ADTC(M) 11/03
Minutes: 26 - 36

NHS GREATER GLASGOW AND CLYDE

**Minutes of a Meeting of the
Area Drugs and Therapeutics Committee
held in the Conference Room
Management Building
Southern General Hospital
on Monday, 13 June 2011 at 2.00 p.m.**

P R E S E N T

Dr J Gravil (in the Chair)

Professor S Bryson	Dr G McKay
Mrs J Camp	Dr C E McKean
Mrs A Campbell	Mrs M Ryan
Mr R Foot	Dr A Seaton
Dr G Forrest	Dr N Smart
Dr R J Hardman	Dr A Taylor
Ms L Hillan	Mrs J Watt
Dr H Hopkinson	Professor D Wray

I N A T T E N D A N C E

Mrs E Watt .. Secretariat

ACTION BY

26. CHAIR'S STATEMENT

The Chair reminded Members that papers and proceedings relating to SMC advice were, in some cases, confidential and should not be disclosed before the relevant embargo dates stated in the agenda.

The Chair also reminded Members that they should make relevant declarations of interest in line with Board policy as agenda items arose.

Members were advised not to speak with members of the press on ADTC business but to refer such enquiries to the Board press liaison office.

27. APOLOGIES

Apologies for absence were intimated on behalf of Dr C Brown, Dr J Burns, Mr A Crawford, Dr J Larkin, Dr G J A Macphee and Mrs A Thompson.

28. MINUTES

The Minutes of the meeting of the Area Drugs and Therapeutics Committee held on 18 April 2011 [ADTC(M) 11/02] were approved as a correct record.

NOTED

ACTION BY

29. MATTERS ARISING

(a) Dalteparin sodium 5,000IU/0.2mL, 7,500IU/0.3mL, 10,000IU/0.4mL, 12,5000IU/0.5mL, 15,000IU/0.6mL, 18,000IU/0.72mL solution for injection (Fragmin®) [683/11] ***[Indication: Extended treatment of symptomatic venous thromboembolism (VTE) and prevention of its recurrence in patients with solid tumours]***

The SMC decision was "Accepted for restricted use within NHS Scotland".

The Chair had undertaken to pursue the issue of communication with DVT nurses with regard to the above. The process for hospital DVT nurses was working well (Glasgow Royal Infirmary, Royal Alexandra Hospital and Inverclyde Royal Hospital).

An article on the key issues, including dose and monitoring, on Dalteparin had been included in the most recent edition PostScript. It was suggested that this also be highlighted in PostScript Primary Care to ensure all GPs had sight of this and also to the Emergency Care and Medical Services Directorate's Medicines Governance Committee.

NOTED

(b) Terms of Reference

Professor Bryson advised that feedback had now been received by the Head of Board Administration and the Terms of Reference had now been approved.

The process to appoint new chairs for the Antimicrobial Utilisation Sub-Committee and the Medicines Utilisation Sub-Committee would be set in motion.

There was also a vacancy for the Vice Chair of this Committee and this would also be set in motion.

NOTED

30. FORMULARY AND NEW DRUGS SUB-COMMITTEE

(1) SMC Evaluations / NICE/QIS Guidance

Dr Forrest gave a brief resume of the SMC reviews, and the Formulary and New Drugs Sub-Committee's recommendations. These had been divided into sections for ease of understanding as outlined in the Appendix to this Minute.

Members were asked to consider and, if appropriate, ratify decisions by the Sub-Committee at their meeting on 3 June 2011. Decisions made by the Committee are summarised in an Appendix to these Minutes and would be further publicised in PostScript and in the cumulative Formulary update available on the website and StaffNet.

Members were asked to declare any interests specific or non-specific, personal or non-personal, on any of the drugs being discussed on an individual basis.

One declaration of interest was declared.

Detailed discussions ensued and the following items were highlighted:-

ACTION BY

(a) Febuxostat 80mg and 120mg tablets (Adenuric®) [637/10] ***[Indication: Treatment of chronic hyperuricaemia in conditions where urate deposition has already occurred (including a history, or presence, or tophus and/or gouty arthritis)]***

The SMC decision was "Accepted for restricted use within NHS Scotland".

A decision on this medicine had been deferred to allow consultation with specialists including a GP with specialist interest. It was noted that the medicine was included in the Therapeutics Handbook as part of a wider guideline on gout. This medicine had a potentially high budget impact if usage was not tightly controlled. It had been agreed that a clear definition of allopurinol intolerance or inadequate effect was required. The advice should note the maximum licensed dose of allopurinol is 900mg, as 300mg is often perceived as the highest dose.

The Formulary and New Drugs recommendation was that this new medicine should be added to the Total Formulary restricted to symptomatic patients whose uric acid levels have failed to respond adequately despite optimal dosing of allopurinol.

The Committee agreed that the advice should emphasise the licensed dosage range for up to 900mg daily.

(b) Fentanyl 100, 200, 300, 400 600 and 800 microgram buccal tablets (Effentora®) [510/09] ***[Deferred Submission] [Indication: Treatment of breakthrough pain (BTP) in adults with cancer who are already receiving maintenance opioid therapy for chronic cancer pain]***

Fentanyl 100, 200, 300, 400 600 and 800 microgram sublingual tablets (Abstral®) [534/09] ***Product Update] [Indication: For the management of breakthrough pain in adult patients sing opioid therapy for chronic cancer pain. Use of sublingual Fentanyl tablets should be restricted to patients who are unsuitable for other short-acting opioids e.g. oral morphine]***

A decision on the above two fentanyl products had been deferred to the Palliative Care MCN. The MCN advised that they cannot choose between oral products and all are requested on the Formulary. Guidance for each will be produced to minimise risk. The original complex titration schedules are not in use.

This was not the desired outcome but members acknowledged the advice from palliative care specialists and that plans were in place to manage the risks previously identified.

It should be highlighted that Fentanyl buccal/sub-lingual preparations are not interchangeable and should be prescribed by brand name.

The Committee suggested contacting procurement to see if a better price could be given for one or other of the medicines. It was pointed out that the volume was small and this may not be necessary at this stage.

(c) Fentanyl 50 micrograms/dose, 100 micrograms/dose, 200 micrograms/dose nasal spray (Instanyl®) [579/09] ***[Indication: Management of breakthrough pain in adults already receiving maintenance opioid therapy for chronic cancer pain]***

Fentanyl 100 microgram/dose and 400 microgram/dose nasal spray solution (PecFent®) [663/10] ***[Indication: Management of breakthrough pain in adults who are already receiving maintenance opioid therapy for chronic cancer pain]***

The above two fentanyl nasal sprays had been deferred to the Palliative Care MCN. The MCN advised that nasal sprays are not preferred and are content that these are not added to the Formulary.

ACTION BY

(d) Tapentadol 50, 100, 150, 200 and 250mg prolonged-release tablets (Palexia® SR) [654/10] ***[Indication: The management of severe chronic pain in adults, which can be adequately managed only with opioid analgesics]***

The SMC decision was "Accepted for restricted use within NHS Scotland".

The SMC restriction was for patients in whom morphine sulphate modified release has failed to provide adequate pain control or is not tolerated.

There is a risk of overuse if place of therapy is not clearly defined. It was noted that oxycodone was the subject of a primary care prescribing indicator.

The Sub-Committee's recommendation was that a decision on this medicine be deferred to allow consultation with the Chronic Pain MCN.

Dr Hardman informed the Committee that this medicine had been promoted by a company representative at a meeting he had attended.

Professor Bryson pointed out that, in line with Board policy on the Code of Conduct, pharmaceutical companies are discouraged from promotion of any medicines which are not on the Formulary.

It was agreed that the Chair liaise with Dr Hardman and write to the pharmaceutical company concerned outlining the breach of the Code of Conduct. **Chair/ Dr R Hardman**

(e) Donepezil, Galantamine, Rivastigmine (Review) and Memantine for the Treatment of Alzheimer's Disease (Review) ***[MTA217]***

The review and re-appraisal of the above for the treatment of Alzheimer's disease had resulted in a change in the guidance. Specifically: donepezil, galantamine and rivastigmine are now recommended as options for managing mild as well as moderate Alzheimer's disease, and memantine is now recommended as an option for managing moderate Alzheimer's disease for people who cannot take AChE inhibitors, and as an option for managing severe Alzheimer's disease.

The Sub-Committee's recommendation was that Memantine be added to Total Formulary restricted to specialist initiation and use in patients with moderate disease who are intolerant of or have contraindications to Acetylcholinesterase (AChE) inhibitors or who have severe Alzheimer's disease.

Professor Bryson asked how this guidance would change current practice and the extent of the financial implication. Mrs Campbell advised that the local guideline was being updated and the specialists indicated that there would be no significant difference to current prescribing patterns. It was agreed this should be monitored. Once finalised the guideline would be reviewed by the by Medicines Utilisation Sub-Committee.

DECIDED:

That decisions made by the Formulary and New Drugs Sub-Committee at their meeting on 3 June 2011 be ratified by the Committee.

(2) Appeals

(a) Macrogol sachets (Moviprep®)

Mr Foot advised that an appeal for Macrogol sachets (Moviprep®) had been received from Dr Aidan Cahill, Consultant Gastroenterologist, Stobhill Hospital. Dr Cahill had no interests to declare.

ACTION BY

Mr Foot gave a summary of the appeal. The main points were as follows:-

- Reduced overall volume (2 litres) of Moviprep to be administered compared to a comparator preparation Klean-prep (4litres).
- Similar rates of successful bowel cleansing between the two products.
- More palatable taste, improved patient compliance, associated with lower incidence of nausea and vomiting and abdominal pain.

There were two supporting evidence papers.

Moviprep seems to be as effective as the most commonly used preparation in GGC (Klean-prep) but patient numbers in studies were low. There may be advantages with respect to taste and volume.

Moviprep would have an adverse budget impact irrespective of the discrepancy between the manufacturer price and current procurement price in GGC.

It was noted that there was no widespread clinical support for this preparation.

The Sub-Committee's recommendation was that this appeal be rejected due to insufficient benefit over existing Formulary options, the adverse budget impact and the potential inability to implement the proposed restriction. It was recognised that there may be exceptional cases for use which could be progressed via existing non-Formulary processes.

A discussion ensued and it was

DECIDED:

1. That the Committee ratify the Formulary and New Drugs decision to reject this appeal.

2. That a response be sent to Dr Cahill outlining the Committee's decision. **Chair**

(b) Hydroxypropyl guar eye drops (Systane®)

Mr Foot advised that an appeal for Hydroxypropyl guar eye drops (Systane®) had been received from Dr Kanna Ramaesh, Consultant Ophthalmologist, Gartnavel General Hospital (supported by Dr W Wykes and Dr Mansfield, Consultant Ophthalmologists, Southern General Hospital and Inverclyde Royal Hospital respectively). Drs Ramesh, Wykes and Mansfield had no interests to declare.

Mr Foot gave a summary of the appeal. The main points were as follows:-

- Systane is very effective in alleviating the symptoms of dry eye and does not cause blurring immediately after application compared with other dry eye formulations.
- The special property of the drop is the viscosity changes after application. It is known to be present in the conjunctival sac for longer periods. This gives prolonged symptomatic relief.
- Systane multi dose, and preservative free unit dose are lower cost than some other Formulary options.

There were five supporting evidence papers.

The latest Formulary Section Review of the Eye chapter took place in June 2010 but Systane had not been discussed as a Formulary addition at that point.

ACTION BY

Systane appears to be well tolerated and there are studies which claim it to be non-inferior to active controls but there remains uncertainty about the validity of their results.

The preparation is less expensive than some of the current Formulary choices.

Subsequent to negotiation with the lead for ophthalmology, the Sub-Committee's recommendation was that the appeal be upheld and Systane should be added to the Total Formulary restricted to use in patients with severe dry eyes. This preparation would replace Optive on the GGC Formulary.

A discussion ensued and it was

DECIDED:

1. That the Committee ratify the Formulary and New Drugs decision to uphold this appeal.

2. That a response be sent to Dr Ramaesh outlining the Committee's decision. **Chair**

(c) Hydromorphone capsules (Palladone®)

Mr Foot advised that an appeal for Hydromorphone capsules (Palladone) had been received from Ms Elaine Harris, Area Pharmacy Specialist (Palliative Care). Ms Harris had no interests to declare.

Mr Foot gave a summary of the appeal. The main points were as follows:-

- Anticipated use in cancer patients with severe pain.
- Can be beneficial in small number of patients whose pain is opioid responsive but who have not been able to tolerate other opioids such as morphine or oxycodone due to side effects/toxicity.
- Hydromorphone should only be prescribed directly by or under supervision of a specialist service
- This is already established practice within GGC on a non-Formulary basis

There was one supporting evidence paper.

Use of this medicine at the anticipated place in therapy is already established practice therefore budget impact should be minimal if added to Formulary.

The MCN have drafted a guideline to aid appropriate use in their specialty which they intend to submit for ADTC approval should the appeal be successful.

There is the risk of this medicine being used outwith the palliative care setting if added to the GGC Formulary which would then result in increased cost. Current use outwith the palliative care setting seems to be low in the acute sector.

The Sub-Committee's recommendation was that the appeal be upheld and Hydromorphone capsules (Palladone) be added to the Total Formulary restricted to specialist initiation and use in palliative care patients who are unable to tolerate other opioids in accordance with local protocol.

A discussion ensued and it was

DECIDED:

1. That the Committee ratify the Formulary and New Drugs decision to uphold this appeal.

ACTION BY

2. That a response be sent to Ms Harris outlining the Committee's decision. **Chair**

(3) Formulary Updates

(a) Requests for Formulary Changes from Mental Health Drugs and Therapeutics Committee

Mr Foot gave an overview of requests and Formulary changes from the Mental Health Drugs and Therapeutics Committee for the undernoted:-

Venlafaxine Preparations

A significant cost differential between the normal release and extended release preparations limits the role of the extended release preparation to specific circumstances. The Mental Health D&T considered the limited use of these preparations to best initiated only by, or on the advice of, a consultant psychiatrist. It was noted that this was for a small cohort of patients.

The Formulary and New Drugs recommendation was that the extended release preparations of Venlafaxine are restricted to initiation only on the advice of a consultant psychiatrist.

Sertaline as an "Antidepressant-of-Choice" within NHSGGC

In the update to the NHSGGC Guideline for the Management of Depression in Primary Care, sertraline, which is a cost-effective alternative to fluoxetine and citalopram is indicated as one of three first-choice agents. Following this draft guidance, the Mental Health D&T have requested that the place of sertraline within the GGC Formulary is reconsidered.

The Formulary and New Drugs recommendation was that sertraline be moved to the Preferred List as an additional agent.

DECIDED:

That the Committee ratify the Sub-Committee's two decisions above.

(b) Macrogol Oral Powder (Laxido Orange)

Mr Foot advised that Macrogol Oral Powder is currently only listed in the GGC Formulary as the brand name Movicol. Laxido Orange represents an equivalent product which has recently been awarded a National Procurement Contract for NHS Scotland. The Formulary required to be updated to reflect the availability and preferred use of this new product.

The Formulary and New Drugs recommendation was Laxido Orange replace Movicol in the GGC Formulary

DECIDED:

That the Committee ratify the Sub-Committee's decision.

(c) Enteral Feeds

Mr Foot advised that the Ensure range of enteral feeds has replaced the Fortisip range in NHSGGC along with agreed national contracts which covers both acute and primary care.

ACTION BY

The Formulary and New Drugs recommendation was that Ensure range of enteral feeds will directly replace the Fortisip range of feeds, Calshake and Scandishake in the GGC Formulary.

A discussion ensued on taste and it was noted that the National Procurement System looked at taste and it was considered similar. If there are issues a dietician could advise.

DECIDED:

That the Committee ratify the Sub-Committee's decision.

(d) Calcium And Vitamin D3 Preparations

Mr Foot gave the background to the proposed change to the Formulary status of the above. Following the addition of Calcichew D3 500mg/400iu caplets in December 2010, ADTC removed Adcal D3 Dissolve from the Formulary prior to the consultation with the Osteoporosis Group being complete. Feedback has now been received from the Osteoporosis Group.

The Sub-Committee's recommendation was that Adcal D3 Dissolve® be reintroduced to the Total Formulary and Cacit D3® Sachets are to be removed from the Formulary.

DECIDED:

That the Committee ratify the Sub-Committee's decision.

31. PRESCRIBING MANAGEMENT GROUP (PMG) – KEY POINTS OF THE MEETING HELD ON 10 MAY 2011

Professor Bryson gave an update of the key points for the above meeting. He highlighted the following items of interest:-

- Finance Report - *Total expenditure for medicines in NHSGGC for 2010-2011 was £341.4M - £2.4M over budget (0.7%) variance. This was broken down as follows:*
  - Acute Services *[£107.1M - £1.8M over budget (1.7%) reflecting a £5.82M (5.7%) increase carry forward 09/10]*.
  - *Partnerships and Public Health [£8.53M]*.
  - *Primary Care – based on extrapolated data from January 2011 [£973,000 over budget (0.48%) reflecting a £3.3M (1.8%) increase carry forward 09/10]*.
- Horizon Scanning for prescribing pressures and efficiency savings (forecast for 11/12) *[Final projections complete, based on SMC timetable changes, recent GGC trends, Directorate/PC feedback and latest savings projections; Paper for agreed for Director of Finance to play into overall NHS Board Financial Plan for 2011/12. No final decision until after the Board meeting on 28 June 2011]*.
- Introduction and availability of new licensed medicines in NHS Scotland – CEL l7(2010) *[Overall NHSGGC response submitted to the Scottish Government at the end of March 2011]*.
- Licensed or Unlicensed Therapy – Management of LE Myasthenic Syndrome *[At the last PMG meeting, following input from the Associate Medical Director for Regional Services Directorate, it was agreed that the status quo should prevail, with preference for the unlicensed product for all LEMS patients, pending clarification of national advice. A process should be agreed by CMT for the management of such scenarios]*.
- ADTC Report *[Update from items referred to PMG from ADTC meeting on 18 April 2011]*.

NOTED

ACTION BY

32. MEDICINES UTILISATION SUB-COMMITTEE

(a) Primary Care Non-Formulary Report

Mr Foot gave a summary of the above report which outlined the number of NF requests by medicine, This report focused on esomeprazole, escitalopram and lidocaine plasters as the medicines recorded the most often on the NF forms (Q3 2010-11).

The main points were as follows:-

- 95 forms had been completed and returned in this quarter (after the exclusion of medicines that were on the Formulary at that time)
- Esomeprazole requests accounted for approximately 35% of all completed forms and shows an increase from previous reports.
- The proportion of Formulary PPIs being prescribed as a total of all prescribed PPIs is increasing, with omeprazole the clear class leader. Esomeprazole has seen a modest increase in volume of prescribing
- PPI prescribing on the whole has increased significantly over the last few years, though the cost of PPI prescribing has fallen significantly also (£3.6m in Q1 2006/07 and £1.6M in Q2 2010-11). This is directly related to patent loss of PPIs (and significant market forces) and indicators/incentives in primary care aimed at prioritising the Formulary PPI choices.
- Despite the seemingly low levels of esomeprazole prescribing, the associated cost accounts for approximately 33% of the spend on all PPIs.
- The majority of requests recorded initiate Lidocaine plasters originated form the acute sector, from a variety of consultants including some associated with Pain Clinics.
- Lidocaine 5% plasters are included in the GGC Formulary restricted to patients who are intolerant of first line therapies for post-herpetic neuralgia or where these therapies have been ineffective. Use for other indications remains non-Formulary. None of the completed forms suggested that the use was in line with SMC restrictions. There has been significant growth of prescribing of lidocaine plasters over the last several years.
- Highlights of the report will be included in a future edition of PostScript Primary Care.
- The response to specific directorate actions will be recorded in the LDP/LCP Directorate Reports that are presented at PMG Acute Service.

The actions to the report were as follows:-

- Reinforce the price difference between esomeprazole and Formulary PPIs within the acute sector, and the impact on the medicines budget across NHS Greater Glasgow and Clyde (particularly primary care) by raising awareness at relevant groups (Emergency Care & Medical Services Cost-containment Group, Clyde Medicines Safety Group and the GGC Formulary and Handbook Group) and in publications (eg PostScript).

- Reinforce the SMC and Formulary restrictions on the use of lidocaine plasters to the Chronic Pain Clinics via Directorate Structure *[Suggested routes via Lead Directorate Pharmacist/Lead Clinical Pharmacist, Surgery and Anaesthetics Directorate]* and via the Chronic Pain Managed Clinical Network. The MCN are to be asked to provide feedback on current utilisation of Lidocaine plasters *(attaching a list of comparative costs).*

NOTED

(b) Clinical Effectiveness Summary Report – Proton Pump Inhibitors

Mrs Watt gave a summary of the above paper which outlined the background, oral PPI audits and guideline development, medicines use evaluation of IV PPIs, limitations and action points.

ACTION BY

There had increasing concerns and debate around the potential over-prescribing of oral PPIs in both acute and primary care. Increasing body of evidence suggest PPIs may be associated with long-term adverse reactions, such as increased risk of *Clostridium difficile* infection, particularly when prescribed long-term in high doses. In July 2010 a 30% increase in the quantity of IV PPIs used in Surgery & Anaesthetics (S&A) Directorate was identified when compared to July 2009. Usage across NHS GGC and S&A has been reasonably stable since July 2010. Recent work led by the Clinical Effectiveness Pharmacy Team include oral PPI prescribing guidance for surgical patients (completed July 2010); series of audits of oral PPI prescribing on discharge from acute sites (completed March 2011); and medicines use evaluation of IV PPIs in S&A (completed May 2011).

- Data were collected for patients who were started on an oral PPI or got their PPI treatment changed during hospital admission. Patients were followed up in primary care up to seven months after discharge.
- Indication for PPI treatment on discharge was appropriate in 60% of cases.
- Sixty-four percent of patients were discharged on a daily dose of omeprazole 40mg or more, or equivalent (lansoprazole 30mg or esomeprazole 40mg). Dosing regimen prescribed on discharge was appropriate in 43% of all cases.
- Of the patients who remained on a daily dose of omeprazole 40mg or more (or equivalent) for longer than eight weeks following discharge, only 23% of cases had an appropriate indication for long-term high-dose PPI at the time of discharge from hospital.
- Poor transfer of information on duration of treatment to primary care – 38% of all followed up patients did not have a documented indication for treatment on discharge documentation (discharge letter and/or discharge prescription) and 48% did not have a documented duration of treatment.
- Overall, very high adherence to Formulary options (97%).
- Guidance for PPI continuation on discharge from surgical units, which included licensed and off-label indications and details on expected duration of treatment, was approved by General Surgery NHS GGC, disseminated to relevant colleagues and included on StaffNet Guideline Store.

The list of action points were noted.

A detailed discussion ensued and the following comments/suggestions were made:-

- Communication to GPs could be improved.
- Clear and concise advice of appropriate dose required.
- Guidance from Dr Derek Gillen, Head of Endoscopy, on prophylactic dose should be sought.
- On new Kardex there is a box to tick if a new drug is required.
- Medical specialty rolling out process with regard to the discharge summary.

Mrs Watt would take on board the Committee's comments.

NOTED

(c) Guidelines

(i) Treatment of Depression in Primary Care

Mrs Watt advised that the Sub-Committee had reviewed the above guideline and comments had been sent back to the authors. This would come back to a future meeting of the Committee.

NOTED

ACTION BY

(ii) Zoledronic Hip Fracture Protocol (Women Aged 75+)

Mrs Watt advised that the Sub-Committee had reviewed the above guideline and comments had been sent back to the authors. This protocol had previously been put in place to address concerns raised, including communication with GPs and dental checks.

The Sub-Committee approved the protocol with minor comments. The medicine denosumab is also indicated in osteoporosis and a separate protocol has been developed. This medicine has not been added to the Formulary as there are outstanding issues in relation to service delivery.

It was noted that assessment of patients would be undertaken in secondary care and no monitoring would be required in primary care. Advice would be given from secondary care.

DECIDED:

That the Committee ratify the Sub-Committee's recommendation.

(iii) Adrenaline Auto Injector Prescription

Mrs Watt advised that the Sub-Committee had reviewed the above guideline and comments had been sent back to the authors. This guideline had been developed by allergy and dermatology services in response to an Ombudsman's report following a fatal accident enquiry.

The Sub-Committee approved the protocol with minor comments including highlighting that the guideline was for children.

DECIDED:

That the Committee ratify the Sub-Committee's recommendation.

(d) Therapeutic Handbook Survey

Mr Foot gave an overview of the 3rd edition Therapeutic Handbook User Survey. This outlined the introduction, questions around usage and content of the Therapeutic Handbook, how information was accessed, how it compares to similar publications in other NHS Boards, questions around smartphone applications, further information from focus groups and conclusions.

Three separate surveys were carried out electronically – 88 senior doctors, 40 junior doctors and 62 hospital pharmacists completed the survey.

In conclusion the survey indicated that the Therapeutic Handbook was well regarded amongst medical staff and pharmacists and was a useful resource for improving the standard of care provided in NHSGGC acute sites. The issues raised through the surveys and focus groups have helped the Editorial Group establish a programme of improvement which will include a review of the index as a priority. In addition, similar publications in other NHS Board areas are also to be examined with the aim of further improving the layout and format of future editions of the Handbook.

The future development of a Therapeutic Handbook App should be considered in response to the changing ways that prescribers are accessing information. It is recognised that such a development may have associated costs in the region of £6,000 - £10,000 if made available free of charge.

NOTED

ACTION BY

33. ANTIMICROBIAL UTILISATION SUB-COMMITTEE : KEY POINTS OF THE MEETING HELD ON 19 MAY 2011

Professor Bryson gave an update of the key points for the above meeting. He highlighted the following items of interest:-

- Scottish Antimicrobial Prescribing Group *[Small improvements noted in national and local trends in prescribing practice with NHSGGC exceeding the natal average]*.
- Primary Care Prescribing – Quarterly report to February 2011 *[Stability in overall DDDs and a steady downturn in 4C antibiotics in particular with NHSGGC below the national average – although some significant variations in prescribing practice remain]*.
- Specific Prescribing Priorities – Clinical incident reporting *[Presentation of results, both overview report and detail from Datix database. This would become a regular agenda item]*.

Dr Seaton gave an overview of issues associated with gentamicin dosing in the Surgical Directorate (specifically orthopaedics). The Sub-Committee had agreed to modify GGC guidance to reduce gentamicin prescribing and allow single dose cephalosporin in specific indications.

NOTED

34. NON MEDICAL PRESCRIBING SUB-COMMITTEE

Mrs Camp advised that there had been a decrease in the number of non-medical prescribers programmes.

National guidance was expected on nurse prescribing carrying out discharge summaries. This would highlight risk factors re prescribing.

NOTED

35. COMMUNICATIONS SUB-COMMITTEE

PostScript - Issue 63 (May 2011) was attached with the agenda papers for information. This edition included articles on prescribing indicators, if I could change one thing, latest ADTC decisions, Formulary news (new licensed indication for dalteparin) and revised unlicensed medicines policy.

Mrs Watt advised that the distribution of PostScript Acute was in the process of being reviewed. including current cascade.

NOTED

36. DATE OF NEXT MEETING

The next meeting of the Area Drugs and Therapeutics Committee would be held on Monday, 8 August 2011 at 2.00 p.m. in the Med C Conference Room, Clock Tower Building, Southern General Hospital.