York and Scarborough
Medicines Commissioning Committee

Minutes of Medicines Commissioning Committee Meeting
Wednesday 9th August 2017
9.30-12pm, West Offices, York

1. Apologies / Attendance

		SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG
Strategic Lead Pharmacist- MMT	Mrs Rachel Ainger (RA)	✓	✓	✓	CANCELLED	✓	✓	✓	✓	✓	✓	✓	A
Chair & Vale of York CCG Pharmacist	Mrs Laura Angus (LA)	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓
GP Prescribing Lead – S&RCCG	Dr Greg Black (GB)	✓	✓	✓		✓	✓	A	✓	✓	✓	✓	✓
Principal Pharmacist Formulary, Interface and Palliative Care	Mrs Jane Crewe (JEC)	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓
Consultant Anaesthetist	Dr Peter Hall (PH)	✓	✓	✓		✓	✓	✓	A	✓	✓	A	✓
Consultant Physician	Dr Paul Jennings (PJ)	✓	✓	A		✓	✓	✓	A	A	A	✓	A
Deputy Chief Pharmacist Tees Esk and Wear Mental Health Trust (TEWV)	Mr Richard Morris (RM)	✓	✓	A		✓	A	A	CW	A	✓	A	✓
GP Vale of York CCG	Dr William Ovenden (WO)	✓	✓	A		✓	✓	✓	✓	✓	✓	✓	✓
GP Prescribing Lead - VoYCCG	Dr Shaun O'Connell (SO'C)	A	✓	✓		A	A	A	A	✓	✓	A	✓
Deputy Chief Pharmacist	Mr Stuart Parkes (SP)	✓	A	✓		A	✓	A	✓	✓	✓	A	✓
Consultant Psychiatrist (TEWV)	Dr Michelle Beaumont (MB)						✓	A	✓	A	A	A	A
Consultant Psychiatrist (TEWV)	Dr Shona McIlrae (SM)	✓	A	A		A	A	A	A				
Consultant Cardiologist	Dr Chris Hayes							✓	✓	A	✓	✓	✓
Regional Drug & Therapeutics Centre, Newcastle – Professional Secretary (BR & MM alternate)	Ms Bhavana Reddy (BR)/ Mrs Monica Mason (MM)/ Mrs Elizabeth Okpara (EO)	✓ MM	✓ BR	✓ MM		✓ MM	✓ MM	✓ MM EO	✓ BR EO	✓ MM EO	✓ MM EO	✓ EO	✓ MM EO

Item	
1	**General business** Laura Angus (LA) chaired the meeting. Apologies were received from Rachel Ainger, Dr Paul Jennings and Dr Michelle Beaumont for the meeting today.

	Declarations of conflicts of interest relating to the agenda No interests were declared for items being discussed today.
2	**Matters arising**
2.1	**Chairs actions to report** VoY CCG approved a request for silk clothing for a 7 year old child who had tried all other treatments. A request was also approved for a GP to prescribe the phosphate binder sucroferric oxyhydroxide for a patient from Leeds. Sucroferric is currently a red drug on the York and Scarborough formulary, but amber shared care in Leeds; therefore approval was granted if the GP was willing to prescribe under the shared care arrangement. **Action:** RDTC to review whether sucroferric should also have amber RAG status in Y&S. There was nothing to report from ScR CCG. **Outcome of VoY SMT/SRCCG Clinical Executive Committee** All recommendations from the June and July MCC meetings were approved by the VoY CCG CE committee including the use of IV zoledronate for improving breast cancer survival in post-menopausal women. MCC had discussed at the July meeting that implementation of this treatment required further consideration with regards to exploring more cost effective ways of administration. However the CE committee's view was that it was clinically appropriate to approve this treatment and the cost was a finance/contracting issue to be considered outside of MCC and the CE committee. VoY CCG informed the group that recommendations will now also be taken to the executive committee after they have been to the CE committee. ScR CCG CE committee were yet to consider the July recommendations as they hadn't met since the last MCC meeting. **Draft minutes and matters arising from last meeting** The minutes were agreed as a true record. **Action log/long-term matters arising** **OAB pathway** – LA informed the group that the person who was working on the pathway has now left. SP offered to take it on if necessary. A first draft is anticipated for the September meeting. **Action:** MMT to submit draft pathway for the September meeting. **Methotrexate SCG** – JEC confirmed that a clinical check of the SCG has been completed. There was a query to be clarified regarding the dose threshold of methotrexate which would permit administration of the varicella zoster vaccine. The SCG will be uploaded onto the formulary website once clarified. **Twelve month audit data MCC outcomes** – MMT are analysing appropriateness of VSL#3 prescribing, and spend on vitamin D products against formulary choices/ medal ranking. **Action:** MMT to submit findings for September meeting. **Apixaban – prescribing data for non-valvular AF** MMT agreed to gather apixaban prescribing data for non-valvular AF to enable MCC to review an issue that had been raised regarding patients unnecessarily prescribed low doses – this is anticipated for the September meeting. WO briefly informed the group of an audit carried out in York Medical Group to identify the appropriateness of prescriptions for apixaban 2.5 mg BD. Nine out of 58 patients on apixaban 2.5 mg BD were prescribed incorrect doses, 6 of which were started by the practice and the others in secondary care. WO indicated that some patients are

	prescribed reduced doses after experiencing nose bleeds. However, he questioned whether it would be more appropriate to stop the drug in such circumstances as the patient would be on a sub-therapeutic dose and potentially exposed to adverse effects. SP offered to discuss this with the anticoagulant clinic and feedback. **Action:** MMT to bring data on apixaban prescribing for non-valvular AF to September MCC meeting. SP to feedback comments from anticoagulant clinic. **TEWV: Safe lithium prescribing and shared care (update)** – The guideline was approved at the July 17 TEWV D&T meeting following minor amendments. RM will forward once the updates have been made. **Action:** RM to forward final version of the guideline. **Formulary amendments agreed in July (TAs 446 – 451)** – Links to all of the TAs have been added to the formulary. The NHSE commissioned drugs that were not already on formulary are to be ratified first by the D&T committee before they get added. **Application for new injectable methotrexate pen – Nordimet®** - Both the formulary and the methotrexate shared care guideline have been updated to include the Nordimet® device. **Liothyronine RAG status for hypothyroid crisis** – The formulary was yet to be updated to reflect a red RAG status for liothyronine injection for hypothyroid crisis. **Action**: JEC to update formulary **Black list assessment: Lactose free formulae** – The formulary has been updated to reflect a black status for lactose free formulae.
3 **3.1**	**Governance** **September meeting** The MCC meeting planned to be held on Wednesday September 13th has provisionally been rescheduled for Wednesday September 20th, depending on the number of agenda items received.
3.2	**MCC 2016/17 Annual report** Comments and suggestions were requested from group members on the format and content of the draft Y&S MCC 16/17 annual report. It was suggested that the report should include more detail on the group's activities e.g. keeping the formulary up to date with NICE guidance, monitoring the impact of the group's approved recommendations, and updated RAG status of mental health and palliative care drugs. **Action**: Comments and suggestions to be sent to MM to incorporate into the report. Group members' thoughts on how well MCC is working were also discussed. The general feeling was that the group is useful and productive. However there were some suggestions on how the group might work better, majority of which related to making the most effective use of the time available: • Having a timed agenda – it was noted that there is sometimes insufficient time to go through all agenda items and a timed agenda might assist with keeping the discussions on track to avoid this. • Discussing certain agenda items bi-monthly rather than monthly. The idea of bimonthly meetings was also suggested but there were concerns about being able to get through agenda items in the time available. It was agreed that the meetings would remain monthly for the time being. • Making more use of email to discuss and agree certain issues as appropriate. • Introducing a threshold and rationalising items to be considered by MCC, in order to make the most effective use of time and resources. • RM informed the group of a new meeting format recently implemented for the TEWV D&T meeting whereby the agenda is split into 3 main sections – items requiring decision and approval, items requiring discussion or comment, and anything else for

	information. This helps to ensure appropriate allocation of time to agenda items and has so far been working well. This idea was well received by the group. • The issue of commissioner attendance at the Trust's D&T committee meetings was also raised as group members from the Trust felt that it would be useful to get their perspective during discussions. However, since most of the D&T discussions are usually around drugs used in secondary care, the benefit of commissioner attendance was thought to be unclear. On the other hand, MCC discusses drugs used both in primary and secondary care. Reinstating commissioner attendance at MCC will be looked into. • Regarding items discussed at the Trust D&T committee, it was noted that PbR excluded drugs should be discussed at MCC rather than D&T as commissioners should be involved in the decisions made about use of these drugs. • It was noted that the group was yet to reach a formal agreement for patients moving from other areas who are on medicines with a different RAG status in the original area than that on the Y&S formulary. Also, the tool for assessing drugs for the Black list is still being trialled by the group and yet to be finalised. • There was a query about how the group would receive feedback from the regional medicines optimisation committee but this is yet to be finalised. **Action**: Members agreed to a gradual introduction of the proposed ideas.
4 **4.1**	**Mental Health Medicines Commissioning** **Tees, Esk and Wear Valley Mental Health Trust:** **D&T confirmed minutes (May 17)** The group noted the minutes. **Annual MO report** This report summarising the medicines optimisation activities of TEWV was provided for information. **D&T feedback - summary from July 17 meeting** RM updated the group that the lithium safe prescribing guidelines and the ADHD medications shared care guidelines (methylphenidate and atomoxetine) had been approved by subject to some minor amendments. He noted that the lithium safe prescribing guidelines now includes criteria for carrying out 6 monthly monitoring although TEWV will continue to carry out monitoring every 3 months. **Action**: RM to forward the final versions once completed.
5 **5.1**	**National and Regional Guidance** **Monthly NICE update (July 2017)** It was noted that TAs 452-454 were terminated appraisals and no further actions were necessary for these. All drugs in TA455 & TA462 are already listed as red drugs in the relevant chapters of the formulary; the TA links are to be added. The drugs in TA457: Carfilzomib for previously treated multiple myeloma, TA458: Trastuzumab emtansine for HER2-positive advanced breast cancer and TA459: Collagenase clostridium histolyticum for treating Dupuytren's contracture are to be added to the relevant chapters of the formulary as red drugs with a link to the TA. Estimated patient numbers for collagenase were requested. TA456: Ustekinumab for moderately to severely active Crohn's disease – ustekinumab is to be added to chapter 1 as a red drug with a link to the TA. JEC/SP informed the group that Trust specialists intended to continue using adalimumab and infliximab first line and patients would now receive ustekinumab instead of vedolizumab. Ustekinumab has the advantages of being cheaper than vedolizumab, and it can be administered subcutaneously whereas vedolizumab is given via IV infusion currently via the Medical Elective Suite. Since April this year 14 patients in York and 1 in Scarborough will who

	were swapped to vedolizumab are likely to be switched to ustekinumab. TA460: Adalimumab and dexamethasone for treating non-infectious uveitis – adalimumab is listed in chapter 11 and currently has a red status for severe refractory uveitis in children and a grey status in adults. The grey status is to be removed as this is no longer used for the Y&S formulary. It should be assigned red status for the NICE approved indication and the TA link added. Dexamethasone intravitreal implant is listed in chapter 11 as a red drug with a statement that VoY and ScR CCG commissions up to 2 injections (per eye) for uveitis; this statement is to be removed as the NICE TA does not specify a maximum number of injections. Estimated patient numbers for dexamethasone were requested. TA461: Roflumilast for treating COPD – roflumilast currently has a black status on the formulary with reference to TA244 in which it was only recommended in the context of research. However, TA461 now replaces TA244. The TA recommends that treatment should only be initiated by a respiratory specialist and it was noted that the corresponding RAG status for the Y&S formulary would be amber specialist initiation. It was also mentioned that the drug may need to be considered within the COPD pathway. The group requested estimated patient numbers and information from specialists on the measures that will be used to evaluate treatment efficacy so that the drug can be stopped in patients with inadequate response. ***Post meeting note:*** *YFT specialists have indicated that the target group would be the "frequent exacerbator" phenotype patients who are relatively unusual and identifiable through frequent rises in CRP and WCC. Use of high dose ICS and low dose macrolide prophylaxis would usually be tried first. Though monitoring criteria are difficult to set, expected benefits of roflumilast would include reduction in bronchitic symptoms and some improvement in QoL scores and lung function. However, the main benefit is significant reduction in moderate to severe exacerbations (including hospitalisations) with an expected average reduction of 45% (i.e. 0.5 to 1 exacerbations per patient per year). Therefore it could be discontinued in patients who have clearly increasing exacerbation rates despite being on the drug. The most common side effects are weight loss and GI disturbance; the drug should be stopped in patients experiencing these to a significant degree. YFT are currently working on estimated patient numbers but expect this to be low given the restriction of specialist initiation only.* NG71: Parkinson's disease in adults has been published to update and replace CG35. The link to the guidance needs to be updated on the formulary. NG12 was noted for information only and required no further action. **Action:** JEC to update formulary accordingly and obtain information requested on patient numbers and specialist feedback. **Medicines Safety (MHRA drug safety update – July 2017)** The drug safety updates for July were noted. The links to the warnings regarding bendamustine, and nivolumab & pembrolizumab are to be added to chapter 8 of the formulary. **RDTC monthly horizon scanning (July 2017)** The group noted the RDTC monthly horizon scanning information. In particular: • Various branded generic versions of pregabalin are now indicated for neuropathic pain, and pregabalin has now moved to category M of the Drug Tariff. However, it was discussed that the category M prices will not result in immediate savings for CCGs as they will be held centrally by NHS England as a system risk reserve initially to be returned at a later date in 2017/18 or subsequent years. The mechanism of how this will be done is yet to be confirmed. • The first triple inhaler containing beclomethasone, formoterol and glycopyrronium (Trimbow®) licensed for COPD is now available. RDTC are currently working on a New Drug Evaluation to review the evidence and will inform the group when the first

	draft is available. • Dimethyl fumarate is now launched for psoriasis. A NICE TA is expected shortly as the Final Appraisal Determination was published on 04/08/17 which recommends its use. It was agreed to await the NICE TA.
5.2	**NHS England consultation on proposed guidance for low priority for funding items** The group discussed the ongoing NHSE consultation on proposed guidance for items which should not routinely be prescribed in primary care due to end on 21st October 2017. Group members were generally in support of the proposed guidance. Concerns were raised that the guidance is largely focused on primary care prescribing and not secondary care. It was felt that this still leaves an open door for prescribing these items and while it is recognised that they might need to be prescribed in specific cases, they shouldn't be used in the vast majority of patients in any sector. Another concern was that the criteria used to inform the recommendations may not be reasonable in all cases. It was suggested that the guidance should be looked at locally rather than following it in a blanket manner; in some cases, there is an agreed local pathway with criteria on when the item can be tried (e.g. lidocaine patch). Regarding proposals for OTC items, there was concern that they may disadvantage people who are not able to pay for their prescriptions as some medicines are expensive to buy. The cost of OTC products should also be considered as part of the consultation. LA informed the group that four North Yorkshire CCGs were collaborating to consult with the public and this is being overseen by the communications and engagement team. It was agreed that there would be a joint MCC response to the consultation but each CCG and the Trust would also respond separately. Group members were requested to send their comments to the RDTC who will collate the responses received with an aim to submit the draft response for the September meeting. Responses were requested by 23/08/17. **Action**: Group members to send their responses to RDTC by 23/08/17.
6 **6.1**	**Formulary and Managed Entry of New Drugs** **Combined Hep A/ Hep B vaccine – review of commissioning position for travel purposes in light of global shortages** MCC were asked to review the current commissioning position of the combined Hep A/Hep B vaccine for travel in light of the current global shortages of the separate vaccines. The VoY travel vaccine guidance currently states that the combined vaccine should not be prescribed on the NHS for travel purposes. This is because while the Hep A vaccine can be given as part of NHS provision, the Hep B vaccine is not remunerated by the NHS when used for travel purposes. Therefore providing the Hep B element using the combined vaccine is inappropriate use of NHS resources. The group noted that Public Health England had issued guidance to help mitigate the shortages and the combined vaccine is recommended in certain circumstances. It was agreed that whilst there remains a shortage, the combined vaccine can be used for those patients requiring Hep A for travel in line with PHE guidance and the travel vaccine guidance would be updated to reflect this. As the Hep B vaccine cannot be given on the NHS, patients requiring it for travel are required to obtain the vaccine privately and this remains applicable when the combined vaccine is used. **Action:** MMT to update travel vaccine guidance to reflect the above.
6.2	**Formulary status review: dicycloverine** A review of the formulary position of dicycloverine was suggested following a significant increase in cost over recent months making it considerably more expensive than other antispasmodics. The group reviewed a summary prepared by the RDTC noting that a 28 day supply of dicycloverine 10 mg to 20 mg TDS currently costs around £155 to £197 compared to £4.44 for mebeverine 135 mg TDS. It was also noted that the NICE CKS IBS guideline and the British Society of Gastroenterologists do not advocate use of dicycloverine for spasms because it is associated with adverse effects. Instead, smooth muscle relaxants e.g. mebeverine, alverine or peppermint oil are recommended. In addition, CKS found little difference in efficacy between different antispasmodics. Based

	on these points, the group felt that this drug should be assessed for black list inclusion. On completing the tool, it was agreed that a black status is assigned to dicycloverine based on the criteria that "the drug is not a cost-effective use of resources". SP will check whether this drug is prescribed by Trust specialists. **Action**: JEC to update formulary accordingly once approved by CCGs. SP to check whether specialists prescribe.
6.3	**RAG status review: dexamfetamine for narcolepsy in adults** This item was deferred as the group required further information on the origin of dexamfetamine prescriptions for narcolepsy to aid discussions. **Action**: MM/EO to liaise with RA regarding origin of dexamfetamine prescriptions for narcolepsy. JEC/SP to obtain information from Trust specialists regarding whether it is used and if they would support shared care.
7 **7.1**	**Interface: Shared Care Guidelines (SCGs) and Pathways** **Glaucoma pathway and formulary section review** This pathway which was discussed at the February MCC meeting was resubmitted following consultation with Scarborough. JEC reminded the group that the pathway was developed to reflect current practice, and the formulary section reviewed to ensure use of the most cost-effective agents. The order of use of carbonic anhydrase inhibitors has been changed based on cost - dorzolamide moved from second line to first line, and brinzolamide moved from first line to second line. Also, additional preservative free preparations have been added so that there is a preservative free (PF) option for each drug group. Since the pathway was last seen by the group, additional guidance has been included within the "preserved pathway" on management if there is insufficient response and a marked reduction in intraocular pressure is required. The group approved the pathway and the proposed formulary amendments including change in order of dorzolamide and brinzolamide stated above, removal of carteolol 2%, timolol 0.5% and levobunolol PF rom the formulary, and addition of bimatoprost PF, dorzolamide PF and dorzolamide + timolol PF to the formulary as amber specialist recommendation. It was noted that the declarations of interest (DOI) section of the formulary section review form was incomplete and the group requested that JEC chase this up with the individuals involved. **Action**: JEC to update formulary to reflect pathway and choices of agents once approved by CCGs, and to chase the DOI with the relevant individuals.
7.2	**Guideline for the administration of subcutaneous furosemide in the community setting** JEC presented this guideline which updates a historical guideline used by Scarborough palliative care/heart failure team and reflects current practice. It was noted that the target audience of the guideline was staff who manage the administration of subcutaneous furosemide in the Trust. However JEC explained that it was submitted to MCC since GPs may be asked to prescribe. The guideline was approved subject to the removal of the reference to metolazone which is now an unlicensed drug. **Action:** JEC to upload following amendment and once approved by CCGs.
8 **8.1**	**Monitoring/reporting** **Twelve month audit data MCC outcomes for recommendations from March, April and May 2016** The group reviewed the audit reports on cost and activity for recommendations made in March, April and May 2016. It was suggested that information on the cost growth from the previous 12 months should be included as this would give a better indication of the financial impact of the recommendations. RDTC could provide support with this if needed. JEC pointed out that the spend on penicillamine approved for cystinuria in March 16 was unlikely to be due to use for cystinuria because the consultant with interest in using it left the Trust and the shared care guideline was never completed. It was suggested that inclusion of other possible indications apart from the one the recommendation relates to may need to be considered. **Action**: RDTC to provide support with audit reports subject to confirmation. MMT to consider inclusion of other possible indications as appropriate.

8.2 **8.3**	**VoY Red drugs data (Jan to Mar 17)** **ScR Red drugs data (Jan to Mar 17)** The reports were noted by the group. The appearance of lisdexamfetamine on the reports was queried since it has an amber RAG status; it was explained that this may be because the status is yet to be updated on the CCG RAG lists. The group questioned whether actions were taken to tackle the red drug prescribing and it was confirmed that the prescribing was challenged locally.
9	**Patient and clinical communications** Nothing to report.
10 **10.1** **10.2** **10.3**	**Items from other groups** **Hull and East Riding Prescribing Committee (HERPC) minutes (May 2017)** The draft minutes were noted by the group. **Antimicrobial stewardship subgroup update** - No updates **York and Scarborough Drug and Therapeutics Committee minutes (March 2017)** The minutes were noted. The group questioned whether the item on rivaroxaban as an option for the treatment of VTE pre-diagnosis should have been brought to MCC. JEC noted that this never went ahead and the Trust decided to continue with the use of dalteparin for this indication. The same question was raised about use of Voractiv (rifampicin/isoniazid/pyrazinamide/ethambutol) which was approved for initial treatment of TB. However, all TB drugs are red drugs prescribed in secondary care only therefore it was deemed appropriate for it to be discussed at D&T and not MCC.
11 **11.1** **11.2** **11.3** **11.4**	**Any urgent business** **First line statin on formulary** It recently came to light that simvastatin is the first line statin on the Y&S formulary and atorvastatin second line when VoY were about to launch a Healthy Hearts campaign which involves switching patients from simvastatin to atorvastatin. The group agreed that atorvastatin should be the first line statin on the formulary in line with NICE guidance. **Action**: JEC to update formulary accordingly. **Shortage of Epipen** JEC informed the group that there was currently a manufacturing problem with Epipen®, as a result, the Trust have been supplying Jext® as an alternative. **RAG status for Spiriva (tiotropium) Respimat inhaler for asthma** JEC noted that there was uncertainty as to the agreed RAG status for Spiriva Respimat inhaler for asthma. Following its inclusion in the asthma pathway, it was added to the formulary as a green drug. However, the original application proposed a RAG status of amber specialist recommendation. LA said she would look to clarify this. **Action**: LA to clarify RAG status for Spiriva Respimat for asthma. **RAG status of Parkinson's disease drugs** JEC had received a query from MMT regarding a discrepancy between the RAG status of Parkinson's disease (PD) agents on the formulary and the CCG RAG lists. The formulary currently has most PD agents as amber specialist recommendation, whereas the CCG RAG list has some PD agents as green. The group commented that PD agents should not have a green status as the RSS guidance on PD states that patients should be referred to a specialist before any treatments are started. Therefore amber specialist recommendation is more appropriate (except where agreed otherwise). MCC recently approved amber specialist recommendation RAG status for PD agents which were previously unclassified. **Action**: JEC to feedback to enquirer.
	Date and time of next meeting: Wednesday 20th September 2017, 9:30am, West Offices, York.