NHS
County Durham and Darlington

AREA PRESCRIBING COMMITTEE

Minutes of meeting held
Thursday 5th July 2012
12.00 – 2.30 pm
Board Room, John Snow House

PRESENT:

Jean Bertram, Patient Representative
Serena Bowens, CD&D PCT (Minute taker)
Geoff Crackett, GP Prescribing Lead (DCLS), NHS County Durham & Darlington
Ian Davidson, Deputy Medical Director, NHS County Durham & Darlington (chair)
Paul Fieldhouse, Regional Drug & Therapeutics Centre
Soraya Mayet, Consultant, CAMHS, Tees Esk & Wear Valleys NHS Foundation Trust
Sarah Hailwood (SJH), Consultant Rheumatologist, County Durham & Darlington NHS Foundation Trust
Betty Hoy, Patient Representative
Sue Hunter (SH), Associate Director of Pharmacy, Tees Esk & Wear Valleys NHS Foundation Trust
Patricia King, Local Pharmaceutical Committee Representative
Graeme Kirkpatrick, Chief Pharmacist, County Durham & Darlington NHS Foundation Trust
Ian Morris, Head of Medicines Management, NHS County Durham & Darlington
Andy Reay, Senior Pharmaceutical Adviser, NHS County Durham & Darlington
Sue Shine, Nurse Practitioner, NHS County Durham & Darlington
Rikki Siddle, Associate Care Group
Joan Sutherland, Senior Pharmaceutical Adviser, NHS County Durham & Darlington
Chris Williams, Deputy Chief Pharmacist, County Durham & Darlington NHS Foundation Trust

APOLOGIES FOR ABSENCE:

Peter Cook, Consultant, CDDFT
Lindy Turnbull, County Durham & Darlington NHS Foundation Trust
Paul Walker, Consultant, Tees Esk & Wear Valleys NHS Foundation Trust
Sarah McGeorge, Consultant, Tees Esk & Wear Valleys NHS Foundation Trust

Due to a number of new attendees a round of introductions was made.

PART 1 – MENTAL HEALTH

ID noted that the meeting today was not quorate as there was lack of representation from TEWV. The committee agreed to proceed as a non-quorate meeting. Introductions were made around the table.

1. <u>New Drug Applications (which are relevant to TEWV)</u>

SH agreed on behalf of TEWV that all formulary applications on the agenda could be considered without a TEWV representative being present, as it was unlikely they would initiate these drugs.

2. <u>Prescribing Guidance Drug Misuse</u>

(Meeting now quorate as TEWV representative had joined the meeting)

It was agreed that this guidance was a very useful resource which needs to be circulated more widely to maximise its impact. PK would like to make this document available to community pharmacists along with training to be organised by the DAAT. It was agreed to take this to the CD LIN to discuss implementation with the DAAT.

A methadone shared care agreement has been in place in Derwentside however it is unclear whether appropriate shared care arrangements remain in place. From a patient safety point of view we need to establish the role of the specialist service in this arrangement, working with DAAT to make sure this model of care remains appropriate and safe. Following this SG would be happy to work with the PCT to amend documentation if necessary. The CD LIN need to review the models of care across the PCT to establish if we need to support the current shared care arrangements, enhance them or discontinue them.

PK stated that from the document her understanding is that there is the intention to get patients off their medication, which differs from previous guidance.

GK will be updating the Trust policy on this area and will be happy to share his work with TEWV

ID stated there could be a bullet point summary to support the document for ease of reference
Action: Raise with DAAT via CD LIN to discuss sharing with this document with community pharmacies and organising training ID September 2012.
Action: Amended guidance for CDDFT GK December 2012.
Action: CD LIN to pick up issue of shared care guidance ensuring this remains safe September 2012.
Action: Produce bullet point summary SH.
Action: Guidance accepted by the Committee, following which uploaded to APC website August 2012.
Action: Clarify with the DAAT at CD LIN whether the intention is to get patients off their medication, or to maintain them on a stabilised dose until discontinuation is appropriate. IM/ID.

2a. Potential Pregabalin Misuse

Potential pregabalin misuse bas been flagged by Barbara Nimmo and Dr Waterworth as an issue in Darlington. PK also felt this was a concern in other areas. JS has a meeting in future with DAAT to discuss this along with gabapentin where misuse in prisons is high. PF stated there is concern of misuse in the Manchester area and the RDTC / NPC are looking at this. Due to the concerns raised by several members it was agreed to raise awareness of this issue in the newsletter, but state that further evidence was being sort.

Action: Raise awareness via short comment via newsletter August 2012 DG.
Action: Wait for further information from RDTC/NPC and circulate as appropriate PF.

3. Guidance for Safe Transfer of Prescribing (Traffic light status substance dependence)

The traffic light status needs to be agreed for drugs used in substance dependence. Methadone and buprenorphine will be covered in the shared care discussions with the DAAT at CDLIN. A treatment pathway for drugs in alcohol misuse is being worked on with Teesside and this will be brought back to the APC, where the traffic light status of these drugs will be ratified.
PF stated a new drug, nalmefene is coming onto market in March 2013 and it will be heavily promoted, therefore new guidance would be timely.
Action: Traffic light status of methadone and buprenorphine will be covered in the shared care discussions with the DAAT at CD LIN. ID/IM.
Action: Treatment pathway for drugs in alcohol to come to APC, traffic light status will be agreed January 2013. SH.

PART 2 - GENERAL

4. Apologies for absence

See front page.

5. Declaration of interests

Andy Reay declared an interest in item 9.8 rivaroxaban – as he has presented at the commissioning show with Dr Russell. AR will leave the room for this item.

6. Minutes from last meeting held 3rd May 2012

The minutes were accepted as a true and accurate record of the previous meeting with amendments to the following two items:

8.3 The last paragraph to read `*At this point in the meeting Sue Hunter, TEWV left the meeting, and following this departure it was noted by the Committee that the meeting was no longer quorate, as there was insufficient representation from TEWV',*

16. Title to read `*Antioxidant vitamin and mineral supplements for* age related macular degeneration'.

7. Matters Arising/Action Log

Action 1.0 - AR has been in touch with South of Tyne to discuss their approach to promote the use of donepezil as a first line treatment. Their impressive proportion of donepezil prescribing as a proportion of overall dementia prescribing was essentially down to the preference of the local consultant and GPwSIs, rather than a proactive approach from the PCT. However since then they have developed a prescribing algorithm promoting the use of donepezil as a first line treatment and they have incorporated this into their prescribing incentive scheme. A copy of the algorithm has been forwarded to SH and JS for consideration by TEWV.
Action: SH to feedback on the South of Tyne dementia prescribing algorithm, September 2012.

Action 11.2 - Magnesium monitoring – CDDFT have produced guidance for their prescribers on magnesium monitoring. Further guidance on magnesium monitoring for patients prescribed PPIs will come to September's APC. PK has provided some very useful information which will inform this debate.

Action 13 - Dabigatran and anti-platelet guidance, CW has arranged a meeting for the 13th August.

Action 15 **-** Urology – AR has contacted Sunderland and Tees and they have no current guidance for this area. Darlington CCG is doing some work in this area and plan to put out simple guidance to primary care. ID stated that any guidance is easier to implement in primary care if secondary care is on board. It may be possible to "cherry pick" sections of the formulary to review and the urology section could be part of this review. CW asked for the gynaecologists to be part of this review. PF produced urology prescribing figures showing areas of high growth in urology at the last meeting and guidance would help in this area.

Action 20 - APC report for last year – AR to work with DG and bring report back to September's APC.

8. APC Formulary Sub Group Update

8.1 Terms of Reference

CW presented the formulary sub-group terms of reference. ID said it would be useful to have paragraph on the application process, including clinician and contracting input. GC asked if it was necessary to look at all NETAG and NICE decisions. ID stated that they would need to come to APC to be formerly ratified, though in most cases this would be a formality.
Action: TOR accepted but to return to September with final paragraph including clinician and contracting input into the process. CW.

8.2 Appeals Process

AR presented a paper on new drug decision making and appeals process. ID asked for the following to be added to the first line "A one member, one vote system will operate on formulary decisions by

the APC." He also asked that any decisions be published on the website, the timescale for this to be agreed outside of the meeting. AR agreed that both of these actions would be useful.
Action: AR to amend document to include 'A one member, one vote system will operate on formulary decisions by the APC'.
Action: AR to email out decisions to members, then email applicant and publish formulary decisions of the website.

8.3 Application Form

CW presented an updated new drug application form, there will be some amendments following recent discussions with contracting colleagues.
Action: The Committee accepted the form in its current state, however an amended final version will be circulated by CW.

8.4 Financial Approval

AR and CW are in discussions with contracting colleagues regarding the financial and contracting approval of new drugs. Significant progress is being made and will be reported back to September's meeting
Action: AR and CW to report back in September.

9. New Drug Applications

9.1 **Collagenase**

The APC were minded to approve collagenase for Dupuytren's contracture in adult patients with a palpable cord as per the NETAG recommendation, subject to final approval from the contract management group.

It will be classed as a red drug and an audit will be undertaken 12 months post-implementation and brought back to the APC. Annual savings of £32k will be to commissioning and not to CDDFT as indicated in the application. GC asked if there are any inappropriate referrals for surgery and if so this should be flagged to primary care.
Action: AR to confirm with contracting that this has been clinically approved by the APC. If inappropriate referrals are taking place contracting will communicate this to primary care.
Action: Audit of usage will be brought back to the APC January 2014.

Post meeting note: a business case has been requested from the applicant by CDDFT and once the PCT's contracting team are satisfied with the contracting arrangements, collagenase will be added to the formulary.

9.2 **Ulipristal Acetate**

The APC were minded to approve ulipristal acetate for the preoperative treatment of moderate to severe uterine fibroids requiring surgery, subject to final approval from the contract management group.

Treatment will be for a duration of 3 months as per the licensed indication. It will be classed as a green plus drug, initiated by a specialist who will supply the first month, with the additional 2 months being prescribed in primary care to patients prior to their surgery for fibroids. Monitoring will be undertaken to ensure this drug is only used for 3 months as per the application.
Action: AR to confirm with contracting that this has been clinically approved by the APC.
Action: CW to organise an audit twelve months after implementation which will be discussed at the Trust's Clinical Standards & Therapeutics Committee by September 2013.

Post meeting note: Contracting have confirmed that ulipristal acetate can be included in the formulary for this indication.

9.3 **Fingolimod**

The APC were minded to approve fingolimod for the treatment of active relapsing-remitting multiple sclerosis, subject to final approval from the contract management group.

Newcastle Hospital will commence use and recharge County Durham and Darlington, therefore this drug needs to be included on the formulary. PF mentioned that this should only be used in accordance with NICE guidelines and asked how we would monitor this. It was agreed this is a red drug.
Action: Committee agreed application and to be included on the formulary as `red' drug, subject to final approval from contracting.
Action: Formulary development group to come up with a process for tertiary care drugs and to ensure in line with NICE guidance.

Post meeting note: Contracting have confirmed that fingolimod can be included in the formulary for this indication.

9.4 **Tostran**

The APC were minded to approve testosterone 2%gel (Tostran) as replacement therapy with testosterone for male hypogonadism when testosterone deficiency has been confirmed by clinical symptoms and laboratory analysis, subject to final approval from the contract management group.

There are potential benefits in the way in which it is formulated and it may be cheaper.
Action: Committee agreed the application and to be included on the formulary as `green plus' drug to be recommended by a specialist, subject to final approval from the contract management group.

Post meeting note: Contracting have confirmed that tostran can be included in the formulary for this indication.

9.5 **Anakinra**

The APC were minded to approve anakinra for acute refractory or difficult gout requiring hospitalisation, this is an UNLICENSED INDICATION.
Action: Committee agreed the application and to be included on the formulary as `red drug', subject to final approval from the contract management group.
Action: Applicant to arrange an audit twelve months post implementation for feedback to the APC. January 2014.

Post meeting note: Contracting have confirmed that anakinra can be included in the formulary for this indication

9.6 **Magnaspartate**
and
9.7 **Fultium D3**

Magnaspartate is a licensed food supplement which is more readily available than other magnesium preparations; it is also less expensive than special preparations and has potential to save up to £40k per annum.

Fultium is a licensed vitamin D preparation.
Action: Committee agreed the application and both preparations to be included on the formulary as "green drugs," subject to final approval from the contract management group.

Post meeting note: Contracting have confirmed that Magnaspartate and Fultium D3 can be included in the formulary.

9.8 **Rivaroxaban**

AR introduced this item for use in patients with DVT which was recently discussed at CD&D D&T, following which he left the meeting, due to a declaration of interest.

Discussion ensued surrounding effects on the current warfarin service should this drug be introduced initially as a pilot. The Committee also raised concerns regarding the safety aspect of this drug. It was also noted that this drug was not yet currently approved by NICE. It was brought to the Committee's attention that Darlington is currently running a pilot system for this drug. Discussion then followed surrounding the appropriate process for future drug applications.
Action: Committee were unable to approve this drug application for inclusion on the formulary at this time however if in the future NICE approved this drug, then the Committee would be happy to reconsider the application.
Action: CW to draft a response to Dr Russell.

At this juncture AR was re-invited to return to the meeting.

Post meeting note: the following response has been sent to Dr Russell:

'The APC was minded not to support the addition of rivaroxaban to the formulary at this stage.

The NICE technology appraisal is due within the next 4 weeks.
The APC felt that an application for rivaroxaban should come across the whole health economy. In this case rivaroxaban is being used as a substitute medication in a previously agreed pathway by primary care contractors only and will mean the operation of two different pathways of care for deep vein thrombosis which may cause confusion for healthcare staff and for patients. The committee felt that that an application of this sort would be best made to propose a change of pathway across the whole health economy of County Durham & Darlington.

The committee is aware that the pilot in Darlington CCG is in progress and would welcome a further application taking into account the committees concerns.

The committee wished to confirm that future applications of this nature should follow the agreed formulary process outlined on the current application form.'

9.9 **Tapentadol**

The APC were minded to approve tapentadol with some restrictions over and above the original application. It was approved as a third line treatment for the relief of severe chronic pain in adults which can be adequately managed only with opioid analgesics AND in whom morphine and oxycodone has failed to provide adequate pain relief or is not tolerated.
Action: Committee agreed the application and to be included on the formulary as a `green plus' drug in a restricted place for third line therapy, subject to contract management approval. The drug should be recommended by a pain specialist who must outline in their recommendation form that the patient has already tried morphine and oxycodone.
Action: audit of use to be undertaken, patients should have tried both morphine and oxycodone before tapentadol is considered, audit to be received by the APC September 2013. CW.

Post meeting note: Contracting have confirmed that tapentadol can be included in the formulary subject to the restrictions agreed by the APC.

9.10 **Targinact**

The APC rejected targinact for chronic pain as a second line opiate where the patient has experienced refractory opiate induced constipation.

The reasons for this decision were the concern of introducing another opioid analgesic into the local health economy from a safety perspective, given that there are already several options available. A lack of comparison of targinact with an opioid plus prophylactic laxatives. The fact that the oxycodone patent is due to expire shortly, therefore targinact may become a comparatively more

costly option in the future. The committee also noted that tapentadol had just been added as a possible option.

The Committee were in agreement that this application be rejected.

10.0 IFR Decisions

No unusual requests to report.

11.0 NETAG Update

NETAG has not met since the last APC, though a meeting is scheduled for next week.

12.0 Medication Safety

12.1 MHRA Drug Safety Update

Has been discussed at D&T, no further actions for APC .

12.2 Quinine Prescribing

PF presented a report on quinine prescribing following the MHRA recommendations in 2010 for short term use. It was agreed that this should go to CCG prescribing committees.
Action: The paper on quinine prescribing will be forwarded to CCG prescribing committees.

PART 3 – PHYSICAL HEALTH

13.0 DMARD Shared Care (action plan to be tabled)

A verbal report was provided by CW. The current shared care guidelines expire at the end of July 2012. The guidelines are going to be reviewed and will include 6-mercaptopurine along with the fact that this drug, along with others in inflammatory bowel disease is unlicensed, though evidence based and therefore supported by the APC. The guidance will be split into sections to make it more user friendly and the aim will be to standardise the guidelines with others across the North East, potentially also including dermatology. To facilitate this important piece of work the committee approved a six months extension to the current shared care guidelines.
Action: **CW to extend the expiry of the current guideline by six months and amend the Trust's website. DG to do the same for the PCT's website.**
Action: CW and SJH to review the current shared care guidelines, bringing them back to the APC, with a list of changes for January 2013.

14.0 TNF Audit

Linda Neely will discuss this with the contracting team and any necessary actions will be brought back the APC.

PART 4 – STANDING ITEMS (for information only)

15.0 Minutes

15.1 CD&D D&T April 2012

For information of the Committee.

15.2 TEWV D&T March 2012

For information of the Committee.

15.3 CD&D FT D&T April 2012

For information of the Committee.

16.0 Drug & Therapeutic Bulletin summaries

For information of the Committee.

17.0 RDTC Horizon Scanning May and June 2012

For information of the Committee.

18.0 Transfer of Discharge Information (item for discussion)

CW presented this document, aimed at improving the transfer of discharge information to community pharmacies. The lack of an NHS NET email address for community pharmacies is a significant barrier to improving the transfer of discharge information and this could make a significant impact on patient safety.
Action: IM will lobby IT to provide support for NHS NET email addresses for community pharmacists.

19.0 Any Other Business

A request was made for the Committee to notify any membership changes so that the membership list on the website can be kept up to date.

The following changes to the membership had been notified today.

Andy Reay - Replacement
Paul Fieldhouse - Replacement
Satinder Sanghera - Retired
Action: Updated membership to be placed on website. DG.

DATE AND TIME OF NEXT MEETING:

Thursday 6th September
11.30 am - 14.30 pm
Boardroom, John Snow House, Durham

Featuring GI and lithium

Confirmed as an accurate record:

Dr Ian Davidson – Chair