

LOTHIAN NHS BOARD

AREA DRUG AND THERAPEUTICS COMMITTEE

Minutes of the Meeting of the Area Drug and Therapeutics Committee held at 14:30 on Friday 3 October 2014, in Meeting Room 8, Waverley Gate.

Present:

Dr R. Williams	General Practitioner (chair)
Ms A. Gilchrist	Lead Pharmacist, Medicines Management Team (vice chair)
Ms K. Davidson	Senior Pharmacist (professional secretary)
Mr M. Hunter	Head of Primary Care Contracting Organisation, Finance
Dr S. Hurding	Medicines Management Advisor
Ms S. Kerr	Lead Pharmacist, Western General Hospital
Professor S. Maxwell	Senior Lecturer in Clinical Pharmacology, University of Edinburgh
Dr W. Riddle	Chair of the Hospital and Specialist Services Committee
Professor A. Timoney	Director of Pharmacy
Dr J. Tomlinson	Consultant in Public Health Medicine

In Attendance:

Dr K. Chapman	General Practitioner (item 4.1)
Ms A. Cockburn	Joint Lead Pharmacist, Antimicrobial Team (item 4.2)
Dr C. Mackintosh	Consultant in Infectious Diseases (item 4.2)
Ms C. Philip	Joint Lead Pharmacist, Antimicrobial Team (item 4.2)
Ms B. Pillath	Committee Administrator (minutes)

Apologies:

Ms M. Christie	Head of Health, West Lothian CHCP
Dr W. Jamieson	Co-Chair of Formulary Committee
Dr R. McDermott	GP, Chair of the Area Medical Committee
Ms S. McNaughton	Associate Director of Community Pharmacy
Ms A. Muir	Associate Director of Pharmacy, Acute Services
Ms L. Shaw	Lead Pharmacist, Co-Chair of Formulary Committee

The Chair welcomed Members and visitors to the meeting and asked everyone to introduce themselves.

1. Minutes and Actions of Previous Meeting (1 August 2014)

- 1.1 The minutes from the meeting held on 1 August 2014 were approved as a correct record subject to one amendment to paragraph 3.4.3.
- 1.2 The updated action note had been previously circulated.

2. Matters Arising

2.1 Chair of the Area Drug and Therapeutics Committee

- 2.1.1 Dr Williams advised that following two nominations, Professor Maxwell had agreed to take on the chair of the Area Drug and Therapeutics Committee from the next calendar year. The next meeting would be Dr Williams' last meeting as chair.

2.2 Revised ADTC Constitution, for approval

- 2.2.1 The revised constitution had been previously circulated. Ms Gilchrist advised that this had been sent to ADTC and ADTC Sub-Group Members for comment, and some minor changes had been made since submission to the previous ADTC meeting. Members approved the revised constitution. This would be submitted to the Healthcare Governance Committee for information.

BP

2.3 Prescribing Resource Group Revised Terms of Reference, for approval

- 2.3.1 The terms of reference for the new Prescribing Resource Group had been previously circulated. The new group would be chaired by the Medical Director to bring together primary and secondary care prescribing issues. A Primary Care Prescribing Forum already existed, which was chaired by Marion Christie and would report into the new group. A similar Acute Prescribing Forum was being set up to parallel the primary care group and would be chaired by Dr Brian Cook and Professor Timoney. Professor Timoney advised that these groups would not be responsible for clinical decisions, which would be the responsibility of the ADTC.

- 2.3.2 Dr Hurding was concerned that there was not enough primary care representation on the group. Marion Christie was listed in the Membership to represent the primary care forum and Dr Jim Cowan would provide a primary care clinical perspective.

- 2.3.3 Dr Williams felt that there was an overlap in the remit of the Prescribing Resource Group and the ADTC and was concerned that there could be conflicting assessment and implementation work done by both committees and that this could present a problem for medicines governance.

- 2.3.4 Professor Timoney advised that the main focus of the Prescribing Resource Group would be on efficiency savings rather than professional clinical direction, which would be the responsibility of the ADTC; it would be an operational group rather than an advisory group. Professor Timoney suggested that the Chair of the ADTC could sit on the Prescribing Resource Group and that a sentence could be added into the terms of reference to clarify that the Prescribing Resource Group would work within the clinical guidance of the ADTC. It was agreed that this would go some way towards addressing concerns and Professor Maxwell agreed to attend the group as Chair, as an observer in the first instance.

AT / SM

- 2.3.5 Ms Gilchrist noted that the Medicines Utilisation Review Group was well established as a sub-group of the ADTC and also looked at efficiencies in medicines use across Lothian, and that the Prescribing Resource Group should take into account the work done in this group by people working in the field. Professor Timoney agreed to highlight this to the Prescribing Resources Committee.

2.4 Patient and Public Representatives

- 2.4.1 Professor Timoney advised that the guidance from the New Medicines Review published by the Scottish Government recommended that two patient representatives should sit on each ADTC. She had spoken to Lesley Baxter, Public Involvement Co-ordinator and there were concerns about how best to utilise patient representatives in medicines governance.

- 2.4.2 Healthcare Improvement Scotland had also invited two patient representatives and one clinician from each ADTC to a national meeting on collaborative working between ADTCs to be held on 20 November 2014. Professor Maxwell had agreed to attend as clinician, Mr Shapiro had been asked, and Dr Williams agreed to ask Lesley Baxter to attend to raise concerns about whether patient representatives sitting on a technical committee was the best use of their time and skills to ensure that decisions being made were informed by the views of patient and public representatives. **RW**

3. ADTC Work Programme

3.1 2013-14 Work Programme

3.1.1 The updated ADTC work programme had been previously circulated. Ms Gilchrist noted that the next step in the review of the Medicines Governance strategy would be the strategy half day to be held on 27 November 2014. Formal invitations would be sent out and there were fifty spaces for ADTC, Sub-Committee and Formulary Committee Members and managerial and clinical leads. The day would be chaired by Professor Timoney, and would address medicines governance developments in Scotland over the last few years and debate the implications of the New Medicines Review to the established processes in Lothian.

3.1.2 The speakers were to be confirmed but there would be presentations from Dr Williams, Professor Maxwell and Professor Timoney as well as a speaker involved with national developments in Scotland.

3.1.3 Professor Timoney noted that the further information expected from the Scottish Government about national plans for the future had not yet been received and the PACS guidelines had not yet been finalised; it was hoped that these would be available in time for the strategy day.

3.2 Policy and Procedure for Prescribing Non-Formulary Medicines

3.2.1 Ms Gilchrist advised that an update of the policy to take into account changes in the Individual Patient Treatment Request policy was required, and that the update would be submitted to the Committee in 2015.

3.3 Review of Unlicensed and Off-Label Medicines recommended on the Lothian Joint Formulary

3.3.1 A report had been previously circulated. This review had been requested in response to a letter from the General Medical Council relating to use of unlicensed and off-label medicines included in the Formulary. Unlicensed drugs had now been identified and annotated on the Formulary.

3.3.2 Ms Gilchrist advised that the Formulary Committee had considered various options as to how to identify medicines recommended on the Formulary for indications that were outwith their licence and annotate these, but that a number of problems had been raised including interpretation of the licence, whether the purpose of the Lothian Joint Formulary was to let prescribers know which medicines were licensed and the amount of resources that would be required to keep the annotations up to date with frequent changes in licence. The Formulary Committee therefore proposed that off label medicines would not be annotated but that a general statement would advise prescribers to check the licence

when considering prescribing for an individual patient. Professor Timoney noted that there were over 1,000 changes to licenses each year, so keeping annotation up to date was not sustainable.

- 3.3.3 Professor Maxwell noted that the British National Formulary contained some information regarding licensed indications, so prescribers could use this for reference.
- 3.3.4 Dr Williams noted that the concern of the General Medical Council was regarding use of unlicensed or off label medicines to make cost savings when a licensed product was available. The Lothian Joint Formulary did not do this and only recommended off label and unlicensed medicines if no licensed alternative was available.
- 3.3.5 The Committee was supportive of the Formulary Committee's position, and Dr Williams agreed to write to the GMC explaining the approach the Lothian Joint Formulary had taken.

RW

4. Patient Safety

4.1 Near Patient Coagulation Testing for Warfarin Patients

- 4.1.1 Dr Williams welcomed Dr Chapman to the meeting and Dr Chapman gave a presentation on the implementation of near patient testing for warfarin in GP Practices.
- 4.1.2 Dr Chapman advised that near patient INR tests were being carried out locally in GP Practices, and that this had been implemented gradually across the East and Midlothian regions over the last few years. This had been developed due a problem with delays in getting results when blood samples were sent to laboratory services for testing; if results were not received until after closing time, they had to be given to the patient by out of hours' service, and it was often difficult to contact the patient. This was a patient safety issue as patients could be out of range but still taking warfarin as unable to be contacted. Patient safety could be improved by using a near patient test where the result could be given immediately to the patient in the surgery.
- 4.1.3 Other advantages of the near patient testing were that they did not require a venous blood sample to be taken which was stressful for patients and could be time consuming for staff.
- 4.1.4 There was need to ensure that the quality of testing was maintained and GP practices had signed up to the national quality standards which the laboratory was required to adhere to. Healthcare support workers would carry out the tests, but a lead clinician would be involved in the testing of all patients. Training had taken place at implementation in each practice, and refresher training would be offered regularly.
- 4.1.5 The near patient test was implemented along with software to predict dosages; this software was proven to be effective, and stable patients could have longer gaps between testing, meaning less time used for both patients and clinics.
- 4.1.6 All practices using the near patient testing were required to participate in audit, so that improvement could be measured and it could be seen if there was a change in numbers of tests done. As the earliest practice to start using near patient testing started only eight months ago conclusive data had not yet been gathered.

- 4.1.7 As part of the monitoring of the change, patient, GP and nurse questionnaires would be carried out.
- 4.1.8 Testing strips were ordered centrally in bulk as this offered a cost saving per year compared with test strips being purchased individually by practices. Costs of near patient testing were likely to be less than testing at the laboratory, but the figure for the laboratory cost was not yet available. Mr Hunter advised that these figures were being calculated in response to a Freedom of Information request and would soon become available. The initiative would continue to be funded by the Community Health Partnerships.
- 4.1.9 In response to a question about available data showing that the testing kits were as accurate and valid as the laboratory tests, Dr Chapman agreed to send a copy of the service level agreement and the data supporting it to support work on a Lothian policy.
- KC**
- 4.1.10 Dr Chapman advised that those practices which had signed up to near patient testing no longer used the laboratory for any INR testing.
- 4.1.11 In response to a question from Professor Timoney regarding the expected measurable benefits of using near patient testing, Dr Chapman advised that the standard measure for INR testing of patients on warfarin was 60% of outcomes in range, but with near patient testing and the software used to predict dosage it was hoped that this could be improved to 90% of outcomes, improving patient safety and reducing admissions to hospital. The formal evaluation would consider improvement in these areas. Professor Timoney noted that as money was not being saved by the implementation of this initiative it was important to ensure that the improvement in patient safety could justify the additional spend.
- 4.1.12 Professor Maxwell noted that if this initiative improved patient safety in Primary Care, then it should also be implemented in hospital wards if the cost was right, as using near patient testing was more convenient than sending blood samples to the laboratory in hospital also. Dr Williams agreed that if data and evidence showed that patient safety would be improved by near patient testing this should become the Lothian policy.

4.2 Antimicrobial Team and Outpatient Parenteral Antibiotic Therapy Update

- 4.2.1 Dr Williams welcomed Ms Cockburn and Ms Philip to the meeting and they gave an update on the progress of the antimicrobial team. Dr Mackintosh was welcomed to the meeting and she gave a presentation on the Outpatient Parenteral Antibiotic Therapy programme.
- 4.2.2 Professor Maxwell felt that the presence of the antimicrobial team pharmacists on the wards and writing comments in patient notes was beneficial, but felt that interventions could be more robust, for instance alerts on TRAK, charts on each ward highlighting any risks, and more direct consultation with clinicians. Ms Cockburn replied that as part of the IVOST (intravenous to oral switch therapy) scheme every patient's chart was reviewed twice per week and there was liaison with ward clinical pharmacists and clinical team; recommending that patients meeting the criteria should be taken off IV antibiotics. This scheme was currently in place at the Royal Infirmary but would shortly be implemented in the Western General and St John's Hospitals also.
- 4.2.3 Professor Timoney agreed with Professor Maxwell that it was important to support clinical leadership and direction on antibiotic stewardship. Dr Mackintosh agreed that it was

sometimes difficult to engage with clinicians in this area. Professor Timoney agreed to find out whether Dr Simon Edgar would be addressing this as part of his work with the Infection Prevention and Control Team in terms of reducing incidence of *Clostridium difficile* Infection, with the suggestion that he and Professor Timoney meet with the Antimicrobial Management Team. **AT**

- 4.2.4 Ms Cockburn noted that there was no direct line from the Antimicrobial Management Team to senior management, and felt that the Chair of the AMT should be on the Clinical Management Team to include the team in governance structures.
- 4.2.5 Professor Maxwell noted that the *Clostridium difficile* Infection investigation form required to be filled in by a clinician following every CDI case was 45 pages long and was not formatted in a way that would encourage engagement. Ms Cockburn advised that the investigation form was written by the Scottish Government and it was mandatory for clinicians to complete. She also advised that ward rounds and root cause analysis was undertaken by the Infection Prevention and Control Team for all CDI cases, and that the Infection Prevention and Control Team was reviewing all CDI documentation as part of a drive to find new strategies to reduce the number of cases.
- 4.2.6 Professor Timoney noted that a business case had been submitted for a further two Antimicrobial Team pharmacist resource, and that there was support for this.
- 4.2.7 In response to a question from Dr Tomlinson, Dr Mackintosh advised that although nursing staff working in the OPAT team were currently at capacity, there were many more patients in Lothian who could benefit from this scheme and with new funding the service would be expected to grow.
- 4.2.8 The recommendations laid out in the Antimicrobial Team update report were supported by the Committee.

4.3 Patient Access Scheme Annual Report

- 4.3.1 Mr Hunter summarised the previously circulated paper.
- 4.3.2 Dr Williams suggested that in future the report on the patient access scheme could be covered by the Prescribing Resource Group's remit rather than the ADTCs.

4.4 Bowel Screening Prescribing Practice and Cost

- 4.4.1 A paper had been previously circulated. This had previously been discussed at the ADTC and had been submitted to the Healthcare Governance Committee. The issue was that medication for bowel preparation was currently issued to patients in a way that did not comply with legislation. A Patient Group Direction was now in place for patients coming in for treatment but there was still an issue around supply of medicine for diagnostic patients.
- 4.4.2 The Healthcare Governance Committee's view was that the risks were being managed appropriately and agreed with the position subject to approval by the ADTC.
- 4.4.3 Ms Kerr advised that ways to resolve the problem were still being considered, no other Board had a better arrangement in place, and that a risk assessment was in place and was on the GI risk register.

4.4.4 The ADTC agreed that there was minimum risk and approved the strategy laid out in the paper.

4.5 Healthcare Improvement Scotland Safe Management and Use of Controlled Drugs

4.5.1 A paper had been previously circulated. Professor Timoney noted that revised regulations in 2013 provided Healthcare Improvement Scotland with a more explicit governance role in the safe management of controlled drugs. In response to this, Healthcare Improvement Scotland carried out a scrutiny exercise which resulted in five recommendations for Health Boards. NHS Lothian already met all five recommendations.

4.6 Hospital Based Prescription Policy

4.6.1 The draft policy had been previously circulated. Ms Gilchrist advised that the Royal Edinburgh Hospital and Associated Services Hospital Based Prescriptions Policy had been adapted into a Lothian policy. The policy would continue to support hospital based prescriptions in REAS and in some proposed services in Acute.

4.6.2 Members approved the policy and asked for it to be sent to the General Practice Prescribing Committee for Information. **BP**

4.7 Consultation on proposals to reschedule ketamine under the Misuse of Drugs Regulations 2001

4.7.1 The consultation paper had been previously circulated. Professor Timoney advised that she would respond to the consultation and send a copy of the response to the ADTC.

4.8 Scottish Palliative Care Guidelines Consultation

4.8.1 A link to the online guidelines was provided with the papers for this meeting. The guidelines were complete but had not yet been published on the public site due to a technical difficulty.

5. **Medicines Utilisation and Review Group (MURG) Reports**

5.1 Mr Hunter summarised the previously circulated reports. Dr Williams noted that the ADTC had written to the Director of Finance highlighting concerns about the process of setting the primary care prescribing budget, and yet these reports showed an expected overspend. Mr Hunter explained that the expected cost was taken into account but was applied to the budget rather than the previous years' spend. Many of the LRP savings had already been identified, but overspend was due to some drugs increasing unexpectedly in price.

6. **Items for Information Only**

Members noted the following previously circulated papers for information:

- 6.1 Scottish Intercollegiate Guidelines Network (SIGN) Newsletter;
- 6.2 Revised Scottish Management of Antimicrobial Resistance Action Plan (ScotMARAP) 2014-8;
- 6.3 Invitation of New Member to the Formulary Committee;
- 6.4 Strengthening Collaborative Working between ADTCs in Scotland;

6.5 MHRA Guidance: Emergency Asthma Inhalers for use in Schools.

7. Minutes from Committees and Division, Exception Reporting

7.1 Hospital and Specialist Services Medicines Committee, 11 June 2014

7.1.1 Dr Riddle noted that psychiatric patients who went off the ward and returned later in the day had trouble getting their medicines because of the recommendation in the policy that if more than an hour had passed after the initial prescription was written, then the prescription had to be re-written by the prescriber. Dr Riddle asked whether the Medicines Policies Committee could consider a solution to this and make a local policy. Dr Williams and Ms Kerr agreed that a possible solution could be discussed and then proposed to the ADTC.

WR

7.2 The previously circulated minutes from the following meetings were noted for information:

7.2.1 Formulary Committee, 27 August 2014;

7.2.2 General Practice Prescribing Committee, 17 June 2014;

7.2.3 Medicines Utilisation and Review Group, 6 May 2014;

7.2.4 UHD Drug and Therapeutics Committee, 11 June 2014;

7.2.5 Cancer Medicines Management Team, 16, 23, 30 July, 6, 13, 27 August, 3 September 2014;

7.2.6 Cancer Therapeutics Advisory Committee, 26 May 2014, 28 July 2014;

7.2.7 Prescribing Resource Group, 29 July 2014.

8. Any Other Competent Business

8.1 NHS Highlands; Proving Value for Money from Medicines

8.1.1 Ms Davidson noted that NHS Highlands were setting up a group similar to MURG and had asked all ADTCs for any information on similar groups in their Boards. Information about MURG had already been sent in response to this, and a member of the NHS Highlands ADTC had been invited to a MURG meeting as an observer.

8.2 Consultation on Healthcare Improvement Scotland Strategic Delivery Plan

8.2.1 The consultation document would be circulated to Members. Professor Timoney noted that the strategic delivery plan was high level and directional and aimed at the Board. Ms Gilchrist noted that there were already policies on some of the areas covered by the plan.

BP

8.2.2 A co-ordinated response to the consultation would be sent by the ADTC. Any comments from Members would be sent to Bryony Pillath for collation by Friday 31 October 2014.

ALL / BP

9. Date of Next Meeting

9.1 The next meeting of the Area Drug and Therapeutics Committee would take place at **14.30 on Friday 5 December 2014 in Seminar Room 8**, Second Floor, Waverley Gate.

9.2 Meeting in 2015 would take place on the following dates:
- Friday 6 February 2015;

- Friday 10 April 2015;
- Friday 12 June 2015;
- Friday 14 August 2015;
- Friday 9 October 2015;
- Friday 11 December 2015.