

<b>Minutes</b>	<b>Title of Meeting:</b>	<b>Area Prescribing Committee Meeting</b>
	<b>Time:</b>	<b>1:00pm</b>
	<b>Date:</b>	<b>Wednesday, 2 September 2015</b>
	<b>Venue:</b>	<b>Listerdale Room, PGME Corridor, TRFT</b>
	<b>Reference:</b>	<b>AG/JAA</b>
	<b>Chairman:</b>	<b>Avanthi Gunasekera</b>

<b>Present:</b>	Avanthi Gunasekera	NHSR CCG (Chair)
	Stuart Lakin	NHSR CCG
	Ravi Nalligounder	GP
	Diana Mowbray	TRFT
	Surinder Ahuja	TRFT
	Jason Punyer	NHSR CCG
	Osman Chohan	TRFT
	Stephen Davies	RDASH
<b>Minutes by:</b>	Julie Abbotts	Project Officer, NHSR CCG

	<b><u>Agenda Item and Action Points</u></b>	<b><u>Action</u></b>
<b>15/47</b>	<b>Apologies:</b> Dr Simon Mackeown	
<b>15/48</b>	<b>Declarations of Interest</b>  No declarations of interest were made.	
<b>15/49</b>	<b>Minutes from the Meeting held on Wednesday, 13 May 2015</b>  Accepted as a true record.	
<b>15/50</b>	<b>Matters Arising</b>	
	<p><b>12/048 &amp; 13/20 &amp; 13/35 &amp; 13/66 &amp; 13/83 &amp; 14/21 &amp; 14/38 &amp; 14/52 &amp; 14/66 &amp; 14/78 &amp; 14/90 &amp; 110 &amp; 15/19 &amp; 15/36 &amp; 15/50</b></p> <p><b>Memantine</b></p> <p><i>RDASH stated that this will not be as much of an issue now Memantine is going to become a generic.</i></p> <p><i>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.</i></p> <p><i>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</i></p> <p><i>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.</i></p> <p><i>RDASH still to comment on the proposals. JPa informed group of Dr Wright's presentation at March PLT.</i></p> <p><i>JPa gave an update from NHS Rotherham CCG MMC some pharmacies are experiencing difficulty</i></p>	

<p>with 3 monthly prescriptions from RDaSH.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>SL - Awaiting further information from RDaSH</p> <p>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.</p> <p>SL informed committee that work is ongoing and he is due to discuss this with Jeremy Seymour.</p> <p>AG reported that SL is speaking to Jeremy Seymour. SCP has been reviewed at NHSR CCG MMC. Discussions ongoing regarding the finance.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>Task complete – remove from minutes.</p> <p>SD asked that if there are any issues with Memantine then to make him aware so that he can resolve the issues.</p> <p>AG questioned Denepozole &amp; 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.</p> <p><b>Action</b> - AG to do a search on Donepezil &amp; Mementine prescribing at Thurcroft practice as a starting point. AG to email her findings to SD to look into this.</p> <p><b>Action</b> – To be brought back to the next meeting on 12<sup>th</sup> November.</p> <p>No update.</p> <p>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.</p> <p>Discussion occurred and it was reiterated that there should be no dual prescribing being transferred to primary care.</p> <p>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.</p> <p><b>Remove from minutes.</b></p>	<p>AG SD</p> <p>JAA</p>
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	<p><b>13/50 &amp; 13/66 &amp; 14/21 &amp; 14/38 &amp; 14/52 &amp; 14/66 &amp; 14/78 &amp; 14/90 &amp; 15/19 &amp; 15/36 &amp; 15/50</b></p> <p><b>Buprenorphine: -</b></p> <ul style="list-style-type: none"> <li>• <b>Buprenorphine detail aid</b></li> <li>• <b>Buprenorphine patch QIPP</b></li> </ul> <p>TRFT confirmed they do use Buprenorphine patches. IC/SA/SL to circulate information to both organisations as a joint communication.</p> <p>Action - SL to liaise with IC &amp; SA</p> <p>AC – not moved any further forward as yet SL-agreed</p> <p>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.</p> <p>Action – Govinder Bhogal and Surinder Ahuja to analyse prescribing and look into this further.</p> <p>Action - SA to liaise with Govinder Bhogal - SA action outstanding</p> <p>SA is in receipt of the patient's names and is reviewing who initiated the treatment, work ongoing.</p> <p>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.</p> <p>Action - APC to recommend a brand for use</p> <p>Action - SL to liaise with Govinder Bhogal about the outstanding action item re brand of use and bring back to meeting on 17 September.</p> <p>No updates – SL not present.</p> <p>Item would be brought back to the meeting in January 2015.</p> <p>Bring to March meeting.</p> <p>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.</p> <p>SA agreed to discuss with Palliative Care to find out if they use Transdec patches regularly.</p> <p>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.</p> <p>SA is still looking into this.</p>	<p>SA</p> <p>SA</p>
	<p><b>13/85 &amp; 14/21 &amp; 14/38 &amp; 14/52 &amp; 14/66 &amp; 14/78 &amp; 14/90 &amp; 15/19 &amp; 15/36 &amp; 15/50</b></p> <p><b>Anticoagulation Therapy Record – (SA)</b></p> <p>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.</p> <p>Action – SA to provide information to SL. SL to incorporate into the December Newsletter.</p> <p>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.</p> <p>Outcome of meeting agreed that CCG &amp; 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.</p> <p>SA committee that anticoagulation booklets will not be updated by TRFT during the system</p>	

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 22<sup>nd</sup> 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

#### Tinzaparin and NOAC

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 7<sup>th</sup> 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

SL/RG

	<p><i>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.</i></p> <p><i>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.</i></p> <p><i>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 9<sup>th</sup> July.</i></p> <p><i>SA agreed to email a copy of the policy to AG. Post Meeting Note – this has now been actioned.</i></p> <p><i>SL said that there was a 293% cost growth and 25.8% cost growth for Q4, 2014/15/Q1. An audit had been carried out where all patients on NOAC's had been looked at and there had been no patients on dual coagulation/incorrect dosage. In 61% of cases there were no reasons why patients could not have been discharged on warfarin. Warfarin is the preferred first line treatment. OC said there was poor understanding around NOACs and initiation across the hospital and education is needed. Members talked about the discussions with patients which NICE says clinicians need to have and a patient leaflet was suggested which gave patients the different options and this would be followed-up with a discussion with their GP. OC also suggested possible use of technology ie a You Tube video for patients to watch rather than a leaflet. OC said there are lots of pathways at the hospital which need to be made clear about first line treatment. There needs to be a focussed plan for this work over the next six months and we need to work towards Warfarin being the first line treatment.</i></p>	<p><b>SA</b></p> <p><b>SL/AG</b></p> <p><b>AG</b></p>
	<p><b>14/24 &amp; 14/38 &amp; 14/52 &amp; 14/66 &amp; 14/78 &amp; 14/90 &amp; 15/19 &amp; 15/36 &amp; 15/50</b></p> <p><b>Tramadol &amp; Pregabalin – restrict initiation</b></p> <p><i>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.</i></p> <p><i>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.</i></p> <p><i>Action – SL &amp; SD to work on this in collaboration to resolve and reduce the numbers and increase communication.</i></p> <p><i>Data will be shared prior to the next APC and will be discussed further at the next APC</i></p> <p><i>SL to share the piece of work that has recently been undertaken. Committee still need to be mindful of the rise in use</i></p> <p><i>Item yet to be actioned – keep on minutes.</i></p> <p><i>AG has now got a date, 19<sup>th</sup> November, to visit Doncaster prison. Mark Pickering from the prison agreed to show SL and AG around and look at the current issues.</i></p> <p><b>Action</b> - Bring back to January meeting with updates on how the visit went.</p> <p><i>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.</i></p> <p><i>AG/SL would be visiting Doncaster Prison on 19<sup>th</sup> November and would report back to the</i></p>	<p><b>JAA</b></p> <p><b>SL/AG</b></p>

	<p><i>January meeting.</i></p> <p><i>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.</i></p> <p><i>The GP agreed to come to a PLT event in July to do a workshop..</i></p> <p><i>The visit was very worthwhile and it made us aware of communications with GP's.</i></p> <p><i>Pregabalin is mainly initiated in primary care and MMT are currently doing a piece of work/audit around this.</i></p> <p><i>PLT is due to be held on 9<sup>th</sup> July and there will be two workshops around this - Pregabalin Problem and Prison Discharge.</i></p> <p><i>Data will be shared with GP's and figures show that prison discharge isn't the problem -it's more about GP prescribing.</i></p> <p><i>Workshops were held at PLT on 9<sup>th</sup> July and audit data was shared with GP's.</i></p> <p><i>Add to Items Pending.</i></p>	
	<p><b>14/47 &amp; 14/52 &amp; 14/66 &amp; 14/78 &amp; 14/90 &amp; 15/19 &amp; 15/36 &amp; 15/50</b></p> <p><b>AOB 1 – Vitamin D and ADCAL D3</b></p> <p><i><u>Vitamin D</u> - 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.</i></p> <p><i><u>ADCAL D3</u> 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)</i></p> <p><i>Further investigation is required.</i></p> <p><i>AG agreed to follow this up.</i></p> <p><i>AG has emailed Mr Poku but not heard anything back as yet.</i></p> <p><b>Action</b> - AG to chase.</p> <p><i>AG still to chase Mr Poku.</i></p> <p><i>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.</i></p> <p><i>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.</i></p> <p><i>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</i></p>	<p><b>AG</b></p> <p><b>AG</b></p> <p><b>AG</b></p> <p><b>LM</b></p>

	<p><i>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.</i></p> <p>SA had been liaising with LM and SA had produced TRFT draft guidelines and agreed to circulate these.</p>	<p>LM</p> <p>SA</p>
	<p><b>15/19 &amp; 15/36 &amp; 15/50</b></p> <p><b>Nalmefene for Reducing Alcohol Consuming in People with Alcohol Dependency</b>  <i>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.</i>  <i>MMC had made a decision to Traffic light RED until the pathway is ratified.</i></p> <p><i>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.</i></p> <p>Public Health have agreed to fund Nalmefene. GP's should use Nalmefene as part of the agreed pathway which should include the agreed package of psychosocial interventions which are provided by the Primary Care Alcohol Team. Nalmefene could, therefore, be uprated to Amber. OC raised the question of if a patient required Nalmefene prescribing whilst they were in hospital and SL said that Public Health would need to be cross-charged for this.</p>	<p>SL</p>
	<p><b>15/19 &amp; 15/36 &amp; 15/50</b></p> <p><b>Tinzaparin Shared Care Protocol Draft</b>  <i>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.</i></p> <p><i>The District Nurse would be informed by the hospital team prior to the patients discharge.</i></p> <p>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.</p> <p>Remove from minutes.</p>	<p>SL</p>
	<p><b>15/36 &amp; 15/50</b></p> <p><b>Mesalazine m/r (Brand Octasa)</b>  <i>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.</i></p> <p><i>SL had looked at this and a decision had been made to leave it as it is.</i></p>	<p>SL</p>

	Remove from minutes.	
	<p><b>15/36 &amp; 15/50</b></p> <p><b>Prescribing of Pregabalin for Neuropathic Pain (MHRA)</b>  <i>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.</i></p> <p><i>Need to educate GP's about this and discussions would take place at the PLT Event on 9<sup>th</sup> July.</i></p> <p>Remove from minutes.</p>	
	<p><b>15/36 &amp; 15/50</b></p> <p><b>Liraglutide</b>  <i>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).</i></p> <p><i>Public Health is leading on this.</i></p> <p>Remove from minutes.</p>	
	<p><b>15/36 &amp; 15/50</b></p> <p><b>Trihexyphenidyl</b>  <i>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.</i></p> <p><i>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.</i></p> <p><i>SL still needed to contact Matt Auckland at NHSE.</i></p> <p>SL to update at next meeting.</p>	<p>SL</p> <p>SL</p> <p>SL</p>
	<p><b>15/37 &amp; 15/50</b></p> <p><b>Infliximab Clinical Project Group Meeting – 20 April 2015</b>  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.</p> <p>OC and SL still to meet up.</p>	<p>OC/SL</p> <p>OC/SL</p>
	<p><b>15/38 &amp; 15/50</b></p> <p><b>Anticoagulation Patient Transfer to GP Form</b></p>	



	<p><i>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.</i></p> <p>Remove from minutes.</p>	
	<p><b>15/39 &amp; 15/50</b></p> <p><b>Shared Care Protocol for Degarelix</b>  <i>SCP had been uploaded to the CCG Intranet and had been downgraded from Red to Amber.</i></p> <p>Remove from minutes.</p>	
	<p><b>15/40 &amp; 15/50</b></p> <p><b>Oxycodone Preparations</b>  <i>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.</i></p> <p>SA/OC would feedback at the next meeting.</p>	<p>OC/SA</p> <p>OC/SA</p>
	<p><b>15/46 &amp; 15/50</b></p> <p><b>Prescribing of Lansoprazole for Children</b>  <i>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.</i></p> <p>Remove from minutes.</p>	
	<b>AGENDA ITEMS</b>	
<b>15/51</b>	<p><b>Dementia Medication</b></p> <ol style="list-style-type: none"> <li>1) AChEI Shared Care Procedure Update - RS</li> <li>2) Memantine Shared Care Procedure Update – RS</li> <li>3) Donepezil Prescribing Guidelines – RS</li> </ol> <p>These had been agreed at RCCG MMC and RS had taken them to RDaSH MMC where they had also been agreed. Discussion occurred about auditing and SL said that they could possibly be added to the LIS Audit programme which is an annual audit programme which GP practices complete.</p> <p>Members agreed that the guidelines could be ratified.</p>	
<b>15/52</b>	<p><b>Nalmefene</b></p> <p>This has been noted under Matters Arising.</p>	
<b>15/53</b>	<p><b>NOAC's Rivaroxaban Discharges</b></p> <p>This has been noted under Matters Arising.</p>	

<b>15/54</b>	<b>District Nursing Cross-Charging</b>  SL told members that dressing prescribing charges from RCCG are £80K/quarter. The Woundcare Project is now being rolled out so District Nurses shouldn't ever need to prescribe dressings. A printout of District Nurses prescribing dressings had been passed to Kate Roberts and she had checked this and found that two nurses who had left TRFT were still being charged to us because they had not been de-registered. Discussion occurred about who needed to be contacted to ensure they were de-registered and it was agreed that SL would contact the PPA to find out who the named person is at TRFT.	
<b>15/55</b>	<b>Paediatric Prescribing Issues</b>  Currently no issues.	
<b>15/56</b>	<b>Traffic Light System</b>  Nalmafene would be moved from Red to Amber.  Tinzaparin – SA would email guidelines. SL said that comments had been received from GP's that they were not receiving Shared Care paperwork. SA said she was contacting departments who may be prescribing and reinforcing the procedure.  SD queried how SCP's are funded and SL explained that they are funded like a LES (Local Enhanced Service). If it is just prescribing then that is OK and comes within the normal GP remit, however, if SCP's involve monitoring etc then this would be seen as a transfer of work and would form part of a LES. For example, one scheme for Denosumab and Testosterone had been fitted into the DMARD LES.	<b>SA</b>
<b>15/57</b>	<b>Horizon Scanning</b>  <u>July 2015</u> <b>Insulin glargine</b> (biosimilar) – a new drug which has been introduced so TRFT may need to have a procedure now. GP's have only ever prescribed one and now there are two which could lead to problems. Need to look at pathway. This will probably be a good opportunity to address the issue of why our insulin prescribing is one of the highest in Yorkshire.  <u>August 2015</u> <b>Naloxegol</b> for treating opioid-induced constipation. SA said that the Palliative Care Team had expressed an interest in this. JP said that he thought that ES had carried out a piece of work around this and would check and feedback at next meeting.	<b>JP</b>
<b>15/58</b>	<b>NICE Guidance</b>  Nothing to update.	
<b>15/59</b>	<b>For information</b>  Barnsley APC Ratified Minutes – 10 June 2015 Barnsley APC Ratified Minutes – 8 July 2015 Barnsley APC Report – June 2015 Barnsley APC Report – July 2015 Barnsley APC Memo – June 2015 Barnsley APC Memo – July 2015 Summary of Barnsley APC Report – no update Doncaster & Bassetlaw APC Minutes – June 2015 Doncaster & Bassetlaw APC Minutes – no update Sheffield Area Prescribing Group Minutes – no update RDaSH MMC Draft Minutes – June 2015	

	RDaSH MMC Draft Minutes – July 2015 Minutes of Drugs and Therapeutics Group Meeting – 10 June 2015	
	<b>Date and Time of next Meeting:</b> Wednesday 28 October 2015, 1.00 pm to 3.00 pm in the Listerdale Room, PGME Corridor, 'D' Level, TRFT – <b>please note change of venue.</b>  <b>Agenda Deadline: by close of play on Friday 9 October 2015</b>	

### Items Pending

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