County Durham and Darlington Area Prescribing Committee

Minutes of meeting held
Thursday 10th March 2011
12.00 – 14.30
Boardroom, John Snow House

Present:

Sally Bell, Deputy Chief Pharmacist, CDDFT
Hazel Betteney, Senior Pharmaceutical Adviser, NHS CD&D (Professional Secretary)
Mark Burdon, LPC Representative
Peter Cook, Consultant, CDDFT
Geoff Crackett, GP Prescribing Lead, NHS CD&D
Ian Davidson, Deputy Medical Director, NHS CD&D (Chair)
Sarah Hailwood, Consultant Rheumatologist, CDDFT (SHa)
Betty Hoy, Patient Representative
Sue Hunter, Deputy Head of Pharmacy, TEWV (SHu)
Nick Land, Medical Director, TEWV
Mike Lavender, Public Health Consultant, NHS CD&D
Dominic McDermott, RDTC
Sarah McGeorge, Nurse Consultant, TEWV
Ian Morris, Head of Medicines Management, NHS CD&D
Stephen Purdy, Pharmaceutical Adviser, NHS CD&D
Satinder Sanghera, GP Prescribing Lead, NHS CD&D (SSa)
Sue Shine, Nurse Practitioner. NHS CD&D (SSh)
Joan Sutherland, Senior Pharmaceutical Adviser, NHS CD&D
Lindy Turnbull, Senior Nurse for Medicines Management, CD&D CHS for CDDFT
Paul Walker, Deputy Clinical Director, TEWV

ID welcomed members to the inaugural APC meeting and round table introductions were made.
The Meeting was initially non-quorate but after 10 minutes CDDFT clinicians arrived to make the meeting quorate.

1. **Apologies for Absence and Deputising arrangements**

Patricia King, LPC representative (Deputy in attendance)
Paul Turner, Commercial Manager, NHS CD&D
Sue White, RDTC (Deputy in attendance)

2. **Terms of Reference (TOR)**
ID introduced the TOR which had been agreed at the PCT Management Executive in October 2010.

The membership and quorum requirements were reconsidered.

SSa queried the PBC representative role, ID advised that this had been discussed with Dr Dinah Roy (GP-Led Commissioning (GPLC) Chair with responsibility for Prescribing) who had been invited to attend, but was happy that the three GPs on the committee would provide representation and was happy to delegate responsibility.

SSa then queried her position as her GPLC consortium (Durham Dales) had decided against a County Durham and Darlington APC. ID advised the group that GPLC in County Durham and Darlington had been granted pathfinder status, with 6-7 consortia working together, and each consortium was currently considering areas of responsibility that should be delegated to localities, countywide or regional level. At present, consortia were considering medicines management via review of a strategy scoping document. ID advised that over the next two years, the PCT will still be in existence and the PCT had decided to establish the APC during the transition period of the next 2 years.

SHu suggested that QIPP should be added to the TOR, IM suggested that this could be added to point 2.2. This was agreed by the committee.

ID pointed out the importance of deputising arrangements to represent each organisations views with delegated authority.

NL suggested that his approach would be to look at the agenda and make sure TEWV fielded the appropriate clinicians based upon the areas of discussion, he went on to suggest that the agenda could be structured into general items, then specialist items could be divided into mental health and physical health, this would ensure the attendance. He felt that he could then offer commitment to send the right clinicians for the relevant items and would prefer this approach to having a mental health subcommittee. This suggested structure for the agenda was agreed.

ID then asked for as to the suggested quorum. NL suggested reducing this commitment to a minimum of one clinician from each of the member organisations and a senior pharmacist. It was felt that the membership should represent a range of disciplines. There was concern that reducing the quorum to one clinician could potentially indicate reduced clinical commitment.
The committee agreed to amend the quorum in the TOR.

NL suggested that there could be different quorum requirements i.e. for general items of the meeting, a full quorum and for the more specific items a mental health and physical health quorum with the relevant clinicians involved.

Action: HB to update the TOR to reflect the discussions at this meeting, with the requirement for one senior pharmacist and one clinician for each trust for the meeting to be quorate and addition of QIPP to the TOR as at item 2.2.

3. Decision Making Process

ID advised the committee that it was crucial to agree what constitutes decision making. He went on to say that with a large group of people, it is difficult to agree a decision if the process for decision making has not been made prior to a contentious item. It was felt that the decision around this did not need to be made at this meeting, but that it was important to open the discussions around this item.

ID advised that the documents associated with this item were based on NPC documents, one covering key steps in local decision making about medicines and a proposed pathway for this.

GC queried if the outcome from the committee would be a binding decision, is the committee purely looking at clinical effectiveness or clinical effectiveness and affordability. ID felt that both needed to be covered, GC added that the output should be binding decisions and the appropriate delegated authority would be required.

NL advised that if the commissioner chooses not to fund a treatment, this may be different to the treatment not being used as the foundation trust may wish to fund the treatment themselves; therefore, he felt that the decision would need to be worded so as not to exclude use of a particular treatment in the geographical area. ID agreed that there should be an understanding that some items may not be suitable for primary care prescribing, IM added, the red/amber/green (RAG) process could be used to support this.

It was felt that the key steps document was a reasonable flow chart of the pathways for approval of medicines, IM queried the PCT decision making function and it was agreed that this needed to be amended to show the APC as the decision making group.

ID then advised the committee that it needed to consider how decisions are made, asking the members to consider the “one member, one vote” mechanism which is used elsewhere, with the chair having the casting vote, a decision on this process needs to be agreed at the next meeting.

Action: HB to update decision making flowchart
Action: HB to agenda this item for further discussion at the next meeting

4. Declaration of Interest

ID advised that this would be a standing item on the agenda for individual meetings, but also that it was important that all members complete a declaration of their interests on an annual basis so that we have a record of where interests lie.

Action: All committee members to complete the declaration of interest form and return to HB

5. Formulary Development

ID advised that although this was a short paper, it required significant discussion as the APC would be responsible for formulary development across County Durham and Darlington.

ID queried whether CDDFT and TEWV currently had their own formularies and how members would feel about consideration of a joint formulary. SB advised that there was an electronic version of the CDDFT formulary, SHu advised that a lot of mental health drugs are covered by NICE guidance, TEWV would tend to adopt NICE in these cases.

SB advised that it was difficult to monitor the formulary at present as CDDFT do not have electronic prescribing ad present, although she felt a formulary would be beneficial for junior doctors. ID advised that at a meeting earlier in the day, he had heard that electronic prescribing may be four to five years away at CDDFT; he wondered if the APC could add pressure to shorten this time frame in order to assure patient safety and support the FT's QIPP plans. SB advised that currently the system isn't very safe. It was suggested that CQUIN could be used as a development tool for this.

ID advised that in primary care not having a formulary isn't taking its responsibilities seriously, SB queried how this could be done and how it could be enforced. SHu added that TEWV FT would look to the PCT for guidance on "physical" drugs.

ML suggested linking in to the North of Tyne formulary and formulary development committee. ID asked how the FT would view this and how would clinicians react, it was felt that it would be useful to see the North of Tyne Formulary to see what was in it and determine any differences in practice. NL suggested taking the North of Tyne formulary and modifying it locally as this would be easier to sell to colleagues, ML added that this sounded like a good idea as long as the local variation has an evidence base.

It was felt that there could potentially be boundary issues with formulary development, ID advised that in the future, it may be necessary for this committee to work closely with other North East APC's. He added that at a local decision making meeting across the North East last week this issue was discussed, and it was suggested that speciality drugs with low potential use should fall within the remit of NETAG. Discussions followed around the benefit of having any local decision making groups compared with the regional groups, and it was felt that there wasn't always relevant clinical input at regional meetings.

ID advised that there was more resource available to the North of Tyne APC, which also has a separate formulary sub-committee. Concerns were raised about whether prescribers in other areas would follow the formulary. The option of linking to the Tees APC was discussed, but it was felt that the North of Tyne formulary was the most evolved, TEWV indicated a preference for a Tees-based formulary, but would be happy to work with the North of Tyne model if it is a well-developed system and was not slavishly adopted.

Overall, it was felt that it would be useful to have a formulary across primary and secondary care and it was felt that the North of Tyne formulary would be a good starting point, but that some modification may be required and that monitoring may be more difficult without electronic prescribing at CDDFT.

Action: ID to seek permission and bring the North of Tyne formulary to the next meeting.

6. Transfer of Prescribing Documents

ID advised that transfer of prescribing documents from both CDDFT and TEWV had been brought to the committee; it was felt that the APC should take responsibility for these and would be the right forum to address shared care. He added that currently these were two very different documents with different colour schemes and wondered if the committee should be looking toward similar processes for both and asked how secondary care would view this.

SHu advised of the background to development of the TEWV document which came from the merger of two trusts. In the predecessor organisations, a number of shared care documents were in place, for a lot of these drugs, NICE guidance was in place with all of the relevant information contained within this guidance. Therefore, the trust wanted to move away from all of the shared care documents and have one document that outlines the principles, since then however, specific shared care documents have been developed for lithium and the management of ADHD.

ID advised at the regional local decision making meeting that it was felt that it would be useful to have a regional definition of red/amber/green status, but that shared care documents should be agreed at APC level. It was agreed that there needs to be shared ownership of APC decisions and that the processes need to be right.

SHa added that the shared care documents for rheumatology were not within the Transfer of prescribing document for CDDFT, there is a separate system and felt that any system needed to be pragmatic not a form filling exercise. ID advised that the fax back system was set up to assure patient safety and avoid duplicate prescribing which can be confusing for patients. SHa advised that in her experience, the fax back system didn’t work and often required considerable time to be spent chasing up responses.

ID felt that the transfer of prescribing documents needed to be reconsidered in order to try to get a consistent approach to the shared care agenda.

7. Low Molecular Weight Heparin (LMWH)

HB presented the report on LMWH prescribing for Venous Thromboembolism (VTE) from CDDFT and advised that the issue of prescribing needed to be discussed and an appropriate way forward across the health economy agreed particularly in relation to prescribing in pregnancy, HB added that the NPSA "how to" guide recommended following the RCOG guidance in pregnancy. HB advised that at present it is significantly cheaper for LMWH to be dispensed by the FT than in primary care and therefore, it may be worth consideration of a way forward with this.

SSa queried if this was the best for patients, GC added that the only way to do this in primary care is to bulk buy. SSa felt it would be a shame if the decision was led by cost difference.

IM queried if there could be different way of supplying in community pharmacy e.g. outside of the usual NHS costs, MB advised that although this could be looked at, community pharmacy would be baying a different price to that procured by the hospital.

ID suggested that Graeme Kirkpatrick's proposal of adopting the All Wales Prescribing Advisory Group (AWPAG) recommendations seemed to be a reasonable one, IM added that he felt we needed to utilise the hospitals purchasing power. It was felt that it would have been beneficial to have finance representatives present at this meeting for further discussion.

ID said that as the maternity patients are high-risk antenatal cases, they will be seen regularly by clinicians and could access supplies this way. MB added that in community pharmacy they were getting significant amounts of unused LMWH injections returned for destruction, suggesting that the cost of waste needed to be factored in as well as the acquisition cost. IM queried if the supply could be dispensed at the hospital and delivered to the patient's GP practice on the hospital van.

ID reiterated that adopting the AWPAG guidance seemed the best way forward but that the financial issues needed to be considered. He also added if waste was a significant issue, would a primary care supply route work better, IM suggested that there should be guidance for the patient should they decide not to use the LMWH as prescribed, they should be able to sign an agreement to empower them to say that they don't want it, rather than collect supplies of a drug they have no intention of using. Discussion around whether the patient may adhere to the treatment if prescribed by the GP concluded that not all of these patients will see their GP regularly, so this will not be an option in all cases.

It was agreed that HB would discuss the funding with the contract manager at the PCT, but that the funding source should be considered as this issue was felt to be wider than a primary care prescribing budget issue and should consider the potential impact on the unplanned care budget too.

GC queried if consortia could bulk purchase, IM advised they could, but that the FT would have bigger buying power.

SB advised that the FT can currently purchase over-labelled LMWH at the same cost as unlabelled stock and suggested that PGDs could be used to enable midwives to supply LMWH at their consultations.

It was agreed that a small working group needed to be established to explore all of the options.

Action: HB to organise a small working group to explore options for supply of LMWH.

8. Prior Approvals

SP advised the committee that he had been asked to review the medication related prior approvals, he explained that prior approvals enable providers to give treatment for specific conditions without individual patient approval by the PCT, the arrangements that he had been asked to review had been in existence for a number of years, however, there was no background or history as to where the recommendations came from. He added that these tended to be specialist or high cost treatments.

SP asked the committee if they felt this was the appropriate forum to take this piece of work forward. ML added that these prior approvals are with CDDFT only and it can be confusing for GPs. He wondered if the formulary may be better way to manage this, adding that the medication related prior approvals could be lifted out of the contract, with the agreement that we only fund treatments that are in the formulary, rather than update the contract yearly.

ID felt that it would fit well into the formulary process. ML added that he was currently being pressured regarding interventions; he advised that this should be done on a regional basis, with local clinical consensus feeding into a North East policies group. This process would begin with high cost or contentious issues and could then feed into a formulary. SHa felt that the document didn't reflect current practice as certolizumab was not included but is cheaper than some of the other options. SP felt that it needed to be a working document but that it needed resource to support and update. IM felt that it was important to work through these prior approvals, but something else will have to stop in order that this can be done. He felt that it may be useful to approach pragmatically looking at the high cost drugs or the most out of date prior approvals, but being realistic about the amount of time this might take, adding that the GP commissioners may wish to support it and provide adequate resource if they want this process to continue.

It was recommended that certolizumab and rituximab needed to be added to the prior approvals as they had been approved by NICE. It was also agreed that the Medicines Management Strategy work that is currently underway should cover which activities clusters which to take on individually or share at a countywide level.

Action: SP to update the prior approvals to include rituximab and certolizumab.

9. Antiplatelet Guidelines

SP explained that the PCT anti-platelet guidelines had been reviewed in line with the latest NICE guidance which required addition of clopidogrel to more indications. He added that as yet very few comments had been received from secondary care but one of the comments that was received suggested that the consultants were going to start to use clopidogrel first line for TIA which differs from NICE.

SP advised that the main changes were that TIA recommendations had gone with NICE guidance and ischaemic stroke and secondary prevention had been split.

ID asked the committee if they were happy to sign off. After discussions around the lack of feedback from secondary care, it was agreed to sign off the amendments as per NICE guidance and await any feedback.

Action: Signed off by the APC, SP to arrange dissemination.

10. Grey List

SP presented this paper to the committee, advising that the grey list prepared was an amalgamation of three existing grey lists and was to be used as a starting point. He added that this document had been discussed at the PCT D&T last month and was brought to the APC for discussion and agreement on how to take forward in terms of content and recommended use.

NL felt that there were lots of lists already in existence and queried why there would be a need for a formulary and a grey list. ID advised that at present there was no formulary in primary care, the grey list was seen as an interim step towards a formulary as it was appreciated that it may take some time to move towards a formulary, and in addition, the grey list was thought to address the QIPP agenda.

PW advised that he liked the introduction and liked the concept of a grey list, even within a formulary. He felt it was a good document however, he had looked through the mental health drugs and wondered if these would be commenced in primary care by GPs or even in secondary care generally, adding that duloxetine, may need to be used by mental health clinicians and he wouldn’t want GPs to feel that they should query all instances of prescribing.

SSa felt that it would be useful when querying prescribing to have an audit trail of how prescribing came about, that gives the rationale behind the decision, but that we need to maintain an awareness that it is not a banned list.

ID highlighted the differences between primary and secondary care prescribing, with secondary care being able to choose to purchase a drug or not, this isn't possible in primary care which is where the concept of a grey list or an "almost never prescribe" list can engage with clinicians, we can't stop prescribers but can issue advice from the APC not to prescribe specific drugs for specific indications.

NL felt that it needed to be made explicit that its not a red list, if it is a red drug and secondary care chose to prescribe it, there should be a good reason for doing so, which should given by the secondary care clinician.

ID advised that the document was designed to make prescribers think, the recommendations can be put onto GP systems and ScriptSwitch. HB added that she had received positive feedback from GPs on the concept of the grey list.

MB queried if this piece of work was being done North East-wide, MB suggested that this could link into work done in North of Tyne.

ID asked if there were any objections to the mental health drugs included in the grey list. Melatonin was discussed regarding the formulations available and the indications it may be used for, with TEWV advising that they recommended a lower cost special order product and PC advising that any prescribing for narcolepsy would be managed by specialists.

IM added that the discussions at the APC were useful to strengthen the position of the grey list; he felt it may be useful to add the opinion of the supporting consultant(s) within the document.

The following suggestions for amendments were agreed:

Low dose antipsychotics – don't name individual drugs
Memantine, may be covered in new NICE guidance
Pregabalin – now covered by NICE guidance for GAD, could add the position in the pathway for chronic pain management and dose optimisation.

Action: SP to make the suggested amendments to the grey list.

11. Individual Funding Requests (IFR) Policy

ML presented this policy to the committee, advising that management of IFR requests involved making fair and reasonable decisions about treatments/individuals not covered by contracts or policies. National guidance comes from cases that have ended up in court for judicial review. The policy is there for information, to advise how we make decisions. This process runs in parallel to population decision making where the individual case doesn't fit. GC was introduced to the committee as a member of the Exceptional Cases Committee (ECC). ID queried how many appeals had been received in the last year, ML advised that there had been 1100 IFR requests, of these, 50 were heard by the ECC and there was one appeal. IM queried what proportion of these were drugs; ML advised that around 50% were drugs. SSa

queried if most of the requests were from consultants, ML advised that most are from GPs requesting routine varicose vein or plastics procedures where they feel that patients are an exception to regional policies or in response to patients demands.

ML advised that requests must come from clinicians and there needs to be evidence of exceptionality. ID felt that it sounded like quite a labour intensive process to tell the patient that they can't have something, IM queried if GP commissioners were aware of this. ML advised that when the PCT goes, GP commissioners will have to make these decisions, there was consensus at a regional workshop that GPs want to tie into the process. In South of Tyne, there were a lot more requests with 3-4 times the number of cases going to the ECC. It was felt that if people were familiar with prior approvals/policies; this may be an opportunity to head things off at the pass.

GC advised that if a specialist advises a GP to make the application, it should be bounced back as the strength of argument supplied supports the decision making process. ID advised that he couldn't see that clinical commissioners would want to drop this process completely as need to address potential conflict of interest.

ML advised that drug requests can be more difficult and contentious, there are often requests for specialist cancer drugs from outside the area with no evaluations, the press and drug companies can get involved in these via patient groups. Therefore, the policy is used to defend the way the decision is made. ML advised that funding doesn't influence the decisions made, effectiveness forms part of the initial decision making process, how any prior courses have been funded, is not considered relevant.

12. Horizon Scanning Document – March 2011 (draft)

DMc presented this document for information; ID felt that this was a useful document to highlight any potential pressures. DMc asked the committee members if there were any aspects that people would like to see changed. NL suggested presenting the document in BNF chapters in the same way as the grey list would be helpful.

13. Recent NETAG and NECDAG Decisions

HB gave an overview of recent NETAG and NECDAG decisions advising that the most significant drug considered was Dabigatran for atrial fibrillation (AF). This could have a significant impact on the prescribing budget. As yet this has not been requested to be added to formulary at CDDFT. ML advised that warfarin is still a good drug and it is important to ensure the community based anticoagulant service is still commissioned. It was suggested that decommissioning anticoagulant services could potentially fund this drug, however, at present AF is the only licensed long term indication, so warfarin would still be necessary for all other indications.

The committee discussed the commissioning issues, risks and benefits of this drug.ID suggested that we needed to let primary and secondary care

prescribers know about the NETAG decision as soon as possible as once the licence is granted, patients will be asking their GP to prescribe. It was felt that it would be useful to issue a prescribing memo across the interface informing prescribers of the NETAG decision which was very specific.

Action: HB to prepare a prescribing memo to highlight the NETAG decision across the interface.

14. IFR Decisions

ML advised that at the last Exceptional Cases Committee (ECC) there were two drugs for consideration:

The first was an intravitreal dexamethasone implant for macular oedema, which was declined.

The second was adalimumab/infliximab for a young patient with severe site threatening uveitis, there is no guidance for this indication, but it was approved for a six month trial.

SHa queried how quickly the referring clinician receives the information on decisions made, ML advised within three working days of the committee meeting.

15. Minutes from constituent trust D&T meetings

These minutes were accepted for information only.

16. Any Other Business

ID had two items to discuss:

1. Communication – how to communicate minutes and also how to develop the Medicines Management website for papers and decisions to be made available.
2. Agenda items – ID agreed to work on a more structured agenda for the next meeting based on the points raised today, looking at an alternating physical/mental health split, including general items for all members to consider, with quorum reflecting the relevance to the agenda.

GC had two items to discuss:

1. Introduction of new drugs and how these will be managed as an interim measure until the formulary is established, should these come to the PCT or secondary care D&Ts.
2. GC felt that there was a need to advertise the APC to start to engage with clinicians and for them to understand that the APC was the new forum for discussing prescribing.

GC added that he knew the FT had a big job to do, but within hospitals, pharmacists can “police” prescribing and the hospital can stock only formulary items.

It was agreed that the committee were going to move forward with a joint formulary and therefore, all requests for additions to the formulary should come to the APC, HB to circulate relevant paperwork to all member organisations.

It was agreed that communication across the interface has not been good historically and the APC can help to drive forward improvements.

It was felt that an advertising campaign for the APC was needed along with a working website that we can refer people to in order to get buy in. ML suggested using Map of Medicine, it was felt that this was a useful suggestion that HB should investigate further.

It was also suggested that more information on the role and remit of NETAG should be added to the NETAG paper for the next meeting.

Action: ID and HB to revise the APC agenda

Action: HB to circulate relevant “New Drug” paperwork to relevant organisations.

Action: HB to investigate the possibility of using Map of Medicine to communicate APC decisions/paperwork etc.

Action: HB to prepare a paper regarding communications for further discussion at the next meeting.

Action: HB to include information on the role and remit of NETAG in the NETAG/NECDAG paper for the next meeting

Date and time of next meeting:

Thursday 5th May 2011
Boardroom, John Snow House
12.00 – 14.30

Confirmed as an accurate record:

Name: Dr Ian Davidson - Chair