NHS
County Durham and Darlington

COUNTY DURHAM PCT & DARLINGTON PCT
Drugs and Therapeutics Committee

Minutes of Meeting held
Tuesday 16th August 2011
Boardroom, John Snow 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
Deborah Giles, Pharmaceutical Adviser
Dr Peter Jones, GP Lead (Sedgefield)
Patricia King, LPC Community Pharmacist representative
Ian Morris, Head of Medicines Management
Dr David Napier, GP Prescribing Lead (Easington)
Anne Phillips, Nurse Practitioner
Ros Prior, TEWV
Stephen Purdy, Pharmaceutical Adviser
Dr David Russell, GP Prescribing Lead (Darlington)
Satinder Sanghera, GP Prescribing Lead (Dales)
Sue White, RDTC
Christopher Williams, Deputy Chief Pharmacist, CDDFT

In attendance:

For item 6.1 – Vicki Vardy, Senior Prescribing Support Technician
For item 6.3 –Ken Ross, Immunisation and Vaccine Co-ordinator
For item 6.6 – Dianne Woodall and Jo Dickinson, Public Health Team
For AOB – Linda Neely, Head of Clinical Quality and Patient Safety

1.0 APOLOGIES

Philip Dean, Chief Pharmacist, North Tees and Hartlepool Foundation Trust
Gail Dryden, Community Matron
Graeme Kirkpatrick, Chief Pharmacist, CDDFT
Chris Mallon, Pharmacist, North Tees and Hartlepool Foundation Trust
Joan Sutherland, Senior Pharmaceutical Adviser

2.0 DECLARATION OF INTERESTS

No interests were declared.

3.0 MINUTES OF LAST MEETING HELD 21ST JUNE 2011

The minutes were accepted as a true and accurate record with the following amendments:

PK requested that the third paragraph on item 4.1 be amended to read:

"PK advised that LPC members don't think they can support it. ID queried if it would be a useful reminder to pharmacies of their responsibilities. PK stated that the consensus was that there is not a lot else we can do on specials. ID wondered why the LPC view differed between Durham and SOTW."

PK requested that the sixth paragraph of the same item be amended to read:

"DR stated that in this case, hopefully for "prn" medication in the future pharmacies would check with the patient/carer if the item is needed prior to ordering via a managed repeat prescription service. It was agreed that a copy of this letter would be shared with the committee at the next meeting."

4.0 MATTERS ARISING

4.1 Final LPC Letter to Pharmacies regarding Repeat Prescribing

ID advised the committee that the letters had been circulated for information, and that he had written to the LPC to thank them for this important piece of work.

5.0 ACTIONS TAKEN BY MEDICINES MANAGEMENT TEAM FROM 21ST JUNE

Please refer to amended action log.

The updated actions were accepted and noted by the Committee.

6.0 AGENDA

6.1 Safe and Secure Handling of Medicines

VV presented this report to the committee advising that it provided assurance of compliance with CQC standards on the safe and secure handling of medicines and safe disposal of medicines waste; she asked that the committee accept the report for information and make any further recommendations.

ID advised that he felt that the problem was that the report showed that there are a number of contractors that have not given assurance that they comply with the CQC standards, and therefore, rather than providing assurance to the committee that the standards were being met in County Durham and Darlington, the report highlighted a number of contractors that required further follow up. He added that the committee were unable to accept the report as it is as it doesn't provide the assurances necessary, therefore, this should be flagged with the NEPCSA and the

team should push for assurance from these contractors either by further follow up phone calls or individual contractor visits. He suggested that the report should come back to the committee in October with assurances from these outstanding contractors.

IM added that the numbers of contractors with outstanding declarations wasn't huge and also that dental practices aren't always engaged in the process. He suggested checking with the NEPCSA if assurances were still required from dental practices as they are now CQC registered.

SS queried where this would sit in the future, we don't know yet if it would sit with the commissioning board or if it would be a responsibility devolved to clinical commissioning groups. IM added that the safe and secure medicines reporting is part of a much wider governance report, with systems and processes open to external scrutiny, this was proposed as a shared function within the Medicines Management strategy document.

Action: VV to follow up outstanding contractor declarations by telephone or individual visits and check with NEPCSA if they require assurance for dental contractors and return the report to the October D&T meeting.

Action: HB to agenda for October D&T meeting.

6.2 Controlled Drugs Report

SP presented this report advising that it was following up a historic action from June last year when a report on controlled drug prescribing had been presented to the committee on the basis of graphs provided by the RDTC. SP highlighted that unfortunately, in the initial report, Darlington had appeared to be an outlier, which had prompted the production of local data, however, it appears that there were problems with the data from the PPA which the RDTC report was based on and Darlington are actually not outliers. He also highlighted the work done by Dr Lambert in Derwentside to reduce pethidine prescribing.

SP asked if the committee would like any of these graphs added to the quarterly controlled drug reporting, it was agreed that pethidine prescribing should be added to this report.

It was agreed that the graphs within this report would be shared with locality prescribing groups for further discussion.

Action: SP to add pethidine graphs to quarterly scheduled controlled drug reports.

Action: GP prescribing leads to discuss prescribing within their locality at their next locality prescribing group.

6.3 Flu Vaccine Ordering

KR presented this item, advising that the paper was part of a national Department of Health (DH) consultation on the way seasonal flu vaccines are procured. He advised that this consultation had been developed following a number of supply issues historically including those experienced last winter. He added that currently flu vaccines are procured in a private arrangement between GP practices and vaccine manufacturers; the DH believes that there are efficiencies that can be made on this process including significant financial savings from a centralised procurement process. The DH proposes to commission supplies from a number of manufacturers allowing for some control at practice level.

KR highlighted the four key questions from the consultation adding that the closing date for responses was 17th August. ID enquired about the outcome of the local consultation exercise. KR advised that there was a general agreement that it could work quite well with the potential to reduce waste and allow practices to order the vaccine in a more managed way similar to childhood immunisations, concerns were raised about the potential for incentivising flu vaccination in the future as it is acknowledged that there is currently a financial advantage associated with seasonal flu campaigns. He added that feedback was generally positive, although there was a general feeling that “if it isn’t broken why fix it”.

ID declared interest in this item as a GP contract holder on behalf of all GP’s in the room and opened this item for discussion. Discussions were around the financial incentive currently available to practices from the profit made on the purchase of flu vaccines and how in many cases this was utilised to fund nursing staff, it was felt for the DH initiative to be successful there would need to be a similar incentive to that currently. Concerns were raised about how the proposal would secure a more robust supply if the supply was coming from the same manufacturers as currently and also around the fact that the current system works.

KR agreed to feedback the committee’s comments as part of the consultation response and forward a copy of the final response to committee members.

Action: KR to feedback comments and forward a copy of the PCT’s consultation response to committee members.

6.4 Medicines Management Communication Strategy

DG presented this paper on a communication strategy for the medicines management team. DG advised that the team were looking to streamline communication mechanisms, with the new ‘www’ website due to launch in September at the centre of these plans. DG added that this new website would be accessible in community pharmacies and from home and would include a search facility and a password protected area which would allow D&T and APC committee members to download papers directly from the site rather than have them fill their inbox.

DG advised that the weekly medicines management email bulletin had been well received and had hopefully reduced the number of emails received by practices.

She added that the Prescribing Matters newsletter would continue to be issued monthly and prescribing guidelines would be sent out as links to the web site rather than as large documents.

With respect to monthly practice ePACT reports, DG advised that currently these are sent out monthly which is a time consuming process as they have to be sent to individual practices, therefore, the team have developed a guide for practices to download these reports from the ePFIP system, feedback from practices that have tried this so far has been positive.

DG also updated the committee on the new PCT IT dashboard "COLIN" this would enable prescribing data to be accessed at a locality or practice level with practices able to build their own graphs and reports. IM added that this was currently in development, but needed some dedicated programmer time to set it up.

CW asked if there would be a "download all" option for D&T and APC papers, DG to investigate if this would be possible. He also asked that the FT are added to the weekly email bulletin.

DR queried if there would be a contacts area, DG advised that this would be in the form of an e-form which would be emailed directly into the medicines email account.

PK asked if she could take this information to LPC, this was agreed, DG advised that currently the team don't have electronic contact details for all pharmacies in County Durham and Darlington and wondered if this was something the LPC could assist with.

ID thanked DG for this useful piece of work.

Action: DG to find out if a "download all" option is available on the new website and to add the FT to the circulation list for the weekly bulletin.

6.5 Specials Report

DG presented this report to the committee advising that the graphs highlighted the spread in the cost of specials across the county focussing on the top 10 specials in terms of cost and items.

PJ queried if specials were the same cost each time from the same pharmacy, HB advised that unfortunately prices can vary each time a special is dispensed.

ID added that this paper had been prepared following discussions at the previous meeting and although there is some work being done nationally, the disparities in cost are quite wide and therefore it would be useful to get some feedback from the LPC at the next meeting.

CW asked if the information on the higher cost specials could be sent to the pharmacy concerned and the cost highlighted to them as being an outlier, IM

agreed that this could be done, looking at those pharmacies who were significant outliers when compared on a price per 5ml.

DR wondered if GP commissioners could have access to information on which pharmacies were incurring such large costs, it was agreed that if the initial approach to the pharmacies is unsuccessful and national guidance is not forthcoming in a timely manner, this may be an option. PK added that this information was commercially sensitive and should be managed carefully.

HB advised that the team had received a number of FOI requests recently regarding specials prescribing, particularly around Darlington's low prescribing position.

IM added that the approach to specials needed to be a two pronged approach looking at pharmacies sourcing products more cheaply and GP's not prescribing specials for patients who don't need them. ID said that the specials issue was raised on behalf of the NHS community, adding that it would be nice if the LPC could acknowledge this difficult issue and give their members advice on this.

Discussions around promoting the use of alternatives to specials and potentially incentivising pharmacies not to issue specials concluded with agreement to await national guidance which is expected to be coming out soon.

Action: PK to discuss with LPC and feedback to next D&T meeting.

Action: IM to write to individual pharmacies who are outliers with respect to the cost of specials.

6.6 Nicorette Quick Mist and NRT Product Selection

ID introduced this item advising that it followed on from discussions at the last D&T meeting and a meeting he had with DW where it was agreed that NRT products should be defined as standard or premium and a guideline around when each type should be used should be produced. He added that the document produced was a helpful document for clarifying the process of selecting drugs, however, in County Durham and Darlington, the APC was working with the North of Tyne new drug evaluation process, and their committee had recently rejected quick mist.

DW explained to the committee that she had looked at the process a stop smoking adviser goes through when determining a route to quit; highlighting that if a client has no pre-conceived ideas of which product they want to use, they would be steered towards a standard tariff product. Adding that the inhalator, quick mist spray and nasal spray are all premium price products and advisers would be advised to use standard products rather than the premium products. JD added that the stop smoking service was a successful service and that they wanted to continue this success by having the full range of products available to them.

There were discussions around the reasons for rejection at North of Tyne and the lack of evidence associated with the quick mist product, noting that other drugs have been rejected by the committee in the past due to a similar lack of evidence.

The discussion concluded that although the piece of work on premium and standard products was good, at the present time, the committee could not accept quick mist spray onto the formulary in line with the decision made North of Tyne. ID added that this was a temporary decision and if convincing evidence becomes available in the coming months, the committee would happily re-consider this product.

STANDING ITEMS

7.0 FINANCIAL/BUDGET UPDATE

7.1 Finance Report – year to date inc. update on 11/12 Prescribing Budget

IM presented this update on the year to date spend, advising that currently practice level budgets have not been set, so current spend had been mapped against the same time period last year and demonstrated a growth in prescribing spend year on year.

Regarding budget setting, IM advised that all consortia had received an uplift of 2%; the methodology for determining individual consortia allocations had been reviewed and the CCG chairs had agreed that rather than set the budget based on the historic amounts allocated to localities, the budget should be set as a federation and then split down to consortia. It was agreed that to move to 100% fair shares in this model would mean that some areas would suffer significant reductions and others significant increases, so a 35% fair shares/65% historic model was used to set the locality budgets. These locality allocations have been shared with CCG chairs for them to determine how the allocation is split at practice level within each individual consortium, as yet this hasn't been agreed.

It was agreed that ID should have a conversation with Dinah Roy as lead chair for prescribing, to discuss this process as it was felt it would be in the best interests of all consortia to have a single budget setting methodology across the federation.

Action: ID to discuss further with Dinah Roy

8.0 QIPP

8.1 Annual Medicines Management QIPP Plan

IM presented this document advising that it is not a list of savings, but a report to highlight areas where prescribing of identified drugs is occurring within each locality in order for work plans to be drawn up in each locality to tackle specific areas utilising their practice support medicines management team.

It was felt that rather than have a PCT QIPP plan for medicines management, each consortium should develop their own, which could then be amalgamated into a federation wide document.

DR suggested adding to this document the potential savings that could be realised if blood glucose testing strips were reviewed and if decapeptyl was considered within the localities.
CW added from an FT perspective, they wanted to use this document to direct a piece of joint working on a strategy for the trust to support the switches being made in primary care e.g. ferrous sulphate to fumarate, this could save a potentially large sum of money in primary care, but cost more to purchase within secondary care, however, if the potential savings were greater than the potential costs then the trust would be prepared to work with the PCT to facilitate such changes.

Further discussions concluded that although it is each individual localities responsibility to prepare their own QIPP plan, a list of five or six standard potential switches/savings should be drawn to up to facilitate working with the FT.

Action: IM/ID to agree five or six standard QIPP areas to forward onto the FT

Action: GP prescribing leads to discuss this document within their localities and feedback plans in September for discussion at Octobers D&T meeting.

8.2 ScriptSwitch Update

DG advised that there had been discussions with ScriptSwitch around the contract renewal, as IFB advised that the contract should be renewed but with a more meaningful contract.

ScriptSwitch haven't agreed to reduce the contract value, and instead have offered additional services that were thought to be part of the original contract, this work is still ongoing and an update paper will be presented at the October D&T meeting.

CW queried if ScriptSwitch could be extended to work on Systm One in walk-in centres etc, which had been discussed some time ago, this was agreed as a good idea in principle to follow up at a later date outside of the meeting.

9.0 MEDICATION SAFETY & NPSA

9.1 Drug Safety Update – (MHRA) – July & August 2011

HB advised the committee that there was little of relevance to primary care in these two bulletins, the information on pioglitazone and risk of bladder cancer had already been disseminated to prescribers.

10.0 APC UPDATE

10.1 Draft Minutes from APC Meeting 7th July 2011

ID gave a brief update on the APC advising that he thought it was encouraging that the FT were looking to move towards electronic prescribing which was fairly imminent for outpatients with agreement to move all prescribing to electronic prescribing in due course.

ID updated the group on the formulary advising that rather than adopt the North of Tyne formulary which referenced many of their local guidelines, it had been agreed that the committee would use the North of Tyne formulary sub-committee as a new drugs evaluation group for new additions to the formulary. It was agreed that the APC would look towards developing its own formulary by January 2012 and a formulary development group was being established to support this.

DN flagged that Easington practices don't really access secondary care services in Durham tending to use City Hospitals Sunderland and North Tees and Hartlepool instead, this was acknowledged by the committee and it was agreed that the formulary would be established initially with Durham hospitals with the intention of extending it to cover all localities over time.

11.1 RDTC UPDATE

11.1 Horizon scanning document & NICE guidance update July & August 2011

SW presented these documents, highlighting that once weekly exenatide is now available and costs around 10% more than the current preparation, the RDTC will be issuing a new drug evaluation on this product in the coming months; the RDTC will be doing a new drug evaluation on fampridine and on new drugs for the management of hepatitis C as there are two new drugs that are potentially curative for this condition, boseprevir which is already launched and telaprevir which is due out soon. Concerns were raised about the potential financial impact of these drugs, it was felt that the RDTC evaluation would cover this.

SW added that the information on NICE guidance had been updated as requested from the August 2011 report and a link had been added to the NICE forward planner.

SW advised that the number of products currently labelled as NCSO had reduced and sertraline, citalopram and prednisolone tablets were no longer in this category.

11.2 RDTC Annual QIPP Report – 2010/11

SW advised that this was a report that had been prepared on a quarterly basis to support the Heads of Medicines Management in reporting achievement of QIPP plans to the SHA. IM commented on the reduction in spend on specials in County Durham and Darlington and the reduction in spend on glucosamine. Concerns were raised around the increase in spend on enteral nutrition considering the contract in place for supplying these products in all localities except Easington.

12.0 PRESCRIBING UPDATES

12.1 Drug and Therapeutics Bulletin July & August 2011

HB advised that unfortunately, due to copyright legislation, the summaries of the DTB produced and circulated were now based on the NELM summaries, if prescribers wanted more detail, they would need to take out an individual

subscription to the DTB, HB added that currently the DTB were offering three months free subscription.

The summaries were accepted for information and onward circulation.

12.2 New Drugs & Products and NETAG recommendations

A summary of decisions made at the previous NETAG meeting was circulated to committee members and included:

- Guidance on dabigatran which ID highlighted contained the phrase "logistical barriers to INR monitoring" as an inclusion criteria, without clear definition of what these barriers may be.

- Novel fentanyl products - rejected

- Bevacizumab was accepted for patients with AMD, although it was recognised that the product isn't licensed for this indication, there is evidence for its use and the significant differences in costs between this product and other available products could not be overlooked and therefore, this was made available for North East commissioners. SW advised that the RDTC were preparing a "Hot Topic" document on this issue.

ID attended the latest NETAG meeting today and summarised the decisions as follows:

- Tolvaptan (appeal) – for hyponatraemia associated with SIADH, previously rejected, the appeal has been deferred, there may be potential to approve for a very limited number of patients, the evidence base for this indication is low.
- Collagenase for Dupuytrens contracture – rejected due to incomplete data.
- Paliperidone for schizophrenia– rejected due to incomplete data
- Pegvisomant for acromegaly – rejected.

13.0 NON MEDICAL PRESCRIBING

No update this month.

14.0 PATIENT GROUP DIRECTIONS

14.1 Assura MSK PGDs

HB advised that these had been submitted for approval by a private provider, she added that she had comments to make about some minor amendments required which she would feedback to IM who has been dealing with this piece of work. The committee agreed in principle that they were happy to support the use of PGDs for the drugs requested by this company.

Action: IM to feedback comments to Assura and formally sign off PGDs as commissioner of the service.

15.0 QOF

HB advised that all localities had either organised or in Easington's case already had their QP QOF peer review sessions; these were on track for the September 30th deadline.

Regarding MM QOF, HB advised that the majority of practices have signed up for their three indicators, but there were a number outstanding, mainly in DCLS, IM agreed to follow this up.

Action: IM to follow up and complete DCLS MM QOF visits

16.0 MEDICINES MANAGEMENT TEAM UPDATE & PUBLICATIONS

16.1 Strategy Update

ID advised that the strategy update document had previously been circulated to all GP prescribing leads and was based on the information that came back from all localities. He added that the document was discussed at IFB, but so far the only action from the discussions was around the unspent practice support vacancy money, however, there was agreement to set up a strategy development group which is due to have its first meeting in the next ten days.

It was felt that there needed to be agreement on what functions should be done centrally as the localities will not have the resource to do all of the areas of work, but the reduced capacity of the central team needed to be considered. It was suggested that consortia may employ their own pharmacists and possibly mange them within the locality, but it was recognised that some functions such as formulary development and negotiation with the FT should be done centrally.

GC said that the DCLS perspective as a consortia was to let things carry on as they are, but to take a pragmatic approach to the funding utilising it for a contract this year, but looking to support the medicines management team in the future as the team are unable to provide any additional support to his locality at present, although it was recognised that the localities may be forced to pick things up if there is no capacity within the central team.

ID highlighted that one of the issues was that the main role that Sharron Kebell had within the team was to manage the practice support team; unfortunately after Sharron left, the team were unable to protect the funding to recruit to this role and there is no resource within the central team to continue with this role. GC suggested that consortia could have agreed to put some funding aside to support this role, but unfortunately in DCLS it was felt that the money should be spent now so it wasn't wasted.

ID felt that it was disappointing that the strategy scoping document had been around since December with the aim of agreeing what was needed before

spending the funding, however, the funding was made available in June and is already being spent before the strategy work is finalised. IM added that there has been no investment in the central team to support the production of additional reports required by the consortia or the management of additional SLA's. ID asked GP prescribing leads to support the central medicines management functions within their respective localities.

17.0 CCG PRESCRIBING LOCALITY UPDATES

17.1 Darlington Prescribing Locality Group

A summary of the meeting held 19th July was circulated for information.

17.2 Derwentside Prescribing Locality Group

No meeting since previous D&T.

17.3 Sedgefield Prescribing Locality Group

A summary of the meeting held 29th June was circulated for information.

17.4 DCLS Prescribing Locality Group

A summary of the meeting held 12th July was circulated for information.

18.0 PROVIDER DRUG & THERAPEUTICS COMMITTEE

18.1 Update from Sunderland CHFT D&T

A summary of the meeting held 7th July was circulated for information.

18.2 Update from North Tees and Hartlepool FT D&T

A summary of the meeting held 8th July was circulated for information.

18.3 Update from County Durham and Darlington FT D&T

A summary of the meeting held 3rd August was circulated for information.

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

RP gave the committee an update from the meeting held 28th July advising that work is ongoing updating lithium registers, there is further work underway with the APC looking at the NICE dementia guidelines in particular the issue of decommissioning and work on a substance misuse guideline which will be brought to the D&T when it is ready for primary care discussion. RP added that an increase in prescribing of pregabalin for generalised anxiety disorder had been flagged and

a re-audit of antipsychotic prescribing in dementia was being carried out as the sample size of the previous audit had been small.

19.0 ANY OTHER BUSINESS

LN presented the NPSA insulin passport to the committee advising that these had been purchased region-wide and were being distributed to GP practices on the basis of the numbers of diabetic patients on insulin. She added that although there was a clear action plan for the distribution of these booklets, they have already been sent out and as yet the PCT team hasn't received a copy. LN advised that the purpose of the passport was to record the type of insulin and device used and the booklets were not intended as a daily record of the dose. She added that her team would be seeking assurances from GP practices that they have responded to this NPSA alert, and that an audit of use of these passports had been added to the annual audit plan and could form the annual community pharmacy mandatory audit for next year.

Discussions around the purpose of the passport and responsibilities for completing/checking the information within the passport concluded that it was the patients responsibility to keep the passport up-to-date and that health care professionals should be aware that this is the case when looking at the information documented within the passport.

18.0 DATE AND TIME OF NEXT MEETING

Tuesday 18th October 2011
12.00 – 2.30 pm
Board Room, Merrington House

Confirmed as an accurate record:

Dr Ian Davidson - Chair