NHS Rotherham

Minutes	**Title of Meeting**:	**Area Prescribing Committee Meeting**
	Time:	**1:00pm**
	Date:	**Wednesday, 28 October 2015**
	Venue:	**Listerdale Room, PGME Corridor, TRFT**
	Reference:	**AG/JAA**
	Chairman:	**Avanthi Gunasekera**

Present:	Avanthi	Gunasekera	NHSR CCG (Chair)
	Stuart	Lakin	NHSR CCG
	Diana	Mowbray	TRFT
	Surinder	Ahuja	TRFT
	Osman	Chohan	TRFT
Minutes by:	Julie	Abbotts	Project Officer, NHSR CCG

	Agenda Item and Action Points	**Action**
15/60	**Apologies:** Dr Ravi Nalliagounder	
15/61	**Declarations of Interest** No declarations of interest were made.	
15/62	**Minutes from the Meeting held on Wednesday, 2 September 2015** Accepted as a true record.	
15/63	**Matters Arising**	
	13/50 & 13/66 & 14/21 & 14/38 & 14/52 & 14/66 & 14/78 & 14/90 & 15/19 & 15/36 & 15/50 & 15/63 **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 is still looking into this.* SA had contacted Doncaster Community Pharmacy and they have stopped using Buprenorphine. SA has also spoken to Dr Broadhirst and she can see a need for it on occasions. SL said there is a strong cost growth on this. Govinder Bhogal is looking at prescribing and where this is coming from and is reviewing use of Buprenorphine in Primary Care. SL agreed to get trend usage data in the hospital to get an idea of usage. Information will be fed back at next meeting.	**SA** **SA** **SL/GB/SA**
	13/85 & 14/21 & 14/38 & 14/52 & 14/66 & 14/78 & 14/90 & 15/19 & 15/36 & 15/50 & 15/63 **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.* *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.*	**SL/RG** **SA** **SL/AG**

	SA agreed to email a copy of the policy to AG. Post Meeting Note – this has now been actioned. *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.* SA said they were currently piloting this on two wards – B1 and surgery but mainly B1, pilot started in September and it was felt that three months data should be sufficient. Discussion also occurred about three patients who had been discharged on Tinzaparin and it was mentioned that the Tinzaparin SCP doesn't have the date when Tinzaparin was started ie initiation so this needs to be amended. SA said she was carrying out some work around this.	**SA**
	14/47 &14/52 & 14/66 & 14/78 & 14/90 & 15/19 & 15/36 & 15/50 & 15/63 **AOB 1 – Vitamin D and ADCAL D3** *<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.* *<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)* *Further investigation is required.* *AG agreed to follow this up.* *AG has emailed Mr Poku but not heard anything back as yet.* ***<u>Action</u>** - 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.* *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*	**AG** **AG** **AG** **LM**

	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. *SA had been liaising with LM and SA had produced TRFT draft guidelines and agreed to circulate these.* SA said she had been liaising with LM and the guidelines had been agreed. SA had spoken to the Endocrinologists and would be circulating the guidelines which say Invita D3 and Fultium.	**LM** **SA** **SA**
	15/19 & 15/36 & 15/50 & 15/63 **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.* *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 pyschosocial 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.* A SCP had been agreed with Public Health and this will be shared with GP's in the next few weeks. It was explained that it would not be necessary for patients to be prescribed these drugs whilst they were in hospital as they were only meant to be taken when the patient is drinking alcohol. AG agreed to email the Alcohol SCP to SA/OC and DM. After discussion it was agreed that Nalmefene would be traffic lighted Amber.	**SL** **AG**
	15/36 & 15/50 & 15/63 **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 still needed to contact Matt Auckland at NHSE.*	**SL** **SL** **SL**

	SL to update at next meeting. SL to email DM Matt Auckland's contact details.	**SL**
	15/37 & 15/50 & 15/63 **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 and SL still to meet up.* OC had attended a meeting recently and said that numbers for our area had been under-reported. OC had met up with SL and ES and costs for the cheaper product are approximately £100K. OC said they were keen to get things in place so that use of Biosimilars could commence by December because there will be a price increase with Infliximab in December.	**OC/SL** **OC/SL**
	15/40 & 15/50 & 15/63 **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.* *SA/OC would feedback at the next meeting.* SA/OC said that it looks like there are problems with reports from TRFT and RCCG and agreed to bring back information to the next meeting.	**OC/SA** **OC/SA** **OC/SA**
	15/63 **Dementia Medication** *1) AChEI Shared Care Procedure Update - RS* *2) Memantine Shared Care Procedure Update – RS* *3) Donepezil Prescribing Guidelines – RS* *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.* *Members agreed that the guidelines could be ratified.*	

	Remove from minutes.	
	15/63 **District Nursing Cross-Charging** *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.* Joanne Mangnall will be meeting with SL to discuss DN prescribing.	
	AGENDA ITEMS	
15/64	**Octasa Brand of Mesalazine** SL asked whether TRFT intended to use this and SA said that this is not dispensed very much. SL pointed out that if we switched to Octasa then the cost saving would be £10K per year. SA/OC said they were happy to switch but patients would need to be given a leaflet to tell them who to contact if there were problems etc. This had been discussed at the RCCG Strategic Commissioning Executive meeting this morning and it had been agreed that ES would switch generic patients to Octasa (branded) and this would take place in either December/January.	**ES**
15/65	**Laxative Guidelines for Adults** SA had been liaising with ES and a couple of drugs have been added to the guidelines. After discussion it was decided that this would need to be traffic lighted to Amber.	**ES**
15/66	**Glaucoma Prescribing** SL said there is a strong cost growth around Glaucoma prescribing ie £41K in 12 months, Latanoprost costs £4.52 per item. SA had sent information to Mr Jabir and he felt that alternative products ie Xalatan and Tamoxin ???? don't work. Mr Jabir is going to discuss Tinaprost??? with colleagues. SL agreed to send data to SA who would share this with Mr Jabir and ask if a representative could attend the next meeting to discuss.	**SL/SA**
15/67	**Orthopeadic Discharge Letters Following Fragility Fractures** SL said that comparative data shows that were under-prescribe in Rotherham. LM has carried out an audit in one of the larger practices and has picked up that there may be a problem with Orthopeadic discharge letters as these do not pick-up whether the issue was a fragility fracture so we need this adding to the discharge letters ie "Was this a fragility fracture" and GP's could then see this straight away. LM will bring back information to the next meeting.	**LM**
15/68	**Testosterone Shared Care Protocol** SL said that the above SCP has now been clinically approved. We are just waiting for a payment schedule for GP's as there is a degree of work involved in carrying out the SCP. It was agreed that SL would ask ES to put the SCP onto the standard template for DMARDs. OC said they would like a list of preparations, evidence base etc and this would then be brought back to the next meeting.	**SL/ES**
15/69	**Paediatric Prescribing Issues**	

	Currently no issues.	
15/70	**Traffic Light System** *Nalmefene 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.* It was confirmed that Nalmefene would be moved from Red to Amber.	**SA** **RS**
15/71	**Horizon Scanning** Nothing of note.	
15/72	**NICE Guidance** Nothing to update.	
	ANY OTHER BUSINESS	
15/73	**Clinicians at Future Meetings** It was agreed that relevant clinicians would be invited to future meetings for specific agenda items as this might quicken the decision process.	
15/74	**COPD Guidelines** A meeting to discuss the guidelines had taken place recently with John Miles and this had been successful. The guidelines agreed contain a mixture of GOLD/NICE guidance. GB is now working on the revisions and the guidelines will then be agreed at the MMC and uploaded to the RCCG intranet and will be for hospitals doctors and GP's. Once agreed at MMC these will be shared with OC/SA.	**GB** **GB**
15/75	**Melatonin for Sleep Disorders in Children** Shared Care will be taken over by Primary Care as long as the licenced product "Circadin MR 2mg Tablets" is prescribed by secondary care. It had recently been found that these tablets can be halved, quartered or crushed. After discussion at MMC it was agreed that LM would be asked to develop a patient information leaflet re crushing/halving tablets and an information bulletin for GP's. LM will then discuss with CH/SA regarding patients being taken over by Primary Care. LM will share the policy with Christine Harrison/SA.	**LM** **LM**
15/76	**Fosfomycin** Fosfomycin is now licenced in the community for resistant UTI's, however, there will be a delay in getting the drug. Information will go in the December Bitesize newsletter.	
15/77	**Meeting Regarding Possibility of a South Yorkshire and Bassetlaw APC** JP had attended a meeting recently regarding the above, however, this was not	

	intended to replace the Rotherham APC and was about shared working/discussing tertiary issues with other areas, things like dealing with governance issues etc.	
15/78	**Avastin** This was raised by GP's at the RCCG Strategic Clinical Executive and SL said that no-one had started using as a first line preparation. OC said that he thought Liverpool were high users of this and agreed to prepare a report on it to find out evidence, pros and cons etc.	**OC**
15/79	**Insulins** OC said there were lots of new insulins coming up including three generics. TRFT will be branding all their Garline ones. The higher strength insulins are worrying so it had been decided to go to one strength to avoid confusion, however, if more patients are found to be on high strength then this would be looked at again, however, the feeling was that high strength insulins should be exceptional rather than opening these up to all patients. SL said that a communication would need to go out to GP's regarding different strengths and ensuring they choose the right one. SL would organise for a paragraph to appear in Bitesize. OC said they were looking to produce an insulin chart – should be all brand prescribed. SL said that a big piece of work would be taking place around diabetes in the next few months.	**SL**
15/80	**For information**	
	Barnsley APC Ratified Minutes – August 2015 Barnsley APG Draft Minutes – September 2015 Barnsley APC Report – September 2015 Barnsley APC Memo – August 2015 Barnsley APC Memo - 9 September 2015/17 September 2015 Quality & Cost-Effective Prescribing Group Meeting Summary of Barnsley APC Report – no update Doncaster & Bassetlaw APC Minutes – July 2015 Doncaster & Bassetlaw APC Minutes – August 2015 Sheffield Area Prescribing Group Minutes – July 2015 RDaSH MMC Draft Minutes – August 2015 RDaSH MMC Draft Minutes – September 2015 Minutes of Drugs and Therapeutics Group Meeting – no update	
	Date and Time of next Meeting: Wednesday 6 January 2015, 1.00 pm to 3.00 pm in the Listerdale Room, PGME Corridor, 'D' Level, TRFT**.** **Agenda Deadline: by close of play on Tuesday 15 December 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**	
02/09/2015	15/50	**Tramadol and Pregabalin**	