County Durham and Darlington Area Prescribing Committee

Minutes of meeting held
Thursday 12th January 2012
12.00 – 14.30
Boardroom, Merrington House

Part 1: Mental Health

1.0 Atypical antipsychotics

1.1 Hyperprolactanaemia Guidelines

SH presented these guidelines and requested that the committee forward any feedback to her.

ID asked for clarification on the acronym `SMAC', which had been referred to in the guidelines and asked whether it could relate possibly to biochemistry results and further clarification was needed around this.

SH informed the committee that the guidance did not currently cover over 65's yet in primary care these patients would form a significant proportion of the monitoring. When monitoring the elderly discretion was advised as Prolactin was higher in the elderly community.

SMc stated that there would be a separate piece of guidance available in relation to this. In passing ID also posed an open question of whether or not a similar piece of guidance was needed for SSRIs?

Apologies had been received from Ingrid Whitton and Paul Walker who is the author of the prolactinaemia paper and is currently looking at reviewing further. SH asked that any further comments are passed back to her for discussion with Paul. To be returned to the agenda at a future date.

1.2 Audit of High Dose Antipsychotic Treatment

SH presented the results of an audit which will be repeated on an annual basis, looking at all patients receiving doses above the BNF maximum dose. If patients were identified as being on two antipsychotic both doses were added together to see if they exceeded a combined maximum dose.

The audit also looked at those patients who were prescribed on an `as required' basis, as opposed to on a regular basis. The audit looked at high dose prescribing in patients and checked to see if indication and consent to high dose treatment had been recorded in the patient notes. The audit looked at both community patients and in-patients. Patient records were documented when the monitoring had taken place and looked at further, following a three monthly interval. Subsequently, patients were to be monitored and re-audited yearly.

Community teams were found to have patients who are more likely to be

prescribed regular high doses but the report does not look at the case load of individual teams so the figures may not be a representation of the proportion of high dose patients in each clinic. Since the previous audit figures had slipped slightly, an RPIW had looked at some of the issues including monitoring and the need for SOPs in community teams, with an aim of driving improvement. The Chief Operating Officer has asked for a re-audit in April 2012.

ID said that GP practices should be aware of patients on high doses within practices and felt that this could make a suitable QOF topic, as primary care numbers would be low.

It was recommended that this Antipsychotic audit be included as an item in the next PCT newsletter, with the recommendations that practices look at carrying out their own audit.

It was noted that there were practices which had been identified on the audit as higher prescribers than other practices and it was confirmed that clinicians were currently working with some practices looking at caseloads.

PK asked if higher doses were shown to improve outcomes and SH replied that some drugs will be titrated until improvement occurs and they are stabilised but others may be changed from one antipsychotic and end up being stabilised on a combination of both the new and old drug. It may be possible though that some of the doses could be brought down by minor adjustments.

ID asked how the standards for the audit was set and SH explained that they relate to the Royal College of Psychiatrists Guidance and they aim to have a compliance of above 80%.

ID also asked if is morbidity and mortality is recorded in the data , i.e. patient has an MI when on antipsychotics as this end point data would be useful to look at. SH said this would be recorded/monitored if thought to be an unexpected event related to treatment.

ID concluded that he was happy with the version presented to the Committee and confirmed that it could be appropriately disseminated and asked for the April audit to be presented at a future APC meeting.

ACTIONS:

- **Include key points in PCT newsletter to GPs**
- **Disseminate the audit as presented (SH)**
- **Bring April 2012 Audit to May 2012 APC (SH)**

1.3 Antipsychotic Savings October 2011 Data

SH presented a report produced by the Regional Drug and Therapeutics Committee about potential savings in antipsychotic medication focussing in particular on the patent expiry of Olanzapine and Quetiapine standard release.

The price of generic Olanzapine has continued to fall quickly since its patent expiry in Sept 2011 and inclusion to category M. Orodispersable preparations were not

reducing in price as significantly so there could be efficiencies if these patients were reviewed to see if such a formulation was needed. The savings for Olanzapine were thought to be in the order of £70k per month for County Durham and a further £20k for Darlington. If half of the orodispersable preparations could also be switched then this would save a further £3k and £1k respectively.

Quetiapine is due to go off patent in March 2012 and if the price dropped in a similar way to Olanzapine then savings would range from £11k per month for Durham and £3k per month for Darlington if the drop was 25%, and would increase to £42k and £10k per month respectively if the reduction was 90%.

ID said this was a pleasing report showing the large potential of windfall savings over the next year and SH indicated that there would be a similar sort of saving for secondary care.
Action: Share with GP Prescribing Leas for LPG discussion.

2.0 Antipsychotic Monitoring

The Committee were asked for any comments on the guidance which had been brought to the Committee today for their information covering the monitoring of patients taking antipsychotic medication.

ID felt it was useful for primary care and SS said it very useful as it will cover a lot as it is in the mental health QOF.

ID indicated that this would be useful to link in with monitoring guidance and shared care guidance. SH indicated that they were aiming to have the final version available at the end of March 2012, following which it could be included onto the Medicines Management website.
Action: Final version to be added to website and promoted in newsletter April 2012.

3.0 Venlafaxine switches

The switching of MR / SR Venlafaxine capsules and tablets to immediate release versions was discussed in length at the previous APC meeting held 3rd November 2011 and prior to any roll out, required a written process. IM informed the Committee that this could be launched via Local Prescribing Groups and roll out via practice teams. It was requested that SW add all permutations of this switch to the RDTC calculator. SW informed the Committee that there was a new Analyst in post and part of their role was going to be looking at Venflaxine in MR, following which the report would be updated every six months so that trends are visible via the report.
Action: Share with GP prescribing leads for discussion at LPG meetings prior to implementation (IM).

Part 2 – General

Present:

Jean Bertram, Patient Representative
Serena Bowens, PA, note taker CD&D
Ian Davidson, Deputy Medical Director, NHS CD&D (Chair)
Sarah Hailwood (SJH), Consultant Rheumatologist, CDDFT
Betty Hoy, Patient Representative
Sue Hunter (SH), Deputy Head of Pharmacy, TEWV
Patricia King, LPC Representative
Graeme Kirkpatrick, Chief Pharmacist, CDDFT
Sarah McGeorge, Nurse Consultant, TEWV
Sue Mole, Patient Representative
Ian Morris, Head of Medicines Management, NHS CD&D
Sue Shine, Nurse Practitioner, NHS CD&D
Chris Williams, Deputy Chief Pharmacist, CDDFT
Sue White, Assistant Head of Prescribing Support, RDTC

In attendance:

Darren Archer, Head of Joint Planning, NHS CD&D
Paul Fieldhouse, RDTC
Alwyn Foden, AMD Clinical Governance

There were a number of new faces at today's meeting, therefore introductions were made around the table.

4.0 Apologies for Absence

Peter Cook, Consultant Physician, CDDFT – not received
Geoff Crackett, GP Prescribing Lead (DCLS), NHS CD&D
Deborah Giles, Pharmaceutical Adviser, NHS CD&D
Mike Lavender, Consultant in Public Health, NHS CD&D – not received
Laura Mundell, Administrator, NHS CD&D (minutes)
Satinder Sanghera, GP Prescribing Lead (Dales), NHS CD&D
Joan Sutherland, Senior Pharmaceutical Adviser, NHS CD&D
Lindy Turnbull, Senior Nurse for Medicines Management, CDDFT
Paul Walker, Clinical Director of Adult Mental Health (County Durham & Darlington), TEWV
Ingrid Whitton, Deputy Medical Director, TEWV

5.0 Declarations of Interest

There were no declarations recorded.

Dr Alwyn Foden was introduced to the Committee and he hadvised the Committee that he was Deputy MD for CDDFT and had taken over from Dr McCulloch on APC.

6.0 Minutes of last meeting held 3rd November 2011

The minutes from this previous meeting were discussed for accuracy and the following amendments were requested:

Item 3.2 – Remove second sentence beginning with "SW asked whether savings can be …."
Item 15 – Include a third Action – `CW to produce covering letter but this was not to be returned to the APC'.
Item 16 – second last paragraph, to remove the sentence: *`GK felt that ibuprofen would be more appropriate and many people use Diclofenac as the first line drug'*
Item 18 - `*CW to make suggested changes to guidance*' to be replaced with the following: **Action *`ID to verbally update the Committee'.***

Following the aforementioned amendments, the minutes were approved for ratification.

7.0 Matters Arising/Action Log

7.1 Action Log from meeting held 4rd November 2011

IM went through the updated action log and the Committee are asked to refer to the updated log.

7.2 Prescribing of Dermatology Specials

IM had reviewed the prescribing data on dermatology specials and found that only a very low portion had been prescribed by the dermatology nurses. It may be however that this team is making recommendations for GPs to prescribe and this could not be ascertained from the data.

8.0 Formulary Update

8.1 North of Tyne Formulary Sub-Committee

IM attended the North of Tyne Formulary sub-committee in December 2011 and gave an update to the Committee today of the discussions.

Bocepravir - for patients with hepatitis C could cost £36k per year per patient. IM fed back to the commissioners that spend could be high in CD&D due to the prison population. The current situation with regard to prison health funding would be investigated further by Joan Sutherland.

The recommendation given in the minutes did not appear to reflect the discussion which both IM and CW felt had taken place at the Formulary committee and this would be fed back.

Radiesse – Approved.

Atriss – Approved.

High Strength fluoride toothpaste – approved for prescribing by dentists and dental hospital prescribers only

Methylphenidate for narcolepsy in paediatric patients – approved subject to informed consent, preparation of shared care protocol, and a longer period of stabilisation prior to GPs taking over prescribing.

Trospium XL – Not approved.

SonoVue – Approved.

Co-phenylcaine spray (unlicensed) – approved.

Buccal Lorazepam – approved as a red drug.

Sitagliptin - Not approved for reinstating to formulary.

Nasal Diamorphine – Rejected.

Buccal Prochlorperazine - Approved as green drug.

GK queried why some drugs were being looked at by the formulary committee when they were for a specific route of administration rather than for a particular drug. It was felt that this was one of the issues highlighted by adopting the current NOT process.

8.2 Update from Durham & Darlington Formulary Development Group

IM updated the group that the formulary development group was currently looking at developing a user friendly web based guide. Currently the Cardiovascular and Mental Health sections of the BNF were being worked up as `dummy' sections and once approved will be cascaded wider.

There was a requirement to still continue with the Formulary Development Group for the foreseeable future and it was confirmed that it will still continue to be item on APC agenda.

8.3 Formulary Approval Process

IM informed the Committee that the development group needs to look at simplifying the current drug approvals processes into a single chart. The APC accepted the three processes in their current state but agreed a single model would be a step forward.
Action: A single process to be developed from the three different flow charts and present at the Feb APC.

9.0 New Drug applications

9.1 Eslicarbazepine

SH had received request to use this drug in TEWV. This drug was approved for use in November 2010 by NOT formulary Committee and APC therefore approved the use of the drug. The drug was to be initiated by LD consultants.

ID questioned where the shared care guidance was suitable for implementing as it was not in the CD&D format and clarity was required as to whether this was to be classified as an amber or a blue drug.
Action: SH to clarify the shared care documentation and confirm its Blue or Amber Status

9.2 Boceprevir

IM verbally informed the Committee and indicated that a request may be received for the use of this drug. This drug had not been formally passed by North of Tyne as clarity is still required.

9.3 NETAG Update

For information NETAG had held an extraordinary meeting in November, where Ferdapse (Amitanpridine) was approved only if clinically critical and Omnipod CS II system was rejected.

10.0 IFR Decisions

IM indicated that there were still issues around Avastin in diabetic macular oedema. NETAG were asked to look at standard treatment and Lucentis was approved as this was a licensed product and Avastin was rejected as although this was a cheaper product it was unlicensed. Subsequently Avastin was rejected by Chief Executives.

WH waiting for information regarding an appeal to NETAG about the reappraisal of Avastin.

Meanwhile patients were being left in limbo until approved by NETAG.

SJH asked that decisions regarding acceptance or rejection of an IFR request could be more widely circulated as this isn't always communicated well to clinicians.

11.0 Medication Safety

11.1 Citalopram and Escitalopram dose reduction letter
11.2 Citalopram and Escitalopram flowchart

Dose reduction letter and flowchart had been disseminated for information only, as it had previously been cascaded in primary care. This was agreed by the APC

11.3 MHRA Drug Safety Update December 2011 (& January 2012)

At the meeting January 2012 DSU was not yet available so only the December DSU was discussed.

IM gave an update of the content of the December DSU which, amongst other items included guidance on Citalopram and Dabigatran.
Action: Include January Drug Safety Update on March 2012 APC agenda

Additional Item:

Cancer Network – Parenteral Diamorphine – to Morphine switch

ID shared with the APC details of the proposal to switch from diamorphine to morphine from May 2012.

Diamorphine subcutaneous injections are given as first line treatment and used for anyone with severe pain, particularly in palliative care patients. More recently certain trusts had moved to morphine which caused concerns with hospices in County Durham. A decision had been taken by North East Cancer Network in conjunction with Accountable Officers to move from diamorphine to morphine as subcutaneous opiate of choice. ID said that this needs to be managed by everyone concerned in the whole process in the interests of patient safety.

PK highlighted the potential impact on community pharmacy especially if stocks of diamorphine were potentially being left unused. It was acknowledged that the cost of this may need to be borne by the PCT. ID asked PK to take the proposal to the LPC for discussion.

ACTIONS:

- **GK to discuss with Callum Polwart, network pharmacist**
- **PK to discuss proposal with LPC and feedback any issues**
- **Agenda for Feb APC.**

12. Tees Shared Care for Rheumatology

At the request of NHS CDD D&T, IM had been asked to bring to the APC copies of Shared Care Rheumatology guidelines produced by Tees Hospitals. This relates to the fact that Easington do not access the CDDFT Rheumatology service and instead refer patients to either Sunderland or North Tees and Hartlepool, Easington locality had therefore been approved to use these guidelines instead of the ones produced in conjunction with the FT.

Sunderland Hospitals monitor in house and there were no guidelines available. ID stated that whoever is prescribing drugs and patients should be followed up and monitored by the prescriber.

SJH said that these guidelines did have some small differences and would be happy to work together to produce some standardised shared care guidelines for these drugs if the current guidelines were considered in light of National Guidelines to see where they differ.

ACTIONS:

- **SJH to liaise with IM and work together to produce share care.**
- **IM to feedback to Easington locality.**

Part 3 – Physical Health

13.0 Exenatide and Liraglutide Shared Care Guideline

CW presented a paper regarding the shared care of liraglutide and exenatide for type 2 diabetes mellitus which had already been rejected by the PCT D&T as it

contained a third option to use these drugs with Insulin which was outside of NICE guidance and was unlicensed.. The Committee were asked to look at a shared cared agreement and consider only the first two options in the paper.. ID felt that there was confusion around the responsibility for who should stop the drug. Prescribing after first prescription is responsibility for primary care yet responsibility for stopping sits with secondary care.

The Committee were informed that a Primary Care audit had been and NICE guidance was not being followed. SS said that often GPs do not receive letters or feedback received from clinics. In summary the following action was agreed:
Action: Remove option 3 and clarify responsibilities before returning to PCT D&T for approval by primary care before being returned to FT D&T.

14.0 <u>Update from Diabetes Strategy Group</u>

DA gave an update from previous Diabetes Strategy Group meetings which identified issues which needed addressing with Type II diabetes. This originated from issues raised at APC which were then taken forward by way of this group.

There had also been a recent meeting where the decision was made to revise the current type 2 diabetes guidelines (produced by Dr Alan Sensier and Sarah Landels and based on Tees Guidelines) and formally ask for these to be adopted by the APC. DA said that there had been a very useful meeting which brought together clinicians and commissioners and had agreed the following next steps:

- Newer drugs have been driving cost so consideration of their place in therapy is needed.
- Organisations will begin to question their own adherence to NICE guidance
- Non Pharmaceutical Approaches will be reviewed
- A formulary of drugs will be produced
- Those prescribed newer drugs will be reviewed to ensure they are still appropriate in light of guidance
- Local training will be arranged.

During the presentation of the paper there was discussion where GK highlighted that there was a regional group that was looking at training to enable to use of a standardised drug chart and GK agreed this could be shared with DA

PK asked about the inclusion of the non-pharmaceutical aspects and DA said these would be covered as part of the CCG based work rather than the drug related issues which will be fed back to APC.

JB and BH said that from a patient perspective they both felt that more could be done when patients are diagnosed and DA said that some of the local groups are now asking for representation from patients.

ID thanked DA for the report and the work that had been done and agreed with the APC the following actions:

ACTIONS:

- **DA to bring a further update to March 2012 APC**

- **GK to share training and drug chart resources with DA.**

16.0 Rifaximin for hepatic encephalopathy

CW had submitted an application to Foundation Trust D&T in December 2010 and it was agreed that this drug would be approved if a flow chart is produced, then taken back to D&T An On-going audit was currently being led by pharmacist and requested feedback to D&T in six months.

ID enquired if there were any monitoring requirements after six months. GK wasn't aware of this but SJH stated that the Microbiologists had concerns.

CW felt this would be used in one or two patients per month of acute episodes.

ID asked if this drug should be passed to GPs after six months or reviewed by consultants before being passed over. GK suggested that consultants should review the patient after 6 months but ID asked why consultants could not continue to prescribe if they were seeing patients anyway as part of the on-going review of the patient.

ID said he was happy to support the protocol subject to patients being reviewed by consultants at six month intervals.

17.0 Ticagrelor update

ID explained that Ticagrelor had been approved by NICE for all coronary syndromes. The Cardiac Network Board had considered the implantation of Ticagrelor prescribing but estimated cost in Count Durham & Darlington would be £800,000. A working group had been established to report back to the Network in two to three months before agreeing a Regional approach to Ticagrelor prescribing.

18.0 Minutes of Drugs & Therapeutics

18.1 County Durham & Darlington PCT D&T

The Committee accepted these minutes for information.

18.2 Tees Esk & Wear Valley D&T

The Committee accepted these minutes for information.

18.3 County Durham & Darlington Foundation Trust D&T

The Committee accepted these minutes for information.

19.0 Drug and Therapeutics Bulletin summaries – December 2011 and January 2012

The Committee accepted these bulletins for information however January 2012 was not available at the time of the papers being circulated.
Action: Include January 2012 DTB on March 2012 APC agenda.

20.0 Horizon Scanning Document & NICE guidance

20.1 December 2011 and January 2012

The Committee accepted these bulletins for information however January 2012 was not available at the time of the papers being circulated.
Action: Include January 2012 Horizon Scanning Document on March 2012 APC agenda.

20.2 Draft Evaluation Report on two new protease inhibitors

A RDTC review on the use of protease inhibitors (Bocepravir and Telaprevir) in the treatment of chronic hepatits C Genotype 1 Infection was shared with the group for information. This also related to one of the drugs recently discussed at the NOT formulary committee.
Action: IM to send a copy to NOT formulary committee chair but to check that a revised version is not already on the RDTC website.

20.3 BMJ Article on two new protease inhibitors

A BMJ paper regarding Protease inhibitors for the treatment of chronic hepatits C Genotype 1 Infection was shared with the group for information. This also related to the same drugs covered in 20.3.

21.0 Any other Business

21.1 Diamorphine to morphine switch

Previously discussed.

Date and time of next meeting:

Thursday 1st March 2012
12.00 - 14.30
Boardroom, John Snow House

Confirmed as an accurate record:

Dr Ian Davidson - Chair