County Durham and Darlington Area Prescribing Committee

Minutes of meeting held
Thursday 1st September 2011
12.00 – 14.30
Boardroom, John Snow House

Present:

Jean Bertram, Patient Representative
Hazel Betteney, Senior Pharmaceutical Adviser, NHS CD&D (Professional Secretary)
Peter Cook, Consultant Physician, CDDFT
Ian Davidson, Deputy Medical Director, NHS CD&D (chair)
Sarah Hailwood, Consultant Rheumatologist, CDDFT (SJH)
Betty Hoy, Patient Representative
Sue Hunter, Deputy Head of Pharmacy, TEWV (SH)
Patricia King, LPC Representative
Graeme Kirkpatrick, Chief Pharmacist, CDDFT
Alan McCulloch, D&T Chair, CDDFT
Dominic McDermott, Pharmacist, RDTC
Sarah McGeorge, Nurse Consultant, TEWV
Ian Morris, Head of Medicines Management, NHS CD&D
Ailsa Scott, Consultant, TEWV
Rikki Siddle, Deputy Divisional Accountant, CDDFT
Joan Sutherland, Senior Pharmaceutical Adviser, NHS CD&D
Lindy Turnbull, Senior Nurse for Medicines Management, CDDFT
Chris Williams, Deputy Chief Pharmacist, CDDFT

In attendance for item 13.0 – Rhoda Cowell, Dermatology Specialist Nurse and Margaret Hall, Student Nurse.

Apologies:

Sarah Burns, Commercial Lead, NHS CD&D
Geoff Crackett, GP Prescribing Lead, NHS CD&D
Suzy Gurguis, Consultant, CAHMS, TEWV
Mike Lavender, Consultant in Public Health Medicine, NHS CD&D
Sue Shine, Nurse Practitioner. NHS CD&D
Sue White, RDTC
Ingrid Whitton, Consultant, TEWV

Ian Davidson welcomed two new members to the meeting; Jean Bertram, Patient Representative (he explained that she would be job sharing the patient representative role with Sue Mole) and Rikki Siddle, Deputy Divisional Accountant CDDFT this was followed by a round of introductions.

Part 1 – Mental Health

1. NICE Dementia Guideline - decommissioning

ID introduced this item, advising that it had been discussed two meetings previously and as dementia was the therapeutic area of focus for this meeting it was felt that the issue of decommissioning dementia drugs should come back for further discussion, ID clarified that decommissioning referred to discontinuation of dementia drugs in this context.

SH handed the discussion over to AS who was in attendance as a specialist in this area of prescribing. AS advised that anyone prescribed dementia drugs should be managed under a shared care agreement with a minimum of six monthly reviews, including an MMSE score, with medication only continuing if there was felt to be a benefit. TEWV should always be involved in these cases and should be reviewing all patients every six months and if it was felt that treatment was no longer beneficial, TEWV would manage the withdrawal of medication.

AS acknowledged that there was an impression that there are patients still on drugs that shouldn't be and felt this needed to be discussed further. AMc advised that a number of end stage dementia patients on dementia drugs are admitted to the trust and a policy on when to stop these drugs would be helpful. AS advised that she would expect whoever was managing the patient from TEWV to look at this issue. AS added that as patients move into nursing care, this may trigger a review of dementia drugs, but the patient would be allowed to settle into new surroundings prior to discontinuation.

AMc felt that there should be a more robust policy for reviewing dementia drugs, ID added that GPs seem to think that there are patients on dementia drugs that shouldn't be, although this may just be a perception, highlighting that if a patient moves into nursing care, they may move GP practice, lose contact with relatives and this may result in the drugs not being reviewed. ID felt that it needed to be clear at what stage these drugs should be stopped/the patient be referred back to the specialists as if these drugs are used inappropriately, patients may be at risk of side effects without any benefit.

It was felt that there should be something in writing for GP's and the acute trust to help to identify when these patients should be referred back to their TEVW clinician for review of their drugs, although it was accepted that there may be exceptions to the guidance as with all guidance, it was felt that this would be a reasonable step forward. It was felt that NICE guidance was too broad; SMc suggested that TEWV could prepare some guidance that elaborated on NICE guidance. SMc also advised the committee that there are four TEWV liaison nurses working in the acute trust who can review such patients.

It was agreed that guidance would be produced on when it is appropriate to refer patients on dementia drugs back to TEWV, SMc also added that TEWV

would find it helpful if other clinicians advised them if they have stopped a patients dementia drugs.

Action: TEWV to prepare prescribing guidance for use across the healthcare community which includes when to stop treatment, to come back to next APC meeting.

Action: HB to agenda for November APC meeting.

ID raised a further issue following previous discussions of the cost impact of NICE guidance bearing in mind that donepezil was due to come off patent next year and wondered if there was anything that could be done locally to minimise the financial impact of NICE guidance. SH advised that she was preparing information to be sent out to prescribers which takes into account dates of patent expiries, it was agreed that this guidance should come back to the next APC meeting.

Action: SH to prepare prescribing information and bring back to next APC meeting

Action: HB to agenda for November APC meeting

2. Generalised Anxiety Disorder Guidance

SH advised that this guidance had been brought to the committee for information and had been produced for prescribers following the publication of the updated NICE guideline on generalised anxiety disorder and was based on a MeReC publication to support the implementation of NICE guidance. She added that there had been an increase in pregabalin prescribing and it was felt that a reminder of where this sits within the guidance and the associated costs would be useful for prescribers. JS added that she felt this was a useful summary which clarified the role of pregabalin.

ID asked whether pregabalin for generalised anxiety disorder should be initiated in primary care, he acknowledged that following initiation prescribing may be transferred, but wondered about initiation as pregabalin was first licensed for epilepsy and although it is widely use for pain management, prescribing for generalised anxiety disorder isn't something he was too familiar with. He also added that it is relatively expensive and could impact on primary care prescribing costs.

It was felt that it was reasonable to have pregabalin at step 3 or 4 of the guidance, but as step 4 was specialist care, it was agreed that in order to ensure appropriate use of pregabalin this may be the best option.

ID asked that the guideline is discussed at the next primary care D&T in October and then any further comments should be fed back to TEWV, with the final version of the guidance to come back to the APC in November.

Action: SH to make amendments to guidance for discussion at NHS CD&D D&T in October, and then to return to the APC in November.

Action: HB to agenda for NHS CD&D October meeting and for the next APC meeting.

Part 2 - General

3. Apologies for Absence and Deputising arrangements

Listed at the beginning of the minutes

4. Declaration of Interests

There were no declarations of interest.

5. Minutes from last meeting held 7th July 2011

The minutes from the last meeting were accepted with no amendments, although it was noted that the following statement on page 2 was inaccurate:

"IM suggested that if patients are picked up earlier, it may be that lower doses were being used."

6. Matters Arising/Action log

6.1 Action Log

Please see updated action log.

6.2 Unlicensed/off-label prescribing guidance update

Please see updated action log.

7. Formulary Update

7.1 Formulary Development Group and North of Tyne Formulary Sub-committee

ID advised the committee that a formulary development sub-group had been established, the first meeting is booked for 6th September with the aim of working towards an early version of a formulary by January 2012, although he accepted that this was an ambitious target.

ID informed the committee that he had attended the North of Tyne Formulary Sub-committee with HB and CW on 23rd August. He advised that at this first meeting they were mainly observers but it provided an overview of how the committee worked and provided an understanding of which sections of the meeting were relevant for our representatives to attend. It has been agreed

that this will run as a six month trial with the next meeting on 20th October 2011.

7.2 CDDFT New Drug Request Process

CW advised that following discussions about how the formulary application process would work in practice, he had developed a flow chart of the process for CDDFT, he added that he wanted to keep it as simple as possible and although initially it was only aimed at the FT, if the committee were happy with the principles, he could look at incorporating all trusts.

ID asked if the process for primary care and mental health would need to look much different to the FT process presented. SH advised that from TEWV perspective, they interfaced with Tees and North Yorkshire trusts as well County Durham and Darlington and therefore, the process may need to reflect this and would require some discussion within the organisation.

ID felt it would be good to have one process for everyone to work to. CW suggested that where the secondary care process referenced support from colleagues, for primary care should this support come from the clinician applying for the drug's clinical commissioning consortium and locality GP Prescribing Lead.

IM queried the role of the North of Tyne formulary sub-committee, wondering how the process would work in practice. CW advised that in the FT an application would come into to him, he would evaluate all of the available evidence and send a critical appraisal to the formulary sub-committee. All papers are read by committee members in advance and discussions within the meeting are directed by the chair of the committee who puts forward a motion which the committee then debate and formulate a recommendation which would then come to the respective APC.

ID added that he wasn't sure if the meeting in August was representative of every meeting, CW informed the committee that from discussions outside of the meeting, he was advised that the meeting was representative of all meetings, although the drugs for discussion at this particular meeting weren't thought to be representative. HB advised that there were resource implications associated with membership of the committee as applications from County Durham and Darlington would have to be evaluated in-house. ID emphasised that it was important to get input from the relevant trust clinicians as the process needs to work.

IM asked what would happen to primary care requests in 2013, it was agreed that this wasn't relevant to the six month trial but that clinical commissioners need to buy-in to processes and the APC.

ID advised that he had a couple of comments on the flow chart, he wondered if there should be an arrow back from finance to the APC, if finance rejected the recommendation, he also asked whether NETAG/NECDAG and NICE decisions should go to finance or the APC first. CW stated that it was

important to get financial sign off as early as possible in the process. ID suggested adding a dual arrow from NICE/NETAG/NECDAG to the APC as one of the roles of the APC is to look at implementation of NICE guidance locally. CW suggested adding a local impact application arrow to the APC, but advised the committee that North of Tyne there are no recommendations made on NICE/NETAG decisions, they are just accepted.

PK queried the impact of formulary development on patients prescribed drugs currently that will not be on formulary in the future. ID advised that any guidance wouldn't preclude other drugs being used if they were already being used, but acknowledged that there may be occasions as there are currently when a patients medication may need to be changed for safety or cost reasons, but that he didn't expect the formulary to drive such processes, adding that the formulary would be expected to drive initiation of new drugs. GK felt it was important to emphasise that the formulary wouldn't be just a list of drugs, as it would be underpinned by guidelines.

Action: TEWV and NHS CD&D to consider the flow chart at their respective D&T meetings and feedback to the November APC meeting with a view to producing one flow chart to cover all organisations.

Action: HB to agenda for October D&T and November APC

CW asked for comments on the "for discussion" area of the flow chart advising that the committee needed to consider a route for changing decisions if necessary, it was felt that the formulary development should work through this process over the next six months and feedback to the committee.

Action: HB to add this discussion to the formulary development sub-group agenda

8. QIPP – joint switch strategy

ID introduced this paper prepared by CW; he advised that he felt it was a really useful piece of work. CW presented the background to this paper, advising that at the last primary care D&T meeting, IM presented a paper on a range of cost effective prescribing options and NPC prescribing recommendations, it was agreed that a number of areas of joint working across the interface should be investigated. The list of areas was agreed by ID and was PPI's, Sartan's, Statin's, NSAIDs, blood glucose test strips and nutritional supplements.

CW presented primary and secondary care data for all of these areas although he advised that the following caveats should be applied, some of the in-house prescribing at the FT may have originated from primary care and also that although there is not a lot of FP10 prescribing from the FT, this was the proxy marker for secondary care prescribing.

It was agreed that restriction of PPI prescribing to generic products only, would benefit both primary and secondary care. CW agreed to establish with

the gastroenterologists the place in therapy of esomeprazole, and advised that a guideline is currently in development. He also suggested that the trust move to lansoprazole first line rather than omeprazole to avoid the pricing difficulties encountered with the 40mg omeprazole strength. IM queried the place in therapy for orodispersible preparations and wondered if there should be guidance on when to use these, CW suggested that this could be built into the guidance.

Regarding sartan or angiotensin 2 receptor antagonist prescribing, it was felt that this was primary care led and prescribing across both sectors reflected similar choices of losartan and candesartan. It was felt that a switching strategy would not be worthwhile, but that the drug choice should be reviewed as part of the work for the next APC meeting when cardiology is the therapeutic topic taking into account the recent publication of revised NICE guidance on hypertension.

Regarding statins, CW advised that you would expect more high cost statin prescribing to be led by secondary care, with atorvastatin due to come off patent, he felt that rosuvastatin may be where the attention should be focussed. CW advised that he was trying to raise the profile of the joint lipid guidance and was working with a stroke physician who currently recommends atorvastatin 80mg in stroke patients, which is outside of the agreed guidance. He added that he hadn't looked at ezetimibe prescribing as he didn't feel that this was secondary care led.

CW advised that blood glucose test strip prescribing in in-patients was appropriate, but that the community diabetes nurses should be involved in the meeting to discuss diabetes test strips and insulin's on 4th November.

Regarding NSAIDs, CW advised that he is going to calculate the potential impact to the FT of changing all diclofenac use to naproxen and he will bring this information back to the committee, he also suggested looking into the prescribing of etoricoxib, SJH advised that she uses it in a small number of ankylosing spondylitis patients but not in other patients. CW added that in North of Tyne, diclofenac was first line for acute prescriptions and naproxen was first line for chronic prescriptions, suggesting that this may be worth exploring.

Regarding nutritional supplements, CW agreed that work needs to be done with the dieticians and although complan shake may not be used the hospital trust due to contractual arrangements for other products, the cost of milk and nursing time to make up the shakes, there is no reason why complan shake shouldn't be recommended on discharge and will work with Rachael Masters on this.

JB advised that from a patient perspective, her concerns were around the differences between generic drugs, not only did different generic manufacturer's tablets look different; they could be more difficult to get out of the packets or to swallow as coatings varied too. She added that she felt it was ok to discuss costs, but felt that the impact of such changes on patients

should be considered. PK advised that community pharmacists try to keep good quality products and will stop using certain generic manufacturer's tablets if there are complaints, but if patients don't alert their pharmacist to the difficulties they are encountering with the tablets, then these issues can't be addressed. BH added that sometimes just opening the child-resistant tablet bottles could be an issue.

ID felt that this raised a very valuable point, that medicines prescribed needed to be taken, and suggested that the patient representatives discuss with the groups they are members of, a list of issues that patients encounter with medication that can form discussions in future APC meetings.

It was agreed that PK would raise these issues with the LPC and determine a way of getting feedback from patients and HB would add a section to the next newsletter advising GP practices to ensure that patients highlight such problems to their community pharmacist to allow issues to be addressed and reduce waste and suggesting that they raise these issues within their patient forum meetings.

Action: CW to work with gastroenterologists on a PPI guideline as part of the formulary development sub-group work

Action: CW to work with Dr Murphy to prepare some guidance on sartans and the new NICE hypertension guidance for the next APC meeting.

Action: CW to ensure community diabetes nurses are aware of the meeting on 4th November.

Action: CW to look at prices of NSAIDs and feedback to the committee the potential impact of changing from diclofenac to naproxen first line.

Action: CW to work with Rachael Masters and the dieticians to look at nutritional supplement prescribing on discharge.

Action: Patient representatives to discuss with their patient groups, issues that patients encounter with medicines, to feedback to the professional secretary/ID for discussion at future meetings.

Action: PK to discuss the issues highlighted by the patients regarding generic medicines with the LPC and feedback at the next APC meeting

Action: HB to add an item to the next newsletter asking GP practices to inform their patients that any problems with generic medicines should be fed back to the pharmacy and also suggest that they discuss this issue within their patient forums.

9. IFR Decisions

HB informed the committee that there had been a number of IFR decisions since the last meeting. Sativex was refused; requests for etanercept, rituximab, romiplostim and eltrombopag were approved.

10. Dates for next years meetings

HB advised that the dates for next year's meetings had been booked on the first Thursday of odd months as they were this year, however, this means that the January meeting could be problematic due to bank holidays. It was agreed to move the January meeting from 5th to 12th January but leave all other bookings as they stand.

Action: HB to rearrange January APC meeting booking and circulate revised dates to committee members.

11. Recent NETAG and NECDAG Decisions and NETAG Ethical Framework

HB advised that the NECDAG decisions were circulated for information and that she had been asked by Calum Polwart at CDDFT to highlight to the committee that although NECDAG approved cabazetaxel, CDDFT currently doesn't have the capacity to deliver this treatment, so patients would need to be treated elsewhere. GK advised that this was due to capacity issues within the day case unit which the trust were currently reviewing, he added that although groups such as NECDAG look at the cost of the drugs, there is no assessment of the impact on workload or nursing or pharmacy capacity, SJH added that this was an issue with NICE approved drugs too.

ID advised that NETAG decisions open up availability of the drug to commissioners and providers who should then negotiate the practicalities associated with the decision as this is not NETAG's role.

ID advised that NETAG decisions up to July 2011 were listed in the summary table, with Augusts decisions being listed in a separate paper, highlighting the most relevant issues as dabigatran and the rejection of the novel fentanyl products. CW added that unfortunately Actiq® (fentanyl) lozenges weren't included in this review so they are available; he suggested that the review should perhaps have covered the delivery route rather than just the new products.

SJH advised that regionally the rheumatologists were challenging the recent NETAG decision on rituximab which had no input from the regional rheumatology group and appeared not to consider that anti-TNF drugs or methotrexate may not be appropriate for some patients e.g. those with interstitial lung disease. ID informed the committee that these issues were discussed at the NETAG meeting although they may not be reflected within the published decision and there was the right to appeal decisions. ID suggested that the NETAG work plan (circulated) should be circulated within

the trusts to ensure that the relevant clinicians have the opportunity to comment on relevant applications and are aware of those in the pipeline.

ID advised that he had brought the NETAG ethical framework to the committee for discussion and to determine if the APC needs something similar or if the formulary sub-committee should have something similar. ID asked the patient representatives if it covered everything they expected, which they agreed it did.

Action: Trusts to circulate NETAG work plan to clinicians

Action: HB to find out if North of Tyne has something similar to the NETAG ethical framework or if this is something that should be developed in partnership.

Part 3 – Physical Health

12. Dermatology Specials

ID introduced this item advising that there is currently a lot of work underway nationally looking at specials prices and wondered if it removed the need for this paper. It was felt that even if prices are set for specials, they will still be expensive and therefore it is still essential to promote rational use of specials.

CW involved the dermatology lead in the preparation of this paper, he advised that the dermatologists don't use a lot of the products within the BAD guidance (circulated) due to the cost. On review of prescribing, the biggest difference between CDDFT prescribing and the BAD guidelines tended to be the base used within the special. It was agreed that the choice of base may affect pricing within the proposed national specials tariff and that this issue should be reviewed once the tariff is available.

CW highlighted that Durham Dales dermatology service prescribed a lot more specials than other services, he advised that he is discussing this with the service lead, he also highlighted the lack of dermatology specials prescribing within Darlington which will be discussed further, this is because all specials are issued by the hospital pharmacy, CW will feed back to the committee the outcome of these discussions.

GK highlighted that there are also issues with some branded dermatology preparations for example, Betnovate NN used to cost around £3 per tube, and this has now increased to £64/tube.

Action: CW to review the specials tariff once it is released to determine the impact on the costs of the specials preferred by the FT and those contained within the BAD guidance.

Action: CW to feed back to the committee the outcomes of discussions around Durham Dales and Darlington dermatology prescribing

Action: HB to ensure Betnovate NN costs are highlighted in the next newsletter.

13. Emollient Prescribing

CW presented this paper advising that the aim was to produce some simple advice of first line, cost effective emollient options. He also felt it was important to highlight that there are some very subtle differences between how different products are listed on practice computer systems which can have a significant impact on cost e.g. Hydromol ointment is the same as Epaderm ointment but is less expensive, however Hydromol cream is significantly more expensive, it was agreed that this should be highlighted to primary care prescribers.

CW advised that when patients first present with a dry skin problem it is important that they find the most appropriate emollient for them, therefore, patients are provided with a number of small, sample-sized tubes of various products, one of the purposes of this paper was to look at rationalising the products available.

RC added that it was important to find an emollient that a patient will use; as all emollients are different, generic prescriptions cannot be used. In addition to this, patients can become sensitised to their regular emollient and have to start the whole trial process again until they find a suitable alternative. RC felt that sample sized packs are very useful for this process. ID added that this tied in well to earlier comments from the patient representatives around the importance to patients of finding an acceptable product.

RC advised that aqueous cream should no longer be used as a leave-on emollient as over four weeks use, it can reduce skin thickness by 10% and should therefore only be used as a soap substitute. It was felt that some guidance on this issue should be issued.

ID summarised that the paper appeared to be a formulary for emollients which could feed straight into the countywide formulary; he suggested that it should be circulated across the interface without the costs as a guideline and formulary over two sides of A4 if possible. It was suggested that aqueous cream should be removed from the formulary and E45 should also be removed due to the potential lanolin-related issues; appropriate replacements for these products should be added. Emulsifying ointment was also discussed; patients experience many problems with emulsifying ointment, so it was felt that this should also be removed.

JS highlighted the issues encountered in community pharmacy when emollients are prescribed generically, as this can make it difficult to determine which product the prescriber intended and patients may have different products dispensed each time. It was agreed that the need to prescribe emollients by brand should be highlighted to prescribers.

Action: HB to ensure a message about Hydromol cream is included in the next newsletter and on ScriptSwitch.

Action: HB to ensure safety concerns around aqueous cream is highlighted to prescribers in the next newsletter and via ScriptSwitch.

Action: HB to ensure guidance is issued to primary care prescribers to prescribe emollients by brand via the newsletter and via ScriptSwitch

Action: CW to prepare final guidance for sign off at the next APC meeting

14. Prucalopride

CW presented this paper to the committee advising that CDDFT D&T in November last year approved prucalopride to be used for constipation in women prior to the release of NICE guidance. Currently, only Dr Yiannikou is authorised to prescribe prucalopride in his constipation clinic, he has requested that other consultants should be able to prescribe this now in line with NICE guidance. CDDFT asked Dr Yiannakou to prepare a guideline for its use and nominate specific clinicians who can prescribe it. The algorithm was presented to the APC, it was felt that there was a section missing before the start of the algorithm which although covered in the notes would be helpful to be covered within the algorithm. It was suggested that an additional step should be added to the algorithm as the effectiveness of prucalopride should be reviewed after four weeks and it should be discontinued if not effective, it was also noted that prucalopride was the only named drug within the algorithm. It was also noted that as prucalopride is only licensed and indicated for women at present, there should be a male/female divide before prucalopride within the guidance.

HB suggested that the document could form the basis of a formulary with a few minor changes; ID added that it would be really useful to see the guideline from the beginning, but from a primary care perspective prucalopride should be initiated by a specialist. CW advised that Dr Yiannakou's interpretation of the NICE guidance which states "clinician with experience of treating chronic constipation" was that this covered all GPs, the committee didn't feel it appropriate to interpret the guidelines in this way.

Action: CW to feedback comments and minor amendments to Dr Yiannakou, revised guideline to form part of the initial formulary to be presented to the committee in January 2012.

15. Midodrine Prescribing

HB presented this paper on midodrine, a drug that is currently unlicensed in the UK but is being prescribed for orthostatic hypotension, the information presented in the paper is from the FDA in the USA. She added that due to its unlicensed status, it is a special order product and costs can vary

considerably. Currently consultants are asking GP's to take over the prescribing of this drug in primary care. ID advised that as a GP he would feel uncomfortable taking on the prescribing of a drug that is unlicensed in this country, not in the BNF where he would be unaware of the potential implications on frail patients. HB advised that in some parts of the country, prescribing is done via a shared care agreement, whereas areas such as Newcastle, only make the drug available via the hospital pharmacy.

GK and CW felt that it would be appropriate to develop shared care for this drug, it was agreed that this would be appropriate in the future, but that a holding position needed to be established until shared care became available. GK also queried where the requests were coming from, HB advised that it appeared to be DMH, but she would investigate further and let GK know. It was agreed that the trust would retain prescribing at the moment until a shared care agreement had been prepared. GK also agreed to look internally in the FT at the management of hypotension across all sites and look toward developing some guidance along with the shared care agreement.

Action: HB to ensure guidance is cascaded to GP's via the newsletter/ScriptSwitch to advise them not to take over prescribing of midodrine until the shared care agreement is available; it will be left up to individual GPs to determine the appropriate management of those patients already receiving midodrine in primary care.

Action: HB to determine where prescribing requests are coming from and feedback to GK.

Action: GK to work with CDDFT clinicians to develop a guideline/establish a place in therapy for midodrine.

Action: HB to work with GK/CW to develop a shared care guideline for midodrine.

Part 4 – Standing Items

16. Minutes from constituent trust D&T meetings

These minutes were accepted for information only.

17. Drug and Therapeutics Bulletin – July & August 2011

These summaries were accepted for information only.

18. Horizon Scanning Document and NICE Guidance

This document was accepted for information only. HB informed the committee that the revised NICE hypertension guidance published in August contained a number of significant changes including the removal of bendroflumethiazide from the recommended diuretic list and a very clear statement that ACEI and angiotensin-2 receptor antagonists should not be co-prescribed for the

management of hypertension. It was agreed that this should be discussed in more depth at the next meeting.

19. Any Other Business

Ticagrelor

HB informed the committee that ticagrelor, a new anti-platelet drug had been added to the South Tees formulary at their D&T this week, although it would not be formally added until it had been discussed at the Tees medicines management committee next week. HB advised that this could have significant impact on both CDDFT and NHS CD&D as patients in County Durham and Darlington go to James Cook University Hospital for interventional cardiology procedures and would be discharged on this drug which must be continued for 12 months. HB advised in County Durham if this drug were used for all of the proposed indications instead of generic clopidogrel, it would cost an additional £1.1 million per year. HB added that NICE guidance is due to be published in November, with draft guidance due out next week.

It was felt that this decision should have been discussed with relevant parties and taken through the relevant processes e.g. CD&D APC or the North of Tyne Formulary Sub-committee. HB advised that she had spoken with her colleagues North of Tyne who had not received a request for this drug yet.

It was agreed that ID would write to the chair of the South Tees D&T committee to advise of the committee's concerns regarding this drug and of the process that should be followed in the future for decisions that impact more widely than their trust. HB to feed comments back to her equivalent in Tees PCTs to ensure the committee's feedback is considered at the meeting next week. It was agreed that the draft NICE guidance on ticagrelor should be discussed at the next APC meeting.

Action: ID to write to chair of South Tees D&T

Action: HB to advise Tees PCT's of the committees comments prior to the meeting next week

Action: HB to agenda draft NICE guidance for November APC meeting.

Prescribing in pregnancy

ID advised that he had been asked to raise this issue by a GP colleague. Currently GP's use ferrous fumarate as their first line iron supplement, whereas the midwives are initiating patients on ferrous sulphate. ID added that there used to be guidance on the management of anaemia in pregnancy, but the last version he had seen was from 1998. CW advised that he wasn't aware of this issue, but would follow it up and see if there was any recent guidance available.

Action: CW to follow up prescribing guidelines and feedback to the committee.

Date and time of next meeting:

Thursday 3rd November 2011
Boardroom, John Snow House
12.00 – 14.30

Confirmed as an accurate record:

Dr Ian Davidson – Chair
15th November 2011