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 April 2015**

Present:	Dr Geoff Sharp (GS)	Chairman, CCG Prescribing Lead
	Steve DuBois (SDB)	Somerset Partnership 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 James Nicholls (JN)	West Mendip Representative
	Dr Carol Reynolds (CR)	North Sedgemoor Representative
	Dr Mark Vose (MV)	East Mendip representative
	Lucy Watson (LW)	Director of Quality, Safety and Governance and Caldicott Guardian – in attendance
	Donna Yell (DY)	Prescribing Support Technician, Secretary
Apologies:	Dr Tony Austin	Chard, Crewkerne and Ilminster Representative
	Dr Diane Bungay	East Mendip Representative
	Dr David Davies	West Somerset Representative
	Dr Steve Edgar	LMC Representative
	Dr Adrian Fulford	Taunton representative
	Gordon Jackson	Lay Representative
	Dr Catherine Lewis	Bridgwater Representative

1 INTRODUCTIONS

1.1 Mark Vose was introduced as the East Mendip Representative standing in for Dr Diane Bungay.

1.2 Lucy Watson was introduced as Director of Quality, Safety and Governance and Caldicott Guardian attending to discuss agenda item 5.1: Prescribing budget and incentive scheme COG decision.

2 APOLOGIES FOR ABSENCE

2.1 Apologies were provided as detailed above.

3 DECLARATIONS OF INTEREST

3.1 Lynda Coles LPC representative now Chair not Vice Chair.

4 MINUTES OF MEETING HELD ON 11th March 2015

4.1 Amendments to be made to point 7.8; Magnolia House (MH) should read Mental Health (MH). Point 9; Minor Ailments scheme LPC report is not a pilot, amended to say evaluation. DY to action.

4.2 Review of Action points

1. Psychosis shared care guideline – On the agenda to be discussed
2. Pivmecillinam – completed
3. Somerset Medicines and Clinical tasks Policy –Sam Pearce to look at developing IT systems to help improve communication regarding changes to medication between GPs and carers.

4&5. SDB discussed with Liz Harewood she is going to raise it at LPC (meet once every 6 months) MAR in policy is an example, every provider has a different MAR chart, Liz doesn't think the council has much authority to

impose a universal MAR chart.
6. Email sent to Karen Taylor, need to discuss further.
7. Bimatoprost – completed.
8. Formulary changes – completed.
9. Xenidate® – completed.
10. Pregabalin – On the agenda to be discussed
11. Temazepam initiation – item to go into next newsletter to highlight the high cost and more cost effective choices of hypnotic.
12. Low Molecular Weight Heparin Bridging therapy for patients who need to stopping warfarin for a surgical procedure – This is high on the safety agenda and there is a lot of variation between hospital policies. This is being taken forward by SPF, will keep PAMM briefed on progress.
13. Infliximab – completed.
14. Budget and Incentive scheme – On the agenda to be discussed
15. Incentive Scheme – On the agenda to be discussed
16. Antimicrobial toolkit – work in progress Ana Alves to lead.
17. Nice Guidance LGB25 and NG5 – On the agenda to be discussed
18. Nice guidance added to newsletter – completed
19. Acute Kidney Injury, sick day rules – Medicines Management have edited the NHS Highland cards to a Somerset version, acknowledging NHS Highland. Supplies have been ordered for distribution across Somerset to GP's, pharmacies and secondary care. A letter will accompany them with clarification on where to position and how to use and explain the information to patients. The intention is to distribute alongside the incentive scheme to link the work streams. LW highlighted the national priority.As GP patient safety lead, Dr Lindsay Smith is taking the lead on this alongside Rachel Rowe and Steve Moore from Medicines Management.
20. SG has not contacted Somerset care yet.

PART 1 – ITEMS FOR DISCUSSION OR DECISION

5 Matters Arising

5.1 Prescribing Budget and Incentive scheme COG decision discussion – led by LW and GS.

BUDGET

LW stated that Finance have to set budgets fairly according to the overall financial position and it isn't possible for them to set it to our requirements. The budget set is £77,034,000 which is significantly less than the figure recommended by SG and PAMM. Finance are also asking for £1.7million savings in QIPP savings against this budget. LW said there are other areas of savings that could be made and it's not all down to primary care.

Concerns were expressed that setting an unachievable budget, could lead GPs to disengage from the medicines management agenda and that this could make the overspend position even worse. LW responded there is a need to look at the things we ask practices to do that makes it something they want to engage with. If the budget overspends because it hasn't been set correctly then it is corporate responsibility.

GS mentioned the huge frustrations for GP's due to out of stock items, shifting prices, brand changes. However, it was recognised that some practices could do more

although it is a delicate balance and an excessively aggressive approach to making savings could have a detrimental effect.

There are no plans to adjust the budget allocation formula for practice budgets this year. SG mentioned the letter that went to COG and that he wants practices to direct the concern about budgets to their COG representative. LW mentioned David Slack and Matthew Dolman should also be involved.

INCENTIVE SCHEME
COG are in agreement that they want to have an incentive scheme but disagreed with PAMM believing that it should not purely be a prescribing incentive scheme. SG has therefore revised the proposed prescribing only incentive to align it with the strategy for other CCG work streams to drive quality improvement.

The financial incentive is no longer linked to overall prescribing outturn but based on a practice's own overall performance. GPs were concerned that the audits should not be too unwieldy and SG was keen to ensure there is some evidence of follow up from any action plans.

The 2015/16 scheme includes payment for 1 mandatory and a maximum 3 out of 5 optional audits. There was concern that the financial incentive to perform the audits does not make it worthwhile. It was emphasised that Somerset GPs are very lucky to have an incentive scheme and that we try to focus on areas of poor outcomes or national strategies. Many other CCGs don't have schemes and this kind of work is expected as core work from GPs. There is a need to get the balance right not to overload practices and to offer support to complete the work.

The finer details of the scheme are still to be determined and passed through COG. GS wants to ensure the information is communicated to practices quickly to ensure we don't lose engagement.
Incentive Scheme Draft agreed to resubmit to COG.
LW left the meeting.

5.2 Suggested item for incentive scheme, email by a GP around using House of Care Model for medication reviews -There was a discussion around the form used by house of care and the group felt that some of the terminology used would not be familiar to the target patients. It was pointed out that lots of medication reviews are done opportunistically so, providing the patient with a a form ahead of the review is not always feasible. PAMM recognised that it is useful to have a medicines focus prior to the review but, as the use of the form would not be readily measurable, it was not a practical option for the incentive scheme.. GS agreed to feedback

5.3 Antipsychotic Shared care Guideline –
In light of the review of NICE CG 178 on the treatment of psychosis and schizophrenia in adults last year, it had been proposed by PAMM in October, that SomPar would retain the prescribing of antipsychotics along with the monitoring for patients initiated on antipsychotics for at least the first 12 months.

However, no agreement had been reached because longstanding arrangements have been that SomPar will ask the GP to take over shared care prescribing arrangements once the patient has stabilised. Specialists made it clear that they are not in a position to be able to support this without an injection of significant funds and

that there are practical implications for patients who have difficulty attending clinic appointments.

PAMM agreed that the position would remain unchanged and the psychiatrists will continue to apply to GP's to take over shared care of prescribing once the patients' condition is stable. SDB clarified that the NICE guideline states that monitoring should remain with the specialist service but it doesn't mention prescribing. During the discussion with the specialists the need for an ECG to be carried out before commencing treatment was raised. Somerset Partnership have not been able to achieve this in every clinic but they are investing in being able to do so. The need for better communication regarding these patients, between mental health and primary care has been fed back to specialists.

It was agreed that while PAMM is unable to implement its interpretation of the guidelines as it would like and although the position is not comfortable, this is the first step to improving outcomes for patients.
SG will share the revised version in due course.

5.4 Leflunomide Shared Care Guideline – the out of date version has been updated by CH. The main changes are:

1. Comment that leflunamide is always used as 3rd line has been removed – specialists say it can be used earlier.
2. Treatment for Psoriatic Arthritis has been added.
3. Loading dose regimen has been removed
4. Clarification on the length of wash out prior to pregnancy and additional guidance around pregnancy added.
5. Monitoring recommendation reduced slightly to align with the British Society of Rheumatologists.

6 Other Issues

6.1 15/16 Flu vaccination programme -
A letter regarding the details of the 15/16 campaign has been circulated to practices.

JN raised that within the list of eligible people 'all children of school years 1 and 2' could be misleading. Does it mean 'Reception and year 1?' SG will review the details.

GS informed the group that COG had a presentation from Julie Yates about immunisations in general, highlighting that Somerset does not perform as well compared with other CCG's in the area for MMR uptake. COG believe that it would be good to have a person/group that is responsible for reviewing and monitoring immunisation uptake on an ongoing basis. It was proposed that PAMM should take on this function.

SG said there aren't the resources within medicines management to monitor vaccine uptake but he will discuss the issue with Lucy Watson.

6.2 14/15 Flu vaccination uptake figures –
The uptake target was 75% for practices, there are a small number of practices who exceeded the target but the majority of practices did not meet the target..

SG asked how we could increase flu vaccine uptake to support the urgent care agenda. JN asked if it was worthwhile asking the practices who achieved the target

to share their strategy.SG agreed to take that forward as an action point.

The low uptake amongst pregnant women was discussed. A number of GPs in the group felt that midwives could do more to encourage pregnant women to be vaccinated against flu. MH said that an issue was raised at the recent flu planning meeting that some patients remain coded as pregnant after they had given birth and that this could affect the flu vaccine uptake figures.

The general consensus was that the CCG could do more to improve vaccine uptake.

7 Formulary Applications

7.1 Branded generic pregabalin products –
Following normal due process for formulary applications it was recommended to add Rewisca® (Consillient) brand pregabalin to the formulary for its licensed uses – all agreed.
SPF to note.

7.2 Aviticol® (Ashfield Healthcare) 20,000iu Vitamin D capsules, the cost is comparible to other preparations on the formulary, an alternative option to expensive specials – recommended to add to formulary – all agreed.

8 Medication Safety Network

8.1 Medication Safety Incidents Report -
Jo Bird, Senior Clinical Audit Facilitator, Nursing and Patient Care was welcomed to the meeting to present her report. Having come to the end of quarter 4 she is able to compare 2 years of medication error reporting data. Jo explained that:

- The new web form went live on the 16th March 2015,.
- Since then, there have been 10 errors reported and, of these, 6 have gone up to the national system, 2 of which had been reported by GP practices.
- There is a link on the CCG form to the national report form which only takes a couple of minutes to complete. This has been developed in the hope that, by having an easier system, more reports will be made.
- one practice had undertaken a significant event audit following an incident. This had resulted in a protocol being written for the drug concerned. The auditing GP was contacted to ask if they would be happy to use the incident for shared learning, they agreed and they also offered to share the protocol.
- Feedback from the small number of people who have used the form has been good. The database is due to be updated to include an addition to automatically upload data to national reporting.

Jo Bird and Karen Taylor have met with the national reporting team recently who are starting to think about a revised national reporting system. They were asked for input on what they would like to include from a primary care perspective. It has a 3 year time scale. It should result in a much better central system which links into Datix and possibly Emis to make reporting a lot easier both locally and nationally.

SG asked about the INR reports and if there is more investigation into those. The pathway is being reviewed at the moment. Currently any INR over 5 should be reported to the CCG as a significant event, Jo looks at the significant event audits done within the practice, any complicated ones are passed to Sheryl Vincent as contract manager along with Rhianna Morris, South West Pathology's INR lead to

review. They produce a quarterly audit for those practices involved. SG wanted to know if there was any learning gained from these incidents that could be used, Jo provided a breakdown of INR incidents for the anticoagulation steering group at the end of last year and she asked if it would be useful to repeat with the data for this year. It was agreed that this would be useful

GS suspects there is significant underreporting and asked if it was possible to compare the reporting with the number of patients with INR >5 information from practices. SG agreed to ask Steve Moore to look into it.

GS asked the clinicians on the group what advice they give to patients taking warfarin regarding dose and INR testing when they are started on an antibiotic. The response was variable about whether to reduce the warfarin dose or not and when to retest INR. SG said advice does depend on the patient and how stable their INR is.

GS asked the Medicines Management Team to include some information in the newsletter regarding INR advice.

8.2 Medicines Safety Network –

The Somerset Medication Safety Network has been established following the National Patient Safety Alert NHS/PSA/D/2014/005 in March 2014. Karen Taylor is the registered Medication Safety Officer (MSO) for Somerset CCG and is involved in local and national safety networks. The group held their first meeting in January 2015 with representation from CCG, SomPar, Care UK – Shepton Mallet treatment centre, YDH and LPC. SWAST were unable to attend, MPH had only just appointed their MSO and did not attend, the group are considering inviting other representatives possibly a lay person and other care agencies. It was suggested that it might be useful to include the Somerset Doctors Urgent Care Service.
An MSO email group has been set up to enable sharing electronically.

From a meeting of the national network the main priority being taken forward was improving the reporting of allergy status. There is a need to correctly code and describe the reaction. Karen Taylor had shared a document with CH summarising how to improve allergy recording in Emis web. It was highlighted that read coding doesn't separate between adverse reactions and allergies and currently any free text on Emis Web does not get pulled through to the patients summary care record. MHo was tasked with testing this before wider distribution.

The group have written their terms of reference. The main objectives of the group are to review local incidents and overview shared learning and identify areas for action; to improve the reporting of incidents, to use the network for shared incident follow-up across all sectors and services.

The main comments were that:
SG believes the network should play a bigger role in any national patient safety alerts regarding medications including the MHRA drug safety update. This builds into the patient safety governance structures of organisations, it also links with the quality review meetings in the acute trusts. CH to feed back to Karen Taylor.

9 REPORTS FROM OTHER MEETINGS

Federation Feedback

- South Somerset – MHo – Main discussion around Symphony, discussed Pregabalin/Lyrica issue and the budget and incentive scheme.
- West Somerset – DD – not present
- Central Mendip – GS – discussed budget, Pregabalin/Lyrica and scorecard, noticed some variability among practices.
- 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 – nothing to report
- North Sedgemoor – CR – haven't met but has had feedback from 1 practice under increased antibiotic surveillance, they have been asked to report their weekly antibiotic use, last 6 months of cephs etc and explain why they've used them, they felt this was excessive. The federation had assumed that these requests had come from Medicines Management but SG pointed out that he is aware that Public Health may have sent letters to the top prescribers of antibiotics from each CCG and that Medicines Management do not know who is involved and are not linked to the letters. Other PAMM members were unaware of this.

It was agreed that practices should be made aware of the increased scrutiny of antibiotic prescribing from Public Health. CH to check with Harry Yoxall, LMC Secretary to see if any information has been included in the LMC newsletter.
COG – main issues discussed budget and incentive scheme
Somerset Partnership D&TC – no meeting since 5.3.15
YDH D&TC –meeting 17.3.15 was cancelled
T&ST D&TC –minutes not received from meeting 13.2.15
BNSSG Formulary Group – minutes not received, nothing noteworthy on their website re formulary decisions.
T&S Antimicrobial Prescribing Group – minutes not received from meeting 18.3.15
RUH Bath DPG – CH viewed the minutes and reported the proposal to use Rivoraxaban unlicensed to prevent DVT's for patients who require lower limb immobilisation following a fracture. CH had contacted Joy Crane the interface pharmacist for Bath who said it hasn't been considered by their formulary committee yet but their recommendation will be that it remains a Red 'hospital only' drug and that RUH should make the whole supply. GS asked CH to make sure an update is included in the newsletter when the decision is made by the BCAP formulary committee.
LPC Report – nothing to report

PART 2 – ITEMS FOR INFORMATION OR NOTING

10 Current Performance

10.1 Prescribing Report – the report was presented including February data. There has been a slight improvement in the financial position but the CCG still forecast a £1.7million overspend. Just 24 practices are predicted to underspend at year end.

The budget for 2015/16 as been set at £77,034,000 which amounts to £1million in growth, of which, at least £600,000 will be spent on category M changes, current

growth stands at is £1,970,749- 2.96% (excluding dressings) which has been flagged to Lucy Watson.

SG recommended that PAMM and COG note the high level of risk with regards to the 2015/16 growth in the prescribing budget.

Prescribing costs in Somerset remain in the lowest quartile of all CCGs and the lowest in BNSSSG. Considerable unmet need remains in Somerset with regards to the CCG priorities of reducing preventable morbidity and mortality from cardiovascular disease.

Avastin®/Lucentis® issue – nationally CCG leaders wrote to the DoH, MHRA and GMC to ask them to review their position on the 'off label' use of Avastin® for AMD. All 3 organisations have replied to say that organisations should use a licensed product ahead of the off license use of another product.

Care home pharmacist service data is showing useful savings and quality and safety interventions – Ana Alves should have a report for the next meeting.

10.2 January scorecard federation trend – practices have reached a steady state on some indicators, this may be because all patients have been reviewed or practices are too busy to undertake further work on them. LW has been made aware that it is not practical to expect to achieve 100% target on these savings and predicting savings from this is unrealistic.

SG reported that the FDA have reviewed the cardiac risks with Saxagliptin and found that Saxagliptin does increase the risk of heart failure. A warning will be issued shortly. At the moment, Alogliptin has not been associated with the same risks. The FDA are now reviewing Sitagliptin and if 2 or more preparations within the same class are found to cause the same problems, then it is likely that all preparations in the class will have a warning issued.

There has been discussion about practice engagement and it was agreed that it is sensible to look at practice performance across the range of scorecard indicators rather than purely concentrating on their financial performance.

How indicators are set was discussed, some national indicators have already been achieved in Somerset. Medicines Management decide on the indicators as a team and are always looking for more opportunities to improve the quality, safety and cost effectiveness of prescribing.

GS asked whether it was useful for practices to be able to see the highest gains and prioritise, SG outlined the intention to look at top 500 savings switches for each practice. They will be asked to look at their list, and prioritise the top savings. They will be asked to notify medicines management whether or not they agree to a switch.

10.3 Safety spreadsheet – viewed and noted.

11 **Medicines Optimisation Dashboard** – the new version is due to be released in April but no changes yet.

12 Rebate Schemes

12 GlucoRx - a rebate scheme has been offered, SG will inform PAMM of the details and if this moves forward.

13 NICE

13.1 TA335 Rivaroxaban for preventing adverse outcomes after acute management of acute coronary syndrome – SG has discussed with Stuart Walker the local cardiologist who is raising awareness of it with the cardiac network. He doesn't think there is a great demand to use it as there are other options available (prasugrel and ticagrelor). They are not in a hurry to implement it. It does need to go through D&TC but will be added to CCG formulary.

13.2 TA336 Empagliflozin in combination therapy for treating type 2 diabetes – now 3 medications in this class though this has slightly different indications. Mostly using Dapagliflozin in Somerset driven by the specialist service, Canagliflozin is also available. Medicines management will be reviewing the cost and formulary positioning for each. Agreed to add to the formulary as a green drug.

13.3 TA337 Rifaximin for preventing episodes of overt hepatic encephalopathy – to consider this as an Amber drug for shared care or stay as a red drug for secondary care. Costs £259 per month, most pts receive 6 months treatment although there is a risk that it may be continued long term. There are no real safety issues. This will be added to the TLS as a red drug and the traffic light status will be reviewed at the SPF meeting in May. CH to add to SPF agenda.

13.4 CG28 Depression in children and young people: Identification and management in primary, community and secondary care - SomPar to discuss, might increase fluoxetine use in children. Also flags licensing issues of fluoxetine in particular age groups.

13.5 NG5 Medicines Optimisation: the safe and effective use of medicines to enable the best possible outcomes – being discussed in medicines management meeting 16.4.15 looking at completing the baseline assessment tool. SG will bring more detail to the next PAMM meeting.

13.6 NG6 Excess winter deaths and morbidity and the health risks associated with cold homes – has been shared with Steven Foster and Ed Ford as there is a review being undertaken regarding this winters deaths.

13.7 NG7 Maintaining a healthy weight and preventing excess weight gain in adults and children – MHo commented that this contained sensible advice on exercise, healthy eating and keeping fit and healthy.

13.8 LGB25 Older people in care homes – flagged to the better care fund, linked to the care home work being undertaken. It was noted that this needs to be highlighted to the complex care GPs.

14 Safety Items, NPSA Alerts and Signals

14.1 March 15 DSU – noted. CH to flag to the Medicines Safety Network to look at these.

15 BNF Changes

15.1 Aceclofenac guidance amended – noted

16 Any Other Business

16.1 Extending EPS to schedule 2 and 3 controlled drugs – estimated to roll out June/July 2015. Should include instalment prescriptions. This has been raised with Martin Silk

and Alison Nation as the implementation leads for EPS. Clarification will be needed for users of the system before it goes live.

16.2 Relaunch of Terra-Cortril® ointment – this contains tetracycline and hydrocortisone and will be recommended to treat infected eczema instead of fucidin / fucibet prescribing which carry risks of causing resistant staph aureus. It was agreed to add this product to the formulary.

Date of Next Meeting

Wednesday 20th May 2015, Meeting Room 1, Wynford House, Yeovil

NHS
Somerset
Clinical Commissioning Group

PRIMARY CARE MANAGEMENT TEAM MEETINGS
SCHEDULE OF ACTIONS

NO.	SUBJECT	OUTSTANDING RESPONSIBILITY	ACTION LEAD
ACTIONS ARISING FROM THE MEETING HELD ON WEDNESDAY 15th April 2015			
1	Amend Declarations of interest for Lynda Coles	Change Vice chair of Somerset LPC to Chair	**Donna Yell 20th May 2015**
2	Somerset Medicines and Clinical tasks Policy	To raise issue of a standardised MAR chart with LPC working group.	**Liz Harewood 20th May 2015**
3	Somerset Medicines and Clinical tasks Policy	To discuss further with Karen Taylor	**Catherine Henley 20th May 2015**
4	Temazepam initiating	Reminder of hypnotics guidance to go in newsletter	**Steve Moore 20th May 2015**
5	T&ST D&TC Proposed bridging therapy stopping warfarin	Being taken forward by SPF to keep PAMM informed	**Geoff Sharp 20th May 2015**
6	Antimicrobial Toolkit data	Work in progress	**Ana Alves 20th May 2015**
7	Acute Kidney Injury, Sick Day Rules Cards	Distribution to be aligned with implementation of the 2015/16 incentive scheme	**Shaun Green 20th May 2015**
8	Somerset Care cutting/crushing tablets policy	Contact Somerset care to discuss	**Shaun Green 20th May 2015**
9	2015/16 draft incentive scheme	PAMM to approve and have reviewed by the governing body.	**Geoff Sharp and Shaun Green 20th May 2015**
10	PAMM advice to COG	COG request for advice on tackling practices who are constantly overspent or disengaged.	**PAMM members 20th May 2015**
11	Antipsychotic Shared Care Guidelines	Revised version to be shared with PAMM	**Shaun Green 20th May 2015**
12	2015/16 Flu vaccination programme	Clarification on the ages of children for the eligible criteria 'all children of school years 1 and 2'	**Shaun Green 20th May 2015**
13	2015/16 Flu vaccination programme	Request information from practices achieving the 75% target, regarding the details of their strategy.	**Donna Yell 20th May 2015**

Continued on next page

14	Formulary changes	• Rewisca® (Consillient) brand pregabalin – green for licensed indications only • Aviticol® (Ashfield Healthcare) 20,000iu Vitamin D capsule – green • Rivoraxaban – add for new NICE tag TA335- amber indication • Empagliflozin – green Terracortril Ointment– green	**Steve Moore** **20th May 2015**
15	INR medication safety incidents reports	Report for the anticoagulation steering group last year to be updated for this year.	**Jo Bird** **15th July 2015**
16	INR medication safety incidents reports	Comparison of reports for INR >5 against practice specific data to tie in with Jo Bird 's report	**Steve Moore** **15th July 2015**
17	INR medication safety incidents reports	Item to be added to newsletter regarding Warfarin dose and INR testing for patients needing antibiotics.	**Steve Moore** **20th May 2015**
18	Medication Safety Network	To feedback the need for the groups involvement with Drug Safety Updates.	**Catherine Henley** **20th May 2015**
19	Medication Safety Network – allergy read coding	To test the summary guidelines for reporting allergies and adverse reactions within Emis web provided by Karen Taylor.	**Mike Holmes** **20th May 2015**
20	RUH rivoraxaban proposal	Inform PAMM when a decision has been made by the formulary committee.	**Catherine Henley** **20th May 2015**
21	Care home pharmacist service	Report to be brought to next PAMM meeting	**Ana Alves** **20th May 2015**
22	GlucoRx rebate scheme	Details to be brought to PAMM if signed	**Shaun Green** **20th May 2015**
23	TA337 Rifaximin	Add to SPF agenda	**Catherine Henley** **20th May 2015**
24	CG28 Depression in children and young people	Add to Sompar agenda	**Steve DuBois** **20th May 2015**
25	NG5 Medicines Optimisation	Baseline tool to be completed	**Shaun Green** **20th May 2015**
26	LGB25 Older people in care homes	Need to link with the complex care GP's	**Catherine Henley** **20th May 2015**