NHS Rotherham

Minutes	**Title of Meeting**:	**Area Prescribing Committee Meeting**
	Time:	**1:00pm**
	Date:	**Wednesday, 8 July 2015**
	Venue:	**Wentworth Room, PGME Corridor, TRFT**
	Reference:	**AG/JAA**
	Chairman:	**Avanthi Gunasekera**

Present:

Avanthi	Gunasekera	NHSR CCG (Chair)
Stuart	Lakin	NHSR CCG
Lisa	Murray	NHSR CCG
Ravi	Nalliagounder	GP
Diana	Mowbray	TRFT
Surinder	Ahuja	TRFT
Jason	Punyer	NHSR CCG
Osman	Chohan	TRFT

Minutes by: Julie Abbotts Project Officer, NHSR CCG

	Agenda Item and Action Points	**Action**
15/33	**Apologies:** Andrew Houston	
15/34	**Declarations of Interest** No declarations of interest were made.	
15/35	**Minutes from the Meeting held on Wednesday, 13 May 2015** Accepted as a true record.	
15/36	**Matters Arising**	
	12/048 & 13/20 & 13/35 & 13/66 & 13/83 & 14/21 & 14/38 & 14/52 & 14/66 & 14/78 14/90 & 110 & 15/19 & 15/36 **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.* *SD/SL no further feedback and transfer of patients has started. An email was issued to all GPs issued a while ago and no further comments have been received. SD informed committee that this item has been discussed at their Clinical Reference Group and memantine has been removed from prior approval. If GPs wish to co-prescribe or prescribe outside of NICE it would then require prior approval.* *Task complete – remove from minutes.* *SD asked that if there are any issues with Memantine then to make him aware so that he can resolve the issues.* *AG questioned Denepozole & Mementine prescribing. SD stated that there should be no dual prescribing being transferred to primary care. If a patient is to be on two drugs then their care should continue with RDASH.* ***Action** - AG to do a search on Donepezil & Mementine prescribing at Thurcroft practice as a starting point. AG to email her findings to SD to look into this.* ***Action** – To be brought back to the next meeting on 12th November.* *No update.* *GP's called relevant consultants/nurses and they were not aware of it. As a result this was looked into and seven patients were found and these patients were sorted.* *Discussion occurred and it was reiterated that there should be no dual prescribing being transferred to primary care.* SD said that some RDASH consultants are unaware of the fact that no dual prescribing is to be transferred to primary care and the principle is not getting through to them. SCP is quite clear but there are some grey areas and SD is picking these up with the RDASH Clinical Director. Raz Saleem has been liaising with Dementia Team with a view to bringing dual dementia prescribing back. An audit is being carried out on patients already on dual prescribing with a view to bringing them back. The plan is to transfer all dual prescribing and Memantine back to RDASH. Once agreed this will appear in the GP newsletter.	**AG** **SD** **JAA**

	13/50 & 13/66 & 14/21 & 14/38 & 14/52 & 14/66 & 14/78 & 14/90 & 15/19 & 15/36 **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.* *SA informed committee of an audit due to be undertaken. Following CD Lin feedback Hapoctosin release rate is 3 days and it is about raising awareness to clinicians that it does not have the same release time as Trans Tec which is 4 days despite being shown as a similar generic medication.* *Action - APC to recommend a brand for use* *Action - SL to liaise with Govinder Bhogal about the outstanding action item re brand of use and bring back to meeting on 17 September.* *No updates – SL not present.* *Item would be brought back to the meeting in January 2015.* *Bring to March meeting.* *Discussion occurred about the pros and cons of prescribing Buprenorphine compared to Fentanyl patches. Some patients suffering from lower back pain or arthritic pain prefer Buprenorphine to codeine as there are fewer side effects.* *SA agreed to discuss with Palliative Care to find out if they use Transdec patches regularly.* SA spoke to Palliative Care and they don't use a lot of Transdec patches. Doncaster have stopped using the patches but a decision hasn't been made yet as to whether to continue in Rotherham.	**SA**
	13/85 & 14/21 & 14/38 & 14/52 & 14/66 & 14/78 & 14/90 & 15/19 & 15/36 **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.*	

	AG attended meeting with Dr Taylor and next meeting is scheduled for July. AG will discuss appropriate anticoagulation and numbers involved. Another piece of work is around transferring stable patients from TRFT to the community and the anticoagulation group will keep a note of inappropriate discharges. AG/SL and Rachel Garrison have undertaken a survey monkey to assess the INR provision within the community. *We have details of 2 inappropriate discharges from wards where the patients have been told to attend GP for warfarin therapy and no other communication from the TRFT has been issued to the GP.* *Action – SL to provide the names to SA who will investigate. This detail will also be shared with Anticoagulation team. Post meeting note: Action complete* *<u>Tinzaparin and NOAC</u>* *AG has spoken to GP colleagues today who agree that patients on Tinzaparin cannot be transferred to primary care until the patient is stable on warfarin. i.e. One INR within therapeutic range.* *SA confirmed that TRFT do supply the required quantity of Tinzaparin whilst they are being stabilised on warfarin and TRFT will continue to monitor.* *AG confirmed that GPs are happy to take over the monitoring once 1 INR in therapeutic range. Action complete – remove from minutes – post meeting note – further information – leave on minutes.* *Meeting with Dr Taylor had been cancelled, this had been rearranged for 15 August. There are six example cases which will be discussed at the meeting. Not all of these are from one ward. Patients on ward are told to go to GP but are not given any details re INR levels, dosage required etc. Anticoagulation Nurses attended a recent PLT event and showed GP's the grey form which is supposed to be given to patients on discharge and patients are asked to take the form to their GP. None of the GP's present had seen the form before. This will be discussed at the meeting on 15 August and AG/SL will report back to the next meeting.* *Meeting went ahead regarding unsafe discharges. The next meeting is due to take place on 7th November 2014. Dr Taylor is working on NOAC guidance. SL will feedback on this with a view to having a single guideline for both primary and secondary care.* *Meeting will now take place on 28 November. Surinder confirmed that she was able to attend. Surinder said that regular meetings were taking place at the hospital.* *Anticoagulation training dates have now been set up for 4 Dec and 11 Dec for Lead GPs and Practice Nurses. District Nurse training dates have yet to be identified. Due to the shortage of District Nurses there is uncertainty as to whether they have the capacity to undertake the training and deliver the service of 'household INRs'. The problems with the testing machines have now been resolved.* *SL said he was working on a first draft of the NOAC guidance and this would need to be taken forward with GPs to seek their opinions.* *GP practices are ready for the transfer of stable patients from secondary care. District Nurses are to perform housebound INR's but due to capacity issues the transfer of these patients has been postponed. At the moment District Nurses borrow the machines from GP practices and the machines are maintained by the CCG. We have recently purchased Co-ag machines for the District Nursing Teams at the hospital, however, there is an issue around the machines belonging to the CCG rather than the RFT. Medical Engineering at the TRFT would need to test the machines but they are unable to do this as the machines belong to the CCG, therefore, there is now a delay whilst this problem is resolved. This is disappointing considering the number of discussions which have taken place. SL/Rachel Garrison will talk to Dr Taylor at the next Anticoagulation meeting scheduled for 13 February 2015.* *We now have a clear pathway and the issue with anticoagulations is that more patients are being discharged from hospital on NOACs when they could have been discharged on Warfarin which is more cost effective and safer. Could we ask Consultants and Doctors to consider Warfarin rather than NOACs.*	**SL/RG**

	SA said they were going to monitor this and would be looking at the guidelines when these are issued. If a SCP is developed then Warfarin should be the first line drug. A discussion had taken place at the CCG Clinical Referrals Management Committee about this and representatives from TRFT had been present. CCG expressed concerns about level of Rivaroxaban prescribing at TRFT which could result in a cost growth of £300-£500K which would have to come from TRFT contract. Dr Taylor is aware that Rivaroxaban is only for prescribing to patients who are not able to have Warfarin and TRFT do not want to expand this. TRFT have drafted a policy which has been out for consultation and is now with the Ratification Group and will hopefully be ratified by the end of the month. SL/AG will try to have a conversation with Dr Taylor at the PLT Event on 9th July. SA agreed to email a copy of the policy to AG. *Post Meeting Note – this has now been actioned.*	**SA** **SL/AG** **AG**
	14/24 & 14/38 & 14/52 & 14/66 & 14/78 & 14/90 & 15/19 & 15/36 **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 to share the piece of work that has recently been undertaken. Committee still need to be mindful of the rise in use* *Item yet to be actioned – keep on minutes.* *AG has now got a date, 19th November, to visit Doncaster prison. Mark Pickering from the prison agreed to show SL and AG around and look at the current issues.* ***<u>Action</u>** - Bring back to January meeting with updates on how the visit went.* *Pregabalin is now white on the traffic lights document. If a patient has a history of substance misuse then Pregabalin is not to be initiated in primary care.* *AG/SL would be visiting Doncaster Prison on 19th November and would report back to the January meeting.* *SL/AG visited Doncaster Prison and had spoken to the a very helpful GP, Dr Mark Pickering (MP) who showed them an A4 sheet which is faxed to GP's to request information about patients – this is sent on prisoner's arrival at prison. They discussed having a similar sheet which could be used as a discharge summary to be faxed to the GPs when a person is released from prison. The GP didn't see any reason why this couldn't be done and agreed to work with us to develop the sheet. We also talked about a list of phone numbers which GP's can call for advice/information and he agreed to provide this.* *The GP agreed to come to a PLT event in July to do a workshop..* *The visit was very worthwhile and it made us aware of communications with GP's.*	**JAA** **SL/AG**

	Pregabalin is mainly initiated in primary care and MMT are currently doing a piece of work/audit around this. PLT is due to be held on 9th July and there will be two workshops around this - Pregabalin Problem and Prison Discharge. Data will be shared with GP's and figures show that prison discharge isn't the problem - it's more about GP prescribing.	
	14/52 & 14/66 & 14/78 & 14/90 & 15/19 & 15/36 **Methylphenidate** *SD to send the Methylphenidate SCP to JMu.* *Action - JMu to add to agenda for ratification at next APC.* *This item would be brought to the September meeting.* *SD confirmed that he is happy with the document. This document is now approved in its current format.* ***Action** – SL to finalise the SCP* *AH asked if they could receive feedback about this. SL to update on progress.* SCP has now been uploaded to the intranet. Remove from minutes.	**SL** **SL** **SL**
	14/47 &14/52 & 14/66 & 14/78 & 14/90 & 15/19 & 15/36 **AOB 1 – Vitamin D and ADCAL D3** *Vitamin D - 400 units daily, if patient is taking calcium there is a risk of kidney stones. Guidance advises healthy start but these are not prescribed but are given by health visitors or sure start.* *ADCAL D3 one a day has renal implications in pregnant women. Incident where patient is dehydrated and vomiting. (SL suggests clinician seek advice if hyperemesis is an issue and consider a Vitamin D only supplement)* *Further investigation is required.* *AG agreed to follow this up.* *AG has emailed Mr Poku but not heard anything back as yet.* ***Action** - AG to chase.* *AG still to chase Mr Poku.* *There is an issue with the new preparation – Judith Wilde has updated the guidelines and these have now been given Lisa Murray for her to liaise with Surinder. If everyone is happy these can then be circulated in Bitesize ie a small paragraph with a link to the guidelines.* *Vitamin D Guidelines had been discussed at the CCG MMC. After discussion it was agreed that LM would liaise with SA about these as there are several issues which need to be addressed ie what to do with pregnant women who are vitamin D deficient during or prior to pregnancy. LM had spoken to Surinder who had talked to Mr Poku and he didn't seem to be concerned about these patients being treated in Primary Care, rather than being referred to Endocrinology. If patients are diagnosed with Vitamin D deficiency as part of symptomatic tests, should these patients be referred to Endocrinology or would Mr Poku be happy for these patients to be treated by Gynae or their GP? Also possibility of a Vitamin D test being taken by Midwives during the first screening. LM agreed to liaise with Surinder/Mr Poku about these issues.*	**AG** **AG** **AG** **LM**

	Guidelines had been brought to the group because LM hadn't received feedback from Mr Poku and the guidelines needed to be reissued. The issue is around treatment in pregnancy and Lisa suggested that treatment of pregnant women should remain within Endocrinology as per current guidelines. After discussion it was agreed that pregnant women should be referred to Obstetricians who have a joint clinic with Endocrinology. It was queried whether we could include the Invita D3 drops to give patients a choice. LM would amend the guidelines to reflect these changes and these would then be issued.	**LM**
	14/78 & 14/90 & 15/19 & 15/36 **New NICE Lipids Guidelines – SL** • **14-07 NICE Lipid Guidance Primary Prevention** • **14-07 NICE Lipid Guidance Secondary Prevention** *AG and SL have taken this to SCE and spoken to Public Health. RMBC are also on board with the guidelines.* ***Action*** *- AG to write to GPC about the concerns and issues with this for the clinicians.* *SD suggested some formatting changes, he suggested the most important areas should be in bold as it makes it easier to find when scanning the document.* ***Action*** *- SA to go through NICE guidance and compare with SL's abbreviated guidance and feed back to SL.* ***Action*** *- SA will discuss with Dr Lord the new NICE guidance and the increased workload.* *After discussion it was agreed that IC would set-up a meeting in January with Dr Muthusamy and Rob Wilson.* *Dr Muthusamy was present for part of the meeting and was asked how he felt about starting patients on atorvastatin 40mg for secondary prevention and leaving it to the GPs to titrate up to 80mg if no adverse side effects. He felt the evidence for atorvastatin 80mg in secondary prevention is substantial and only a few patients actually suffer intolerant side- effects on that dose. He also felt that if patients were well educated on the benefits of the high dose statin at the start they are more likely to tolerate some minor side effects. The few patients that do experience side effects are likely to try a lower dose.* Remove from minutes.	**IC**
	14/79 14/90 & 15/19 & 15/36 **Shared Care Protocols** Gastroenterology – protocols agreed. Rheumatology – protocols agreed. ***General SCP's for Children*** *– CH raised the question of where there are SCP's for adults can these be also used for children. Discussion occurred about this and CH said the numbers were low, probably around 30. RN felt that there may be some apprehension from GP's and it was felt that because of the low numbers it would be better to treat children within secondary care. This was to be discussed at MMC.* Remove from minutes.	**RN**
	15/19 & 15/36 **Principles of Shared Care Protocols** *Shared Care Protocols have been developed over Rotherham, Sheffield, Doncaster, Barnsley and Bassetlaw. General principles had been developed and now need to be approved by the five areas. The group were happy with these but there was just one question – is the SCP between consultant and GP or Hospital and Surgery – what happens if a patient moves from one GP to another within same practice, or changes to another GP surgery does the SCP travel with them? SL agreed to clarify this.*	

	SL said that the SCP had been agreed for Sheffield Teaching Hospitals and after discussion the group were happy for them to be agreed for Rotherham. Remove from minutes.	**SL**
	15/19 & 15/36 **Nalmefene for Reducing Alcohol Consuming in People with Alcohol Dependency** *Anne Charlesworth from Public Health attended the MMC meeting. There is new NICE Guidance for Nalmefene which is a drug which reduces the desire for alcohol but only works if there is counselling in place. There are potentially a lot of patients in Rotherham who will want this drug. John Radford, Director of Public Health (but now retired) had felt that funding for Nalmefene sat with Public Health and had made provisions for this in the Public Health budget* *In Rotherham we are uniquely placed to offer Nalmefene in primary care due to the Alcohol LES and the community primary alcohol team. Doncaster has spoken to Public Health about secondary care use.* *MMC had made a decision to Traffic light RED until the pathway is ratified*. Funding for this sits with Public Health as the NICE Guidance says that the drug should not be prescribed unless counselling is also offered. Discussion occurred about whether we needed to chase progress with Public Health. A new Director of Public Health, Terri Roche, had recently been appointed and it was agreed that SL would contact Terri in a couple of weeks to discuss this further.	**SL**
	15/19 & 15/36 **Tinzaparin Shared Care Protocol Draft** *Currently there is a 14 day supply with a discharge letter being faxed to the GP on the day of discharge. It had been decided that a 28 day supply would be a better way as this would give more time for allowing the discharge letter to get to GPs. Discussions occurred about costing implications and SL agreed to speak to Keely Firth, Finance, RCCG.* *The District Nurse would be informed by the hospital team prior to the patients discharge.* Discussion occurred and it was agreed that there needs to be a robust process for how the SCP will be communicated to GP's. After discussion it was agreed that faxing is the best way as every GP practice has fax machines.	**SL**
	15/19 & 15/36 **Traffic Lighted Drugs** *Discussion occurred about Red Lighted Drugs and the costings attached and there was concern about the financial burden to TRFT. IC thought that we needed to question the source of funding for these drugs – some are in tariff and some can be £400-£500. There was concern that the TRFT is carrying an unfair financial burden. SL said that we needed to go through the Traffic Light System and review these. There are some drugs which we definitely don't want prescribing and there may be some we could look at. After discussion it was decided that this needs to be discussed with finance/contracting – SL to set-up meeting.* Remove from minutes.	**SL**
	15/19 & 15/36 **Degarelix** *Jan Farrell says she is putting a lot of patients on this drug. It's a metastatic for patients who have not had any castration. After discussion it was agreed that SL/IC would meet up to discuss this further and decide what rating this drug should be. SL would also contact SA to see where we are with it with regards to red lighting.*	**SL/IC**

	RN said there was no SCP for Degarelix and this drug had been red lighted on the CCG Traffic Light system. RN was asking if we could change this to Amber and can this be incorporated into other SCP's. SA agreed to look into this and would bring back to the next meeting. Remove from minutes.	**SA**
	15/36 **Interactions With Statins** *SA wanted to raise the issue of patient's coming into hospital on Simvastatin 40mg with drug interactions. Most GP's don't prescribe Simvastatin now, following NICE lipid guidelines, they prescribe Atorvastatin, but historic patients will remain. JP had said that he had seen letters from the hospital where Simvastatin 40mg had been reduced to 20mg and that in primary care we had advocated changing to Atorvastatin, long before the new lipid guidance so patients got an evidenced based dose of statin. SA confirmed that this was likely to be the surgeons and cardiology always switched to Atorvastatin.* *Discussion took place about titrating patients up, although previous discussions with Mr Muthusamy he had been asked his views on starting patients on Atorvastatin 40mg for secondary prevention and leaving it to the GPs to titrate up to 80mg if no adverse side effects. He felt the evidence for Atorvastatin 80mg in secondary prevention is substantial and only a few patients actually suffer intolerant side- effects on that dose. He also felt that if patients were well educated on the benefits of the high dose statin at the start they are more likely to tolerate some minor side effects. The few patients that do experience side effects are likely to try a lower dose.* *MMC had previously carried out an audit on this and it was agreed that this would be refreshed to check for any new patients with interacting drugs and Simvastatin 40mg.* Remove from Minutes.	**SL**
	15/36 **Mesalazine m/r (Brand Octasa)** *There is a new brand called Octasa and there is a £10 difference per pack compared with Asacol. The usage isn't as high as to warrant anything doing at the moment. It was felt that the two brands would cause confusion for TRFT. SA is looking at data and it isn't widely prescribed. A decision needs to be taken as to whether to change brands. SL would be asked to look at this.* SL had looked at this and a decision had been made to leave it as it is.	**SL**
	15/36 **Prescribing of Anti-epileptic Medicines (MHRA)** *There was a major alert last year which prompted TRFT to carry out a piece of work around how to make prescribing workable, looking at what kind of prescribing is taking place to ensure branded prescribing took place where recommended . There are now two generic brands of Carbamazepine and this is causing problems for TRFT as they don't keep all brands and wanted to know what we are doing about this and the way forward. After discussion it was agreed that SL would look at adding this to the MMT work programme to look at branded prescribing of anti-epileptics in line with MHRA guidance.* Remove from Minutes.	**SL**
	15/36 **Prescribing of Pregabalin for Neuropathic Pain (MHRA)** *There is a court case in July and in the meantime RCCG would be reiterating the guidance given in the documents which had been circulated by NHSE and PSNC.* Need to educate GP's about this and discussions would take place at the PLT Event on 9th July.	

	15/36 **Liraglutide** *A licence had recently been issued for treatment of obesity. This should not be routinely issued by GP's for obesity and should only be issued through specialist services ie RIO (Rotherham Institute of Obesity).* Public Health are leading on this.	
	15/36 **NICE Medicines Optimisation Guidance** *Discussion occurred around this and RN mentioned that this had been discussed at the RCCG MMT. RN and SL had both gone through the document but hadn't felt that there was anything in the report that needed implementing.* Remove from Minutes.	
	15/36 **Tinzaparin SCP** *SA told members that the SCP's are now in place and TRFT will be issuing 14 days' supply. After discussion it was felt that TRFT need to communicate to the patient that they need to see their GP asap before the 14 days are up because if they see their GP just as their medication is running out it is sometimes difficult for pharmacists to get hold of the drug and this will mean the patient will be without medication or will have to go back to the hospital for their medication. RN also asked whether discharge summaries could be faxed to GP's quickly.* Remove from Minutes.	
	15/36 **Trihexyphenidyl** *DM said there had been an issue with a child who had been prescribed Trihexyphenidyl and the mother had taken the prescription to the Pharmacy whose Wholesaler didn't have this medication in stock and the Pharmacist had refused to go to an alternative wholesaler as they had a policy of only dealing with one supplier. DM was asking whether Pharmacists were able to do this. JP said that Pharmacists are obliged to dispense a prescription as part of the essential services of their contract and had to try and obtain stock from wherever they could. If they use an alternative supplier and they incur out of pocket expenses for example, delivery charges, they can claim reimbursement for these via the PPA by endorsing the prescription.* *DM had suggested that the parent contact SL to discuss this and SL would possibly be raising this with Matt Auckland at NHSE. SL to update on this.* **SL** SL still needed to contact Matt Auckland at NHSE. **SL**	
	AGENDA ITEMS	
15/37	**Infliximab Clinical Project Group Meeting – 20 April 2015**	
	OC fed back information from the meeting and this was discussed. Savings of £5.2M for Yorkshire could be generated if Infliximab was switched to Biosimilars. There are three main areas where this could take place – Rheumatology, Dermatology and Gastroenterology. New patients are fine as they can be started on the Biosimilars straight away but it will be more difficult to switch patients who are already on Infliximab. OC agreed to share statistics with SL and SL said that usage data could be generated from Bluteq regarding numbers of patients on Infliximab. In areas where they have already gone live they have generated massive benefits. OC and SL would meet to discuss the various options and the way forward.	**OC/SL**

15/38	**Anticoagulation Patient Transfer to GP Form**	
	The form is now in use and had appeared in the GP Newsletter last month. There had been some confusion about GP's faxing the form back to the Anticoagulation Department to accept the patient and the message had been reiterated in the Newsletter.	
15/39	**Shared Care Protocol for Degarelix**	
	SCP had been uploaded to the CCG Intranet and had been downgraded from Red to Amber.	
15/40	**Oxycodone Preparations**	
	Discussion occurred about the different brands of Oxycodone preparations which can be used and the prices. An agreement had been reached last Autumn to use Oxycodone, however, TRFT would like to move to other preparations as these were more cost effective. The decision had been taken to use Oxycodone over Longtec and Shortec as it was felt that it was safer as there would be less confusion about the name and that it was better to stick to one brand. It was agreed that if this causes a problem for TRFT then they should use whichever product is best for them. OC and SA agreed to discuss this.	**OC/SA**
15/41	**Paediatric Prescribing Issues**	
	No updates.	
15/42	**Traffic Light System**	
	Degarelix moved from Red to Amber	
15/43	**Horizon Scanning**	
	• **May 2015** • **June 2015** **These were noted by members.**	
15/44	**NICE Guidance**	
	Nothing to update.	
15/45	**For information**	
	Committee reviewed the enclosures:- Barnsley APC Ratified Minutes – April 2015, May 2015 Barnsley APC Memo –May 2015 Doncaster & Bassetlaw APC Minutes – April 2015, May 2015 Sheffield APG Minutes – April 2015, May 2015 RDaSH MMC Minutes – May 2015 Minutes of Drugs and Therapeutics Group – January 2015, March 2015	
	ANY OTHER BUSINESS	
15/46	DM told members that she had recently received three letters from GP's regarding prescribing of Lansoprazole in children as it was not licensed. The alternative drug is Omeprazole which is also not licensed in children. Discussion occurred about this and it was agreed that SL would include a paragraph in the GP Newsletter ie if it is in the BNFC for children, even though it is not licensed it can be used.	
	Date and Time of next Meeting: Wednesday 2 September 2015, 1.00 pm to 3.00 pm in the Listerdale Room, PGME Corridor, 'D' Level, TRFT – **please note change of venue.** **Agenda Deadline: by close of play on Monday 17 August 2015**	

Items Pending

Week last appeared	Item last appeared	Item to be brought back for discussion when appropriate	Last action
23/07/2014	14/52	**DMARDS Share Care Protocols and LES June 2013 -** JPa from MMC	*Work ongoing*
14/05/2014	14/38	**Rotherham Heart Failure Prescribing Guidelines & Overview**	*Work ongoing*
23/07/2014	14/52	**Prucalopride & Linaclotide (SL)**	*Work ongoing*
29/10/2014	14/66	**SYB NOAC Policy**	*Work ongoing*
12/11/2014	14/90	**Prucalopride & Linaclotide (SL)**	
12/11/2014	14/90	**Bluteq**	