AREA PRESCRIBING COMMITTEE
Thursday 10th January 2013
11.30 – 2.30 pm
Board Room, John Snow House

PRESENT:

Geoff Crackett, GP Prescribing Lead (DCLS), NHS County Durham & Darlington
Ian Davidson, Deputy Medical Director, NHS County Durham & Darlington (chair)
Alwyn Foden, AMD Clinical Governance, County Durham & Darlington Foundation Trust
Suzy Guirguis, Consultant, CAMHS, Tees Esk & Wear Valleys NHS Foundation Trust
Sarah Hailwood (SJH), Consultant Rheumatologist, County Durham & Darlington NHS Foundation Trust
Sue Hunter (SH), Associate Director of Pharmacy, Tees Esk & Wear Valleys NHS Foundation Trust
Graeme Kirkpatrick, Chief Pharmacist, County Durham & Darlington NHS Foundation Trust
Sarah McGeorge, Consultant, Tees Esk & Wear Valleys NHS Foundation Trust
Ian Morris, Head of Medicines Management, NHS County Durham & Darlington
Patrick Pearce, County Durham & Darlington Foundation Trust
Andy Reay, Senior Pharmaceutical Adviser, NHS County Durham & Darlington
Sue Shine, Nurse Practitioner, NHS County Durham & Darlington
Lindy Turnbull, Senior Nurse for Medicines Management, CDDFT
Laura Walker, Minute taker, NHS County Durham & Darlington
Paul Walker, Clinical Director, Tees, Esk & Wear Valleys NHS Foundation Trust
Sue White, Regional Drug & Therapeutics Centre
Chris Williams, Deputy Chief Pharmacist, County Durham & Darlington NHS Foundation Trust

APOLOGIES FOR ABSENCE:

Jean Bertram, Patient Representative
Peter Cook, Consultant, County Durham & Darlington Foundation Trust
Betty Hoy, Patient Representative
Sue Mole, Patient Representative
Joan Sutherland, Senior Pharmaceutical Adviser, NHS County Durham & Darlington

PART 1 - MENTAL HEALTH

1. NEW DRUG APPLICATIONS (RELEVANT TO TEWV)

Sue Hunter tabled a formulary application for perampanel, in line with the NETAG recommendation. The APC supported the use of perampanel as a green plus drug. The application will go to the CDDFT's Clinical Standards group for information.

ACTION: CW to take application to the CDDFT's Clinical Standards group for information.

2. DEMENTIA TREATMENT PROTOCOL

The group discussed the Dementia Care Pathway, which provides guidance on first, second and third line treatments for dementia. The group welcomed this development and the moves that TEWV have made to make generic donepezil the first line treatment for the majority of patients.

It was agreed that TEWV will incorporate guidance for stopping dementia treatment into this document. All patients should be review 6 monthly by TEWV and primary care should contact TEWV for any patients where this doesn't happen, as this review is the ideal place to consider stopping treatment. In other areas of health it is sometimes asked whether it would be a surprise if the patient passed away within 12 months when considering long term treatment and TEWV may want to consider applying this principle. When the guidance for stopping is included, the APC logo should also be added to the document.

In the future the APC would be happy to consider a proposal from TEWV to move the status of dementia drugs from amber to green plus.

SH tabled the Behavioural and Psychological Symptoms in Dementia Decision Making Pathway for information. This will be brought back to the D&T in February and the APC in March.

ACTION: Primary care to be informed that patients who do not receive regular reviews should be referred to TEWV.

ACTION: SH to produce guidance on the withdrawal of treatment in dementia and incorporate into dementia care pathway

ACTION: SH to return the Behavioural and Psychological Symptoms in Dementia Decision Making Pathway to D&T in February and March APC with amendments.

ACTION: SH to make a proposal to the APC to re-classify the traffic light status of dementia drugs from amber to green plus.

3. VENLAFAXINE MR

ID informed the group that there is no guidance on switching patients from Venlafaxine MR to Venlafaxine IR when patients are under TEWV consultants. PW suggested this is not a problem as long as TEWV are informed. AR informed the group that North of Tyne PCT have an SOP for this and there was an understanding that work had already been done on this in County Durham and Darlington It was agreed that we should revisit the work done on venlafaxine switching and promote our SOP. If necessary it should be amended so that if a patient was under the care of TEWV, the consultant should be informed of the switch proposal, so that they could let the GP know if there was a specific problem.

ACTION: JS to promote the SOP and to ensure the importance of informing TEWV about switches is included.

4. **MIDAZOLAM**

A decision on which preparation(s) of buccal midazolam should be included on the formulary needs to be made. This will be referred to the formulary group who will make a recommendation to the APC in March

ACTION: Formulary group to bring recommendation to the APC in March.

PART 2 - GENERAL

5. **APOLOGIES FOR ABSENCE**

See front page.

6. **DECLARATION OF INTERESTS**

None declared.

7. MINUTES OF PREVIOUS APC MEETING HELD 1ST NOVEMBER 2012

The minutes were accepted as a true reflection of the meeting. It was noted that Geoff Crackett was the Chair of the meeting and this should be reflected in the attendance sheet.

ACTION: LW to amend November minutes.

8. MATTERS ARISING/ACTION LOG FROM APC MEETING HELD 1ST NOVEMBER 2012

AR gave a brief summary of the action log and will email a copy of this to the group.

9. APC FORMULARY SUB GROUP UPDATE

9.1 NICE GOOD PRACTICE GUIDE, DEVELOPMENT & UPDATING OF LOCAL FORMULARIES

CW presented the preliminary gap analysis paper which contained a RAG rating for the NICE developing and updating local formularies criteria . One of the issues highlighted was the need for terms of reference for the formulary group, the group decided the terms of reference should be agreed at the formulary group and to return to March APC. The group discussed the appeals process and the need for an appeals panel. The group felt the APC currently does this but there may be some resource issues from April 2013 following the restructure of the PCT and that this issue should be raised as soon as possible. GK informed the group he will raise the issue around the resources for the APC in an executive meeting he is attending in February. The group felt the formulary group should devise an action plan for this guidance and for this to be returned to APC for approval.

ACTION: Terms of reference for the formulary group to be returned to March APC.

ACTION: The formulary group should consider this documentation and devise an action plan to fulfil this guidance.

9.2 APC FORMULARY

ID thanked those who have worked on the formulary and praised them for getting the formulary to its current position. AR presented the formulary website tool which has been circulated to key people for comments. Really useful feedback has been obtained from this exercise and subsequent changes will be made following the feedback received. AR informed the group that there are still some technical changes to be made to the formulary which he will be picking up with IT.

It was agreed that if a drug is not on the formulary that does not mean it should never be prescribed. However, in such cases clear communication must be made in the notes and letters justifying the rationale for prescribing a non-formulary drug.

AR asked the group whether they would be happy for the formulary to be launched in February, the group were in agreement. It was decided to promote this in as many ways as possible; GK will promote this at the executive meeting he is attending in February. It was agreed by the group to locate the formulary on the Medicines Management website, as this is a public website and the usage of the website can be tracked.

ACTION: To launch the formulary in February 2013 and for this to be widely publicised.

9.3 TRANSFER OF PRESCRIBING DOCUMENT

AR explained that currently there are no guidelines in place for the transfer of prescribing between primary and secondary care. He brought a draft document to the group with some questions for agreement as follows;

1. The group were happy with the definition of red, amber, green plus and green drugs.

2. The group discussed the possibility of GP's being able to prescribe red drugs under very exceptional circumstances. AF felt this would help with delays in prescribing medication, ID was wary of doing this based on patient safety. The group felt that GP's could provide prescriptions in very exceptional circumstances as long as there had been effective communication and agreement between the GP and the specialist. CW suggested that he and AR could re-word this section of the document to take in to account the comments received. ID felt it needs to be highlighted in the document that the prescriber has responsibility over their prescribing decisions.

3. It was agreed that the length of supply and whether treatment recommendation forms could be used would be stipulated in the list of green plus drugs which will be drawn up.

4. All agreed that generally a minimum of one month's stabilised dose of an amber drug should be provided by the specialist prescriber before considering transfer of prescribing, but the specific length of supply for each drug should be stipulated in the shared care guideline.

5. The group agreed that amber drugs should be kept to a minimum but felt that this should be reworded. Safety not cost must be the overriding factor.

6. AR asked the group if electronic copies of shared care protocols would be acceptable when receiving requests to transfer prescribing of amber drugs. AF questioned whether there would be a safe way of doing this as he is aware not everyone uses NHS net. The group did agree with electronic copies if used in a safe way, as this will future proof the system, but we must be explicit in communication on how to access electronic copies. For example, the specialist should state in the letter that copies of the shared care guideline could be found on the internet, stating the website address.

7. The group were in agreement that amber drugs not covered by the shared care agreements are to be considered to be red drugs.

8. The group had a discussion around requesting GP's to opt-in/opt-out of shared care on an individual patient basis. AF felt the administration of this would not be feasible. SJH's team uses an opt-in/opt-out system for one of their patient groups and it is a time consuming system, with regards to chasing up responses for example. GK suggested that as a default GP's accept this but have the option to opt-out if necessary. ID asked whether patients could be copied into the letter from the specialist prescriber. AF has found not all patients want to be copied in. The group agreed the best option would be for the standard position to be that shared care would be accepted automatically by GPs. If GPs wish to decline for a specific reason, they must inform the specialist promptly, stating their reason for refusal.

   AR asked whether a register should be kept with the information of who has opted-in/opted-out. The group felt this would be a good system however it would take a lot of maintenance, therefore it was agreed such a register would be an aspiration for the future.

9. The group generally agreed with the suggested review period for patients by the specialist, but this should be stipulated in the specific shared care guideline.

10. CW suggested that a draft letter should be created to replace the information in appendix 2, the shared care request form. SH felt there were some important details to be added to this from a TEWV perspective. This letter is therefore to be drafted by CW/AR with input from SH.

GK asked whether electronic signatures would be accepted and it was agreed that they would be.

ACTION: CW's rewording for point 2.

ACTION: AR to reword point 5.

ACTION: To review this document at May's APC.

9.4 NICE PUBLISHES FIRST EVIDENCE SUMMARY: UNLICENSED OR OFF-LABEL MEDICINE

AR presented this paper for information which highlights what to expect from the NICE evidence summaries for unlicensed or off-label medicine, CW added that these will be reviewed at the sub-group.

ACTION: AR to take to Formulary Group, who will review documents when released.

9.5 ADRENALINE AUTO-INJECTOR DEVICE

AR informed the group that following a tender exercise, Jext adrenaline auto-injector devices had been awarded the regional contract. Training for this device will be rolled out across the region and the product will be added to the formulary.

SS has experience of this device and stated it has a better shelf life than other adrenaline devices and it is easy to use.

The APC supported this formulary addition.

9.6 ACHIEVING SAVINGS FROM HIGH COST DRUGS

AR stated this document, which has been produced by the Department of Health shows potential savings to be made on the purchasing of high cost drugs. GK explained that he now has the role of responsible officer for home care and he is going to set up a sub-group which could tie in with the APC and could explore releasing these potential savings.

10. FUTURE OF APC

ID informed the group that the terms of reference are to be reviewed in March 2013; however there is a debate as to whether there will be the resource required to continue this group from April 2013. ID explained that a meeting is taking place in February to discuss the future of the APC.

11. NEW DRUG APPLICATIONS

The new drug application brought to this meeting was discussed under the mental health section of the meeting (Item 1.)

12. IFR UPDATE

There was nothing to report from the IFR requests, it was mentioned that the IFR process is being reviewed and there will be a regional process for these requests.

13. NETAG UPDATE

AR presented this paper for information which includes Perampanel which was discussed by the group in item 1.

14. MEDICATION SAFETY

14.1 MHRA DRUG SAFETY UPDATE OCTOBER

For information.

14.2 MHRA DRUG SAFETY UPDATE NOVEMBER

For information.

14.3 MHRA DRUG SAFETY UPDATE DECEMBER

For information.

It was agreed that in future the formulary sub- group will review future Drug Safety Updates and bring back recommendations for action to the APC and D&T.

PART 3 – PHYSICAL HEALTH

15. UPDATE FROM RESPIRATORY MEETING

A respiratory meeting has taken place with AF, AR, CW, Dr Basil Penney, Dr Dillys Waller, Julie Cottee, and Dr Neil Munro. CW gave the group an update of the decisions made at this meeting. In summary tiotropium respimat will be removed from the formulary due to on-going safety concerns. A memo will be circulated listing alternative products. Formulary applications for aclidinium and glycopyrronium will be supported. Following the meeting primary care representatives have requested that a formulary application for Flutiform should also be supported. An application for Fostair will not be submitted.

AF asked the group if anyone had electronic copied of the COPD guidelines, as the respiratory group were going to be reviewing these. IM agreed to send AF a copy of the guidelines. ID agreed that some definite guidelines are required which the APC have ownership of.

ACTION: IM to locate and forward the COPD guidelines to AF.

PART 4 – STANDING ITEMS (FOR INFORMATION ONLY)

16. MINUTES OF PREVIOUS MEETINGS HELD:

16.1 COUNTY DURHAM & DARLINGTON PCT DRUGS & THERAPEUTICS (21ST AUGUST 2012)

For information.

16.2 TEES ESK & WEAR VALLEY D&T (27TH SEPTEMBER 2012)

For information.

16.3 COUNTY DURHAM & DARLINGTON CLINICAL STANDARDS AND THERAPEUTICS COMMITTEE (3RD OCTOBER 2012)

For information.

17. DRUGS & THERAPEUTICS BULLETIN SUMMARIES

For information.

18. RDTC HORIZON SCANNING

18.1 HORIZON SCANNING NOVEMBER 2012

For information.

18.2 HORIZON SCANNING DECEMBER 2012

For information.

19. ANY OTHER BUSINESS

Due to a number of attendees having to leave the meeting to move their cars due to issues with the lack of car parking spaces, PW suggested the venue of the meetings for 2013 should be reconsidered. AR informed the group that the next meeting is being held at Bede House, Belmont however the remaining meetings can be looked into being re-arranged.

ACTION: LW to arrange for the APC meetings in 2013 to be in a different venue.

Date and time of next meeting:

Thursday 7th March 2013
Training Room, Bede House, Belmont, Durham

Confirmed as an accurate record:

Dr Ian Davidson