Minutes	**Title of Meeting**:	**Area Prescribing Committee Meeting**
	Time:	**2:00pm**
	Date:	**Wednesday, 19th March 2014**
	Venue:	**Level A RFT Pharmacy Seminar Room**
	Reference:	**AG/JMu**
	Chairman:	**Avanthi Gunasekera**

Present:	Avanthi	Gunasekera	Commissioning Executive NHSR RCCG (Chair)
	Stuart	Lakin	Head of Medicines Management – NHSR CCG
	Surinder	Ahuja	TRFT
	Stephen	Davies	RDaSH
	Diane	Mowbray	TRFT
	Christine	Harrison	TRFT
	Christina	Dazelek	TRFT – on behalf of Ian Cawthorne
Minutes by:	Julie	Murphy	Project Support Officer NHSR CCG

	Agenda Item and Action Points	**Action**
14/18	**Apologies:** Simon MacKeown (General Practice Representative), Ian Cawthorne Chief Pharmacist TRFT	
14/19	**Declarations of Interest** Standing interested declared by Avanthi Gunasekera and Simon Mackeown in anything that affects GP practices.	
14/20	**Minutes from the Meeting held on Wednesday, 15th January 2014** Minutes approved as a true and accurate record of the meeting.	
14/21	**Matters Arising**	
	12/048 & 13/20 & 13/35 & 13/66 & 13/83 & 14/21 Memantine *RDaSH stated that this will not be as much of an issue now Memantine is going to become a generic.* *SCP agreements – RDaSH are meeting with PCT/CCG commissioners to discuss SCP and the direction to take. RDaSH have provided the financial modelling relating to the number of patients for memantine up to November 2013.* *Committee queried if there is a need to revisit the clinical SCP for memantine or is it still applicable. It is agreed in principle that prescribing in accordance with NICE guidance will at some point in the future be transferred to primary care. Prescribing that is outside NICE guidance will be retained by RDASH* *SD has sent a baseline of Doncaster's shared Care to start the conversations. SD is liaising with the 3 consultants and recommends GPs liaise with SL.* *RDaSH still to comment on the proposals. JPa informed group of Dr Wright's presentation at March PLT.* *JPa gave an update from NHS Rotherham CCG MMC some pharmacies are experiencing difficulty with 3 monthly prescriptions from RDaSH.* *AH - RDaSH are aware of the 84 day prescriptions, these are being prescribed from a pragmatic*	

	point of view due to the frequency that patients are seen. ***Action -*** *AH to discuss this with colleagues with regards to NOMADs, proposal would be to provide 3 x 1 monthly prescriptions for this purpose to prevent degrading of drug.* *AH – informed committee of a recent RDaSH wide meeting on the use of memantine that RDaSH are awaiting revised pricing. NHS Rotherham CCG and RDaSH have an in principle verbal agreement that if prescribing is within NICE guidance then the CCG will be willing take over the prescribing in line with the SCP, any prescribing outside of NICE guidance will remain with RDaSH.* *SL - Awaiting further information from RDaSH* *All agreed that at present we are awaiting memantine to come off patent for cost reasons. It is agreed in principal that Primary Care will take over prescribing within NICE guidance criteria.* *SL informed committee that work is ongoing and he is due to discuss this with Jeremy Seymour.* *AG reported that SL is speaking to Jeremy Seymour. SCP has been reviewed at NHSR CCG MMC. Discussions ongoing regarding the finance.* *SD reported a lot of work has been undertaken and a recent revised draft has been received for approval. There are 4 generic products available and the tariff is the same. Memantine may reduce and finance conversations are taking place.* SL/SD reported that discussions have been taken place outside the meeting and the SCP has been agreed and ratified at CCG MMC and Jerry Seymour is happy with the SCP and for the transfer of memantine prescribing back to primary care. SL will notify GPs via the GP Newsletter with the caveat from SD to review if other evidence / guidance comes to light. Committee agreed. This will be formally ratified at a later APC.	
	12/052 & 13/20 & 13/35 & 13/66 & 13/83 & 14/21 Ocular Lubricants *SA & Jason Punyer are liaising with ophthalmologists* *JPu is developing guidelines relating to new drug and dispensing unit on offer. SL explained to committee that NHSR would like to implement these guidelines and this product. Tearlac is hypromellose version. SL has requested a response from Mr Jabir.* ***Action -*** *SL to forward final draft version to Ian Cawthorne to also take forward with relevant consultant.* *SA received guidance from JPu and reiterated comments from Mr Jabir, SA informed group that TRFT would have to increase stock range in line with guidance.* ***Action -*** *SL to discuss with JPu* *JPu - Guidelines have been circulated and Ocular Lubricants is on QIPP for this year creating cost reductions.* *SA to take the guidelines to Ocular Team and Audit committee in Mr Jabir's absence. Suggests review in a year's time.* ***Action -*** *JMu to add a reminder to last agenda of the year.* ***Action*** *from last time - add a reminder to last agenda of the year.* *AG informed committee that GPs are aware of first line medications from Newsletter and PLT.* ***Action*** *- SA to send information again to TRFT doctors.* Guidance has been circulated and TRFT doctors are aware. **Action - SA to upload to the NET formulary**	**SA**
	12/068 & 13/20 & 13/35 & 13/66 & 13/83 & 14/21 **Ergocalciferol vs Colecalciferol** *Colecalciferol is the Vitamin D of choice.* *SA is discussing this with the TRFT consultants. Dr Franke recently attended a conference and the outcomes from this are that TRFT would like to use/order larger quantities which will have financial benefits. SA is awaiting confirmation on dosing and length of use i.e. 40,000 units once a week for 12 weeks. Committee agreed provided the dose preparations can be ordered and GPs will follow the guidance given.* *SA - Pro D3 consultants are happy to use, but dose needs clarifying as there is a variance in the guidance i.e. NHSR do daily dose and TRFT do weekly dose.* ***Action*** *– Ruth Dales to send clarification to Dr Franke and cc Surinder for info.*	

	SA guidelines stated a daily dose and TRFT prescribe a weekly dose. This information has been relayed directly to Ruth who is updating the guidelines. ***Action –*** *SL to discuss with Ruth evidence relating to falls weekly vs daily dose to present back to SA. SL to discuss Osteoporosis guidelines in relation to above.* *Once guidelines agreed TRFT would like to adopt for use in secondary care* *SA - Once weekly dose could be added and TRFT have implemented the dose and it has been tolerated.* ***Action -*** *Ruth Dales – to check Vit D guidance in conjunction with National Osteoporosis Society guidelines and amend accordingly.* ***Post meeting note:*** *SL emailed RD 26/07/2013* *Colecalciferol is the Vitamin D of choice.* *Ruth Dales has submitted the Vitamin D guidance to Dr Franke and we are currently awaiting agreement. SL explained that there had been recent changes in prescribing such as unlicensed products and a move from large doses to smaller divided doses for evidence based reasons.* *SL informed committee that the guidelines have been updated and uploaded onto the intranet.* *SA informed committee that Dr Franke is prescribing once a week dose.* *RD has reviewed the guidance and MMC approved guidance at 13/11/2014 meeting and will be published at end of the month.* ***Action -*** *SA to speak to RD with comments* *Guidance has been finalised and has been uploaded onto the intranet/internet. Necessary feedback is being received and the pathology labs are giving guidance when required.* *SA queried the Pro D3 has been removed from the guidance due to not being license and restriction re; Fultium & Desunin.* ***Action*** *- SA to speak to RD. Action complete* SA/RD have discussed the doses and feedback has been given to the TRFT Doctors. SA reported that TRFT Doctors would like to keep the weekly dose which may have switching implications for primary care with regard to being discharged on a non-licensed preparation. SA reminded committee that the initial and discharge dose are a full course and the primary care are to prescribe a maintenance dose according to existing vitamin D guidelines. DM – advised SA discuss the length of dose with the pharmacies so they are aware. **Action - SA to discuss further, obtain clarification and draft guidelines and bring back to the next APC.**	**SA**
	13/53 & 13/66 & 13/83 & 14/21 DMARDS Share Care Protocols and LES June 2013 - JPa from MMC *Data presented following ES work and update of contacts.* *Mycophenolate now has a generic brand which will create savings if used. APC advice is that GPs be aware of what brand the patient is on.* *Regarding Mycophenolate and Tacrolimus NHSR CCG will not be switching patients to alternative brands. The CCG has no preference what brand secondary care uses and is happy if patients are switched to alternative brands by secondary care clinicians, the CCG requires that on any communication the brand of Mycophenolate and Tacrolimus that the patient is taking is clearly identified.* *Eloise Summerfield is still liaising with dermatology. Gastroenterology is complete.* *JP to discuss further with Dr Muncaster regarding Roaccutane.* *Gastroenterology SCP is complete. Judith Wilde is going through the traffic light system for SCPs. GPs have no appetite to take over the prescribing of Roaccutane* SCP with Dermatology is being discussed. ES is following this up. SL reported that Gastroenterology SCPs are in place and Dermatology SCP is outstanding. **Action - SA to take this forward with Dermatology and ES.**	**SA**

	13/07 & 13/20 & 13/35 & 13/66 & 13/83 & 14/21 **Rotherham Heart Failure Prescribing Guidelines & Overview** *MMT updated heart failure guidance in relation to NICE.* *Shared with Dr Muthusamy and Simon Smith. Committee agreed that guidelines should follow NICE.* *Committee discussed the redundancy possibilities of heart failure nurses and the direction given in the guidance. Therefore, this may need to be reviewed if redundancies occur.* ***Action** - SA taking to TRFT D&T and will report back* *SL – Guidelines have been updated and now on the intranet.* *SL to meet with the nurses on 22nd March regarding tele-health proposals.* ***Action** - SL to write a report on use of tele-health package and how it is used and report results back.* *SL - Updated and matter now closed* *Sarah Briggs wishes to amend the guidelines for Primary Care use and add relevant drugs into them. It was discussed that the GP's will not see it appropriate to initiate specialist drugs.* ***Action** - SL to discuss a plan with Sarah on how to take this forward.* *SL to meet with Dr Muthusamy today. Work is ongoing with heart failure Specialist Nurses.* *SL on annual leave awaiting feedback* SL reported the guidelines need updating. **Action - SL to contact Sarah Briggs and finalise.**	**SL**
	13/50 & 13/66 & 14/21 Buprenorphine: - • ***Buprenorphine detail aid*** • ***Buprenorphine patch QIPP*** *TRFT confirmed they do use Buprenorphine patches. IC/SA/SL to circulate information to both organisations as a joint communication.* ***Action -** SL to liaise with IC & SA* *AC – not moved any further forward as yet SL-agreed* *Buprenorphine prescribing for Rotherham is high. It was discussed that fentanyl tolerability is often an issue so buprenorphine is considered second line. It is also deemed as safer for some patients. Elderly Osteoarthritis patients are prescribed.* ***Action** – Govinder Bhogal and Surinder Ahuja to analyse prescribing and look into this further.* ***Action** - SA to liaise with Govinder Bhogal* - SA action outstanding SA is in receipt of the patient's names and is reviewing who initiated the treatment, work ongoing.	
	13/69 & 14/21 Tramadol and Related Deaths *SL-This is a topic intended for a Bitesize newsletter article to be cascaded to Rotherham GP's.* *Stuart questioned whether it could be taken of formularies?* *IC-Feeds back that TRFT are controlling the amounts given on prescription more than previously although the number of patients discharged in tramadol has probably not changed.* *JP suggests TRFT lead on this so that community GP's can follow the trend/behaviour.* *Post op surgery is where the main volume of tramadol prescriptions arise.* *SL requests that GP's are advised by the hospital not to put it on repeat for patients as this prescribing should be acute.* ***Action** – All agreed to wait for the conclusion of the current review being undertaken and then this is to be discussed further when the outcomes of the review can be shared. SL-To produce the newsletter article and share with RGH/RDASH* *IC has reviewed the Tramadol comparing benchmarking against SY&H and shared the chart relating to TRFT surgery. Committee agree that work is required in Rotherham to address the issues with Tramadol prescribing/dispensing.* *SL – Locally prescribing data is more than the national average but this is improving and the community are aware of the issues.* *Recommendation nationally is for Tramadol to become a CD scheduled 3 medication.*	

	AG advised that community are not prescribing Tramadol due to recent relation to mortality data. *IC informed committee that this medication is for short term use only. SD had concerns if GPs are initiating prescribing and repeat prescribing. AG assured committee that at patient review GPs are advising patients not to continue on Tramadol and to try an alternative. For new patients Tramadol is not being initiated as a long-term analgesic.* APC awaiting agreement from TRFT **Action - SA to follow up with the TRFT Doctors**	**SA**
	13/85 & 14/21 Anticoagulation Therapy Record – (SA) *SA informed committee that Dr Barker requested this item for discussion. The dose is to be updated and the booklet will not be updated in time. Therefore, a printed copy will be provided in the interim.* ***Action** – SA to provide information to SL. SL to incorporate into the December Newsletter**.*** ***CRMC –** Discussions with Maxine Dennis, John Miles, Nicky Doherty, another laboratory person and anticoagulant nurse regarding patient's warfarin being monitored by hospital and then patient's moving into the community. The aim is to move patient's monitoring into practice however there is an issue which may be around TRFT using DAWN system and the community using INR Star.* *Outcome of meeting agreed that CCG & TRFT for those patients' who are stable are to be treated in the community and for patients who are not stable to be treated by TRFT.* *SA committee that anticoagulation booklets will not be updated by TRFT during the system change. Tracey Taylor (anticoagulation nurse) has provided information for the GP newsletter.* This will be a tear off slip with the dose. AG is meeting with Dr Taylor and there will be an anticoagulation meeting on the 22nd April 2014 AG will be in attendance.	
	13/86 & 14/21 Prucalopride & Linaclotide (SL) *Require agreement on the traffic light as Prucalopride is specialist prescribing by the consultants, as we have patients in the community, SL recommends clear guidance be given to GP on how long to continue within the community.* *Linaclotide is a new medication. Do we need a SCP for onward management?* ***Recommend that both drugs are Amber.*** ***Action** - SA to take to consultants/surgeons. SL to ask ES to liaise with SA if SCP required.* *SA still investigating with surgeons and nothing further to report today.* *Committee did not feel there was a requirement for an SCP for Prucalopride; however, further investigation needs to be undertaken and the guidance be obtained.* *Committee agreed for Prucalopride to become Amber.* *Committee agreed for Linaclotide as open use in accordance with new laxative guidelines* TRFT would like to adopt the guidelines. Gastro surgeons, Colorectal nurses and Pharmacy are meeting as a working group. SL reported that 60% of patients are on osmotic medication and further work is required.	
	13/87 & 14/21 Antiplatelet Guidelines – (SL) *Guidelines on website require updating. Initial thoughts were that they were too complicated but they are comprehensive. Proposal at MMC to adopt the guidelines as a reference document and in the meantime MMC are to produce a simpler succinct version for GP practice.* *SA has discussed this document with Dr Muthusamy and suggested SA contact the other consultants to confirm radiation* ***Action** - SA to follow up with clinicians Dr Okwera and Dr Nawaz and bring back to meeting**.*** *SA cardiology, vascular & stroke – SA has discussed this with Dr Muthusamy who suggested contacting the other consultants.*	

	SA has further information and will forward to SL SA has emailed Dr Muthusamy and received a response today. SA has forwarded the email to SL. SL informed the committee that NICE guidance cannot be deviated from.	
14/22	**Hospital use of Diclofenac**	
	IC has identified that TRFT are over using Diclofenac and work is to be undertaken to address this issue. This was discussed at TRFT Drugs & Therapeutic Committee and feedback will be given at the next meeting.	
14/23	**SYB NOAC Policy**	
	SL not in attendance Committee agreed to carry forward to next meeting. *AG gave an update on RCCG position of Apixaban as first line unless otherwise directed.* SL to circulate the guidelines to TRFT Dr Muthusamy and SA. First line was agreed as Apixaban. **Action - SA to share her piece of work with SL**	**SA**
14/24	**Tramadol & Pregabalin** – restrict initiation	
	SL reported that the agreement is in place for Tramadol to be initiated for <u>short term use only.</u> Pregabalin / Gabapentin data is showing quite a few patients with a substance misuse code and the numbers are approaching the national average. SL to share this piece of work once the data is complete. AG informed the committee that communication to GPs relating to discharge of prisoners into primary care is not happening. SD was of the understanding that there was communication and that the prisons should be discharging back into RDaSH services as well as GP care. SD suggested that a summary care record may be the key, however they are aware of a few information sharing issues i.e. consent to share which would need to be addressed. **Action – SL & SD to work on this in collaboration to resolve and reduce the numbers and increase communication.** **Data will be shared prior to the next APC and will be discussed further at the next APC**	**SL/SD**
14/25	**Buccal Midazolam**	
	DM reported problems with patients coming in on different types of Buccolam and Midazolam as the doses and strengths are slightly different between the types of medication. TRFT have already switched the Children patients who have attended TRFT. SL is happy to switch children and adult patients. DM to provide information to SL to ensure the switches are correct. **Action – DM to speak to David and feedback to SL.**	**DM**
14/26	**Controlled Drugs**	
	Policy of medication on admission regarding substance misuse Discussed under Pregabalin 14/24	

14/27	**Paediatric Prescribing Issues**	
	GP referrals to the hospital for blood tests and the use of local anaesthetics – (DM) *GPs are requesting blood tests to be provided at TRFT but not asking for the anaesthetic to go with it. Is there a reason why GPs are not providing the anaesthetic request?* *Committee discussed that the GPs might not be aware, that the cream takes 30-45 minutes to work and that parents could apply it in advance but this raises other concerns that this may be too many steps for parents at a time when their child requires a medical procedure and that there would be a supply of anaesthesia in the community.* *APC agreed that it would be better if the phlebotomists could apply the cream and keep a stock although this raised concerns of its own regarding hospital procedures requiring patient's medical record and clinician authorisation.* *Hypothetically - IC can this be ordered with the blood test?* ***Action** - IC to speak to Andrew Jackson.* *IC spoke to AJ, AJ's concern was that the patients do not want to wait the length of time for the cream to work whilst at TRFT. Initial discussions at APC were that the community pharmacies would not have the anaesthetic cream in stock for parents to and apply before attending.* *AG to discuss further at MMC and look to putting guidance into the next newsletter and to discuss ethyl chloride spray for phlebotomy to store.* ***Action** - JMu to put on MMC agenda. Action Complete* *<u>Melatonin discussed in traffic light section</u>* *Summary of issues are:-* • *Burden on prescribing,* • *Clinics and patients.* • *Treating symptoms and not able to do something long-term.* *CH informed committee that ideally TRFT would like to work on the sleep behaviour but have no resources in place to support it.* *SD suggested that if an SCP is required then this would need to be across the board and involve the RDaSH CAMHS service.* ***Action** – AG to take this forward with CRMC* AG has discussed this with Dr Polkinghorn and a local sleep clinic would not take priority at the moment. See 14/25 for Buccolam & Midazolam discussions.	
14/28	**NPSA Alerts**	
	Nothing to discuss. Committee agreed to keep this as a standing item on the agenda.	
14/29	**Horizon Scanning**	
	• **January** • **February** • **March** SA reported that some may have implications for TRFT/CCG in the future • **Travelprost will have a different dose coming through. SMC have rejected it.** • **New inhaler Relvar - Gov to review.** • **Fentanyl**	
14/30	**NICE Guidance**	
	<u>January & Supplementary information</u> ➢ No implications for APC	

	<u>February</u> ➢ TAs no implications for APC. Pixantrone would not be initiated in primary care ➢ Quality standard for Faecal ➢ Osteoarthritis no implications ➢ Psychosis and Schizophrenia – SD highlighted implication for GPs and HC Professionals 'should monitor the physical health of patients with Psychosis and Schizophrenia and copy of results be sent to the patients Psychiatrist' the guidance also states that the 'overall monitoring of the patient be maintained by RDaSH for the first 12 months of Shared Care'. **Action - SD to forward information to SL/AD to discuss with CCG colleagues and feedback.** **Action - AG to discuss this with Russell Brynes once information has been received.**	**SD** **AG**
14/31	**Blueteq**	
	13/76 & 14/14 Blueteq *Web based software to aid specialist prescribing. A template will be filled in per patient online if a specialist drug is initiated. This will be auditable and useful for forecasting.* *JP – Useful tool to identify what proportion of prescribing is in line with NICE guidance.* *IC confirmed that an internal post has been advertised for a technician to support Blueteq and the interviews will be done within the next two to three weeks. IC invited SL to be involved in the interview process.* *SL confirmed that a 4 hour training session has been scheduled for 28th November 2013.Blueteq to advise where it will be held.* *IC staff have received training and further meetings are to take place to understand and use the system.* SL to obtain sign off by Sue Cassin and then complete the finances and payment to Blueteq. Rheumatology will be the first wave.	
14/32	**For information**	
	Committee reviewed the enclosures:- Barnsley APC Memo January & February 2014 / Minutes – 08/01/2014 Barnsley Memo enclosures – ➢ Metoclopramide restrictions in use Trent MI, - AG suggested disseminating Metoclopromide information to GPs via Bitesize ➢ Quetiapine QIPP Detail Aid, - SD reported Quetiapine has been discussed at RDaSH MMC and request communication be made regarding change of generic and branded medication, as some clients are more susceptible following the changes. ➢ OAB Algorithm. - OAB – Rotherham have their own guidelines. Doncaster APC Minutes/Prescribing Data Report Bulletin 28/11/2013, 30/01/2014 Sheffield APC Minutes 19/11/2013 & 21/01/2014 ➢ Amiodarone – Pulmonary Fibrosis case in Sheffield. The Coroner stated there should be a formal SCP across the country. Sheffield are developing guidelines and these may also be developed nationally. ➢ Amiodarone is classified as Amber and this would not be initiated in primary care.	

	➢ AG suggested looking at the numbers taking this medication and what monitoring is taking place. Committee agreed ➢ SA offered to share Wales information relating to Amiodarone and what they have already developed. Committee agreed. RDaSH MMC 10/01/2014 ➢ Clozapine has been reviewed ➢ RDaSH are reviewing insulin and the way this is recorded and RDaSH have developed a new drug card. ➢ RDaSH to discuss with CCG regarding Diabetic Liaison.	
14/33	**Any Other Business**	
	<u>14/33 AOB 1 - Premature ejaculation</u> New drug Dapoxatine – Evidence has shown marginal benefits. SL to propose that this is classified as Amber and informed the committee that Urology has applied for the guidance. Further information regarding monitoring is required. <u>14/33 AOB 2 - Rifaxamine</u> Prescribing for some patients is not being continued within the community. Dr Hoeroldt has seen good results. No issues known to the group and no conversations. This drug is not on the traffic light system – SL suggests monitoring. **Action – SA to forward information to SL/AG** <u>14/33 AOB – Low drug stocks</u> Sartin – switch to candesartan or losartan. Bumetanide is in short supply and will not be available till October 2014. SL informed committee that all GPs have been notified of the switch to candasartin. SL will investigate the Bumetanide.	**SL/SA**
14/34	**Agenda Deadline: by COP Tuesday 29th April 2014** **Date and Time of next Meeting: Wednesday 14th May 2014 @ 13.00 in Pharmacy Seminar Room, Level A, TRFT**	