

NHS DORSET CLINICAL COMMISSIONING GROUP

DRAFT

Minutes of the meeting of the Medicines Optimisation Group held on **Tuesday 5 December 2017, 9.30am at Meeting Rooms 13 & 14, Vespasian House, Barrack Road, Dorchester, DT1 1TG**

Present:	Dr Paul Mason (PM)	GP Locality Lead, NHS Dorset CCG (Chair)
	Dr Chris Barringer (CB)	GP Locality Lead, NHS Dorset CCG
	Lucie Barton (LB)	Pharmacy Technician, NHS Dorset CCG
	Ian Gall (IG)	Patient and Public Involvement Representative, NHS Dorset CCG
	Sue Howshall (SH)	Patient and Public Involvement Representative, NHS Dorset CCG
	Dr Diana Gannon	GP Locality Lead, NHS Dorset CCG
	Katherine Gough (KG)	Head of Medicines Optimisation, NHS Dorset CCG
	Dr David Laird (DLa)	GP Locality Lead, NHS Dorset CCG
	Dr Daniel Lee (DL)	GP Locality Lead, NHS Dorset CCG
	Dr Liz Long (LL)	GP Locality Lead, NHS Dorset CCG
	Dr Alistair McPhail (AMcP)	GP Locality Lead, NHS Dorset CCG
	Dr Ian Platt (IP)	GP Locality Lead, NHS Dorset CCG
	Dr Clive Quinnell (CQ)	GP Locality Lead, NHS Dorset CCG
	Lorette Sanders (LS)	Locality Pharmacist, NHS Dorset CCG
	Dr Kathy Scott (KS)	Locality Pharmacist, NHS Dorset CCG
	Vanessa Sherwood (VS)	Senior Pharmacist, NHS Dorset CCG
	Dr Rob Timmis (RT)	GP Locality Lead, NHS Dorset CCG
	Michelle Trevett (MT)	Senior Pharmacist, NHS Dorset CCG
	Richard Wakelam (RW)	Deputy Head of Finance Reporting and Management Accounts, NHS Dorset CCG

In attendance	Lauren Parkes	PA, Quality Directorate, NHS Dorset CCG (Minute taker)
		ACTION
1.	APOLOGIES FOR ABSENCE	
1.1	Apologies were received from Dr Simon Brown and Dr Andrew Purbrick.	
2.	INTRODUCTIONS AND DECLARATIONS OF INTEREST	
2.1	Introductions took place across both sites with the new lay member for Patient and Public Involvement, Sue Howshall, welcomed to the meeting.	

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	KG informed the group that as from March 2018, Dr Rav Ramhotal from Highcliffe Medical Centre would be the new MOG Chair, but was unable to attend this meeting.	
3.	DRAFT MINUTES OF MEETING HELD ON 26 SEPTEMBER 2017	
3.1	<p>The minutes of the meeting held on 26 September 2017 were approved as an accurate record subject to the following amendments:</p> <p>Under 5.9 – four practices have applied for more practice pharmacists, but still have not received feedback from Weymouth & Portland regarding their funding.</p> <p>Under 5.10 – there was a typographical error – to be amended to read “diabetic” rather than “dietetic”.</p>	
4.	MATTERS ARISING	
	Action plan	
4.1	Item 6.12 - resource packs to support practices with the medicines measures had been updated to meet the new standards. These to be circulated.	KG
4.2	Item 6.14 – the link to the location of the GP Bulletin had been circulated.	
4.3	Item 6.21 – STOPP/START tool – this had been discussed at the last IT group and more information is being sought.	
4.4	Item 6.25 – there was no update on the possibility of pop-up for flu-like illness symptoms an update will be provided to next meeting.	
4.5	Item 7.4 - Working group GP representation – it had been identified that the main gap in representation was in the Rheumatology Working Group. In light of this, the next meeting would be held in June next year. PM offered to attend in June.	MT
5.	PRESCRIBING FINANCE REPORT AND FORECASTS <ul style="list-style-type: none"> • performance on prescribing practices and locality- month 5 • Locality Prescribing Report 	
5.1	<p>Performance on prescribing and forecast</p> <p>It was noted that the overall prescribing forecast was for a significant overspend. This was due in part to the NCSO market shortages and price concessions. Assurance was provided that NHS England and Department of Health are fully aware of the impact.</p>	

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5.2	The list and cost of drugs published in November, through the NCSO, may rise. Two examples were Olanzapine and Pregabalin, although Pregabalin became generic, the price immediately rose in the NCSO lists.	
5.3	The cost pressure has significant implications for the CCG and the local health system.	
	Locality Prescribing	
5.4	Members were asked to note the report.	
5.5	GP members raised that there were barriers with time and effort for individual practices to achieve savings, specifically with resource.	
5.6	With regard to stoma ancillary products, GPs felt there was no real expertise in primary care to make any changes, with practices having to rely on the stoma nurses. It was pointed out that the ancillary list had been produced with the stoma nurses. It was noted that these are ancillary products and not products directly used to manage the stoma, e.g deodorants, which should be more acceptable for switching to more cost effective products.	
5.7	According to Q2 data, the area of the savings plan with greatest potential for change is emollients. There was concern raised by some GPs that this would cost practices time and resource with no real gain, only for the CCG. Others had successfully made changes which had been well accepted by patients. Assurance was provided that the Dermatology working group was reviewing appropriate emollients, especially within care homes and will continue to highlight the first-line products to secondary care.	
5.8	A query was raised regarding diabetic blood glucose monitoring sticks for patients with Type 2 diabetes. Within the report it did not suggest looking at cost savings for Type 1. Clarification was sought on whether it would remain as an initiative for Type 2's only. A suggestion was put forward for this to be made clear within the InFocus document. VS agreed to check	VS
5.9	All practice visits have now been completed, and Practices have agreed dates for actions to be completed by and forms to be completed and returned by the agreed date. Actions agreed at previous visits will be checked and progress reviewed as data becomes available.	
5.10	Discussion took place as to whether there should be some level of administrative resource within the localities for GPs for making these changes. RW agreed to liaise with the primary care team regarding financial implications.	RW

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5.11	After some discussion, it was proposed that Finance would review the possibility of admin support depending on contracts, and locality groups would undertake general discussions on what are priorities. Feedback would be given at the next meeting.	
6.	PBR AND EXCLUDED DRUGS REPORT	
6.1	A brief update was provided on the PBR and Excluded Drugs Report.	
6.2	It was noted that for the three acute Trusts in Dorset, there was a variation in current spend against predicted at month 7. Poole were underspent to date, with RBH and DCH slightly overspent, which is of concern. This is not a cost pressure for the CCG as the budgets are within the financial envelope of the Trusts.	
6.3	GP members enquired why there was less control for out of county providers, which included Salisbury and Yeovil. It was clarified that this was due to different contracting mechanisms and not being lead commissioner.	
6.4	A biosimilar framework has been published to ensure high uptake of biosimilars for new and existing patients. The CCG will be giving assurance of plans in place to NHS England.	
7.	REPORT – HEAD OF MEDICINES OPTIMISATION – FOR NOTING	
7.1	Members were asked to note the report.	
7.2	The group was informed that Dr Forbes Watson, Chair of Dorset CCG, had suggested that a member of the CCG Governing Body be appointed as MOG Chair. Therefore, Dr Rav Ramhotal, who is also the clinical chair for Christchurch, and works at Highcliffe Medical Centre, will take up the role in 2018.	
7.3	Due to clinical commitments, this means that meetings will need to be moved to a Wednesday from June. There was considerable discussion around this as members had set commitments in practices and a number would be unable to attend. KG agreed to take this forward. TOR to be updated	KG
7.4	It was further noted that the Medicines Question query answering service was being audited, due to significant increases in numbers of queries received. GP members suggested that this was due to the value prescribers get from the service.	
7.5	Members were made aware of a variance in the referrals to the familial hypercholesterolaemia clinic and suggested it could be due to geographical awareness and the clinic's location, and the use of different laboratories and reporting, with laboratories in the West	

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	directing GPs to Dr Olufadi's clinic. This would be fed back to the cardiology group.	VS
8.	ANTIMICROBIAL STEWARDSHIP REPORT	
8.1	Members were asked to note the report.	
8.2	One of the key areas of Regional Medicines Optimisation Committee (RMOC) work that had been identified was that of antimicrobial resistance (AMR) in both primary and secondary care. GP prescribing measures used in primary care were shared with Trusts. Minutes of the last RMOC group meeting would be available on the link outlined in the report. A further meeting was scheduled in the south for the end of January.	
8.3	The antimicrobial stewardship working group has agreed to focus on both UTIs and <i>E.coli</i> next year. Pilot work is planned for the East Dorset locality.	
9.	MEDICINES SAFETY OFFICER (MSO) REPORT	
9.1	Members were asked to note the report.	
9.2	The report mentioned the latest Drug Safety update which includes information on quinine, which should be prescribed with caution. Appropriate prescribing of quinine is one of this year's prescribing safety audits.	
9.3	Importance of recording actions after a MHRA or other alert is received by practices affected, was emphasised, following discussion with the CQC at the Dorset MSO meeting. It was noted that the CCG have a system for recording alerts on a spreadsheet, and there was discussion about whether this would be useful to send to GP prescribing leads. However, the responsibility would still lie with GP practices to ensure that all alerts are received and actioned but this could act as a summary/back-up document.	
9.4	The group heard details of drug related deaths in the county and that often patients were prescribed several psychoactive drugs. It was agreed to bring the DRD CIP annual report to the next meeting for information. Confirmation was provided that Oramorph Oral Solution had been included in the CD profiling tool so that practices could be contacted directly if it appears there is prescribing of large quantities.	KG

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10.	DORSET MEDICINES ADVISORY GROUP UPDATE (DMAG)	
10.1	A brief update was provided given the length of the report. The DMAG met on two occasions, one in September and one in November, to consider the Dorset formulary, interface issues and NICE TAs.	CB
10.2	<p>CB raised some concern regarding the ascorbic acid letter template which was still being referred to GPs from local Trusts about prescribing. He agreed to forward a copy to KG as this should be challenged.</p> <p>Post meeting Note: we have had confirmation from RBH that the recommendation to prescribe ascorbic acid has been removed from the letters.</p>	
11.	POLYPHARMACY UPDATE	
11.1	Members were asked to note that the Polypharmacy Working Group met in November where it was agreed that mapping of the current pathways and referral criteria to access a polypharmacy review at any of the local Trusts should be undertaken, as there was evidence that reviews vary across the county with referrals not clear.	
11.2	A number of work streams had supported the need for the group to meet including level three medication reviews within the frailty service specification for GPs and the polypharmacy comparators on epact 2.	
11.3	A video named "Meet Mo" had been released by Wessex AHSN to support communication. The video contained footage of a patient's experience of polypharmacy prescribing.	
11.4	A suggestion was put forward to consider four of the polypharmacy comparators as a potential audit, and it was agreed to further discuss this under the agenda item.	
11.5	Members were happy to approve the considered actions and indicators outlined within the report.	
12.	MEDICINES IT GROUP PAPER AND ACTION PLAN	
12.1	Members were asked to note the report.	
12.2	It was highlighted that there would shortly be a pop-up alert on the high cost of liquid nitrofurantoin.	
13.	PROPOSALS FOR AUDITS	
13.1	Members were asked to note that it was proposed that audits be derived using the polypharmacy comparators in EPACT 2 data, including age and number of medicines.	

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13.2	It was noted that there were still a few practices had audits outstanding.	VS
13.3	The group were asked to consider anti-cholinergic burden and DOACs as possible topics.	
13.4	Members mentioned that there were many issues with wrong dosing and excessive dosing for age for patients being discharged in their 80's and 90's initiated on DOACs.	
13.5	There was some concern over time and resource allocation to conduct searches in order to carry out audits, as this had proved a heavy burden on resources.	
13.6	<p>After some discussion, it was agreed that an audit on anti-cholinergic burden items be investigated as has a large potential impact. The audit needs to include combined education, and how to adjust medication and how best managed. It was suggested to get systems up and running in the first year and focus on patients on medication with an anti-cholinergic burden score (ACBS)>9, then consider extending to patients on medication with an ACBS>6 in the following year. PrescQIPP was suggested for educational information. All agreed that patient safety is the focus. The GPs in the sub-group working to develop audits are still waiting to hear from the BSA about the patient-level information that can be provided to them to identify the patients with an ACBS score. If the BSA are not able to provide this information then other audits may have to be considered.</p> <p>It was further agreed that these audits be presented at the next MOG meeting in March 2018 and to circulate any further ideas by email. A reserve audit of Amiodarone should also be considered.</p>	
14.	SAVINGS PLAN FOR 2018/19	
14.1	Members were asked to note that the Respiratory working group had set up a Task and Finish Group to look at potential annual savings available, in light of the production of new inhalers.	
14.2	<p>There were a few recommendations put forward, with the following points highlighted:</p> <ul style="list-style-type: none"> • a price drop in Symbicort® has been planned for January 2018; • reviewed strengths of Seretide® inhalers with a view to changing to a more cost effective formulary option; • Braltus® had also been considered, although there had been a few safety concerns whereby patients swallow capsules rather than place them within the device. 	

14.3	In summary, where clinically appropriate selected switches can be made this may represent a significant financial saving for Dorset.	
14.4	The group looked for swift approval towards switches therefore implementation models had been discussed to take this forward.	
14.5	A query was raised as to whether there would be a 100% switchover. It was confirmed that they had considered 50 - 100% switchovers which was reflected in the potential savings in Appendix 1. PM suggested that the charts produced by Dr Will McConnell will need to be amended to reflect these recommendations.	
14.6	<p>A further query was raised regarding the lead in time between notification of a drop in price, and the actual drop. A timeframe of three months was advised.</p> <p>KG confirmed that she would be discussing with the finance task force the possibility of a healthcare resource to look at potential savings. In the meantime, a savings review could be potentially undertaken in annual patient reviews. Once a response has been received through the finance task force, a more detailed plan could be produced.</p>	
	Low Value Drugs	
14.7	Members were asked to note the estimated potential savings from the NHS England Low Clinical Value consultation which has been published.	
14.8	There was a brief discussion around the drugs in the plan that would no longer be prescribed within primary care, classified as red on the formulary, with the exception that liothyronine which could switch to specialist prescribing.	
14.9	KG agreed to look at resource implications with technicians assisting GPs with searches on particular drugs, as this had been too time-consuming for the practices. She would raise this at the next Drugs & Therapeutic Committee at RBH.	KG
14.10	A query was raised regarding the prescribing of Co-Proxamol and its continued limited availability. KG confirmed that this was on a list of possible drugs for blacklisting presented to the Health Minister in the new year, if accepted and legislated then would become unavailable on NHS.	
14.11	Soluble and effervescent preparations of analgesics contain high sodium and are more expensive, this has been highlighted as an area for cost-saving and safety by Open Prescribing. Dorset is in the top 10% for prescribing volume of these products. It was recommended that these should be prescribed as a second-line option and only for patients with genuine swallowing problems.	

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14.12	DL raised a query regarding drugs recommended for removal from pan-Dorset formulary for warts, and whether this meant patients would have to provide self-care. He was advised that most wart treatment preparations can be purchased over the counter. KG agreed to circulate information supporting the GP approach of offering self-care, rather than having to prescribe.	KG
15.	NICE REPORT	
15.1	Members were asked to note the NICE TAs being released in the near future. It was noted that the volume of TAs to be published was decreasing following a significant number being published in the summer and autumn.	
16.	ANY OTHER BUSINESS	
16.1	RT raised the query about whether it would be acceptable to undertake the rebate scheme raised at the last Cardiology Working Group meeting, especially regarding edoxaban. KG pointed out that as rebate schemes are not recommended at primary care level and the PPRS agreement is being renegotiated, then the current CCG position remains.	
17.	DATE OF NEXT MEETING The date of the next Medicines Optimisation meeting is Tuesday, 13 March 2018, 9.30am-11.30am, VH Boardroom, Meeting Room 1, CH via VIDEOCONFERENCE.	