County Durham and Darlington Area Prescribing Committee

Minutes of meeting held
Thursday 7th July 2011
12.00 – 14.30
Boardroom, John Snow House

Present:

Hazel Betteney, Senior Pharmaceutical Adviser, NHS CD&D (Professional Secretary)
Geoff Crackett, GP Prescribing Lead, NHS CD&D (Acting Chair)
Deborah Giles, Pharmaceutical Adviser, NHS CD&D
Suzy Gurguis, Consultant, CAHMS, TEWV
Betty Hoy, Patient Representative
Sue Hunter, Deputy Head of Pharmacy, TEWV
Patricia King, LPC Representative
Graeme Kirkpatrick, Chief Pharmacist, CDDFT
Mike Lavender, Consultant in Public Health Medicine, NHS CD&D
Alan McCulloch, Deputy Medical Director, CDDFT
Ian Morris, Head of Medicines Management, NHS CD&D
Sue Shine, Nurse Practitioner. NHS CD&D (SSh)
Joan Sutherland, Senior Pharmaceutical Adviser, NHS CD&D
Paul Walker, Deputy Clinical Director, TEWV
Sue White, RDTC
Chris Williams, Deputy Chief Pharmacist, CDDFT

Apologies:

Peter Cook, Consultant Physician, CDDFT
Ian Davidson, Deputy Medical Director, NHS CD&D (chair)
Nick Land, Medical Director, TEWV
Sarah McGeorge, Nurse Consultant, TEWV
Mark Pickering, Head of Finance, NHS CD&D
Frances Taylor, Finance, CDDFT
Lindy Turnbull, Senior Nurse for Medicines Management, CDDFT
Paul Turner, Commercial Manager, NHS CD&D
Satinder Sanghera, GP Prescribing Lead, NHS CD&D

GC informed the committee that he was acting as chair for this meeting in ID's absence.

Part 1 – Mental Health

1. Impact Assessment – NICE Dementia Guideline

SH presented a paper looking at the cost impact associated with implementing the new NICE guidance for dementia, highlighting the main changes in the guidance which are that acetylcholinesterase inhibitors are

now recommended as options for mild as well as moderate disease and memantine is now recommended in certain circumstances.

SH advised that she had worked with JS to look at the NICE costing template and a modelling tool produced by the RDTC, she added that it was quite a challenge to try to pull all of the information together and pull out something meaningful.

SH outlined the key factors to consider as follows there are increasing numbers of people with dementia, with the national audit office advising that around half of the people with dementia are not diagnosed; diagnosis rate varies between 20% and 70% and the impact of the new guidance on specialist referral rates is unclear, it is anticipated that levels will rise from around 60% to 70%. SH added that the patents for donepezil and memantine are due to expire soon so the drug costs for the treatment of Alzheimer's disease are set to decrease.

SH summarised the impact assessment for the committee advising that the NICE tool allowed an estimate of the diagnosed and undiagnosed dementia patients within the population to be made, adding that QOF registers can also be used to get a local figure. In County Durham and Darlington the figures estimated using both models were very close and in line with NICE expectations for diagnosis rates.

SH went onto explain that the NICE model suggests that 39% of diagnosed patients are expected to be treated, looking at current actual expenditure on treatment and dividing by average daily quantities, gives an indication of numbers. SH advised that in County Durham and Darlington, higher treatment rates than expected may be due to higher diagnosis rates, higher treatment rates or prescribing of treatment outside of NICE guidance.

IM suggested that if patients are picked up earlier, it may be that lower doses were being used.

SH stated that spend is currently higher than expected by NICE, so the guidance may have less impact in the future. She added that the RDTC have modelled the effects on prescribing costs of increased prevalence or increased detection rates, these were projected with average daily dose costs, if applied in the NICE model the estimated annual increase in spend is £240,000 for County Durham and £41,000 for Darlington.

IM queried if these estimates were based on current drug costs, as if donepezil goes off patent, this may reduce costs. SH advised that they had used NICE proportions to calculate projected impact, working on a prescribing rate of 60% donepezil, although this may vary locally. She added that there may be an initial increase in spend as the guidance is adopted but once generics become available this increase may stop and start to decrease as the price drops.

GC asked if there was anything that needed to be done practically around implementing this guidance, such as suggesting the use of donepezil first line and also looking at decommissioning treatment for those patients whose MMSE score has decreased. It was agreed that this would be taken back to TEWV D&T for further discussion with feedback at the September APC meeting.

BH asked if donepezil was the best drug, SW advised that it was the first drug so there was more experience of its use and there isn't much to choose between them. BH advised that at the groups she attends, Alzheimer's disease was moving up the agenda for a lot of people and she wondered if long term it would be cheaper to treat earlier and reduce the burden on carers. GC advised that these drugs don't alter the course of the disease in the long term.

IM queried if the cost of referrals had been factored into the calculations, JS advised that it hadn't been. JS added that the paper had been shared with the PCT finance representative as he was unable to attend the meeting and he offered the following advice. "The PCT will need to manage the financial consequences of this and other NICE guidance implementation on primary care prescribing budgets in-year. The secondary care impact is already built into the inflationary increases applied to tariff and block contracts passed onto providers as part of contractual agreements at the commencement of the financial year, and as such will need to be managed by providers in a similar way." SH said that she would feed this information back to TEWV finance department.

Action: SH/JS to discuss decommissioning issue at TEWV D&T

Action: HB to agenda decommissioning issue for September APC

2. Unlicensed/Off-label Prescribing Guide

SH presented this guidance for unlicensed and off-label use of medicines, initiated by TEWV, with the appendices of this document detailing the current uses of unlicensed/off-label prescribing that TEWV accept within their clinical practice. She added that medicines highlighted in red are those which are not suitable for transfer to primary care.

GC queried how it works practically, asking if there's an application form for these drugs. SH advised that if the use is for a drug outside of the list for an individual, it has to be signed off by the clinical director, if it is for a group of patients it has to be considered by the committee within the trust.

GC added that he had noticed that there was a form within the document to explain the situation to the patient but wondered what process was in place for informing GPs. SH advised that it is up to the individual to write a letter, GC queried if a standard proforma could be used. Discussions around whether this should be an opt-in or opt-out process and how this decision

should be communicated with GPs concluded with the recommendation that a standard paragraph could be included in a letter to GPs, with further discussion with GP prescribing leads as to whether an opt-in/out arrangement would be appropriate. It was agreed that JS would contact the GP prescribing leads for their opinions prior to the TEWV D&T to allow for further discussion of this issue which could then be fed back to the APC.

Action: JS to email GP prescribing leads about the content of a standard paragraph within a letter and opt-in/out arrangements and feedback to TEWV D&T.

Action: SH to feedback final decision from TEWV D&T to the next APC meeting.

GC asked committee members if there were any further items around mental health that required discussion. IM advised that he had received a query about different sites within TEWV having different versions of clozapine and the potential problems this may cause if patients are transferred between trust sites. SH advised that although there are different brands in use, all of the Lloyds branches within the trust can dispense either brand, so this shouldn't be an issue.

Part 2 - General

3. **Apologies for Absence and Deputising arrangements**

   Listed at the beginning of the minutes

4. **Declaration of Interests**

   There were no declarations of interest.

5. **Minutes from last meeting held 5th May 2011**

   The minutes from the last meeting were accepted with one minor amendment:

   Page 9 – NETAB to be changed to NETAG

   PW sought clarification on the amendment to TEWV ADHD guidance for atomoxetine, SH advised that she would confirm that the amendment had been made.

   Action: SH to confirm amendment made to guidance

6. **Matters Arising/Action log**

   6.1 Action Log

   Please see updated action log.

6.2 Electronic Prescribing in Secondary Care

GK updated the committee on electronic prescribing; he advised that the IT system in the trust had been updated to deliver electronic prescribing and medicines administration within the trust. He added that he is currently writing a business specification for this and was going to Derby and Salford later in the month to see the system in use. GK advised that this work was beginning to take shape but that it would be 18 months to two years until its use would be widespread.

Regarding out-patient prescriptions, GK advised that the Trust were trying to progress this sooner, and that he was currently working up a specification looking at producing FP10's on an electronic system and hoped to have something in place by September. GK added that he was also looking into getting treatment recommendation forms prepared electronically.

PK stated that from a community pharmacy perspective, she was very excited about these developments.

7. Formulary Development

HB updated the committee, advising that following the presentation by the North of Tyne APC pharmacists at the last meeting, representatives from TEWV, CDDFT and CD&D PCTs met to discuss a way forward for formulary development and formulated the following proposal.

"County Durham and Darlington APC feeds into the North of Tyne new drug evaluation process, sending appropriate representatives from all three trusts to sit on this group. Ian Davidson has agreed to discuss this option with the North of Tyne committee.

In order to move forward with formulary development, it is recommended that the North of Tyne formulary is reviewed and a County Durham and Darlington version is developed, based upon local prescribing guidelines."

HB added that the BNF formulary electronic tool is being reviewed as an option for dissemination of the formulary to clinicians across all three trusts.

HB asked that in order to support the development of a formulary, a formulary development sub-group is established for a six month period, with membership changing dependent on the area of prescribing to be discussed.

GK advised that he felt that the North of Tyne formulary was a list of drugs that link their guidelines not ours, he suggested that the formulary should be personalised to suit the local situation. GK added that he was not keen on having just a list of drugs as this doesn't tend to engage clinicians and can be seen as a way of restricting prescribing, he was more in favour of guidelines feeding a list of drugs, suggesting that ensuring good guidelines are in place for the big therapeutic areas will provide a list of drugs. CW added to this using PPI's as an example, if there was a guideline in place across the

healthcare economy; clinicians could then understand the reasoning behind prescribing decisions/recommendations.

SW advised that North of Tyne they have a locally modified version of the BNF available on their intranet, HB to investigate how this works.

ML asked that the guidelines that form the basis of the formulary be linked into map of medicine; HB advised that this would be possible once the APC website was established.

GC highlighted the area of anti-muscarinic prescribing in urology as a priority therapeutic area which is complicated by the fact that the clinicians providing the service in Durham and Darlington come from outside the area. GK suggested that applications for new drugs should not be considered without a supporting guideline and suggested that the urologists are asked for their guidelines.

The proposal for formulary development was agreed by the committee.

Action: HB to investigate electronic BNF used by North of Tyne

Action: HB to set up formulary development sub-group following the presentation on the BNF electronic formulary tool

Action: ID to write on behalf of the committee to South of Tyne and South Tees urologists requesting copies of the guidelines they are working to as part of the formulary development process.

Action: Finance to explain how the PCT manages financial consequences.

8. Specific therapeutic areas for future meetings

HB advised that following discussions between the three trusts represented at the APC, it was felt that it would be useful to have a pre-defined schedule of therapeutic areas for discussion at the APC meetings in order that the trusts can ensure there is enough notice to field the relevant clinicians at the appropriate meetings. HB added that the following schedule of therapeutic areas has been proposed until the end of the financial year:

Meeting Date	Physical Health	Mental Health
September 2011	Dermatology	Dementia
November 2011	Cardiovascular	ADHD & Melatonin
January 2012	Diabetes	Anti-psychotics
March 2012	Respiratory	Depression

CW added that he felt it should be a rolling programme of therapeutic areas, set out at the beginning of each year in order to try to get better clinician attendance.

GC asked BH if as a patient, there was anything she would like to see on the agenda, BH advised that at present she didn't know enough about the committee yet but could provide a lay member view on items discussed. There was further discussion around concerns about the financial discussions within the committee, but it was felt that one of the benefits to the committee of having a lay representative was that they can challenge the decision making process and provide a different perspective.

The schedule of therapeutic areas for future meetings was agreed.

Action: Trust representatives to utilise the agreed schedule of therapeutic areas to invite the appropriate clinicians to relevant meetings.

9. QIPP – see item 15

10. Drug and Therapeutics Bulletin – May & June 2011

HB advised that currently Dr David Russell summarises the Drug and Therapeutics bulletin for cascade to primary care prescribers and these were the most recent summaries. Secondary care representatives advised that they may put these summaries onto their intranet for prescribers to access. A query was raised about whether MeReC publications should be circulated to all prescribers, it was felt that information needed to be targeted to avoid information overload.

GC suggested that there were only a few items of interest within these summaries and felt that it would be more appropriate to bring these summaries to the meeting for information only, but that any issues within them could be raised on the agenda as appropriate.

Action: HB to move these summaries to the information only section of the agenda for future meetings.

11. Horizon Scanning Document and NICE Guidance – June 2011

SW advised that the RDTC are currently working on adding the potential financial impact of NICE guidance to this document following a request from CD&D D&T. She added that there were no major issues within the June document but that the RDTC would be preparing a short evaluation report on fampridine for the improvement of walking in adult patients with multiple sclerosis as it was quite unusual to have a conditional marketing authorisation for unmet medical need.

CW asked if the NETAG annual plan could be added to this document, SW advised that the document was circulated wider than the North East, so it was felt that NETAG decisions/work plans shouldn't be included. HB suggested that this could be included within the NETAG/NECDAG decisions paper as an additional section.

Action: HB to ensure the NETAG work plan is included in the NETAG/NECDAG decisions summary for future meetings

12. Recent NETAG and NECDAG Decisions

No new decisions since last meeting.

13. IFR Decisions

ML advised that there were no new ECC decisions to report. HB advised that recent IFR requests included rituximab for unusual indications, omalizumab for asthma and botox for migraine.

Part 3 – Physical Health

14. Pain Management Guideline

DG presented these guidelines to the committee, advising that they are an update of guidelines currently used in primary care, with the main changes based on NICE guidance for neuropathic pain. She added that they had been discussed at both the PCT and CDDFT D&T meetings and suggested changes had been made to the comparative doses of opiates.

PK queried why there was no mention of duloxetine for diabetic neuropathy, she was advised that this was because this was general pain management guidance, but it was agreed that a reference to the NICE guidance for neuropathic pain should be added to the guideline.

IM asked if the guideline should be amended to state APC rather than County Durham and Darlington PCT's and it was suggested that "for primary care" should be removed from the guideline title.

It was suggested that rather than put all trust logos on the document, a logo for the APC should be devised and used for all APC documents.

Action: DG to make minor amendments to guidance and look at developing an APC logo.

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

15. Blood Glucose Test Strips

HB presented this paper to the committee advising that it was a combination of a paper tabled at CD&D PCT D&T and an RDTC report looking at the prescribing of blood glucose test strips.

HB advised that currently 22% of the prescribing budget spent on diabetes in the North East, is spent on test strips, yet the evidence for the benefits of testing for all patients isn't good, in addition, some patients don't appear to be receiving an adequate quantity of lancets to match the quantities of test strips prescribed. HB went onto discuss charts produced by the RDTC looking at the potential benefits of reduced test strip prescribing and using less costly strips, which was the proposal tabled at the PCT D&T and how this may allow for reinvestment into intensive lifestyle support to prevent the development of type 2 diabetes in those patients at high risk.

HB added that the committee were asked to agree a way forward to address this issue across the healthcare economy.

SS advised that in her experience, the biggest influence on the prescribing of blood glucose test strips is that patients can buy themselves a machine from community pharmacies and then present at the GP surgery asking for the strips. In addition, one manufacturer has been emailing GP practices offering them as many meters as they want at no cost, and where a meter is required for a patient, you tend to supply whatever you have in stock.

AM advised that there is little evidence of the impact of blood glucose monitoring on glycaemic control and complications; the NICE guidance outlines where prescribing of test strips is appropriate and therefore, those patients receiving test strips inappropriately should have their supply stopped to rationalise the prescribing of strips and allow reinvestment of the savings. He added that if it was a drug that was being discussed rather than a test strip where there is no evidence of benefit; NICE guidance would not approve the prescribing. He concluded that the principle of the proposals outlined was sound, but agreement across the interface was needed.

Discussions around why patients purchase their own blood glucose meter, including a patient perspective on the value of this approach and how this could be influenced concluded that a multi-disciplinary, multi-agency pathway-based approach to the early education of newly diagnosed diabetics was required to ensure that patients get a consistent message from all of their contacts within the healthcare system. It was reported that currently newly diagnosed patients wait between eight and thirteen weeks for an appointment on the DAPHNE/DESMOND programme.

ML advised that although he welcomed the suggestion that the potential freed up resources were directed to prevention, there may be more benefits from investing in early education. AM added, the quality of diabetes control can be fed back to diabetic patients in other ways, rather than them monitoring their blood glucose.

It was agreed that a working group needed to be established to look at this issue across the interface inviting key stakeholders from primary and secondary care, community pharmacy via the LPC and patient groups meeting in mid-late October in order to be able to present the outcomes of their discussions to the January 2012 APC meeting. ML suggested that

Darren Archer may be able to facilitate this piece of work as long-term conditions lead.

Action: HB to contact Darren Archer to discuss how this can be taken forward

Action: HB to agenda for January 2012 APC meeting.

16. Insulin Prescribing

It was agreed that rather than discuss the content of this paper at this meeting, it should be discussed by the small working group suggested in response to item 15. This group can then feedback recommendations to the January 2012 APC meeting.

Action: HB to agenda for January 2012 APC meeting.

17. Minutes from constituent trust D&T meetings

These minutes were accepted for information only.

18. Any Other Business

GK asked if the time on the agenda could be set for specific therapeutic areas e.g. if some of the items within the general section could be moved to the end of the meeting to allow the physical health section to begin at 1.30 pm.

Action: HB to discuss structure of agenda with ID to take on board this suggestion.

Date and time of next meeting:

Thursday 1st September 2011
Boardroom, John Snow House
12.00 – 14.30

Confirmed as an accurate record:

Dr Ian Davidson - Chair