County Durham and Darlington Area Prescribing Committee

Minutes Meeting held
Thursday 3rd November 2011
12.00 – 2.30 pm
Board Room, John Snow House

Present:

Jean Bertram, Patient Representative
Peter Cook, Consultant Physician, CDDFT
Geoff Crackett, GP Prescribing Lead (DCLS), NHS CD&D
Ian Davidson, Deputy Medical Director, NHS CD&D (chair)
Deborah Giles, Pharmaceutical Adviser, NHS CD&D
Suzy Guirguis, Consultant, CAMHS, TEWV
Sarah Hailwood, Consultant Rheumatologist, CDDFT (SJH)
Anne Henry, North East NPC Facilitator, NPC
Betty Hoy, Patient Representative
Sue Hunter, Deputy Head of Pharmacy, TEWV (SH)
Patricia King, LPC Representative
Graeme Kirkpatrick, Chief Pharmacist, CDDFT
Mike Lavender, Consultant in Public Health, NHS CD&D
Sarah McGeorge, Nurse Consultant, TEWV
Ian Morris, Head of Medicines Management, NHS CD&D
Laura Mundell, Administrator, NHS CD&D
Satinder Sanghera, GP Prescribing Lead (Dales), NHS CD&D
Joan Sutherland, Senior Pharmaceutical Adviser, NHS CD&D
Chris Williams, Deputy Chief Pharmacist, CDDFT
Sue White, Assistant Head of Prescribing Support, RDTC

Apologies:
Sue Mole, Patient Representative
Sue Shine, Nurse Practitioner, NHS CD&D
Lindy Turnbull, Senior Nurse for Medicines Management, CDDFT
Paul Walker, Clinical Director of Adult Mental Health (County Durham & Darlington), TEWV
Ingrid Whitton, Deputy Medical Director, TEWV

As there were a number of new faces at the meeting, introductions were made around the table.

Part 1: Mental Health

1. NICE Dementia Guideline – Decommissioning

SH presented this item following the previous APC meeting where it was suggested the guidance should be extended to include information on when to stop treatment or refer patients on dementia drugs back to TEWV, and also to consider the place of Donepezil in light of its patent expiry.

ID asked the committee for comments on the updated guidance, commenting that the updated guidance has addressed the issues raised last time about how to approach the discontinuation of dementia drugs and in view of Donepezil's place in view of it going off patent in 2012. SH confirmed that the patent expiry should not significantly change the use of Donepezil as it is already the first line product so patients are only usually only taking alternatives if Donepezil is not appropriate.

ID queried where the guidance would go from here. SH advised that the guidance had been presented to consultant's meeting at TEWV, the TEWV D&T where it had been approved, and also to Tees Medicines Management Committee who also approved.

ID queried whether the updated guidance would alter shared care or if this would be added as an appendix. SMc said that this would not affect shared care and SH confirmed that the shared care guidance is not due for review when asked by ID but this information will be shown as an appendix to the current guidance.

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ID asked whether it would be possible to add a template clinic letter with a section specifically justifying continuation of anti-dementia drugs. SS felt that this would be helpful, JS agreed however wondered whether there could be some interface issues. SS thinks this could be easily done when reviewing medication, and also when GPs receive a letter from the consultant. ID commented that there are still big resource issue relating to the changes in NICE guidance.

SMc advised that mental health prescribers are encouraged to communicate this information via letter to GPs, however not all clinics do this at present. SMc agreed to discuss this further with colleagues.

BH asked if carers are consulted with regards to how well/ unwell the drugs are working. SS said there are some discrepancies around this issue. ID informed the group that carers are very much involved in decisions and input.

ID would like to bring this back to the APC in 6 months' time and has asked SH, JS and SW to work together to get a costing template.

ACTION: Dementia prescribing guidance approved – DG to add to website and newsletter.

ACTION: SMc to liaise with colleagues regarding a letter to GPs stating whether anti-dementia drugs still considered necessary.

ACTION: To return to APC in 6 months' time – SH, JS and SW to work together on a costing template.

2. Generalised Anxiety Disorder

SH advised there had been some discussion surrounding the initiation of Pregabalin at the last D&T meeting, and following comments from Committee members, this has been added to step 3 of the guidance, only to be initiated by specialists in secondary care.

The revised guidance was accepted by the Committee.

ACTION: DG to add guidance to website and newsletter.

3. Mental Health Prescribing Data

3.1. Melatonin

SW presented this data explaining that melatonin prescribing is a big issue in the North East and that County Durham appears to sit in the middle compared to the rest of the region.

SW explained that cost is the problem in County Durham and that the biggest spend is on melatonin liquid 5mg/5ml. SW went on to inform the group that melatonin 5mg/5ml oral

solution and suspension has now been included in the Drug Tariff, under the Basic Price list of Unlicensed Medicines (part VIIIB). SW commented that most people do try to use the licensed melatonin preparation, Circadin, however, once in community costs can't always be controlled if an unlicensed preparation is used.

SH advised the Committee that TEWV are currently reviewing melatonin, and are trying to standardise the 3mg tablets as they use a broad range of preparations at present.

SW suggested that there may soon be more unlicensed melatonin preparations added to the Drug Tariff. PK advised that when this happens the costs should come down.

SH informed the group that melatonin remained a red drug in TEWV.

ID summarised that although there is still no clear guidance for primary care prescribers on the use of melatonin, there are no stand-out problems. The committee is aware that this is a red drug and this is something that could be looked at again in 12 months' time and possibly added to the Medicines Management QOF for 2012/2013.

3.2. Escitalopram and Venlafaxine

SW presented this data which looked at the potential cost savings from switching patients from Venlafaxine MR to Venlafaxine IR and switching from Escitalopram to Citalopram.

Venlafaxine was looked at first and ID asked if there could be any potential problems with switching preparations. SH confirmed that TEWV are now using venlafaxine IR as first line for all patients and have already switched their patients on doses below 225mg daily. ID commented that patients currently taking MR doses below 225mg OD could potentially be switched to IR preparations, however in primary care this could be difficult as Venlafaxine is often initiated by secondary care.

JS highlighted that many patients taking slow release versions of Venlafaxine had already had their medication switched from capsules to tablets, and switching these patients again from a once daily to a twice daily dose could be a lot for some patients to take on board. JS also commented that there could be problems with asymmetric dosing when patients are switched to a twice daily preparation.

ID asked the Committee how the long term issues surrounding this could be addressed and questioned if the APC should be issuing something for prescribers, for example a standard letter, to give to patients about the change to immediate release preparations including advice from specialist services. BH agreed this would be a good idea for patients and ID opened the discussion to other GPs on the Committee for their views on this.

GC agreed this would also an opportunity to highlight high dose prescribing and asymmetric prescribing. SW suggested this could be done if a patient was due for a medication review and advised this was something that had been done in other areas without any major inconvenience and was currently being looked at on a countrywide basis.

JS highlighted that this would also involve linking in with the TEWV consultants, and that something similar had already been done in the Tees area with a list of patients being provided to consultants which then acted as a filtering mechanism.

ID summarised that some switch guidance needs to be prepared and disseminated as soon as possible. SH advised that she would be happy to work with JS on producing this, basing guidance on what has already been produced and used by NHS Tees. IM added that this could be added to the QIPP plan.

The discussions then moved on to Escitalopram. GC asked if all consultants would be happy with patients being switched from Escitalopram to Citalopram. JS also commented that some GPs may not be happy with this switch.

SH advised that switching from Escitalopram to Citalopram would be more difficult than the Venlafaxine switches discussed, and JS added that lots of GPs who have initiated Escitalopram would not be happy to change. ID suggested work could be done looking at patients taking Escitalopram without previously being on Citalopram first, JS advised that there was some work to be done in this area, however it would be a much slower change compared to that of Venlafaxine.

ACTION: JS & SH to prepare and disseminate guidance for switching Venlafaxine MR to Venlafaxine IR including standard letter and advice to patients.

ACTION: IM to add Venlafaxine switch to QIPP plan.

3.3. ADHD Drugs

SH presented this paper, advising that although prescribing patterns were quite different in some areas this was an area currently being addressed by TEWV.

The committee accepted this report.

4. QIPP Plan for Mental Health Medicines Management

SH introduced this item, advising that the document had recently been compiled by Mental Health Trust Chief Pharmacists and agreed at the College of Mental Health Pharmacists conference a month ago. SH added that the document provided a good focus, although there was nothing within the document that TEWV were either not already working on or not already aware of. ID commented it was encouraging that almost everything was being worked on.

SH asked the Committee if there were any areas the APC wanted to specifically focus on and SW added that the RDTC could help monitor and provide data for any areas requested.

ID said that melatonin and venlafaxine have already been looked at so asked if antipsychotic prescribing in dementia could be looked at, as big variations in practice have been identified in the Durham area. SW confirmed that the NHS Information Centre have looked at this and there are lots of low dose antipsychotics used for other reasons and so this could only be looked at on a practice/secondary care level, however nationally a suitable comparator is being developed. ID asked whether this could be something that can be tied in with QOF. SMc added she doesn't have much data but the data she does have she is happy to share.

JS advised that the profile of antipsychotic prescribing had been raised through the audit carried out by the Medicines Management Team in practices which is scheduled to come back to the D&T Committee meeting in December 2011. JS also highlighted substance misuse, especially the use of Suboxone, which is having an impact on prescribing costs and ID felt that substance misuse could be a useful future topic.

ID concluded that it was encouraging that many of the areas were being tackled there were still areas the APC could work on together and look at in future APC meetings.

ACTION: IM to add to list of potential PCT QIPP areas.

ACTION: SMc to share antipsychotic data with IM.

Part 2 – General

5. Apologies for absence

Listed at the beginning of the minutes.

6. Declaration of Interests

There were no declarations of interest.

7. Minutes from last meeting held 1st September 2011

The minutes from the last meeting were accepted with no amendments, however it was mentioned by CW that both Sarah Hailwood and Sue Hunter have the same initials, Sarah Hailwood confirmed that she will be initialled as SJH and Sue Hunter will remain as SH. It was also noted on page 7 that "complain shake" should read "complan shake".

8. Matters arising/action log

8.1 Action Log

Please see updated action log.

8.2 Generic Medicines Update

JB informed the Committee she had been unable to gather any further information on this issue from patient forums due to cancellations. JB did however raise the issue of the same medication often coming in various shapes, sizes and colours which can be very confusing for patients. JB also highlighted that patients are sometimes given medication without a patient information leaflet, especially when tablets are packed down into non-original containers. JB asked the Committee if there were any specific regulations on these issues.

PK explained that all medicines must have a product licence and must pass certain standards for this to be granted, however there are no formal regulations or guidance on the shape, size or colour of products. JB informed the Committee that she has contacted her MP about this issue and is currently awaiting a response.

PK commented that one of the main problems is getting patients to talk about these issues; if patients don't inform pharmacists and other healthcare professionals then they don't get to know about them. PK advised that lots of patients ask for screwtop bottles etc. and this facility is available in all pharmacies. JB suggested patients need to be made aware of this and BH questioned if information could be placed in all GP practices asking patients to feed back any problems with medication.

ID asked if the LPC would be able to look into the issues raised. PK advised this could be difficult as it would require individual research, however agreed that it would be useful to get the message out that pharmacists are available to talk to patients and discuss any issues they have with medication. JS highlighted the issue mentioned by BH of patients not receiving information leaflets with their medication and felt that the LPC has a role in reminding pharmacists of their contractual obligations surrounding this issue. JS asked PK if she would raise this with the LPC.

ID asked PK if this could be advertised more and could PK talk to the LPC about the issues raised. PK agreed to find out if any research has been done around this and will bring this back to the next APC meeting.

ACTION: PK to raise the issue with the LPC and feed back to the committee at the next meeting.

9. Formulary Update

9.1 Formulary Development Group and North of Tyne Formulary Subcommittee

IM attended the North of Tyne Formulary Subcommittee meeting with CW, DG and GC on 20th October and gave a verbal update of decisions considered. IM advised that there was a need to look at how to best circulate this information.

IM advised that the issue of gender dysphoria was discussed at the meeting and the lack of clear prescribing guidelines for this area was highlighted alongside the issues surrounding many GPs not feeling confident prescribing for this. JS agreed that many GPs may not feel confident prescribing in this area and added that there were big governance issues with many patients being reviewed in London and not locally. IM suggested that it may be useful to look at the process developed by North of Tyne and ID suggested this should be considered further outside of the APC meeting.

CW highlighted potential problems with the timing of submissions for the Formulary Committee and how this would fit in with the APC meeting dates. ID agreed there was a need to address processes surrounding this and how they fit into the APC meetings.

ACTION: ID/IM to develop formulary approval process.

ACTION: IM to review North of Tyne gender dysphoria medicines management process and develop a similar process for County Durham and Darlington.

9.2 Formulary Development Update

CW updated the group with the formulary development. He noted that chapter 4 of the BNF will be looked at further at TEWV D&T at the end of this month. Chapter 2 of the formulary has been disseminated to consultants for review and will also be forwarded to GP Prescribing Leads to disseminate to their colleagues for comment.

CW advised that a simplified traffic light system was to be adopted with red indicating drugs restricted to hospital use only, green indicating drugs suitable for initiation and use in primary care, and amber covering anything else for which caution was required, including drugs requiring specialist initiation in secondary care and drugs for which shared care agreements are in place.

CW advised the formulary would be comprised of a list of preferred medicines and guidelines, and IT were in the process of producing a mocked up version of an online formulary for demonstration. ML suggested an alternative route would be using the Map of Medicine. CW commented that the long term goal would be for this to be linked to the Map of Medicine.

10. IFR Decisions

ML informed the Committee that there were no decisions of note on the commissioning side as the PEC has not met for the previous 2 months.

11. APC Meeting Dates 2012

It was noted that the next APC meeting will take place on 12th January due to the New Year bank holiday.

12. Therapeutic Areas for Future Meetings

ID advised the Committee the therapeutic areas for meetings had been set until March 2012; however the Committee needed to start looking at potential areas for the remainder of 2012 and asked for any suggestions.

ID suggested rheumatology as a potential area, specifically concentrating on the DMARD guidance. SJH advised that the Foundation Trust's current DMARD guidance expires in 2015 however added that she had received queries from GPs requesting advice regarding biologic drugs. SJH informed the Committee that she wanted to make sure the DMARD guidelines were made available for general use and reference and was aware that there are currently no good documents providing advice on biologics, however her team were currently in the process of putting together some information on this area including advice for GPs on what to know about patients on biologics. SJH added that she would like to bring this document back to the Committee to ensure it can be disseminated in the most appropriate way.

GC suggested the Committee look at urology, in particular the bladder relaxant drugs, with secondary care urologists often prescribing the newer drugs which have a high impact on primary care prescribing budgets. GK agreed this would be a useful area to discuss, however highlighted that there may be some problems encountered as urologists were not employed directly by the Foundation Trust. ID agreed to add urology as a therapeutic area to be discussed at a future meeting.

ID advised that SH had suggested ideas for mental health areas could include lithium, compliance aids, transfers of information, shared care and substance misuse.

ID asked for any further suggestions to be fed back to the APC Professional Secretary.

ACTION: IM to add Rheumatology and Urology to future physical health areas and add Lithium, Compliance Aids, Transfers of Information, Shared care and Substance misuse as future mental health areas for discussion.

ACTION: APC members to forward any other potential topics to IM.

13. NETAG Update

ID advised that the last NETAG meeting was held on 11th October and referred the Committee to the APC papers detailing decisions made.

There was some discussion regarding dabigatran and NICE draft guidance superseding guidance issued by NETAG. CW expressed concerns that the draft NICE guideline superseded the NETAG guidance and IM queried whether draft NICE guidance should be viewed as actual guidance. ID agreed to feed the Committee's comments back to NETAG.

ACTION: ID to feed the Committee's comments back to NETAG.

14. New Medicines Management Website

DG presented the new Medicines Management website to the Committee, and demonstrated the pages relevant to the APC. DG advised the website would be openly accessible on a www address, however some pages are restricted to APC members only,

for which members will receive an username and password via email to enable them to access. DG explained that for future meetings, members would receive an email with a link to the APC website page containing meeting papers for download, rather than papers being sent as email attachments. Those members receiving copies of papers in the post will continue to receive papers as before.

SS asked if other GPs can access the site, DG confirmed that they can and that the website is available to all users of the internet. ID thought that the site was easier to access now and that it is very IT friendly. BH asked if she could have the link for the website, DG will email the link to all when the website goes live. GK suggested the papers be made available on the screens in the boardroom whilst the APC meeting is in progress. IM thanked DG for her hard work in developing the site.

PK asked how regularly the website is updated. DG said that the website will be updated as soon as any information is available. CW queried the branding of the website, asking if CDDFT and TEWV would be incorporated as giving their endorsement to the general content.

Action: DG to arrange usernames and passwords for the website to be allocated to APC members.

Action: DG to arrange for information indicating endorsement by CDDFT and TEWV to be added to the website.

Part 3 – Physical Health

15. Emollient Prescribing for Dry Skin Conditions

CW presented this paper and presented a list of potential emollients; he informed the group that the dermatology nurses were unable to attend today's meeting.

SS was surprised that Diprobase wasn't on the list. CW informed the group that prescribers are moving away from Diprobase. SS told the group that community dermatologists use Diprobase as well as Epaderm. CW advised that Epaderm ointment contains the same active ingredients as Hydromol ointment.

SS mentioned that Doublebase gel comes in a large dispenser and there is significant waste with this as you can't get all of the gel out. CW felt that it was more important to standardise the list. CW asked the group if they felt the list was too long. ID was happy with this; he told the group that this will never cover all issues.

GC thinks this will be a behavioural change for the GP and the patients and there should be some guidance with an explanation of why there have been changes.

CW asked whether Oilatum should be added in the first line list. SS then asked if the list should be emollients which shouldn't be used and the reason why. JS said that this should be a list of items which should be used as there is a wide range of products available making a "do not use" list unwieldy. ID added he was happy to accept the list presented.

JS asked if community pharmacists could support this at the point of dispensing, especially for new preparations. JS also asked if some information could be included in the next LPC newsletter. PK agreed to add this, adding that changes to emollients are not usually a problem, especially when pharmacists explain the rationale behind the change.

JS also queried whether this information should be added to ScriptSwitch. ID said the paper would need to be agreed, then would be sent with a cover letter to all GPs.

ACTION: CW to produce a covering letter to accompany the guidance explaining why it had been produced and return paper to January's agenda.

ACTION: DG to add information to ScriptSwitch when made available.

ACTION: CW to produce covering letter but this was not to be returned to the APC.

16. Joint QIPP Initiatives between CDDFT and NHS CDD

CW updated the Committee on the joint initiatives between CDDFT and NHS CDD:

- PPIs – a trust wide switch to using 2x20mg omeprazole rather than a single 40mg capsule was expected to save approx. £2000

- Ferrous Sulphate to Ferrous Fumarate - As Ferrous Fumarate is only available in pack of 100 the costs of packing this drug down into packs of 28 mean that this is not a practical initiative at this time.

- Dermatology Specials – Some products are now included in the Drug Tariff however only a small proportion of these are Dermatology Specials. There is some question over the data relating to prescribing in the Dales and it was thought that some of this prescribing could be coming from sources other than the FT.

- NSAID prescribing: CW discussed the Diclofenac to Naproxen switch, ID queried whether this shows a significant cost saving. CW said it could potentially but GC thought that anaesthetists prefer to use Diclofenac post-operative and this could be why it comes in the community. The switch could potentially have a small net increase in cost to the trust however.

SJH questioned the fact that Naproxen 250mg TDS is not the same potency as prescribing Diclofenac 50mg TDS. GC raised the fact that there would be an issue if the medication wasn't controlling the pain.

SS asked why ibuprofen wasn't looked at, CW said that this report was looking at second line drugs. CW confirmed that CDDFT stock Diclofenac.

ID concluded that the APC supported the suggested QIPP initiatives.

ACTION: CW & IM to look into the prescribing source of dermatology specials and feed back at the next APC meeting.

17. NICE Hypertension CG127 – Local Medicines Implications

CW presented this paper, advising that North of Tyne had produced a paper regarding thiazides and asked how the APC felt about the issue, advising that North of Tyne Formulary Subcommittee had deferred its decision until their hypertension guideline group had considered the updated NICE guidance.

IM highlighted issues with Chlortalidone where the 12.5mg dose in the NICE guidance would require quartering a 50mg tablet and the compliance issues this would lead to. JB also raised concern about quartering tablets from a patient perspective asking how can it be guaranteed the correct dose is being delivered when quartering a tablet. ID suggested that Indapamide should be used until such a time as Chortalidone is available as a 12.5mg tablet.

ML raised the issue of blood pressure monitoring which could be quite onerous if going down the route proposed by NICE. IM queried the strength of the evidence base behind the new guidance, particularly the use of Chortalidone 12.5mg, which is currently commercially unavailable in the UK, with CW adding that most of the studies were from the US.

SS informed the Committee a number of practices in the Durham Dales had started to implement the changes, with a few practices comparing the results from home monitors when in direct comparison to a reading taken on the practice equipment. ID advised that this would be an issue for individual practices and Clinical Commissioning Groups, however SS commented at present this would be not be high on the agenda for CCGs. ID added that the difficulty was that different practices and areas were at different stages, however agreed to take the issue to the next D&T meeting for onward cascade to CCGs via prescribing leads.

PK advised that hypertension was one of the conditions selected to be included in the recently introduced New Medicines Service for community pharmacies, this is a fairly simple but quite different service to anything delivered previously. IM added that there was also an option for primary and secondary care to refer patients directly into the New Medicines Service. ID added that to enable this appropriate exchange of information needed to be ensured, which could be best taken forward with locality prescribing groups.

ID was happy to accept the guideline for use in County Durham and Darlington and added that the issues surrounding monitoring should be taken forward for further discussion at the next D&T meeting.

ACTION: ID to discuss at D&T.

18. Dabigatran in AF

CW presented this paper and suggested some revisions to the flow chart presented for stroke risk stratification, including changing the text in the box which reads "Contraindications to warfarin" to "Contraindications to warfarin or other anticoagulation drug". It was also suggested that a new box be added which would read "Dabigatran" and this would sit between the box which currently reads "contraindications to warfarin" and "aspirin 75 to 300mg/day if no contraindications".

ID had no objection to the changes, however PK asked for clarification. CW advised that Warfarin would remain first line, and patients for whom warfarin is contraindicated or who are not controlled on warfarin would be suitable for Dabigatran. JB asked how Dabigatran worked and if patients could be deliberately non-compliant on Warfarin to be switched to Dabigatran. CW advised that Dabigatran was a new drug, and would have a similar effect to Warfarin, however without the need for monitoring.

ACTION: ID to verbally update the Committee.

19. Ticagrelor for the Treatment of Acute Coronary Syndromes

ID advised that this had been discussed by NHS Tees who had decided to suspend their decision on Ticagrelor and wait until NICE issue further guidance.

ID asked about price implications, and SW advised it would be approximately £700 per annum per patient. IM added this was about twice the original price of Clopidogrel which at the time was responsible for significant spend.

ID queried what the tertiary centres were doing regarding this and IM suggested that some work needs to be done to link in with Newcastle hospitals and South Tees. ID suggested

this should be brought back to the next APC meeting with some additional information and associated costings.

Action: CW to bring back to the next APC meeting with more information.

Part 4 – Standing Items (for information only)

20. Minutes

20.1 CDPCT D&T

Accepted for information.

20.2 TEWV D&T

Accepted for information.

20.3 CDDFT DTC briefing

Accepted for information.

21. Drug and Therapeutics Bulletin Summaries – September & October 2011

Accepted for information.

22. Horizon Scanning Document & NICE Guidance – September & October 2011

Accepted for information.

23. Any other business

No additional business was discussed.

Date and time of next meeting:

Thursday 12th January 2012
12.00 – 14.30
Merrington House, Spennymoor

Confirmed as an accurate record:

Dr Ian Davidson - Chair