County Durham and Darlington Area Prescribing Committee

Thursday 1st March 2012
12.00 – 14.30
John Snow House, Durham

MINUTES OF MEETING HELD

Present

Jean Bertram, Patient Representative
Serena Bowens, Administrative Co-ordinator, NHS County Durham & Darlington (minutes)
Geoff Crackett, GP Prescribing Lead (DCLS), NHS County Durham & Darlington
Ian Davidson, Deputy Medical Director, NHS County Durham & Darlington (chair)
Paul Fieldhouse, Regional Drug & Therapeutics Centre
Deborah Giles, Pharmaceutical Adviser, NHS County Durham & Darlington
Suzy Guirguis, Consultant, CAMHS, Tees Esk & Wear Valleys NHS Foundation Trust
Sarah Hailwood (SJH), Consultant Rheumatologist, County Durham & Darlington NHS Foundation Trust
Betty Hoy, Patient Representative
Sue Hunter (SH), Acting Associate Director of Pharmacy, Tees Esk & Wear Valleys NHS Foundation Trust
Patricia King, Local Pharmaceutical Committee Representative
Graeme Kirkpatrick, Chief Pharmacist, County Durham & Darlington NHS Foundation Trust
Sarah McGeorge, Nurse Consultant, Tees Esk & Wear Valleys NHS Foundation Trust
Ian Morris, Head of Medicines Management, NHS County Durham & Darlington
Satinder Sanghera, GP Prescribing Lead (Durham Dales), NHS County Durham & Darlington
Sue Shine, Nurse Practitioner, NHS County Durham & Darlington
Joan Sutherland, Senior Pharmaceutical Adviser, NHS County Durham & Darlington
Lindy Turnbull, County Durham & Darlington NHS Foundation Trust
Paul Walker, Consultant, Tees Esk & Wear Valleys NHS Foundation Trust
Chris Williams, Deputy Chief Pharmacist, County Durham & Darlington NHS Foundation Trust

PART 1: MENTAL HEALTH

1. Depression

1.1. Updated depression guidance

SH presented a draft Depression Pathway Medication Guideline, revised following recent MHRA warnings on citalopram and escitalopram doses. SH advised this guideline had not yet been to TEWV Drug & Therapeutics Committee for discussion. JS commented the recently published NPC Key Therapeutic Topics document did not contain venlafaxine and also highlighted there were differences between the monitoring requirements in this guideline and the antipsychotic monitoring document presented to the January 2012 APC meeting. Discussions ensued about monitoring requirements for venlafaxine, SH will clarify monitoring requirements as our guidance says this is needed.

ID queried why venlafaxine was chosen as a first line choice and was listed before Fluoxetine. SH advised venlafaxine was one of a number of first line choices and the list was not in order of preference, the rationale for it being included as a first line choice was that it was now available as a generic, lower cost preparation.

ID queried if there had been a change from HAD scores as only PHQ- 9 was mentioned as an assessment tool ID said that GPs currently use both and suggested it would be useful to have both mentioned.

ID commented there was no mention of monitoring requirements for prolactin levels for patients taking SSRIs in the updated guideline. PW commented separate prolactin guidelines were available and were discussed at the January 2012 APC meeting, and wasn't aware of a requirement for regular monitoring, however agreed to check the monitoring requirements for SSRIs with Vincent Connelly, endocrinologist.

ACTION: Amendment to be made to Guideline to return to APC in May 2012 once finalised at TEWV D&T.

1.2. Updated citalopram/ escitalopram maximum dose guidance combined with ECG algorithm

PW advised this appeared a complicated guidance document and as such he would find it difficult to recommend to other clinicians. ID agreed. JS suggested reformatting the coloured chart containing information on ECG requirements as some of the print had been lost on the version presented.

PK queried if any guidance would be issued to community pharmacists to use when counselling patients. ID suggested it would be reasonable for community pharmacists to use the guideline presented. PK suggested pharmacists could help ensure monitoring requirements are met by asking patients how they are doing on citalopram, however noted that asking patients if they had had a baseline ECG may not be popular with patients. GC added that patients may need as many prompts as possible. JS suggested if pharmacists were to get involved, they should approach GPs prior to questioning patients, however noted this could lead to a huge amount of work.

Discussion ensued surrounding the implications of the ECG monitoring requirements and the increased workload this could generate for GP practices, however ID commented this issue needed to be dealt with irrespective of the size of the problem. It was acknowledged that all citalopram patients would need an ECG, and under 20mg the monitoring would be more to identify underlying ECG issues rather than the drug itself causing initial problems at this dose.

GC asked if reference ranges for normal QT intervals could be included in the document. ID concluded this was a useful document, asking for the guidance to be disseminated to primary care.

ACTION: Guidance to be disseminated with accompanying advice statement clarifying ECG monitoring requirements.

2. Lithium: summary of POMH-UK audit – monitoring of patients prescribed lithium

SH advised this was a national benchmarking audit, adding that TEWV were very pleased with the results which showed significant improvements and highlighted the success of work undertaken around lithium and patient monitoring, especially since data for all 825 patients had been submitted. ID congratulated TEWV on the results of the audit, adding that the audit demonstrates how far the mental health trust has come with lithium over recent years with many areas being better than the national sample while acknowledging that some work is still needed with regard to recording weight and BMI.

SH informed the Committee of a new web based system, developed by Norfolk & Waveney Mental Health NHS Foundation Trust for which lab results are uploaded automatically and enables GPs and pharmacists to access results for lithium patients remotely. SH advised the lithium database currently in use in TEWV was very work intensive, requiring each test result to be transcribed manually. SH advised she has seen a demonstration of the system; TEWV are keen to go ahead and look at this in further detail and asked if the PCT would be interested to have some input into this.

JS suggested this could be very useful in community pharmacies especially and could add an extra level of patient safety. ID added it would be useful to look at anything that would help address safety concerns with lithium.

GC questioned if the system would be able to add much more to what is already available e.g. WebICE and queried if TEWV needed access to the ICE system. ID commented he shared GC's concerns, however stated that if there were significant added benefits it could still be worth looking into, commenting that it would be useful to get some representation from primary care to look at the implications of the system and would like to attend the demo of the system at TEWV.

3. Buccal midazolam guidance

SH advised this had been discussed at the last TEWV D&T meeting following the launch of Buccolam, a licensed buccal midazolam preparation, where Committee members agreed to use the licensed product in TEWV as opposed to the unlicensed product. SH added that there needed to be some agreement for the transfer of prescribing of this from primary to secondary care.

SSh expressed concerns that the training of people to administer the new product could be a big problem, as it is currently proving difficult to access training on how to use Buccolam® in the community for carers and healthcare professionals. ID agreed this was an important point, and it needs to be established appropriate support is available for primary care. The training of school nurses to issue Buccolam was also queried and it was felt this should be picked up by TEWV.

JS advised of a patient safety CAS alert, circulated within the past week, which highlighted the need to emphasise doses of buccal midazolam in mg and mls.

IM commented that Buccolam was rejected by the North of Tyne Formulary Subcommittee at their previous meeting, adding North of Tyne were keeping Epistatus as their formulary choice. GK commented that buccal midazolam had already been approved for formulary; this was a change in brand, not a change in product.

ID concluded that the Committee would support the process for the transfer of prescribing, however would need a combined primary and secondary care document first.

ACTION: Combined document for transfer of prescribing to return to next APC meeting.

4. ADHD shared care guidelines

SH advised these guidelines had previously been accepted by the Committee, however had been brought back following amendment of the monitoring requirements in line with the MHRA safety warnings for atomoxetine. ID asked for clarification of 'cardiovascular status', referred to within the guidelines and suggested this should be changed to 'blood pressure and pulse rate' which the committee agreed with. ID also queried blood pressure and pulse centile charts, adding that GPs may not know how to access these charts, suggesting if they were necessary they should be included within the guidelines. SSa echoed this concern and queried if the charts were necessary and SH agreed to look into this.

CW queried the responsibilities for investigations; whether this would be the hospital's or the GP's. SH advised this would be dependent on who does the prescribing. It was agreed there was a need to clarify these responsibilities to ensure essential monitoring would not be missed. SG advised this information is usually included on a letter from the consultant. SSa stated this is not always the case so the responsibilities needed to be more clearly stated in this document, and suggested reminders on monitoring could be included in patient referral letters and CW suggested shared care agreements should be attached to hospital letters to GPs. PW

commented there may be some work needed in TEWV to look at the systems in place for sending letters and shared care agreements to GPs..

JB added that patients and carers also need to be involved in this and be made fully aware so they can be aware of monitoring that is needed.

Clarity was also to be sought on whether or not the documents covered adults and off label use.

ACTION: Shared care guidance to return to May 2012 APC meeting as a joint primary and secondary care document with the recommended changes and clarifications.

5. Adherence with medicines: suggestions from TEWV Pharmacy Reference Group

SH informed the Committee this paper contained feedback on what different people/ healthcare professionals can do to help people adhere to their medicines from TEWV's Pharmacy Reference Group, a group of service users and carers who meet quarterly to provide feedback on pharmacy policies and guidelines.

It was agreed this feedback in this paper contained powerful discussion points and ID suggested the GP Prescribing Leads should take this forward for further discussion within their localities and CCGs. It was also agreed this would be shared with the LPC.

ACTION: Document to be shared with GP Prescribing Leads for discussion at local prescribing groups and LPC for further discussion.

PART 2: GENERAL

6. Apologies for absence

Peter Cook, Consultant, CDDFT
Mike Lavender
Sue Mole, Patient Representative

7. Declaration of interests

No interests were declared.

ID informed the Committee forms for declaration of interests would be circulated with the papers for the next meeting, as these need to be received from all members on an annual basis.

ACTION: Circulate declaration of interest forms with May APC papers

8. Minutes from last meeting held

Clarification was needed in the minutes between SJH and SHa, and GK and GKP.

The minutes were accepted as a true and accurate record of the last meeting.

9. Matters arising/ action log

9.1. Action log

IM took Committee members through the action log. The updated actions were accepted.

9.2. Revised APC terms of reference

ID informed the Committee the current terms of reference for the Area Prescribing Committee were due for review. Copies of the updated terms of reference with minor amendments to incorporate CCGs were circulated and all changes were accepted by committee members.

It was noted at this point the meeting was no longer quorate due to the departure of some committee members, however the committee agreed to proceed with the meeting.

ACTION: ID to write to Committee members not regularly attending meetings.

ACTION: Revised terms of reference to be circulated and published on APC website.

10. Formulary update

10.1.Update from North of Tyne Formulary Subcommittee

IM advised the Committee he attended the North of Tyne Formulary Subcommittee meeting with CW on Tuesday 28th February. Minutes of the meeting were not yet available for discussion, however IM provided a verbal update on the most pertinent points:

Telepravir – Currently approx. 50 patients have been treated with this drug.
Depodur – An application from CDDFT was rejected
Infliximab – for Juvenile Idiopathic Arthritis, Juvenile Dermatomysitis, Paediatric onset Bechts Disease – Approved as a red drug but will need to check NETAG decision first.
Coleocalciferol 800iu vit D supplement – approved
Buccolam – Not approved, will continue to use Epistatus

10.2.Update from County Durham & Darlington Formulary Development Group

See item 10.3

10.3.Formulary approval process

IM advised there were currently three different processes for drug approval and there was a need to develop a single, smoother process. The paper presented posed a number of questions and ID suggested the Formulary Development Group should make some recommendations to present to the APC at the next meeting as the meeting at this point was not quorate to be able to make these decisions.

GK suggested the process should be more local, however accepted there are issues surrounding resource, and ID agreed there was may not be enough resource at the present time to support this. GK queried what may happen with this post 2013; IM advised that the Medicines Management strategy had been approved by all three County Durham and Darlington CCGs which included the APC and associated processes continuing beyond April 2013.

LT queried the robustness of the North of Tyne process. GK queried if the APC could potentially use the North of Tyne evaluation process and also queried what the RDTC's role could be in this. PF advised that NICE were due to publish guidance on formulary development groups, however added this was not due out until December 2013. PF also advised the RDTC does support formulary development groups in other areas, providing drug evaluations, however this depends on the SLA in place. GK questioned if the current RDTC SLA needed to be reviewed. ID agreed that it would be useful if the RDTC could provide some broad information on the costs involved in an enhanced SLA to support formulary development.

BH and JB asked for clarification why the Committee were using the North of Tyne formulary processes. ID advised this was currently the only trust in the region with a formulary subgroup in place, therefore this was the only option.

ACTION: Formulary Development Group to work on recommendations to bring to the next APC meeting.

ACTION: PF to provide estimation of costs for an enhanced SLA from the RDTC to support the formulary process in the future.

11. IFR decisions

No update was provided as Mike Lavender was not in attendance.

12. Medication safety

12.1.MHRA Drug Safety Update

Contents of the February 2012 Drug Safety Update were reviewed and there was nothing of significant importance for the Committee.

13. CDDFT principles of medicines management

GK advised it was important there was some shared understanding between the Foundation Trust and the PCT on what will be dispensed from the FT for outpatients and on discharge. GK asked if the paper presented would be of use and asked the Committee how best to take this forward. IM agreed this could be a useful document and stated there was a need to look at this prior to the dissolution of PCTs in April 2013.

ID commented the system had become very complicated, which GK echoed and suggested the APC may not be the most appropriate place for this discussion, however a working group may be a good idea who could come back to the APC with recommendations. IM agreed with this proposal.

GK also advised electronic outpatient prescribing would be piloted in the Foundation Trust from 2nd March 2013 and advised he had met with Stewart Findlay regarding this.

ACTION: GK and IM to meet and take the issue forward with contracting before bringing back to the APC.

14. Compliance aids

CW advised there were many issues regarding carers/ care homes inappropriately requesting compliance aids and the FT is finding it difficult to meet the demand. PK commented some paperwork was produced in the past as a result of a RPIW looking at discharge processes, and queried if this was in use as the paper seemed to cover what was already agreed following the RPIW. CW advised a piece of work was currently being undertaken in the Foundation Trust.

IM commented there was currently no defined, single assessment for people requiring compliance aids. ID suggested the issue would not be solved in this meeting, however suggested broadening this piece of work to work towards adopting a single process involving representatives from the PCT, TEWV, the Foundation Trust and the LPC.

ACTION: IM and CW to work together to produce a joint piece of work to bring back to a future APC meeting.

15. Controlled drug patches

CW advised this issue had been brought to APC following discussions at a meeting of the Controlled Drugs Local Intelligence Network where a number of incidents involving CD patches had been discussed. ID suggested prescribers should be advised to avoid prescribing CD patches unless clinically appropriate and suggested it would be useful to address this issue. Many problems surrounded this issue including different formularies containing different products and some patches needing to be left on for different periods of time.

LT informed of issues for district nurses and commented that using the application charts was very useful for changing patches and working with families and carers. CW said that in the past Linda Neely had produced something for care home which was adopted in CHS but isn't yet in place in the FT

ID queried if a guideline would be useful. CW advised this issue may be addressed in a cancer network guideline, currently in development. SMcG advised of the need to emphasise this refers to controlled drug patches only.

ACTION: CW and IM to produce a joint piece of work on the use of analgesic controlled drug patches and reducing errors with CD patches.

16. Diamorphine to morphine switch

GK advised this issue had been discussed at the last APC meeting in January 2012, and that a regional approach was being taken with this switch. GK advised he had received a schedule containing information on the leads for this which he would share and this showed that 20% of all practices would be visited by Robin Armstrong (Cancer Lead GP) and there would be 4 regional events about this switch.

PK queried if information on this switch would be communicated to community pharmacists and queried if there would be reimbursement available for any surplus morphine stock.

ACTION: GK to share draft guidance and action plan with IM and ID.

PART 3: PHYSICAL HEALTH

17. Liraglutide/ Exenatide shared care guidelines

CW advised that the guidelines had been endorsed by the PCT and had been brought back to APC for final sign off following minor amendments. ID noted it was important to recognise 'specialist' could refer to GPSIs in diabetes, not solely CDDFT diabetes specialists. With this change it was agreed to accept the guidance

ACTION: CW to amend wording of 'specialist'

Other shared care issue:

At this time the Committee were advised an apomorphine shared care guideline, previously presented to the Committee, had been omitted from the agenda, however it was agreed to approve this by Chairman's action.

18. Update from Diabetes Strategy Group

IM briefly introduced this update on discussions on insulin prescribing for type 2 diabetics in County Durham and Darlington. The Committee noted the contents of the paper.

PART 4: STANDING ITEMS

19. Minutes

The following minutes were accepted for information.

19.1.CDPCT D&T
19.2.TEWV D&T
19.3.CDDFT D&T

20. Drug & Therapeutics Bulletin summaries

This item was accepted for information

21. RDTC horizon scanning

This item was accepted for information

22. Any other business

Emollient Guideline

A letter received from Reckitt Benckiser regarding minutes from the September 2011 APC meeting was circulated to the Committee. The letter stated

> *"The September 2011 minutes of the County Durham and Darlington APC have come to our attention via your website regarding a mention of E45 and "potential lanolin related issues". We believe that the mention of E45 and these concerns around lanolin relate to a misunderstanding of the ingredients in E45, specifically E45 Cream®."*

It was acknowledged the September 2011 APC minutes (page 11, item 13) should have read "E45 cream". ID also suggested some dermatology should be asked to re-consider their opinion in light of this letter.

ACTION: ID to acknowledge letter from Reckitt Benckiser.

Diabetes Advisory Group

BH queried if place for a patient representative on the Diabetes Advisory Group had been found. ID advised the meeting had not yet taken place, however he would bear this in mind. CW added that the group was not a decision making group. ID added that the group would consider again the need for service user input.

JB highlighted an anomaly in the diabetes guideline presented to the January 2012 APC meeting. IM suggested this could be picked up outside of the meeting.

Date and time of next meeting:

Thursday 3rd May 2012
12.00 – 14.30
John Snow House, Durham

Confirmed as an accurate record:

Dr Ian Davidson - Chair