preferred a diabetic screening approach although it was subsequently established that they do not have the capacity with their existing OCT scanners. Also for baseline Chesterfield CIG's preferred an Optom approach. A Public Health Consultant met with a DDCCG commissioner to start drafting an options appraisal; work is still ongoing for this. There are proposed costs for each option; however there are some inconsistencies, for instance Chesterfield Royal Hospital NHS Foundation Trust (CRHFT) may be charging an additional tariff for an OCT and clarification was needed around tariff.	
6.	**JAPC ACTION SUMMARY**	
a.	**Continence** Mr Dhadli is awaiting an update from UHDBFT as the continence nurses were not complying with some of the formulary choices. A meeting was due to be held with the nurses; however Mr Sutton has not heard anything further about this as yet. Mr Dhadli requested that this be added to the Derbyshire Medicines Management Shared Care and Guideline Group (MMSCGG) Action Tracker to track, however requested an update from UHDBFT.	**SD**

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Item		Action
b.	**Liothyronine** Liothyronine is due to be discussed at the January Derbyshire Prescribing Group meeting.	CE
7.	**NEW DRUG ASSESSMENT/TRAFFIC LIGHT ADDITION**	
a.	**Buprenorphine subcut injection** Mr Dhadli reported that this is a new formulation as a prolonged release subcut injection administered weekly or monthly. There has been a request from the Operational Medicines Optimisation Group (OMOG) for JAPC to look at this following a pharmaceutical rep request. Supporting evidence has come from three national reviews essentially using the same clinical study. The study was a trial of prolonged release subcut injection versus buprenorphine and naloxone (JAPC noting that it is not sub lingual buprenorphine on its own). The key study uses a randomised controlled trial of 428 adults diagnosed and seeking treatment for moderate to severe opioid use disorder. The first review is taken from NICE Evidence Summaries New Medicines (ESNM) February 2019. It is a non-inferiority study with a combination of buprenorphine and naloxone not commonly used in the UK, more commonly used in the US healthcare setting, with only one site study in a primary care setting. Seventy percent use was heroin which does reflect the type of patient in the UK. Primary outcomes were disease orientated outcomes rather than patient orientated outcomes and they used urine samples. Patient orientated outcomes they did use were derived from exploratory outcomes (craving/withdrawal scores). Thirty days supply of buprenorphine prolonged release sub cut injection costs £239.70 (excluding VAT), methadone costs £15 - £30 and sub lingual tablets cost £140 - £250. NICE recommend its use where there is a risk of diversion or concerns about the safety of medicines stored at home; it must be given by a healthcare professional. The second review from Scottish Medicine Consortium (SMC) in July 2019 who accepted its use when methadone is not suitable and buprenorphine is considered appropriate. In the same phase three study they also included an open label study to assess the long term safety. There was no additional safety concerns however there were differences in the injection site (treatment emergent adverse events). Their health economics were based on cost minimisation so they considered drug costs, administration costs, monitoring and supervision, they removed the hospitalisation costs. There is some degree of uncertainties in the model, however the committee considered additional factors not captured in the model and they decided that the economic case was demonstrated. The third review by the All Wales Medicine's Strategy Group accepted its use in September 2019. Buprenorphine (Buvidal®) is recommended as an option for use within NHS Wales for the treatment of opioid dependence within a framework of medical, social and psychological treatment. Treatment is intended for use in adults and adolescents aged 16 years or over. They looked at cost utility and found it is less expensive; the injection dominates the tablets and there is some gain in Quality Adjusted Life Year's (QUALY's) however the expense model includes drug costs, admin costs, pharmacy costs and healthcare costs notably including hospitalisation.	

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	A discussion took place and the committee agreed that this should be classified as RED. Dr Markus added that it needs to be made clear that this can only be administered by a health care professional and not in primary care. **Agreed:** JAPC classified Buprenorphine subcut injection (Buvidal) as **RED**.	**SD**
b.	**Moxifloxacin** Mr Dhadli stated that moxifloxacin use has been proposed by Dr F Nathani Lead Clinician for use within Integrated Sexual Health Services (ISHS). Moxifloxacin has currently no traffic light classification. It is an antibiotic being used more often within the ISHS, as the number of patients that are being tested for the presence of the mycoplasma genitalium are increasing. Moxifloxacin is in the NHS England/Public Health England (PHE) antimicrobial guidance as first line for mycoplasma genitalium associated Pelvic Inflammatory Disease. It is also mentioned in the British Association for Sexual Health and HIV (BASHH) guidelines for mycoplasma genitalium treatment of complicated urogenital infection (PID, epididymo-orchitis) and treatment of uncomplicated urogenital infection (urethritis, cervicitis), if the organism is known to be macrolide-resistant or where treatment with azithromycin has failed. Currently for patients whose test results are positive, they are being issued an FP10 prescription. Patients then have to go to pharmacies outside of the service. A discussion took place and the committee agreed that moxifloxacin should be classified as RED to enable this to be prescribed within ISHS as one umbrella of service to be more convenient for the patient. **Agreed:** JAPC classified moxifloxacin as **RED** for use in line with PHE/NICE and BASHH guidance within sexual health services.	**SD**
c.	**Silver Dressings** Mr Dhadli stated that there is a discrepancy between the proposal and the local wound care guidance; therefore he is recommending that this paper go back to the MMSCGG for further discussion. **Action:** Mr Dhadli to take the Silver Dressings paper back to a MMSCGG meeting for further discussion.	**SD**
8.	**CLINICAL GUIDELINES**	
a.	**Actinic Keratoses** Mr Dhadli reported that the Actinic Keratoses guideline is not up for review until April 2020 however there is a request from the Joined Up Care Derbyshire (JUCD) Dermatology group to make some changes. This includes the removal of the restriction of 'specialist and GPs that have attended training' to prescribe 5-fluorouracil 5% cream (Efudix) and the removal of Ingenol as a treatment option. The JUCD met in July 2019 to discuss relaxing the traffic light classification for Efudix. This would bring it into line with Nottingham and reflect the confidence and experience in primary care. It will also help to prevent referrals to secondary care, Dr Bleiker has offered	

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	training via attendance at clinics if GP's feel this would be helpful. JUCD discussed removing Ingenol from the pathway given its cancer concerns as noted by the MHRA and current usage. This is supported by Dr Kid Wan Shum and Dr Bleiker Consultant Dermatologists UHDBFT, Dr K Bagshaw Assistant Medical Director DDCCG, Dr L Riches GPwER (extended role) in Dermatology and Dr M Wood GP Clinical Lead in Dermatology. A discussion took place and the committee agreed that Ingenol will be removed from the pathway and re-classified as BROWN specialist recommendation due to limited role and concern on safety. Efudix will be classified as GREEN when prescribed in line with the Managing Actinic Keratosis pathway. **Agreed:** JAPC classified Ingenol as **BROWN specialist recommendation** and 5-fluorouracil 5% cream (Efudix) as **GREEN** when prescribed in line with the Managing Actinic Keratosis pathway. **Agreed:** JAPC ratified the Managing Actinic Keratoses guideline with a review date of 3 years.	**SD** **SD**
b.	**<u>Chlamydia</u>** Mr Dhadli advised that the Chlamydia Testing and Management guideline has a review date of December 2019 and a partial update took place in June 2019 following NICE/PHE guideline. Notable drug changes included the azithromycin dose change from stat to stat +2 days. This guideline has been circulated to UHDBFT/CRHFT GU consultants and Dr F Nathani Sexual Health lead at Derbyshire Community Health Services NHS Foundation Trust (DCHSFT). The drug treatments remain unchanged due to the more recent update. There was a query raised in regards to test of cure and repeat testing, so advice was followed from the BASHH guidance which states that test of cure is three weeks after the end of treatment. It is not routinely recommended except in pregnancy, LGV or where poor compliance is suspected. Repeat testing is done three to six months after treatment in all under 25s, it is not carried out in over 25s unless there is considered to be a high risk of infection. Dr Nathani, Lead Clinician commented that it is important to discuss azithromycin treatment with women at risk of pregnancy due to potential risk of spontaneous abortion. Azithromycin is associated (note not proven causation) with risk of spontaneous abortion; however, it is better tolerated and more effective than other antibiotics. Other changes and advice supported by consultants and the BASHH guidance are as follows: the removal of the first void urine sampling method on page 1, the addition of abstaining from sex for one week on page 2 and MHRA quinolone advice added to page 2. Dr Markus asked who would be responsible for recalling patients for repeat testing for under 25's. Dr Emslie responded to say that if a patient is tested for chlamydia through the Integrated Sexual Health Service then it should be their responsibility to arrange for the patient to come back for repeat testing and the same process should be happening within primary care. Mr Dhadli advised that he will contact Dr Nathani to confirm what process they use. Dr Markus felt it important that all GP's record when they have asked a patient to return for repeat testing.	**SD**

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	Dr Emslie suggested that information be circulated via the JAPC bulletin. **Action:** Mr Dhadli to contact Dr Nathani to confirm processes within the ISHS for repeat testing after treatment of chlamydia. **Agreed:** JAPC ratified Chlamydia Testing and Management Chlamydia Testing and Management guideline with a review date of 3 years.	**SD** **SD**
c.	**Medication and falls prevention in the older person** Mr Dhadli stated that the Medication and falls prevention in the older person guideline was last reviewed in September 2017 and it is based on a PrescQipp document originating from 2014. It was due for a review in August 2019 and the document has recently been reviewed and updated by a DDCCG Medicines Management Pharmacist. This document is a useful tool which is available to any member of the health and social care profession, to look for potential drugs that might contribute to a fall. It essentially remains unchanged other than an amendment made to olmesartan which has been reclassified as AMBER; this was classified as RED in error on a previous version of the policy. **Agreed:** JAPC ratified the Medication and falls prevention in the older person guideline with a review date of 3 years.	 **SD**
d.	**Nebuliser guideline for Chronic Obstructive Pulmonary Disease (COPD)** Mr Dhadli reported that the Nebuliser guideline for COPD has a review date of November 2019. This was sent for review and comment to Ms H Stroud Nurse Practitioner CRHFT, Ms M Gibson Nurse Practitioner DCHSFT and the Right Care Respiratory Delivery group. There has not been a response from Ms H Stroud and Ms M Gibson. The Right Care Respiratory Delivery group made the following amendments: South/Erewash and North respiratory teams contact details have been updated, fax details have been removed and replaced by email details, referral forms have been updated. Dr Markus queried the guideline where it states 'It is the responsibility of the prescribing clinician to ensure the patient/carer is educated in how to use the nebulisers' and asked for clarification as to whether this would be the Respiratory Team who prescribe the nebuliser or the GP who may prescribe the nebules. Dr Emslie advised that it would be the clinician prescribing the nebuliser and the guideline will be updated to reflect that. Dr Markus also asked if the new referral form was embedded into the clinical systems. Dr Emslie would check this along with the current referral form used to ensure it was the most up to date version. **Agreed:** JAPC ratified the Nebuliser guideline for Chronic Obstructive Pulmonary Disease (COPD) assessment and initiation, with a review date of 3 years.	 **SD** **CE** **SD**
e.	**Neuropathic pain** Mr Dhadli stated that the Neuropathic Pain guideline was last updated in December 2017 and was due for review in December 2019. The document has been sent to pain consultants at both CRHFT/UHDBFT and the Clinical Director of Psychological Consultancy at DCHSFT.	

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	There has been an update to prices along with general maintenance and formatting of the guideline. Dr Makkison Pain Consultant from CRHFT commented that the maximum morphine dose per day, as in previous consultations and the threshold for referral should be reduced to 60mg total morphine equivalents per day. Since these comments have been received the guideline has further been updated to include recent pain publication from SIGN (updated in Aug 2019). Considering the national picture of over opioid use and dependence, along with last month's PHE paper some recommendations about morphine have been made. Information has been added to state that doses of equivalent morphine >50mg should be subject to an annual review and doses >90mg may seek specialist advice. SIGN rates this as GRADE D, evidence based on case reports and expert opinion. Whilst low grade evidence the national picture and trend warrants a cautious approach of using morphine. Mr Dhadli went on to say that another change being proposed is in regards to duloxetine. NICE CG173 (November 2013) states to 'offer a choice of amitriptyline, duloxetine, gabapentin or pregabalin as initial treatment for neuropathic pain'. The suggestion is to re-position duloxetine in light of its cost alongside other 2nd line treatment options such as gabapentin and pregabalin, noting that amitriptyline is to remain 1st line. Mrs Needham questioned whether duloxetine should be considered ahead of gabapentin and pregabalin due to problems associated with excess use of these drugs. Dr Emslie advised that it may be beneficial to keep them all as 2nd line as there will be circumstances where one drug might be considered over the other depending on the patient's medical history. Mrs Needham commented that there is a national document which issues a warning in regards to patient's who may become addicted to gabapentin and pregabalin and she suggested that this statement could be incorporated into the guideline. Mr Jones queried the risk of hyponatremia from patients who are on antidepressants SSRIs and may be prescribed carbamazepine. Mr Dhadli confirmed that carbamazepine is included in the guideline as the preferred initial treatment for trigeminal neuralgia. Mr Jones also highlighted where patients are taking tramadol, duloxetine may not be an appropriate choice. Mr Dhadli stated that there is a discrepancy in dosing and titration with SIGN. He suggested that this is picked up at the MMSCGG and confirmation will be sought that pain consultants are in agreement. **Agreed:** JAPC ratified the guideline for Managing Neuropathic Pain in Primary Care with a review date of 3 years.	**SD** **SD**
f.	**<u>Nicotine Replacement Therapy</u>** Mr Dhadli reported that the Nicotine Replacement Therapy (NRT) guideline was due for a review in 2019, it was sent to various stakeholders including public health as the service is local council commissioned. The purpose of the document is to promote cost effective choices and it contains prescribing advice for primary care, for GPs wanting to supply outside of the commissioned service. Live Life is the service in Derbyshire County and Live Well is the service in Derby City. Reference to community pharmacists has been removed from page 1 as this is no longer commissioned. Advice on the use of e-cigarettes has been included on page 2 in regards to them being less harmful; however there has currently been no national review	

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	that has taken place to recommend it through the service. Special cautions on page 3 have been updated in line with BNF advice and cost effective options have been updated. Mrs Needham advised that Voke is now available on prescription; JAPC agreed to classify (Voke) as BLACK pending a national review. **Agreed:** JAPC classified Nicotine Voke as **BLACK** pending national review and clinician request. **Agreed:** JAPC ratified the Derbyshire Formulary for Nicotine Replacement Therapy (NRT) with a review date of 3 years.	**SD** **SD** **SD**
g.	**<u>Proton Pump Inhibitors (PPI)</u>** Mr Dhadli stated that a routine review was due for the Proton Pump Inhibitor (PPI) guideline. It was sent for comment to Dr. W Goddard Consultant Gastroenterologist UHDBFT, Dr. A Austin Consultant Hepatologist UHDBFT, Mr M Shepherd CRHFT and the Gastroenterology Delivery Group. Additional risk factors as per NICE Clinical Knowledge Summaries (CKS) have been added to page 1 and the hypomagnesaemia section has been expanded on page 2, as per the All Wales Medicines Strategy Group (AWMSG) document. Ms Braithwaite suggested that reference be made to the WHO third Global Patient Safety Challenge: *Medication Without Harm* within the guideline. **Agreed:** JAPC ratified Proton Pump Inhibitors (PPI) guideline with a review date of 3 years.	**SD** **SD**
h.	**<u>Vitamin B Position Statement</u>** Mr Dhadli reported that there is a position statement on Vitamin B Compound and Vitamin B Compound Strong tablets as DDCCG does not support the routine prescribing of them. They are only advised for specialist use as a short course, post-acute admissions or for refeeding syndrome. RMOC have produced a position statement for oral vitamin B supplementation in alcoholism (November 2019), as it is a national publication JAPC must have due regard and consider this. A discussion took place and committee members agreed to give this an additional classification, it was suggested BROWN for medically diagnosed deficiency due to lifelong or chronic condition, or following surgery that results in malabsorption following specialist advice. **Agreed:** JAPC classified Vitamin B Compound Strong as **BROWN** for medically diagnosed deficiency due to lifelong or chronic condition, or following surgery that results in malabsorption following specialist advice. This vitamin has multiple classifications and the Traffic Light Classification (TLC) database should be seen for more information.	**SD**
9.	**MISCELLANEOUS**	
a.	**<u>Gluten Free</u>** Mr Dhadli advised that the Gluten Free foods prescribing policy was due for its periodic review. The document has been updated to say Derby and	

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	Derbyshire CCG replacing, when mentioned, the previous four Derbyshire CCGs. There was an Equality Impact Assessment (EIA) and Quality Impact Assessment (QIA) completed for this which went to panel in December 2019, it was accepted noting that it affects more women than men. **Agreed:** JAPC ratified the Gluten Free Foods Prescribing Policy with a review date of 3 years.	**SD**
b.	**<u>Ophthalmology high cost drug algorithms</u>** Mr Dhadli informed the committee that the Age-Related Macular Degeneration (ARMD), the Diabetic Macular Oedema (DMO) and the Macular Oedema due to Branch Retinal Vein Occlusion (BRVO)/Central Retinal Occlusion (CRVO) high cost drug prb excluded algorithms expired in December 2019. They were sent to Mr M Shepherd Chief Pharmacist CRHFT and Ms S Smith Lead Pharmacist UHDBFT. Comments have not yet been received from UHDBFT however Mr Dhadli advised that the algorithms are TA compliant. As a result of the NICE TA613 update, the following statement has been added to the DMO algorithm: 'Fluocinolone acetonide intravitreal implant is not recommended as an option for treating chronic diabetic macular oedema that is insufficiently responsive to available therapies in an eye with a natural lens (phakic eye)'. The committee felt it appropriate to have a review date of 3 years on the algorithms and update them each time a NICE TA is published. **Agreed:** JAPC ratified the Age-Related Macular Degeneration (ARMD), Diabetic Macular Oedema (DMO) and the Macular Oedema due to Branch Retinal Vein Occlusion (BRVO)/Central Retinal Occlusion (CRVO) Ophthalmology high cost drug algorithms, with a review date of 3 years.	**SD**
10.	**REGIONAL MEDICINES OPTIMISATION COMMITTEE (RMOC)**	
a.	**<u>Shared Care Guidance for consultation</u>** Mr Dhadli reported that the RMOC have produced 'Shared Care Guidance, A Standard Approach' for consultation. The document they have issued defines the principles for a national system of shared care and aims to provide a framework for the seamless sharing of care for a person between the specialist service to a primary care prescriber, where this is appropriate, benefits and is supported by the patient. The RMOC are asking Area Prescribing Committees to comment on the document and reply back by 7th February 2020. Mr Dhadli advised that he has drafted a response in regards to content of the shared care guidance; he has also looked to see if there is anything in the RMOC shared care guidance that can be used in the Derbyshire local shared care guidelines or vice versa. Mr Dhadli remarked on key difference, Appendix 1 in the RMOC guidance states that primary care prescribers should reply to specialist colleagues by letter within 14 days so that arrangements can be made for the ongoing provision of prescriptions and monitoring arrangements under shared care. As the Derbyshire local shared care guidelines don't currently have any time restrictions JAPC members were asked if they wished to adopt a 14 day response. The committee queried whether this would be 14 *working* days and if this would start from when the GP receives the shared care agreement	

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	letter. Mr Dhadli then referred to Appendix 2 in the RMOC guidance titled Shared Care Request Letter (Specialist to Primary Care Prescriber). The local shared care guidelines do have an agreement letter; however the RMOC example contains additional information in regards to confirmation criteria. Members were asked to comment if they felt this would add value to the Derbyshire local guideline. Appendix 3 is an example of the Shared Care Agreement Letter (Primary Care Prescriber to Specialist) which is something that the local shared care guidelines don't currently have, as the GP is only obliged to respond when declining to accept a shared care agreement. Appendix 4 is an example of the Shared Care Refusal Letter (Primary Care Prescriber to Specialist). Within this it asks GPs to state the clinical reason as to why they are not undertaking the share care. It was suggested that JAPC members consider adding this into the letter within the local shared care guidelines. Dr Markus highlighted that some GP's do not have capacity to take on a shared care agreement. Mr Dhadli advised that reference is made to adequate resources being available; however he felt this was a separate issue as to how shared care agreements are commissioned and funded. This is currently an ongoing discussion within the Enhanced Services Review group. Ms Derricott highlighted that the Enhanced Services Review group Service Level Agreement surrounding PSA, monitoring Drugs affecting the Immune Response (DMARDS) and shared care drugs state that practices must be in agreement to take on care, however there is no timeframe included. Ms Derricott suggested that she take this to the next meeting to ask if they feel it beneficial to have a specific timeframe. Mr Dhadli agreed that this would be useful. Mr Dhadli referred to Appendix 5 in the RMOC guidance. It includes the following which are not currently categories within the Derbyshire local shared care template however they are included within the document: • locally agreed off-label use (local guidelines include this in the indications section) • advice to patients and carers (local guidelines include this in the body of responsibilities) • references – other resources are mentioned throughout the local shared care guideline, however Mr Dhadli suggested it may be beneficial to include a reference section. Appendix 6 includes a list of medicines identified as suitable for shared care Mr Dhadli stated that he has been through this list and checked them against the Derbyshire traffic light classifications. There are only four that are not currently classified as AMBER. Mr Dhadli has fed back to the RMOC that medicines identified as suitable for shared care should be examples that can be formally agreed by the local Area Prescribing Committee not necessarily a must do. Mr Dhadli informed JAPC members that he has sent comments back to the RMOC committee in regards to their document. JAPC are to consider adopting some of the RMOC templates into the local shared care guidelines.	**JD** **SD**

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Item		Action
11.	**JAPC BULLETIN**	
	The December 2019 bulletin was ratified.	**SD**
12.	**MHRA DRUG SAFETY UPDATE**	
	The MHRA Drug Safety Alert for December 2019 was noted. Mr Dhadli highlighted the following MHRA advice: • Domperidone for nausea and vomiting: lack of efficacy in children; reminder of contraindications in adults and adolescents – domperidone is no longer licensed for use in children younger than 12 or those weighing less than 35kg. Results from a placebo-controlled study in children younger than 12 years with acute gastroenteritis did not show any difference in efficacy at relieving nausea and vomiting compared with placebo. Mr Dhadli advised that domperidone is also used outside of its authorised indications in children in the UK for gastrokinetic effects in conditions other than nausea and vomiting. If a specialist physician considers, based on their professional judgement and available evidence of the medical condition, that domperidone use in any condition is justified in a child younger than 12 years, the patient or parent/caregiver should be fully informed of the potential benefits and risks of the different options. JAPC are to note the MHRA update and use of domperidone off licence for the following indications: • Gastroparesis and other gastric outlet physiological impairment • Babies and children (normally prescribed by specialists) • Nursing mothers to promote lactation	
13.	**HORIZON SCAN**	
a.	**<u>Monthly Horizon Scan</u>** Mr Dhadli advised JAPC of the following new drug launches, new drug formulations, licence extensions and drug discontinuations: • Gilteritinib (Xospata) – classified as **RED** (as per NHS England commissioning intentions) • Meropenem + vaborbactam (Vaborem) – classified as **BLACK** await national guidance or clinician request • Talazoparib (Talzenna) – classified as **RED** (as per NHS England commissioning intentions) New drug launches in the UK: • Nicotine (Voke) – classified as **BLACK** – await national guidance • Zanamivir (Dectova) – classified as **BLACK** pending clinician request Licence extensions: • Beclometasone (Qvar) – previously classified as **GREEN** • Daratumumab (Darzalex) – previously classified as **BLACK/RED** • Liraglutide (Victoza) – previously classified as **BLACK/BROWN** • Pembrolizumab (Keytruda) – previously classified as **BLACK/RED** • Ranibizumab (Lucentis) – previously classified as **RED** Drug discontinuations: • Imbruvica (Ibrutinib) • Pinofen Seven Plus (Ibuprofen)	

Item		Action
	• SimAlvia (Alverine/simethicone) • Slo-Phyllin (Theophylline) • Copegus (Ribavirin) • Calmurid • Aptivus Oral Solution (Tipranavir)	
14.	**NICE SUMMARY**	
	Mr Dhadli informed JAPC of the comments for the CCG which had been made for the following NICE guidance in December 2019: TA614 Cannabidiol with clobazam for treating seizures associated with Dravet syndrome – classified as **RED** (NHS England as per NICE TA614) TA615 Cannabidiol with clobazam for treating seizures associated with Lennox–Gastaut syndrome – classified as **RED** (NHS England as per NICE TA615) NG148 Acute kidney injury: prevention, detection and management – NICE has made new recommendations on preventing acute kidney injury in adults having iodine-based contrast media. NG23 (updated from Nov 2015) Menopause: diagnosis and management - updated table included in the current menopause guideline.	
15.	**GUIDELINE GROUP ACTION TRACKER**	
	The summary of key messages from the Derbyshire Medicines Management Shared Care and Guideline Group meeting held in December 2019 was noted. Mr Dhadli highlighted the following: Traffic Lights: • ~~Cimetidine GREEN~~ (see post meeting note for JAPC) • Sucralfate liquid – classified as BROWN consultant/specialist recommendation for empirical management of patients with severe GORD or post-cholecystectomy, alongside use of PPIs • Calcipotriol and beclomethasone – classified as BROWN Dovobet and Enstillar. Do not add as repeat prescription. See skin formulary appendix 2 for guidance on use in psoriasis • Hyoscine hydrobromide patch – classified as BLACK for use in the treatment of travel sickness Formulary Update (Chapter 1 – Gastro-intestinal System): • Ranitidine replaced with cimetidine due to supply disruption • Pantoprazole removed due to increased cost • Message regarding phosphate enema added – 'long-tube' significantly more expensive compared to 'short-tube' • Links to UHDBFT bowel prep for GI endoscopy guideline/form updated Clinical Guidelines: • Qvar 50 and 100 MDI licensing for asthma changed from age 12 and over to age 5 and over. Formulary chapter respiratory and asthma guideline updated	

Item		Action
	• Information on AliveCor heart monitor inserted into Atrial Fibrillation guideline. May be useful diagnostic tool but does not replace 12 lead or continuous ECG monitoring Website Changes/Miscellaneous: • De-prescribing Policy has been updated to include amended definition, references, and contact details Guideline Timetable: • The guideline table action summary and progress was noted by JAPC	
16.	**BIOSIMILAR REPORT**	
	Mr Dhadli reported that the biosimilar report has been tabled for information.	**SD**
17.	**TRAFFIC LIGHTS – ANY CHANGES?**	
	Classifications Buprenorphine (Buvidal) Subcut injection – RED new formulation of a long acting injection, available for use within substance misuse service. Moxifloxacin – RED for use in line with PHE/NICE and BASHH guidance within sexual health services. 5-fluorouracil 5% cream (Efudix) – GREEN (re-classified from GREEN consultant/specialist initiation). Ingenol – BROWN specialist recommendation. Duloxetine – GREEN reclassified to second line treatment for neuropathic pain alongside gabapentin and pregabalin due to it loss of patent and cost. ~~Cimetidine – GREEN~~ (see post meeting note for JAPC) Vitamin B compound strong – BROWN for medically diagnosed deficiency due to lifelong or chronic condition, or following surgery that results in malabsorption. This vitamin has multiple classifications and the TLC database should be seen for more information. Calcipotriol and beclomethasone topical – BROWN reclassification from GREEN. Dovobet and Enstillar. Do not add as repeat prescription. See skin formulary appendix 2 for guidance on use in psoriasis. Sucralfate liquid – BROWN following Specialist/ Consultant recommendation for empirical management of patients with severe GORD, or post-cholecystectomy, alongside use of PPIs (liquid formulation previously classified as BLACK). Gilteritinib – RED as per NHSE commissioning intentions. Meropenem + vaborbactam (Vaborem) – BLACK pending clinician request. Hyoscine hydrobromide patches – BLACK for use in the treatment of travel sickness. Talazoparib (Talzenna) – RED as per NHSE commissioning intentions. Nicotine (Voke) – BLACK await national guidance. Zanamivir (Dectova) – BLACK pending clinician request. Cannabidiol with clobazam – RED as per NICE TA614: For treating seizures associated with Dravet syndrome in people aged 2 years and older. Cannabidiol with clobazam – RED as per NICE TA615: For treating seizures associated with Lennox–Gastaut syndrome in people aged 2 years and older.	
18.	**MINUTES OF OTHER PRESCRIBING GROUPS**	
	• Sheffield Area Prescribing Group 17/10/2019 • UHDBFT Drugs and Therapeutics Group 19/11/2019	

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Item		Action
	The following items were highlighted in the Sheffield Area Prescribing Group minutes: • The Respiratory chapter now highlights the carbon footprint of various inhalers which patients may wish to consider as part of the decision process. The licensed ages have been added to the different preparations listed in the formulary in line with their product license and to provide clarity for prescribers. • A new shared care protocol has been developed to enable community pharmacies to participate in the care of patients with hypertension. • The ADHD in Childhood and Adults sees the addition of guanfacine. Although NICE guidance and the product licence for guanfacine does not cover for use in adults, the shared care guideline does allow for those patients stable on guanfacine at the age of transition to adulthood, to continue on treatment where appropriate, although this would be off-label use. • Sodium valproate will be unlicensed in patients who have declined to take part in the pregnancy prevention programme PREVENT. The annual risk assessment form, including the detail of why the patient has declined to take part in PREVENT will continue to be completed for these patients. The decision to prescribe off license will be made in secondary care and if it is decided to continue prescribing as off license, the decision will be communicated to the patient and their GP by letter.	
19.	**ANY OTHER BUSINESS**	
a.	**Hospital shortage of Diamorphine** Ms Braithwaite informed the committee that there is a nationwide shortage of lower strength diamorphine which is currently mainly affecting hospitals. DCHSFT hospital ward stock will gradually switch to morphine except for Urgent Treatment Centres. In North Derbyshire CRHFT and Ashgate Hospice are using morphine for syringe drivers, anticipatory breakthrough pain and end of life care. UHDBFT are using morphine for breakthrough pain and diamorphine in syringe drivers. Mrs Needham queried whether this has been discussed with the End of Life Care groups as relevant documents may need to be updated. Ms Braithwaite confirmed that a discussion has taken place with End of Life Care groups and they are aware of the situation. DCHSFT documentation was also confirmed as current. Mrs Needham confirmed that DDCCG documents would need to be updated along with System One. Ms Braithwaite highlighted that this will only affect a very small amount of patients per year within DCHSFT. Dr Emslie suggested that an investigation into whether there is a shortage of diamorphine within the Derbyshire community should be carried out before a decision is made as to whether DDCCG documents should be updated from diamorphine to morphine. Mr Dhadli advised that he will add this as a key message to alert prescribers that diamorphine or morphine may be used in syringe drivers due to stock issues.	**KN** **SD**
20.	**DATE OF NEXT MEETING**	
	Tuesday, 11th February 2020 at 1.30pm in the Coney Green Business Centre, Clay Cross.	