NHS
County Durham and Darlington

COUNTY DURHAM PCT & DARLINGTON PCT
Drugs and Therapeutics Committee

Minutes of Meeting held
Tuesday 18th January 2011
Boardroom, Appleton House
12.00 - 2.30 pm

Present:

Hazel Betteney, Senior Pharmaceutical Adviser
Dr Geoff Crackett, GP Prescribing Lead (DCLS)
Dr Ian Davidson, GP Prescribing Lead (Derwentside) - Chair
Gail Dryden, Community Matron,
Patricia King, LPC Representative
Ian Morris, Head of Medicines Management
Linda Neely, Head of Patient Safety
Ros Prior, TEWV
Dr David Russell, GP Prescribing Lead (Darlington)
Dr Satinder Sanghera, GP Prescribing Lead (Dales) (SSa)
Sue Shine, Nurse Practitioner (SSh)
Sue White, RDTC

1.0 APOLOGIES

Dr Peter Jones, GP Lead (Sedgefield)
Dr David Napier, GP Prescribing Lead (Easington)
Stephen Purdy, Pharmaceutical Adviser
Joan Sutherland, Senior Pharmaceutical Adviser
Christopher Williams, Head of Medicines Management, NHS Provider

2.0 DECLARATION OF INTERESTS

There were no interests declared.

3.0 MINUTES OF LAST MEETING

There were no amendments; therefore the minutes were accepted as a true and accurate record.

3.0 MATTERS ARISING

4.1 Gluten Free Limited List

IM outlined the background to the gluten free scheme which was currently being piloted in the DCLS locality, advising that it is a scheme for patients to access gluten free products without the need to see their GP or have a prescription. Although the scheme currently runs very well at the present time, it has been agreed by DCLS PBC cluster that the products available should to be restricted to a limited list.

IM advised that looking at FP10 prescribing data for CD&D, it was established that annually £210k was spent on 17,000 prescriptions, in addition to the £60k top sliced for the DCLS scheme. On further analysis, it was found that a high proportion of the cost was for gluten free bread which accounted for 58% of costs. Currently there are 23 different products available on prescription; however, 98% of the costs in CD&D came from six different product types.

IM advised that in order to compile a limited list, he broke down the prescribing data by product to find the commonest product, if there were a number of similar products, he selected the cheapest product available. Possible products for the limited list would be - Gluten and wheat free bread; gluten and wheat free pasta; gluten and wheat free biscuits. ID queried if having a limited list would have an effect on prescribing costs. IM advised that currently biscuits account for 10% of the costs, therefore, removing biscuits could reduce spend on gluten free products by £20k. DR suggested a grey list of gluten free products if it was felt that we needed to stop prescribing some products.

SSh advised that currently patients are given a pre-printed sheet by the dietician which allows the patient to request items to be prescribed for them.

ID said that on reading the guidance from the coeliac society it is suggested that 1% of the population have coeliac disease at a cost of £520/patient/year, therefore, this could have the potential to increase prescribing costs.

IM advised that he had recently met with the dieticians and obtained a list of products which should be available to coeliac patients. It was highlighted also that there were products which weren't on the gluten free list which should be available to coeliac patients. They advised that patients should be tested to ensure an appropriate diagnosis has been made and then appropriate products can be recommended; patients should also be monitored on a regular basis.

PK queried if it was possible that there was a risk of the patient's condition not being managed correctly. ID suggested that now there are a significant number of gluten-free products available, it may be that patients are choosing to buy a wider variety of products than that which is currently prescribable. IM emphasised that there were

significant levels of gluten intolerance and undiagnosed coeliac patients in the community.
DR suggested looking at expensive prescriptions as a starting point and adding these to a grey list e.g. expensive breads and biscuits. LN suggested that patients could have a balanced diet without the need for prescriptions for bread, biscuits etc.

PK advised that DCLS patients liked and accepted the pilot scheme and added that pharmacies were currently undertaking a lot of work to find products for their patients which could be extremely time consuming, but allowed patients access to more interesting products.

IM advised that there is NICE guidance available on diagnosis and prescribing for coeliac disease, but it was felt that limiting the availability of products was a different matter with committee members suggesting dietician involvement.

SW advised that in Rotherham the budget for enteral nutrition and gluten free products was handed over to the dieticians to manage, could the APC support this? IM agreed that he would work with GC and the dieticians to move this piece of work forward. ID raised concerns regarding publicising or promoting the scheme as this could potentially increase costs.

IM informed the Committee that he was currently looking at other schemes which are in place throughout the country and to further meet with the Dieticians

Action: IM and GC to work with Dieticians and bring this proposal back to the D&T.

4.2 NPC Regional Meeting – Local Decision Making – Thursday 3rd March

ID invited all GP Prescribing Leads to attend this event in Newcastle, together with representatives from the Medicines Management Commissioning Team.

Action: HB to cascade the invite and booking information as soon as this becomes available.

5.0 ACTIONS TAKEN BY MEDICINES MANAGEMENT TEAM

Please refer to updated action log.

6.0 AGENDA

6.1 APC Update and Final Terms of Reference

HB informed the Committee that the first APC meeting had been scheduled for Thursday 10th March 2011 and will occur bi-monthly.

The schedule of dates for 2011 was included in the paper that was circulated for information, together with the final TOR.

HB advised, as the APC will be scheduled to meet on alternate months it was proposed therefore that the D&T meeting is also held on alternate months commencing with effect from 15th February 2011. Previously D&T meetings were historically not held during the months of August and December, however, it was agreed that meetings for August and December would be reinstated.

PK queried that if meetings were to be held bi-monthly that the D&T agenda would become larger than at present. ID informed the Committee that some D&T agenda items would move across to the APC agenda and the APC will produce a decision paper which will then in turn feed into D&T.

ID informed the D&T Committee that representation was required from the Primary Care and required nominees as per the agreed membership in the TOR to attend the APC meetings. The following membership was agreed:

Hazel Betteney, Senior Pharmaceutical Adviser, MMC as professional secretary
Geoff Crackett, GP Prescribing Lead (DCLS)
Satinder Sanghera, GP Prescribing Lead (Dales)

The above membership was agreed based on the fact that DN attends Sunderland D&T; PJ attends North Tees Hartlepool D&T; SSa attends TEWV D&T and GC attends CDDFT D&T. As TEWV and CDDFT will be represented at the APC, it was agreed that the obvious choice would be GC and SSa due to their established links with these trusts.

LN informed the Committee that a representative from Clinical Governance/Patient Safety had been requested via Debbie Edwards to attend the APC. ID questioned whether this representation was required and advised that he would liaise with Debbie Edwards and LN outwith of this meeting to take the discussion forward.

HB advised that an LPC representative was required to attend the APC and PK informed the Committee that this was for discussion as an item on the LPC agenda at their next meeting.

HB also advised that a NMP representative was required to attend the APC and that Sue Shine volunteered to fulfil this role. However SSh informed the Committee that the D&T would require a new member to represent practice-based NMPs at the D&T from April 2011.

Action: HB to advertise for a practice-based NMP representative for the D&T from April 2011

Action: SB to disseminate the dates and venues for the August and December meetings to the Committee

6.2 INR test strips

HB advised that this piece of work has been on-going for two years and is now complete. HB advised that there were a number of patients across CD&D monitoring their own INR, the arrangements for the management of these patients is not always clear and it was felt that some guidance was needed.

HB has developed guidance, based upon national guidance from the British Haematology Society in order to assure the safe management of these patients. HB welcomed any comments on the document prior to final cascade. LN queried whether the document should go through contracting first as it may result in double funding the management of some patients, HB advised that she will discuss with them prior to dissemination. Regarding those practices currently prescribing test strips, HB agreed to contact all surgeries on the list to ensure practices are aware that they have patients who self-monitor their INR. The Committee approved the INR monitoring guide for cascade and use.

Action: HB to contact contracting regarding potential impact on funding.

Action: HB to arrange dissemination of this guidance.

Action: HB to contact prescribers of INR test strips to highlight this prescribing to them.

6.3 QOF 2011/2012 and Prescribing Incentive Scheme

HB informed the Committee that one paper had been presented but had been divided into three separate parts.

QOF MMC targets

HB advised that as in previous years, there were potentially four QOF points available to practices for agreeing to work on medicines management indicators and a further four points for action within these agreed areas.

Previously education and audits were part of the QOF model, however this had proven to be time consuming and the team doesn't currently have the staff resource to support this work. The committee felt that the audits that have been undertaken in the past were useful and the NPC training has been excellent. LN added that the previous model had been shortlisted for an award and ID requested confirmation that it wouldn't be possible to go with the historic model which was popular amongst prescribers. ID requested confirmation from IM that there was

no funding and as the training comes from provider currently, who are moving over to the Foundation Trust , they may not able to guarantee their services. External trainers would entail even higher costs to what had been approved in the past.

Unfortunately due to the current constraints there were no staff resources or the budget to undertake the same model as had been arranged as in previous years. HB advised that the Medicine Management team had discussed the QOF targets recently and recommended that practices should choose two prescribing targets from a number of topics and as the third option, select from a number of medicines management indicators i.e. repeat dispensing.

ID asked whether the Non Medical Prescribers Conference could be used as an option as a compromise, offering funding in support and adding it as an option to QOF. It was agreed that Chris Williams would be approached by IM regarding the funding for the NMP conference.

SS asked whether wound management dressings and formulary could be part of the target areas for QOF, could the NMP conference target wound management?

Following the changes to the PCT in the future, moving over to GP commissioning, would this be what they require? LN suggested that members of the medicines management team could be trained as NPC trainers, but this would require funding. However, it was felt that this may not prove cost effective to undertake, especially if GP commissioners do not wish to support this service. ID felt that training was a useful way of engaging with prescribers. SSa suggested that to change the format this year would not mean giving up on the option, but potentially something to pick up at a later date. The committee felt that it should be acknowledged that the previous year's approaches had not failed in any way. The Committee felt that the NPC education sessions and the audits had been a success and requested that this this should be reflected and evidenced in this document. The Committee were reminded that the QOF agreement for 2011/2012 needed to be signed off before the beginning of the financial year.

PK thought that the repeat dispensing option was a great idea and also suggested to consider targeted MUR's as an option for QOF with practices signing up to support their local pharmacy providing this service. However IM advised that MURs will not be commissioned from MM and could potentially create extra work. HB suggested that there may be difficulties identifying which pharmacy could provide the service, it was felt that this was not an option for QOF at present.

ID felt that there needed to be clear targets and that targets needed to be measurable, how would waste and repeat prescribing be measured. HB advised that practices would be required to submit evidence of their revised repeat prescribing protocol or of the waste campaigns

undertaken. DR reminded the committee that this scheme was for a minimal number of points.

Action: IM to confirm that there is definitely no funding available for education sessions.

Action: IM to discuss with CW the possibility of linking QOF to the NMP conference.

Action: HB to update QOF paper based on todays discussions and bring to February 2011 meeting of D&T.

Prescribing Incentive Scheme

ID advised that if the committee wanted a prescribing incentive scheme, they needed to ensure that items weren't duplicated in the incentive scheme and the QOF targets. ID advised that Dinah Roy was in favour of a prescribing incentive scheme. DR queried how a prescribing incentive scheme would work if practices were only rewarded if the prescribing budget is underspent. IM queried where the money would come form if the prescribing budget was overspent, how would the cluster balance their books?

SSa had been speaking to some of the higher spending practices in the Dales who don't feel that there is a level playing field when budgets are set, they were concerned that expensive medicines had not been included historically. IM advised that budgets have been set on previous year's figures and therefore any historic spend on expensive medicines would have been incorporated.

DR queried whether it was the cluster or the practice that would need to be underspent. ID added that perception needs to change from practice to locality. DR advised that in Darlington they think collectively, rather than individually.

SSa raised concerns regarding how the prescribing incentive scheme would link up with the APC and with clusters. ID felt that there was no place at the APC, but that it does involve the clusters. SSa advised that currently Stewart Findlay decides with the practices what is done in the Dales; ID advised that the D&T acts as an advisory body to the clusters.

GC suggested that prior to spending time developing a prescribing incentive scheme, ID advised that D&T need to make the decision. IM added that the monitoring and target setting would need to be done centrally and the MM team would be unable to support 6 different schemes. GC suggested that therefore, would it be better to work on tools to support clusters coming in under budget rather than spend time developing this scheme at present. ID agreed that it may not be the

best use of time and resources focussing on a prescribing incentive scheme now, clusters could choose to do so if they wanted to.

Therefore, it was agreed that at present there would be no further work on a prescribing incentive scheme and that some of the ideas proposed could be incorporated into the QOF.

Action: HB to update the QOF paper with the options proposed for an incentive scheme and to present this to D&T in February 2011.

Grey List

In response to a number of requests for a countywide formulary, it was felt that a "grey list" may be a first step towards this. HB advised that she had reviewed a number of grey lists available nationally and listed all of the items covered as a first draft for the committee to consider. ePACT data had been prepared for those items that had not recently been targeted in CD&D.

It was proposed that once agreed, the grey list would go to the first APC meeting for final sign off across the whole health economy. Messages could then be added to ScriptSwitch indicating which items are "grey listed" as well as a hard copy of the grey list being sent to all practices. A tag could be set up on the ePACT system to monitor adherence to the grey list.

The committee agreed that a definitive list should be brought back to the next D&T for ratification; DR offered to support this piece of work and RP advised that she would discuss the mental health drugs with the TEWV D&T and share any feedback with HB.

HB also advised that in response to the data pulled from ePACT a memo regarding the prescribing of formula milk was issued, this memo then had to be amended due to queries from prescribers. However, it was agreed that this was an area of prescribing along with preparations for colic that required review and DR and Clare Lynch would be taking this piece of work forward. It was suggested that they should link with a health visitor and paediatrician.

Action: HB to work with DR to prepare a final version of the grey list to be brought back to February 2011 D&T.

Action: RP to discuss mental health drugs with TEWV D&T and feedback response to HB.

Action: DR and Clare Lynch to work with a health visitor and paediatrician to prepare guidance on prescribing of formula milk and preparations for colic.

6.4 Medicines Management Strategy

IM and ID gave an update on the development of a MM strategy. IM advised that they had utilised the NPC document looking at both the competencies and the key functions check list which states what the organisation required to deliver medicines safely and effectively. IM advised that they had worked through it in a check list form looking at the strategic overview and working through the aims to create local objectives. The idea of the document presented is that clusters can work through the document to determine what they feel is needed at what level e.g. North East wide, federation, cluster or GP practice level. The aim is that the summary of objectives will be used when looking at services for the future. Initially the aim is to agree with PBC chairs and prescribing leads prior to cascading to clusters. It was felt that it was a comprehensive document raising awareness within the clusters of the service areas that the MM team undertake and deliver. ID advised that the document has been shared with Dinah Roy and he is pending feedback/comments from her. ID is awaiting an invite to the PBC chairs meeting. SSa queried if it would be for clusters to decide what services were required, ID advised that the feeling from Dinah Roy was that it would be a bottom up approach from the clusters upwards.

PK queried if the organisation would be marked on this as the NOC document was a tick box document. ID advised that it was a competency framework which has been used as a framework for strategy development.

PK felt that the document covered work with GP practices well, but felt that the NPC document mentioned pharmacies which was not included in the strategy document. ID advised that the pharmacy contracting process now sits with the PCSA rather than the PCT.
PK stated that the PCSA were taking over national contract but the enhanced services would be for GP consortia to manage which has been missed from the strategy document. ID advised that he would try to address this and requested that PK put in writing what she felt had been omitted from the document but advised that they had tried to look at it from the perspective of the commissioning group.

PK queried why section 3 onwards of the NPC document was not included in the strategy document. IM advised that one part of the NPC document was a checklist and the other part was a competency framework, the document presented to the committee was the scope for a strategy.

ID advised that the original plan had been to get this document out to clusters by the end of January 2011. SW queried if some of this had already been agreed at SHA level. IM said that we can't factor this in at present.

It was agreed that the document should be submitted to clusters before the end of the financial year. IM requested that should anyone wish to

comment on the document if they would please provide the information in writing.

Action: Committee members to feedback any comments about the strategy document to IM as soon as possible.

STANDING ITEMS

7.0 FINANCIAL UPDATE

7.1 Monthly finance report

HB presented the finance reports for September and October and advised that November data had just come out and showed the overspend pulling in further. She advised that these reports were now being cascaded to GP prescribing leads as well as PBC chairs.

8.0 QIPP

8.1 ScriptSwitch Update

IM advised that DG is producing a comprehensive report on ScriptSwitch, including the outcome of the practice surveys for discussion at a meeting with GP prescribing leads on 1st February.

9.0 MEDICATION SAFETY & NPSA

9.1 Drug Safety Update

HB gave a brief summary of the December update and advised that the items weren't relevant to primary care this month.

9.2 NPSA – Medication Loading Doses

LN gave an update on the NPSA medication loading doses rapid response report (2010/RRR018) that was released in November 2010. She advised that the alert mainly applied to secondary care, however, the alert sought to ensure that primary care clinicians including community pharmacists challenge any abnormal doses with the prescriber.

LN has developed a patient safety warning to go out with the rapid response alert. LN requested D&T to ratify the critical list and recommended doses over which pharmacists and GPs would challenge. The document was presented as final draft to D&T for ratification prior to cascade via the CAS system. The wording in the warfarin section required minor amendment. PK queried if 200mg amiodarone was too much for the elderly, LN advised that this was intended to be a guide as to which does to challenge.

GC queried if pharmacists can flag up on their computer systems any doses that have been queried in the past in order that they don't query the same doses constantly. PK advised that it was possible but not always done. LN advised that the document would be mentioned at the next LPC meeting. The document was approved by the committee.

Action: LN to arrange for cascade of the document via the CAS system.
Action: DG to add the document to the Medicines Management website.

9.3 Lithium Update

LN informed the Committee that she has been working with TEWV to review the processes around lithium prescribing and how patients are initiated and monitored. A pilot was established in Middlesbrough and also in other areas and soon would be rolling out in CD&D. LN advised that she had met with ID and JS and asked for amendments to the proposed letters.

LN advised that there were two aspects to highlight – no standardised format for consultants when communicating with GPs and pharmacists. The most important aspect is the Lithium hand held records which LN requested should not be sent to GPs until the roll out was complete.

All patients registered in secondary care will be issued with a booklet and a database of patients held for checking purposes. TEWV FT have now given approval to disseminate these booklets to GPs and Community Pharmacists, these can then be issued to those patients no longer managed by secondary care.

DR queried why the pathway provided references Middlesbrough, RP advised that this was the pilot and would be revised to contain local information as it is rolled out.

ID highlighted that the Algorithm had not been amended, querying the abbreviation TSU, it was felt that the required monitoring should tie in with the PCT monitoring guide.

LN handed out some booklets at today's meeting for review and advised that a label has been attached to the front of the booklet detailing the medicines helpline information for patients. LN requested that if anyone had any booklets without this information attached, they be returned to her for this to be done.

GC advised that he had recently had a patient within his practice on lithium with a level of 1.2 on a Friday night and informed LN that the on call number was unable to offer any advice to the GP, it was a senior registrar rather than a consultant on call, the process wasn't very clear and that the outcome was that the patient was sent to casualty. These

revised processes have started to roll out across CD&D from January 2011. It was agreed that the information should be added to the medicines management website.

Action: LN to make requested amendments and forward the Lithium Guide to DG for addition to the Medicines Management website.

10. PROVIDER DRUG AND THERAPEUTICS COMMITTEE

10.1 Update from Sunderland CHFT D&T – 10th January 2011

This update was deferred to February's meeting due to the absence of DN.

10.2 Update from North Tees and Hartlepool FT D&T – 14th January 2011

SP attended this meeting and provided information to be fed back to the committee by HB. HB advised that Gravax had been approved for the treatment of children with moderate to severe grass pollen allergy (hay fever) who have failed standard medical therapy; prescribing was limited to one consultant. Fluticasone Furoate (Avamys) nasal spray was added to the formulary second line to beclometasone.

10.3 Update from County Durham and Darlington FT D&T – 8th December 2010

HB advised that this meeting had been held as a telephone conference – a number of items were discussed, it was agreed that dermatology specials and the transfer of prescribing document should be discussed at the APC.A number of items were deferred until the next meeting as more information was required. A guideline on the management of recurrent UTI is to be discussed at the PCT D&T in February.

10.4 Update from Tees Esk and Wear Valley Mental Health Trust D&T

No update this month – next meeting 27th January 2011.

10.5 Community Health Services Medicines Management Committee

There was no update this month.

11.0 RDTC UPDATE

11.1 Horizon Scanning Document – December 2010 and January 2011

SW advised that she did not have a work plan to cascade at present but in summary the RDTC were working on the following documents– new drug evaluation, anti-platelet for acute coronary syndrome, a briefing document for self monitoring of blood glucose products with associated stakeholder report, an update on insulin analogues, a "hot

topic" document on prasugrel and also some detailed documents on specialised commissioning and cancer products. She also advised that a cost trend report on ezetimibe products would be circulated and an analgesic therapeutic report is in production as this is an area of significant cost growth. SW advised that a report on quinine had recently been cascaded. SW requested that if any committee members require a document to be produced for any topic, they liaise directly with SW.

11.2 QOF Report

Due to time constraints the report was deferred to February's meeting. SW informed the Committee that she would not be attending the February meetings and will forward some narrative directly to HB.

12.0 PRESCRIBING UPDATES

12.1 Drug and Therapeutics Bulletin

HB briefly summarised the December and January bulletins. DR advised that he cascaded to all of prescribers and suggested it should be cascaded in all localities.

It was agreed that insulin prescribing should be reviewed at the April meeting of the D&T looking at the DTB recommendations. The committee also felt that a search should be carried out on topical antibiotic prescribing with advice issued in accordance with the DTB and local guidelines.

Action: HB to request a report on insulin prescribing and agenda for April D&T.

Action: HB to arrange for the data on topical antibiotics to be reviewed and advice to be issued via the next prescribing matters newsletter.

12.2 New Drugs & Products and NETAG recommendations

NETAG met on 18th January 2011. ID updated the committee on the outcome of this meeting as follows:

Adacolumn for inflammatory bowel disease was not approved.

Dabigatran for atrial fibrillation was approved only for patients in whom warfarin is contraindicated or in patients who have failed to demonstrate adequate anticoagulant control based on a threshold of time-in-therapeutic range (TTR) 50% after a defined period of warfarin therapy. Warfarin remains the treatment of choice for AF in all other cases. It is estimated that this could cost £1.5 million in the first year.

aVEGF (bevacizumab or ranizumab) for macular oedema secondary to retinal vein occlusion was reviewed, Bevacizumab (Avastin®) 1.25 mg using a 'when required' (PRN) regimen is recommended for use within NHS North East in the management of macular oedema secondary to retinal vein occlusion. However, this was on the understanding that aVEGF was not funded previously by chief executives as they were awaiting NICE guidance.

ID also advised that NETAG have agreed that they need to review terms of reference.

12.3 NICE Guidance

HB provided a brief overview of these papers, advising that the most pertinent piece of guidance was issued in December around antiplatelet prescribing. This impacted on the PCT antiplatelet guidelines and it was agreed that these needed to be updated to reflect the change.

Action: HB to ask for these guidelines to be updated by Stephen Purdy

13.0 NON MEDICAL PRESCRIBING

No update this month.

14.0 PATIENT GROUP DIRECTIONS

There were no updated PGD's.

15.0 QOF QUARTERLY UPDATE

This item was discussed within the main agenda.

16.0 MEDICINES MANAGEMENT TEAM UPDATE & PUBLICATIONS

16.1 Prescribing Support Update - bimonthly

IM handed out a schedule form practice cover in all localities to GP prescribing leads. IM informed the Committee that DCLS had been allocated an extra half day session to catch up on the backlog of work due to their reduced cover in recent months and therefore have been allocated 5.5 days rather than the 5 days allocated to all other localities. This will be reviewed if and when further capacity becomes available. IM also advised that Easington had 0.75 days of unallocated cover to mop up work as and where needed.

IM requested each of the GP prescribing leads check their locality prior to further cascade which will be via email, he also advised that different localities had chosen to utilise their allocated cover differently,

with some covering all practices and others having specific hot spot practices.

Action: GP Prescribing leads to confirm with IM that their locality cover is correct.

17.0 PBC PRESCRIBING LOCALITY UPDATES

17.1 Darlington Locality Prescribing Group – 14th December 2010

This update was received by the committee for information.

17.2 DCLS Locality Prescribing Group –7th December 2010

This update was received by the committee for information.

17.3 Derwentside Locality Prescribing Group – 21st December 2010

This update was received by the committee for information.

17.4 Sedgefield Locality Prescribing Group – 14th November 2010

This update was received by the committee for information.

18.0 ANY OTHER BUSINESS

HB advised that SP and CL are currently updating guidelines on osteoporosis and pain management, and requested an extension be granted for the expiry date to April 2011, this was agreed by the committee.

19.0 DATE AND TIME OF NEXT MEETING

Tuesday 15th February 2011
Merrington House
12.00 – 2.30 pm

Confirmed as an accurate record:

Name:

Dr Ian Davidson - Chair