County Durham and Darlington Area Prescribing Committee

Thursday 3rd July 2014
11.30 am – 2.30 pm
Board Room, John Snow House

MINUTES

Present

Dr Geoff Crackett, GP Prescribing Lead, North Durham CCG
Dr Ian Davidson, Director of Quality & Safety, North Durham CCG (chair)
Sue Dickinson, RDTC
Dr Catherine Harrison, GP Prescribing Lead, DDES CCG
Sue Hunter, Associate Director of Pharmacy, TEWV
Sarah McGeorge, Nurse Consultant & Clinical Director, TEWV
Dr Robin Mitchell, Deputy Medical Director, CD&D FT
Ian Morris, Senior Medicines Optimisation Pharmacist, NECS
Alastair Monk, Medicines Optimisation Pharmacist, NECS
Joan Sutherland, Medicine Optimisation Lead Pharmacist, North Durham CCG
Gill Stephenson, Administrator, NECS (minutes)
Chris Williams, Deputy Chief Pharmacist, CD&D FT
Alwyn Foden, Associate Medical Director ,CD&D FT
Graeme Kirkpatrick, Trust Chief Pharmacist, CD&D FT
Sarah Hailwood, Consultant, CD&D FT

In attendance

Lisa Brown, Nurse Consultant and Clinical Director, TEWV (Observing)

Part 1 – Mental Health (11.30)

1.1 **Diazepam prescribing in crisis teams**

SH informed the group that TEWV has been working with prescribers to reduce the use of Diazepam and this has shown a decrease in an internal report in February 2014.

GC said this seemed to mirror prescribing recommendations and it was good to know these issues were being addressed. One concern though was why this prescribing was passed on to GPs by Crisis teams as GPs were being left to manage patients before passing the patient to another team to manage, this may be an issue prescribers could notify SH about.

ACTION: Prescribing Leads to discuss with LPGs to see if there is a continued issue and report back to APC

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Action: SH to continue to monitor prescribing by TEWV teams.

1.2 Safe transfer of prescribing guidelines – amendments

SH discussed amended guidance with the group. Initially there was a template designed to show how information is communicated to GPs**.** The template has been removed and new wording has been included in the document but for shared cared prescribing there is still a template that can be used for green+ drugs.

ID said he was happy with the document, however he was uncomfortable with alcohol misuse prescribing drugs as Acamprosate and Disulfram are red but secondary care seem reluctant to take this on in the Durham area. It was therefore suggested these should be in a shared care "Amber" group.

SH said that in Tees these drugs are used as red drugs but they may have better access to services so are able to manage these patients more in services.

CW said there is a caveat written underneath that says there may be pathways set up so this may be considered more of a guidance document for TEWV than a primary care document. CW noted however that on the APC formulary that these alcohol misuse drugs were indeed Green plus but may be red in some circumstances.

Discussion then moved on to the dementia section which noted that this part of the guidance only related to where monotherapy was been used. It was acknowledged that where two drugs were being used then these patients should remain under secondary care management.

Action: The document Safe Transfer of Prescribing document was agreed subject to the statement about dual therapy in Dementia being a secondary care managed situation being added by SH.

1.3 **NICE CG 178 Psychosis and schizophrenia in adults**

SH discussed with the group the NICE clinical guideline for Psychosis and Schizophrenia and said that secondary care services would now need to look after side effects and monitor patients for 12 months, or until stable, whichever is longer.

ID asked if this affected the shared documents, SH added that there may be another amendment, patients might need to be with them for 12 months, ID thought that this might impact on the contract so it needs to be monitored, and SH said that this was already been discussed at internal meetings.

1.4 **Lithium shared care guidelines – amendments**

SH said as part of the monitoring process, an audit was done to look at how many patients have renal problems and what guidance could be issued for these patients. They have now put some information in the document to give practical guidance regarding renal monitoring.

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IM asked if TEWV could amend the last bold part on page 3 which mentions PCTs, SMC will do this.

IM asked about shared care and GPs, should there be some acknowledgement from the GPs when they receive the paperwork, ID agreed there should be an acknowledgement so nothing "slips through the net" during transfer of information. As a result it was agreed that explicit acceptance by the GP practice should be added to the document

ID raised two issues with the document, the first was regarding page 5, where it was asked who's responsibility is it to monitor renal function , should it be the GP, if so should this be written in, SMC thought the consultants should be proactive in this, she would expect them to monitor this, SH said they would have known if they had been referred to nephrology.

The second issue that ID referred to was regarding consecutive decline, SH said should only be of concern if the eGFR goes below 60. RM thought that the renal network may be able to help with this.

It was noted that the specific advice given in the document did not cover North Durham ID asked if TEWV could look into this to get similar guidance. eg Sunderland nephrology department, SH said will look into this.

ACTION: This document is to be adopted subject to the following changes:

- **Amend reference to PCT on page 3**
- **Add the requirement for GP practices to formally accept the management of the patient**

Action: SH to seek guidance from Nephrology colleagues covering North Durham to give equivalent advice to that received from Nephrologists from other parts of the area.

1.5 **Clozapine guidance for GPs**

SH presented a first draft of an aide memoire for GPs on the use of Clozapine.

Initial comments had been received but SH wanted additional comments to be sent to her.

During the discussion it was asked that the concentration figures to be correctly written ie $x10^9$/L rather than x109/L , and it was also asked that the frequency in which the side effects occur were added to the table. It was also asked if the document could be made to fit two sides of an A4 piece of paper .

Action: Members of the APC to notify SH of any recommended changes by the end of August 2014

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Action: SH to bring revised document back to APC in September 2014

Part 2 – General (12.30)

2.1 Apologies for absence:
Paul Davies, Medicines Optimisation Pharmacist, NECS
Betty Hoy, Patient Representative
Laura Walker, Administrator, NECS
Paul Walker
Ingrid Whitton

2.2 Declarations of Interest
RM noted he has another role working with clinical networks

Action: It was agreed that Paul Davies should circulate declarations of interest forms to members

2.3 Minutes of the previous APC meeting held 1st May 2014

Item 1 – reword to say " …. however the system ~~does~~ is not yet avaialable in primary care"

Item 6 - reword to say "GC highlighted the IFR process and the system that is currently in place for recording decisions"

Item 7 (pg3) – remove the wording "PD explained Darlington are not currently signed up to the scheme"

Item 7 (pg 4) – add to the end of the first sentence *"….. the other preparations*, as this was covered in the Osteoporosis guidelines"

7.7 Reword final sentence to say "CH and PK felt a ~~recall~~ further switch would be difficult and patients would not take it very well having a further switch"

Item 16 (Pg 7) second para, second sentence. Reword to say "ID explained that the formulary recommends which drugs should be prescribed but ~~you can~~ GPs are able to prescribe off formulary drugs. "

Item 16 , change final sentence to "CW agreed that there needs to be a system within ~~CD&D FT~~ the APC area for off formulary prescribing"

Item 19 – Add a final sentence to say "The APC agreed to support this research"

2.31 **APC Terms of Reference**
The APC TOR was discussed and whilst it was acknowledged that the whole TOR requires a review the discussion mainly focussed on the memberships section.

ID said he had discussed Public Health representation with the local authority

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but at present there was insufficient capacity for them to attend at present. It was also noted that the number of CCG Senior Pharmacists should be amended to two to reflect the current CCG arrangements.

The group also agreed that the quoracy should stay the same ie "*Two GP representatives plus one clinician and one senior pharmacist for each of the two trusts CDDFT, and TEWV to which the agenda is relevant "*

2.4. Matters arising including action log

Item 1 – Adult DHD prescribing – SH confirmed that this was being discussed at the TEWV D&T and can be discussed at the Sept APC

Item 2 – Review of clozapine system – SH had checked the situation with regard to transferring hyoscine prescribing back to primary care and could confirm that this was already happening. In light of this she had spoken with consultants and local quality groups to highlight the need for good communication with GPs. SH also confirmed that the clozapine document is now also in a draft form

Item 3 – Lithium (notification of practices not recalling practices) – SH said that some practices had need to be reminded that three monthly monitoring is needed and a list of practices that had needed to be contacted was passed to ID.

Item 4 – Lithium process review – not due until Sept 14

Item 5 – Diazepam prescribing by crisis teams – covered in this agenda (CLOSED)

Item 6 – Formulary Steering group were asked to decide on an annotation to highlight drugs in the formulary with a positive NICE TA but which were not for conditions treated by the trust. CW confirmed an asterix had been added to drugs where this was the case. (CLOSED)

Item 7 – Formulary committee to circulate work plan – this was done at may APC (Closed)

Item 8 – Promotion of the formulary – it was agreed that this should be an ongoing process (CLOSED)

Item 9 – Entering of formulary work for an award – IM had reviewed current awards and no category was appropriate for a submission, although future awards would be considered when they become open to applicants.(Closed)

Item 10 - Draft a PGD for Sayana press – as Public Health had not commissioned this no PGD has been drafted (Closed)

Item 11 – Medroxyprogesterone products – Intramuscular and Subcutaneous had been added to the relevant drug entry in the formulary (Closed)

Item 12 – Declarations of interest – this is to be added to the next agenda (OPEN)

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Item 13 – Lixisenatide – this has now been added to the formulary as a green+ product (Closed)

Item 14 – The review of NSAIDs had been added to the CCG newsletter (closed)

Item 156– Formulary steering group to review NSAID again in 6 months' time – not due until Sept 14 (OPEN)

Item 15 - ID has not written to the Chair of the Programme Board yet regarding a programme budget approach for diabetes but it was agreed to close this action as discussions had taken place instead (CLOSED)

Item 17 – Glucose monitoring guidelines have already been updated so it was agreed to close this item (CLOSED)

Item 18 – Paul Peter had drafted some guidance about the use of liraglutide with insulin. CW will discuss this with him before it is circulated.

Further updates:

Matters arising – PD is looking at Agenda and some of other actions which are historic

IFR – more clarity is needed, ID has had several emails back, he informed the group that he has written to Stephen Childs, also there is a review group, GC has gone back to ask if they can have information in a certain way. ID thinks that the APC is the best forum for this item.

In his absence PD asked IM to say would like to have some interim guidance on urinary incontinence. ID said we need to say that we agreed to wait until November or we will use what we have

2.5 APC Formulary steering committee

2.51 Formulary Steering Group Minutes (April 2014)
Received for information.

2.52 Formulary Steering Group Minutes (May 2014)
Received for information.

2.53 NICE MHRA update (April 2014))
Received for information.

2.54 NICE MHRA update (May 2013)
Received For information.

2.55 Formulary Update and Online Formulary Changes
Summary received for information

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2.56 Cinacalcet shared care

It was noted that this item was listed in error twice on the agenda so items 2.56 and item 2.64 were combined and discussed at this point in the agenda.

The discussion tackled two issues. Firstly if the drug could be moved from Red to amber as many GPs elsewhere were managing this in primary care. This was agreed subject to the shared care document being acceptable.

The debate then went on to discuss the shared care document and it was felt that there were discrepancies in the monitoring frequencies e.g.

- recommending the specific number of months between tests (not 2-3 months)
- Mention that patient must be stable before transfer and specify a timeframe for this
- Add that patients will still be under the care of the service
- Confirm that parathyroid hormone does not need monitoring etc In addition to this there also needed to be mention of a patient

ACTION:

Cinacalcet can be shared care subject to the documentation being revised to take into account comments received ie:

- recommending the specific number of months between tests (not 2-3 months)
- Mention that patient must be stable before transfer and specify a timeframe for this
- Add that patrients will still be under the care of the service
- Confirm that parathyroid hormone does not need monitoring etc In adition to this there also needed to be mention of a patient

Note – Chairman's action may be taken to approve the document

2.57 Oxycodone

CW told the committee of the latest advice to prescribe oxycodone by brand which came from the CQC/NHS England summary of patient safety repots linked to Oxycodone products. The committee agreed to the proposal.

ACTION: Add to the formulary a statement echoing the recommendation to prescribe by brand where possible.

2.58 Inclusion of indications to accepted drugs

CW discussed with the group whether or not indications should be included with formulary status. Some indications had already been added but there may be issues if licenses change etc.ID felt it is a lot of work but it was a good idea.

CW proposed that a list of bullet points could be drawn up to allow future applications to be considered against certain things in order to see if including the indication would be necessary on a drug by drug basis.

ACTION: It was agreed in principle to consider adding indications for drugs to the formulary but CW is asked to bring a checklist to a future APC which may be used when considering this.

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2.59 Grey List

IM discussed the issue of the Grey list which had been in place before the formulary was developed and said some elements predate the formulary but are still relevant today.

There was mixed views on whether or not a grey list was still needed now the formulary was in place and CW suggested that a gap analysis was done to see where the formulary does not cover the issue raised in the grey list.

ACTION: CW to take document to Formulary Steering Group to do a gap analysis to identify which areas may still be relevant for a Grey List.

2.59b Formulary Steering Group TOR

CW brought the revised Formulary Steering Group TOR to the APC which included three amendments:

- Addition of NTAG recommendations to the standing agenda items in section 1
- Adding NTAG to the list of reputable sources in section 5
- Adding that "The group will review proposed traffic light status changes including a review of submitted shared care protocols" to section 5.

The group accepted the revised TOR.

2.6 New Drug Applications

2.61 Levonorgestrel (Jaydess)

The committee considered an application for Jaydess IUD. Prior to the meeting there had been discussions about the pricing and the committee felt that this product gave an additional IUD option. CH also said that it was a smaller diameter than Mirena so may be easier to insert. There was also discussion that the product contained less hormone so whilst possibly leading to more bleeding than Mirena it may have less side effects due to a lower dose.

Jaydess was approved

2.62 Brimonidine

The committee considered the evidence present in the application as well as the tools that were submitted to support the application.

The application suggested that Brimonidine could be used first line in patients with moderate to severe persistent erythema of rosacea that is causing psychological or social distress.

The APC felt that the product had not demonstrated sufficient efficacy that would justify the current use of health economy resources. The group also noted that the product has not be supported by any national appraisals such as NICE or the Scottish Medicines Consortium.

The APC made a decision to reject the application for Brimonidine.

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2.63 Voractiv

An application was considered for Voractiv, which is a combination tablet that contains current formulary approved drugs for TB.

The committee discussed the application and felt the combination product brought safety and compliance benefits.

The APC approved the addition of Voractiv to the formulary

In addition to this there was discussion on whether or not this would be automatically be included in the pharmacy TB scheme so IM said he would check the wording of the scheme to make sure it was covered.

Action: IM to check wording of TB scheme to ensure Voractiv was covered and notify pharmacies of its addition to formulary.

2.64 Cinacalcit Shared Care Agreement
Discussed in 2.56

2.65 Lubiprostone
An application for lubiprostone was discussed which was for the treatment of chronic idiopathic constipation in both men and women. This was a similar indication for Prucalopride but was for both sexes.

The committee noted the positive NICE FAD and then discussed the principle of adopting a product that NICE are planning to review but have not yet issued a TA. As a result of these discussions the committee agreed to defer the decision until the NICE TA is issued.

ID noted that if NICE is positive when finally published then he could look to take Chairs action to add to the formulary.

In the meantime however the committee asked for the pathway to be updated.

Action: CW to ask for pathway for constipation to be reviewed

Action: ID to work with CW once NICE has issued guidance to see if Chairs action can be taken to add Lubiprostone to formulary

2.7. NTAG Update

2.71 Process for including NTAG decisions within formulary.
The group discussed a paper presented by Chris Williams which covered the inclusion of NTAG decisions in the formulary

The group were happy with the proposal where negative NTAG decision will be classed as “rejected” on the formulary whereas positive decisions will be open to a formulary application.

At this time there was also discussion about sequential therapies in macular oedema secondary to Retinal Vein Occlusion as the Clinical Lead Ophthalmologist had noted that this was recommended in recent guidance. As

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a result the clinician should be asked to follow the appeals process if they think the final decision was incorrect.

2.8 Compliance Aid Pathway

2.81 Pathway for managing compliance aids

AM fed back on a paper written by Paul Davies and explained that the work around managing compliance aids was progressing with three meetings do far. The work was based on a 2012 document, primarily written by Chris Williams, entitled "Pathway for Managing Compliance Aids" and it was acknowledged that the appendices in this original document are likely to change following further discussions. This document has changed many times, AM said the whole process is back on track, there is a meeting on 17th July and both Local Authorities will be there. The pathway is aiming to improve the quality of use of compliance aids. The Local Authorities now realise there is an issue with this.
ACTION: APC members to feed back any comments they have on the "Pathway for Managing Compliance Aids" document.

Part 3 – Physical Health (1.30)

3.1 Branded Oral Contraceptives

CW updated the formulary. There is guidance from UKMI indicating that oral contraceptives should be prescribed by brand. The APC supported the addition of branded oral contraceptives to the formulary where alternative brands containing the same ingredients have already been approved.

3.2 Osteoporosis Guidelines

IM presented an updated version of the Osteoporosis guidelines which had been developed in conjunction with Matt Bridges, Consultant Rheumatologist. This was in response to MHRA updated warnings about Strontium and these were now worked into the document. The group approved the updated guidance.

3.3 Diabetes Steering Group

IM updated the group on the progression of the insulin analogue work. This has reasonable input from a cross section of people including Paul Peter and specialized nurses and the group needs the continued support from the CCGs to push this forward.

Currently the group is also looking at the number of hypos that ambulance service is responding to relating to analogue insulins. ID said it was nice to see that progress had been made.

The discussion also mentioned the diabetes test strip work and the working group which had been formed to support this was confident that any initial issues had been addressed and the outstanding questions regarding blood glucose testing strip quality has been addressed.

The group thanked IM for the update

3.4 COPD Update

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The group discussed the recent proposed changes to the COPD guideline as drafted by the COPD CAG. AF said that although he felt the draft Durham pathway for COPD was very good due to its succinctness, he didn't feel able to support the 60% FEV1 treatment threshold.

In the Journal reading AF has done in the past year, coupled with meetings that he's attended in this period (Eur Resp Soc & and worldwide COPD update chaired by Prof W Wedzicha from London), he has not come across any evidence that supports the 60% FEV1 cut off debate.

AF said that in general the move seems to be away from inhaled steroids for COPD, and towards combination LAMA/LABA inhalers of the new generation. To support this discussion AF also shared some slides which had been used as part of a presentation he had given about the management of COPD

ID said this debate has been going on for some time now, and requests had been sent to the COPD CAG asking for evidence before they go against NICE.

ID asked how we could take this forward, and it was agreed that ID should write to the respiratory network on behalf of the APC.

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ACTION: ID to write to the Respiratory Network seeking further evidence regarding moving away from NICE guidelines.

3.5 Prescribing Protocol for Oral Analgesia in Adults with Non-Cancer Pain

The committee agreed that this guideline should be updated, especially in light of the recent changes to the legal status of Tramadol and the recent revision of the NSAID section of the CDD formulary.

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Action: FSG / NECS to review and update the "Non-Cancer Pain guideline".

Part 4 – Standing items (for information only)

17 Minutes of previous meetings held:

17.1 CD&D D&T

For information.

17.2 TEWV D&T

For information.

17.3 CD&D FT Clinical Standards and Therapeutics Committee

For information.

18 RDTC Horizon scanning – May – June 2014

For information.

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19 **Any Other Business**

20 **Date and time of next meeting:**
Thursday 4th Sept 11.30 – 2.30 Boardroom, Appleton House

Contact for meeting: Laura Walker | Tel: 0191 374 6055 | laura.walker6@nhs.net

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