County Durham and Darlington Area Prescribing Committee

Minutes of meeting held
Thursday 5th May 2011
12.00 – 14.30
Allergate House, Belmont

Present:

Hazel Betteney, Senior Pharmaceutical Adviser, NHS CD&D (Professional Secretary)
Geoff Crackett, GP Prescribing Lead, NHS CD&D
Ian Davidson, Deputy Medical Director, NHS CD&D (Chair)
Betty Hoy, Patient Representative
Sue Hunter, Deputy Head of Pharmacy, TEWV
Patricia King, LPC Representative
Graeme Kirkpatrick, Chief Pharmacist, CDDFT
Alan McCulloch, Deputy Medical Director, CDDFT
Sarah McGeorge, Nurse Consultant, TEWV
Ian Morris, Head of Medicines Management, NHS CD&D
Jerry Murphy, Consultant Cardiologist, CDDFT
Mark Pickering, Head of Finance, NHS CD&D
Satinder Sanghera, GP Prescribing Lead, NHS CD&D (SSa)
Sue Shine, Nurse Practitioner. NHS CD&D (SSh)
Joan Sutherland, Senior Pharmaceutical Adviser, NHS CD&D
Frances Taylor, Finance, CDDFT
Lindy Turnbull, Senior Nurse for Medicines Management, CDDFT
Paul Walker, Deputy Clinical Director, TEWV
Sue White, RDTC
Chris Williams, Deputy Chief Pharmacist, CDDFT

Guests:

For item 10:

David Cook, Pharmacist, Northumbria Healthcare NHS FT
Matthew Lowery, Pharmacist, Newcastle Hospitals NHS FT

For item 19:

Barbara Nimmo, Medicines Management Advisor, NHS CD&D

Part 1 – Mental Health

1. Atomoxetine Shared Care for Adults with Adults with ADHD

SH advised that this document had been approved by TEWV D&T for those adults with ADHD who do not tolerate methylphenidate. The shared care

document presented for atomoxetine mirrors that for methylphenidate. HB requested clarity on patient numbers, SH indicated that patient numbers would be low.

IM queried the cover arrangements as the document referenced a temporary telephone number and a mobile, SH agreed to discuss this with the consultant concerned as other clinicians are now in post to support the service.

There were a few queries around BP monitoring and ECG's, however this information was agreed as the document is exactly the same as methylphenidate.

A further query was raised regarding prescribing arrangements, the document stated "Transferred to GP once stabilised, after three months if newly diagnosed, or after one month pre-existing ADHD or transition from C&YPS", it was felt that clarity was needed regarding this difference.

It was agreed that this was a good document which was accepted with minor changes.

Action: SH to make minor amendments and circulate the final document

2. High Dose Antipsychotic Treatment

SH advised that this document had been developed by TEWV for use within TEWV. A very small number of patients may be on a single high dose of anti-psychotics or a combination of oral and depot injection, it was recognised that there may be patients where the oral part of these high doses may be transferred to their GP for prescribing. If the GP does take over prescribing, the high dose needs to be made clear to the GP.

It was recognised that this guidance would apply to a relatively small number of patients. There was discussion about what was meant by a high dose, it was felt that this needs to be made clearer at the beginning of the document and highlight the combination depot/oral high dose.

It was felt that GPs needed to review their patients and identify those that may have been lost to secondary care follow up. SH advised that a standard letter would be sent to GPs to transfer prescribing, with specific reference to high dose antipsychotics within the letter.

ID felt that it would be useful to see the letter as part of a paper for primary care looking at the issues for primary care prescribers.

It was felt that this was a good piece of work with lessons to be learnt in primary care.

Action: JS/SH to prepare a paper for NHS CD&D D&T meeting

3. Melatonin

ID advised that when this paper went to PCT D&T, concerns were raised by the community pharmacy representative. PK advised that she felt that the paper is misleading regarding costs in community pharmacy and is not a safe policy as the price may vary.

There were discussions around prescribing of specials and the significant differences that could occur with respect to costs. SH advised that currently melatonin is a red drug at TEWV, therefore all prescribing is done within the trust, therefore the trust were recommending prescribing of the bio-melatonin brand. SSh added that paediatric consultants often asked for this drug which can cause problems. JS advised that when melatonin prescribing was audited around 18 months ago, a third of prescribing came from TEWV, a third from CDDFT and a third couldn't be determined, therefore the aim would be to dovetail any work done by TEWV with CDDFT.

ID summarised that there have been issues for sometime with TEWV having melatonin as a red drug, whereas there was no agreement at CDDFT, therefore, he felt that the APC may be able to support getting agreement across the board. The guidance was supported, but it was felt it couldn't be used in primary care due to the varying prices of specials at present. It was felt that the specials issue needed to be discussed further with the LPC. There were further discussions around the use of the licensed MR product where appropriate, prior to initiation of the unlicensed product.

Part 2 - General

4. Apologies for Absence and Deputising arrangements

Peter Cook, Consultant, CDDFT
Sarah Hailwood, Consultant Rheumatologist, CDDFT
Nick Land, Medical Director, TEWV
Mike Lavender, Public Health Consultant, NHS CD&D
Paul Turner, Commercial Manager, NHS CD&D

5. Declaration of Interests

There were no declarations of interest.

6. Minutes from last meeting held 10th March 2011

The minutes from the last meeting were accepted with the following amendments:

Page 1 – remove (SSh) from Stephen Purdy and add to Sue Shine

Page 3 – amend the fifth paragraph of item 3 to read “It was felt that the key steps document was a reasonable flow chart of the pathways for approval of medicines, IM queried the PCT decision making function and it was agreed that this needed to be amended to show the APC as the decision making group.”

Page 4 – amend the fourth paragraph of item 5 to read “ID advised that in primary care not having a formulary isn’t taking its responsibilities seriously.”

Page 7 – correct spelling of Certolizumab x 2

7. Matters Arising/Action log

7.1 Action Log

HB advised the committee that all items on the action log were complete apart from item 4- declaration of interest, HB handed out forms for completion by those who had yet to return them.

7.2 Scheduling of future meetings

ID asked members of the committee if the meeting dates were ok for all members or if there were any preferred alternative dates. It was agreed to continue with the schedule of dates for this year, but it was suggested to shorten the agenda to two hours. Members from TEWV advised that splitting the agenda into three parts had been very helpful from their perspective. It was therefore suggested to maintain the meeting length as two and a half hours but continue to split the agenda into three parts. It was also suggested to change the title of the “physical health” section to “non-mental health” for future meetings.

7.3 Electronic Prescribing in Secondary Care

Following on from discussions at the last meeting, ID raised the issue of electronic prescribing in secondary care. ID outlined the current situation stating that primary care clinicians have had electronic prescribing since 1986, yet it is still not in place in secondary care, although there are plans for the future. ID wondered if the APC could in some way influence the schedule for this as to improve patient safety and facilitate adherence to the formulary and to deliver QIPP. GK advised that he would find out the timescales within CDDFT and feed this information back to the committee.

Action: GK to feedback to the committee timescales for electronic prescribing in CDDFT

8. Terms of Reference (TOR)

HB updated the TOR following the last meeting, changes were highlighted in yellow. FT raised concerns about the delegated authority section of the TOR; she advised that CDDFT executive board had not agreed for the APC to make

decisions on its behalf. She added that CDDFT D&T only has authority to spend within existing budgets. ID advised that he was currently in e-mail discussions with the PCT Director of Finance (DOF) to determine a way forward regarding delegated authority. MP added that the committee needs to understand the financial impact of decisions e.g. moving prescribing form secondary to primary care in order to make an informed decision. ID felt that the APC will help to address issues in a timely fashion, but that the remit of the committee required further clarification with the DOF as the statement within the TOR doesn't fit with the current arrangements. It was agreed to note that this was the case and to discuss further at the next meeting.

Action: ID to seek further clarification from DOF.

Action: HB to agenda for next meeting

9. Decision Making Process

ID proposed that the committee emulate the North of Tyne "one member, one vote" approach outlined in this paper and as discussed at the previous meeting. ID asked the committee if they would accept this proposal for decision making. FT suggested that the approach was acceptable not with-standing financial impact.

Discussions followed around how the committee would make a decision, CW asked if committee members making a formulary request would be asked to leave for those discussions, it was agreed that they would. GK queried how to ensure the balance of people in the room doesn't influence the vote, proposing one vote per organisation. ID felt that it should be a whole healthcare economy approach, rather than a "them and us" approach. It was agreed to adopt the North of Tyne decision making process.

A process for hearing appeals was also discussed, with concerns raised about the committee members making decisions possibly being the same as those hearing the appeal, it was felt that attendees vary from meeting to meeting, therefore it was agreed to adopt the North of Tyne process and see how it works in practice.

Action: HB to prepare a summary of the decision making process for the APC website

10. Formulary Development

ID introduced David Cook and Matthew Lowery from the North of Tyne (NOT) APC who had come along to present the NOT formulary to the committee and explain the processes and sub-committees.

DC explained that the committee was formed in 2007and meets bi-monthly. A lot of business is carried out in the sub-committee stage. There are currently four sub-committees, a formulary sub-committee, a shared care sub-committee, an anti-microbial sub-committee and they have recently

established a QIPP sub-committee. In NOT all documents relating to the APC including the formulary were available on a “www” website (http://www.northumbria.nhs.uk/section.asp?id=245069) which they have found is a good method of communication which also reduces the numbers of FOI requests.

DC and ML outlined the operation of the APC and sub-committees to the committee as follows. The formulary committee meets bi-monthly, a month before the APC on a lunchtime. ML’s team evaluate the agents proposed on formulary applications, varying the length of evaluation dependent on the agent/proposed indication. NICE guidance, NETAG and NECDAG guidance are summarised and accepted by the APC. The formulary sub-committee is made up of primary and secondary care representatives, it makes a recommendation to the APC to approve or reject an application and also advises on the status of the drug e.g. red/amber/green, generally recommendations from the formulary committee are ratified by the APC. Around 50% of the members of the formulary sub-committee are also members of the APC, commissioners sit on the APC in order to make financial decisions. GC queried if clinicians attend the formulary sub-committee to present their application. DC advised that they are only invited to attend the APC in the case of an appeal, when they are given a set amount of time to make their appeal as the sub-committee’s role is to make a recommendation; the decision is made by the APC.

ML and DC advised that as meetings are planned for the year ahead with set cut off dates, the work tends to flow through the system well. ID queried the resource involved in managing the APC and sub-committees. DC advised that the professional secretary (employed by the secondary care trust) is also the formulary pharmacist and has a procurement role, but spends at least a day per week on APC work as they receive a lot of queries particularly around the formulary, with workload varying dependent on when meetings are scheduled. Pharmacists from different member organisations take on the professional secretary role for the various sub-committees.

GK queried if formulary decisions were binding on all trusts, bearing in mind the potential financial implications, DC advised that there are commissioners on the committee. IM queried if affordability was considered by the formulary committee, DC advised that it was.

There were discussions around how decisions were disseminated, DC advised that they were published on the internet site and member organisations had responsibility for dissemination within their organisation.

IM queried how formulary compliance was monitored as he felt it was easier to assure compliance in primary care compared with secondary care. DC advised that this had been raised at their last APC with around 90% compliance in secondary care compared with around 60% in primary care.

SSa queried what kudos APC decisions have with clinicians; DC advised that decisions are generally accepted although some tertiary specialist clinicians are less comfortable with the process.

ID summarised the discussions from the previous meeting around adoption of the formulary where committee members were interested in establishing an overarching formulary and wanted to consider an established formulary such as the NOT formulary. ID requested committee members views of a way forward now that they had seen the NOT formulary. It was felt that it made sense to link into the NOT formulary as it was already established, geographically not too far away and the process was well-resourced. ID advised that if the committee wanted to link into to the NOT process, we would have to contribute to the process and would need to field clinical representatives at the formulary sub-committee and offer some resource, ID would need to discuss this further with the NOT APC chair.

Following further discussions around whether to link in with just the formulary sub-committee or all sub-committees and the APC and other potentially closer geographical alternatives to NOT. It was felt that GP-led commissioners (GPLC) may not be ready for such substantial sharing arrangements and although GPLC may be keen eventually to have a regional APC, not all clusters within the region support this at present.

ID summed up that the committee were still interested in more detail around a shared formulary committee with NOT, there may be interest in sharing other resources over time once full clinical engagement is established, more formal decision making on adoption of the formulary will be agreed at the next APC meeting.

The committee thanked DC and ML for their presentation.

Action: ID to discuss proposal to link into the NOT formulary sub-committee with the NOT APC chair.

Action: HB to agenda the formulary for further discussion at the next APC meeting

11. Communication

HB gave an overview of the three issues outlined in this paper around communicating APC decisions. SSa queried having yet another website and wondered if this could be done via NHS evidence. It was felt due to the different organisations involved, that one website that was accessible by all would be appropriate. The recommended mechanisms for communication were accepted. At this point, it was felt that the adoption of the NOT formulary should also be discussed, to ensure agreement from all three trusts. It was agreed to add the formulary as an agenda item for the next meeting, and suggested that all trusts review the content of the NOT formulary to determine if there are any incompatibilities with current practice within their trust, these issues can then be discussed at the next meeting.

Action: All trusts to review the content of the NOT formulary

Action: HB to agenda this item for discussion at the next meeting

12. QIPP

12.1 Grey List

HB advised the committee that the grey list had been revised following comments made at the last meeting; the document had been returned to the committee for final sign off.

PW requested that a couple of minor amendments were made to the document. Firstly for item 4.2.1 he asked that adherence problems be added to swallowing problems as a potential reason for using liquid antipsychotic preparations. Secondly, for item 4.3.4 he advised that in TEWV consultants may wish to use duloxetine but not first or second line. He asked that the statement be changed to read “should only be commenced in secondary care, usually as a third line option or in patients with co-morbidities e.g. neuropathic pain.

SMc was concerned that adoption of the grey list may mean that patients established on any of the treatments listed may have their treatment altered, it was agreed to amend the first line of the explanatory text at the beginning of the grey list to read “The Grey List is a locally-agreed list of medicines which are not recommended for new initiation in normal practice”.

It was agreed to sign off this document with the suggested minor amendments.

Action: SP to make required amendments to the grey list

Action: HB to circulate final grey list to all three trusts for onward dissemination.

13. NICE guidance

The summaries produced by the PCT were discussed, it was agreed that all trusts should have processes in place to assess the impact of relevant NICE guidelines individually within their organisation utilising the modelling tools available from NICE as appropriate. PW added that Jill Matthews from NICE would be coming to the TEWV consultants committee in June, suggesting that it may be useful to invite her to an APC meeting in the future. ID felt that the NICE guidance for Alzheimer’s disease needed to come back to the committee along with an impact assessment, SW added that the RDTC would be looking at this.

Action: RDTC to prepare a summary/impact assessment of NICE guidance for dementia for discussion at the next meeting.

14. Drug and Therapeutics Bulletin (DTB)

HB advised that a summary of the Drug and Therapeutics bulletin had been prepared for the PCT D&T and it was felt that it may be useful to members of the APC committee. It was felt that the article on category M and branded generics would be useful to be shared with primary care clinicians, and it was suggested that the APC endorse the guidance from the DTB and circulate to localities.

Action: HB to forward this summary of the category M/branded generics article to localities within the PCT advising that it has been endorsed by the APC.

15. Horizon Scanning Document – April 2011

SW gave a brief overview of the April Horizon Scanning document highlighting that there weren't many new drugs entering the market at the moment. She advised that the RDTC wouldn't be looking at the new analgesic, tapentadol as this was being done by another medicines information service. The RDTC have produced a new drug evaluation for fingolimod, a new oral agent for multiple sclerosis.

Other new agents of interest were apixaban, for prevention of VTE following elective hip and knee surgery and a new C1 inhibitor for prevention of angioedema attacks.

Further work from the RDTC included a review of the new NICE guidance on Alzheimer's disease, looking at the potential financial impact of this.

SW advised that amendments to the horizon scanning report requested at the last APC meeting around presenting the document in BNF categories and addition of relevant patent expiries were being incorporated into future documents.

16. Recent NETAG and NECDAG Decisions

HB outlined the recent NETAG and NECDAG decisions, advising that the summary document would be updated for each meeting. It was felt that there were still issues around Dabigatran, HB advised that it was due to launch in July. SW added that documentation has been prepared by the RDTC. JM advised that the arrhythmia sub-group of the cardiac network have been working on this and will be feeding back at a meeting next week.

Action: JM to update the committee on the outcome of this meeting.

17. IFR Decisions

HB updated the committee on recent IFR decisions advising that there had been a number of requests for intravitreal preparations – Lucentis® and Ozurdex® as well as requests for Sativex®.

Part 3 – Physical Health

18. Osteoporosis Prescribing Guideline

HB presented this guideline on behalf of Clare Lynch, advising that the guideline was an update of guidance previously issued in the PCT, it was agreed to ratify the guideline for dissemination.

Action: HB to arrange dissemination of this guideline.

19. Lipid Modification Guideline

BN presented this guideline to the committee, summarising the changes compared with the previous guideline and advising that it was difficult to update this guideline as NICE guidance is in the process of being updated. It was felt that this was a useful document. Discussions around the content of the guideline centred around the recommendation of doses lower than 40 mg simvastatin in the flow chart, whether service specifications referenced within the document were still current, atorvastatin dosing for ACS, it was felt that the 40mg option needed to be more prominent and when the document should be reviewed.

It was agreed that the simvastatin dose within the flowchart should be reworded to ensure that it was clear when you would use a dose other than 40mg, BN to clarify if the service specification was still current, the atorvastatin 40mg option to be made more prominent and a review date of two years (or if new evidence becomes available) to be added to the document.

The guidelines were ratified by the committee with these minor amendments.

Action: BN to make minor amendments to the document

Action: HB to arrange dissemination of the final version of this document

20. Formulary Application – Indacaterol

It was agreed that this item would not be considered at this meeting following earlier discussions about adoption of the NOT formulary. This agent is currently being considered for addition to the formulary in North of Tyne.

Action: HB to advise applicant of this decision

21. Minutes from constituent trust D&T meetings

These minutes were accepted for information only.

22. Any Other Business

MP requested that the cover sheet of all APC papers has a section for consideration of financial impact to ensure that this is considered and available to the reader at a glance. The committee agreed with this suggestion.

Action: HB to update the APC paper cover sheet to include financial impact

Date and time of next meeting:

Thursday 7th July 2011
Boardroom, John Snow House
12.00 – 14.30

Confirmed as an accurate record:

Dr Ian Davidson, Chair