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NHS DORSET CLINICAL COMMISSIONING GROUP

PRIMARY CARE COMMISSIONING COMMITTEE

MEDICINES OPTIMISATION GROUP REPORT

Date of the meeting	05/04/2017
Author	K Gough, Chief Pharmacist
Purpose of Report	The purpose of this report is to update the committee on medicines, prescribing and dispensing issues and the activity of the Medicines Optimisation Group. The report also includes controlled drugs monitoring activity reported to the NHS England Controlled Drug Accountable Officer.
Recommendation	The Committee is asked to **approve** the audits and incentive payment schedule.
Stakeholder Engagement	There are patient representatives on the Medicines Optimisation Group(MOG) and the GP prescribing leads for each locality are members of the MOG and work closely with the medicines team on prescribing issues.
Previous GB / Committee/s, Dates	Parts of this report have been to the Medicines Optimisation Group

Monitoring and Assurance Summary

This report links to the following Strategic Principles	• Services designed around people • Preventing ill health and reducing inequalities • Sustainable healthcare services • Care closer to home

	Yes [e.g. ✓]	**Any action required?**	
		Yes Detail in report	**No**
All three Domains of Quality (Safety, Quality, Patient Experience)	✓		✓
Board Assurance Framework Risk Register	✓		✓
Budgetary Impact	✓		✓
Legal/Regulatory	✓		✓
People/Staff	✓		✓
Financial/Value for Money/Sustainability	✓		✓
Information Management &Technology	✓		✓
Equality Impact Assessment	✓		✓
Freedom of Information	✓		✓
I confirm that I have considered the implications of this report on each of the matters above, as indicated	✓		

Initials : KMG

1. Introduction

1.1 The purpose of this report is to provide an update on the working of the Medicines Optimisation Group (MOG) and medicines optimisation and prescribing activity underway in the CCG.

1.2 In addition for this meeting, the audit plan for medicines optimisation and savings is presented to the group for approval, having first been presented to the Medicines Optimisation Group.

2. Report

2.1 MOG: meeting on 14 March minutes had not been completed in time for this meeting. The General Practice prescribing budget is forecast to be slightly underspent at year end. This is due to medicines price changes realised through the pharmacy contract that was imposed in December. There are risks on the horizon with the implication of the weaker pound and changes to medicines pricing that may happen as a result, but this is not yet clear and will be reviewed in the next financial year.

2.2 The 14 March MOG agreed audits for 2017/18 in: Dual antiplatelet therapy and Quinine prescribing, as well as quality payments to improve antibiotic prescribing and achieve the national quality premium. The audits and supporting information are attached as appendix 1 a-c.

2.3 A payment schedule to incentivise completion of this work is presented as appendix 2. The members of the committee are asked to approve these for implementation from 1 April. Locality GP prescribing leads have been involved in the development and testing of these audits.

2.4 Prescribing Performance: The General Practice prescribing budget is forecast to be slightly underspent at year end. This is due to medicines price changes realised through the pharmacy contract that was imposed in December. There are risks on the horizon with the implication of the weaker pound and changes to medicines pricing that may happen as a result, but this is not yet clear and will be reviewed in the next financial year.

2.5 DSQS: considerable work has been done by dispensing Practices identified at the beginning of the year as struggling to meet the minimum quality requirements. All Practices have now had visits and are working to achieve, or have achieved action plans set. Going into financial year 2017/18 most, if not all, should be operating at the minimum standards expected from DSQS. As the statement for financial entitlement does not allow part payment for this service, a group will be convened to establish how to address Practices that were not fully compliant throughout the year. A programme of post payment verification checks will begin in April.

2.6 EPS Electronic prescription services: A number of Practices have yet to implement electronic prescription services. These are mostly dispensing practices, as initially the system was not available, and also some are concerned about losing dispensing patients. The current position is as follows:

- Milton Abbas & Cerne Abbas now live;
- Yetminster, Portesham, Corfe Castle, Whitecliff Mill, Quarter Jack surgeries and Puddletown are yet to go live;
- Durdells: are not dispensing, but use the Vision system, and due to no local IT support for the system, it is not practical for them to implement electronic dispensing at present.

2.7 As well as convenience for patients, reduced workload for prescribers and reception staff, it has also materialised that data from the AHSN has found that it takes a GP 27 seconds to sign a paper repeat prescription and 15 seconds to do an electronic prescription giving big workload advantages to implementing this service, especially in a larger Practice processing in excess of 200 repeat prescriptions at a time.

2.8 Locality prescribing leads are being asked to support Practice colleagues in recognising the benefits of electronic prescribing and identify buddy-dispensing practices to support them in their localities. There is no evidence to date that there is a reduction in dispensing created by implementation of this service. However patients have a choice of where to take their prescriptions in law.

2.9 Electronic repeat dispensing: The time savings gathered from electronic prescribing is increased if this is converted to electronic repeat dispensing, as the advantages of generating electronic repeat prescriptions every six months is thought to release several hours a week of GP time.

2.10 The medicines team are trying to roll out a programme of promoting electronic repeat dispensing starting one practice at a time. Initial indication show this is working, but is a slow process.

2.11 To highlight the benefits and increase understanding and use of eRD, NHS Digital has developed a new toolkit, e-learning package and webinars to promote the use of eRD. These can be found on the NHS digital website. This is being promoted to practices.

2.12 Pharmacy Urgent Repeat Medicines Service (PURMS) and NHS Urgent Medicine Supply Advanced Service (NUMSAS): In Dorset 178 patients had accessed the pharmacy urgent repeat medicines service up until the end of January 2017, predominantly because their prescription had not been available for collection in the week. The majority of patients declared that they would have gone without their medicines or contacted out of hours or NHS111 if they had not had access to the service. It is hoped that patient education and increased availability of electronic prescription services and electronic repeat dispensing will mean that this service will be self-limiting.

2.13 There is now a national advanced service, NHS Urgent Medicine Supply Advanced Service (NUMSAS). This is following a staged rollout across the country, it has some differences to the local PURM service and both will continue in Dorset initially, this will then be reviewed. More details regarding NUMSAS the rollout date in Dorset will be communicated shortly.

2.14 Antibiotic premium: current data suggests that the CCG will meet the requirements for the antibiotic premium in 2016/17 pending prescribing data for the last three months of the year. The data from EPS will be used for measurement of 2017/18 antibiotic quality premium. If Practices are not using EPS for the vast majority of prescriptions then this may compromise the quality of the data and the CCG chances of achieving the measures.

2.15 Medicines Safety Officer: The Medicines Management team continues to develop a process to ensure that MHRA, and other safety alerts that have the potential to affect the safety of primary care patients locally are reviewed and actioned by affected practices.

2.16 Between November 2016 and February 2017 there were 16 notifications received from MHRA or CAS. Of these, two were determined to have the potential to affect the safety of primary care patients locally. The relevant practices have been contacted and asked to review the affected patients in line with guidance issued nationally.

Gluten free prescribing

2.17 It was planned to consider gluten free prescribing as a prescribing savings plan in 2017/18. There has now been more information about a planned national review released in a parliamentary debate on 1 November 2016, this section spoken by David Mowat the health minister responsible:

> *"CCGs should not withdraw gluten-free products without a consultation. ……. ……..there is the issue of the postcode lottery. It is true that we give CCGs a lot of power in our system, in terms of making clinical decisions. The idea behind that is that they look at local considerations and balance the various options that they have. However, I will see to it that a review is done, hopefully within the next six months, of prescribing policies, and we will endeavour to come together with something that is more consistent, in a way that means we can actually make progress on this. ……*

2.18 The full link is available below:

https://hansard.parliament.uk/commons/2016-11-01/debates/4BB02B4E-A485-477B-81D9-569AFDDA81ED/CoeliacDiseaseAndPrescriptions

2.19 As a result it is proposed that we await the result of this review and national guidance before proceeding. There is considerable media interest including freedom of information requests about whether this CCG has "banned" the gluten free products and other initiatives that have been in the media including "banning" paracetamol etc.

3. Conclusion

3.1 The medicines team and Medicines Optimisation Group continue to ensure that there is safe and effective prescribing underway.

3.2 The Committee is asked to **approve** the audits for Antiplatelet dual therapy and Quinine prescribing recommended by the MOG and the payment schedule to incentivise completion of the audits and the measures for the antibiotic premium.

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APPENDICES	
Appendix 1a	**Dual antiplatelet audit**
Appendix 1b	**Quinine Audit**
Appendix 1c	**Audit background information**
Appendix 2	**Payment Schedule**