Appendix 1

NHS DORSET CLINICAL COMMISSIONING GROUP

D R A F T

Minutes of the meeting of the Medicines Optimisation Group held on Tuesday 20 June 2017, 9.30 am by videoconferencing between the Boardroom, **Vespasian House, Barrack Road, Dorchester, DT1 1TG and meeting room 1 at Canford House, Discovery Court, Wallisdown Road, Poole.**

Present	Dr Paul Mason (PM)	GP Prescribing Lead, NHS Dorset CCG (Chair)
	Dr Chris Barringer (CB)	GP Locality Lead, NHS Dorset CCG
	Dr Simon Brown(SB)	GP Locality Lead, NHS Dorset CCG
	Ian Gall (IG)	Patient and Public Involvement Representative, NHS Dorset CCG
	Dr Diana Gannon	GP Locality Lead, NHS Dorset CCG
	Katherine Gough (KG)	Head of Medicines Management, NHS Dorset CCG
	Helen Kennedy (HK)	Prescribing Analyst and Senior Pharmacy Technician, 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 Andrew Purbrick (AP)	LMC representative
	Dr Clive Quinnell (CQ)	GP Locality Lead, NHS Dorset CCG
	Lorette Sanders (LS)	Locality Pharmacist, NHS Dorset CCG
	Sarah Sanderson (SS)	Locality Pharmacist, NHS Dorset CCG
	Dr Kathy Scott (KS)	GP Locality Lead, 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	Jacky Bowers (JB)	Senior Administrator/PA, Quality Directorate, NHS Dorset CCG (Minute taker)
	Hayley Braid (HB)	Medicines Management technician, NHS Dorset CCG

		ACTION
1.	**APOLOGIES FOR ABSENCE**	
1.1	Apologies were received from Dr Ian Platt	

2.	**INTRODUCTIONS AND DECLARATIONS OF INTEREST**	
2.1	The Chair reiterated that it was important to complete one Declaration of Interest (DOI) every year relating to any specific items. Confirmation was provided this had been done. If the last completed DOI was prior to April then a further one is required to be completed. The DOI database will be checked and those who are required to complete a new DOI will be contacted. Further interests should be declared in-year where necessary.	**LP**
3.	**DRAFT MINUTES OF MEETING HELD ON 14 MARCH 2017**	
3.1	The minutes of the meeting held on 14 March 2017 were approved as an accurate record subject to the following amendments: • Amend PS to read PM • 8.2 – Audit of antiplatelet therapy should be "Dual antiplatelet therapy" • Richard Wakelam and Dr Kathy Scott to be noted on the list of those present at the meeting.	**JB**
4.	**MATTERS ARISING**	
	KG advised that the majority of the Matters Arising had been completed or had been included on the agenda.	
4.1	Point 7.5 – attendance – **Completed**	
4.2	Point 12.4 – policy – on the agenda	
4.3	Point 4.15 – Use of pregabalin – KG provided a verbal update and advised that as soon as notification of the change has been advised practices can switch to prescribing the generic alternative. AMcP queried whether a covering letter would be available that practices can send out with the prescriptions when the change occurs. KG confirmed that a letter can be developed for this purpose, she will liaise with MT and circulate once drafted. The Chair added that there would be no harm in undertaking searches for patients prior to the change. Post meeting note: NHSE sent out a legal letter for delivery by 26 June, confirming that practice should return to normal from 17 July.	**KG/MT**
4.4	Point 4.17 – MT to review statement to highlight disease monitoring may be required – MT advised that disease monitoring requirements rather than drug monitoring are included as a potential request within the service specification. Drug monitoring requirements have been updated in accordance with BSR/BHPR guidelines and will be discussed at the Rheumatology Working Group on 21 June 2017. There have been	

	other issues around the NHS standard contract 2017/18 recently and the requirements on Trust which are not being met. Work is ongoing.	
4.5	Point 6.12 – Section to be included on the Declaration of Interests - **Completed**	
4.6	Point 8.13 – format of the proposed "In Focus" document to be reviewed and feedback to be provided to VS –VS confirmed that feedback is being received. **Completed**	
4.7	Point 12.3 – link could be located within a clinical system, VS to research and take forward –see agenda item MSO report.	
4.8	Point 12.4 – VS to review and distribute Appendix 2 of the MSO Report making clear it did not remove practice responsibility to ensure they are up to date with issued alerts – **Completed**	
4.9	Point 12.5 – VS to amend page 9 of Appendix 1 of the MSO report to ensure all information remained anonymised – VS advised that this will be done for all future reports and will amend the previous report.	**VS**
4.10	Point 14.4 – Update on A&E prescribing of antibiotics.– VS advised that Dr Sawyer was to send information ahead of antimicrobial meeting, this had not yet been received.	**VS**
5.	**PRESCRIBING FINANCE REPORT AND FORECASTS** • **performance on prescribing** • **Locality Prescribing Reports** • **Appendix 2 – Performance – March 17** • **Appendix 3 – Locality Outturn**	
5.1	KG reported that the final outturn for prescribing was £1,554,189 underspent. Growth for the financial year was held to 1.96% which was an extremely good result, despite a growth in list size of 0.65%. Calculations had been completed and the actual benefit was a £4.5m category M saving, this outweighed the growth in NOACs. Since the report had been written KG advised that the savings plan had been reviewed and rather than the £1.4m savings the figure achieved was £200,000. The further potential for financial saving needs to be carried over to this financial year and consideration given to reviewing the savings plan on a two-year cycle rather than one. This will be included in the September MOG meeting.	**KG**
5.2	Due to the rising diagnosis of AF, and treatment with newer therapies KG stated the current spend on NOACs/DOACs was just under £5m, but this is forecast to possibly rise to £7m next year. Discussion took place around the percentage of NOACs compared to warfarin prescribing achieved, KG advised that currently when looking at	

	the MOG dashboard, locally almost 33% which is mid table compared to other CCGs with the highest being 70%. It was noted that generally it is difficult to account for financial savings by suggested improved outcomes as care costs are not counted, these are an estimate. Discussion took place around stroke and the anticipated savings.	
5.3	RW thanked everyone for the hard work undertaken in making the savings, which had helped the CCG meet their control total. He advised that on top of the £1.5m there had also been a saving of £0.5m on non GP prescribing areas. It was acknowledged that 2017/18 will be a difficult year to reach a balanced budget as there is the need for £10m savings and difficult conversations may need to be undertaken. RW advised that the focus is on variation and QIPP targets.	
5.4	KG added that within appendix 1 all adjustments had been noted. There had been issues with PCSE, wrong coding and out of area prescribing. In order to set the figures for next year KG was seeking approval from the MOG for the suggested adjustments. The group **Approved** the adjustments.	
5.5	Finance – uplift on outturn for 2017/18 due to category M coming in lower. KG and RW had reviewed the figures and looked at QIPP and growth and anticipated an achievable budget. Discussion took place on how the £1.5m savings made will be communicated to practices and would they be incentivised to deliver next year. KG recognised that hard work had been undertaken but the 16/17 savings were due to the category M drugs. There is very little money in the system to incentivise practices to undertake savings, but savings can be made by using more generic products.	
5.6	Practice Pharmacy Teams – it was queried whether the CCG should invest in practice pharmacists. It was noted that this is led by NHS England and that the national steer is for these to become part of the GP workforce. The group asked if the CCG could provide medicines management support within practices to undertake specific pieces of work to realise savings, but it was recognised that this is a workforce issue and that there are no monies within the system to support employing long-term staff.	

	RW stated that he would be happy to explore workforce if this will lead to savings.	
5.7	RW added that the incentive is money for Dorset patients and that there is the need to find a balanced system. As a CCG system wide there is the need to save money. It was noted that many practices are disinterested in making savings if they cannot see the benefit. AMcP advised that problems are being encountered when changes are requested, it is difficult to get the message across to other GPs, together with issues and arguments with patients when trying to make savings.	
5.8	Prescribing budgets at practice level was discussed and it was felt that this is not necessarily a good way of rewarding practices. It was noted that there is no national formula for practice prescribing and locally it has been set at locality level based on outturn with the emphasis on quality, resulting in some degree of savings. RW added that if there is a focus on quality measures, usually the budget will take care of itself.	
5.9	The group felt that it would useful if the formulary could be integrated into GP systems. MT advised that this is work in progress but not imminent as this is a time resource and the team need to find the time and people to undertake this. Currently there is no capacity to undertake this. MT also advised that long term integration by net-formulary into practice systems was a long way off. It was noted that at CCG IT meetings they were looking to move all practices to SystmOne and using the Arden templates. However, it was noted that there had been issues in convening the MOG IT group, PM suggested that formulary integration should be placed on the agenda as a priority. LL advised that in North Dorset the Ardens templates are being used. The team at Ardens are able to update more rapidly than the CCG. KG requested that this be taken to the MOG IT group to provide a steer. MT to liaise with Simon Longman who sits on the CCG IT group, she will provide an update to the MOG in September. Discussion took place on the funding if this system was implemented and whether it would be a stepped approach.	**MT**
5.10	IG stated that he understands that there is pressure on GPs when implementing any change to medication and queried whether there is any education being undertaken with patients to assist with	

	conversations that the GPs have to undertake with the 1-2% who have issues with switching. AMcP advised that the difficulty being encountered is when a patient is aware that their original drug is available and they have a right to have this. KG advised that there is not an appetite nationally to black list some drugs at the current time, which would assist with this issue. She agreed that letters to assist practices in communicating the reasons for changes to patients could be drafted where these would be useful.	**Meds Man team**
	Locality prescribing	
5.11	This report was provided to give an update on the visits being undertaken with practices. LS advised that the team had tried to increase communication and visits to ensure that practices were aware of what audits and actions would be required. It was noted that the visits had been made more bespoke for practices.	
5.12	KS advised that she felt that the visits were much improved. LL noted that the savings plan was published after the visits had taken place. KG stated that they had hoped to have the savings plan in place prior to the visits but this did not happen on this occasion. She added that the savings plan should be the priority going forward and there may be occasion when not all practices will be visited in year as the team may need to use the savings plan to re-prioritise visits.	
5.13	**Appendix 2 – Performance – March 17** This was covered within the previous discussions.	
5.14	**Appendix 3 – Locality Outturn** Central Bournemouth and East Bournemouth have had revised locality outturns. RW will circulate this.	**RW**
6.	**REPORT – MEDICINES OPTIMISATION REPORT** • **Terms of Reference** • **CD report** • **GF consultation** • **Overseas travel prescribing** • **Prescribing Permissions**	
6.1	**Terms of Reference** – these had been updated following the last meeting and had been included as Appendix 1 within the report. If no further comments are received this document will be published.	

6.2	Primary Care Workforce – KG advised that a successful rotation of pre-registration pharmacists had taken place and she is keen to discuss with the workforce centre a Band 7 practitioner rotation, but a business case is required.	
6.3	**NICE Associate role** – the Deputy Director of Engagement and Development has discussed with locality chairs and deputies the role of the NICE Associate for the CCG/health community. Their guidance is that this should be absorbed into the GP locality prescribing lead role. Members of the MOG are asked to consider how this can be facilitated. Any comments to KG.	**ALL**
6.4	GMS changes – Frailty tools are being introduced as part of the updated GMS contract. KG asked the group for any volunteers to sit on a group to discuss medication reviews. LL and RT volunteered to be part of this group. Discussion took place around minimum standards or suggestions around medicines reviews. KS felt that recommended standards would be useful. It was noted that e-pact2 will generate comparator tools for polypharmacy such as a list of patients over 85 on multiple medications, and will also highlight areas where reviews could be targeted.	
6.5	The updated NHS Standard contract 17.18 also has implications on hospital and provider contracts regarding discharge and outpatient prescribing, with the intention that swift discharge information should reduce the workload implication for practices on the follow up of patients. A task and finish group is to be convened to ensure that existing CCG guidance on outpatient and discharge prescribing are aligned. This will be done alongside the LMC, CCG commissioning teams and medicines team. GP prescribing leads were invited to link to this group. DL and DLa volunteered to be part of this group to ensure that there is input from the East and the West of the county.	
6.6	**Pseudoephedrine:** following horizon scanning the medicines team has identified potentially excessive quantities of pseudoephedrine on prescription. Strict rules are in place for sales from pharmacies as it is known to be used in the illicit production of crystal meth. The team have identified regular quantities of in excess of 100 being supplied on prescription. At present this is green on the formulary, although labelled as less suitable for prescribing in the BNF. Members of the MOG are asked to support a formulary change to non-formulary. The group **agreed** to this change and MT will take this forward through the Formulary Group.	**MT**

6.7	The medicines team will be changing their name to the Medicines Optimisation Team, which is more appropriate.	
6.8	KG advised that the CCG policies are being updated into standards and this includes the "working with the pharmaceutical industry" arrangements. There is considerable interest in joint working for Dorset at the current time and there are potential joint working programmes on the Atrial Fibrillation guidelines being initiated at present. KG asked MOG to consider a position on joint working and how this can be used to the advantage of Dorset patients. In order to start this process off a summit is likely to be planned for the autumn. Discussion took place around this, DL felt that this could be risky as the pharmaceutical companies could be biased by their own agenda. It was also strongly felt that there would be a huge element of trust involved in this joint working. KG stated that the CCG would have to agree what could be worked on that is non-promotional, in a structured way and with patient engagement.	
6.9	**Rebate Schemes** – KG advised that she has been asked to reconsider the acceptance of rebate schemes for medicines used or for switching brands. At present the CCG medicines team does not participate in any rebate schemes, however as the financial position worsens then there may be considerable sums available. The MOG were asked to consider a position on this. The group advised that they were uncomfortable to pursue this any further at this point in time.	**KG**
6.10	Urology Group support for LHRH policy – it was felt that there needed to be some patient choice.	
6.11	Prostap discounting offer to Poole Bay – the locality is reluctant to switch due to anticipated profit drop. This has been discussed across the CCG. There is an NHS saving by switching to triptorelin administered six-monthly and should realise savings in workload for practices.	
6.12	**Salbutamol inhalers** – it was noted that there is a requirement within the community pharmacy contract that asthma patients, for whom more than six short acting bronchodilator inhalers were dispensed without any corticosteroid inhaler within a six-month period, are referred to an appropriate health care professional for an asthma review.	

6.13	**Enteral Feeds** - DCHFT dieticians have identified a mechanism where they can make savings on the enteral feed budget. They are looking for approval on whether the CCG can fund this. KG will circulate to the group for comments. Any funding would need to be found within the flat cash environment.	**KG**
6.14	**CD Report –** this report was included for information.	
6.15	**GF consultation –** the response to the consultation was **approved** by the group.	**KG**
6.16	**Overseas travel prescribing –** the guidance was **approved**.	
6.17	**Prescribing Permissions – updated guidance** - KG advised that in 20I6/17 it was highlighted that when transfer took place to SystmOne all system users were put on as prescribers. Those people who should not be prescribing were removed. There is an issue with DHUFT and their nurses, where they should be risk assessed as to who should prescribe at practice level. DHUFT felt it was too great a risk for non-prescribers to have permissions to generate prescriptions, therefore the guidance was updated to reflect this. It should be less of an issue when the system starts to undertake integrated working. The guidance was **approved.**	
7.	**MEDICINES STANDARDS PAPER** **APPENDIX 2 – OVERARCHING MEDICINES MANAGEMENT POLICY** Approved.	
7.1	**Medicines Standards Paper** Relates to the policies that used to be brought forward individually. This report has been developed to provide information on how the policies will be presented in the future. There will be one overarching policy with a set of standards sitting underneath it. The group **approved** this change.	
8.	**DORSET MEDICINES ADVISORY GROUP UPDATE (DMAG)** • **REPORT ON DMAG INCLUDING PUBLISHED NICE GUIDANCE AND DORSET FORMULARY**	
8.1	MT advised that this report covers meetings held on 21 March and 16 May 2017. All NICE TAs have been implemented within required timescales.	
8.2	Some of the new drugs reviewed by DMAG included:	

	• Enstilar® (betamethasone/calcipotriol) - this is a topical treatment of psoriasis vulgaris in adults and is an alternative to Dovobet® ointment in a foam formulation at a similar cost. DMAG recommended to include it on formulary as a "green" drug as an alternative to the ointment; • Respiratory Inhalers - Fostair® 200/6 (beclometasone/formoterol) is used for adults in the regular treatment of asthma where use of a combination product (inhaled corticosteroid and long-acting beta$_2$-agonist) is appropriate. The use of this high dose steroid inhaler would provide a cost saving over using Seretide® 250. • Emollient Creams -Isomol®, Epimax®, Zeroderm® and Alpoderm® were recommended by DMAG to support the use of cost effective first line emollients. They will be added to the formulary.	
8.3	Medicines already on the formulary were recommended for re-categorisation: • Escitalopram - recommended that this should be re-categorised as "green" as an option in line with the relevant NICE guidance for the use of antidepressants. However, in the absence of a clinical rationale for a particular antidepressant the most cost-effective agent to be selected; • Sildenafil for digital ulceration associated with systemic sclerosis (an off-label indication) - recommendation for re-categorisation from "red" to "amber with shared care guidelines" with use being consistent with the NHS England policy for sildenafil and bosentan for the treatment of digital ulceration in systemic sclerosis. MT advised that there is a small cohort of patients who are prescribed Sildenafil. Further work was undertaken around financial implications and it should have minimal impact; • Azithromycin - A proposal for the prescribing of this drug for the reduction of exacerbations in adults with bronchiectasis was discussed. It was recommended that for this indication azithromycin should be re-categorised from "red" to "amber with a shared care guideline". This will be kept under review; • Colesevelam for bile acid malabsorption – this is an "off label" use medication. The recommendation was for re-categorisation from non-formulary to "amber". As this was often a difficult condition for patients to manage, it was therefore considered that a one-year trial with subsequent review of the overall benefit to patients and the local GI services should be recommended. The small cohort of patients could be maintained in Primary Care.	

8.4	Regional medicines optimisation committees (RMOCs) - It is intended that the four regional committees will operate together as part of a single system to eliminate duplication of medicines optimisation activity across England. Recruitment to the committees is currently underway. The first year of these committees is seen as an establishment phase. The initial meeting in the South will be held in September.	
8.5	NICE fast access scheme - fast track appraisals will apply to drugs with a likely cost per extra year of quality-adjusted life of under £10,000, "offering exceptional value for money" and may allow such drugs to be available from a month after launch. This is the area where drugs which are CCG commissioned are likely to be involved.	
8.6	**Annual Report** The Annual report was noted. MT advised that there are currently gaps in several of the working groups. Currently there are approximately 20 working groups in place. MT will circulate an updated list to the group, this will include the vacancies, timescales and dates of meetings. Anyone wishing to become a member of one of the working groups to contact MT. KG noted that the CCG is aspiring to integrate the working groups with the Rightcare groups, which in the longer term will reduce the number of meetings.	**ALL**
9.	**NICE TA TRACKER AND HORIZON SCANNING UPDATE**	
9.1	MT advised that the TAs which have been published since the last MOG meeting which have been implemented by the CCG are: • Ixekizumab for treating moderate to severe plaque psoriasis: NICE TA 442 published 26/04/2017; • Certolizumab pegol and secukinumab for treating active psoriatic arthritis after inadequate response to DMARDs: NICE TA 445 published 24/05/2017 The following drugs with TAs are anticipated for publication before the next MOG meeting: • Third molars (impacted) - prophylactic removal [ID898] anticipated publication date June 2017; • Chronic obstructive pulmonary disease – roflumilast [ID984], anticipated publication date July 2017; • Hyperuricaemia (chronic) in gout - lesinurad [ID761], anticipated publication date July 2017; • Ustekinumab for previously treated moderate to severe active Crohn's disease [ID843], anticipated publication date July 2017; • Uveitis (non-infectious) - adalimumab and dexamethasone [ID763], anticipated publication date August 2017;	

	• Obesity, overweight with risk factors - naltrexone-bupropion (prolonged release) [ID757], anticipated publication date August 2017.	
10.	**PAYMENTS BY RESULTS EXCLUDED DRUGS REPORT**	
10.1	**PbR Excluded Drug Monitoring December 2016 (Month 9)** As highlighted by KG earlier in the meeting there is flat funding for in county Trusts, therefore the local Trusts will be expected to manage their own high cost drugs budgets. Currently Salisbury is a concern as this saw a significant increase in spend last year. Dr Paul Mason queried whether Biosimilars make a difference. MT advised that they have made significant savings in the implementation of biosimilar infliximab and etanercept. Also biosimilar adalimumab will help at the beginning of next year. Many of these savings are offset by increased use of other biologics due to further NICE guidance being published	
11.	**MEDICINES SAFETY OFFICER (MSO) REPORT**	
11.1	This report provided an update on the most recent alerts. **Valproate Warnings** – DLa advised that his practice had sent a letter to all patients using valproate, together with a copy of the handout that was on the toolkit. It is planned that a letter will be sent to these patients yearly. It was noted that there are only a small number of patients using this in the East of the county. The PSA has a deadline of October 6th for completing all actions and VS will remind practices in advance of this deadline. All new materials have been added to the Formulary and included in KTTT newsletter.	
11.2	**Local MSO network** - Following attendance, as an observer, at the Hampshire Medicines Safety Group, it was noted that there is a plan to develop a Dorset MSO group of the four Trust MSOs and the CCG MSO. A first meeting is provisionally planned for the end of July.	
11.3	**Appendix 1** MT advised that this appendix is a tool to help people be aware of the reporting process and how to report incidents. LL reported that she had tried to log-on to the system, but it requested a user name and password, which she did not have and was therefore unable to access it. Dr Paul Mason suggested that it would be useful to provide guidance and clarity on how to use the system and what this system does compared to national reporting.	**KG**

	KG will feed this issue back to the Patient Safety Team. It was noted that this is a local system and does not link to the national system. KG agreed should be promoting NRLS reporting. It was agreed that guidance on what to report to whom would be developed.	
11.4	**Appendix 2** This appendix notes drug alerts and recalls and was included for information.	
11.5	**Appendix 3** This appendix relates to the alert around Valproate and was included for information.	
12.	**ANTIMICROBIAL STEWARDSHIP (AMS) REPORT**	
12.1	**AMS Working Group** It was noted that in March 2017 the Antimicrobial Stewardship pharmacists from the four Dorset trusts and the CCG met to start to develop work stream priorities. Three GP prescribing leads have expressed an interest in being the primary care representatives for this group, dependent on days/times of the scheduled meeting. The next meeting is potentially scheduled for the end of July when the CMM has started the weekly sessions at the CCG. This working group will report to DMAG. The objectives of the group are to: • Develop a pan-Dorset anti-microbial stewardship strategy; • Understand issues around antibiotic prescribing and surveillance; • Offer education and training • Reduce variation/improve consistency in antimicrobial use across Dorset.	

12.2	**Progress against antimicrobial aspects of Quality Premium 2016/17** Dorset CCG, compared nationally for the two quality premium indicators; and was below target at February 2017: • Co-amoxiclav, cephalosporins and quinolones: **8.4%** (target < 10%) • Antibacterial items/STAR-PU: **1.009** (target < 1.161) The CCG expects to meet the antibiotic prescribing portion of the quality premium for last year (2016/17). Dr Paul Mason queried how much money was received by the CCG for being successful against the Quality Premium. RW advised that if all targets are achieved the CCG would receive the maximum of £380,000. KG added that the CCG are being monitored heavily on antimicrobials and will be reporting regularly.	
13.	**IT GROUP REPORT**	
13.1	HK advised that the Red drugs pop-up had been activated which despite some initial teething problems was well received. This replaced the existing red drugs pop-up which was active in some practices but had not been updated for a number of years. The new red drugs pop-up will be updated regularly. Following the implementation of the pop-up it has become apparent that there is widespread prescribing of Sorbaderm® barrier cream which is listed on the pan Dorset formulary as a red drug as advised by tissue viability nurses. This issue will be raised at the next wound formulary group meeting. It was noted that many requests for Sorbaderm® are coming via the District Nurses. KG will link with pressure ulcer colleagues to develop a statement around the rationale for why this medication is being used.	**KG**
13.2	**Trimethoprim pop up** – HK will chase up issues as this is not in place for all practices.	**HK**
14	**AUDIT REPORT**	
14.1	**Appendix 1 – poster – cpc – 4** This appendix provides a summary of the audit undertaken last year. HK thanked all those who had worked on the template. During the period of the audit there was a reduction in antibiotic usage. Feedback from practices was largely positive and some practices have kept the pop up following the end of the audit.	

14.2	PINCER - The majority of practices had a cycle two months apart. 88 practices - cycle 1 and 86 - cycle 2. Overall there was a 48% reduction in absolute number of patients identified as a risk during the two cycles. During the audit a safety issue around Warfarin and INR was identified, there is now a plug in on system which notes this. HK advised that licences are available until the end of June and would encourage practices to use it whilst it is freely available. KG added that there had been a criticism that the information does not always get back to practices, she will liaise with HK and circulate the information as a news type version.	**KG/HK**
15.	**DSQS ANNUAL REPORT**	
15.1	KG advised that post verification checks were currently being undertaken. The report was included for noting.	
16.	**ANY OTHER BUSINESS**	
16.1	Savings plan – KG advised that emollients is one of the savings plans, she attended the Clinical Commissioning Committee and the group are keen to set this in motion. KG added that this should be a fairly non-controversial change. The information will be sent to locality prescribing leads initially Dr Paul Mason queried whether the In Focus document is attached to the formulary. MT will double check that this is still attached.	**KG** **MT**
16.2	KS asked whether the "Keep taking the Tablets" is sent to practice managers and prescribing leads. HB advised that it is sent to both and she also maintains a list of locums which it is also circulated to.	
16.3	HK advised that the CCG email server had changed and will not send large documents, she requested the groups views on whether they wished to continue to receive two/three emails containing the agenda and papers for the MOG, or whether they would prefer to sign up to Securesend. The consensus was to continue receiving two/three emails.	**LP**
17.	**DATE AND TIME OF NEXT MEETING**	
17.1	The next meeting of the Medicines Optimisation Group was confirmed as Tuesday, 26 September 2017, 9.30am, The Brewery, Blandford.	