COUNTY DURHAM PCT & DARLINGTON PCT
Drugs and Therapeutics Committee

Minutes of Meeting held
19 April 2011
Boardroom, Merrington House
12.00 - 2.30 pm

PRESENT:

Hazel Betteney, Senior Pharmaceutical Adviser
Dr Geoff Crackett, GP Prescribing Lead (DCLS)
Dr Ian Davidson, GP Prescribing Lead (Derwentside) – Chair
Gail Dryden, Community Matron
Anne Henry, Pharmacist, CDDFT
Dianne Hough – Patient Safety & Complaints Administrator (note taker)
Patricia King, LPC Representative
Dr Peter Jones, GP Prescribing Lead (Sedgefield)
Dr David Russell, GP Prescribing Lead (Darlington)
Dr Satinder Sanghera, GP Prescribing Lead (Dales)
Joan Sutherland, Senior Pharmaceutical Adviser
Sue White, RDTC

In attendance:

For items 6.1 & 6.2 - Barbara Nimmo, Medicines Management Advisor
For item 6.2 - Richard Buckland, Tissue Viability Nurse
For item 6.3 - Clare Lynch, Medicines Management Advisor

1.0 APOLOGIES

Graeme Kirkpatrick**,** Chief Pharmacist, CDDFT
Ian Morris, Head of Medicines Management
Dr David Napier, GP Prescribing Lead (Easington)
Linda Neely, Head of Clinical Quality & Patient Safety
Ros Prior, TEWV
Stephen Purdy, Pharmaceutical Adviser
Sue Shine, Nurse Practitioner
Christopher Williams, Deputy Chief Pharmacist, CDDFT

2.0 DECLARATION OF INTERESTS

There were no interests declared

3.0 MINUTES OF LAST MEETING

The minutes were accepted as a true and accurate record, subject to a minor amendment to page 12. Item 11.2 to read “SW advised that there was a new drug evaluation for ticagrelor available on the RDTC website; she advised that currently the company are providing this to secondary care at a reduced cost, but only for an initial two month period until it is included on GP prescribing systems.

4.0 MATTERS ARISING

4.1 Melatonin Update

JS tabled an information sheet prepared by TEWV on prescribing of Melatonin which is a red drug in TEWV, with prescribing remaining with the consultant. TEWV were concerned about the huge variation in acquisition costs, they are aware that they can’t specify the brand to community pharmacies, but as they are prescribing it and have a pharmacy on site, they have made some recommendations around the use of Bio-melatonin®.

JS highlighted to the committee that she had been unaware that the licensed melatonin product, Circadin® was supplied in a special container as a calendar pack of 21 tablets as it is only licensed for three weeks. SW offered to incorporate this information as a practice point in a short report the RDTC are compiling on melatonin.

JS advised that only a third of the melatonin prescribing in County Durham and Darlington was found to originate from TEWV in an audit carried out by Sharron Kebell, with a third from paediatrics within CDDFT and the final third unable to be identified from the records available.

ID felt that this was a suitable document for consideration by the APC and should be considered for comments by the D&T committee. SW advised that currently for quarter 3 County Durham PCT was spending £6/100 patients on melatonin, in Darlington; it is £2/100 patients. HB suggested taking the document to the APC along with primary care prescribing data.

DR queried if this information sheet would be circulated to all prescribers. JS advised that it was to be circulated within TEWV at present. PK highlighted to the committee that Bio-melatonin was unlicensed and therefore had no list price; different community pharmacies may use different wholesalers and may not be able to obtain supplies from the wholesaler listed in the information sheet. JS acknowledged this and advised that it had been discussed at TEWV. PK felt that there was a danger of incurring higher costs if used unlicensed products rather than Circadin®. JS advised that unfortunately, Circadin® is a sustained release product and therefore has limitations.

PK felt that the committee needed to understand the specials issue, as it was an unlicensed product that was recommended, costs could be variable, adding that community pharmacists are under financial pressures, so if the prescription isn't for Circadin®, there is no guarantee of price.

HB queried whether it would be worth looking at the work being carried out South of Tyne with the LPC regarding specials prescribing.

Action: JS to prepare a paper for APC including primary care prescribing data

Action: HB to add to APC agenda for May 2011

Action: PK to feed back to the committee at the next meeting on the specials work being carried out South of Tyne

5.0 ACTIONS TAKEN BY MEDICINES MANAGEMENT TEAM FROM LAST MEETING HELD 15 FEBRUARY 2011

Please refer to updated action log.

6.0 AGENDA

6.1 Lipid Management Guidelines

BN presented an update of the lipid management guidelines, highlighting areas where changes had been made. ID thanked BN for presenting the document to the committee for discussion, but advised that the guidelines would go to the APC for sign off.

BN advised that currently all of the NICE guidelines relating to lipid management are ready for review so this was a difficult document to update and there may be changes needed later in the year as NICE guidance is published. She added that the guidelines had been circulated for comment with comments taken on board where appropriate.

ID felt that this was a very comprehensive document and asked the committee for any comments. ID asked if there was any information on discontinuing statins that could be incorporated as we need to consider the "decommissioning end" of prescribing guidelines as well as initiation of treatment. BN hadn't come across anything, a quick literature search was suggested or the addition of a pragmatic statement around when it would be appropriate to discontinue treatment.

DR suggested that the references to risk calculation tools should be generic as there are a number of tools available now. A review date of two years was suggested, with the caveat that the guideline is reviewed if new evidence becomes available. SW suggested adding a line to recommend contacting the

teratology information service in the pregnancy section. ID thanked BN for a good piece of work.

Action: BN to make suggested amendments then present the final document to the APC

Action: HB to agenda for next APC meeting

6.2 Wound Management Formulary

RB presented the updated wound management formulary, advising that the previous version of the formulary had been developed in 2008 and was due for review. Following audit of wound care and the use of dressings, RB has been working with BN and Lindy Turnbull on this revised formulary utilising the evidence-base where it is available, where evidence is not available, expert opinion has been used.

RB explained that he had managed to secure funding to reprint the tissue viability booklet (2,500 copies) which has more generic guidance covering all aspects of tissue viability, with the intention of producing the formulary as an A5 insert for this booklet. RB expected that the formulary would be adhered to in 80% of wound management cases.

DR felt that the document was very good and easy to understand and wondered if it would be possible for the formulary to be uploaded onto all GP systems to assist with prescribing decisions; it was felt that this would be helpful along with adding the information to ScriptSwitch.

RB advised the committee that he was looking at delivering a number of training sessions to roll-out the new formulary across the County, targeting district nurses initially. ID felt that this was a good piece of work which the committee would be happy to support and asked RB how the guidance would be disseminated particularly with respect to care homes and community hospitals. RB advised that community hospitals would be included in the launch and the booklet and formulary could be shared with care homes quite easily.

ID concluded the discussions by saying that the committee accepts the formulary and would be happy to support the dissemination once the final document is available.

Action: RB to forward final version of wound management formulary to HB for addition to website and ScriptSwitch and addition to publicity in the next medicines management newsletter.

6.3 Osteoporosis Guidelines

CL presented these updated guidelines to the committee. ID advised that these guidelines will go to APC for a final sign off, but could be considered for

comment. CL advised that the main change was the inclusion of denosumab, a new agent for treatment and prevention of osteoporosis which has been recently approved by NICE. Denosumab has been added to the guidelines at the same point as strontium, teriparatide was in the previous version of the secondary prevention guidelines, but has been removed from the main body of the guidelines and referenced elsewhere as initiation is in secondary care. CL added that NICE are currently working on primary prevention guidance which is due out at the end of the year and wondered if the review date of these guidelines should reflect that. DR queried if the first injection of denosumab should be given in secondary care on both pathways and queried the potential additional cost of a secondary care referral. It was felt that this approach would help to police guidance to ensure prescribing is appropriate.

PK queried the statement which says that alendronic acid should be reviewed after 10 years, wondering who would review it. SS advised that at the rheumatology talks she has attended, it was suggested that it is reviewed every five years, it was also suggested that treatment can stop at five years, with DEXA scan after a further 5 years. DR suggested changing the guidance to read “review after 5-10 years”. As the EMA have reviewed the risk of atypical stress fractures after 5 years, it was felt that this was a reasonable suggestion.

It was agreed to make the amendment suggested and change the review date to the end of this year.

Action: CL to make required amendments then present the final document to the APC.

Action: HB to agenda for next APC

6.4 Vitamin D

CL advised that she had been asked to prepare and present a user friendly summary of guidelines produced by CDDFT for the management of vitamin D deficiency. The summary included a flow chart covering investigations in patients at risk of vitamin D deficiency, dietary advice, prescribing information and monitoring of these prescribed vitamin D supplements based on the CDDFT guidelines.

It was felt that this was a very complex area where opinion differs between different consultants/specialties. GC felt that the guidance didn’t identify who to test and was more about, managing those who have been identified as having vitamin D deficiency. SS added that you need to be able to understand the significance of the results.

ID summed up the discussions saying there appears to be a lack of clarity within the CDDFT document that CL summarised and therefore, not sufficient guidance available to ratify this document for use within primary care, GC

added that the guidance needed the “front end” sorted out, with agreement between rheumatologists, biochemists and endocrinologists.

ID said that because the clarity isn’t there we could say we have failed, but sometimes we just have to accept that the task is too big and complicated. ID apologised to CL for this, adding that in this instance the committee set an impossible task and despite CL’s best efforts this is can be taken no further at this point in time.

6.5 HPV Update

HB presented an updated set of graphs looking at HPV prescribing as a follow up to work presented to the committee last year. HB advised that the data demonstrates a significant reduction in prescribing with only two or three practices prescribing Gardasil very occasionally. HB felt that this data highlights a success story for the work of the committee adding that when you look at the graphs; we’ve managed to demonstrate that we can get things to change.

It was agreed that the two or three practices that are still prescribing occasionally should be reviewed within their respective locality prescribing group.

Action: GP prescribing leads to pick up the ad-hoc prescribing within their locality prescribing groups.

6.6 Treatment of Alzheimer’s

JS presented a document that had been drafted by Sue Hunter, Deputy Head of Pharmacy at TEWV following discussions at TEWV D&T with regards to the new NICE guidance for the treatment of Alzheimer’s disease. JS advised that the discussions covered the decommissioning of medicines as well as which guidance to follow. JS added that this document has been circulated to all prescribers within TEWV as a basic summary of what is expected of prescribers to do and to highlight cost differences. It was also felt that it should be highlighted to GP’s if specialists are not using MMSE scores what they are using instead and why.

DR highlighted to the committee that galantamine and rivastigmine would be coming off patent next year, followed by donepezil. ID queried the potential impact on the prescribing budget, and asked if this was something the RDTC could cost for us. SS queried if patients would have theri treatment stopped if their condition is not improving as she hasn’t seen this in practice. ID felt that this may be due to the pressure on secondary care prescribers from patient’s families. JS added that this is a very emotive subject and needs to be handled in a consistent and sensitive manner.

ID added that another element that needed to be considered is the issue of patients lost to secondary care follow up, who would make the decision on when to discontinue medication in these patients, SS added that advice was needed from secondary care on what MMSE score would indicate that discontinuing medication would be appropriate. It was suggested that a review of patients prescribed medication for Alzheimer's disease could form the basis of a medicines management QOF audit.

In summary ID said that the committee would be happy to acknowledge the information and share with primary care prescribers in the next newsletter.

Action: HB to add to this summary to the next newsletter.

6.7 Route to Quit and Request for Nicorette QuickMist

This item was deferred until the next meeting.

STANDING ITEMS

7.0 FINANCIAL/BUDGET UPDATE

7.1 Monthly Finance Report – January 2011

HB summarised the January finance report tabled, advising that the February report is currently being produced as the data has just come out. HB advised that NCSO is significantly affecting the budgets; SW said that February figures demonstrate a similar position to January. ID added that the end of year forecast suggests an over spend of between 3.5 and 4%.

PJ queried what was happening with regards budget setting for 2011/12, HB advised that there was an initial meeting with Finance in February and there are now on-going conversations with commissioners. ID felt that the three year methodology agreed last year probably wouldn't change. Last year the budgets were set 100% historic as a locality pot, with the DH budget setting methodology applied to 75% at practice level with the remaining 25% set on historic spend, this year an 85/15% split was planned.

HB advised that all graphs within the finance report would be reviewed at the end of the financial year; ID added that this was done at a meeting last year and worked well, and therefore, proposed to do it in the same way this year. PJ volunteered to be part of this process again this year.

8.0 QIPP

8.1 QIPP Topics

ID suggested that there needs to be a QIPP Plan for Medicines Management set up, this will be asked for by the organisation and therefore, utilising the information within the document circulated to the committee there is the

opportunity to be proactive about this. ID asked if there were any areas that committee members felt would be useful to include in this plan. AH wondered if there was already enough QIPP information or if this document muddied the water further. SW suggested that venlafaxine MR to standard release was in the North East SHA QIPP plan; ID thought that it may be worth looking at calcium channel blockers, adding that some of these topics may become targets for the QP QOF this year. ID asked that any comments were sent to Ian Morris by the end of May.

Action: IM to develop a QIPP plan and bring back to next D&T meeting in June.

8.2 ScriptSwitch

ID advised that there was some progress on ScriptSwitch and there is a date in the in the diary for further discussions in two weeks time. PJ queried the future of ScriptSwitch. ID said that the idea was to try to get it working properly for the last six months of the contract, but we are rapidly running out of time to make all of the desired changes. This will mean a difficult debate come September when we need to make contractual decisions. ID said surveys have been carried out and the majority of people seem happy with it, however, it was difficult to determine if the system was delivering value for money. It was felt that when the time comes, we will need to broaden the debate and look at what other mechanisms we can use.

8.3 Toothpaste on prescription

ID felt the committee needed to discuss the current email debate around the prescribing of toothpaste on repeat prescription by GPs at the request of a dentist. ID said the debate raised a number of questions including when do you know when to stop prescribing and how many tubes of toothpaste should be allowed on the NHS in a 12 month period? ID suggested that as we don't know the answers to these questions would it be worthwhile a member of the Medicines Management team sitting down with a dental representative to clarify this position, as currently they are creeping into primary care repeat prescribing.

HB asked for a GP prescribing lead to support this process. GC volunteered.

Action: HB to ask Deborah Giles to set up a meeting with the dental representative and GC to discuss this issue and report back to the committee

9.0 MEDICATION SAFETY & NPSA

9.1 Drug Safety Update – March 2011 & April 2011

HB briefly summarised these reports advising the there was very little within them for primary care highlighting the Modafinil safety issues which have already been flagged to secondary care following a previous bulletin and a

article reminding prescribers about the monitoring requirements for patients prescribed antipsychotics, it was agreed that this article should be highlighted in the next newsletter.

Action: HB to ensure antipsychotic monitoring is included in the next newsletter

10.0 APC UPDATE

10.1 Draft Minutes from APC Meeting – 10 March 2011

ID advised the committee that he had been very pleased with how the first APC meeting went; the meeting was quorate although unfortunately there were no finance representatives or the deputy medical director for CDDFT in attendance, it was noted that TEWV fielded a very strong team. Generally, he felt that there was willingness to work together and an agreement to look at a shared formulary looking potentially at linking into the North of Tyne Formulary sub-committee.

SS advised that her only concern was that when the committee was discussing particular therapeutic areas or pathways, it is impossible for the clinicians aligned to the committee always to be representative, e.g. how can we expect a rheumatologist to be a representative when we are discussing antiplatelet guidelines, but wondered how feasible it would be to have the relevant clinical specialities represented. ID felt that if we can manage to make it the APC important enough, we may get more consultants in attendance. HB added that there is a wide range of specialties represented in the membership; the difficulty is that they all require notice to book the meetings and we don't know what is on the agenda in enough time to give them adequate notice. GC said that his biggest worry was the finance side, at CDDFT D&T the finance representatives were asking what we were doing at this committee. ID advised that he has written to the Director of Finance to agree funding limits for APC and is currently awaiting feedback.

11.0 RDTC UPDATE

No Cheaper Stock Obtainable (NCSO)

SW presented a report prepared by the RDTC on the NCSO price changes, advising that the potential savings made on category M may be wiped out by price changes under NCSO or concessionary price increases and at the moment, we don't know how long this will last. DR asked if it was worth sending some information out to prescribers. PK advised that there is a problem related to manipulation of the marketplace system, adding if prescribers all used different drugs, there wouldn't be a problem.

PJ queried if this list was changing rapidly, and wondered if there should be a drugs to avoid section as part of the newsletter. JS added that the list of drugs affected doesn't come out until mid-month which is causing huge problems for

community pharmacists and impacting on the work of the team due to incorrect endorsements of prescriptions. The committee agreed that this was a big problem and decided that a memo should be sent out alerting prescribers to the issues. It was agreed that this memo should highlight that fluoxetine was an option for new initiation in depression and also signpost prescribers to the PSNC website as a source of information on this.

Action: HB to ensure a memo is sent out highlighting these issues to prescribers

Horizon Scanning Document – April 2011

SW advised that there was a new "tramadol-type" drug that had just been launched, tapentadol. Fingolimod, has also just been launched for the management of MS in patients with high disease activity, costing £1400/month; at present, it is unclear whether there will be a patient access scheme for this. NICE guidance on this drug is due to be released in August 2011, in the meantime, it was agreed that a prescribing memo should be developed advising that this should not be prescribed in primary care.

Action: HB to ensure a memo is prepared regarding fingolimod

Work plan/Prescribing Reports

SW added that a drug update on insulin analogues is now available, with a prescribing report due out soon. A report on self management of blood glucose is also due out soon and a report on new drugs in diabetes is being prepared.

12.0 PRESCRIBING UPDATES

12.1 Drug & Therapeutics Bulletin

HB tabled a summary of recent articles for information and discussion. DR felt the report was unclear. HB advised that we didn't want to breach copyright regulations, but wanted to allow people to see an overview of the topics covered so that they could determine whether they wanted to purchase a subscription.

Action: DR to work with Deborah in the future to determine the content of these summaries.

12.2 New Drugs and Products and NETAG recommendations

ID updated the committee on the NETAG meeting on 12th April 2011. Dabigatran was discussed, the group is still awaiting guidance from the cardiac network, it is understood that this work is in progress but yet to be fed back to the group.

Three treatments were also considered by NETAG this month:

- Bevacizumab, for neovascular glaucoma secondary to ischaemic central retinal vein occlusion.
- Verteporfin, to be used with photo-dynamic therapy in the management of chronic central serious chorioretinopathy.
- Tolvaptan, for treatment of the syndrome of inappropriate anti-diuretic hormone secretion (SIADH).

All three products were rejected for use within NHS North East for the specified conditions.

ID advised that NETAG has a new Chair, a primary care Medical Director, Mike Prentice. He added that the Terms of Reference had been revised to take into account GP-led Commissioning.

12.3 NICE Guidance Review – February 2011 & March 2011

JS presented a summary of the reports prepared by Wendy Stephens, it was agreed that there were no guidelines of relevance to primary care within these summaries.

13.0 NON MEDICAL PRESCRIBING

13.1 Non Medical Prescribing Q3 2010/11 Update

JS presented a summary of this report looking at NMP for quarter 3 2010/11, advising that it built on previous reports and utilised a database that had been built to support the reporting process allowing for data to be automatically emailed out and mapped against declared competences. NMP's were advised that if they haven't declared their prescribing competencies yet, their managers will be contacted by the team, and their prescribing may be discussed further within the PCT, this has resulted in a few more NMP's submitting their competencies. JS added that the development of this database has highlighted an issue whereby staff are employed by one practice, then move onto another without informing us of the changes, meaning they remain on the database and may also have some prescribing if repeat prescriptions have been attributed to their nurse prescriber code.

JS advised that there were no surprises within the top 10 items or spend by BNF chapter, adding that controlled drug prescribing was an area that needed to be unpicked further as prescribing of controlled drugs by NMPs is limited to specific therapeutic indications e.g. oxycodone for palliative care, this prescribing needs to be challenged on an individual basis.
JS added that around 75% of prescribing for wound management was outside of the formulary, although this will need to be updated in-line with the new wound management formulary.

JS said that so far the feedback received from NMP's has been positive as they feel the report enables them to reflect on their practice. GD advised that although she is a community NMP rather than a practice NMP she uses the ePACT data in clinical supervision and appraisal.

ID asked how to close the loop; he queried whose responsibility it is to ensure these are returned is it the NMPs responsibility or the practices responsibility, as it stands, 25% of NMP's have not declared their competencies despite being contacted three times for their declarations. It was agreed that it was time to act, and that a letter should be sent from Mike Guy to NMP's and their practice manager and practice prescribing lead. ID added that it was important that practices understand the issues, and that this could potentially affect them as a contract holder. JS also added that many of the NMPs were desperate for some clinical supervision as they were not aware that it should come from their employer rather than the PCT. HB queried if locality prescribing groups could facilitate this.

Action: JS to prepare a letter to NMPs/practices to be sent out from Mike Guy

14.0 PATIENT GROUP DIRECTIONS

14.1 Updated PGDs

HB advised that 7 vaccine PGDs expired at the end of March, all 7 have been updated and circulated to practices before the end of March. HB added that all PGDs are now being uploaded onto the medicines management website for practices to download.

15.0 QOF

15.1 QOF 11/12 Amendments

ID presented a summary of the changes to QOF for 2011/12, he advised that the MM QOF indicators were still in QOF, but there were new QIPP QOF indicators for prescribing and referral management. He added, the QIPP QOF targets are quite complex, dealing with targets for individual practices which have to be agreed with and signed off by the PCT.

ID advised that because of the QIPP QOF prescribing indicators, the prescribing targets within the Medicines Management QOF have had to be removed as many of them fit better with the QIPP QOF indicators. ID added that unfortunately there hasn't been time to change the QOF document for this meeting, due to the timescale, however, it was agreed that audits would have to be added back into this year's scheme, but alternatives such as on-line education could be considered for the future. It was suggested that some of the audit tools used in the past could be reused this year. A meeting has been booked in the May D&T slot for GP prescribing teams and the medicines management team to agree this year's scheme.

ID said that he had attended a North East Head of Medicines Management meeting to discuss the QIPP QOF indicators where it was agreed that a suite of prescribing targets that could be used across the region would be developed, this approach would support the North East PCSA who would be responsible for monitoring them. It was agreed that these targets would also be discussed at the meeting in May. PJ suggested looking at pregabalin prescribing, HB advised that at present due to NCSO affecting gabapentin prices, it may not be a good time to look at this, although because of the flat pricing structure, a review of patients on tds dosing maybe worthwhile.

16.0 MEDICINES MANAGEMENT TEAM UPDATE & PUBLICATIONS

16.1 Prescribing Support Update

HB advised that IM was currently in discussions with GPLC regarding prescribing support; she added that SLA's have gone out to providers for 12 months, although some may have liked a longer contract, currently 12 months is all that is on offer, some providers are unhappy with this. ID added that there is still some slippage in the medicines management staffing budget which could be reviewed following receipt of consortia responses to the strategy scope.

16.2 Strategy Scope Update

ID advised that the strategy document that was produced mid December had been circulated to all consortia for discussion, unfortunately, not all consortia have responded yet. He added that once all consortia have responded, all responses will be amalgamated into a single document for review and discussion with Dinah Roy in order to develop a strategy for the next two years. Once this is agreed, the medicines management staffing budget could be reviewed. This process had been agreed by the IFB.

17.0 PBC PRESCRIBING LOCALITY UPDATES

17.1 Darlington Prescribing Locality Group

A summary of the meeting held 1st March 2011 was circulated for information.

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17.2 Derwentside Prescribing Locality Group

A summary of the meeting held 5th April 2011 was circulated for information.

18.0 PROVIDER DRUG & THERAPEUTIC COMMITTEES

18.1 Update from Sunderland CHFT D&T

A summary of the meeting held 1st March 2011 was circulated for information.

18.2 Update from North Tees and Hartlepool FT D&T

A summary of the meeting held 11th March 2011 was circulated for information.

18.3 Update from County Durham and Darlington FT D&T

A summary of the meeting held 6th April 2011 was circulated for information

18.4 Update from Tees Esk and Wear Valley Mental Health Trust D&T

JS presented a summary of the TEWV D&T on 24th March. She advised that a switch from modified release venlafaxine to standard release venlafaxine had been proposed as a QIPP initiative regionally. JS added that this proposal had been prepared by the Tees PCT's who had not done any work on venlafaxine modified release preparations whereas in County Durham and Darlington patients have been switched from modified release capsules to tablets. There are some concerns around this proposed switch and TEWV have asked to be notified at least a month in advance of any switches to the medication of patients currently seen by them.

19.0 ANY OTHER BUSINESS

There were no further matters for discussion.

19.0 DATE AND TIME OF NEXT MEETING:

Tuesday 21st June 2011
Board Room
Merrington House
12.00 – 2.30 pm

Confirmed as an accurate record:

Name:

Dr. Ian Davidson – Chair
22nd June 2011