COUNTY DURHAM PCT & DARLINGTON PCT
Drugs and Therapeutics Committee

Minutes of Meeting held
Tuesday 18th October 2011
Board Room, JSH
12-2.30pm

Present:

Hazel Betteney, Clinical Services Pharmacist, TEWV
Serena Bowens, Administrative Co-Ordinator, NHS CD&D (minutes)
Dr Geoff Crackett, GP Prescribing Lead (DCLS)
Dr Ian Davidson, GP Prescribing Lead (Derwentside)
Deborah Giles, Pharmaceutical Adviser, NHS CD&D
Gail Dryden, Community Matron
Dr Peter Jones, GP Prescribing Lead (Sedgefield)
Patricia King, LPC Community Pharmacist Representative
Dominic McDermott, RDTC
Ian Morris, Head of Medicines Management, NHS CD&D
Laura Mundell, Administrative Assistant, NHS CD&D (observer)
Dr David Napier, GP Prescribing Lead (Easington)
Dr David Russell, GP Prescribing Lead (Darlington)
Dr Satinder Sanghera, GP Prescribing Lead (Dales)
Joan Sutherland, Senior Pharmaceutical Adviser, NHS CD&D
Christopher Williams, Deputy Chief Pharmacist, CDDFT

In attendance:

Item 6.1 - Michelle Grant, Commissioning & Technical Manager, Medicines Management Commissioning
Item 10.2 - Clare Lynch, Pharmacist, Medicines Management Commissioning
Item 6.2 - Vicki Vardy, Senior Pharmacy Technician, Medicines Management Commissioning

1.0 APOLOGIES

Linda Neely, Head of Patient Safety and Clinical Quality, NHS CD&D
Anne Phillips, Nurse Prescriber
Ros Prior, TEWV

Ian Davidson thanked Hazel Betteney for her previous commitment and hard work dedicated to the D&T Committee and wished her well in her new role at TEWV.

ID then went on to welcome Deborah Giles, Medicines Management Commissioning, in her role supporting the D&T. Ian Morris informed the Committee that following the departure of Hazel Betteney, he would be taking on the role of Professional Secretary.

2.0 DECLARATION OF INTERESTS

No interests were declared.

3.0 MINUTES OF LAST MEETING OF HELD 16TH AUGUST 2011

The Committee accepted the minutes as a true and accurate record.

4.0 MATTERS ARISING (not on agenda)

Flu vaccine consultation (16.08.11 item 6.3)

Ken Ross was to be re-contacted as no information had been forthcoming.

5.0 ACTIONS TAKEN BY MEDICINES MANAGEMENT TEAM FROM 16TH AUGUST 2011

Please refer to amended action log.

The updated actions were accepted and noted by the Committee.

6.0 AGENDA

6.1 Gluten Free (verbal update)

Michelle Grant informed the Committee of a piece of work involving North Durham Clinical Commissioning Group, looking into the Gluten Free Scheme currently in place in the DCLS locality.

A toolkit has recently been launched by Coeliac UK, the Pharmaceutical Services Negotiating Committee (PSNC) and the National Pharmacy Association (NPA), produced to give guidance to PCTs and Clinical Commissioning Groups on how they can improve the supply of gluten-free foods. The toolkit presents two options for the supply of gluten free foods: through repeat dispensing; or through a local enhanced service which is currently in place in the Durham and Chester-le-Street locality. The new guidance, produced by the Coeliac society in Sept 2011 should be adhered to for both options whereby patients get a limited number of units per month based on their individual nutritional needs.

ID added that CCGs need to be wary of the escalating costs that could be involved with the scheme.

Action: MG to produce a more detailed paper for discussion at the December meeting.

6.2 Safe & Secure Handling of Medicines 2010/2011

Vicki Vardy presented an updated paper following discussions at the previous D&T meeting, where declarations were still outstanding from a number of contractors.

VV informed the Committee that following the previous meeting all declarations that were outstanding have now been completed and returned, giving assurance that all contractors in NHS County Durham and Darlington are compliant with core

standards C4(d) and C4(e) of the Care Quality Commission's Standards for Better Health.

Queries arose as to whether this information should be forwarded to the Management Executive (ME) or Interim Federated Board (IFB) for their information.

Action: IM to check if the final report should proceed to ME or IFB.

6.3 Annual Controlled Drugs Report 2010/2011

IM presented the report which went to Board in September summarising the work the Medicines Management team had undertaken in relation to annual declaration processes for controlled drugs, investigations and destructions in GP practices and community pharmacies. This work was a statutory responsibility following the Shipman Inquiry.

IM informed the committee that the Board had agreed to reaffirm the position of Ian Davidson as Accountable Officer for Controlled Drugs for NHS County Durham and Darlington for 2011/2012 or until such time as the CCGs take over this statutory responsibility.

The report covered the role and the function of the Local Intelligence Network, currently a statutory responsibility of the PCT where all providers of healthcare services are required to submit quarterly occurrence reports and share incidents as they occur.

The report also highlighted the issues surrounding annual controlled drugs declarations, required from all clinicians listed on the Performers' List, currently held by the North East Primary Care Services Agency (PCSA) and all practices within County Durham and Darlington. A number of clinicians and practices failed to return completed declaration forms, in some cases this was due to incorrect addresses on the Performers' List and included a number of GP practice branch sites. IM informed the committee that the annual declaration process would be changing for 2011/2012, with forms being completed online through the new Medicines Management website.

Discussions ensued surrounding the responsibility for controlled drug processes including the annual declaration process, investigation of controlled drug incidents and controlled drug destructions, which currently lies with the PCT Medicines Management Team, and where responsibility would lie in the future. IM informed the Committee a number of risks had been identified in the area of controlled drugs, including incorrect addresses on the Performers' List affecting the annual declaration process, prescription coding errors made by the Prescription Pricing Division for example metoclopramide being incorrectly coded as methadone leading to unnecessary investigations, and a reduced capacity within the PCT Medicines Management Team to be able to effectively deliver these functions. Concerns were also raised that some of the issues highlighted will be difficult for CCGs to deliver in the future.

IM informed the committee there is currently no guidance to indicate where these functions and responsibilities will lie in the future, however they would remain a statutory responsibility of the PCT until March 2013. DR raised the issue of GP appraisals and queried whether the controlled drug declaration/ validation process

could be tied into this process, however noted this would need to be changed nationally. There was strong support for this amongst the Committee members and ID agreed to raise the issue at the next Medical Directors meeting.

Action: ID to raise issues flagged at next primary care Medical Directors meeting.

ID informed the committee of two recent controlled drug incidents involving opioid concentrated oral solutions; in the first incident methadone oral concentrate solution 20mg/ml was prescribed instead of 1mg/ml and in the second incident Oramorph® concentrated oral solution 100mg/5ml was prescribed instead of 10mg/5ml. No actual patient harm occurred, however both incidents were near misses and has the potential of causing serious harm.

ID proposed producing a medication safety memo for circulation to all GP practices and community pharmacies, advising that concentrated opioid oral solutions should not be prescribed in non-specialist environments. PK advised that community pharmacies do receive prescriptions for concentrated opioid oral solutions from non-specialist prescribers, which may be appropriate in some circumstances and queried what would happen to patients already being prescribed these preparations from non-specialist prescribers.

Following discussion it was agreed a memo would be produced reminding clinicians of the risks involved with concentrated opioid oral solutions and advising that prescribing of concentrated opioid solutions should be avoided other than in exceptional circumstances.

Action: MM team to produce medication safety alert regarding opioid concentrated oral solutions and disseminate to all GP practices and community pharmacies

Action: DG to check ScriptSwitch alerts for concentrate opioid preparations.

6.4 King's Fund Report: Areas of Development of Primary Care Prescribing

ID presented this report which makes a number of recommendations and proposes quality indicators that could be used to describe high quality prescribing, most of which ID acknowledged are being covered in County Durham and Darlington already.

SS commented this was an excellent report which touched on all areas and key topics, most of which were relevant to the current workings of the D&T Committee.

ID asked if there were any areas highlighted within the report that the D&T Committee needed to look into further. PJ commented that the document was ambitious and highlighted policies for pharmaceutical companies, querying how many practices had written policies in place. PJ also queried how strongly the Committee should be discouraging the prescribing of branded generic drugs, as he is still aware of GPs who still prescribe these. ID stated that information on this was sent out to CCG chairs last year and the report presented reinforces the Committee's position on branded generic drugs.

PK added that the current pricing structure in place was to drive the price down and added that some pharmacy income comes from mark up on category M and if

bypassed in an area this could severely disadvantage pharmacies. Branded generics was considered a short term gain however, as IM commented some smaller pharmaceutical companies may not be able to supply in quantities large enough to meet demand, therefore patients are either switched back to the original brand or pharmacies are forced to go directly to the manufacturer.

ID highlighted a section in the report looking into patient centred care and suggested there was a need to consider how to best involve and interact with patients. There was agreement that cost should be discussed with patients; ID asked if clinical commissioning would be a suitable forum for these groups, and commented that more patient centred work would fit nicely into prescribing groups. SS agreed that patients should be made more involved, however DN thought this may be difficult to resource as a number of patients would be required.

ID advised of the need to draw ideas from the report to move forward. Prescriber training was another area mentioned which has been moved away from in recent years due to cut backs. The report highlighted this as a very important area; however ID queried how this could be reinvented.

SS highlighted the need for better co-ordination of prescribing between hospitals and general practice for those patients newly discharged from hospital, also examined within the report. It was suggested that patients are not necessarily always informed about medication changes following discharge from hospital. SS suggested that community pharmacies may be able to help in this area; practices could inform their local pharmacy when a patient has been discharged from hospital which could then prompt the pharmacy to undertake a medication review. PK agreed that this was an area pharmacy can help with, and pilot schemes have shown that hospital discharge errors can be picked up quickly and effectively.

ID informed the Committee he would be meeting with patient focus groups and highlighted the need to communicate better with patients and decide how to move forward with this, suggesting if the D&T Committee has a future in this process they could act as a resource to produce patient information for CCGs.

GC raised the issue of prescriber training, suggesting it needed to be more powerful around the influence of branded generics and could incorporate items such as how to read a paper, factors to consider when speaking with Company Representatives etc. ID commented that NPC training was developed for use in these circumstances and DN added that the NPC training was currently better than anything else available. ID suggested that training was an issue that maybe needed looking into further.

Action:

The Committee would focus on the following issues in the future:

- **Pharmaceutical industry**
- **Interface working between hospitals and general practice**
- **Branded generics**
- **Patient support and engagement**
- **Prescriber training**

6.5 Alignment of GP Prescribing Leads and New Job Description

ID informed the Committee there had been talk for some time of aligning GP Prescribing Leads with Clinical Commissioning Groups (CCGs) of which there are currently three in County Durham and Darlington:

- North Durham, incorporating Durham, Chester-le-Street and Derwentside;
- South East Durham, incorporating Durham Dales, Sedgefield and Easington;
- Darlington.

ID advised that from the end of October 2011 all staff currently employed by the PCT must align with either a CCG, the Commissioning Support Unit (CSU) or be retained in the remainder of the PCT. At present the GP Prescribing Leads will be aligned to CCGs from the end of October 2011, however it is still unknown as to how this will work in practice and what structures will be in place to manage GP Prescribing Leads in CCGs.

ID advised that a paper containing the proposals has been to the PCT Strategy Development Group, however it has not yet been cascaded elsewhere. ID proposed this paper should be taken forward to be presented to the PCT Interim Federated Board.

PJ asked if there would be some integration of functions within CCGs whilst still keeping a locality focus for clinical engagement. IM stated that there was still support for six GP Prescribing Leads across County Durham and Darlington. DN commented that there will still be a need for the GP Prescribing Lead role in the future with a local focus to which ID also agreed.

Action: ID to take the paper forward to the next IFB meeting.

6.6 New Drug Request Process for Primary Care

IM disseminated a paper to the Committee regarding a new drug request process for primary care, based on a similar process produced by CW for the Foundation Trust for new drug requests in secondary care. IM advised the committee this was part of the formulary development work currently being undertaken by the Area Prescribing Committee (APC).

Action: Committee members to send any comments regarding the process to IM within the next 10 days.

Action: CW to share the most recent "updated" Foundation Trust process with IM.

6.7 Substance Misuse

JS presented new prescribing guidance produced by TEWV for drug misuse. JS advised that the document still required some amendments and informed the committee of a meeting planned with Wolfgang Custer (Consultant in Substance Misuse, TEWV) and Fiona Imms (Prescribing Adviser, NHS Tees) in November where this would be discussed. JS asked the Committee to forward any comments before 21st November.

JS also advised of the need to think how this guidance links in with community pharmacies and the DAAT and suggested a crib sheet where key points are clearly presented for prescribers who are unfamiliar with prescribing for these patients.

DN commented the guideline was well written, however queried if prescribers in non-specialist settings should be prescribing for substance misuse, and also commented he had some reservations that a crib sheet could be potentially dangerous for non-specialist prescribers, providing them with confidence to try and prescribe outside of their competencies.

JS advised there may be a need to pick out the more useful parts of the guidance for use in primary care and also highlighted potential issues in the document, including guidance for crushing Suboxone® tablets which is unlicensed if this is done and could be an issue in community pharmacies, potentially affecting an individual pharmacist's indemnity insurance.

IM asked if methadone concentrate was mentioned in the guidance, advising this would be something worth flagging for addition to the document.

Action: Guidance to be circulated to LPC and DAAT for comment.

Action: Committee members to forward any further comments to JS before 21st November 2011 to allow issues and concerns to be raised with TEWV.

6.8 Generalised Anxiety Disorder (amended version following APC)

ID advised this paper had previously been to the APC, however as there was little GP representation at this meeting it was agreed it would be brought to D&T for a primary care based discussion.

ID asked the Committee for comments on the guidance, specifically on step 3 and if pregabalin should be included on this step or moved to step 4.

PJ commented that pregabalin was very expensive and SS advised she would be concerned if GPs were being asked to prescribe.

The Committee were in agreement that pregabalin should remain in step 3, however be moved onto a separate line/ separate bullet point in step 3 of the guidance.

Action: Joan Sutherland to feed back to TEWV that pregabalin should be moved onto a separate line in step 3 of the guidance.

STANDING ITEMS

7.0 FINANCIAL/BUDGET UPDATE

IM informed the Committee that all CCGs have now chosen their budget setting models, as detailed in the Finance Update report. IM advised that none of the CCGs had requested an expensive medicines fund for 2011/2012 and that two areas, Darlington and Durham Dales required a NRT scheme, for which money would be top sliced from the prescribing budget. IM informed the committee that

the next steps would be for the CCGs to agree prescribing budgets for individual practices and put in place QIPP plans to tackle any projected overspend.

IM advised that statutory responsibility for budgets would remain with the PCT until March 2013.

GC queried what would happen to the budget for prescribing support. ID advised that this was still the PCT's budget.ID also advised that the practice support staff budget would also be aligned to CCGs and discussions were currently taking place with practice support staff as to which CCG staff members would be aligned to.

GC asked about the vacancies in the Medicines Management Team and if any recruitment would be taking place. ID advised that the PCT were attempting to recruit to the non-practice based team, however there had also been significant recruitment of new SLA practice support pharmacists which would run until the end of the current financial year. ID also informed the Committee that some areas had asked for support in co-ordinating SLA practice work.

8.0 QIPP

8.1 QIPP Plans – Feedback from Localities

There was no specific feedback from localities. ID added that sharing QIPP plans would be useful.

9.0 SCRIPTSWITCH (verbal update)

DG informed the Committee that a paper was presented to the PCT IFB in August 2011 with options for the future of ScriptSwitch in County Durham and Darlington. The IFB agreed to the renewal of the existing ScriptSwitch contracts, however with amendments to include penalty clauses if ScriptSwitch failed to work and deliver in practices.

IM advised that a letter had been sent to ScriptSwitch asking for compensation for the issues experienced with the system over the past year, however this was refused. IM also added that clauses need to be in the contract so a better service can be delivered and advised that CCGs need to ensure ScriptSwitch is being used in practices where it is installed, otherwise the PCT will be paying for a service not being used.

GC enquired about the duration of the contract and IM stated the new contract would be for 36 months with a break clause in at 12 months.

DR asked if information could be cascaded via email detailing the practices not using ScriptSwitch or for whom no data is received.

GC highlighted that the pop up system works, however the data received back is not useful. GC also noted that the annual cost of the system would more than cover the cost of employing someone to manage the formulary. PJ asked if anything useful was gained by using ScriptSwitch. SS commented that ScriptSwitch was not only about drug switching but also about the safety aspect and ID agreed it would be difficult to "cost" the benefits with regard to safety.

Action: Meeting to be arranged with ID, DR, IM and DG to discuss wording of penalty clauses for inclusion in new contract.

Action: DG to forward information on practices not using ScriptSwitch to GP Prescribing Leads.

10.0 MEDICATION SAFETY & NPSA

10.1 Drug Safety Update – (MHRA)

Committee members agreed there was nothing of great significance in the September 2011 Drug Safety Update, and the only item of note in the October 2011 Drug Safety Update was information on a new buccal midazolam product (Buccolam) for which care is needed when transferring from unlicensed formulations.

10.2 Community Acquired *C.Difficile* and Antibiotic Prescribing Report

CL presented an update on prescribing trends and associated reports of *C.Difficile*, advising the Committee there had been 49 cases of *C.Difficile* reported to the PCT in the first 6 months of 2011 with most patients being prescribed two or less courses of antibiotics in the preceding six months and 40% of this prescribing not complying with the PCT Antibiotic Guidelines.

GC questioned the need to raise awareness of the issue of low doses of flucloxacillin and erythromycin being used. DR commented that oral flucloxacillin solutions were still very expensive and added some guidance on alternatives would be useful.

ID thanked CL for this piece of work and for her support to the D&T Committee and wished her good luck for the future on leaving the organisation.

Action: CL to share further information with GP Prescribing Leads

Action: DG to add item to newsletter highlighting the need for adequate doses of flucloxacillin and erythromycin, and alternatives to oral flucloxacillin solutions.

10.3 Drugs in Transplant (verbal upate)

IM advised the Committee of a letter received regarding the use of branded products for patients receiving drugs post-transplant. HB informed that the issue was scheduled for discussion at the Heads of Medicines Management meeting last week.

Action: IM to research further and produce a paper for discussion at the next D&T meeting.

11.0 APC UPDATE

Draft minutes from APC meeting held 1st September 2011

A copy of previous minutes had been circulated to the Committee for information. ID highlighted the progress that had been made with a guideline for dementia, that

the APC were hoping for an emollient prescribing guide, and updated on progress made with the formulary.

12.0 RDTC UPDATE

12.1 Horizon Scanning Document September & October 2011

DM presented these documents, advising there was currently a lot happening, including changes to NICE guidance for hypertension, generic pioglitazone and a new gliptin with a slight advantage for patients with severe renal impairment.

There was discussion surrounding dabigatran, and the Committee were informed that reps were currently promoting the product in the area and should be following NETAG guidance on its use. ID also informed the committee that an agreement was currently in place ensuring that if a patient needed to be switched from dabigatran back to warfarin the cost will be covered by the manufacturers of dabigatran.

Action: MM team to produce report highlighting spend on dabigatran for next D&T meeting.

12.2 Estimated Savings from October 2011 Category M Generic Drug price Reductions

DM informed the Committee that estimated savings from October 2011 for Category M generic drug price reductions would be in the region of £165,000. IM fed back that his calculations suggested saving close to £150k for Darlington and £950k for Durham with the £165k figure seeming to relate more to the apparent monthly saving.

12.3 NCSO and Concesionary Price Increases July 2011

DM informed the Committee that the RDTC will no longer be producing this report as the problems that have previously caused issues now seem to have been resolved.

Action: add item to newsletter.

13.0 PRESCRIBING UPDATES

13.1 Drug and Therapeutics Bulletin Summaries

ID highlighted an article on dabigatran, which may be of interest in primary care. Another article in the DTB discussed home oxygen and ID asked what the current situation regarding the supply of home oxygen was. IM advised that there had been a change in the national contract which the PCSA was leading for County Durham and Darlington, which requires GPs to go online and choose the equipment patients' use to deliver oxygen.

Action: IM to find out further information on the home oxygen service and notify the PCSA of the lack of clarity regarding the new arrangements.

13.2 New Drugs & Products and NETAG recommendations

A summary of decisions made at the previous NETAG meeting was circulated to committee members.

14.0 NON MEDICAL PRESCRIBING

No update this month.

15.0 PATIENT GROUP DIRECTIONS

Following request for approval for Assura to use MSK PGDs IM informed the Committee that the PGDs had been returned as the incorrect volume of lignocaine had been documented. As yet Assura have not responded further.

16.0 QOF (Quarterly Update)

DG informed the Committee that two outstanding practices have now completed the peer review and all QOF work was currently up to date.

17.0 MEDICINES MANAGEMENT TEAM UPDATE & PUBLICATIONS

17.1 Strategy Update

IM advised the Committee that a draft strategy for use at federation level had been developed following the initial scoping work. This was also being used as the basis for a similar document which would be available for use at a consortia level for developing a more local strategy.

ID opened the document for comments, adding he appreciated any steer from the Committee on their views. SS commented that prescribing support would sit naturally with GP Prescribing Leads and added that she had found feedback from the practice support team useful. ID added that it was about ensuring a variety of work, not just QIPP.

DN commented that having no federated structure for CCGs was a major difficulty and was preventing work from being moved on. ID stated that once quality standards have been developed, they must be maintained even though budgets may be tight. ID added that controlled drugs are still a big issue as is patient safety, and that even if these issues are sorted regionally, the CCGs will be statutorily responsible and need to be actively involved in the management of these and other issues.

PK brought up the NEPCSA and queried if their function has been defined. ID advised this would be performance and contract monitoring, however they would not be involved in controlled drugs.

ID advised of the need to continue to flag these issues at an amalgamated level and SS added that issues need to be collectively flagged, as one single voice is not strong enough.

Action: Meeting to be arranged between IM and GP Prescribing Leads Tuesday 3rd November 13.00 – 14.00 to discuss how to move forward.

18.0 CCG PRESCRIBING LOCALITY UPDATES

18.1 Sedgefield

A summary of the above meeting was circulated to the Committee for information.

19.0 PROVIDER DRUG & THERAPEUTICS COMMITTEE

19.1 Update from Sunderland CHFT D&T – 8th September

A summary of the meeting held was circulated to the Committee for information.

19.2 Update from North Tees and Hartlepool FT D&T – 9th September

A summary of the meeting held was circulated to the Committee for information.

19.3 Update from County Durham and Darlington FT D&T – 5th October

A summary of the meeting held was circulated to the Committee for information

19.4 Update from Tees Esk and Wear Valley Mental Health Trust D&T – 3rd October

A summary of the meeting held was circulated to the Committee for information.

20.0 ANY OTHER BUSINESS

Mental health drugs

PJ informed the Committee that at a recent meeting with TEWV he raised the issue of £4 million worth of drugs that could be reviewed. ID advised that Sue Hunter from TEWV was currently working to develop a QIPP plan for mental health drugs that would be presented to the APC.

21.0 DATE AND TIME OF NEXT MEETING

Tuesday 20th December 2011
12.00 – 2.30 pm
Board Room, JSH

Confirmed as an accurate record:

Dr Ian Davidson – Chair
20th December 2011