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, 11th November 2015**

Present:	Dr Geoff Sharp (GS)	Chairman, CCG Prescribing Lead
	David Bell (DBe)	Governing Body Member/Chair Joint Commissioning Committee
	Dr Toby Burne (TB)	CLICK Representative
	Dr David Davies (DD)	West Somerset Representative
	Dr Steve Edgar (SE)	LMC Representative
	Dr Adrian Fulford (AF)	Taunton representative
	Shaun Green (SG)	Associate Director, Head of Medicines Management
	Matt Harvey (MH)	LPC Representative
	Catherine Henley (CH)	Locality Medicines Manager
	Dr Mike Holmes (MHo)	South Somerset Representative
	Dr Catherine Lewis (CL)	Bridgwater Representative
	Dr James Nicholls (JN)	West Mendip Representative
	Dr Carol Reynolds (CR)	North Sedgemoor Representative
	Dr Piers Jennings (PJ)	East Mendip representative
	Donna Yell (DY)	Prescribing Support Technician, Secretary
Apologies:	Dr Diane Bungay (DB)	East Mendip Representative
	Steve DuBois (SDB)	Somerset Partnership Representative
	Gordon Jackson (GJ)	Lay Representative
	Liz Harewood (LH)	Somerset Partnership Representative

1 INTRODUCTIONS

- David Bell, Joint Commissioning Committee Chair was introduced as an observer of the meeting
- Dr Piers Jennings was introduced as the East Mendip representative, taking over from Mark Vose.
- Karen Taylor arrived at 9.45am to present the Medications Safety Network update, she left after making her presentation.

2 APOLOGIES FOR ABSENCE

2.1 Apologies were provided as detailed above.

3 DECLARATIONS OF INTEREST

3.1 GS asked if PJ had submitted his declarations which he confirmed he had.

3.2 GS highlighted that budget setting is on the agenda and all GPs present would have an interest.

4 MINUTES OF MEETING HELD ON 15th July 2015

4.1 Agreed as an accurate record of the meeting.

4.2 **Review of Action points**

GS ran through the action points from the last meeting. Most actions were complete or raised on the agenda. The following items were specifically noted:

- Weston Hospital Bowel Prep requests -.CR will inform SG of any further requests.
- Sliding Scale / Variable Rate Dosing Insulin - MHo informed He has not taken

further with LH.
GS would like feedback from LH on sliding scale / variable dose rate insulin progress within SomPar.

- Learning from 2014/15 incentive audits - this is still ongoing. GS asked that it be brought to January PAMM.
- Newsletter articles - discussed the frequency of medicines management newsletters, the aim is bi-monthly but there is some slippage which results in a larger content. GS is concerned that by being too large it doesn't have the impact it could because people might not read it all. Comments from members welcomed.

PART 1 – ITEMS FOR DISCUSSION OR DECISION

5 Matters Arising

5.1 **October Clinical Operations Group (COG) Prescribing Recommendations** – Letter to practices from senior management team was viewed.

This letter was sent to prescribing leads and practice managers following an in depth review of prescribing at COG.

The aim is to encourage practices to adopt best practice and to bring them all to the same level.

There was a discussion where the following points were made:

- SE said he had not seen the letter at LMC or practice level.
- CL said her practice has had difficulties importing the EMIS Web protocols. GS confirmed they are not intuitive and some practices are not running EMIS Web.
- Action 6, 'Commit to achieve 15/20 green indicators on the prescribing scorecard by the end of March 2016', was felt to be the most challenging. COG have asked what needs to be done to enable these changes to be made more quickly. They have been advised the Medicines Management Team need more resources to support practices with this.
- It was felt that practices do want more support and also recognise the need for investment in this area.
- The use of the word 'commit' was queried, SG explained that it is expected that practices will respond with their intention to implement the 6 actions or not. The Medicines Management Locality Managers will be tasked with contacting practices and collating their responses to take back to COG.
- This subject will be discussed at the Prescribing Leads away afternoon on the 26th November.

6 Other Issues

6.0 **Somerset Medication Safety Network (MSN) Update**

Karen Taylor was welcomed to the meeting and shared the minutes of the last MSN meeting. The main points were:

- Patient Discharge pilot where the patient's discharge letter goes to their local pharmacy as well as the GP. MH informed the group the initial pilot from Wellington Hospital has failed and the next phase will involve YDH, it is expected that their electronic discharge system will make this easier however there are various governance and patient consent issues which are being ironed out.

- The difficulties with producing MAR charts for patients in domiciliary care. CH to link with KT and the Medicines and Clinical Tasks Policy Group on this.
- Patients prescribed macrolide antibiotics and oral antifungals who take statins need to be warned to stop the statin for the duration of the antibiotic course. MH confirmed that pharmacists would give this advice at the point they dispense a prescription. GP's usually advise at the point of prescribing the antibiotic, and sometimes add information to the dose line of the prescription. MH was asked to send a reminder to pharmacies through the LPC.
- Dr Steven Edgar is now representing the LMC on the MSN committee.

6.1 **PAMM Terms Of Reference (TOR) additional points**

COG have requested an amendment of PAMM TOR triggered by an enquiry from the LMC, for clarity around drugs approved onto the formulary possibly having an impact on Primary Care workload and requiring an enhanced service. If there are wider implications that require commissioning action PAMM should be making a recommendation for consideration by the Primary Care Joint Commitee.

The following points have been added to the TOR:

5.3. Where a drug is approved for prescribing in primary care which may satisfy the criteria for inclusion in an existing enhanced service the committee will recommend consideration of such inclusion to the Primary Care Joint Committee.

5.4. Where a drug is approved for prescribing in primary Care which may satisfy the criteria for a new enhanced service the committee will make such a recommendation to the Primary Care Joint Committee to consider the matter.

- Any comments from PAMM members around the wording are to be fed to SG, who will take the draft to COG for approval.
- There are currently no enhanced service criteria, in the past where PAMM have approved the use of something where we believe there is a need for an enhanced service we have already flagged e.g. injectable methotrexate and injectable risperidone.
- SE asked if enhanced service criteria should be devised. SG agreed – to be discussed at a later PAMM. Currently anything requiring monthly monitoring is considered an enhanced service and anything less than monthly is not necessarily considered enhanced service.

6.2 **Urology overactive bladder (OAB) prescribing pathway**

The proposed new OAB prescribing guideline was viewed.

The following points were discussed:

- The one page document is compliant with NICE guidelines and sets out Somerset Formulary recommendations.
- CR raised issues with poor continence team support, lengthy delays in seeing patients
- Conservative management is usually discussed around a leaflet given to the patient. This is problematic for GP's to action and monitor, they would suggest methods but may have difficulty reviewing.

- The pathway incorporates the recent safety warning that mirabegron is now contraindicated in severe, uncontrolled hypertension.
- Document to be added to the formulary and shared via the newsletter.

6.3 **Review of scorecard indicators**

The top 40 cost saving switches for Somerset were viewed and considered for adding to the scorecard indicators.

- Rosuvastatin – switching to atorvastatin would deliver the third largest available cost saving for the CCG. It is already covered by the Statin indicator, the recommendation is to keep the statin indicator but raise the target percentage.
- Low Dose Inhaled Corticosteroids – to remain on scorecard.
- Tiotropium to Eklira switch - not yet an indicator, potential £14k monthly saving for the CCG. Suggested as a possible future indicator.
- Seretide to Sirdupla switch - not yet an indicator, potential £13k monthly saving, work has started on this, suggested to add, possibly bundled with Duoresp.
- Fortisip – the price will drop in January 2016, there is still a potential saving if switched to dry powder, sip feeds possibly useful as a future indicator.
- Urinary Incontinence – remain on scorecard, raise target percentage.
- Tadalafil – already covered in the Sildenafil as a % of all PDE5's indicator.
- Co-codamol to Zapain – potential £10k monthly saving.
- Liraglutide to Lixisenatide – Dulaglatide has also dropped in price. SG commented that unless GP's have a special interest in diabetes, this switch would probably generate lots of negative responses. Sue Down (Diabetes Specialist Nurse) has been asked to undertake this switch via her team but no response yet. The diabetes group are not supportive of the switch.
- Mebeverine to Colofac – Colofac is currently in limited supply.
- Metformin to Sukkarto – potential £10k monthly savings available to the CCG, across all strengths.
- Felodipine to Amlodipine – currently on scorecard

Comments from the group were:

- There are currently 20 scorecard indicators with very few that can be changed. SG proposed removing three or four of the current indicators as they are green for the majority of practices and there is very little cost saving to be gained from them now.
- In raising targets too high, we could risk losing practice engagement. SG said there is scope to increase the targets for some of the indicators. None are ever set at 100% as this is unrealistic, patients who are intolerant, non-compliant or who have previously tried our recommendations would not be suitable to switch. The urinary incontinence indicator for example was raised from 50% to 60% this year and could potentially be increased to 65% next year, this would allow for new patients being initiated onto formulary preference and current patients on third line choices to be reviewed.

- MHo mentioned the difficulty for some practices where the work involved in making the switches sometimes costs more than the savings made.
- The scorecard savings scheme has saved £2.4million over the last four years, if savings are not made against budget, on an ongoing basis, other services will need to be cut.
- SG will bring proposals of which indicators to drop to next PAMM. Final decision needed March/April 2016.
- This information was felt to be useful evidence for the CCG to illustrate how few savings opportunities are left.

6.4 **Review of budget setting process**

SG shared the draft Prescribing in Primary Care Budget Setting Process 2016/17 document.

70% of budget is based on Age, Sex and Temporary Resident Originated Prescribing Units (ASTRO PU). Changes in Astros affect practice budgets.

Almost 30% is based on high cost drugs where GP's don't have control over drug choices.

1.5% is based on indexes of deprivation, these were updated in October 2015 by Public Health England. There are some changes in Somerset at ward level, SG hasn't been able to get practice level data yet, it has been requested.

The following points were discussed:

- Should consideration be given to practices who grow rapidly in the year?
- Does the proportion of the budget allocated to deprivation (currently 1.5%) need to be increased? – SG proposed an increase to 3% which was supported by PAMM but it will need to be checked as to the impact on final budgets to make sure that it does not unfairly disadvantage particular practices. The budget allocated to deprivation was roughly £2million last year.
- Need to review the 'exceptional high cost drugs list'. Pricing changes have occurred over the years which mean we could remove the dementia drugs. Diabetes drugs need debate incorporating a scorecard indicator around the gliptins while including diabetes drugs on the exceptional high cost drugs list could act as a disincentive for practices to prescribe these drugs cost effectively. Similarly, with the contraceptives. Propose to remove categories of drugs where most products are available generically. Practices should not be rewarded in their budget allocation for going against the scorecard recommendations.
- PJ asked how other CCG's go about budget setting and if our process is adequate. SG informed the group that following some public health analysis it showed our process brought all practices within the expected level of variation and the process is felt to be robust.
- Some practices who don't grow as much in the previous year may receive a budget less than the previous year though we try to give all practices an increase.
- Can overspend be attributed to budget setting or practice behaviour? In general practices who are underspent have complete all switches and scorecard savings.
- July 2015 data shows a spending growth of 5.3%.

- PPRS drugs have increased more than expected, there is a five year agreement, no change for the first two years but we are now entering the final three years where the prices can increase by 1-1.5%. There has also been some activity where companies have bought old brands, discontinued them and then launched expensive generic equivalents.
- SG shared some information about Sacubitril/Valsartan, a potential new high cost drug for heart failure. It is not yet licensed but has good reports from the trials and is expected to be approved by NICE in June/July 2016. Trials were stopped early as it worked convincingly better than the control. It is anticipated that there may be a demand from patients to receive it. Treatment is likely to cost of £1000 - £1500 per patient, per year and this poses a significant financial risk. In Somerset currently there are 4706 patients, of whom, potentially 2000 could be eligible for this treatment, which could lead to an extra £3million in costs per year.
- New weight loss drugs that are due to be licensed shortly could have similar implications for the prescribing budget.
- The group viewed the Prescribing Outlook New Medicines September 2015, NHS horizon scanning document. Some medications listed have an impact for primary care.
- Other factors that drive prescribing costs include population growth, unmet need and longer durations of treatment but drugs coming off patent do help to offset increasing costs.
- There were no Category M increases in October and there has been no announcement by the PSNC which could mean either that there is no need for adjustments or, that any announcement has been delayed until January
- SG is drafting a letter to finance to help plan for next year's budget, he will raise the financial risks as detailed above in the letter. He proposed to ask for a 5% increase on this year's final outturn. – 5% agreed by PAMM members.
- GS also mentioned that pressure is being put on secondary care to make savings, including the use of biosimilar products, as they become available, as a cheaper alternative to high cost rheumatology, dermatology, ophthalmology and gastroenterology treatments.
- Dates in the document need changing and need to ensure that ASTRO-13 units are used and referenced throughout the document.
- The document needs tidying and house styling.
- The final decision is needed by May 2016

6.5 **Proposals for audits 2016/17**

- At the beginning of this year COG asked for the Prescribing Quality and Improvement scheme to be made less onerous.
- The aim is to make improvements on prescribing quality and safety and the scheme is felt to achieve this.
- Members were asked to consider if there should be a scheme for 2016/17 and to consider particular areas they may want to look at including.
- It was suggested that one audit should be to re-audit an area previously undertaken to demonstrate improved prescribing quality

- Comments to be provided to SG and he will detail proposals at January PAMM.

6.6 **PAMM horizon scanning and assessment of prescribing growth required 2016/17 -** Discussed under item 6.4.

7 Formulary Applications

7.1 **AirFluSal Forspiro 50/500®** (salmeterol/fluticasone) Dry Powder Inhaler *Sandoz*

- AirFluSal Forspiro is licensed for the symptomatic treatment of adults with COPD, with a FEV1 <60% predicted normal (prebronchodilator) and a history of repeated exacerbations and who have significant symptoms despite regular bronchodilator therapy.
- It provides the same drugs and doses as Seretide Accuhaler 50/500 but unlike Seretide, it is not licensed in asthma or for use in under 18 year olds
- Cost= £32.74 compared to Seretide Accuhaler® 50/500 = £40.92
- Expected launch at the end of November, brought to PAMM early as no meeting in December.
- Approved, add to formulary as **GREEN**

7.2 **Ivermectin Cream (Soolantra®)** 10mg/g *Galderma UK*

- Licensed for the treatment of the inflammatory lesions of rosacea
- Price =£18.29/ 30g
- NICE guidance due in December.
- More costly than topical metronidazole (roughly £14) but it may stop a cohort of patients progressing to oral antibiotics.
- It has good evidence and, unlike other products, it is a parasiticidal and is thought to target mites that are associated with rosacea.
- PAMM has looked at this before and discussed with MPH dermatology who haven't had time to submit a formal application.
- Proposed to add to formulary as **GREEN** with dermatology support – agreed.
- GS asked for advice from MPH on the place this product has in therapy for rosacea.

7.3 **NEJM: Empagliflozin, Cardiovascular Outcomes, and Mortality in Type 2 Diabetes**

This journal article was reviewed which looks at cardiovascular events and mortality in type 2 diabetic patients at high risk of cardiovascular events taking empagliflozin vs placebo through a randomised double blind, controlled trial.

The study showed that patients with type 2 diabetes and at high risk of cardiovascular events who received empagliflozin compared with placebo, had a lower rate of primary composite cardiovascular outcome and death from any cause when empagliflozin was added to standard care.

- Given that there is very little data around cardiovascular outcomes and mortality with many of the newer antidiabetic agents, and in view of this evidence it was

agreed that empagliflozin should be made first choice of SGLT2 inhibitor in the formulary.

7.4 **Praluent®** solution for injection in pre-filled pen (alirocumab) *Sanofi*

- This is another in a new class of lipid lowering drug (an IG1 monoclonal antibody) licensed for:
    - Adult patients with primary hypercholesterolaemia (heterozygous familial and non-familial) or mixed dyslipidaemia, as an adjunct to diet:
    - in combination with a statin or statin with other lipid lowering therapies in patients unable to reach LDL-C goals with the maximum tolerated dose of a statin,
    - alone or in combination with other lipid-lowering therapies in patients who are statin-intolerant, or for whom a statin is contraindicated.
- The SPC states that the effect of Praluent® on cardiovascular morbidity and mortality has not yet been determined.
- Cost = £168 per pen / £336 per month
- Due to the cost and lack of clinical outcome data, it was agreed that the CCG will wait until NICE publish their guidance (due June 16) or until SPF receive a specialist application. This product will have a **BLACK** 'Not recommended' TLS status.

7.5 **Trulicity® (dulaglutide)** 1.5mg and 0.75mg prefilled pen *Eli Lilly.*

- This is a long acting GLP-1 analogue launched earlier this year, licensed to improve glycaemic control in adults with Type 2 diabetes mellitus as monotherapy or add-on therapy.
- The dose is once weekly.
- This product was considered in March 2015 and not added to the formulary because at £90.95 for 4 doses, it was significantly more expensive than modified release exenatide.
- The price has now been reduced to £73.25 for 4 doses which compares favourably with modified release exenatide.
- There is no comparative data with other weekly dose GLP-1 receptor agonists.
- NICE evidence summary was viewed, it is thought to be non-inferior to Liraglutide 1.8mg which NICE do not recommend but there is some use in Somerset, implemented by specialists.
- Recommended to add to formulary as **GREEN**.

8 REPORTS FROM OTHER MEETINGS

Commissioning Locality Feedback

South Somerset – MHo – Had a successful away day where Ana Alves did a very good presentation on asthma. Ana had demonstrated that if less than 50% of the suggested respiratory cost effective switches were made, then the South Somerset Commissioning Locality overspend would disappear.

West Somerset – DD – nothing to report.

Central Mendip – GS – nothing to report.

Bridgewater Bay – CL – nothing to report.

Taunton – AF – nothing to report.

Chard, Crewkerne and Ilminster – TB - nothing to report.

East Mendip – PJ - nothing to report.

West Mendip – JN – nothing to report.

North Sedgemoor – CR – nothing to report.

COG - discussed under items 5.1 and 6.1

Somerset Partnership D&TC - last meeting 05/11/2015 – minutes not received, CH attended the meeting and reported that:

- Sompar have agreed that they would support a switch from Concerta to Matoride.
- Following an audit of patients with learning disabilities who are taking antipsychotics which showed that this group of patients is not being as well monitored as some other groups of patients who are prescribe antipsychotics, SomPar is undertaking work to improve standards of monitoring in this group.

YDH D&TC - next meeting 19/01/2016

T&ST D&TC – next meeting 13/11/2015

BNSSG D&TC - last meeting 23/9/15 – minutes received**,** CH had viewed the minutes and reported that:

- BNSSG are potentially going to approve Toujeo – a high strength insulin, which could present some safety issues. This was declined at a previous PAMM.

T&S Antimicrobial Prescribing Group - next meeting 11/11/15

RUH Bath DPG - last meeting 08/10/2015 – minutes received, CH viewed and reported nothing to note.

LPC Report – MH – Devon and Cornwall LPC have highlighted the safety issues of high dose insulins and report the packaging is not that different to the usual insulins. Pharmacies have been advised to ensure that they separate concentrated insulins from the standard products in their fridges.

Medicines Safety Network – discussed under item 6.0

PART 2 – ITEMS FOR INFORMATION OR NOTING

9 Current Performance

9.1 **Prescribing Report**

No formal report brought due to significantly reduced prescription numbers submitted in August, giving inaccurate data.

- The scorecard project report from Eclipse was viewed.
- Overall Somerset is in a good position compared to national position.
- Statin position is approximately 1% below the national position due to high levels of rosuvastatin use.
- The report details the 20 poorest performing practices for each scorecard indicator.
- It is a useful report and shows the high levels of analysis undertaken by SG.
- This tool will be used to determine the indicators with the lowest available savings and therefore those which could potentially be removed from the scorecard next year.

9.2 **August Scorecard Federation Trend**

- The scorecard trend now includes a worksheet showing the overall position of the CCG on one page.
- The CCG has improved against most indicators over the year, gradually moving from red to amber to green. Not all indicators are currently green i.e. 'target achieved', but the trend is heading in the right direction.
- Other sheets detail the individual indicators and are broken down into commissioning localities and practices.

9.3 **August Safety Spreadsheet** – viewed and noted.

- Domperidone included following the safety alert about raised QT interval last year. Monthly items have reduced by about 200 items over the last year.
- Hydroxyzine items are reducing.
- Prednisolone 25mg has been added following the recommendation at October PAMM to remove from formulary – only 6 items in August. The practices have been asked to review.
- Mirebegron has been added following the recent safety alert and a new Eclipse Live alert has been designed.
- Where numbers of items do not decline practices are routinely asked to review and are made aware of the safety implications.
- It was agreed that the safety spreadsheet provides good evidence that the Medicines Management Team does not just focus on cost saving.

10 Rebate Schemes

- Newly signed Spiolto, Enoxaparin & Edoxoban
- To comply with correct governance process, rebate schemes are only signed for items that have already been approved for formulary use and not before.

11 NICE Guidance

11.1 **NHS Sheffield CCG framework of NICE guidance -** Viewed and noted

- Most new guidance this month relates to secondary care items or those commissioned by NHS England and aren't applicable for PAMM consideration.
- SG mentioned Tolvaptan for autosomal dominant polycystic kidney disease,

which has been confirmed as 'CCG commissioned and is going to SPF for review this afternoon.

12 NICE Technology Appraisals

12.1 **Final Appraisal Determination (FAD): Vortioxetine** – For noting

The positive NICE FAD for Vortioxetine in major depressive disorder was discussed. NICE are likely to recommend that vortioxetine is an option to treat major depressive episodes in adults whose depression has responded inadequately to two different antidepressants within the same episode. Sompar have commented that it is surprising that the FAD looks at a trial comparing vortioxetine with agomelatine which was not approved by NICE (the appraisal for agomelatine was terminated because the manufacturer failed to submit evidence).

It was agreed that:

- Vortioxetine would not be recommended for early implementation, the CCG has an obligation to implement NICE approved items within 3 months. Vortioxetine NICE recommendation is not due till the end of November.

13 NICE Clinical Guidance

13.1 **NG16: Dementia, disability and frailty in later life – mid-life approaches to delay or prevent onset** - Noted

This guidance recommends ensuring that promoting healthy lifestyles could help delay or prevent the onset of dementia. Lifestyle choices are already recommended to prevent many health issues. This could be another persuasive factor to encourage people to improve their lifestyle.

14 Safety Items, NPSA Alerts and Signals

14.1 **Mirabegron (Betmiga): risk of severe hypertension and associated cerebrovascular and cardiac events** – viewed and noted

- Is on formulary and doesn't have the anticholinergic implications of other urinary incontinence drugs.
- An eclipse live alert has been set up.
- Information to be shared in the newsletter.

14.2 **NHS Patient Safety Alert: Support to minimise the risk of distress and death from inappropriate doses of naloxone** – viewed and noted.

- No recommendations for practices from PAMM.
- Practices should have processes for dealing with safety alerts.
- A paper presented yesterday shows the government will be including naloxone amongst the list of injectables which can be administered by anyone in an emergency situation. We may therefore see naloxone being used more widely. Public Health will review local implementation.

15 BNF Changes

15.1
- Hard copies of the new edition have arrived.
- BNF editorial committee have removed the chapter, paragraph and subparagraph numbering, which has had a number of unexpected implications. This has

impacted on Epact data searches, monitoring of PBR excluded drugs which are referenced to BNF chapters and commissioned services e.g. SomPar, who reference the BNF codes. The eBNF will continue to have numbering for as long as necessary.

16 Any Other Business

16.1 **Antibiotic stewardship**

- SG attended the regional antibacterial stewardship meeting, the agenda for antibacterial stewardship is expected to get larger and incorporate veterinary medication, secondary care and primary care.
- Somerset is in a good position due to the work done over the past 10 years however our peers are catching up and overtaking because of the increased focus.
- Public Health evidence shows those practices with the best anti-microbial stewardship have lower levels of 'workload' from inappropriate patient appointments and requests for antibiotics.
- There was a discussion around CRP testing. SG will raise internally with the CCG the suggestion that the purchase of CRP testing equipment and test strips, could be made from money earned through the Prescribing Quality and Improvement Scheme.

16.2 **Flu Epidemic**

GS asked if there is a plan in place in the event of a flu epidemic. SG confirmed there is a plan and that it was tested last week at a simulation event.

16.3 **Leg Ulcer Clinic**

CR reported that a patient at her practice who attended the SomPar leg ulcer clinic had recently had one leg discharged, while the other was still being treated by SomPar. The practice wasn't informed. CR to report concerns via the health professional feedback form.

16.4 **Health Visitor Prescribing**

CL reported experiencing several occasions where Health Visitors have requested prescriptions from GPs. This seems to be because Health Visitors now operate under Public Health and no longer have access to prescription pads.

SG raised the issue several months ago. He will raise it again.

16.5 **Seasonal Flu Vaccination**

SG had attended the regional flu vaccination group and reported that, there is some concern about the impact pharmacy vaccination is having on GPs. A discussion covering the points below followed:

- Members were asked if they have overstock remaining because of this which might have an implication on GP funding. No-one reported any issues with this.
- There is an issue with District Nurses leaving it too late or not approaching patients to have the vaccine. SG to raise this with district nursing leads.
- Ordering next year's flu vaccines may be an issue for practices, since they have to order in February but the pharmacy marketing won't happen until Aug/Sept. This creates uncertainty for practices around how many vaccines they should order.

- SG stated that because of this and the chance practices may have overstock practices may decide to purchase more expensive vaccines next year to offset any loss. This will go against the scorecard indicator for using the lowest cost vaccines. SG has asked practices with a large overstock of vaccines to inform him and discuss possible compensation of costs.
- Pharmacies vaccinating patients should notify the GP by the next working day, at the latest. There have been some incidences where this has not happened, which the LPC have tackled. Data is reported daily into a national system.

Date of Next Meeting
Wednesday 13th January 2015, Meeting Room 2, Wynford House, Yeovil

NHS
Somerset
Clinical Commissioning Group

PRESCRIBING AND MEDICINES MANAGEMENT GROUP MEETINGS
SCHEDULE OF ACTIONS

NO	SUBJECT	OUTSTANDING RESPONSIBILITY	ACTION LEAD	STATUS
ACTIONS ARISING FROM THE MEETING HELD ON WEDNESDAY 11th November 2015				
1	LMWH perioperative bridging policy	CH to chase response to SPF suggested changes for next SPF	**Catherine Henley 13th Jan 2016**	Ongoing
2	MAR charts for patients in domiciliary care	CH to link with Karen Taylor and Medicines and Clinical Tasks Policy Group regarding this MSN item.	**Catherine Henley 13th Jan 2016**	Ongoing
3	Antibiotics for patients taking Statins	Reminder to go out to pharmacies via the LPC about advising patients to stop the statin for the duration of a macrolide antibiotic course.	**Matt Harvey 13th Jan 2016**	Completed
4	Sliding Scale / Variable Rate Dosing Insulin	Update on the progress of District Nurses being able to administer Sliding scale / variable dose rate insulin. MARR chart amendment.	**Liz Harewood 13th Jan 2016**	Revised MAR being reviewed 23/12/15
5	PAMM TOR additional points 5.3 and 5.4	Comments around the wording to be fed to SG who will take the draft document to COG for approval.	**PAMM members & Shaun Green 13th Jan 2016**	On agenda
6	Seasonal Flu Vaccination	• District Nurses leaving it too late or not approaching patients to have the vaccine - raise this with District Nurse leads • Practices to inform SG if they have a large overstock of vaccines.	**Shaun Green & PAMM members 13th Jan 2016**	No response
7	Place of Ivermectin in rosacea treatment	Advice to be sought from MPH dermatology to prioritise the formulary products for this indication.	**Shaun Green 13th Jan 2016**	On agenda
8	Health Visitor Prescribing	To raise the issue of Health Visitors not having access to prescription pads with Public Health.	**Shaun Green 13th Jan 2016**	On agenda
9	Draft budget setting document.	• Dates in the document need changing. • ASTRO-13s need to be referenced. • The document needs tidying and house styling.	**Shaun Green 13th Jan 2016**	Completed
10	Prescribing Budget request for 2016/17.	Draft letter to finance detailing financial risks for 2016/17 and request 5% increase on 2015/16 final outturn.	**Shaun Green 13th Jan 2016**	On agenda
11	2016/17 Quality and Improvement scheme	• Suggested areas of audit for January PAMM. • Raise internally with the CCG the suggestion of adding CRP testing equipment and test strips to the list of approved items which can be purchased with scheme money.	**Shaun Green 13th Jan 2016**	On agenda Completed

Continued on next page

12	Practice scorecard and budget	Raise GP awareness that the prescribing budget is not a 'virtual budget' and the impact that overspending may have on other budgets. To be raised at the prescribing leads away afternoon.	**Shaun Green 26th Nov 2015**	Completed
13	Scorecard Indicators	Bring proposals of which indicators to drop and include next year to future PAMM	**Shaun Green 13th Jan 2016**	On agenda
14	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 clarified and tidied.	**Steve Moore & Shaun Green 13th Jan 2016**	On agenda
15	Formulary changes	**Urology Overactive Bladder** - pathway to be added to formulary **AirFluSal Forspiro 50/500®** (salmeterol/fluticasone) Dry Powder Inhaler *Sandoz* ° licensed for the symptomatic treatment of adults with COPD ° Cost= £32.74 ° Approved add to formulary as **GREEN** **Ivermectin Cream (Soolantra®)** 10mg/g *Galderma UK* ° Licensed for the treatment of the inflammatory lesions of rosacea ° Price =£18.29/ 30g ° Proposed to add to formulary as **GREEN** with dermatology support. - agreed. **Empagliflozin** - to be made first line SGLT2, due to evidence of improved cardiovascular outcomes. **Trulicity® (dulaglutide)** 1.5mg and 0.75mg prefilled pen *Eli Lilly.* ° £73.25 for four pens of either strength. ° Licensed to improve glycaemic control in adults with Type 2 diabetes mellitus as monotherapy or add-on therapy. ° Recommended to add to formulary as **GREEN**.	**Steve Moore 13th Jan 2016**	Completed
16	Traffic Light changes	**Praluent®** solution for injection in pre-filled pen (alirocumab) Sanofi • Due to the cost and lack of clinical outcome data, It was agreed that the CCG will wait until NICE publish their guidance (due June 16) or until SPF receive a specialist application. This product will have a **BLACK** 'Not recommended' TLS status.	**Steve Moore 13th Jan 2016**	Completed

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17	Newsletter articles	• Urology overactive bladder prescribing pathway. • Mirabegron (Betmiga▼): risk of severe hypertension and associated cerebrovascular and cardiac events	**Steve Moore 13th Jan 2016**	Completed