York and Scarborough
Medicines Commissioning Committee

# Minutes of Medicines Commissioning Committee Meeting
# Wednesday 11th October 2017
# 9.30-12pm, West Offices, York

## 1. Apologies / Attendance

| | | NOV | DEC | JAN | FEB | MAR | APR | MAY | JUN | JUL | AUG | SEP | OCT |
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| Strategic Lead Pharmacist- MMT | Mrs Rachel Ainger (RA) | ✓ | CANCELLED | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | A | ✓ | ✓ |
| Chair & Vale of York CCG Pharmacist | Mrs Laura Angus (LA) | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| GP Prescribing Lead – S&R CCG | Dr Greg Black (GB) | ✓ | | ✓ | ✓ | A | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Principal Pharmacist Formulary, Interface and Palliative Care | Mrs Jane Crewe (JEC) | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Consultant Anaesthetist | Dr Peter Hall (PH) | ✓ | | ✓ | ✓ | ✓ | A | ✓ | ✓ | 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 | ✓ | A | ✓ |
| GP Vale of York CCG | Dr William Ovenden (WO) | A | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| GP Prescribing Lead – VoY CCG | 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 | A | A |
| Consultant Cardiologist | Dr Chris Hayes (CH) | | | | | ✓ | ✓ | A | ✓ | ✓ | ✓ | A | A |
| In attendance | Faisal Majothi (FM) | | | | | | | | | | | | ✓ |
| Regional Drug & Therapeutics Centre, Newcastle – Professional Secretary (BR & MM alternate) | Ms Bhavana Reddy (BR)/ Mrs Monica Mason (MM)/ Mrs Elizabeth Okpara (EO) | ✓ MM | | ✓ MM | ✓ MM | ✓ MM EO | ✓ BR EO | ✓ MM EO | ✓ MM EO | ✓ EO | ✓ MM EO | ✓ MM EO | ✓ MM EO |

| Item | |
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| 1 | **General business**<br>Laura Angus (LA) chaired the meeting.<br>Apologies were received from Dr Chris Hayes, Dr Michelle Beaumont and Stuart Parkes for the meeting today.<br>Group members welcomed Faisal Majothi, newly appointed pharmacist at Vale of York |

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| | CCG who attended the meeting today.<br><br>**Declarations of conflicts of interest relating to the agenda**<br>No interests were declared for the agenda items being discussed today. |
| **2** | **Matters arising** |
| **2.1** | **Chairs actions to report**<br>There were no Chair's actions to report.<br><br>**Outcome of VoY SMT/SRCCG Clinical Executive Committee**<br>The VoY CCG CE committee approved all recommendations from the August and September MCC meetings.<br>The ScR CCG CE Committee also approved all recommendations from the September meeting. However, the committee raised some comments about the Treatment Advice Notes (TANs) within the Outpatient Prescribing guidelines. It was felt that the TANs are often not clear/legible therefore typed letters would be preferred. Also, patients often expect that they will get a prescription for the medicine straightaway when they present the TAN to the GP surgery which is not the usual procedure. Trust representatives explained that some clinics will type letters soon after the consultation, while some are behind on typing letters, and some operate completely on hand written communication e.g. antenatal. TANs can be used to communicate with the GP before they receive typed clinic letters. They also explained that patients should not be given the expectation that they will get the medicines straightaway. It was agreed that the issue of legibility of TANs and patient expectations would be highlighted through the directorates but it was requested that ScR CCG try and find out if the issue is in a specific area which could be targeted directly.<br>**Action:** JEC to contact all directorates to highlight the issues with TANs; ScR CCG to try and find out if the issue is in a specific area; RDTC to check timeframe within which GPs should receive clinic letters.<br><br>**Draft minutes and matters arising from last meeting**<br>The minutes were agreed as a true record following few minor amendments.<br><br>**Action log/long-term matters arising**<br><br>**Twelve month audit data MCC outcomes** – see agenda item 6.4.<br><br>**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. RA informed the group that this work would be handed over to their new pharmacist who will be starting in October.<br>**Action:** MMT to bring data on apixaban prescribing for non-valvular AF to November MCC meeting.<br><br>At the August 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. He 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.<br>Feedback received from the anticoagulant clinic was that in general, they would not recommend a dose reduction for patients who have nose bleeds. However, individual clinicians might choose to do something different. The group accepted that there was no consensus regarding this issue. |

**Combined Hep A/Hep B vaccine – review of commissioning position in light of global shortages -**
Following the CE committee approval, VoY CCG will now update their travel guidance to reflect the agreed temporary position in light of the vaccine shortages.
**Action:** MMT to update travel guidance.

**RAG status review: dexamfetamine for narcolepsy in adults** – The group requested further information on the origin of the prescriptions and whether it is used by Trust specialists and if they would support shared care. RA is still waiting to hear back from the consultant involved who is based at South Tees hospital. Trust specialists yet to be contacted as awaiting information from South Tees first.
**Action:** Issue to be considered outside of the meeting and brought back if necessary.

**Glaucoma pathway and formulary section review** – This pathway has been approved and the formulary has been updated to reflect the approved choices of agents and the pathway. However, the group requested information on the declarations of interest of individuals involved in the pathway which hadn't been completed on the application form. JEC informed the group that one of the consultants has been in charge of the annual Yorkshire Glaucoma Symposium sponsored by Allergan, organized glaucoma teaching for the department in June sponsored by Thea and has been an invited speaker at SAS symposium also funded by Allergan where she will be presenting in November. Others involved are yet to provide information on DOI, it was requested that JEC chase these up.
**Action:** JEC to chase information on DOI from the remaining individuals.

**Guideline for the administration of subcutaneous furosemide in the community setting** – The approved guideline is yet to be uploaded onto the formulary.
**Action:** Guideline to be uploaded onto formulary.

**Formulary amendments agreed in September (TAs 463-467, TAs 471-473, NTAG link to sodium oxybate recommendation, drug safety updates)** – JEC has updated the formulary accordingly.

**Specialist feedback on use of eluxadoline (TA471)** – see agenda item 6.1.

**Data on biosimilar prescribing trends** – In relation to monitoring uptake of biosimilar products, the group requested that SP submits data on biosimilar prescribing trends to be reviewed at the next MCC meeting.
**Action**: SP to submit data for November meeting.

**Formulary application: Resource ThickenUp Clear®** – The formulary has been updated with Resource ThickenUp Clear® as the first line thickening agent (green). Since Leeds retained Thick and Easy® on their formulary for the children and patients with significant renal impairment, SP agreed to check with the YFT SALT team what they usually do for these patient groups.

Feedback from the SALT team was that renal patients could use Resource ThickenUp Clear® but that Thick and Easy® would still be required for paediatrics. It was agreed that Thick and Easy will be left on the formulary as green for use in paediatrics.

**Formulary applications approved: new indications for ondansetron & granisetron; ferric maltol, glucodrate** – JEC has updated the formulary accordingly.

**Formulary status review: Topical diltiazem** – At the September meeting, it was proposed that both diltiazem cream and ointment should be included in the formulary as the cream is cheaper in secondary care while the ointment is cheaper in primary care. However, it was questioned whether there is much prescribing of topical diltiazem in

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| | secondary care as it is mostly prescribed as an outpatient drug and by GPs and as such the formulary should include the item that is cheapest in primary care. JEC agreed to check levels of prescribing and feedback to the group.<br>JEC informed the group that they found topical diltiazem was being dispensed for outpatients and they will be looking into this. The formulary has been updated to state that the most cost effective item should be prescribed – this would be ointment in primary care and cream in secondary care.<br><br>**Mycophenolate SCG** – first drafts of the mycophenolate SCGs for transplant and non-transplant indications are expected for the November meeting. See agenda item 7.1 regarding approval of non-transplant indications.<br>**Action**: SP/JEC to submit first drafts of SCGs for November meeting.<br><br>**OAB pathway** – Following review of a first draft of this pathway submitted by SP, MMT will be taking over its development, incorporating the comments made by the group.<br>**Action**: MMT to submit revised draft for a future MCC meeting.<br><br>**Pigmanorm cream** – It was highlighted that dermatologists had been recommending Pigmanorm cream (hydroquinone/hydrocortisone/tretinoin) for prescribing in primary care. This is an unlicensed product that is very costly in primary care.<br>**Action:** JEC has been asked to feedback to the dermatology department that this item is not for prescribing in primary care. |
| **3** | **Governance**<br>Nil |
| **4**<br>**4.1** | **Mental Health Medicines Commissioning**<br>**Tees, Esk and Wear Valley Mental Health Trust**<br><br>**TEWV D&T committee July 2017 – confirmed minutes**<br>The group noted the minutes.<br><br>**TEWV D&T committee September 2017 – summary report**<br>The main point to highlight from this was the updated depression and anxiety medication pathways which are for discussion on the agenda – see below.<br><br>**Depression and anxiety medication algorithms – for consultation and comment**<br>RM presented these updated pathways to the group. They have been simplified and expanded from secondary care only previously to now include primary care. Treatments have been colour coded to give an indication of the treatments that would be expected to be red, amber or green. The pathways were well received by the group but the following points were made:<br>• Titles of the algorithms should be indicated on each page for clarity<br>• The depression pathway states that mirtazapine 15 mg ON is more sedating than 30 mg ON which seems contradictory. However RM clarified that this correct and not an error. It is a paradoxical effect of mirtazapine. It was requested that this should be stated in the pathway so users are clear.<br>• In both pathways, the recommended starting dose of sertraline is not clear. The pathways state sertraline "100 mg OM (titrate to dose)". However it is unclear whether this means the starting dose should be 100 mg OM or a lower dose should be used which is then titrated to 100 mg OM. A recommended starting dose of 100 mg OM would represent a change in practice for prescribers who are used to starting at 50 mg OD. Therefore this requires clarification.<br>• Prazosin is included as an option in the anxiety pathway for patients with post-traumatic stress disorder for nightmares. It was noted that Greater Manchester recently disapproved its use for this indication based on recent US guidelines which found insufficient evidence to recommend for or against the use of prazosin for PTSD-related nightmares. Hence, its inclusion in the pathway may be worth looking |

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| | into.<br>• Escitalopram is recommended as the preferred alternative SSRI in the anxiety pathway. The group questioned why this has been selected over citalopram as although escitalopram was relatively inexpensive, it still costs nearly twice as much as citalopram (£1.35 vs £0.72p for 28 x 20 mg tablets). RM explained that escitalopram was preferred as it is slightly safer than citalopram with respect to QT prolongation. It was suggested to consider amending the pathway such that citalopram would be preferred and escitalopram used for patients at risk of QT prolongation.<br>RM noted that they were still considering better ways of presenting the information in the embedded documents containing references and supporting information so that they could be easier accessed. He also noted that the updated NICE depression guideline is due in November and the pathways would be reviewed to ensure they are in line with NICE.<br>They are anticipating D&T approval of the pathways in November 2017 after which they will be brought back to MCC as final versions.<br>**Action**: RM to look into issues raised by the group for clarification. Final versions to be brought back to MCC after TEWV D&T approval. |
| **5**<br><br>**5.1** | **National and Regional Guidance**<br><br>**Monthly NICE update (September 2017)**<br>The drugs in TA474 (sorafenib for treating advanced hepatocellular carcinoma) and TA476 (paclitaxel as albumin-bound nanoparticles with gemcitabine for untreated metastatic pancreatic cancer) are already listed on the formulary; the TA link is to be added to the relevant section of the formulary.<br>TA475 (dimethyl fumarate for treating moderate to severe plaque psoriasis) is discussed in agenda item 6.2.<br>NG73 (endometriosis: diagnosis and management) was noted to include recommendations on analgesia and combined hormonal contraception. The link to this guidance is to be added to sections on combined hormonal contraceptives and hormone replacement therapy.<br>NG74, NG75 and PH38 were noted for information. No further action was necessary for these items.<br><br>**Medicines Safety (MHRA drug safety update – September 2017)**<br>The group noted the drug safety updates for September on OTC miconazole oral gel & warfarin, and loperamide. The links are to be added to the relevant section of the formulary.<br><br>**Requested formulary amendment**<br>It had been identified that Spiolto Respimat® (tiotropium and olodaterol) is currently on the formulary as an amber drug for COPD. However this is not in line with the COPD pathway as other LABA/LAMA combinations for COPD are on the formulary as green drugs. Therefore Spiolto Respimat® will also be changed to green.<br>**Action:** JEC to update formulary accordingly following CCG approval. |
| **6**<br><br>**6.1** | **Formulary and Managed Entry of New Drugs**<br><br>**Eluxadoline – specialist feedback on place in therapy and review**<br>The group requested information from Trust gastroenterology specialists on the use of eluxadoline in line with TA471: Eluxadoline for treating IBS with diarrhoea. They asked for the estimated number of patients that will be eligible, the position of eluxadoline in the treatment pathway and how treatment will be reviewed.<br>Specialist feedback was that there was likely to be only a small number of patients (<10 per year) who would be treated with this drug. Only patients refractory to diet measures, |

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| | loperamide and a tricyclic antidepressant would be considered and this is said to be uncommon. Treatment will be started in secondary care as specified in the TA and the specialists proposed that patients would be reviewed in clinic at 4 weeks to determine benefit. It was suggested that this review didn't need to take place in clinic and could perhaps be done over the phone but there were questions around patients getting timely prescriptions for further supply after 4 weeks if needed. The group requested that the pathway for review and further supply in a timely manner be clarified by the specialists. In the meantime, eluxadoline will be added to the formulary as an amber specialist initiation drug in line with the TA following CCG approval.<br>**Action**: JEC to update formulary following CCG approval and obtain requested clarification from specialists. |
| **6.2** | **Dimethyl fumarate for plaque psoriasis – specialist feedback on place in therapy**<br>TA475 recommends dimethyl fumarate (Skilarence®) as an option for treating plaque psoriasis in adults if the disease is severe and has not responded to other systemic therapies or if these are contraindicated or not tolerated.<br>The proposed place in therapy by YFT dermatology specialists is as a further option to be used in a similar way to the agreed use of apremilast i.e. those with a contraindication/intolerance to biologics, in exceptional cases for those who have a significant psychological problem with injections, or if biologics had failed.<br>There is already a cohort of patients who were on treatment with Fumaderm® - an unlicensed product containing dimethyl fumarate as the main active ingredient. Following approval by the Trust D&T Committee in July, these patients have been switched to Skilarence® - 4 patients each in VoY and ScR. As a NICE approved drug, there may be slightly more use than unlicensed Fumaderm, however specialists do not expect the numbers to change greatly, and it may delay or avoid the need for biologics in some patients.<br>The specialists proposed that those patients who have been successfully switched from Fumaderm® to Skilarence® be moved to the GP for ongoing prescribing. However, it was noted that other areas have maintained Skilarence ® as a red drug. In addition frequent monitoring of full blood counts, renal and hepatic function is required whilst on treatment, so if primary care prescribing is considered, there would need to be a shared care guideline. The group requested that RDTC look into the suitability of dimethyl fumarate for psoriasis as an amber shared care drug. For the time being, it will be added to the formulary as a red drug following CCG approval.<br>**Action**: JEC to update formulary following CCG approval. RDTC to look into suitability of amber shared care status for dimethyl fumarate for psoriasis. |
| **6.3** | **FreeStyle Libre® – NHS availability**<br>The group discussed the upcoming NHS availability of FreeStyle Libre from November 1st 2017 subject to local health economy approval. FreeStyle Libre is a flash glucose monitoring system which allows patients to measure interstitial glucose levels and trends without regularly performing capillary (finger prick) testing.<br>VoY CCG had already received a number of queries regarding this item. Also, the Trust is currently working on an application for FreeStyle Libre and Continuous Glucose Monitoring to submit to MCC.<br>The group noted that this issue is currently on the Regional Medicines Optimisation Committee's (RMOC) work plan and it is hoped that it will be discussed at the North RMOC meeting later in October, or failing this at the South RMOC meeting on 9th November. It was also noted that there had been discussions around developing a Yorkshire and Humber Wide position led by the Y&H Diabetes Clinical Network. There was agreement that the group should await regional recommendations before adopting a formal commissioning position on FreeStyle Libre.<br>Whilst awaiting regional recommendations, VOY and ScR CCGs have sent out holding statements requesting that GPs do not prescribe FreeStyle Libre until a formal commissioning position has been agreed.<br>**Action**: No further action required whilst awaiting regional recommendations. |

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| **6.4** | **Vitamin D prescribing – analysis of use in line with formulary**<br>At a previous MCC meeting, high spend was noted for Pro D3 within the 12 month audit report for recommendations from February 2016 when Pro D3 was assigned Black. Based on this, MMT was requested to analyse spend on vitamin D products against formulary choices/ medal ranked vitamin D supplements. The analysis showed that most of the vitamin D prescribing was of approved products, however there was a significant proportion of generic colecalciferol prescribing. The issue with generic prescribing is that any product can be supplied against a prescription for generic colecalciferol which might not be the most cost-effective choice. It was suggested that the formulary be annotated to specify that vitamin D should be prescribed by brand in primary care. MMT will work locally to tackle generic prescribing, and prescribing of unapproved products.<br>**Action**: JEC to update formulary; MMT to tackle prescribing of generic colecalciferol and unapproved vitamin D products locally. |
| **7**<br><br>**7.1** | **Interface: Shared Care Guidelines (SCGs) and Pathways**<br><br>**Non-transplant indications for mycophenolate**<br>The group agreed at the September meeting that there should be separate SCGs for transplant indications (until repatriation fully implemented) and non-transplant indications. It was highlighted that non-transplant indications are unlicensed and have not been formally commissioned; therefore there were concerns around including them in the SCG without first evaluating the evidence to support use. SP provided a list of non-transplant indications for which mycophenolate is used by The Trust. These included connective tissue disease, vasculitis, ulcerative colitis, systemic lupus erythematosus, dermatomyositis, polymyositis, severe psoriasis, severe atopic dermatitis, blistering conditions, pyoderma gangrenosum, autoimmune bullous dermatoses (e.g. pemphigus), uveitis, scleritis and ocular sarcoidosis.<br>Using this list, the RDTC produced a summary indicating which of the indications are known to be established uses/accepted practice based on information already available including national guidelines and SCGs from other areas. This would avoid the need to carry out full evidence reviews from scratch for each indication which would take a significant amount of time. Most of the indications were recognised uses of mycophenolate. Further evaluation was recommended for two indications – ulcerative colitis and ocular sarcoidosis as there was less information on these compared to others. The group accepted this approach and agreed to the inclusion of the indications found to be accepted practice and with supporting information, in the mycophenolate SCG for non-transplant indications.<br>The first drafts of both the transplant and non-transplant indications are expected for the November meeting.<br>**Action**: RDTC to carry out further evaluation on use of mycophenolate for ulcerative colitis and ocular sarcoidosis to be submitted for a future MCC meeting. |
| **7.2** | **Prescribing Guidance for adjuvant bisphosphonates in postmenopausal women with breast cancer**<br>The group had previously approved the use of adjuvant bisphosphonates (oral ibandronate and IV zoledronate) in postmenopausal women with breast cancer, and this guidance has been developed based on the Sheffield guidance to support the implementation. The guidance includes an algorithm for selecting suitable patients, information on the responsibilities of hospital specialists and primary care clinicians, and a counselling checklist for patients.<br>Concerns were raised about the tolerability of daily oral ibandronate. The Trust previously said that around 20% of patients would not tolerate oral ibandronate and these patients would be treated with IV zoledronate. However, the group questioned whether this was a realistic figure due to known tolerance and adherence issues with bisphosphonates, and given that ibandronate would be administered daily. It was felt that the proportion of patients not tolerating oral ibandronate would likely be higher than the proposed 20%, which would lead to significant additional costs. The group considered the possibility of alternative options such as the use of a different oral bisphosphonate, or |

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| | different dosing regimens e.g. weekly or monthly but acknowledged that there was lack of evidence to support these alternatives.<br>The guidance was approved subject to:<br>• Removal of the recommendation to use IV zoledronate for patients who cannot tolerate oral ibandronate – the implementation of treatment with IV zoledronate still requires further consideration to find the most cost-effective method of delivery particularly given that there may be a higher proportion of patients moving to IV treatment due to intolerance of oral ibandronate. Therefore IV treatment will not be included in the guideline until this has been finalised after which the guideline can be updated. This matter will be considered by CCGs outside of MCC.<br>• Inclusion of the criteria for treatment previously specified by the specialists within the algorithm for selection of suitable patients i.e. post-menopausal women (>50 yrs) with at least one of the following: tumour size 20mm or greater (T2-4); grade 2 or 3; node positive including those with micromets.<br>• Consideration of a switch of the recommended calcium and vitamin D product from Adcal D3 to either Accrete D3 or Calceos as these are the CCGs first line choices.<br>JEC has been asked to circulate the guideline to group members once the above issues have been addressed.<br>Ibandronate 50 mg tablets will be added to the formulary as Amber Specialist Initiation for this indication.<br>**Action**: JEC to feedback above comments to specialists and update group members as necessary (to inform SO'C regarding the calcium and vitamin D product issue); guidance to be circulated to group members once above issues addressed. Formulary to be updated with ibandronate as amber specialist initiation for this indication following CCG approval. CCGs to review cost-effective means of delivery of IV zoledronate. |
| **7.3** | **Wound care formulary**<br>The wound care formulary had been updated by the tissue viability team. It was noted that this version was much shorter than the existing formulary. It has been sent out for consultation to a wide variety of specialties including all district nurse team leaders, practice nurses, podiatry, dermatology, plastic surgery and all CCG leads. The group appreciated the effort that had gone into developing the formulary and felt that it was a good start but made the following points:<br>• The list of products is still too long. It was compared to the Leeds formulary which is a lot shorter and more restrictive, and use of anything outside the list required permission<br>• There is no ranking/prioritising to indicate which products in the various categories should be used first.<br>• No information on evidence to support use of selected products had been provided.<br>• VoY CCG have an ONPOS system that gives guidance on products that can be used by district nurses and those that can be used by tissue viability nurses only etc. This has not been reflected in the formulary. ScR CCG does not have the ONPOS system to guide selection so such guidance would be essential for them.<br>• No details of conflicts of interest have been provided<br>**Action**: LA will feed back the above comments for the team to address. |
| **8**<br>**8.1**<br><br><br>**8.2** | **Monitoring/reporting**<br>**Twelve month audit data MCC outcomes for recommendations from July 2016**<br>The report was noted by the group.<br><br>**ScR Red drugs data**<br>This item is reported quality. |
| **9** | **Patient and clinical communications**<br>Nothing to report. |

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| **10**<br>**10.1**<br><br><br>**10.2**<br><br>**10.3** | **Items from other groups**<br>**Hull and East Riding Prescribing Committee (HERPC)** – The draft minutes of the July meeting were noted<br><br>**Antimicrobial stewardship subgroup update** - No updates<br><br>**York and Scarborough Drug and Therapeutics Committee minutes** – Nil |
| **11** | **Any urgent business**<br>Nil |
| | **Date and time of next meeting: Wednesday 8th November 2017, 9:30am, Rowntree room, West Offices, York.** |