

MINUTE

A meeting of the Area Pharmaceutical Committee held on
Tuesday 28 October 2025 at 18:15 – 19:45; via Microsoft Teams

Item	Detail	Timescale
1	<p>Welcome: MOD welcomed all present to the meeting.</p> <p>Present: Martin O’Dwyer, Chair, Community Pharmacist (MOD); Malcolm Clubb, Director of Pharmacy (MC); Kyna Harvey, Clinical Pharmacist (KH); Jacob Hetherington, Community Pharmacist (JH); Jillian Kerr, Community Pharmacy Technician; Keith Maclure, Lead Pharmacist – Medicines Utilization (KM); Cathryn Park, Interim Lead Pharmacy - Primary & Community Care; George Romanes, Community Pharmacist (GR); Theresa Thorburn, Community Pharmacist (TT); Paul Young, Community Pharmacist (PY).</p> <p>Apologies for absence: Gareth Cook, Community Pharmacist (GC); Holly Hamilton-Glover, Contracts Manager P&CS; Kate Warner, Meeting Administrator (KW) – meeting to be recorded.</p>	
2	<p>Draft Minutes from previous meeting: -</p>	
2.1	<p>Draft minute of the meeting held 22 July 2025 was approved as an accurate record of the meeting with no changes.</p> <p>ACTION: Remove draft and save. (KW)</p>	
3	<p>Matters arising from previous meeting (not covered in meeting agenda): -</p>	
3.1	<p>None.</p>	
4	<p>For Discussion/Approval/Action: -</p>	
4.1	<p>Launch of private (non-NHS) prescribing call for evidence - The UK governments Department for Health and Social Care have launched a UK-wide call for evidence on the topic of private (non-NHS) prescribing. This call for evidence is now live and will remain open for 12 weeks, closing at 23.59 on 4 November 2025. Respondents are encouraged to consider the call for evidence page and share views and / or evidence using the online survey. Responses are welcome from individuals and organisations. The attached has been forwarded to yourself as an interested stakeholder. KMacl spoke to this request to ensure private prescriptions are being dealt with in the correct manner. MC commented on recent weight loss drugs and the pressure on the NHS to support patients who are passed to them when the treatment results in hospitalisation or further consultation required by medical practices. Also commented on private prescriptions, for example for ADHD, without any shared care. If medicine/treatment requires shared care then it needs to be an additional service and systems put in place. Community pharmacy dispensing – how do you do due diligence on if it is a legitimate prescriber and prescription? Fake prescriptions are circulating to add to the concerns. It is more difficult when you don’t know who the prescriber is when they are not local GPs. These are some of the areas we need to think about and respond to. APC agreed with these comments and the scale of the work involved with just weight loss drugs and its subsequent costs. This is something that the Board needs to address and provide clear guidance. MC commented on the Private Prescriptions Policy which has been approved by Board recently and he gave examples of content and circumstances for GPs to advise or not, to take on</p>	

	<p>prescribing or not. If shared care is required then GPs can refuse to take back the patient under their care. APC noted that NHS will outsource in specialities that have large waiting lists, but these patients are referred back into NHS care and for travellers from abroad visiting Scotland and requiring care. National guidance was questioned as this is an increasing situation for Boards – this has come from previous national guidance and now has gone through committees in NHS Borders.</p> <p>ACTION: Share the policy with all (MC→KW).</p> <p>ACTION: Draft response and share with APC to send an APC response (MC).</p>
4.2	<p>APC reviewed the Invest to save – increase Homecare capacity business case. KH provided background to this service at NHS Borders and the newly developed IT system designed to improve facilitating the service as well as governance. Since then, there has been an increase in the number of drugs by 13 and increase in patient numbers by almost 40% in 18 months. Homecare system has many advantages including cost efficiency and getting drugs directly to patient’s homes. The business case has been approved by Pharmacy Senior Management Team, Medicines Resource Group and, after review by APC, will go to Financial Improvement Programme group for approval and funding. The request is to increase staff capacity from part-time to a full-time Band 5 and a full-time Band 3; this will give cross-cover during periods of leave. APC supported this business case going forward.</p> <p>ACTION: Take business case forward to FIP (KH).</p>
4.3	<p>APC discussed the procedure for emailing clinical queries for hub and GP practices; MOD had asked if a traffic light system be put in place for answering queries, for example, red answer ASAP same day (patient needs urgently); amber next working day; green non urgent but needed within 3 days. CP gave APC an update on the Pharmacy Hub and a concept of volume of work. Busy summer and reflected on that and how much the workflow was affected by leave etc or was true workload. To put this into context, today 800 workflow items came into the Hub for a team of 6-7 members of staff. Prioritising is difficult as items come in, and we are trying our best. When the Hub was set up the priority of the workflow was to sort out discharge letters first, followed by clinic letters. There are clinic letters coming in which may be ten days old to turnaround and we are reviewing how we can work on this going forward. Every practice sending in urgent workflow –can be 100 pieces of work coming in. CP is not dismissing the idea of a traffic light system, but we have been telling the practices that if something needs dealt with same day or next day then it has to be dealt with in practice by either a GP, duty doctor or practice pharmacist. There is a challenge of remote hub that work is pushed our way without those sending it understanding what is happening in the hub. There is a RAG system in play so that we can email practice managers for awareness. Two new pharmacy technicians have been recruited recently, currently undergoing training and we have pharmacy support workers who are really well trained for simple clinic letters and reconciliation. The workflow is coming in too fast, and we are taking a step back to see what we can do. Practices and pharmacies need quick answers, and we do need to look at prioritisations as we receive some information but don’t know all of it until the technicians call the patients. The team are working incredibly hard, but we are reaching a point of picking up urgent work being a challenge. MC echoed this. Solution would be more staff as there is no quick electronic communication for this coming from the hospital. The team see 10-15% of letters, often drafts, have errors so they cannot be processed quickly. Scenario discussed. Fixed pool of money for ANPs, Physios, and the original Pharmacotherapy budget has been trimmed down. Tackling waiting lists has been a welcomed priority recently but extra operations mean extra discharge letters, but no resource given to increase that workload. Fixed pool of money and 60% more workload than in 2023; when the team were originally in practices they would have done workload there on that day, now they are in the Hub it keeps coming in from all practices all the time. Standards are set, for example processing an iDL in 48 hours – achieving at 90% before summer, now about 70%. We were not expecting 250 Mounjaro letters a week adding extra medicines reconciliation to the team. E are now receiving the Mounjaro to Wegovy switch letters – unexpected workflow that wasn’t in the capacity model. Recently we started receiving death certificates and sick notes in the Hub; work from GP Practices is not being streamlined and we have tried to request no acutes, but we receive acutes – there is no filter and once it is the queue the team still have to go through it all</p>

	<p>and deal with it even if inappropriate. TT asked - can we put a request in and ask for it to go to duty doctor and not the hub – MC replied that this could go to the practice pharmacist if they are in but not straight to doctor as this may not be appropriate for the practice. JH spoke about any query that has the word medication on it goes straight to the Hub even if that is not appropriate and a more urgent response is required. Is there some way of this changing that would benefit all of us. CP replied that some scoping work is planned to find a way to unpick this at a local level. Lead technicians supporting practices with education on workflow and sort out at ground level where that is required and we can identify issues. MOD asked about other Boards and their work. He commented that it is frustrating as patients are looking for answers and the same prescriber who had the interaction with the patient should be the one to respond. Practices are reducing their own workload, and they have to remember there are patients at the end of this. If community pharmacist can do some element of traffic lighting for themselves then we could maybe know that GP practice needs to deal with. MC noted that there is a need to recognise workflow that is inappropriate. Other boards only deal with iDLs. HIS demonstrator sites (we are one) has compared other demonstrator sites' workflow to Hubs – most are around 20% and NHS Borders is 80% - completely different. Possibly, we took on too much in the Hub after the change to the service when staff were in the practices and the efficiency we anticipated for the Hub. Difference in volume was not expected. Traffic light system is a good idea, but the days suggested are unrealistic. We also have to set patients expectations as they don't always understand the volumes and system pressure. Merit in discussing this further after the work CP is doing to review this. GR asked if someone more senior could deal with this? MC spoke of the GP contract 2018 – all acutes, repeats, meds recs included in this task based contract that are meant to be covered by Pharmacotherapy. We are covering more than we ever did before, however it was noted during the week of care that we are not covering all the acutes and repeats - if GPs signs then they have dealt with it. We have to unwind the political rhetoric around task based contract to one where we add value – polypharmacy and med reviews would be adding more value. MODs patients ask why patients haven't received tests and check and MC replied that there is no requirement for GPs to deliver this as there is no incentive around these checks. Some practices have carried on providing this for patients, and others have chosen not to and contractually they don't have. In summary, this will be taken forward by CP to work with the team to review; and asked contractors to get in touch if any local issues – this would be helpful feedback as taking a step back is not an easy thing to do. APC noted this.</p>
4.4	<p>APC discussed the procedure for sending scripts as emailed images of a script - scanned or photo often sent from clinicians' phone. Is there an easier way to do this - a proforma email form that gets filled in in the body of the text of an email; to save photos and scanning. It would allow stock to be ordered at least, and contractors would know then to look out for the script. KH commented that the mental health team will email a practice if they want an urgent prescription done and she suggested asking them to cc in the pharmacy as opposed to taking pictures and sending. It would be via emails form NHS Borders. MOD replied that it can be different depending on clinician – KH will go back to them with a change of practice as community pharmacies can order stock from the email at same time as it goes to the practice and not wait for the photo to be sent. JH commented – emails from CAHMS – happy to dispense ahead of script for some medication but concerned about typos on form and stock is ordered incorrectly. Seeing prescription on screen means you can validate it. This is quick from the clinician and is available to send via a device. Useful if APC asked for electronic solutions from secondary care to be part of this solution – it is important in secondary care as well to write blue scripts rather than emailing the practice. KMacl commented from a governance perspective – you do want an image of the original not transcribed - if sent electronically then it can be traced back more quickly.</p>
5	Regular Updates - for review and discussion: -
5.1	<p>Efficiency Programme – KM updated APC on the financial improvement programme and will forward a paper for that to members of APC; reviewed the projects recently worked on, just about to finish and those planned for quarter 3. Dapagliflozin will consume the team until nearer to the end of the quarter. Important for pharmacists to be able to work through the stock and patients will be made aware. Cyanocobalamin moving from oral to injection and will be in done in conjunction with CTAC team. APC noted this update.</p>

	ACTION: Forward efficiency papers to APC (KMacl).
5.2	Serial Prescribing – KMacl updated APC that the numbers are steady and there are specific practices that are increasing and have a clear uptake trajectory; there are three major practices declining at the same rate and overall, the increase is flat. Looking at putting in extra support for the practices requiring this after working out the narrative of why this is decreasing. Plea to community pharmacy is to put the claims in – not the TSRs but the claims - as these are not being paid and so are not showing in the data. This would make the project more stable and the more traffic, the more business as usual it will become. TT asked if they could see data by practice and KMacl will send this to APC members. APC noted this update.
5.3	Pharmacotherapy Project most included in update above. MC gave an update on the Community medicines monitoring team – part of demonstrator site bid – look at taking on prescribing and monitoring for some of the high risk medicines. Medication that requires routine monitoring. System in place to do this monitoring on behalf of GPs and we have pharmacists, support workers for this. We can request bloods through CTAC and make recommendations. Test of change has been done with Mesalazine in Kelso practice, then Peebles, and further roll out from there practice by practice. Bloods are prebooked and patient can phone CTAC to make appointment; once content we can use a serial prescription for ongoing care and include other medication on this. They can print prescription in the Hub to send to community pharmacists. Patient numbers are not huge so far. We want to get more complex medicines, those that need more frequent monitoring. Progress is being made. APC noted this update.
5.4	Pharmacy First Plus – MC updated that there are no more new sites; not sure if there are anyone starting training soon. No increase in numbers; patients are used to pharmacists being able to do more. GR reported he has two members of staff who have started on IP course in Romanes. From their perspective there is an increasing demand as it is easy for patients to access pharmacists that are prescribers – the danger is having to consider limits or appointment system as there can be a queue to see the pharmacist with the daily business still to manage. MOD echoed this from own perspective; level of consultation frequency has increased, weekends are more difficult as some patients don't want to go through the triage at surgery and hoping to circumvent this. APC noted this update.
5.5	Care Home Service – MC reported that the LES is still in place and being followed by visits which produces useful information. Good wrap around care in place with GP enhanced service in place. Comment from Geriatrician consultant that prescribing in care homes and polypharmacy reviews had improved over recent years with better standardisation evident. Frailty pathway being followed and the Board appreciates the work of community pharmacies in this. APC noted this update.
5.6	Palliative Care Service – introducing an extra site in Galashiels, Farrens, this is a reflection on hospital outreach / hospital at home, and it is important to have an extra pharmacy in Galashiels especially on a Saturday. MC will report from the palliative care clinical strategy meeting. APC noted this update.
6	Secondary Care Update: -
6.1	Secondary Care – KH reported on the new aseptic unit which is due to be delivered mid-December and should be operational by February after a commissioning and handover phase. Switching from Dalteparin to Enoxaparin from 1 st December for the treatment of DVT and prophylaxis and KH has been reassured that there are not many community patients getting this. If on Dalteparin in community they won't be switched it is more when they come into hospital changed to Enoxaparin due to a contract change; we need to change to stay in line with NHS Lothian. Getting to end of service review and will announce to team soon; new structure will come out of that. Three more band 6s recruited recently and band 2s in place and we almost have a full team. There are vacancies out for Frailty and Mental Health pharmacists. Lead Clinical Pharmacist is leaving in January and this will leave a big knowledge gap particularly in paediatrics, women's and children's, obstetrics and

	neurology so if you have queries in those areas please bear with us if we require help from elsewhere. Patients on Valproate for Neurological conditions will be getting a letter soon with more information about MRHA guidelines and will be seen by consultants in a special clinic. They should continue with prescribed treatment until being seen in clinic. Encourage patients to attend and contact us with any questions. Secondary care savings so far are around £550,000 with homecare and contract switches and another £5-600,000 planned for the next 6 months. APC noted this update.
7	IM&T Updates: -
7.1	ProScript issues no update and can be removed from the agenda. ACTION: Remove item from the agenda (KW).
8	Items for inclusion in update to Area Clinical Forum → Feedback to NHS Borders Board
8.1	MC commented on Area Clinical Forum and he and KH attended to discuss the clinical strategy. Key piece of work with lots of meetings coming up for engagement. Pharmacy wants to have a say in each speciality. MC proposed that ACF works better; the Delivery Group within the organisation is a decision-making, clinically led group which has member that are 50% clinicians and 50% managers. ACF discussed that papers which usually go to Delivery Group could go to ACF first to be discussed out with peers as papers are often written in silo and this would allow wider discussion. So, there is an opportunity for ACF to express their views clinically, on risk and so on, before they go to the Board. This will be helpful when we come to take papers, for example HEPMA, forward and get backing from ACF. This would make ACF more relevant. There were no independent contractors there because of the time of the meeting and it was discussed to change the time to lunchtime. Papers can be brought here to APC and then escalate to ACF. Items for inclusion to Area Clinical Forum -
9	Information for Noting
9.1	None
10	Prescribing Data for Noting: -
10.1	UCF - Community Pharmacy Activity Data available at nhsborders.scot.nhs.uk/patients-and-visitors/our-services/pharmacies/community-pharmacy/community-pharmacy-activity-data/
11	NHS Circulars for Noting: -
11.1	NHS Circulars issued to Community Pharmacy; forwarded to all CPs as available are at https://www.cps.scot/latest-sg-circular
12	AOCB:-
12.1	Dispensary email – some are not manned and KH to check the automated message to refer pharmacies to the correct place.
12.2	Out of Hours – application from George to amend opening hours in Coldstream, change from current 08:45 – 17:30. GR keen to close at lunchtime as there are staff issues in the store. Hoping this is for a short period of time but currently struggling with staff levels and making sure safe and secure. Permanent change – to a change of hours to include a break at lunchtime from 1 st December 2025. APC approved this change.

12.3	Letter from Health Improvement Scotland – safety of GLP1s; unintended exposure to pregnancy. Gall bladder issues have presented at BGH and there have also been news of illegal online selling of this drug, and this alert identifies how they may be presenting. First of a series of safety briefings but not sent to Directors of Pharmacy. Link excludes providers and MC will ask questions on both these points as well as how it is known who the prescribers are. APC agreed this was useful information but missing in some areas.
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Date of Next Meeting: - Tuesday 27 January 2026; 18:15 - 19:45 via MS Teams