NHS COUNTY DURHAM AND DARLINGTON
Drug and Therapeutics Committee

Minutes of meeting held

Tuesday 20th December 2011
Board Room, John Snow House
12.00 – 14.30

Present:

Dr Geoff Crackett, GP Prescribing Lead (DCLS)
Dr Ian Davidson, GP Prescribing Lead (Derwentside)
Deborah Giles, Pharmaceutical Adviser, NHS CD&D
Dr Peter Jones, GP Lead (Sedgefield)
Victoria Julian, Medicines Management Technician, NHS CD&D
Patricia King, LPC Community Pharmacist Representative
Dominic McDermott, RDTC
Ian Morris, Head of Medicines Management, NHS CD&D
Laura Mundell, Administrative Assistant, NHS CD&D (minutes)
Dr David Napier, GP Prescribing Lead (Easington)
Anne Phillips, Nurse Practitioner, NHS CD&D
Ros Prior, Clinical Pharmacy Services Manager, TEWV
Dr David Russell, GP Prescribing Lead (Darlington)
Dr Satinder Sanghera, GP Prescribing Lead (Dales)
Joan Sutherland, Senior Pharmaceutical Adviser, NHS CD&D

In attendance:

Victoria Julian, Pharmacy Technician, NHS CD&D

1. APOLOGIES

Linda Neely, Head of Clinical Quality & Patient Safety, NHS CD&D
Christopher Williams, Deputy Chief Pharmacist, CDDFT
Gail Dryden, Community Matron, CDDFT

2. DECLARATION OF INTERESTS

No interests were declared.

3. MINUTES FROM LAST MEETING HELD 18TH OCTOBER 2011

The minutes were accepted as a true and accurate record with the following amendments:

Page 3 – Dr Peter Jones in the present list to be changed to *Dr Peter Jones, GP Prescribing Lead (Sedgefield).*

Page 11 – to delete the end of the first paragraph from item 17.1.

4. MATTERS ARISING

Flucloxacillin

DR informed the committee he had spoken with a microbiologist from CDDFT regarding alternatives to flucloxacillin, due to the high costs of flucloxacillin liquid preparations and unpalatable flavour especially to children, following October's D&T meeting. DR advised that cefaclor, clarithromycin and co-amoxiclav were discussed as alternatives to flucloxacillin in children. IM highlighted the fact that this is not currently in line with the PCT's antibiotic guidelines, however these are due for review in April 2012. ID asked for this issue to be highlighted in the next newsletter.

ACTION: DR to forward a summary of his conversations with the microbiologist for inclusion in the next Medicines Management newsletter.

Flu vaccination consultation

ID informed the committee he had spoken to Ken Ross regarding flu vaccine procurement who confirmed there was no further news or update for the committee on this issue.

4.1 C. Diff rates

ID introduced this item by informing the group of the reported increase of community acquired C.Diff cases which was raised at the previous D&T meeting and asked for feedback from the GP prescribing leads. PJ was keen on taking this forward however felt he needed further evidence of the link between C.Diff and prescribing in the community. PJ advised he had spoken with Dr Schloss a year ago who was unable to provide any evidence.

IM informed PJ that there is some guidance on the Medicines Management website regarding C.Diff. DN agreed with PJ and felt that they need some hard evidence to show to GPs to prove that there is a link. ID agreed, however he mentioned that this has become accepted practice nationally and that we need to focus on reducing the prescribing of broad spectrum antibiotics. PJ said that he intends for a practice in his locality which has high antibiotics prescribing rates will have training from NPC. ID felt that apart from targeting these practices and offer further training session there is not much more to be done at present.

IM informed the group that the Medicines Management team investigates community acquired C.Diff cases. He confirmed that some of the recent cases investigated by the Medicines Management team have involved patients prescribed a number of antibiotics over a short time period. IM advised a graph showing the percentage of prescribing of first line antibiotics according to the PCT antibiotic formulary will be available in the next set of practice level graphs

ID asked for this item to stay on the D&T agenda.

5. ACTIONS TAKEN BY MEDICINES MANAGEMENT TEAM FROM LAST MEETING

Please refer to the amended action log. The updated actions were accepted and noted by the committee.

6. AGENDA

6.1 Updated D&T Terms of Reference

The updated Terms of Reference were noted and accepted by the Committee. ID advised that the Terms of Reference would be reviewed again in April 2012 due to the NHS reorganisation.

6.2 Dabigatran prescribing guidance

ID advised the committee that NICE guidance on the use of dabigatran in AF was expected to be published on 15th December, however, following an appeal NICE's final decision has been put on hold until February 2012.
PJ questioned who put the appeal in and asked whether this appeal was due to the guidance being too broad. IM advised the appeal was from NHS Salford.
A discussion followed where the committee expressed their concerns for dabigatran. ID summarised this conversation by stating that there are outstanding safety concerns with dabigatran, that this is not a widely used drug and GPs are generally uncomfortable prescribing this drug. ID expressed concerns that if NICE were to give this drug a positive opinion, patients may well begin a lobby for the use of the drug due to the need not to monitor as often as warfarin.
ID informed the group that until NICE release final guidance, the NETAG guidance should be followed

6.3 Updated NICE hypertension guidance

The committee discussed the apparent downgrading of bendroflumethiazide in the updated NICE guidance and expressed concerns about this. PJ highlighted a recent article published in December's Drug & Therapeutics Bulletin, entitled "Whatever happened to thiazides?". DM advised that many GPs have decided to continue prescribing bendroflumethiazide until further evidence is published due to the practicalities of using other drugs for example chlorthalidone which requires quartering the tablet to deliver the dose recommended by NICE.
ID asked for the committee's thoughts on whether prescribers should be advised it is reasonable to continue prescribing bendroflumethiazide. DM advised the RDTC will be publishing a report in January on this issue. ID suggested adding an item to the newsletter about this issue once the RDTC report has been published.

SS asked whether cost was an issue. PJ advised that there is little evidence supporting the use of bendroflumethiazide, however there is a body of evidence supporting chlorthalidone. ID commented that one paper had predicted savings of between £50 and £320 per person over their lifetime if the new NICE diagnosis guidelines were implemented; however felt this was a gross underestimation. PJ felt that although less people may be diagnosed, the ones who are will be treated more aggressively.
ID summarised that the committee will await the RDTC report in January and will then publish an article in the newsletter. ID confirmed that in the newsletter there should be a section for hypertension and this will include the use of thiazides in hypertension. IM suggested carrying out ePACT searches to monitor any changes in trends of bendroflumethiazide prescribing.
ACTION: Add article to newsletter after RDTC report is published in January.
ACTION: Analyse trends in bendroflumethiazide prescribing from ePACT prescribing data.

6.4 Future commissioning of practice based prescribing support

ID explained this paper had been brought to the D&T committee for discussion on how to address the procurement and employment of practice prescribing support within the CCGs.

ID informed the committee that following this paper being cascaded to committee members, there had been further organisation changes which would have an impact on the paper,

whereby the practice support pharmacists and technicians employed directly by the PCT may not be transferring to CCGs as originally thought when the paper was originally written, but would be aligning with the CSU. ID advised that the committee must recognise that a further option to this paper therefore, would be practice support employed through the CSU.

IM suggested a shared structural approach should be taken to discussions and commented that wherever the practice support team sits they need security. IM suggested discussing the intended structures and use of money with the GP Prescribing Leads and formulating a plan for the future on how best to spend the money available.

After discussion amongst committee members, ID summarised an additional option needed to be added to the original paper which included practice support staff being directly employed by the CSU.

ID suggested that a risk of practice support staff being employed directly by CCGs could lead to staff being at risk of being included in management cost savings.

JS advised the Medicines Management team were trying to provide practices and CCGs with the support they need where they need it.

SS suggested GP Prescribing Leads should be involved in moving this issue forward with their CCGs.

ID reiterated that this paper was a discussion paper and no decisions could be made regarding this at this meeting.

ID summarised that option 1 should be removed from the paper and option 2 should be amended to take into account direct employment from the CSU. ID asked for the paper to be forwarded to GP Prescribing Leads and pharmacy leads within each locality, following which the GP Prescribing Leads would take the paper to their executive meetings within their CCGs to ensure the issues are discussed and decisions are made. ID advised he would like a decision to be made over this in January.

JS added that all pharmacists and technicians present in the meeting may need to declare an interest in this paper.

ACTION: JS/KH/MG to amend paper as per discussions summarised above.

6.5 <u>Best practice guidance: optimising treatment and care for people with behavioural and psychological symptoms of dementia</u>

JS introduced this item, explaining the report had been discussed at TEWV D&T and had been brought for further discussion as the guidance was aimed at primary care. JS advised that one of the main issues from this paper was the fact that the new Citalopram guidance has not been incorporated.

RP advised that the report had flagged to TEWV that antipsychotic use in dementia patients needs looking at further, explaining that TEWV's current treatment recommendations differed from those recommended in the report. RP also explained that TEWV were planning to carry out work on the limited evidence base on treating depression in dementia and how this will be impacted by, and fit in with, the recent updated guidance for citalopram and escitalopram.

RP advised that TEWV's elderly care directorate have been looking into collaborative work for the treatment of depression and RP has flagged to them that agreements need to be made as to how this is communicated. RP commented that the report refers to 'acute hospitals'

however it wasn't clear if this was referring to district general hospitals or hospitals such as TEWV's sites.

RP suggested TEWV work with the committee and other medicines management teams to decide how to approach the interface working and RP asked the committee for their comments on how they wished to move forward with this. SS commented she found the report useful, but would like to see further emphasis to be on the first and second stages of treatment before anti-psychotics are prescribed. SS advised that she had raised this issue with her CCG and GPs had queried what else could be done in primary care apart from prescribing anti-psychotics.

JS advised that the medicines management team have been carrying out work in this area, including an antipsychotic audit to be discussed later on in the D&T agenda, and informed the committee that £15,000 had been allocated to County Durham and Darlington from NHS North East to reduce prescribing of anti-psychotics. JS informed the committee she has been made aware of two Four Seasons centres in County Durham and Darlington who have been specifically looking at using sensory awareness in the management of patients with dementia, and have relatively low numbers of patients prescribed antipsychotics.

ID asked the committee if this document should be recommended to prescribers. JS felt that this could be refined, and that some joint work with TEWV should be undertaken. This could then be returned to the D&T. SS was concerned at the size and format of the current document. ID asked whether the flow chart that is in the document would be appropriate. SS felt that this needed more detail, and RP suggested the report needed to be amended slightly.

ID asked about a timescale, RP informed that this will need to go to TEWV D&T first and should be ready in spring 2012. JS suggested sharing this information as it is now with an explanation that further work will come out in 2012.

ID asked JS what timescales had been given to use the money provided for reducing prescribing of antipsychotics in dementia patients. JS advised she had only very recently received notification of this and so expected the money could be used into 2012/2013. JS also advised she would like to research further the work being done by Four Seasons.

IM advised that dementia is on the agenda for APC in May 2012. ID confirmed this would be brought back to the D&T meeting in April 2012 prior to APC with a hope to roll out a final version in June/ July 2012.

ACTION: JS and RP to work further on this report to produce guidance tailored for use in County Durham and Darlington.

ACTION: To return to D&T in April 2012.

6.6 <u>Prescribing guideline for AChE inhibitors for Alzheimer's</u>

The Prescribing guideline was considered.

PJ informed the committee of a recent survey within his practice which highlighted a difference between consultant and CPN reviews, but found many patients didn't want these drugs stopping.

SS commented she felt there was little education at the initiation of treatment and advised that she has spoken to psycho-geriatricians at TEWV who agreed it is often hard to stop treatment. ID informed the group this issue had been discussed at the APC where discussions took place to try to ensure that guidance goes to patients and carers initially, and also that guidance goes

to prescribers for the review to specifically assess whether they need the treatment. ID informed the group that GP's should flag any issues up as they find them.

The guideline was accepted by the committee.

6.7 Antipsychotic audit feedback

VJ presented this paper, summarising this piece of work undertaken by the Medicines Management practice support technicians had improved communication with GPs on this issue and highlighted a number of dementia patients prescribed antipsychotic drugs requiring additional monitoring and annual dementia reviews. JS added the audit took lots of work, involving a particularly large audit tool.

ID thanked VJ and her colleagues on behalf of the Committee.

6.8 Antipsychotic audit reports

ID asked whether the dissemination of the audit reports to localities should be delayed until an appropriate toolkit is made available. JS felt it would be appropriate to share the reports with the localities, which DN agreed, and PJ felt this would provide an incentive for practices to act upon in tackling these issues.

PK suggested the reports should include information on the numbers of patients on the dementia register regularly prescribed antipsychotics. ID agreed this information should be added to the reports, which should then be sent out to each locality for discussion amongst clinicians, with a note that local guidance was in development. RP asked if the reports could be shared with TEWV clinical leads for County Durham and Darlington which ID agreed.

ACTION: to amend reports to include the total number of patients on the dementia register as well as those regularly prescribed antipsychotics.

ACTION: to disseminate to localities for discussion amongst clinicians once amendments have been made.

ACTION: to share reports with TEWV clinical leads for County Durham and Darlington.

6.9 Emollient prescribing guideline

ID asked for any comments about this paper which had been produced by the dermatology nurse specialists and previously discussed at the APC meeting.

PJ felt there should be mention of the downgrading of Aqueous cream and why this is no longer recommended in the guidance. ID felt that this should be put in the newsletter with a link to the guidance with a comment regarding Aqueous cream. SS also felt that E45 should be commented on as this has also been downgraded.

DR asked whether price is an issue in these guidelines, ID did not think this was the case. IM informed all that the 1st line emollients will be the cheaper ones, but also that if patients comply then there will be less waste. GC mentioned the issue that this seems fine for new users but for established GPs who have always used Aqueous cream would need a covering letter. ID asked whether this should be sent as a memo, all agreed.

ACTION: to add an item to the next newsletter with a link to the guideline and a comment regarding aqueous cream and E45 cream.

ACTION: memo to be produced to be sent out with the guideline with further information on the rationale behind not including aqueous cream and E45 cream.

6.10 Apomorphine shared care guideline

Calum Polwart from County Durham and Darlington NHS Foundation Trust (not in attendance) had requested this item on the agenda for primary care feedback prior to taking to the APC meeting in January 2012.

JS advised this had been brought to her attention by some GP practices who she informed this was a red drug. ID queried who provided the service to which the committee did not have any further information. IM suggested getting further information on this from CDDFT.
The committee felt this guideline could not be accepted without further clarification so the guideline was rejected.

6.11 North Tees & Hartlepool DMARD shared care guidelines

IM presented this paper explaining that the PCT and CDDFT have some shared care guidelines for gastroenterology and rheumatology covering DMARD drugs. These, however, aren't relevant to some Easington practices, and a Sedgefield practice who refer patients to North Tees & Hartlepool NHS Foundation Trust. IM provided a chart listing the differences between the North Tees & Hartlepool guidance and the CDDFT guidance. Easington locality had asked the committee to consider approving these guidelines for use for those patients referred to North Tees & Hartlepool.

DN commented the differences between the CDDFT and North Tees & Hartlepool guidelines were minor and said he would be happy to use either guideline. ID agreed that only minor differences existed and felt this is something that should be done on a regional level across the whole of the North East.

ID asked for the paper to go to the next APC meeting. GC mentioned that the Tees guidelines suggest that Methotrexate should be stopped if patient has an infection requiring antibiotics. GC feels many GPs aren't aware of this so this message should be made clearer. ID suggested mentioning this issue in the newsletter. SS feels that further to this a change needs to be made on the GP system in practice as this is something that might not happen often.

The Committee approved the paper but agreed that the issue of developing a single Regional guideline should be raised at the APC.

ACTION: to add an item to the next newsletter summarising the issue with infections in patients prescribed methotrexate or biologic drugs.

ACTION: to add to the APC agenda for January 2012.

6.12 NHS Tees switching of venlafaxine MR capsules/ tablets to immediate release tablets

JS presented this paper, adopted by NHS Tees from guidance originally produced by NHS North Yorkshire and York. JS advised that TEWV now prescribe standard release rather than modified release venlafaxine and are now in the process of switching patients to a standard release tablet BD dose rather than a modified release OD dose.

Committee members were in agreement and the paper was accepted.

7. FINANCIAL/ BUDGET/ QIPP UPDATE

IM informed the group that budget memos should be disseminated this week. IM informed all that the category M price changes have made a difference in the October data. County Durham PCT are forecasting an overspend of £85,000 for the end of the year, 0.096% overspend. Darlington have a forecast of 1.34% which is an over spend of £ 213,000. IM informed the group that these figures are yet to be ratified.

8. MEDICATION SAFETY AND NPSA

8.1 Yellow Card Reporting

ID presented this paper which shows Darlington reports a lot of "Yellow Cards", in comparison to County Durham. ID wondered whether this data takes into account the hospital trusts as well. RP felt that it was unclear to see which trust (mental health, primary care etc.) these were being reported from. PJ felt that all could report more and felt that it may be worth mentioning this in the newsletter, the graph could be included in the newsletter with a covering statement to encourage reporting. SS felt that time constraints may prevent GP's from reporting. RP commented that patients can also report using the yellow card. GC highlighted the fact that smoking cessation staff need to be encouraged to report as these patients aren't always seen by GPs.

ACTION: item to be added to newsletter to raise awareness alongside graph showing Yellow Card reporting rate for County Durham and Darlington PCTs.

8.2 MHRA Drug safety update

The November alert was initially discussed. IM mentioned the change to dosing guidelines for Paracetamol for children. Packs of Paracetamol were now being supplied to pharmacies bearing the new dose guidance. This was discussed at the previous D&T and it was decided not to send any information out as packing had not changed. PK mentioned that it makes a difference when mentioning the dosages to patients as many give the upper end of dose.

IM discussed the December issue which discussed the new dose restrictions following safety concerns with Citalopram and Escitalopram. ID asked whether guidance has been sent out on Escitalopram and JS confirmed that guidance has only been sent out in relation to Citalopram.

RP informed the group that this will be discussed at TEWV D&T in January 2012. ID asked RP if there was any mention of heart disease in the guidance that was sent out as it is mentioned in the safety report that ECG should be carried out before starting treatment. ID was concerned that there are people with heart disease who are taking these drugs. DR suggested that if the patient has a history of heart disease then they should have an ECG and this should be repeated as necessary. ID confirmed that guidance should be sent out about this.

SS questioned whether LFT monitoring should be carried out along with an ECG, ID feels this should be taken into consideration. PK asked if there is something else that can be used rather than escitalopram, ID feels that something needs to go out as Citalopram can't be stopped instantaneously and this needs to be sent out as soon as possible. IM suggested using the text from the two yellow boxes that are on the MHRA safety update, ID agreed but felt there needs to be more on there as this doesn't consider existing patients. JS felt that in future the committee should wait until the MHRA has published its reports before the committee sends out guidance.

ID also mentioned Dabigitran which was highlighted in December's Drug Safety Update and asked for this to be highlighted in the newsletter.

ACTION: Item to be added to newsletter advising of new dose recommendations for paracetamol in children.

ACTION: Guidance/ patient safety memo to be produced and disseminated regarding citalopram/ escitaopram safety concerns, especially in relation to ECG and heart disease monitoring.

ACTION: summary of dabigatran guidance included in December's Drug Safety Update to be included in next newsletter.

8.3 Chemotherapy Policy draft

IM presented this draft paper, informing the group that he is currently working with the cancer leads, the oncologist and the medicines management team on this. GC asked whether any treatment is being prescribed already, IM confirmed that they are. IM did reiterate that this is an early draft and more work is needed. IM intends to do more work on this and to return to a future D&T.

ACTION: to be brought back to D&T once policy has been agreed and commented on by CDDFT and other parties.

9. APC UPDATE

PJ queried the discussions surrounding gender dysphoria from the minutes. IM informed the group that there have been many queries about this and advised this is a service that is commissioned as a specialist service however there was no money put aside for drug costs meaning the GP are being asked to prescribe the drugs which many GPs are not comfortable with.

PJ also mentioned that he felt disappointed that TEWV aren't looking at a move from Quetiapine to Risperidone. ID informed PJ that this issue is coming to the APC in May.

10. RDTC UPDATE

The committee accepted this paper for information.

11. PRESCRIBING UPDATES

11.1 Drug & Therapeutics Bulletin summary

ID mentioned the report on thiazides, highlighted previously in item 6.3 which he felt may be useful for the newsletter.

11.2 NETAG Update

The committee accepted this paper for information.

12. NON-MEDICAL PRESCRIBING

JS gave a verbal update and mentioned that there seems to be a lot of "out of scope" prescribing, or non-medical prescribers declaring they are competent at every area of the BNF. JS suggested that this is taken back to locality level and taken to prescribing sub-groups for further discussion. ID agreed with this.

AP expressed concerns with the way areas of competence are declared, adding it was not an ideal situation. JS mentioned that when picking an area if competence it is hard to map this on

ePACT if all areas are selected. ID asked JS if this is something she will return to D&T, JS confirmed this would go out to locality prescribing groups for clinical engagement rather than return to the D&T committee.

ACTION JS to ensure 'out of competency' prescribing issues reviewed by end 2012 via Locality Prescribing Groups.

13. PATIENT GROUP DIRECTIONS

IM informed the group that there are some PGDs due to expire. There has been a request for the intradermal flu vaccination to be included on a PGD as one practice ran short of their usual vaccine; IM has sent this request to Ken Ross to advise the practice on which suppliers still have their usual vaccine available.

A sexual health service has asked to use some PGDs.

14. QOF

DG summarised the paper and advised the committee of the need to make changes to the Medicines Management QOF for 2012/2013 due to the organisational changes within the NHS and the limited resources available.
DG asked the committee for agreement on which of the options presented in the paper the committee would prefer and agreement on therapeutic areas to concentrate on. DG added that a final document would be presented to D&T in February 2012 for dissemination to practices in March.
DR queried what resources were already available and DG advised that NPC online resources had been looked into, however they had limitations and some topics were geared towards sessions being presented in person. DN suggested looking into the BMJ's e-learning resources, commenting that some are related to NICE guidance and are openly accessible.
DN questioned how well attended a workshop session would be, and added that if e-learning sessions were offered, all members of staff from a practice could potentially take part. ID asked if both e-learning and educational workshops could be used. IM advised that the staff resources needed to deliver both may be a problem. SS and ID both commented that they found educational workshop events had been well attended in the past, however SS commented e-learning could be done from within the practice in a few hours which would be advantageous. PJ commented that the workshops in previous years were well attended as they were mandatory but felt it would be more cost-effective for practices to complete e-learning.
PJ asked if all prescribers should complete the e-learning, however ID advised that this will all require validation at the end of March 2013 and with the uncertainty of the NHS organisational changes and the amount of work required to validate QOF it would be a large task if all prescribers were to complete this work. ID added that the NPC educational sessions were free of charge so could possibly be used in an alternative way.
ID summarised that the e-learning appears to be the best option but the face to face education session could be ran separately as they are provided free and so these should be used. ID suggested that the e-learning needs further research.

ACTION: to look further into the e-learning options available and bring a final document to D&T in February 2012.

15. MEDICINES MANAGEMENT TEAM UPDATES AND PUBLICATIONS

15.5 <u>Medicines Management Strategy Update</u>

ID intended this draft document be the main focus of discussion between the GP prescribing leads after this meeting. IM informed the group of an amendment to the paper: the removal of

the comment which says the CCG level functions will definitely be provided by the commissioning support unit. This will show no favour as to who the future provider will be.

IM mentioned that this paper has been moved forward and the document gives a summary of what is thought to be CCG cluster level functions thought to be individual CCG functions and individual locality functions. These should form the basis for any local strategies or CCG wide strategies.

IM highlighted that this document is not for onward circulation outside of the D&T committee.

16. CCG PRESCRIBING LOCALITY UPDATES

Summaries of CCG prescribing locality sub-groups were circulated for information.

17. PROVIDER DRUG & THERAPEUTICS COMMITTEES

Summaries of provider Drug & Therapeutics committee meetings were circulated for information.

18. ANY OTHER BUSINESS

IM informed the group of discussions at the North of Tyne Formulary committee which was attended by IM and GC. The place of Dabigatran in therapy was discussed, as was Duraphat fluoride toothpaste which was approved for use in dental hospitals only, buccal lorazepam which was accepted as a red drug only and intranasal diamorphine which was rejected from formulary.

PJ mentioned that in his locality money left over from now until April can be used to reward individual practices. They have to submit a bit in assumption that for every pound spent there is one pound saved per annum and PJ has offered that model to the committee. PJ has only had one bid so far. ID felt this would be useful to be shared. PJ informed the group that his locality is keen on is creating an incentive scheme. ID feels this would be useful for 2012/2013 as the QP QOF will no longer be in use.

ID discussed the late paper received from Chris Williams (Liraglutide/ Exenatide shared care guidelines for type 2 diabetes mellitus). JS informed the group that this is currently not a licensed indication and therefore can't be approved until this changes.

DATE AND TIME OF NEXT MEETING

Tuesday 21st February 2012
12.00 – 14.00
Merrington House, Spennymoor

Confirmed as an accurate record:

Dr Ian Davidson - Chair