NHS
County Durham and Darlington

COUNTY DURHAM PCT & DARLINGTON PCT
Drugs and Therapeutics Committee

Minutes of Meeting held
15th February 2011
Boardroom, Merrington House
12.00 - 2.30 pm

Present:

Hazel Betteney, Senior Pharmaceutical Adviser
Serena Bowens – Administrative Co-ordinator (note taker)
Mark Burdon, LPC Representative
Dr Geoff Crackett, GP Prescribing Lead (DCLS)
Dr Ian Davidson, GP Prescribing Lead (Derwentside) - Chair
Jacqueline Fletcher, Medicines Management Adviser, CHS
Dr David Napier, GP Prescribing Lead (Easington)
Linda Neely, Head of Patient Safety
Ros Prior, TEWV
Stephen Purdy, Pharmaceutical Adviser
Dr David Russell, GP Prescribing Lead (Darlington)
Sue Shine, Nurse Practitioner
Joan Sutherland, Senior Pharmaceutical Adviser
Sue White, RDTC

1.0 APOLOGIES

Gail Dryden, Community Matron
Dr Peter Jones, GP Prescribing Lead (Sedgefield)
Patricia King, LPC Representative
Ian Morris, Head of Medicines Management
Dr Satinder Sanghera, GP Prescribing Lead (Dales)
Christopher Williams, Head of Medicines Management, NHS Provider

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, with the following amendments:

Page 2 – second last paragraph reads `*could this have the potential to increase prescribing costs'* which indicates a question, to be reworded to read as a statement `*this could have the potential of increasing prescribing costs'.*

Item 6.1 – additional action, '*SB to disseminate the dates and venues for the August and December meetings to the Committee'.*

4.0 MATTERS ARISING

4.1 Antiplatelet Guideline

SP advised the committee that following a review of NICE guidance on anti-platelets, our local guidance needed to be revised. Clopidogrel has been moved up the agenda especially for ischaemic stroke with dipyridamole and aspirin now only recommended when clopidogrel is not tolerated. The guidance also recommends clopidogrel as an option for PVD.

SP advised that the proposed changes have been discussed with secondary care. CDDFT have discussed internally and are recommending clopidogrel for TIA and ischaemic stroke, although clopidogrel is not licensed for TIA.

The committee discussed the options on how to proceed with this guidance as locally it was felt that secondary care were moving away from NICE already. Questions were raised about what to do with patients who had already had a stroke, currently prescribed aspirin and why the aspirin dose following bypass surgery is 150mg. It was also felt that the choice of PPI with aspirin should be clarified. It was agreed that SP should amend the sections on ischaemic stroke and secondary prevention and chase up further feed back from secondary care. The updated guidance could then be discussed at the APC. SW also advised that NICE guidance due out on ticagrelor in July 2011.

Action: SP to update the PCT guidance and follow up secondary care feedback.

Action: HB to agenda for March APC.

4.2 Antipsychotic Audit

JS updated the committee on the progress of this piece of work which is being undertaken by the PCT Medicines Management Technicians across the County, initially in Dales and Derwentside with the intention of being completed across the whole County by the end of this financial year. JS advised that the audit tool had been shared regionally with Janette Stephenson and is to be shared with the Department of Health.

4.3 Methylphenidate Shared Care

JS advised the committee that this was the final version of the shared care document for methylphenidate for adults with ADHD that she had worked through with Dr Edwin. This document was presented for information and for the committee to agree these shared care arrangements, all patients would be kept under the care of a consultant. This document was agreed by the committee

Action: JS to arrange dissemination.

4.4 Specials

IM had sent a paper for discussion on this matter as he was unable to attend the meeting. The committee agreed that the paper was a good starting point but was locality specific for DCLS. The committee queried whether a link could be put onto the medicines management website to the UKMI resources on specials which had been used to review prescribing in this locality.

It was agreed that a definitive countywide paper on specials should return to the D&T committee in April 2011.

Action: IM to return a definitive paper to April 2011 D&T.

5.0 ACTIONS TAKEN BY MEDICINES MANAGEMENT TEAM FROM LAST MEETING HELD 18TH JANUARY 2011

Please refer to updated action log.

The updated actions were accepted and noted by the Committee.

6.0 AGENDA

6.1 Prior Approvals

SP presented this paper, he advised that he had been asked to review the medicines management aspect of the prior approvals scheme looking at tariff excluded drugs.

SP advised that review of the document was difficult as following PCT reorganisations, it was unclear when this document was written and by whom, where the information included came from and where it was signed off.

SP advised that he had reviewed NICE guidance related recommendations, but some of the other recommendations would require further review. It was felt that D&T was a suitable forum for sign

off; the contracting team require sign off as soon as possible in order to get through contract negotiations.

SP feels that the entire document is not ready to be signed off, but there are some areas which could be shared with the acute trust as a draft and then signed off such as those reflecting NICE or BNF guidance.

It was felt that this is a significant piece of work, the committee were asked to comment on any items that they felt should not be included within the prior approvals list. It was felt that IV antibiotics didn't need to be covered by this document, sodium oxybate has been reviewed by NETAG and the document needs to reflect this and NICE have recently issued a statement on strontium, so this may not need to remain within the document. Additional items for consideration included certolizumab.

It was agreed that the committee was not currently in the position to ratify this document, but it was felt the review process was a valuable one, as in previous years the recommendations had just been rolled on. It was agreed that the document should be finalised and then taken to the APC for sign off.

Action: SP to update the document following discussions at D&T ready for discussion at APC

Action: HB to agenda for APC

6.2 RDTC QOF Data and report

SW advised the committee that this data was presented as a hypothesis generator only and local knowledge needed to be taken into consideration.

SW advised that there were four main areas where CD&D differed from the North East as a whole and these were the areas she had focused on. It was highlighted that there may appear to be differences in QOF achievement, but this may be due to differences in QOF verification and exception reporting. The four focus areas were hypertension, lipid lowering, COPD/asthma and diabetes.

It was felt that these were really useful graphs, particularly at locality level where reasons for practice variations could be discussed. It was felt that these graphs should be repeated but that the mental health indicators were not that useful. It was also felt that an indication of disease prevalence alongside these charts would be useful as this could explain some of the variability, alternatively proxy markers could be used e.g. for COPD, tiotropium prescribing.

It was felt that refinements to the graphs needed to be discussed, but that the graphs would be useful to take out to clusters and individual practices. It was suggested that the graphs could form part of discussions at GP appraisals as it was important to discuss variations. It was agreed that it would be useful to look at outcomes and hospital admissions and to see if sharing this data affects behaviour and changes outcomes.

Action: Committee members to feedback to SW any suggestions for amendments to the data presented.

Action: GP Prescribing Leads/MMT to take practice level data to clusters and practices

6.3 UTI Prophylaxis CDDFT Guidelines

HB presented these guidelines to the committee; they had been prepared by Caroline Bradley antibiotic pharmacist at CDDFT. GC had requested that Caroline make a few amendments to make them more GP friendly. The committee felt that this was a helpful document, and accepted the guidelines with one amendment, an algorithm needed to be added to clarify the section on how to deal with patients already on prophylactic antibiotics.

Action: HB to arrange this amendment and dissemination once amended.

6.4 Repeat Prescribing

ID advised the group that an issue around pharmacies ordering repeat prescriptions on behalf of patients had been raised at Derwentside Locality Prescribing Group. It was suggested that this is happening quite widely and may have been a response to repeat dispensing not taking off as it could have done.

MB advised that this issue has been raised nationally with some hotspots in the North East and tends to become problematic for prescriptions for “as required” medication. It has been raised with the DH as a source of waste and nationally, terms of service are to be reviewed to incorporate this e.g. “to ask the patient what they need.” Once this is in the terms of service, issues can be challenged.

Issues were raised about the same problem with repeat dispensing and it was felt that currently it was difficult to raise such issues although pharmacies have to have an SOP for this, the quality is not reviewed at contract visits, there are, however, national template SOPs available.

MB advised that he would raise the issues discussed with the LPC and feedback the outcome to the D&T.

Action: MB to discuss with LPC and feedback to D&T

6.5 Palliative Care Drugs in Community Pharmacy

JF presented this paper; she advised that CHS colleagues have raised the issue of accessing palliative care medicines in pharmacies. Prior to reorganisation most of the former PCTs had a scheme in place with the PCT meeting the costs for date expired stock. Since reorganisation, the process has become less clear with the LPC being unsure of what was happening, although the Commissioning Medicines Management Team had paid some invoices from pharmacies who had participated in historic schemes.

JF proposed that a countywide scheme should be established with the LPC involved at an early stage, asking pharmacies to opt in and then be reimbursed if stock expires. Initially it was suggested that expressions of interest could be requested from pharmacies, it was felt that two to three pharmacies per locality in different geographical locations particularly those with longer opening hours would be most appropriate. The information on which pharmacies were part of the scheme could be circulated to community teams.

The committee felt that this was a useful piece of work and would support its implementation. It was suggested that it was discussed with Ian Morris in order to determine a way forward.

SW advised that NHS North of Tyne had done a similar piece of work and may be able to give some idea of the costs involved.

Action: JF to discuss a way forward with Ian Morris

6.6 Antibiotic Prescribing and Community Acquired C. Difficile infection

LN presented this report to the committee. She advised that the numbers were too small to show statistical or clinical significance. Audit returns demonstrated that 100% of GPs reported compliance with the PCT antibiotic guidelines, however, 50% of prescribing was found not to be in line with these guidelines. Unfortunately, the data captured did not include sensitivities which may explain some of the prescribing decisions.

One of the key issues highlighted was that often the doses of amoxicillin and flucloxacillin prescribed are too low, it was agreed that the next newsletter should highlight the appropriate flucloxacillin dose for cellulitis. A further issue raised was the high rates of antibiotic prescribing by NMPs; however, it was felt that it was important to note that there are significant numbers of active NMPs in CD&D and it was suggested that it may be worth determining the % of NMPs, SW suggested that the RDTC could support LN with this.

LN recommended that in future when collecting information from GPs with regard to antibiotic prescribing and community acquired C.Difficile infection, the letters sent should have a copy of the abridged version of the PCT antibiotic guidelines attached.

SS wondered whether supply of antibiotics on PGD or from urgent care centres could be incorporated into this report. ID would have liked to see something regarding cephalosporins and co-amoxiclav to see if there were any relationships to C.Difficile rates.

It was agreed that a six monthly update should come to D&T.

Action: HB to ensure that appropriate flucloxacillin dosing is covered in the next newsletter.

STANDING ITEMS

7.0 FINANCIAL UPDATE

7.1 Monthly Finance Report – November 2010

HB presented the finance report for November 2010, she advised that December data had just come out and was currently being analysed. Category M changes had reduced overspend in November, with some clusters coming in under spent for the month. SW advised that December data was significantly over spent perhaps due to the bank holidays and extra prescriptions being issued for the holiday period. She advised that the PPA were due to issue a statement regarding this and it was hoped that it would pull in the following month.

HB advised the committee that the team were currently revising the reports issued and would welcome any feedback from committee members around the content of these reports.

8.0 QIPP

8.1 ScriptSwitch Update

ID gave an update on the meeting held with GP Prescribing Leads and the Medicines Management team to discuss ScriptSwitch on 1st February. At this meeting it was noted that we are in the last 12 months of the contracted period and realistically have around 6 months to try to get the system working effectively. At the time of the meeting it was thought that the easiest way to do this would be to adopt the ScriptSwitch basic profile, however, following this meeting DR and DG met and discussed the basic profile and the differences from the

bespoke County Durham profile and felt that further discussions were needed.

It was agreed that a small working group of ID, DR, IM and DG needed to meet with some urgency to review the profiles and determine an appropriate way forward.

Action: SB to arrange a meeting between ID, DR, IM and DG ASAP.

8.2 Proposed Grey List

SP presented this item, advising that following last months meeting, the grey list had been finalised and had been brought back to the committee for further discussions. Some of the items had TBC in the evidence section where evidence is based on local decisions, SP will follow this up.

ID queried the inclusion of pregabalin for generalised anxiety disorder as NICE recommend this third line. RP advised that the grey list had been discussed at TEWV D&T and the concept was supported, although it was felt that it needed to be made clear to GP's why drugs were initiated in secondary care. It was felt that the grey list was a useful starting point for a formulary and could be amended over time. Compliance to the grey list could be measured as a potential incentive scheme target, however, the target would have to be a % compliance as 100% would not be possible. It was agreed that addition of the grey list messages to ScriptSwitch could support the implementation in primary care.

It was agreed that the grey list should be taken to the first APC meeting for final sign off, RP to feedback to SP any recommended changes from a TEWV perspective. It was requested that current prescribing rates were presented along with the grey list to aide discussion at the APC.

Action: SP to make amendments to grey list suggested by RP

Action: HB to agenda for APC

8.3 Prescribing Incentive Scheme

ID updated the committee advising that some funds may be available for this scheme and that there was some enthusiasm within clinical commissioning for a prescribing incentive scheme. It is proposed that adherence to the grey list and the better care, better value indicators could be the basis for a scheme. It was felt that one scheme for all clusters rather than seven schemes would be easier to manage and monitor.

8.4 Update on Wound Management Formulary

Barbara Nimmo (BN) had provided a written summary on the progress to date regarding the updating of the wound management formulary as she was unable to attend the meeting.

BN had made three recommendations for the committee to consider, these were considered as follows:

1. Support a business case for a seconded member of staff to liaise with non-medical prescribers and provide advice – the committee felt that they would need to see the business case before they could offer support.
2. Invite Richard Buckland and Lindy Turnbull to the April D&T meeting to present and discuss the wound management formulary – the committee agreed to this, but requested that BN also attends in April.
3. Ensure the new formulary is cascaded within GP practices – the committee agreed, but also felt it should be cascaded to district nurses and care homes too.

The committee then discussed how to tackle this area of prescribing suggesting that funding could perhaps be given to the district nurses and removed from the prescribing budget; however SS advised that this had been unsuccessful in the past in Sedgefield. It was felt that there may be an opportunity to revisit this as CHS staff were due to TUPE transfer to CDDFT in April and the FT has significant purchasing power, the committee felt it was important to have just one formulary across the health economy rather than a primary and secondary care formulary reflecting cost differences.

Action: BN to bring the wound formulary to April D&T for discussion.

9.0 MEDICATION SAFETY & NPSA

9.1 Drug Safety Update - January 2011 & February 2011

HB gave an update on these two bulletins; the February bulletin had just been released so had not been forwarded to committee members. HB advised that there was little of relevance to primary care in either bulletin, however, the potential for the combination of pioglitazone and insulin to cause cardiac failure was of relevance in the January issue and the risk of adverse events with dronedarone was of relevance in the February issue.

Action: HB to add the two relevant areas to the next newsletter.

Action: HB to circulate February bulletin to committee members for them to review and feedback any additional points for inclusion in the newsletter

10.0 PROVIDER DRUG AND THERAPEUTICS COMMITTEES

10.1 Update from Sunderland CHFT D&T –10th January 2011

DN gave a brief update from Sunderland CHFT D&T, he advised that the following products had been considered:

- Intravitreal dexamethasone implant (Ozurdex®) – it was agreed that this needed to go via commissioning as it involved a procedure and had also already been considered by NETAG.
- Denosumab – this was rejected.
- Sevelamer Carbonate was approved for shared care.

10.2 Update from North Tees and Hartlepool FT D&T

No update this month - next meeting 11th March 2011.

10.3 Update from County Durham and Darlington FT D&T – 2nd February 2011

GC gave an update from CDDFT D&T. He advised that there were three main points of relevance to primary care:

Sildenafil for Raynaud's phenomenon – GC advised that this had previously been to D&T and a management plan and patient information leaflet had been requested. GC handed round some copies of these documents for committee members to review and comment on. Currently the evidence for this indication was very limited and the trust could not provide much information at present, it was felt that this was a specialist indication and should remain with the specialists as a red drug until sufficient evidence was available to enable primary care prescribers to prescribe safely.

Action: GC to circulate the documents electronically to committee members who could then email comments back to GC.

Rifaximin – GC advised that this was considered again by the committee for hepatic encephalopathy, Dr Saksena is very keen to prescribe and had been asked to bring further financial information and evidence to the committee, unfortunately this was not forthcoming,

therefore the committee have agreed that this should not be prescribed until the D&T can consider all of the relevant information.

Action: HB to add to next newsletter advising GP's not to take on prescribing of rifaximin.

Enoxaparin – GC advised that both the post-discharge supply and maternal supply was discussed. The hospital D&T had agreed that the hospital would supply, but this had cost around £500,000 to date. The trust would like to sort this issue out; it is acknowledged that the hospital trust can purchase this at a lower cost than primary care; however for patient convenience in some instances they felt it would be useful to have some shared care. This issue is currently in discussion between the contracting teams.

10.4 Update from Tees Esk and Wear Valley Mental Health Trust D&T – 27th January 2011

JS gave a brief update on the content of this paper prepared by Michelle Grant who had attended this meeting. JS advised that one point of interest for the committee was that TEWV have restricted NMP's to prescribe clozapine and lithium as supplementary rather than independent prescribers in response to incidents, this approach to high risk drugs may be worth consideration in primary care.

10.5 Community Health Services Medicines Management Committee and Durham Cluster Prison Drug & Therapeutics Committee

There was no update this month.

11.0 RDTC UPDATE

11.1 Horizon Scanning Document – February 2011

It was felt that there was not much of relevance to primary care this month. SW advised that there was a draft NDE currently in development for fingolimod an oral treatment for MS, however a price has not been determined yet so the document remains in draft.

Current Work Plan Prescribing Report

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.

12.0 PRESCRIBING UPDATES

12.1 NICE Guidance – January 2011

JS provided an update on NICE guidance issued in January 2011, advising that the guidance on generalised anxiety disorder recommended sertraline as the first line treatment, recognising that it is unlicensed for this indication.

13.0 NON MEDICAL PRESCRIBING

13.1 NMP Competencies

JS updated the committee on NMP. She advised that a database had been developed which utilised prescribing data to produce prescribing reports which are automatically emailed out to NMPs. Quarter 2 data had recently been sent out and had generated a lot of discussion between NMPs regarding their stated competencies, with many requesting to review their competencies. SSh advised that many NMPs didn't understand what they were declaring when they completed their initial competency declaration.

It was agreed that a definitive paper on NMP should be brought to the April 2011 D&T meeting.

Action: JS to prepare a paper on NMP for April 2011 D&T

14.0 PATIENT GROUP DIRECTIONS

HB advised that there were no requests for new PGDs this month, but there were seven PGDs currently in the process of being updated.

15.0 QOF QUARTERLY UPDATE

15.1 QOF Audit reports 09/10

HB advised that the audit team had reviewed the audit data from the QOF audits carried out in 2009/10 and prepared reports on the outcomes of each audit. It was felt that these audits probably needed to be repeated to complete the audit cycle.

Action: To discuss within the MM team how and when these audits should be repeated.

15.2 QOF 11/12

HB advised that following the discussions at the D&T in January, an initial QOF document had been pulled together for discussion and sign off. It was acknowledged that unfortunately due to current staffing

levels, education sessions and audits could not form part of the MM QOF indicators this year and it was agreed that the suggestions made were a pragmatic alternative.

HB briefly discussed the prescribing targets advising that specials may not be suitable for a cost reduction target as some practices may not be able to reduce their spend due to specialist patients, this option could be moved into section two as a medicines management area. HB also suggested that due to the lack of an enteral feeding contract in Easington, setting targets for enteral feeds may be difficult and may need to be removed.

It was agreed that HB would forward the document to all committee members for comment outside of the meeting and then bring the final document for sign off to the April D&T meeting.

Action: HB to cascade the QOF document electronically for committee members to feedback.

Action: HB to bring back a definitive document to April 2011 D&T.

16.0 MEDICINES MANAGEMENT TEAM UPDATE & PUBLICATIONS

16.1 Prescribing Support Update - bimonthly

There was no update this month.

17.0 PBC PRESCRIBING LOCALITY UPDATES

17.1 Darlington Locality Prescribing Group update

There was no update this month - next meeting 1st March 2011.

17.2 DCLS Locality Prescribing Group update

There was no update this month.

17.3 Derwentside Locality Prescribing Group update –25th January 2011

This update was received by the committee for information.

17.4 Sedgefield Locality Prescribing Group update –2nd February 2011

This update was received by the committee for information.

18.0 ANY OTHER BUSINESS

There were no further matters for discussion.

19.0 DATE AND TIME OF NEXT MEETING

Tuesday 19th April 2011
Merrington House
12.00 – 2.30 pm

Confirmed as an accurate record:

Name:

Dr Ian Davidson - Chair