ADTC(M) 12/04
Minutes: 44 - 58

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, 13 August 2012 at 2.00 p.m.

P R E S E N T

Dr J Gravil (in the Chair)

Professor S Bryson	Dr J MacKenzie
Dr J Burns	Dr G J A Macphee
Mrs J Camp	Dr G McKay
Mrs A Campbell	Dr P Moultrie
Mr R Foot	Mrs M Ryan
Dr G Forrest	Dr A Seaton
Dr R J Hardman	Dr G K Simpson
Ms L Hillan	Dr A Taylor
Dr J Larkin	Mrs A Thompson

Mrs J Watt

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

Ms N Downes .. Lead Clinical Pharmacists, Medicine for the Elderly/Care Homes
Ms H Harrison .. Senior Prescribing Adviser
Mr S McGlynn .. Cardiology Pharmacist Specialist *[To Minute 47(1)]*
Mrs E Watt .. Secretariat

B Y I N V I T A T I O N

Mr P Hamilton .. Lay Representative
Mr A McMillan .. Lay Representative

ACTION BY

44. 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.

She 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.

ACTION BY

45. APOLOGIES AND WELCOME

Apologies for absence were intimated on behalf of Dr H Hopkinson and Dr C E McKean.

The Chair welcomed Mr Peter Hamilton and Mr Alex McMillan, who were attending in a lay capacity, to the meeting and outlined that it would be useful to consider lay representation on the Committee. She also welcomed Ms Noreen Downes, Lead Clinical Pharmacist, Medicine for the Elderly/Care Homes (attending to give an update on the Polypharmacy Sub-Committee), Ms Heather Harrison, Senior Prescribing Adviser (attending as an observer), and Mr Steve McGlynn, Cardiology Pharmacist Specialist (attending to give an update on ticagrelor).

As there were a number of attendees, the Chair asked Members to introduce themselves.

46. MINUTES

The Minutes of the meeting of the Area Drugs and Therapeutics Committee held on 11 June 2012 [ADTC(M) 12/03] were approved as a correct record.

NOTED

47. 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.

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.

Three interests were declared.

The following was highlighted:-

Ticagrelor 90mg film-coated tablets (Brilique®) [699/11] ***[Indication: Co-administered with aspirin, for the prevention of atherothrombotic events in adult patients with acute coronary syndromes (unstable angina, non ST elevation myocardial infarction [NSTEMI] or ST elevation myocardial infarction [STEMI]); including patients managed medically, and those who are managed with percutaneous coronary intervention (PCI) or coronary artery by-pass grafting (CABG)*]**

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

A decision on this medicine had been deferred to allow further consultation with the Heart MCN in collaboration with the interventional cardiologists for consideration of the place in therapy. Due to the tertiary nature of the interventional cardiology service, it was agreed that a regional approach was required.

Advice from the regional group had been that a national consensus was desirable but this had not been achieved to date. In the interim while the national/regional discussions were ongoing to determine the place in therapy there were a small group of patients who

ACTION BY

should have routine access to this medicine without delay – those who were intolerant to clopidogrel and patients who had a stent thrombosis on clopidogrel.

The Formulary and New Drugs Sub-Committee's recommendation was that this medicine should be included in the GGC Total Formulary for the indication in question restricted to specialist initiation only for patients who are either intolerant to clopidogrel or have a stent thrombosis on clopidogrel. Use in other patient groups currently remains non-Formulary until the regional/national position was clarified.

A summary statement of the current Regional Cardiac Prescribing Group position was attached with the agenda papers which outlined the situation, background, assessment and recommendation.

Mr McGlynn, a member of the Heart MCN and the West of Scotland Cardiac Prescribing Group, gave the background and update on the regional/national position at this time.

The following was highlighted:-

- At present the National Ambulance Service give aspirin and clopidogrel for primary PCI patients. There was support from within the West of Scotland Cardiac Prescribing Group for this to be changed to ticagrelor but the Ambulance Service have indicated that a change in their protocol cannot be implemented without national consensus. There was no consensus around Scotland.

- Contact had been made with NHS HIS to see if they could facilitate a national consensus but, to date, no feedback had been received.

- The Cardiac Prescribing Group revisited prasugrel but ticagrelor was the preferred option.

- A holding statement had been produced and this was a standing item on the West of Scotland Cardiac Prescribing Group.

- In the absence of a national consensus a West of Scotland position was required.

The ADTC decision was that this medicine should be included the Total Formulary for the indication in question restricted to specialist initiation only for patients who are either allergic or intolerant to clopidogrel or have a stent thrombosis on clopidogrel. Use in other patient groups currently remains non-Formulary until the regional/national position was clarified. The ADTC would support the position with regard to a regional/national consensus.

Fidaxomicin 200mg film-coated tablets (Dificlir®) [791/12] ***[Indication: Treatment of adults with Clostridium difficile infections (CDI) also known as C. difficile-associated diarrhoea (CDAD)]***

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

The SMC restriction was for treatment of adults with a first CDI recurrence only on the advice of local microbiologists or specialists in infectious diseases.

There was no evidence of superiority in severe disease therefore this group of patients was excluded.

Local advisers (specialist ID consultants/pharmacist/microbiologist) had indicated a more restrictive place in therapy would be appropriate: at second relapse. This medicine would be included on the ALERT list.

ACTION BY

It was suggested that incorporation of this medicine into the current protocol would be helpful although this had recently been published within the Therapeutics Handbook. It was pointed out that this would be prescribed by a small team of specialists.

There was some uncertainty around potential patient numbers which would influence the financial impact.

The Formulary and New Drugs recommendation was that this medicine should be included in the GGC Total Formulary for the indication in question restricted to specialist use only in adults with a second relapse as an alternative to pulsed/tapered vancomycin on microbiological/infectious disease physician advice. This should be flagged to the Prescribing Management Group (PMG) re potential costs. **Mrs A Campbell/ Prof S Bryson**

Dr Seaton advised that this was a relatively expensive agent in comparison to current treatment options. He indicated that there may not be full support from other microbiologists and infectious disease physicians for the proposed restricted positioning and recommended that it should be discussed at the Antimicrobial Utilisation Sub-Committee.

This medicine may occasionally be used in primary care and clarification of whether a GP might be asked to prescribe was requested, including how this affected the financial impact. This may require to be flagged to PMG as this was not included in the NHS Board's Financial Plan 2012/13.

A detailed discussion ensued and it was agreed that a decision should be deferred until this has been discussed by the Antimicrobial Utilisation Sub-Committee for a consensus between the microbiologists and the ID consultants on final positioning within the protocol. The financial impact is dependent on the positioning and will be highlighted to PMG as appropriate. **Dr A Seaton**

Eplerenone 25, 50mg film-coated tablets (Inspra®) [793/12] ***[Indication: In addition to standard optimal therapy, to reduce the risk of cardiovascular mortality and morbidity in adult patients with NYHA class II (chronic) heart failure and left ventricular systolic dysfunction (LVEF ≤30%)]***

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

Feedback from a local adviser indicated that GGC heart failure guidance will refer to using "an aldosterone antagonist" and also that spironolactone was the first choice aldosterone antagonist. This medicine may have some advantages over spironolactone in terms of ADRs.

The Formulary and New Drugs recommendation was that this medicine should be included in the GGC Total Formulary for the indication in question restricted to consultant initiation only for use in patients intolerant to spironolactone.

Mr McGlynn advised that this was on the Regional Cardiac Advisory Group agenda next month. There may be varying opinions across the West of Scotland region.

A discussion ensued and the ADTC decision was that this should be restricted to initiation by prescribers working with specialised heart failure teams only for use in patients intolerant to spironolactone.

DECIDED:

That decisions made by the Formulary and New Drugs Sub-Committee at their meeting on 30 July 2012 be ratified by the Committee subject to a change for in the restriction for ticagrelor and eplerenone and a decision on fidaxomicin being deferred *[reason indicated above]*.

ACTION BY

(2) Methotrexate Injection (Pre-Filled Syringe)

Mr Foot advised that the above was on the Formulary for the treatment of rheumatoid arthritis as specialist use only. As GPs would now be reimbursed for monitoring costs associated with methotrexate injection for rheumatoid arthritis, he asked if the Committee would be in agreement for this to be changed to specialist initiation. This was agreed.

DECIDED:

That Mr Foot amend the relevant Formulary entry for the above to "specialist initiation".

(3) Six Monthly Update

Dr Macphee gave a summary of the report presented by the Formulary and New Drugs Sub-Committee.

A detailed report on the work of the Formulary and New Drugs Sub-Committee had been presented to ADTC in February 2012. Business continues on a bi-monthly basis with regular reports into ADTC on implementation of SMC advice, advice from NHS Health Improvement Scotland on relevant NICE technology appraisals and updates to Formulary, including appeals.

As a result of communication from Scottish Government SGHD/CMO(2012)1, February 2012 "Guidance to further strengthen the safe and effective use of new medicines across the NHS in Scotland" the ADTC are expected to reach a decision on an SMC accepted medicines within 90 days of the issue of SMC advice to NHS Boards. This was from the date of receipt which was approximately 30 days in advance of the public domain date. Some flexibility was allowed when additional time may be required for introduction of testing or training/premises requirements and NHSGGC interpretation was that this also includes development of local/regional protocols.

An informal analysis had been conducted of the time intervals between SMC advice and Formulary decision in NHSGGC for the period July 2011 to June 2012 to gauge current adherence to this standard and explore the reasons when the desired timeframe has been breached – this was attached with the agenda papers.

Two thirds of medicines processed were within the desired timeframe. This can depend on when the ADTC meeting occurred.

The Formulary and New Drugs Sub-Committee recognised that sometimes it took longer than desired to reach a Formulary conclusion and would work with relevant groups to complete this work.

Professor Bryson pointed out that the SMC timeframe of 90 days only came into operation in April 2012 and if this analysis had started from this period, a different answer may have been given.

NOTED

48. WEST OF SCOTLAND CANCER NETWORK PRESCRIBING ADVISORY SUB-GROUP – SUMMARY OF ADVICE TO NHS BOARDS ADTCs – AUGUST 2012

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

ACTION BY

Mrs Campbell gave the background to this advice and outlined that if this advice note was received in time for the Formulary and New Drugs (FND) Sub-Committee meeting then the relevant medicines are contained within the FND report. If it arrives between the meetings of the FND and the ADTC then it comes direct to ADTC in order to minimise delay to Formulary status for SMC accepted medicines.

Local implementation of the undernoted medicines are included in the FND tabled discussed at Minute 47(1) above:

- Nilotinib for first line chronic phase CML *[SMC 709/11]*.
- Dasatinib, high dose Imatinib and Nilotinib for the treatment of Imatinib resistant CML *[NICE MTA 241]*.
- Azacitidine (Vidaza) for MDS, CMML or AML not eligible for stem cell transplant *[SMC 589/09]*.

The Committee was asked to consider whether this report should be dealt with directly by FND and only come to this Committee when received after FND meetings or whether the Committee wishes this paper to remain a standard item on the agenda.

A discussion ensued and it was

DECIDED:

That the West of Scotland Cancer Group advice to ADTCs should be dealt with directly with FND and come to this Committee only when received after FND meetings.

49. MEDICINES UTILISATION SUB-COMMITTEE

Six Monthly Update

Dr Simpson gave a summary of the key outputs from the Sub-Committee during February to August 2012. The work of the Sub-Committee continued to focus on the following areas:-

- Guidelines/Protocols *[Seven guidelines had been reviewed during the last six months]*.
- Medical Utilisation report *[An update was given on results of the GLP-1 Analogues and Gliptin Prescribing / Non-Steroidal Anti-Inflammatory Drug Prescribing reports]*.
- Clinical Effectiveness Projects *[Work continues by the Clinical Effectiveness Team. Highlighted were three new projects (including their aims) started in the last six months and an overview of ongoing projects]*.
- GGC Therapeutics Handbook *[Updates on the progress of the Handbook were received at each Sub-Committee meeting. As the value of the Handbook had grown, so had the desire for the inclusion of increasingly more detail and new guidelines. As a result, the 5th Edition has grown in size considerably and the Editorial Group would be challenged in the future to manage the content within a limited page capacity. A detailed review to identify guidelines suitable for significant editing was to be undertaken by the Editorial Team between August and November, with subsequent editing to be made both by the Editorial Team and guideline authors following that. The authors of all other guidelines would be expected to maintain the level of content within an allocated number of pages]*.
- Medicines Education *[The Sub-Committee approve PostScript Extra publications as part of their routine business. Two PostScript Extras are under development; these are New oral anticoagulant agents and NSAIDS – what's new?]*.

In addition to the core items the following ad hoc issues had been discussed:-

- Process for the Management of Level 2 Individual Patient Treatment Requests.
- Primary Care Access to StaffNet.

ACTION BY

A discussion ensued and the following comments were made:-

- Dr Moultrie asked if the Handbook was distributed to sessional GPs. It was pointed out that this was an Acute Division publication but could be accessed on the Prescribing website at http://www.ggcprescribing.org.uk.
- With regard to the guideline for the supply of medication at hospital out-patient clinics, it was noted that there was a standard letter for use by acute care specialists in out-patient clinics when recommending new treatments to be initiated in primary care. A patient information leaflet was in draft form at the present time.

Dr Burns congratulated the Therapeutics Handbook Team outlining that it was valuable to new doctors.

NOTED

50. POLYPHARMACY PRESCRIBING SUB-COMMITTEE

Dr Macphee advised that the Scottish Government Health Department (SGHD) National Polypharmacy Guidance was to be launched imminently to provide guidance for clinicians undertaking face to face medication reviews. The guidance also provided direction to NHS Boards planning services to address the polypharmacy agenda. NHSGGC would be provided with details of approximately 9000 patients aged over 75 years with a SPARRA risk score of 40-60% considered high priority for review. NHS Boards would be asked to regularly report on supportive activities as part of the SGHD Quality and Efficiency Programme.

In line with the above a Polypharmacy Sub-Committee had been set up in NHSGGC under the auspices of the ADTC of which Dr Macphee is the Chairman. This would develop a single polypharmacy system in NHSGGC which will provide key recommendations to improve safety and quality and develop educational programmes.

Ms Downs advised that regular updates would be provided to the ADTC, for sharing with the PMG, and the Scottish Government.

(a) Terms of Reference

The Committee were asked to give its approval to the Terms of Reference. This outlined the remit, objectives, membership, accountability, communication and frequency of meetings.

Dr Taylor noted that there was no LMC GP Sub-Committee representative on the Sub-Committee. Ms Downes indicated that she would contact the LMC GP Sub-Committee with the view to gaining representation on the Sub-Committee. **Ms M Downes**

DECIDED:

That the Terms of Reference of the Polypharmacy Prescribing Sub-Committee be approved subject to inclusion of a GP member nominated by the Local Medical Committee.

(b) NHSGGC Polypharmacy Strategy – Mindful Prescribing

A draft Polypharmacy Strategy and associated work plan to address the SGHD requirements had been developed. The strategy would support engagement with prescribers and patients to encourage a collaborative, mindful approach to use of medication. The key aim was to establish mechanisms to deliver regular face to face multidisciplinary polypharmacy reviews in normal practice.

An overview of the above strategy was given by Ms N Downes. This strategy included the introduction, drivers for change, interventions to address polypharmacy, NHSGGC polypharmacy recommendations, next steps with major milestones and four appendices

ACTION BY

(1) consequences of pharmacy, (2) membership of the Sub-Committee, (3) published research on interventions to address polypharmacy and (4) polypharmacy initiatives in other NHS Scotland Health Boards.

Currently a range of services across NHSGGC settings provide polypharmacy reviews. The Sub-Committee would provide guidance on patients to be considered priority for review with standardised evaluation tools to allow interventions from the range of activities to be collated to create NHSGGC-wide reports.

Ms Downes advised that regular updates would be provided to the ADTC and Scottish Government.

A discussion ensued and the following comments were made:-

- This could have an impact on GPs whereby education would be required. *[Ms Downes indicated that the policy document was in early stages. In the interim Rational Prescribing Indicators would be used by GPs. Mrs Ryan indicated that this mechanism supported GPs and that polypharmacy was a more complete prescribing system than RPIs]*.

- A query was raised regarding the definition of polypharmacy. Members expressed various definitions of polypharmacy and suggested that a definition should be included in the strategy.

- Dr Simpson outlined that the Medicines Utilisation Sub-Committee review guidelines/protocols which can contain a number of drugs and asked whether the Polypharmacy Committee would want to review these. *[Specific wording be prepared to be included in the checklist which accompanied guidelines/protocols to be considered by the Medicines Utilisation Sub-Committee]*.

- One of the national workstreams was to sustain polypharmacy guidance.

- It was highlighted that polypharmacy was an important issue and this work should promote consistency of approach across NHSGGC.

DECIDED:

That the Committee give its approval to the initial draft of the Polypharmacy Strategy.

51. PRESCRIBING MANAGEMENT GROUP (PMG) – KEY POINTS OF THE MEETING HELD ON 19 JUNE 2012

Professor Bryson advised that these minutes had still to be approved and these would be deferred until the next meeting on 8 October 2012.

NOTED

52. SAFER USE OF MEDICINES SUB-COMMITTEE

Dr Mackay advised that there was no update for this meeting.

NOTED

ACTION BY

53. THERAPEUTICS SUB-COMMITTEE

Mrs Camp spoke on her paper which asked the Committee to approve the addition of Infantrini Peptisorb to the Dietetics Formulary (which is under the auspices of the Therapeutics Sub-Committee). This was a new product, only high energy (1kcal/ml) hydrolysed protein feed for infants birth to 18 months. This would reduce current risks of incorrect feed preparation and contamination at home as ready to use product and would be first line for infants failing to thrive, fluid restricted or have high nutritional requirements.

An outline of the costings was given and the estimated patients numbers for NHSGGC were estimated at 15 per annum.

A detailed discussion ensued on the processes for inclusion in the Dietetics Formulary. Mrs Camp indicated that the Formulary and New Drugs Sub-Committee documentation had been used to review this and it was intended that the Therapeutics Sub-Committee processes would mirror those of the Formulary and New Drugs Sub-Committee which were well validated.

It was pointed out that this preparation would have implications for primary care. Mrs Camp advised that there was LMC representation on the Sub-Committee and this had been seen by the Primary Care PMG.

Mrs Watt offered to liaise with Mrs Camp outwith the meeting to establish the processes. **Mrs J Watt**

The Committee felt unable to approve the addition of Infantrini Peptisorb to the Dietetics Formulary without approving the process first.

DECIDED:

That a decision on the above be deferred until the process for products being added to the Dietetics Formulary were in place. Mrs Camp would bring a paper on the processes for consideration at the next meeting on 8 October 2012. **Mrs J Camp**

54. ANTIMICROBIAL UTILISATION SUB-COMMITTEE (AUC)

(a) Minutes of a Meeting held on 22 May 2012

The above minutes were attached for information.

NOTED

(b) Gentamicin Prescribing, Administration and Monitoring Form and Guidance Note

The Committee was asked to note for information the above. The purpose of the chart was to facilitate prescription, administration and monitoring of gentamicin, reduce gentamicin associated risk (renal and ototoxicity) through monitoring and restricted duration and promote timely administration in serious infections.

This form had been rolled out across all NHSGGC hospital sites and feedback was requested.

A discussion ensued and it was noted that this was not for use in primary care.

DECIDED:

That Dr Seaton update the Committee on the feedback received with regard to the above at the next meeting on 8 October 2012. **Dr A Seaton**

ACTION BY

55. COMMUNICATIONS SUB-COMMITTEE

(a) PostScript

Issue 70 (July 2012) was attached with the agenda papers for information. This edition included articles on Yellow Cards and adverse drug reactions, 2012 Therapeutics Handbook, updated diabetes guidelines, ADTC decisions, new Paediatric Formulary, other NHSGGC Formularies, safety update, PPIs, tacrolimus: prescribe by brand and web watch: clinical guidelines resource directory.

Mrs Thompson gave a brief update of articles which would be included in PostScript 71.

NOTED

(b) Social Media Policy

During a review of PostScript distribution, the potential in relation to use of social networking sites was been highlighted but previously there had been communication from the NHSGGC banning the use of these sites.

Mrs Thompson advised that the NHSGGC Social Media Policy had now been agreed and was now on StaffNet. She would make a business case for using social media sites for distribution of PostScript.

The Committee would be kept advised of developments.

NOTED

56. NATIONAL THERAPEUTIC INDICATORS

The National Therapeutic Indicators (NTIs) had been produced by the Quality and Efficiency Support Team, Scottish Government, of which Mr S MacBride-Stewart from the Central Prescribing Team was one of the authors.

Mrs Ryan outlined the background to the NTIs which were a combination of prescribing indicators that measure the proportion of prescribing for a certain medicine or group of medicines within a wider selection of medicines and indicators that measure the volume of prescribing that is normalised using the registered population of the practice. They identify areas for improving prescribing and reduce unwarranted variation, waste and harm to patients both between NHS Boards and across practices in NHS Boards. The aim was to improve the quality of care while reducing prescribing inefficiency.

Mrs Ryan gave a summary of the paper on NTIs which outlined information on the baseline data, practice population as a denominator, NTI January – March 2012 baseline figures, Scottish Quality Prescribing Initiative – NTI Achievement and next steps.

Dr Larkin was concerned that the indicators were out of kilter with general prescribing. Mrs Ryan responded by indicating that the NTIs variation was based on actual GP prescribing in each practice within the individual NHS Boards.

It was explained that there are 12 NTIs across Scotland for which GPs are asked to choose two in conjunction with their CH(C)P prescribing lead where an improvement in prescribing could be achieved. Mrs Ryan also stated that there was an implementation guide for each NTI to support GP practices in their prescribing review.

The NTIs are operated within the Scottish Quality Prescribing Initiative (SQPI). A payment was available to GPs who take on the indicators and positively change their prescribing according to

ACTION BY

defined parameters for the work involved. Dr Forrest outlined that there appeared to be different advice given if a practice was not able to achieve the required prescribing change. Mrs Ryan would pursue the discrepancies. **Mrs M Ryan**

A discussion ensued on weighted population and the consideration that use of weighted population reflected prescribing need more accurately than unweighted practice population. Mrs Ryan highlighted that where possible NHSGGC prescribing indicators used weighted population. She did state, however, that the NTIs used unweighted population but that was a national decision.

DECIDED:

That the Committee note the position of NHSGGC in comparison with other NHS Boards in Scotland and the progress of NHSGGC in implementing the National Therapeutics Indicators.

57. PATIENT INFORMATION LEAFLET – NEW MEDICINES IN SCOTLAND

Professor Bryson advised that the above HRIS leaflet was produced as supporting information for patients about access to new medicines in NHS Scotland and the processes involved as part of Scottish Government Circular CEL17(2010).

The publication stated that it would be reviewed in April 2012 (two years after introduction) but at that stage Health Rights Information Scotland (HRIS) indicated that the leaflet was considered suitable for a further period and consideration would be given in a year's time.

The Clinical Governance Team in the Pharmacy and Prescribing Support Unit were not content with the HRIS response and believe there were aspects of their leaflet which required clarification and NHSGGC wish to prompt HRIS for early reconsideration of the content and presentation.

The Committee was asked to consider the leaflet and submit comments for collation as part of an NHSGGC response to HRIS.

Two NHSGGC documents were also attached with the agenda papers for information. These were:

- Access to new medicines in the NHS – a guide to Individual Patient Treatment Requests
- Process for the managed introduction of cancer medicines *[A member thought that this document required to be a bit clearer for patients. Professor Bryson indicated that this leaflet was not intended for issue to patients without direct professional support]*.

A discussion ensued and minor suggestions were made for the HRIS leaflet.

DECIDED:

That any further comments on the HRIS be sent to Professor Bryson *Scott.Bryson@ggc.scot.nhs.uk* / Mrs Campbell *Alison.Campbell@ggc.scot.nhs.uk* by 31 August 2012 for inclusion in a Board-wide response.

58. DATE OF NEXT MEETING

The next meeting of the Area Drugs and Therapeutics Committee would be held on Monday, 8 October 2012 at 2.00 p.m. in the Conference Room, Management Building, Southern General Hospital, 1345 Govan Road, Glasgow, G51