# County Durham and Darlington Area Prescribing Committee

**Thursday 1st May 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, Quality & Safety Lead, North Durham CCG (chair)
Paul Davies, Medicines Optimisation Pharmacist, NECS
Sue Dickinson, RDTC
Dr Catherine Harrison, GP Prescribing Lead, DDES CCG
Betty Hoy, Patient Representative
Sue Hunter, Associate Director of Pharmacy, TEWV
Patricia King, LPC Representative
Sarah McGeorge, Nurse Consultant & Clinical Director, TEWV
Dr Robin Mitchell, Deputy Medical Director, CD&D FT
Ian Morris, Senior Medicines Optimisation Pharmacist, NECS
Andy Reay, Senior Medicines Optimisation Pharmacist, NECS
Joan Sutherland, Medicine Optimisation Lead Pharmacist, North Durham CCG
Laura Walker, Administrator, NECS (minutes)
Chris Williams, Deputy Chief Pharmacist, CD&D FT

## In attendance

Item 14: Mrs Mary Garthwaite (MG), Consultant Urologist and Mrs Vivienne Kirchin (VK), Consultant Urologist

Item 16: Dr Patrick Ojechi, GP and Dr Paul Peter, Consultant Physician and Clinical Lead



**Part 1 – Mental Health (11.30)**

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| **1.** | **Clozapine CQRG**<br>SH explained the need for standardising the management of patients taking Clozapine. There is now a shared area in TEWV to see where the patient is in the system with Clozapine, however the system does is not yet available to primary care. It is recommended that GPs document if their patients are taking Clozapine (although they would not prescribe it) to ensure secondary care is aware if the patient is admitted. A discussion was held around the risks of inadvertent prescribing, and whether this risk could be mitigated. Some GP systems allow medicines to be included for information only. Information is being developed by TEWV to send to GP's. | **Action**<br>**SH** |

**ACTION: Take to June Drug & Therapeutics CAG, and return to September APC**

**2. Dosulepin guidance**

SH returned this document following amendments. AR highlighted a current supply issue which could prompt patient reviews. The document was approved by the committee.

**Part 2 – General (12.30)**

**3. Apologies for absence:**

Dr Peter Cook, Consultant, CD&D FT
Dr Alwyn Foden, AMD Clinical Governance, CD&D FT
Dr Suzy Guirguis, Consultant, CAMHS, TEWV
Dr Sarah Hailwood, Consultant Rheumatologist, CD&D FT
Graeme Kirkpatrick, Chief Pharmacist, CD&D FT
Monica Mason, Principal Pharmacist, RDTC
Dr Paul Walker, Consultant Psychiatrist, TEWV
Dr Ingrid Whitton, Deputy Medical Director, TEWV

**4. Declarations of Interest**

ID suggested declarations of conflicts of interests should be reviewed as it has been over 12 months since the previous review.

RM informed the group that he is the Regional Director of the Clinical Network.

**5. Minutes of the previous APC meeting held 9th January 2014**

**Item 6.** Sarah McGeorge gave apologies.

**5.1. Letter to APC members following cancelled March meeting**

ID apologised to the group for the cancellation of the March meeting.

**5.2. Attendance at APC by members 2013 - 2014**

BH asked whether another lay member would be welcomed as she may know someone who would be interested in joining. The group would welcome another lay member.

CW informed the group that the CD&D FT are currently reviewing their consultant membership to the group.

**ACTION: Review the membership of the group and create an active members list.** **PD**

**5.3 APC Terms of Reference**

ID suggested public health attending the meetings, if so the local authority would have to be added to the terms of reference. IM explained there are separate public health teams for County Durham and Darlington. ID will discuss this with the teams.

The group agreed that the Senior Finance representatives should

be removed. They felt the local area teams should have representation, as well as CCG senior pharmacists. PD highlighted the lack of support from Darlington CCG, the group agreed and also suggested the chair role is rotated between the CCG representatives.

CW noted the number on the document needs amending as some parts are incorrect.

**ACTION: Add an active members list as an appendix to the terms of reference.** **PD**

**ACTION: Contact the public health teams in County Durham and Darlington.** **ID**

**Action: Remove Senior Finance Representatives from the terms of reference.** **PD**

**ACTION: Write to the Local Area Teams and invite to APC.** **ID**

**ACTION: Add CCG Senior Pharmacists to the terms of reference.** **PD**

**ACTION: Discuss with Darlington CCG representation at the APC.** **ID**

**ACTION: Amend the numbering of the document.** **PD**

**6. Matters arising including action log**

AR discussed the action log. CH suggested the action log be numbered and add the date the action was generated to make it easier to follow.

GC highlighted the IFR process and the poor system that is currently in use. There are issues regarding the system used and the lack of being able to look up previous decisions. It has also been noted that there appears to be no one in charge of the service.

**ACTION: Add numbering and date action was raised to action log.** **PD**

**ACTION: ID to write to NECS requesting clarity on the IFR service.** **ID**

**7. APC Formulary steering committee**

PK felt it would be useful to include drugs on the minor ailment scheme on the formulary, PD explained Darlington are not currently signed up to the scheme and it is currently under review so these drugs will not be added. ID highlighted an issue with the use of many brands of oxycodone and suggested specifying one brand. GC asked whether there are differences between the preparations, CW informed the group further research would need to be done on this.

CW asked whether work has been done with Ad-Cal D3 caps as these are cheaper than the other preparations.

CW informed the group that asenapine was previously rejected from the formulary and wondered whether the group were happy with this decisions, all were in agreement.

**7.1.1 Formulary Steering Group Minutes (January)**
For information.

**7.1.2 Formulary Steering Group Minutes (February)**
For information.

**7.1.3 Formulary Steering Group Minutes (March)**
For information.

**7.2.1 NICE MHRA update (December 2013)**
For information.

**7.2.2 NICE MHRA update (February 2014)**
For information.

**7.2.3 NICE MHRA update (March 2014) including TAs**
For information.

**7.3 Online Formulary Changes**
The group found this a useful document and agreed to the format.

**7.4 Chapter 5 Update**
This is now online. ID suggested that the antibiotic guidelines for each trust should be put under each header.

**ACTION: Add trust guidelines under each header. CW**

**7.5 Chapter Review Process Update**
CW informed the group that chapter 11 (eyes) will be reviewed next. CW informed the group that the new process will involve consultants and trusts to be given time to pass comment before the review is complete. The group agreed with this process.

**7.6 Formulary Sub-Group Workplan**
The group were happy with the workplan, ID encouraged the group to be pro-active with the upcoming work.

**7.7 Regional Contract for Adrenaline Auto-Injector**
Following the recall of Jext adrenaline auto-injectors CW asked the group which adrenaline auto-injector they recommend for use. It was noted that Newcastle Trust are using Jext. The group discussed the fact that patients have been contacted regarding the Jext recall which may impact on patients trust in the product. CH and PK felt a recall would be difficult and patients would not take it very well having a further switch.

ID felt it a little unfair as the company declared the problem and is

being penalised for this. BH felt confidence in the product for doing this as would be confident any further issues would be raised. SD highlighted the fact that both products will be being used. GC suggested new users should be given Jext, it was agreed that Jext would be the first line choice but Epipen would also be in the formulary.

**ACTION: Add Jext as first line adrenaline auto-injector with Epipen being on the formulary as second choice.** **CW**

**8. New Drug Applications**

**8.1 Fostair**

The group discussed the potential cost savings of Fostair and felt it should be on the formulary however, the issue was raised that the formulary is beginning to include a large amount of drugs. CW informed the group that the CD&D FT has no objections but noted the drug has previously been refused. The group agreed it should be on the formulary.

**ACTION: Add Fostair to formulary** **CW**

**8.2 Formulary Decision Process - Fostair**

See 8.1.

**9. NTAG Update**

**9.1 TOR**

For information.

**9.2 Membership**

For information.

**10. CDDFT Medication Discharge Standards**

CW informed the group that an audit was carried out on medication discharge letters. This document shows which areas will be in discharge letters. ID suggested GP would find it useful to know whether a patient has had their medication reviewed. CW said the medications won't have been reviewed in case the medication history of the patient was incorrect.

The group approved this document.

**11. NHS England Alerts February**

For information. It was noted on the April 2014 alert that the homecare services are now with the contracting department.

**Part 3 – Physical Health (1.30)**

**12. Use of Branded Oral Contraceptives**

PD asked the group whether they would support the use of branded oral contraceptives as a cost saving measure. PK queried why oral contraceptives cannot be generically prescribed. JS explained branded prescribing is recommended to help with compliance and feels there may be some guidance on this from the MHRA.

**ACTION: Approve the use of branded oral contraceptives, unless no guidance is found and therefore return to APC.** **PD**

**13. Draft COPD Guidance (13.2 and 13.3 copied from March APC)**
Deferred to July meeting.

**14. Guidelines for the Drug Treatment of Urinary Incontinence**
AR presented this item explaining that the guidelines were written incorporating NICE guidelines and local guidance. It was highlighted that darifenacin is recommended as a treatment option, AR explained this drug is shortly coming off patent and would seem to be as good a choice as solifenacin, PD explained that solifenacin is still on the formulary.

MG informed the group that the NICE guidelines are based on female incontinence. There appears to be no reason for the choice of darifenacin. It was also noted that oxybutynin is not well used in the service. MG suggested the first line choice should be tolterodine, there is little data to suggest which is the preferable second choice. MG explained she works locally with Darlington CCG regarding incontinence, ID explained there is no representative from Darlington CCG so this information isn't being fed back.

It was mentioned by both MG and VK that conservative management with patients should be implemented early in the process. The bladder and bowel service is not well used but patients should have been through this prior to being referred to the Urology service.

VK highlighted the need for guidance to be the same for primary and secondary care and suggested taking this to the Urology network to take forward. The group were in all agreement with this, and noted the need for a single guidance as two different trusts cover County Durham & Darlington.

ID thanked MG and VK for attending the group and welcomed the joint working.

**ACTION: MG and VK to return to November APC with paper for further discussion.** **MG/VK**

**15. NICE Neuropathic Pain – Pharmacological Management**
Deferred to July meeting.

**16. The Diabetes Clinical Advisory Group update**
PO thanked the group for the work done with the blood glucose monitoring test strips, however noted the implementation could have gone better. ID explained that the APC approved the test strips to go on the formulary, the implementation was down to the GP practices to carry out. PP noted a letter had been sent out regarding this and queried who had sent it. AR explained that the County Durham and Darlington D&T CAG had created an implementation plan and information pack which was sent to GP surgeries. This offered suggestions to practices on how to

implement the changes. PP suggested it may have been better if the diabetes CAG had sent the information pack out, ID agreed the process should have been followed through and lessons have been learnt from this process, and recommended that a steering group is established to support implementation of this scheme.

PP raised the issue of new drugs which are not on formulary. ID explained that the formulary recommends which drugs should be prescribed but you can prescribe off formulary drugs. PO queried the way drug combinations are prescribed within the FT. CW agreed that there needs to be a system within CD&D FT for off formulary prescribing.

IM thanked PO and PP for attending.

**ACTION: PD to establish steering group** **PD**

**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 – January – April 2014**
For information.

**19 Any Other Business**
Discussed with MG and VK in attendance. IM informed the group of a Urology trial which is being undertaken whereby a group of patients, who intermittently self-catheterise, will be treated with prophylactic antibiotics alongside another group not being treated this way. IM raised a concern about the increased risk of C.Diff with this trial and the pressure on CCG's to meet C.Diff targets.

MG is aware of this trial and explained that the trial involves a small number of patients from each region. MG explained that the people who would take part in the trial would be likely to be taking prophylactic antibiotics. ID felt this would not be a problem for CCG's, the group agreed.

**20 Date and time of next meeting:**
Thursday 3rd July 11.30 – 2.30 Boardroom, John Snow House