ADTC(M) 11/06
Minutes: 65 - 81

NHS GREATER GLASGOW AND CLYDE

Minutes of a Meeting of the
Area Drugs and Therapeutics Committee
held in the Board Room
J B Russell House
Gartnavel Royal Hospital
on Monday, 12 December 2011 at 2.00 p.m.

P R E S E N T

Dr J Gravil (in the Chair)

Dr A Bowman	Dr J Larkin
Professor S Bryson	Dr G J A Macphee
Dr J Burns	Dr C E McKean
Mr A Crawford	Mrs M Ryan
Mr R Foot	Dr A Seaton
Dr G Forrest	Dr N Smart
Dr R J Hardman	Dr G Simpson
Ms L Hillan	Dr A Taylor
Dr H Hopkinson	Mrs A Thompson

Mrs J Watt

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

Mr A MacLaren	..	Lead Pharmacist, Clinical Governance *[from Minute 70]*
Ms A Timoney	..	Chair, Scottish Medicines Consortium
Mrs E Watt	..	Secretariat

ACTION BY

65. 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.

66. APOLOGIES

Apologies for absence were intimated on behalf of Mrs J Camp, Mrs A Campbell and Dr G McKay.

The Chair welcomed Dr G Simpson, New Chairman of the Medicines Utilisation Sub-Committee to his first meeting of the Committee. She also welcomed Ms A Timoney, Chair of the SMC,

ACTION BY

who was in attendance to give a presentation on the work of the SMC (along with Dr J Burns) to the Committee

67. MINUTES

The Minutes of the meeting of the Area Drugs and Therapeutics Committee held on 10 October 2011 [ADTC(M) 11/04] were approved as a correct record.

NOTED

68. WORK OF THE SMC

Ms Timoney gave a presentation on the work on of the SMC. This included information on the aim, remit, office bearers, stages in the discovery and development of a new medicine, the three hurdles for marketing approval (licensing) by EMA, the fourth hurdle, health technology appraisals, QALYs, advice to NHS Scotland, membership, how the process works (from the company submission to the advice being made public), outcome of assessments, post-SMC : NHS Board ADTCs, orphan medicines and other issues, SMC modifiers – assessment of medicines with an orphan indication, assessments of medicines – higher cost per QALY, data on medicines with an orphan indication (to October 2011), what is a biosimilar and where we are now, new issues, conclusion and ADTC questions.

The aim of the SMC visiting ADTCs was to update them on the role, remit and progress of SMC; this was a two way communication around new medicines issues and formal collation of views from ADTCs. The core activity of SMC was the rapid Health Technology assessment of new medicines. Other issues included horizon scanning and antimicrobial stewardship.

An outline of how the process was given from the company submission down to the advice being in the public domain which takes approximately 18 weeks. An explanation was given on cost per QALY.

The SMC provides a robust, transparent evidence based approach to assessment cost effectiveness of new medicines.

A question and answer session took place with Ms Timoney and Dr Burns responding to members' questions. The following was highlighted:-

- Reduction in postcode prescribing – a key role for SMC.
- Discussion on the affordability for NHS Boards after SMC decisions. It was pointed out that this was an issue beyond the SMC remit.
- Not recommended decisions are steadily climbing - if a company do not submit the decision is automatically made not recommended.
- Role of ADTCs – A number of FOIs have been received about the timing of Boards implementing SMC decisions. Delays can occur due to deferring decision to MCNs and Regional Cancer Advisory Group for their decision. It was noted that the timeline should be 90 days. It was agreed that GGC ADTC should tighten procedures / communications to avoid uncertainty about Formulary status beyond this timeframe.
- DAD submissions – Members felt that the content of the DADs were very complex with the health economic side very difficult. Ms Timoney asked if workshops would be helpful and members thought this would help. This would also be discussed with other ADTCs and SMC would also consider whether explanatory notes on complex health economic principles should be included.
- Medical devices – The Scottish Health Technology Board look at these and use a similar methodology to SMC.

The Chair thanked Ms Timoney for her presentation.

NOTED

ACTION BY

69. ADTC APPOINTMENTS

Second ADTC Vice Chair Appointment

The Chair advised Mrs Janice Watt had been appointed as the second Vice Chair of the Committee.

NOTED

70. MATTERS ARISING

The Use of Unlicensed Medicines in Preference to their Licensed Alternative on Grounds of Cost Effectiveness

A paper on the various approaches to the approval of the use of off label medicines/unlicensed medicines had been discussed at the last meeting. It has been recognised that in some circumstances to maximise the health gain for the whole population from available resources it may be appropriate to prescribe an unlicensed or off label medicine in preference to a licensed one because it is more cost effective. At the last meeting a change to the wording of the policy had been agreed subject to taking on board the Committee's comments. This had now been updated and the new wording was as follows:-

"Off label or unlicensed medicines may be prescribed in preference to their licensed alternative on the grounds of improved cost effectiveness for GG&C if all the following criteria are met:-

- Only following a robust risk assessment of the efficacy, safety, and procurement and service issues **and**
- When the risk assessment suggests that the use of the off label or ULM would have no additional risks for patients **and**
- Where using the licensed medicine would have a substantial financial impact potentially affecting the provision of other health services".

Mr Crawford asked who validates the robustness as risk profile may change. Authorisation would be the role of the Directorate signing off the off label medicine/unlicensed medicine.

NOTED

71. CHANGING ROLE OF SUB-COMMITTEE REPORTING

The Chair advised that each Sub-Committee would give a report on its work and direction twice a year. Minor issues could be raised when required.

NOTED

72. FORMULARY AND NEW DRUGS SUB-COMMITTEE

(1) SMC Evaluations / NICE/QIS Guidance

Dr Macphee 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. 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 new prescribing website and StaffNet.

ACTION BY

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.

No declarations of interest were made.

The following was highlighted:-

Dabigatran etexilate 110mg and 150mg hard capsules (Pradaxa®) [672/11] ***[Indication: For the prevention of stroke and systemic embolism in adult patients with non-valvular atrial fibrillation with one or more of the following risk factors: previous stroke, transient ischaemic attack, or systemic embolism; left ventricular ejection fraction <40%, symptomatic heart failure; ≥ New York Heart Association (NYHA) Class 2; age ≥75 years age ≥65 years associated with one of the following; and diabetes mellitus, coronary artery disease or hypertension]***

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

A decision on this new indication had been deferred to await the outcome of national consensus and obtain the Heart MCN's interpretation. The Heart MCN had accepted the national consensus statement.

The Sub-Committee's recommendation was that this new indication should be added to the Total Formulary restricted to use in accordance with National Consensus Statement available on the NHS HIS website.

A very detailed discussion and various comments/suggestions were made including:-

- Budget allocation agreed via PMG.
- An article on dabigatran was included in the last edition of PostScript.
- Use is restricted. Patients currently treated with warfarin, who are clinically stable with INR in the normal range ≥ 60% of the time, should remain on warfarin.
- The MCN's view is that the Anticoagulant Service would start patients on warfarin – and change this if required and it was noted that a large proportion of suitable patients would be identified via this service.
- Implementation of advice will be closely monitored.
- Discussion about how other patient groups may be monitored with suggested model based on the Alert Antibiotic system with completion of form necessary. Who would manage and monitor this would need to be discussed.
- Initially it suggested to restrict to Anticoagulant Service in line with national consensus statement. However, Members felt that this would cause issues and require an increase in referrals to the Anticoagulant Service that may not be manageable and a consultant or GP should also be able to make the decision.
- A short life working group, chaired by Dr D Murdoch, had been in place on the lead up to the national consensus statement. This group could be reconvened to discuss how to deal with the other patient groups who are not currently on warfarin. This would be a short, sharp process with a strict timetable to reach a final decision at the February meeting.

The ADTC agreed to add dabigatran to Formulary, with the restriction to patients currently receiving warfarin who have poor INR control despite evidence that they are complying, or patients with allergy or intolerable side effects from coumarin anticoagulants. Use in other patient groups remains non-Formulary. Further information regarding dabigatran can be found in the National Consensus Statement on the NHS HIS website.

Further work would be undertaken with the MCN to clarify use of this medicine in the patient group not currently on warfarin. **Mrs A Campbell**

ACTION BY

Ranibizumab, 10mg/mL solution for injection (Lucentis®) [732/11] ***[Indication: For the treatment of visual impairment due to macular oedema (MO) secondary to retinal vein occlusion (RVO) (branch RVO or central RVO) in adults]***

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

The SMC restriction is for use in patients with macular oedema secondary to central retinal vein occlusion (CRVO).

Feedback from local advisers indicated that higher patient numbers were predicted locally based on experience and prevalence data. A protocol had been requested. This would have a budgetary impact.

Telaprevir, 375mg, film-coated tablets (Incivo®) [742/11] ***[Indication: In combination with peginterferon alfa and ribavirin, is indicated for the treatment of genotype 1 chronic hepatitis C in adult patients with compensated liver disease (including cirrhosis) who have previously been treated with interferon alfa (pegylated or non-pegylated) alone or in combination with ribavirin, including relapsers, partial responders and null responders]***

Telaprevir, 375mg, film-coated tablets (Incivo®) [743/11] ***[Indication: In combination with peginterferon alfa and ribavirin, for the treatment of genotype 1 chronic hepatitis C in adult patients with compensated liver disease (including cirrhosis) who are treatment-naïve]***

The SMC decision for the above medicines above was "Accepted for use within NHS Scotland".

The Hepatitis MCN is considering this in conjunction with advice on boceprevir and a protocol has been developed which includes "response guided therapy". This was attached with the agenda papers.

The protocol was an update to the current treatment guideline and outlined the background, new developments, key changes in the guideline – genotype 1 HCV, PI regimen, monitoring of therapy, retreatment for treatment experienced patients, PI stopping roles and management of PI adverse effects.

Professor Bryson gave an overview of the protocol. A discussion ensued and the following was highlighted:-

- Standard treatment is dual therapy with pegylated alfa interferon and ribavirin
- Large clinical trials in genotype 1 HCV demonstrate significant increases in response rates. GT1 generally more resistant to standard therapy than some other genotypes. 40% cohort at a cost of £20,000 pa – £30,000 pa. GGC estimated 160 patients which equates to a cost of £2-4 m pa. at current prices.
- Key local changes – start all patients on dual therapy. There will be a cohort of patients who can continue on dual therapy to the end of the course and another cohort whose therapy will be stopped after first four week phase.
- This protocol would go to the next full MCN meeting on 19 December 2011 and implementation was anticipated implementation in February 2012.
- There would be a small number of GGC specialist prescribers and a preferred agent may emerge. This would be discussion at ECMS Cost Containment Group.
- Caution around off label use of EPO was noted.

(2) Protease Inhibitors in the Management of Hepatitis C Infection : Guideline amendment from NHSGGC HCV MCN

Please see above.

ACTION BY

(3) Section Review Recommendations – Chapter 13 : Skin (Part 1)

Mr Foot advised that the first part of the above section review had been undertaken. There were a number of changes in content and prescribing notes and this had been reviewed in detail at the Sub-Committee meeting and approval for the changes had been given.

NOTED

(4) GGC Formulary Database Housekeeping

Mr Foot advised that with the new GGC Prescribing website it was much easier to maintain the Formulary and housekeeping issues could be carried out easily and instantaneously. He had prepared a paper on Section 11.8.1 of the Formulary - Tear Deficiency. There were a number of changes in content and prescribing notes This had been reviewed and approved at the Sub-Committee meeting.

NOTED

73. WEST OF SCOTLAND REGIONAL PLANNNG – DEFAULT POSITION FOR LIPID LOWERING AGENTS

The Chair spoke on the above guidance received from the West of Scotland Regional Planning Group which relates to the default position for the prescribing of simvastatin and the disinvestment in the prescribing of ezetimibe.

Confirmation from the MCN outlines that no change is required as GGC prescribes in line with the default position.

NOTED

74. PRESCRIBING MANAGEMENT GROUP (PMG) – KEY POINTS OF THE MEETING HELD ON 8 NOVEMBER 2011

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

- Age Related Macular Degeneration.
- Hepatitis C Management *[Discussed previously at Minute 72(2)]*.
- Finance Report *[Total expenditure for medicines in NHSGGC for April – September 2011 was £173.3M, £1.3M over budget (0.8%) and £3.17M (1.9%) > last year. This was broken down as follows:*
  - Acute Services *[£53.8M - £1.8M under budget, reflecting a slowing of growth – 2.3% >2010/11]*.
  - *Partnerships and Public Health [4.3M, slightly under budget]*.
  - *Primary Care – [£115.2M (extrapolated from April – August) (£1.5M over budget) (1.3%), largely attributable to excess supply costs]*.
- Horizon Scanning for 2012/13.
- Dabigatran *[Discussed previously at Minute 72(1)]*.

NOTED

75. WEST OF SCOTLAND CANCER NETWORK PRESCRIBING ADVISORY SUB-GROUP – SUMMARY OF ADVICE TO NHS BOARDS ADTCS – DECEMBER 2011

A summary of advice was tabled with the agenda papers from the Regional Cancer Advisory Group Prescribing Advisory Sub-Group. This outlined local implementation of SMC Guidance

ACTION BY

and NICE/QIS MTAs, regional guidance, clinical management guidelines and current work programme.

The local implementation of SMC advice had been undertaken by the Formulary and New Drugs Sub-Committee and was included in the New Drugs Recommendation table discussed earlier in the meeting.

The remainder of the advice would be processed locally via the Cancer Therapeutics Group.

(a) Bendamustine hydrochloride 25mg, 100mg powder for solution for infusion (Levact®) [694/11] ***[Indication: First-line treatment of chronic lymphocytic leukaemia (CLL) (Binet stage B or C) in patients for whom fludarabine combination chemotherapy is not appropriate]***

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

A decision on this medicine had been deferred to allow consultation with the Regional Cancer Advisory Group for development of a protocol.

A regional protocol was now available which was in line with SMC guidance and provides information on budget and service impact.

DECIDED:

That this new medicine should be acknowledged on to Total Formulary restricted to use in accordance with regional protocol.

(b) Capecitabine, 150mg, 500mg, tablets (Xeloda®) [716/11] ***[Indication: The adjuvant treatment of patients following surgery of stage III (Dukes " stage C) colon cancer in combination with oxaliplatin]***

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

A decision on this medicine had been deferred to allow consultation with the Regional Cancer Advisory Group for development of a protocol.

A regional protocol was now available which was in line with SMC guidance and provides information on budget and service impact.

DECIDED:

That this new indication should be acknowledged on to Total Formulary restricted to use in accordance with regional protocol.

76. ANTIMICROBIAL UTILISATION SUB-COMMITTEE (AUC)

(a) General Update

The Sub-Committee was formed in August 2008 and was chaired by Professor Bryson until late last year when Dr Seaton took over.

Dr Seaton spoke on his paper which gave an overview of the work of the AUC. This gave information on the role/remit, membership, key outputs and items for discussion. An appendix to the paper included a list of all antimicrobial guidelines *(which outlined the title, approved by, review date, current version on StaffNet and comments)* available on StaffNet.

ACTION BY

Dr Seaton outlined the role and remit of the AUC which was as follows:-

- To support the development and application of safe and cost-effective antimicrobial policy and guidance in primary and secondary care in NHS GG&C.
- To influence, on behalf of the ADTC, guidance relating to antimicrobial therapy.
- To support and implement recommendations of the Scottish Antimicrobial Prescribing Group.

- To support the application and monitoring of Scottish Government antibiotic prescribing indicators underlying the *Clostridium difficile* HEAT target.
- To support NHS GG&C in the antimicrobial aspects relating to Healthcare Environment Inspectorates.
- To report to ADTC, Board Infection Control Committee and the Board Medical Director.

Dr Seaton indicated that it was crucial that senior infection control team were members of AUC.

He gave a brief overview of the key AUC outputs which included the following:-

- Infection management guidelines for in-patients.
- Infection management guidelines for primary care (adults).
- Infection management guidelines for primary care (children).
- Surgical and procedural prophylaxis guideline (principles and speciality specific).
- Gentamicin and vancomycin prescribing guidance.

NOTED

(b) Guidance on the Production and Approval of Guidelines/Protocols involving Antimicrobial Medicines

Dr Seaton advised that Mrs Y Semple, Principal Clinical Effectiveness Pharmacist, had produced guidance on the production and approval of guidelines/protocols involving antimicrobial medicines.

The ADTC had made provision for the AUC to have devolved responsibility for antimicrobial guideline approval within GGC. All guidance which incorporated an antibiotic recommendation should at first be screened by a member of the AMT and then reviewed by the AUC if there was potential impact beyond a single directorate.

Dr Simpson advised that the Medicine Utilisation Sub-Committee had at its last meeting reviewed a guideline on COPD which included antibiotics. This had been passed to the Antimicrobial Management Team for their comments. Dr Seaton indicated that guidelines with antibiotics should been seen by both the AMT and AUC. There are also criteria for guidelines to be referred to ADTC, eg if a medicine is used outwith its Formulary restriction.

DECIDED:

That the Committee give its approval to the above guidance for guidelines.

(c) Adult Parenteral Gentamicin: Prescribing, Administration & Monitoring Chart

Dr Seaton gave an overview of the above chart. This had been produced by the AUC. This is a one page form used for gentamicin prescribing. The form should be kept with the patient's medicine chart.

ACTION BY

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

- There were similar forms used with success in the Royal Alexandra Hospital.
- Highlight limited duration of gentamicin prior to clinical review
- Space was limited in the Action/Comment column.
- Pilot implementation via SPSS criteria on multiple sites – refine if necessary.
- Store with Kardex.

DECIDED:

That the Committee give its approval to the above monitoring form subject to the Committee's comments being taken on board.

77. COMMUNICATIONS SUB-COMMITTEE

(a) General Update

Mrs Thompson gave the background to how the Committee works. There was an Editorial Group which meets bi-monthly and the membership consists of acute and primary care medical and pharmacy staff. There are difficulties in engaging nursing staff. There is also a Steering Group which meets twice a year.

An overview of the work of the groups was given was given and it was highlighted that work is given to a strict timetable. The following was highlighted:-

- PostScript *[There are a number of brands under PostScript: PostScript Acute, PostScript Community, PostScript Pharmacy, PostScript Extra, PostScript Primary Care and PostScript Safety. These can be accessed on the GGC Prescribing website at www.ggcprescribing.org.uk. Mental Health wish to do their own.* 65 *editions have been published on a regular schedule. Positive feedback was received from a limited survey].*
- Content of bulletins.
- Articles for further editions.
- Liaising with MCN and SMC.
- More contributions were required from clinical staff.

Mrs Thompson highlighted some potential changes as indicated below:-

- Review format of bulletins.
- New template for PostScript.
- Style guide and abbreviations – make consistent.
- Co-ordinate key messages.
- Expand way bulletins are sent. Contact the Communications at the Corporate Headquarters re use of social medial.
- Useful to identify e-link for all junior doctors. *[Noted that junior doctors tend not to use the GGC email address, therefore, this would be an unlikely way of communicating with them].*

NOTED

(b) Minutes of a meeting held on 22 November 2011

The above minutes were attached for information.

NOTED

ACTION BY

(c) PostScript – Issue 65

PostScript - Issue 66 (November 2011) was attached with the agenda papers for information. This edition included articles on use of dabigatran in atrial fibrillation, latest ADTC decisions, recent safety issues, tapentadol – a new drug for severe chronic pain, and web watch.

NOTED

78. MEDICINES UTILISATION SUB-COMMITTEE

(a) Individual Patient Treatment Request (IPTR) Survey

Mr Foot gave a summary of the above paper which was for information only. This included an executive summary, individual patient treatment requests by directorate and by medicine and detail of submitted IPTRs.

This report was based on the formal NHSGGC IPTR report submitted to the Scottish Government at the end of October 2001 and covered the first two quarters of the 2011-12 financial year. Only those submissions which were regarded as true Level 3 IPTRs were included in these data.

NOTED

(b) Adult Acute Intravenous Flush Policy

Dr Simpson advised that the Sub-Committee had reviewed the above policy which was produced by an IV Flush Short Life Working Group. The group stated that this policy would not in any way change current practice but improve governance arrangements.

An IV flush of normal saline 0.9% will be administered to all patients on insertion of a PVC or CVC or at routine time intervals to maintain patency.

IV flush will be administered before and/or after the administration of an IV medicine and/or between the administration of multiple IV medicines via PVC, CVC or other indwelling IV device as necessary. This will routinely be 0.9% sodium chloride but glucose 5% may be used if the IV medicine would be more suitably flushed with this medicine.

The key issue was that the flush solutions are licensed medicines and this new policy states that they do not require to be prescribed on the Kardex or administration recorded (UNLESS the administration is delegated to a non registered staff member eg healthcare worker, where other policies apply).

The Sub-Committee had recommended that this be passed to the Board's Quality and Performance Group for a judgement on the acceptability of this practice.

A detailed discussion ensued and the following comments were made:

- With this medicine not being prescribed or recorded, there was a marginal risk that patient safety was inadvertently being exposed and, if so, there was also an organisational risk.
- There a greater risk not allowing this process to happen.
- The limitations of ADTC to resolve this matter were acknowledged

Process through Governance Group or CMT. Prepare paper highlighting issues to be discussed.

ACTION BY

DECIDED:

That Mr Crawford prepare a short paper on the issues and legislation with regard to the above policy and take to the Clinical Governance Implementation Group. **Mr A Crawford**

79. SAFER USE OF MEDICINE SUB-COMMITTEE

(a) Medicines Reconciliation in Hospital Guidance & Standards

Mr Maclaren gave an overview of the above paper. This outlined the executive summary, introduction, background, current practice, standards, responsibilities, medicines reconciliation process, education and training, audit and monitoring and appendices.

Effective Medicines Reconciliation is an essential component of clinical governance, ensuring patient safety through the safe and appropriate use of medicines in each individual patient. It is a basic principle of good medicines management and is underpinned by good prescribing practice and communication at the interfaces of care. The process involves establishing and maintaining an accurate, up to date list of medicines and details of changes from admission, through transfer and at discharge back to primary care. Poor medicines reconciliation processes lead to medication errors, patient harm, longer stays and re-admissions.

This document sets out standards for medicines reconciliation in hospital and provides guidance for implementing safe and reliable processes across NHSGGGC. It is acknowledged that the organisation and delivery of care varies according to the clinical setting and nature of the hospital admission. Each clinical area needs to take into account its local processes and skill mix to develop a reliable medicines reconciliation process which is consistent with the standards set out in this document.

The standards relate to medicines reconciliation on admission, during hospital stay and at discharge. It outlines the respective roles and responsibilities of medical, pharmacy and nursing staff. The appendix includes tools to support medicines reconciliation and provides an illustration of how the process works in practice.

A discussion ensued and comments included the following:-

- GPs would welcome this.
- Final discharge letter should be sent out quickly. Difficulty could arise in light of capacity issues with secretarial staff. There could be a risk if a patient's drugs have changed.
- Concern that it is the consultants who are accountable for ensuring their patients are prescribed the right medicine when it may be junior medical staff who have carried out completing the medication history on admission and documenting their decision about which pre-admission medicines are to continue, change, stop or be withheld and responsible for writing up prescription.
- Significant concern also raised on Appendix 1 that the consultants are not sure what they are signing for.
- Soften language.
- No mention of interaction between patient and clinician.
- The GGC infrastructure to support this programme is in development.
- Recognise prescribers have responsibility. First practitioner has responsibility for process. This is an importance message.

Mr MacLaren thanked the Committee for their comments. There was an intensive programme of work to promote implementation at the right level of activity on all GGC hospital wards.

ACTION BY

DECIDED:

That any further comments be sent to Mr MacLaren. Mr MacLaren would, in turn, send a revised version for members' information. **Members**

(b) Voluntary Ban on Methotrexate 10mg Strength Tablets

Mr MacLaren gave a brief summary of his paper on the above. This outlined the introduction, implementation plan, conclusion and letter to acute and primary care prescribers.

In 2009 the ADTC endorsed a policy of using only the 2.5mg strength methotrexate tablets and was included in the NHSGGC Formulary. Despite this there is still significant use of the 10mg tablet strength across NHSGGC. To improve this prescribing trend and promote patient safety, the NHSGGC Local Medical Committee has now supported a voluntary ban on the prescribing of methotrexate 10mg tablets in primary care.

DECIDED:

That the Committee endorse the Safer Use of Medicines Sub-Committee plan to fully implement the policy of prescribing only the 2.5mg methotrexate tablets.

(c) Request for Endorsement of Off-Label Use of Enoxaparin Prophylaxis

Mr MacLaren gave a brief summary of the above paper. This outlined the situation, background, assessment and recommendation.

Enoxaparin prophylaxis is being routinely administered off-label in some clinical areas, into patients' upper arms rather than via the licensed route ie via the anterolateral or posterolateral abdominal wall.

The Safer Use of Medicines Sub-Committee's recommendation was that when the licensed abdominal route is not viable for enoxaparin prophylaxis, the preferred alternative is to administer the drug off-label into the anterior aspect of the thigh.

DECIDED:

That the Committee endorse the Safer Use of Medicines Sub-Committee recommendation above.

80. MEETING DATES FOR 2012

The meeting dates were attached with the agenda papers. A discussion had ensued around the February meeting date and there was a suggestion to change this.

Post Meeting Note: **The meeting date for February would stay as 13 February 2012.**

81. DATE OF NEXT MEETING

The next meeting of the Area Drugs and Therapeutics Committee would be held on Monday, 13 February 2012 at 2.00 p.m. in the Conference Room, Management Building, Southern General Hospital, 1345 Govan Road, Glasgow.