MINUTES OF THE MEDICINES MANAGEMENT GROUP MEETING

Date & Time of Meeting:	Wednesday 27th February 2013 @ 1.30pm
Venue:	The Boardroom, Glangwili Hospital, Carmarthen
Present:	Chair, HDHB (Chair) Head of Medicines Management (Acting), HDHB (HMM) Ceredigion Lead for Pharmacy & MM (CeL) Pembrokeshire Lead for Pharmacy & MM (PL) Senior Pharmacy Manager Carmarthenshire, (SPMC) Consultant Anaesthetist, Carmarthenshire (CA) GP, Carmarthenshire (GP) Director of Therapies and Health Science Therapies and Health Science (DTHS) Clinical Effectiveness Co-ordinator (Guidance), HDHB (CEC) Associate Director of Nursing, HDHB (ADN) Head of Financial Planning, HDHB (HFD) Lead Clinical Development Pharmacist, HDHB (LCD) Medical Director, HDHB (HMM)
In Attendance:	Welsh Audit Office

Agenda Item	Item	Action
1	The Chair then noted that apologies for absence had been received from: CHC Representative Carmarthenshire Lead for Pharmacy & MM Consultant Psychiatrist The meeting was quorate.	
2	**Declaration and Register of Interests**	
	There were no declarations and register of interests noted at the meeting.	
3	**Introduction of new drugs or dressings onto the**	

	formulary/update of formulary review.	
	Any approved decisions are added to the formulary and Script switch. **A. Flutiform® APPROVED** – The MMG approved the use of Flutiform as an option for the regular treatment of asthma where the use of a combination product (an inhaled corticosteroid and a long-acting β_2 agonist) is appropriate: • For patients not adequately controlled with inhaled corticosteroids and 'as required' inhaled short-acting β_2 agonist or • For patients already adequately controlled on both an inhaled corticosteroid and a long-acting β_2 agonist. Comments were received from some other respiratory consultants but no objections. The development of future Clinical Network groups by Associated Medical Director was noted. MMG and Medicines Management will form links with the Networks. **B. Forceval soluble adult & Junior® APPROVED for restricted use** in patients with swallowing difficulties. Initiation is on the advice of a dietician. The duration of treatment (for refeeding syndrome) to be discussed with dieticians and communicated to pharmacists. **C. Lidocaine/Adrenaline/Tetracaine solution APPROVED for unlicensed use within Secondary Care only.** This preparation will replace Cocaine & Adrenaline solution in Carmarthenshire. The Withybush Protocol will be adopted for use as a Hywel Dda protocol. **16 & 17 Bevacizumab (ICON7) and Lapatinib for Breast Cancer (ABMU)** **APPROVED for use in an approved care pathway and subject to audit.** CA outlined the discussion held in the Clinical Formulary Subgroup. The points of principle noted were that we needed to ensure equity of access for Hywel Dda patients and that we should follow the lead of the contracted specialist tertiary care centre. However we need to be sure that an accepted care pathway is being followed and audit is needed to ensure that patients fulfil the criteria for treatment. MMG & the HDHB Board accept that non-NICE/AWMSG or IPFR approved treatment may need to be used and appropriate provision made for the financial impact. The view of the South Wales Cancer Network should be sought and feedback given that the 2 centres in South Wales working together would be valuable to ensure equity of access. It was noted that, while treatment given in AMBU, is reimbursed via the High-Cost Drugs mechanism of the contract, treatment given in Hywel Dda hospitals is included in expenditure against the budgets held by the Counties and subject to rigorous financial scrutiny. It was requested that the Board is aware of this and that	LCD to inform applicant LCD add to Formulary & Scriptswitch LCD to discuss duration of treatment with dieticians and annotate Formulary LCD to develop the Hywel Dda protocol with A&E LCD to draft letter for Chair to South Wales Cancer Network

	Counties administering treatments initiated by ABMU consultants are not penalised. Patient Access Schemes should also be available for treatments administered in Hywel Dda as per ABMU. HMM and LCD are meeting with the Formulary and Cancer Care Pharmacist and HoPMM for ABMU as part of the implementation of NICE GPG1: Developing and updating local formularies, which promotes working with neighbouring decision-making groups.	HMM & LCD to meet with ABMU Pharmacists
4	**NICE & AWMSG Guidance**	
	NICE & AWMSG Steering Group Update HMM gave an overview of developments to date. Discussion was held and concerns expressed about the duplication of work and groups and the need to streamline the process. This process will link in with the Clinical Networks when established. The Board will still need to prioritise the implementation of NICE/AWMSG guidance. MD informed the group that she now held the lead for Quality & Safety and, following the publication of the Francis Report, all the ToRs of the Q&S committees will be reviewed. As the Health Board Committee structure develops the NICE/AWMSG Steering Group will continue to evolve. HMM demonstrated the initiation audit forms that can be completed via the intranet. These audit forms could be linked to the Formulary. It was noted that pharmacists could use the information in the audit forms to initiate a discussion about appropriate prescribing with the prescriber at the point of dispensing and consider whether additional approval (eg IPFR, non-formulary or 'off-label' use) is needed. The AHMM County leads have a responsibility for Medicines Management and are able to discuss prescribing with individual prescribers if needed.	HMM & MMG to link with the future Clinical Networks. LCD to link audit forms to Formulary.
4a	**4a. December to February Summary.** LCD summarized the assessments completed for January and February so far, highlighting the 2 NICE ID assessments that had been done prospectively. **5. NICE Guidance Report** CEC summarized the NICE guidance report. Clinical Guidelines will be assessed and any alterations to the Formulary and Clinical pathways will be indentified and fed through the Clinical Formulary Subgroup to MMG. **6. AWMSG** **6a. Ministerial Ratification of AWMSG recommendations** Following the development of the NICE/AWMSG Steering Group CEC and LCD will discuss the presentation of information to MMG to reduce duplication. **6b. National Prescribing Indicators** It was discussed how to raise awareness of the Indicators in Secondary Care, as Secondary Care recommendations do influence prescribing in Primary Care. It was noted that individual feedback to GPs on their prescribing is helpful. Currently	CEC & LCD to rationalise information presented.

	prescribing is not costed to Consultant teams in secondary care. Increased attendance of pharmacists at secondary care medical team meetings to discuss prescribing and Postgrad centre would be helpful. MD asked if Consultants audited their prescribing (their teams do specific audits) and noted that these would be useful for revalidation. **7. AWMSG Monitoring of medicines appraised by AWMSG & NICE** HMM informed MMG that, although the data was useful starting point, it was not 'clean' and included IPFR and off-indication use. She will look at the paper in more detail and report to the next meeting. It was noted that different information had been given to the Cardiac Networks regarding the prescribing of rosuvastatin – this has been fed back to AWMSG.	County Leads to take to CPD events with secondary care clinicians HMM t o report next meeting.
	Medicines Management Strategy Update	
8	**Medicines Management Strategy Progress** Good progress had been made in some areas. Limitations include IT, pharmacy capacity and resources. Comments and feedback are welcomed. When e-discharge arrives, pharmacy resource issues will need to be addressed this needs to go onto the risk register.	HMM to add to Risk register
9	**Financial summary update.** HFP summarized the financial position- Secondary care-expenditure is increasing however if the effect of NICE and increased activity is removed then the underlying trend is flat. Primary Care has improved in Month 11. The Pharmacy primary Care Teams have worked hard to deliver Category M and patent expiry reductions. NICE horizon scanning predictions have been broadly accurate. Expenditure on Dabigatran and protease inhibitors for BBV was less than expected but others were more than anticipated. We will continue to track the costs of last year's introductions. It was noted that the cost of temazepam tablets has increased 5-fold. 3,500 boxes are prescribed in HDHB per month. Only patients admitted on hypnotics have them continued on discharge from hospital. An opportunity was identified to remind prescribers to review prescriptions and stop where possible via the Prescribing Newsletter. Psychiatric Consultants will also be informed.	Article in Prescribing Newsletter & inform Cons Psychiatrists.
9a	**Savings Plan 2013-2014** For Information.	
10	**Prescribing Management Scheme** The scheme remains broadly the same as last year and will be assessed and evaluated at the end of this year. The localities are working together to produce business cases to support changes. There is a need to develop primary-secondary working and	

	clinical networks. As targets are tightened, care needs to be taken to ensure that good performing practices are not penalised and demotivated. A review of the scheme is needed perhaps to introduce quality indicators which were discontinued in the past three years due to feedback from GPs.	
11	**Oramorph® Deregulation Pilot results** The pilot has been completed and problems with documentation were identified. Solutions have been proposed and are being tested in the extended pilot before rolling out. When the pilot is completed they will report back to MMG.	
12	**Homecare Update and Toolkit** HMM update group that work in on going on an All Wale s basis. PPH had agreed a way forward for all new patients, but for existing patients to be moved over to pharmacy would represent a significant impact on capacity in terms of the clinical checks and administration support. **A tool kit has been developed that is due to go to the AWMSG for approval with recommendations on strengthening the homecare service.**	
13	**Complan in Hospital (Appendix to Enabling Policy)** **APPROVED** as an appendix to the Enabling Policy	ceL to circulate chart sticker to CLPh
	Prescribing Guidance	
	All policies endorsed by MMG would be submitted to the Clinical Policy Group (see discussion below)	
14	**HDHB Compassionate Use Policy** **APPROVED** subject to the revision of the Membership of the group on Page 13, point 6.5 to reflect that of the IPFR Panel. The final page needs to be completed before CPRG submission.	LCD to make amendments
15	**HDHB 'Top Up' Policy** **Chairman's Action APPROVED** following the HDHB adoption of the ABMU Policy. The only change is that payment will be after each cycle of treatment rather than an up-front deposit. The IPFR Panel will appoint a representative to discuss the financial aspects with the patient.	HMM and LCD to amend ABMU Policy. Chair's Action.
16	**HDHB Working with Industry (Comments & Feedback)** Concerns were expressed that the far reaching impact of this Policy had not been recognised in the comments received back and wider consultation is required so that the impact and practical aspects for the organisation can be worked through. A summary and examples of permitted and non-permitted activities will be prepared and circulated to inform discussions.	HMM & LCD to produce Summary & Examples to circulate
17	**HDHB Splenectomy Guidelines** **APPROVED** subject to rewording Page 17 First bullet point to emphasis life-long antibiotic prophylaxis.	LCD to contact author to reword

18	**HDHB Antibiotic Guidelines for Surgical Prophylaxis** **APPROVED**	
19	**HDHB Potassium Chloride Policy** **APPROVED** Potassium chloride (KCl) to be removed from Theatres and A&E as stock. Check if paediatrics Withybush stock KCl. Letter to be sent to all wards reminding them that KCl ampoules ordered for an individual patient should be returned to pharmacy as soon as they are no longer required. This work is a result of review of existing NPSA guidelines to ensure that we	LCD to write letter and check with WGH.
20	have HB wide consistency.	
	HDHB Rivaroxaban for DVT Policy Referred to the Thrombosis Committee meeting for advice on which group of patients and prescribers should use rivaroxaban. The wider issue of the prescribing or recommendation of 'black triangle drugs' and Non-Medical Prescribers was raised. To bring	
21	to next meeting.	
	HDHB DKA and HONK Policy **APPROVED as a Pilot in Pembrokeshire (WGH)** PL will feed back to the author the following comments: 1. Is the situation of a patient presenting with acidosis, ketosis but normal blood sugars addressed in these guidelines? 2. Please provide a glossary of abbreviations and remove brand names. 3. What is the proposed duration of the pilot?	PL to feedback.
22		
	HDHB Ambisome Guidelines	
23	**APPROVED**	
	HDHB Statins Interactions Table	
24	**APPROVED** Circulate to GPs and Secondary Care	HMM & LCD
	HDHB Digifab Guidelines	
25	**APPROVED** Make guidelines available to pharmacy on-call service. The stock held and location needs to be decided. The Welsh Poisons Centre wishes to discuss the location of antidotes within West Wales.	LCD
	HDHB GTN in Stroke Guidelines These need to be considered with the guidelines for labetolol as	
6	part of the Stroke Pathway at the next meeting.	
	HDHB NICE Ivabradine in Heart Failure Guidelines **NOT APPROVED** These appear to be based on the SHIFT trial rather than the NICE guidance. To be reviewed and brought to the next MMG meeting.	
	A discussion was held about which guidance needs to go to the CPRG following MMG approval. LCD outlined proposed future developments to the Formulary and Pharmacy & Medicines Management website which may make guidance more readily	

	available to staff. MD reminded MMG that clinical guidance should not just be available on the Intranet. The Communication Team will be able to advise	
	Patient Group Directions	
27	AND summarised the PGD group Report and workplan drawing attention to the following points: 1. Menitorix, Men C, Pediacel, MMR and Revaxis were approved for the Childhood Immunisation Programme and Clarithromycin and Doxycycline for use in A&E have been approved. 2. Lidocaine & Bupivacaine PGDs Lip[id rescue. It was noted that currently lipid rescue is not available in MIU (or Primary Care). There was a general agreement that the proposed 999 response would be acceptable but as a extra control measure it was proposed that the supply and drawing up of the drug be limited to 2ml at a time by supplying only 2ml vials to MIU. Advice on the practical implications of this advice would be sought. 3. An dose-banding table for antibiotic doses for children has been added the antibiotic PGDs used in MIUs to allow a sole practitioner to operate under them. 4. Pembrokeshire OOH Service. A meeting has been held which has agreed that the current PGDs in operation should be correlated, reviewed and updated where required before assessing which new PGDs need to be developed. A rationale for development & approval of PGDs on which MMG will base its decisions will be developed (giving examples of appropriate use) for the next MMG meeting. Dr Sue Fish informed MMG that a 3-Counties model for OOH Services has been agreed.	AND to correlate existing Pembs OOH PGDs LCD to draft rationale for PGD development
	Minutes of MMG Subgroups	
28	**Thrombosis Committee Update** PL reported that the Thrombosis committee had not met and the next meeting was on the 1st March 2013. NPSA needs to be a Standing Item for the Committee as they need to work through and ensure that previously issued advice has been implemented.	HMM to advise re NPSA work
29	**Acute Pain Meeting** CA highlighted the continued non-compliance in Bronglais hospital with the NPSA advice on the use of dedicated epidural pumps. This should be highlighted as an exception report in the MMG report to Q&S for their ratification. It should also be added to the NPSA Risk Register and the steps taken to mitigate the risk stated. The Epidural Policy should be taken forward without the pump brand being specified. **Antimicrobial Management Committee**	LCD to highlight in MMG report to Q&S HMM to add to NPSA Risk Register

30	Minutes noted	
	Formulary Update	
31	**Sip Feeds** **APPROVED** for addition to Formulary. Use will be monitored and adjusted in a year's time. Hospital Pharmacies will not have to alter their stocks.	
32	**Formulary Update** Links to Medicines Management related Policies had been added.	
	Drug Safety	
33	**Yellow Card Champion** SPMC will forward the GGH link to LCD	SPMC to forward GGH link
34	**NPSA** The NPSA alerts are currently under review. The new post of Medicines Management Nurse Coordinator will facilitate updating the alerts. Actions will be brought back to MMG for discussion and approval	
	For Information	
35	Matters arising **Risk Register –Updated scores** The lack of a 7 day pharmacy service (particularly with regard to TTH dispensing) in parts of the HB needs to be added to the Risk Register. The work done to mitigate the risks in a stepwise manner needs to be added to the report. This needs to be done through the work stream.	HMM to add to RR HMM to add to work stream meeting.
	Minutes of the last meeting	
41	**The minutes of the meeting held on 12th December 2012** were **APPROVED** with one amendment: Page 3 Item 4 should read 'Chair stated that an executive or non-executive director should be attending MMG.' **Matters arising:** **Attendance of executive or non-executive director at MMG.** MD explained that the non-executive directors have an assurance role and fulfil this through attending Q&S. She, as executive director, attends MMG but these clash with the main Executive meeting. She will attend MMG twice a year in future. She has delegated responsibility to the Chair to take decisions on her behalf and to ensure that MMG exercises its functions and authority appropriately. **Clinical Medical Support at MMG** The support of medical staff for MMG and its subgroups is vital for ensuring the safe and effective use of medicines in the HB and	MD to review medical

	developing Care Pathways and needs to be a priority. MD is reviewing AHMM and medical responsibilities and will take this forward.	priorities for MM
	APPROVED 8TH May 2013	
	Date of Next Meeting	
	Wednesday 1st May 2013 at 1.30pm Venue to be advised	