COUNTY DURHAM PCT & DARLINGTON PCT
Drugs and Therapeutics Committee

Minutes of Meeting held
Tuesday 16th November 2010
Board Room, Merrington House
12.00 - 2.30 pm

Present

Hazel Betteney, Senior Pharmaceutical Adviser
Dr Geoff Crackett, GP Prescribing Lead, DCLS
Dr Ian Davidson, GP Prescribing Lead, Derwentside
Gail Dryden, Community Matron
Dr Peter Jones, GP Prescribing Lead, Sedgefield
Patricia King, LPC representative
Ian Morris, Head of Medicines Management
Dr David Napier, GP Prescribing Lead, Easington
Linda Neely, Senior Pharmaceutical Adviser
Dr David Russell, GP Prescribing Lead, Darlington
Dr Satinder Sanghera, GP Prescribing Lead, Dales
Sue Shine, Nurse Practitioner
Joan Sutherland, Senior Pharmaceutical Adviser
Sue White, RDTC
Christopher Williams, Head of Medicines Management, CDD CHS

1.0 APOLOGIES

Ros Prior, TEWV

At this juncture, ID welcomed Satinder Sanghera, who has recently been re-appointed as GP Prescribing Lead to the Dales locality.

2.0 DECLARATIONS OF INTEREST

There were no interests declared.

3.0 MINUTES OF LAST MEETING HELD 19TH OCTOBER

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

Page 1 – Chris Williams' title should read, `*CDD CHS'* and not `NHS Provider'.

Page 15 - amend first line of second paragraph to read *'SW not sure if the RDTC will re-run this report in the future as the information centre is due to report benchmarking data on antipsychotic prescribing this autumn.'*

Page 16 – completely remove sentence in first paragraph which reads - *`IM queried the prescribing indicators used, could this explain the change, SW thought although this was unlikely, it could be possible'.*

Page 16 – amend final sentence to read *'SW advised that this may become a BCBV indicator; new indicators may be introduced three at a time.'*

4.0 MATTERS ARISING

4.1 <u>CDDFT Outpatient dispensing and VTE update following Acute CQRG</u>

LN gave an update on outpatient dispensing and VTE prophylaxis in pregnancy, post surgery, risk assessments and supply of full courses. LN advised that she was aware that HB had done a lot of work on this. LN took the matter to the acute CQRG meeting where the matter was discussed at director level and it was agreed that if full courses are funded, full courses should be provided. LN advised that she had sent evidence to the trust of agreement to supply full courses and advised that full courses should now be supplied, if this is not the case, then the PCT needs to be informed.

HB advised that CDDFT had contacted her to discuss a way forward for maternal VTE and had requested that HB and GC form part of a sub group of CDDFT D&T to discuss this further. HB advised that the acquisition cost of LMWH is considerably cheaper in secondary care. Until such time as any further agreement is reached, the advice not to prescribe for VTE prophylaxis in pregnancy issued by the Medicines Management Team in June still stands.

CW advised that the community midwives are currently employed by CDDFT and therefore their prescribing is not currently monitored by CDPCT or CDDCHS.

LN advised that regarding outpatient dispensing, things were at 'status quo' at the moment but that a meeting had been arranged in the next couple of weeks to take this forward and that ID would be in attendance, this meeting would cover red drugs and how these are managed.

5.0 ACTIONS TAKEN BY MEDICINES MANAGEMENT TEAM

Please refer to updated action log.

The Committee agreed that the historic actions were to be addressed by ID and HB outside of today's meeting and will be fed back to the D&T Committee.

AGENDA

6.1 Quarter 1 Non-Medical Prescribing (NMP) Report

JS informed the Committee that this data had not yet been cascaded as it was to be cascaded to NMPs with a new children's BNF, however, unfortunately the team were still awaiting delivery of these BNFs, which are due in later this week.

JS advised that the report was an overview of NMP in County Durham and Darlington, 37% of NMPs had not returned a declaration of competency and 47% of those who had declared competencies were prescribing outside of one or more of their declared competencies. Once the data is sent out to prescribers, they will be asked to review their competencies in line with the data.

JS advised that the wound management formulary is currently going through the revision process; however, 57% of prescribing in this area by NMPs was off formulary.

With respect to controlled drugs, JS advised that there is a misunderstanding of which drugs NMPs can prescribe for which indications, this also dependent on whether they are prescribing as a supplementary or independent prescriber, NMPs need to be aware of their limitations. 34% of CD prescribing is outside of the DH approved list, this will be monitored. CW advised that this is not exclusive to County Durham NMPs. PJ queried prescribing of nitrazepam, CW thought that this was probably a repeat prescription.

JS then discussed high risk/unexpected prescribing, there is no definitive guidance as to what would be considered high risk/unexpected, so this section of the report was based on what we would expect NMPs to prescribe. JS suggested that it may be possible that repeat prescribing is being picked up by NMPs and that work needs to be done with NMPs and their employers as to what they should and shouldn't be doing.

SSh advised that as a NMP representative on the committee she felt that this was a good piece of work and was shocked by some of the things that had been prescribed. She advised that some of the NMPs didn't understand what they were being asked to complete regarding their competency. She added that some bigger surgeries have nurses who act as specialists running clinics. Regarding repeat prescribing she said that NMPs may think that it is ok to issue a prescription if a doctor has prescribed it first or it may be that the patient requests a prescription for one of their regular repeats whilst in seeing the NMP for a consultation.

ID advised that he was concerned regarding NMPs filling in statements of competency and wondered what percentage of NMPs who had reported their competency were actually prescribing within it, JS advised that this piece of work had not been completed yet. CW advised that the declaration of

competency itself is flawed e.g. CNS chapter includes paracetamol; nurses may prescribe this but no other medicines from the CNS chapter.

JS advised that the reporting of competencies should change as prescribers become aware once they receive their quarter 1 data. ID queried what action had been taken to follow up those NMPs who have failed to return a declaration of competency; JS advised that they have had at least 3 letters, ID then asked what action was needed. JS felt that we should await feedback following quarter 1 data, ID suggested that this was discussed further at the primary care CQRG which reviews clinical quality within primary care contractors. It was also felt that practice managers need to be aware of what can and can't be prescribed by NMPs.

It was felt that the limitations of competency declarations need to be prior to further discussion; the form is very basic but is aimed at facilitating thinking about competency. IM advised that the high risk drugs section was very useful, although CW advised that in some cases it may be justified as it may not be the nurse's signature on the prescription.

SSh advised that it was good to see the data but as it is not monitored as closely, nurses may become a little blasé. DR queried whose signature would it be if not the nurse, it was possible that these NMP prescriptions could find their way into the doctors signing pile; as there are some IT issues which can cause difficulties when producing repeats. GC asked what was going out to NMPs; JS advised that each NMP would receive a report of what is in and outside of competency with all of their ePACT data. GD advised that when you receive these reports, it does make you stop and think.

ID said that he feels that we have not supported NMPs as much as we could have; CW advised that they have always received quarterly data historically. JS advised that in addition to their ePACT data, they would be issued information from the DH on which CDs can and can't be prescribed.

Action: To be taken to PCCQRG on 23rd November for discussion and to agree a way forward.

6.2 RDTC Non-medical Prescribing Report

SW presented this report, she advised that the report was a useful overview however; it is difficult to draw any conclusions due to the small numbers of NMPs and will now be produced by the RDTC annually or more frequently if requested by PCTs.

SW advised that she feels that the report needs to be revamped and should include controlled drugs, additionally; controlled drug prescribing by NMPs will be covered in the controlled drugs report. SW requested that committee members contact her if they feel that there are any additional items that should be covered by this report.

SW advised that it is difficult for the RDTC to access active prescribers; they can only access data for registered prescribers. The measure of prescribing used is cost or prescribing frequency for individual prescribers, the RDTC also look at the number of NMPs per head of population; Darlington has the third highest number of NMPs per head of population, with County Durham having the fifth highest in the North East. SW also advised that there was virtually no pharmacist prescribing. PJ queried if pharmacists could issue and sign all repeats and was advised that this was not how NMP was intended to be used and the pharmacist may not have competency in all areas of the patients repeat.

ID queried if a community pharmacist would dispense a prescription that is a repeat prescription signed by a nurse prescriber, PK advised that she has not come across it, JS has seen it in community pharmacy and queried it as a locum. PK advised that it is very confusing as to what can and can't be prescribed, so she would tend to just dispense the prescription. The PPD would not pick whether an item was appropriate dependent on the status of the prescriber as all prescriptions would be treated in the same way regardless of the independent/supplementary status of the prescriber, further discussions around professional judgement and looking at prescriptions on a case by case basis concluded by ID advising that guidance on what should and shouldn't be prescribed by NMPS should be reiterated. SSh added that there was pressure in GP practices for NMPs to issue repeat prescriptions and also felt that although there are high numbers of NMPs in County Durham and Darlington, there isn't a lot of support available.

Overall SW concluded that there were no major concerns, within wound management prescribing is high in Darlington, but when this is considered at a cost per item level, Darlington is cost conscious and cost effective, therefore the higher overall spend may just be related to the numbers of prescribers. SW added that cost per item may be a more useful indicator in this instance.

Looking at figure 10 – antibiotic prescribing, Darlington NMPs have one of the highest prescribing frequencies, although there are no major concerns relating to the types of antibiotics prescribed in County Durham or Darlington. Only 2.5% of prescriptions issued in the North of England are issued by NMPs.

Looking at the top 20 drugs prescribed, in County Durham, nicotine has reduced and varenicline has increased, however in Darlington, varenicline prescribing has reduced. SW advised that it is interesting to compare this top 20 profile with GPs noting that both NMPs and GPs have fluticasone high up in their top 20's. IM queried why substance misuse drugs appeared in the top 20's, it was felt that this may be due to a nurse-led substance misuse clinic in the area and could be related to supplementary rather than independent prescribing.

It was also suggested that high risk drugs should be added to the report, especially since the local report produced by JS highlighted an instance of an NMP prescribing drugs for HIV.

PK raised concerns regarding a NMP signing a prescription for a patient they hadn't seen; it was felt that this was a professional matter.

ID felt that overall, it was a reassuring report for County Durham and Darlington compared with the North East and the Country. Although it was agreed that a plan of action was required to bring NMP into line with the standards required once the competency recording issues have been resolved. It was felt that the education day delivered by CW team would be an important part of this and should be continued if funding available.

6.3 Antibiotic Awareness Day

LN informed the Committee that a European antibiotic awareness day was occurring on 18th November 2010, which has been promoted by the DH. LN requested that she be sent some pads, posters and information leaflets to distribute countywide, however only a limited amount of these resources were received and therefore, practices are to be sent a sample of the available materials and informed that if they require further promotional materials, they should order them direct from the DH. LN advised that there would be no SHA funded antibiotic campaign this year. LN asked the committee for £3k to put the promotional video for this campaign onto the televisions in GP practices; LN wondered if this could be top-sliced from the prescribing budget. LN was advised that unfortunately, the prescribing budget is now a PBC budget and is currently in an overspent position so this would not be possible. ID felt that currently there was not enough time or resource available for this year's campaign; however, the committee agreed that it would be worth looking at next year well in advance of the awareness day and adopt an SHA wide approach.

GC advised that he had recently read an article that advised if a child had more than seven courses of antibiotics in childhood they could be at increased risk of inflammatory bowel disease. GC agreed to share the reference with the MMT for inclusion in the next newsletter. SSh advised that parents think they are doing the right thing, PJ quoted Philip Little who said that it is a GPs perception that a patient wants antibiotics. DR suggested that the limited promotional materials available be allocated to practices who are high prescribers of antibiotics; the materials were handed around the table to the GP Prescribing Leads to distribute within their clusters.

Action: Promotional materials to be allocated to high antibiotic prescribing practices.

6.4 Gluten Free Limited List

IM presented the list of gluten free products currently prescribed across County Durham and Darlington. He advised that he has been asked to review the present GF list for the pilot gluten free pharmacy supply scheme in DCLS locality and produce a "limited list" of products and felt this provided an opportunity to produce guidance across the whole of County Durham and

Darlington. Expenditure on the DCLS pilot scheme has recently increased which is partly due to patient's individual specific requests for GF products. IM recommended that the limited list would include a two product selection of pasta; white and brown bread and biscuits. The refusal of prescribing products outside of the recommended list would then be at the discretion of the GP's but would have D&T support. SSh advised that dietetics needed to be involved in drawing up this limited list as often the range of products available and specific products are recommended by dieticians. It was felt that it was important to link with secondary care.

It was agreed that each PBC locality would look at the proposed "limited list" and agree it for their locality, and then details of the "approved products" can be added to ScriptSwitch. DR queried the quantity of gluten free products that should be ordered per month, IM advised that increasing quantities had been seen and therefore, advice would be needed on a reasonable quantity to supply.

It was felt that there was still work to do on this "limited list", ID asked that once the initial list had been prepared by the MMT, it should be emailed to committee members for discussion, the final version could then be agreed by chairs action and then taken to PBC localities for agreement. It was also felt that once the guidance was issued to practice, it should be issued in the form of a memo to enable GPs to have something to show patients.

Action: IM to meet with Dieticians.
Action: IM to prepare a draft "limited list" and email to GP prescribing leads for discussion prior to sign off by the D&T chair.
Action: IM to share the finalised "limited list" with PBC localities for locality sign off.

6.5 Community Nurse Transcribing in CDD CHS

CW informed the Committee that locally and nationally it was common practice for GP's to sign administration charts to enable community nurses to administer medication to patients in their own home. CW advised that this was not always possible and historically, different arrangements were in place in different localities, therefore CHS were currently in the process of trying to standardise the process in line with NMC guidance and to establish a more robust system for those occasions when a signed administration chart is not available or where there are difficulties getting the administration chart signed. There were concerns that nurses could write up drug/dose on an administration chart from a hospital discharge letter and later find that drug/dose may be incorrect. The guidance recommends using the label from the medication and another available document e.g. right hand side of prescription to ensure that there are no dispensing errors. CW advised that as the policy requires co-operation from GP practices it was important to bring the guidance to the D&T committee. SSh requested clarification on the definition of transcribing which was given by CW.

Care homes were also discussed, generally community pharmacies provide a MAR chart to care homes which could be classed as a direction to administer, PK advised that as a community pharmacist, she was sometimes asked to prepare additional labels for addition to an administration chart.

GC felt that the default position should be that GPs should complete the administration chart; CW advised that there were some practical difficulties with this as some GPs don't want to do it or feel that the FP10 is the direction to administer. Insulin was discussed as often the directions are not on the label, it was agreed that the default position should be that this should be returned to the GP for clarification as the NPSA rapid response for insulin advised that it should be labelled.

CW advised that the guidance provides a framework for nurses to transcribe but they should have a signed and dated piece of paper e.g. signed right hand side of prescription or summary report which could be received by fax or email.

ID queried if there were any implications for care homes, there is CQC guidance for care homes and it is the care homes responsibility to get medication administered. It was felt that although the LMC may take the view that GPs don't need to sign the paper copy, in the interests of patient safety, it would be reasonable to do so, GPs around the table were happy with this approach. It was agreed that nurses should not be transcribing controlled drugs, and it was thought that this could possibly extend to all end of life pathway drugs. A specific example of where this policy would be used would be for vitamin B12 injections.

This policy was supported by the D&T committee.

6.6 NPC Prescribing, Medicines Management and pharmacy functions in Primary and community care – competency framework

An overview of this document was given and the committee were advised that this would be a good starting point for a Medicines Management strategy for the organisation, a lot of the functions were already being undertaken by the Medicines Management team; although IM advised that the workforce section on page 11 required more work. The document advises what needs to be in the future state and covers a depth and breadth of Medicines Management functions. PK queried if this was a change in direction as community pharmacy had not previously been supported, IM advised that there has always been some support to community pharmacists e.g. pharmacy contract panels, however often this sort of work done in the background by the team is not seen.

ID felt it was a useful and timely document to ensure that the new GP-led commissioning consortia understand the complexities of the medicines management functions. IM advised that he would be working with the senior team to develop a strategy. It was agreed that the senior management team

need to assess medicines management against this competency framework and take this assessment to the management executive and PBC. It was agreed that any gaps need to be identified not just within the medicines management team but within the wider PCT e.g. contracting. ID felt that this should be done before the end of March 2011. IM advised that the document also covered commissioning of services.

SW advised that the North East SHA have been looking at local decision making working with the NPC, this would link to the proposed mapping exercise. The secondary care chief pharmacists and primary care HOMM have set up a task and finish group to map stakeholder decision making bodies across the region including NETAG and NECDAG using focus groups and face to face meetings. SW advised that as far as she was aware, County Durham and Darlington PCTs were not represented at this task and finish group and it was suggested that IM should approach Janette Stephenson to be included in this group. This group reports to the SHA and needs high level buy in with PCTs working together to drive this agenda forward.

Action: Senior team to complete the self assessment competency framework and return the completed document to D&T and management executive before the end of March 2011.
Action: IM to liaise with Janette Stephenson regarding the region wide task and finish group.

7.0 FINANCIAL BUDGET UPDATE

7.1 Monthly Finance Report

HB presented the report on prescribing data for August, but advised that the data for September had just arrived and was showing some improvement due to the revised PPA profile from September which includes category M changes.

8.0 QIPP

IM informed the Committee that the work undertaken by the MM practice pharmacists had saved £380k forecast to the end of the year, based on the work so far this year. IM advised that mechanisms for allocation of practice pharmacist support are currently being discussed with each PBC locality, some localities have agreed a targeted approach to identified “hot spots” with greater potential savings. IM advised that meetings with SLA pharmacists are currently being held to discuss areas of work. IM highlighted that the quick win simple switches are now being exhausted and the team will need to look at more complex work e.g. clinical area reviews such as asthma/COPD.
PJ queried if a switch from other sartans to losartan could be done easily as this could produce high cost savings. IM advised that patients would need to be seen as potential dose titrations would need to be made.

DR advised that he had an email from nephrologists regarding dose equivalences of ACEI/ARB which he could share with the group. ID felt that it was worth considering this switch; PJ felt that patients are receiving changes to their medication better in the current financial climate. ID advised that he has made these changes in his practice in the past with BP and U&E checks two to four weeks following the change; this was not a complex switch to complete.

IM also highlighted that the price of clopidogrel had dropped further than previously anticipated releasing more savings and the new category M prices may release further savings still.

Action: DR to email information regarding dose equivalences to MMT.
Action: MM team to develop and promote SOPs for the potential switch from other sartans to losartan.

8.1 ScriptSwitch Update

DR presented a paper outlining his recommendations for which products should have a repeat reauthorisation ScriptSwitch message, he advised that he had reviewed the profile and by and large the list of messages was good. DR recommended the following changes - to add a repeat reauthorisation message to all ARBs that are not losartan, prednisolone EC, viscotears unit dose vials and venlafaxine MR capsules. The committee approved these recommendations for implementation by Deborah Giles.

Action: Deborah Giles to make the agreed amendments to the ScriptSwitch profile.

9.0 MEDICATION SAFETY & NPSA

9.1 Drug Safety Update – (MHRA) –November 2010

HB gave a brief summary of this update, the committee agreed to add information regarding tamoxifen interactions, bisphosphonates and tiotropium respimat.
Action: HB to ensure these items are included in the next newsletter.

9.2 NPSA Insulin

LN gave a verbal update indicating that an NPSA alert had recently been cascaded regarding the administration of insulin which is not applicable in GP practices, but advised that the PCT were seeking assurances that the alert had been implemented by all of its providers. LN advised that she could not remember the timescales involved but it was agreed that once a final report was received, it should be brought back to the D&T

Action: LN to confirm timescales and feedback report to D&T

9.3 Care Home Update

LN gave an update on a DH directive which came out in February 2010 and required action by May 2010. Unfortunately, this piece of work has been on the back burner until resources were available. LN advised that currently there are a lot of errors in nursing and care homes, sometimes poor standards of care are investigated and include medicines management issues including dispensing and prescribing errors.

LN advised that the action plan shows where we are to date based on a multidisciplinary meeting to identify benchmarking. LN also advised that she would be adding something into the PNA. LN added that we needed to find out how many problems occur when patients are admitted to hospital. Barbara Hudson will be linking with GP practices. LN felt that once this was complete we should be able to improve things. LN advised that one quick fix piece of work involved the development of a tool to record patch placement.

LN requested a GP prescribing lead to link with her on this piece of work, ID advised that he would like to contribute to this as it fitted with potential enhanced services work.

10.0 PROVIDER Drug &THERAPEUTICS COMMITTEES

10.1 Update from Sunderland CHFT D&T – 1st November 2010

This update was received by the committee for information, two new products were added to the formulary, Nuvaring® and Sevelamer carbonate (Renvela®). Combodart® was rejected from formulary.

10.2 Update from North Tees and Hartlepool FT D&T – 12th November 2010

SP attended this meeting and provided information to be fed back to the committee by HB. HB advised that the trust are looking at gonadorelin prescribing, reviewing prescribing of liquid specials on the wards and to stop using prednisolone EC. The trust are also preparing a shared care guideline for tinzaparin. Additions to the formulary included liraglutide with shared care to be developed and prucalopride for consultant use only.

10.3 Update from County Durham and Darlington FT D&T - 6th October 2010 & verbal update on meeting discussing dermatology specials

GC advised that the rheumatologists want to use Sildenafil for Raynaud's Syndrome and pass prescribing out to community. In view of the difficulty prescribing sildenafil 50mg in the community for this indication they agreed to prescribe the 20mg tablets, they also agreed to initiate prescribing and provide an information leaflet to GPs.IM queried if this could be dispensed in community pharmacy, and was advised it would be possible as long as it was dispensed as the 20mg tablets as it is not an 'SLS' indication. ID queried whether some guidance needed to be issued to GPs; GC advised that there would only be one rheumatologist would be prescribing this at present. The

limited evidence base and unlicensed status was queried, as was the potential status as an expensive drug.

GC advised that the issue of dosette boxes was discussed, the trust are trying to sort this out; a number of drugs subject to NICE guidance were approved including tocilizumab, denosumab and dronedranone.

GC also added that there was a formulary request for fesoterodine, however, it was agreed that the trust would look at all anti-muscarinics as there was a potential for savings, and there is NICE guidance available, he wondered if we could volunteer to lead this. It was agreed that the medicines management team would need to look at this as a piece of work (SW offered to help with the ePACT data if needed) and would offer to do so at the next CDDFT meeting.

Action: HB and GC to discuss antimuscarinics at next CDDFT D&T meeting.

GC also advised that he had a meeting with Dr Carr; Dermatologist regarding dermatology specials, the outcome of the meeting is that Dr Carr will draw up a “limited list” of around ten items. The group were also looking at getting agreements with community pharmacists in the areas where there are GPSIs using the hospital supply chain to source the specials. GC advised that the base of these creams was felt to be critically important by Dr Carr; she feels that the quality of the base used varies between manufacturers. IM advised that specials are part of the national QIPP initiative. GC advised that there was to be no further meeting, but that CDDFT would look at moving this forward.

Action: HB and GC to work with CDDFT to move forward with dermatology specials.

10.4 Update from Tees Esk and Wear Valley Mental Health Trust D&T 23rd September 2010

JS gave a brief update from this meeting covering antipsychotics, methylphenidate for adults with ADHD and venlafaxine XL.

10.5 Durham Cluster Prison Drugs and Therapeutics Committee

CW requested that this item is merged with the following item in future meetings and had prepared a paper to cover both.

10.6 Community Health Services Medicines Management Committee

CW presented the paper covering the CHS Medicines Management Group Meeting and the Prison Cluster D&T meeting which was accepted by the committee for information. CW also presented a report covering the Non-Medical Prescribing Conference in June 2010, he advised that this conference was funded by “learning in the workplace” funding and was aimed at both

practice and community non-medical prescribers with a theme of "prescribing with competence". It was noted that it was mainly attended by CHS staff with disappointing numbers from practices, which was thought to be due to it being a full day event. ID congratulated CW on the report and the committee were keen for this to become an annual event.

11.0 RDTC UPDATE

11.1 Horizon scanning document and Publications list

SW presented the November 2010 Horizon scanning document highlighting in particular that there was an intranasal flu vaccine on the horizon and also that ticagrelor, a new antiplatelet was due on the market soon.

SW also gave an overview of the RDTC publications advising that there is a new drug evaluation publication for combodart and 'hot topic' documents available on ezetimibe and escitalopram.

12.0 PRESCRIBING UPDATES

12.1 D&T Bulletin November 2010

HB briefly outlined the content of this month's bulletin, highlighting the editorial on prasugrel, which advised that the NICE guidance on prasugrel was based on the historic higher prices for clopidogrel, the price of clopidogrel has now dropped significantly and therefore, the assessment may no longer be valid.

The committee also requested that the article on dronedarone be circulated to FT's.

Action: HB to check if NICE will be reviewing their guidance on prasugrel.
Action: HB to circulate DTB article on dronedarone to the local FTs.

12.2 New Drugs & Products and NETAG recommendations

There were no new drugs for discussion this month and NETAG have not met this month.

12.3 NICE Guidance

JS presented a brief overview of NICE guidance advising that guidance had been issued for liraglutide, although guidance around continued prescribing was unclear and also that denosumab had been approved for use in osteoporosis within specific parameters.

13.0 NON MEDICAL PRESCRIBING

Please see agenda item 6.1.

14.0 PATIENT GROUP DIRECTIONS

IM informed the Committee that the PGD's were currently in the process of being transferred between MMC and CHS. 25% were to be retained by MMC and 75% were to be transferred to CHS for them to manage. IM advised that there were a number of PGDs awaiting completion and sign off prior to the handover.

15.0 QOF (quarterly update)

No update this month.

16.0 MM UPDATE & PUBLICATIONS

16.1 Prescribing Support Update

IM informed the Committee that Debbie Edwards had recently been appointed as lead nurse and that the Medicines Management Team had been aligned to a new director, Pat Keane form 1st December 2010.

IM informed the Committee that he and ID were currently in the process of meeting with SLA providers of practice support and also that the MMT were looking at realigning practice support to allow an equal share of support per locality and address hot spots as agreed by the PBC clusters.

17.0 PBC PRESCRIBING LOCALITY UPDATES

17.1 Darlington Locality Prescribing Group -update from 5th October 2010

This update was received by the committee for information.

17.2 DCLS Locality Prescribing Group – update from 28th September 2010

This update was received by the committee for information.

17.3 Derwentside Locality Prescribing Group – update from 14th October 2010

This update was received by the committee for information.

18.0 ANY OTHER BUSINESS

PJ enquired as to what was happening about NICE, ID advised that he felt that the proposed changes to NICE would allow for local decision making, locally, we just need to get the structure in place to facilitate local decision making such as the APC.

19.0 DATE AND TIME OF NEXT MEETING

18th January 2011
Merrington House
12.00 – 2.30 pm