NHS
Somerset
Clinical Commissioning Group

Minutes of the **Prescribing and Medicines Management Group** held in **Meeting Room 1, Wynford House, Lufton Way, Yeovil, Somerset**, on **Wednesday, 15th July 2015**

Present:	Dr Geoff Sharp (GS)	Chairman, CCG Prescribing Lead
	Dr Steve Edgar (SE)	LMC Representative
	Shaun Green (SG)	Associate Director, Head of Medicines Management
	Matt Harvey (MH)	LPC Representative
	Liz Harewood (LH)	Somerset Partnership Representative
	Catherine Henley (CH)	Locality Medicines Manager
	Gordon Jackson (GJ)	Lay Representative
	Dr Carol Reynolds (CR)	North Sedgemoor Representative
	Dr Mark Vose (MV)	East Mendip representative
	Donna Yell (DY)	Prescribing Support Technician, Secretary
Apologies:	Dr Tony Austin (TA)	Chard, Crewkerne and Ilminster Representative
	Dr Diane Bungay (DB)	East Mendip Representative
	Dr David Davies (DD)	West Somerset Representative
	Steve DuBois (SDB)	Somerset Partnership Representative
	Dr Adrian Fulford (AF)	Taunton representative
	Dr Mike Holmes (MHo)	South Somerset Representative
	Dr Catherine Lewis (CL)	Bridgwater Representative
	Dr James Nicholls (JN)	West Mendip Representative

1 INTRODUCTIONS

1.1 Liz Harewood was introduced to members she had not previously met.
Jo Bird arrived at 9.30am to present her medicines incident report and anticoagulation report, she left after making her presentation.

2 APOLOGIES FOR ABSENCE

2.1 Apologies were provided as detailed above.

2.2 Tony Austin is unable to attend future PAMM meetings, the CLICK federation has been informed to seek a new representative to attend in his place.
Geoff and the PAMM members would like to thank Tony for his past attendance and contribution to PAMM.

3 DECLARATIONS OF INTEREST

3.1 SE sits on the Symphony Project Board

3.2 MV noted that his declarations were missing from the list.
DY has actioned the amendments for the next agenda.

4 MINUTES OF MEETING HELD ON 17th June 2015

4.1 Agreed as an accurate record of the meeting.

4.2 Review of Action points

1. Somerset Medicines and Clinical Tasks Policy – comments have been passed on

2. Stroke Prevention in AF, Interface clinical services programme – CH has requested governance assurance from Rachel Rowe but not received yet. CH to chase.

3. BNSSG formulary group meeting minutes – Still unavailable, CH does chase but they are slow to issue minutes. To be brought to PAMM as report from other meetings when received and remove from actions.

4. Medication Safety Network – CH has received an email from Karen Taylor. The Terms of Reference (TOR) have not yet been finalised. LH was able to reassure PAMM that Sompar are represented as she is the representative. GS asked her to check that she is named on the TOR.

5. Antipsychotic shared care guidelines – On agenda to be discussed.

6. Eastern Europeans immunisation uptake – info has been passed to Public Health.

7. Immunisation uptake monitoring – it has now been clarified that PAMM is not expected to monitor the uptake of immunisations. Terms of Reference (TOR) have been amended to reflect this.

8 & 9 Warfarin bridging therapy guidelines – on agenda to be discussed.

10. Out-Patient Letter – Covering letter has been sent to the trusts to promote the use of the standard letter template. GS would like acknowledgement that they have received the letter and their views on using it. CH to check the covering letter to see if GS asked for acknowledgement.

11. Guideline for the supplementation and blood monitoring of bariatric patients – on agenda to be discussed. Also on SPF agenda to be discussed on 15th July 2015.

12. DSU, Codeine in children <12 contraindication – Steve Moore searched Eclipse and found 2 patients aged 10 and 11. The practices have been sent an email alert notification.

13. Learning from 2014/15 incentive audits, information to be amended, clarified and shared – Steve Moore to do.

14. Formulary changes – all done

15. Newsletter articles – newsletter has been drafted, currently doesn't have an article on hospital issue recording in EMIS. SG to discuss with Steve Moore.

16. NG9: bronchiolitis in children – Ana Alves has flagged the new guidance to the antimicrobial group.

17. Amoxicillin 3g sachets in UTI – Bob Baker reported he has found no published evidence to support the use of 3g sachets. No change to current guidance.

18. RCN insulin syringe guidance – still awaiting Sompar response.

19. Analgesic, tramadol and codeine ski-slopes – have been shared with federations.

20 & 21 INR medication safety incidents report – on agenda to be discussed

PART 1 – ITEMS FOR DISCUSSION OR DECISION

5 Matters Arising

5.1 Warfarin bridging therapy guidelines – this document still requires a number of amendments to reflect changes in current guidance. It is being discussed at SPF this afternoon (15/07/2015). It is unclear within the draft how clear communication between secondary and primary care will be managed which is essential for consistency and safety. CR mentioned an experience with a Musgrove Hospital patient her practice has had recently where the patient information differed from the practice information, there was no date for the planned surgery and the patient was not supplied their injections. This created a huge amount of work and additional expense for the practice.
It's an enormously complex issue, SG highlighted that within Somerset we have four different hospitals doing four different things. Consistency is going to be very difficult to achieve.
The aim is to get to a position where the CCG can agree and sign off on the document or will have to note our differences.
SE mentioned that there is a sub working group within the symphony project looking at perioperative management.

5.2 Immunisation uptake monitoring – It has been clarified that PAMM is not expected to monitor this as it is being done by other committees. DY has amended the TOR to reflect this decision.

6 Other Issues

6.1 Medicines Incident reports and Anticoagulation report Quarter 1 – Jo Bird arrived at the meeting at 9.30am to present her reports.
There has been a software update since March and the addition of an e-form for reporting incidents which has enabled more sophisticated reporting. Jo created a dashboard of information showing the Red Amber Green (RAG) rating applied to each of the incidents, it shows some themes around the types of incidents reported and the adverse event reported. She also showed where the risk grading matrix comes from which the team use to be able to risk score the reported incidents. Within quarter one there were 18 very low, 17 low and 4 moderate risk incidents reported. Low risk incidents are dealt with by the patient safety team. Moderate to high involves the medicines management team. Higher again involves the directors.

Lots of incidents around communication and documentation particularly around discharge from hospitals. Any issues to do with communication are also raised with the clinical documentation and communication group.

The quarterly benchmarking table compares quarterly information since 2013/14 and shows an increase in the number of reports being made, this quarter has been the first quarter where the reasons for errors occurring has been collected so moving forward it will be possible to drill down into the data for why incidents have occurred. Information is also going to start being gathered through patient experience teams and the patient advice and liaison service.

SG has spoken nationally about the Somerset approach to NOACs, he is often challenged about the adverse events from these drugs and about the issue that there is no antidote for them. He always highlights the issues with Warfarin and the incidents reported with raised INR, of which there are hundreds shown on this report.

SG congratulated Taunton Deane Federation their high level of reporting.

LH asked where Sompar should report to when their staff find issues that aren't made by Sompar but have been found by their staff. They also use DATIX to report. Ideally the practice involved should make the report but anyone can make reports and specify the area the incident originated from. SG clarified that there is a system to identify multiple reporting of the same incident.

SG mentioned that there are 10million items per year prescribed across Somerset, we expect a certain number of errors and are receiving only a small amount of reports. It's only by more central reporting that you can see the common themes and put steps in place to prevent them recurring.

It was confirmed that the data mostly comes from practices reporting themselves –. The e-form that is completed in the practice automatically uploads the information to DATIX and alerts the patient safety team. Any Significant Event Analyses (SEA) received are manually inputted into DATIX by the patient safety team.

If a medication incident is received from Primary or Secondary care relating to a pharmacy medication incident, the details are forwarded to england.bnsssg-pharmacy@nhs.net where it is picked up by the area team as we do not commission pharmacies. The patient safety team rarely get a response and it is not clear who manages the system or how the incidents are managed. Jo to investigate and feedback how it operates at next PAMM.

MV raised that if an incident is to do with a wrongly dispensed item at a pharmacy they do not hear anything back or learning from the event as a result of that report. His practice has invited the local pharmacists into the practice to a significant event discussion meeting for the first time. He was commended on this proactive measure.

MH was asked to respond - every time a medicines incident is reported to a pharmacy they will investigate to find any route cause and report to the MHRA. If the patient has taken the medication they will inform the GP. If the patient has not taken it, they may not inform the GP as there has been no harm caused. MV felt it would be useful to receive copies of the report from pharmacies about incidents for the practices own learning. It was felt to be useful to build a relationship with the pharmacy, MV said there have been numerous occasions where he has been protected by the intervention of a pharmacist and felt that at no time was the intervention inappropriate.

GS asked MH to raise at the LPC meeting in September to encourage dialogue and a no blame culture between pharmacies and practices, sharing medicines incident reports to increase learning opportunities without additional paperwork.

Jo next presented the anticoagulation report. Currently the process for reporting is for all INRs greater than 5 to be reported by the practice to the CCG using an SEA which should detail any test results, the actions of the practice to get the patient back into range and any reasons why the patient was out of range. Back in 2013/14 reporting was very poor, they were reported but had no detail. Southwest pathology services provided some training at that time to practice staff to highlight the importance of reporting and how to fill out a report and to include the detail around that incident. We do now get better data however still very little. Steve Moore searched Eclipse to

compare with Jo's data. There were similar numbers but only one patient identified by Eclipse had been reported. There could be a delay in the SEA received by post being inputted onto the system, it may be that practices are retrospectively reporting after an SEA discussion meeting, it is also thought that they may not be reported if there has been no ill effects to the patient.

Jo is looking to streamline the reporting process it has been suggested to report any >8 or if the patient has come to harm via the DATIX e-form and any >5 but <8 where there has been no harm will be reported to southwest pathology on a monthly basis directly from the INR star software from which a quarterly report gets sent to the patient safety team. The changes should enable a better focus on the higher risk patients. This is tied into a new anticoagulation enhanced service specification which is going through the approval process with the governing body. GS suggested that PAMM might want to consider promoting this new process as it would encourage better reporting from practices – suggested as a newsletter article when the specification has been approved.

There was a discussion around when to report, should the practice discuss first and then report. Or report, and potentially not discuss within the practice. If this change is implemented a patient with an INR of 5.1 would not be reported as an SAE to the CCG but the practice still needs to manage the issue and review as an adverse event. Jo said the majority of INR >5 reports caused no harm it's very rare to have reports where it caused harm. The practices who are reporting are very good at including all details and have utilised the training from southwest pathology.

6.2 Guidelines for the supplementation and blood monitoring of bariatric patients – SG brought guidance from BOMSS and the RCGP top ten tips which he has compared to the Musgrove Park Hospital (MPH) guidance. He feels the MPH guidance is not as substantial as these other two national documents. MPH guidance contains a number of expectations of primary care and some recommendations that do not agree with the national documents. SG has asked MPH to compare their guidance with the national guidance. He has also asked the LMC for comments on the RCGP guidance and whether it's something they can sign up to.
The national papers suggest specialists should not be requesting shared care until two years post surgery but MPH are suggesting it earlier.
The topic is on the SPF agenda for discussion this afternoon (15/07/2015).

6.3 Antipsychotic shared care guidelines – Sompar amended the guidance to include patients with bipolar disorder who are on antipsychotics. Shortly after this change NICE published guidance for patients with challenging behaviour and learning disabilities which mentioned patients taking antipsychotic medication should be monitored in the same way as recommended in the NICE schizophrenia and psychosis guidance. It was requested that Sompar also add this into the shared care guideline.

Sompar have two concerns, that well patients may end up referred back to the service inappropriately and there are a number of patients coming into the area who are not part of the Somerset service which could create an unmanageable workload.

The purpose of the shared care guidance is mainly to look at new patients because the responsibility lies with Sompar services for the initiation of antipsychotics and the monitoring of the patient for the first year of treatment.

Sompar agree with the proposal to add learning disabilities to the guidance as long as it's clearly related to newly initiated Somerset patients.

SG attended a call to action meeting last week which identified 35,000 learning disabilities patients taking inappropriate antipsychotic and/or antidepressant medication in the UK. Eclipse Live has identified 300 patients in Somerset who are not currently part of a shared care service because they do not have psychosis but still need to be reviewed. Work needs to be done outside the shared care guidance to support GP's with these patients.

7 Formulary Applications

7.1 Nutriplen Compact – suggested as a switch from Fortisip Compact as it is 25% cheaper - Approved

7.2 Fultium D3 oral drops 2,740 IU/ml and Invita D3 2,400 IU/ml oral drops solution – similar products offering slightly different strengths, suggested to add to formulary but not actively promote – Approved

7.3 Laxido Paediatric Plain – suggested to add to formulary as it offers a cost saving over Movicol – Approved

7.4 Ivermectin Cream (Soolantra) 10mg/g for the treatment of the inflammatory lesions of rosacea – Brimonidine (Mirvaso) gel is already on formulary used to reduce flushing in rosacea. Ivermectin has good evidence to reduce the lesions which may be caused by mites, trials show it is more effective than metronidazole. It is about £6 per tube more expensive then metronidazole but may help with antibiotic stewardship by stopping patients going onto oral antibiotics. – Request a view from dermatology specialists before approval. On SPF agenda this afternoon (15/07/2015).

8 REPORTS FROM OTHER MEETINGS

Federation Feedback

- South Somerset – MHo –not present
- West Somerset – DD – not present
- Central Mendip – GS – meeting after PAMM on 15/07/2015
- Bridgewater Bay – CL – not present
- Taunton – AF – not present
- Chard, Crewkerne and Ilminster – TA – not present
- East Mendip – MV – nothing to report
- West Mendip – JN – not present
- North Sedgemoor – CR – nothing to report

COG – GS not present, SG presented quarterly paper and financial position. No new issues

Somerset Partnership D&TC – no minutes available yet for the meeting held 9/7/15. LH gave a verbal update, they discussed the use of medicines guidance and the violence and aggression guidance. Their wound group has been approached to review a new dressing product- Casipliq20®. They are the only trust in the country who are involved. It has been developed by a French professor with an interest in wounds. It is potentially revolutionary as it takes a wound out of an inflammatory state. It is not currently marketed. They are being provided with supplies free of charge.

The wound formulary is reviewed weekly and ONPOS is updated accordingly. SG mentioned that ONPOS had not been rolled out to the Frome and Beckington areas as expected. However, this is starting to move forward.

Translabel was brought to the attention of PAMM. It is a free website http://www.translabel.co.uk/ that offers a service for translating pharmacy labels into a large number of different languages and can also do large print labels. It does not provide additional warning labels. All the language translations are validated. MH suggested printing a page for information for patients rather than printing labels to attach to medications. LH will share a link with the attendees.

YDH D&TC – CH reviewed the minutes and reported they have approved Apremilast for chronic plaque psoriasis, no NICE final decision yet, they have a memorandum of understanding with the drug company where the drug is provided free of charge until NICE publish their guidance. If the NICE appraisal is negative, the manufacturer will have to continue to supply free of charge. YDH have also approved Apomorphine for certain patients with Parkinson's disease. It remains a Red Drug on formulary and is not a PBR excluded drug. Primary care should not get involved with the supply of the drug or the delivery system. YDH have approved Micafungin for invasive candidiasis in line with TST as well as Magnaspartate. They are looking at potentially using Prednisolone Dompe but some concerns about large volume for high doses. Have approved antidepressants for IBS.

T&ST D&TC – next meeting 31/7/15

BNSSG Formulary Group – last meetings 2/6/15 and 14/7/15, minutes not received.

T&S Antimicrobial Prescribing Group – next meeting 12/8/15

RUH Bath DPG – CH viewed the minutes and reported they have approved Dulaglitide on the basis that it is licensed for a wider range of patients and has a better needle guard and some patients find it more comfortable to inject compared with others in it's class. PAMM decided against adding it to the Somerset formulary at PAMM March 2015.

LPC Report – met last week, they will be issuing a weekly bulletin to pharmacies to help share information more quickly than their quarterly newsletter.

Medicines Safety Network – next meeting 28/7/15

PART 2 – ITEMS FOR INFORMATION OR NOTING

9 Current Performance

9.1 Prescribing report – no formal report as PMD only became available yesterday (14/7/15). SG presented the latest available figures from May 2015. No forecast available until the quarter 1 data is published. SG will bring a more in depth report in September. A 5 year trajectory has been flagged to finance for the 2020 budget.

9.2 April scorecard federation trend – viewed and noted. A lot are continuing themes that were started last year. There are a lot of Respiratory products coming onto the market and a price war has begun. We will not chase every product and suggest multiple switches. Instead it would be better to ensure that patients are either having only DPI or MDI devices and that they are appropriately stepped up or down. Eclipse

live has identified a higher number of patients than expected prescribed just LABA without a steroid, and a number of patients just prescribed Salbutamol. There will be a lot of focus on asthma this year in response to a recent child death. There was concern about continually changing preferences for switches. SG assured the attendees that there is an unwritten agreement that any work done on savings switches using the information at the time would be justified for two years and acceptable not to suggest repeated switching within that time.

9.3 April Safety spreadsheet – viewed and noted. This was presented yesterday (14/7/15) alongside a bigger annual medicines management report that went to the patient safety and quality committee highlighting the non-financial aspects of the work we do around quality and safety and trying to have decision support tools flagging thing to GPs. We look at the trends for each item and try to ensure they are on a downward trend. Somerset has been working on this over the last 3 or 4 years which has put us in a good position moving forward. Good assurance to the governing body and the public that we also have a focus on good quality and safe prescribing. Medicines Management make recommendations on these items to the GP's who are responsible for the clinical decision on using the medication.

10 Rebate Schemes – nothing new.
SG has signed an increased rebate for Seretide in response to the new Sirdupla brand.

11 NICE Guidance

11.1 NG13 Workplace policy and management practices to improve the health and wellbeing of employees – noted, SG has raised it internally within the CCG, it raises common sense suggestions and may be useful for practices as employing organisations.

11.2 NG12 Suspected cancer: recognition and referral – the cancer group have been looking at the implications for this and whether or not it is implementable.

11.3 NG8 Anaemia management in people with chronic kidney disease – lots of these patients are currently potentially being inappropriately treated and not having erythropoetins or IV iron at the right level. Some patients may be over transfused.

There is an ambulatory care group looking at giving IV iron infusions outside secondary care. Commissioning is not within our budget the funding lies with secondary care, the pathways, guidance and budgetary issues have not been agreed. The intention to treat patients nearer to home is a good one but if the funding remains with secondary care potentially the NHS gets charged twice. SG is trying to ensure the Frome pathway group follows due process. The intention is to save the PBR activity cost but this can be outweighed if the drug cost is greater than the PBR cost saving.

SG has suggested that ideally secondary care should supply the preparation to be administered in primary care. However Mendip County Practice has informed SG that they have been asked to prescribe the iron by RUH. SG responded that GP's have not prescribed IV iron for some time and the idea that they can restart doing that needs to be challenged.

PAMM agreed with SG's suggestion of secondary care supplying the IV iron for use in primary care and support the ambulatory care groups work.

12 Safety Items, NPSA Alerts and Signals

12.1 SGLT2 inhibitors (canagliflozin, dapagliflozin, empagliflozin): risk of diabetic ketoacidosis – a letter has gone out to all GP's, Somerset is using twice the national average of these products, it seems to be being driven by Sue Down and the diabetes team, Dr Sarah Pearce is the clinical diabetes lead for the CCG and SG concerns have been raised at that group. He has also raised the concerns with Debbie Rigby the CQRM lead and will be drafting a letter to Andrew Dayani the medical director for Sompar. LH said that Sue Down has confirmed they do not use SGLT2 inhibitors in type 1 diabetics. A number of type 1 diabetic patients taking these medicines have been identified in Somerset.

12.2 High-dose ibuprofen (≥2400mg/day): small increase in cardiovascular risk - there are very few patients on such a high dose, GS mentioned the possible interaction with low dose aspirin, an issue that has been known for a number of years. It is unlikely to have an effect, potentially the cardiovascular risk increases with very high doses.

12.3 Intrauterine contraception: uterine perforation, updated information on risk factors – The Sompar CASH team have been involved and any practices providing the services need to note.

12.4 Medical Safety Alert Xenidate XL 36mg prolonged-release tablets (methylphenidate hydrochloride), incorrect number of tablets in packs from a specific batch - Noted

13 BNF Changes

13.1 June 15 Newsletter – viewed and noted
SG recommended that GP's use the eBNF and note the monthly updates.

14 Any Other Business

14.1 Clinical Pharmacists in General Practice Pilot – there is national subsidised funding for 3 years (60% in the first year, 40% in the second year, 20% in the third year and no subsidy following that) for 300 pharmacists to be employed by GP practices. Generally available to areas under staffed with GP's, currently not much in Somerset. SG has had quite a lot of interest, looking at the job descriptions and expectations of pharmacists it resembles a lot of what we do in Somerset anyway SG's hope and expectation is that when the pilots get started they will move forward quickly and encourage pharmacists to be part of the practice integrated workforce. It was asked if there is a surplus of pharmacists in the area, MH said no, there is a shortage in the southwest generally. There is an oversupply of pharmacists nationally, mainly in cities where there is a school of pharmacy. The LPC discussed regionally and there is a worry that there aren't spare pharmacists in Somerset to work onthis pilot. They did think that you need to be a prescribing pharmacist to be involved however SG clarified that you do for the more senior posts but not for all and you need to be employed in a prescribing service to be able to qualify as a prescriber which mostly happens in secondary care. Hopefully this will encourage more pharmacist prescribers in primary care.

MV did mention his practice is employing a pharmacist in Frome who is performing very well. They are handling the repeat prescription desk difficulties and queries particularly with initiations, discharged patients and queries from pharmacies. He

would definitely recommend supporting the employment of pharmacists in practices.

14.2 Impact of diverticulitis antibiotic treatment – there are different sets of guidance from different bodies which disagree on whether for patients with mild to moderate diverticulitis antibiotics treatment is of any benefit. We have quite a bit of co-amoxiclav prescribing in Somerset which is one of the antibiotics we have been asked to reduce the use of. It has been raised nationally with NICE and Public Health England whether they can review all the different guidance that has come out to see if they can change what NICE says in their CKS guidance that antibiotics are of benefit and update it with what Cochrane and NICE Eyes on Evidence say that antibiotics are of no benefit. Hopefully then we can start to give out more direct guidance to GP's that they should not be using co-amoxiclav for diverticulitis, at the moment it is outside the antibiotics guidance we produce, the suggestion is that we add a line to recommend GP's seek microbiologist advice until we get some national feedback.

14.3 LH mentioned that an issue that has come to light in Sompar. An M92 key, a master key available on the internet, which accesses most lockers and office furniture with small barrel locks, can be used to access their patient medication lockers and also their filing cabinet where all their FP10's are stored. You can tell if the key will work in a lock because the lock has M9 followed by three other digits on it, changing the lock doesn't solve the problem. SG asked her to raise it with Andy Knight so he can raise it through security.

14.4 It has become apparent that Weston hospital has changed their policy on providing bowel products for patients undergoing surgery or investigation, they have been asking GP's to supply. The CCG made a move away from that back in 2009 following an NPSA alert. SG has challenged this. CR asked what GPs should do as Weston are refusing to perform the test unless the GP prescribes the preparation. SG stated that the Somerset position is that the hospital should supply and the GP should push back to the hospital but the decision to supply rests with the GP.

The LMC will support the GP saying no to ensure safe and appropriate care of the patient. SG to copy in PAMM members to the email conversation.

Date of Next Meeting
Wednesday 9th September 2015, Meeting Room 1, Wynford House, Yeovil

NHS
Somerset
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PRESCRIBING AND MEDICINES MANAGEMENT GROUP MEETINGS
SCHEDULE OF ACTIONS

NO	SUBJECT	OUTSTANDING RESPONSIBILITY	ACTION LEAD	STATUS
ACTIONS ARISING FROM THE MEETING HELD ON WEDNESDAY 15th July 2015				
1	Stroke prevention in AF – Interface Clinical Services programme	Check with Rachel Rowe that correct governance processes has been followed.	**Catherine Henley 14th Oct 2015**	Ongoing
2	Medication Safety Network	check the terms of reference when finalised.	**Catherine Henley 9th Sept 2015**	On Agenda
3	Out-patient letter	CH to check the covering letter for request of acknowledgement from the trusts.	**Catherine Henley & Geoff Sharp 9th Sept 2015**	Completed
4	Medication Safety Network	Liz Harewood to check she is named on the TOR as Sompar representative.	**Liz Harewood 9th Sept 2015**	Completed
5	M92 master keys	Raise security issue of M92 keys with Andy Knight	**Liz Harewood 9th Sept 2015**	Completed
6	Medicines Incident Reports	To raise at the LPC meeting in September to encourage dialogue and a no blame culture between pharmacies and practices, sharing medicines incident reports to increase learning opportunities without additional paperwork	**Matt Harvey 14th Oct 2015**	Ongoing
7	Medicines Incident Reports – Pharmacy net	Jo to investigate england.bnsssg-pharmacy@nhs.net, who manages it and to request feedback on the incidents forwarded to them from the patient safety team.	**Jo Bird 9th Sept 2015**	Currently under review.
8	RCN insulin syringe guidance	Sompar to respond with their policy decision at next PAMM.	**Steve Du Bois 9th Sept 2015**	Completed
9	Future PAMM dates	Book meeting dates and rooms for January to December 2016	**Donna Yell 9th Sept 2015**	Completed
10	SGLT2 inhibitors (canagliflozin, dapagliflozin, empagliflozin): risk of diabetic ketoacidosis	Letter to be written to Andrew Dayani to raise concerns about high prescribing in Somerset	**Shaun Green 9th Sept 2015**	Completed
11	Provision of bowel preparations from Weston Hospital	To copy PAMM members into the email conversation to support them saying no to supplying bowel preparations for Weston hospital patients undergoing investigations or surgery.	**Shaun Green 9th Sept 2015**	Completed

Continued on next page

12	Learning from 2014/15 incentive audits	Clarification on the meaning of the percentage ranges for the Antipsychotic and COPD audit results. Summary of results and recommendations to be shared with practices. Results to be tidied and slide 13 typo "beta clocker" to be corrected.	**Steve Moore & Shaun Green 14th Oct 2015**	Ongoing
13	Newsletter articles	• Hospital Only medication recording. Article with a "How to" guide for EMIS web prescription records. • Promote the e-form and share the link for practices to report incidents via DATIX • To promote the change in reporting of INR >5, following the approval of the enhanced service specification.	**Shaun Green & Steve Moore 14th Oct 2015**	SG shared Ongoing Ongoing
14	Formulary changes	• Nutriplen Compact – Green • Fultium D3 2,740 IU/ml Oral Drops – Green • Invita D3 2,400 IU/ml oral drops solution – Green • Laxido Paediatric Plain - Green	**Steve Moore 9th Sept 2015**	Completed