York and Scarborough
Medicines Commissioning Committee

Minutes of Medicines Commissioning Committee Meeting
Wednesday 20th September 2017
9.30-12pm, West Offices, York

1. Apologies / Attendance

		OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP
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	✓	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 - 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	A
Consultant Cardiologist	Dr Chris Hayes (CH)						✓	✓	A	✓	✓	✓	A
Regional Drug & Therapeutics Centre, Newcastle – Professional Secretary (BR & MM alternate)	Ms Bhavana Reddy (BR)/ Mrs Monica Mason (MM)/ Mrs Elizabeth Okpara (EO)	✓ BR	✓ MM		✓ MM	✓ MM	✓ MM EO	✓ BR EO	✓ MM EO	✓ MM EO	✓ EO	✓ MM EO	✓ MM EO

Item	
1	**General business** Laura Angus (LA) chaired the meeting. Apologies were received from Dr Peter Hall, Dr Shaun O'Connell, Dr Chris Hayes, Dr Michelle Beaumont and Richard Morris for the meeting today. **Declarations of conflicts of interest relating to the agenda** SP declared an interest regarding baricitinib (Eli Lilly) within item 5.1 therefore would not

	participate in any decisions made around this item. JEC informed the group that she had participated in drug lunch sponsored by Pharmacosmos the manufacturer of Monofer® which appeared within item 6.3, however no decisions on the use of this medicine was being made today. There were no further declarations of interest relating to agenda items being discussed today.
2	**Matters arising**
2.1	**Chairs actions to report** There were no Chair's actions to report. **Outcome of VoY SMT/SRCCG Clinical Executive Committee** The ScR CCG CE Committee approved all recommendations from the July and August MCC meetings including the use of IV zoledronate for improving breast cancer survival in post-menopausal women. It was noted that discussions would take place outside MCC regarding the implementation of treatment with IV zoledronate for both CCGs. The VoY CCG CE Committee were yet to consider recommendations from the August 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** – see agenda item 7.3. **Twelve month audit data MCC outcomes** – MMT were asked to look into whether VSL#3 is being used appropriately for the approved indication (i.e. pouchitis) and carry out analysis of spend on vitamin D products against formulary choices/medal ranking. RA reported that ScR CCG had looked at a small sample of patients prescribed VSL#3 and discovered that some patients had been prescribed it for indications other than pouchitis e.g. IBS. It was felt that tackling historical prescribing for unapproved indications may not be so straightforward and it might be better to focus on new prescriptions for unapproved indications, reminding prescribers when it can be used. RA noted that the analysis of vitamin D products was a rather large task and yet to be completed. The findings will be submitted to a future meeting. **Action:** MMT to submit analysis of spend on vitamin D products against formulary choices/medal ranking to a future 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. RA informed the group that this work would be handed over to their new pharmacist who will be starting in October. **Action:** MMT to bring data on apixaban prescribing for non-valvular AF to October/November MCC meeting. 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. **Action:** SP to feedback comments from anticoagulant clinic. **Liothyronine RAG status for hypothyroid crisis** – JEC has updated the formulary to indicate a red status for liothyronine injection for hypothyroid crisis.

	RAG status of sucroferric oxyhydroxine – see agenda item 6.7. **Formulary amendments agreed in August (TAs 455 to 462, NG71, DSUs on bendamustine and nivolumab)** – JEC has updated the formulary accordingly. **NHSE consultation on proposed guidance for items which should not routinely be prescribed in primary care** – See agenda item 5.2. **Combined Hep A/Hep B vaccine – review of commissioning position in light of global shortages -** VoY CCG were awaiting CE committee approval before updating their travel guidance to reflect the agreed temporary position. **Action:** MMT to update travel guidance once VoY CE committee has approved recommendation. **Dicycloverine – Black status assigned** – JEC has updated the formulary to reflect a black status for dicycloverine. SP reported that there was no particular interest in using dicycloverine in the Trust. **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 has been trying to contact the consultant involved but is still waiting to hear back from them, and Trust specialists were yet to be contacted. **Action:** Feedback from prescriber and Trust specialists to be brought back to MCC once received. **Galucoma pathway and formulary section review** – Following approval at the August meeting, the formulary has been updated to reflect the approved choices of agents but the pathway is yet to be uploaded. Information is still awaited on the declarations of interest of individuals involved in the pathway. **Action:** Pathway to be uploaded onto formulary and information on DOI obtained from the relevant individuals by JEC. **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. **RAG status for Spiriva (tiotropium) Respimat inhaler for asthma** – see agenda item 6.5.
3	**Governance** Nil
4 **4.1**	**Mental Health Medicines Commissioning** **Tees, Esk and Wear Valley Mental Health Trust** Nil
5 **5.1**	**National and Regional Guidance** **Monthly NICE update (August 2017)** It was noted that TAs 468-470 were terminated appraisals and no further actions were necessary for these. The drugs in the following TAs require addition to the formulary or removal of grey status and are to be included as red drugs: TA463 (cabozantinib), TA465 (olaratumab), TA467 (Holoclar), TA472 (obinutuzumab & bendamustine) and TA473 (cetuximab). All of these drugs are commissioned by NHS England therefore there will be no cost impact to CCGs. All drugs in TA464: Bisphosphonates for treating osteoporosis are already listed in the

formulary; the TA link is to be added to the relevant section of the formulary.

TA466: Baricitinib with methotrexate for moderate to severe rheumatoid arthritis – baricitinib is to be added to the formulary as a red drug along with the TA link. The Trust estimates that around 20 to 25 patients per year will be treated with baricitinib across York and Scarborough. Baricitinib will be placed as second line (i.e. instead of biologics) and this is expected to lead to cost savings.

TA471: Eluxadoline for treating irritable bowel syndrome with diarrhoea – eluxadoline is to be added to chapter 1 of the formulary and the group agreed an amber specialist initiation status in line with the TA. However, the group requested information from Trust specialists on the estimated number of patients that will be eligible, the position of eluxadoline in the treatment pathway and how treatment will be reviewed.

It was noted that TA160 & TA161 had been partially updated by the new TA464 noted above. NG72 and CG160 were also noted for information. No further action was necessary for these items.

Action: JEC to update formulary accordingly and obtain information requested on patient numbers and specialist feedback.

NTAG recommendations

The recent recommendations from NTAG on rituximab biosimilars, sodium oxybate, pitolisant and Qutenza® (capsaicin patch) were reviewed.

It was noted that NTAG recommends biosimilar products should be considered as a first line option in new patients suitable for treatment with rituximab; and for existing patients, consideration should be given to switching where it is clinically appropriate and as part of a clinician led management programme which has appropriate monitoring in place.

SP informed the group that from September 1st, the Trust were starting new patients on the rituximab biosimilar Truxima® for rheumatology indications and will also be switching existing patients. For haematology indications, Truxima® will mainly be used for new patients.

MM asked how the uptake of biosimilars was being monitored, noting that the commissioning framework for biologic medicines recently published by NHS England placed emphasis on monitoring. SP noted that biosimilar uptake was actively monitored by model hospital metrics produced by NHS England which indicate that YFT is among the top performing Trusts in the country for biosimilar uptake. With regards to gain share for biosimilars between the CCGs and the Trust, SP noted that this was under discussion but they were currently working to a 50:50 agreement. Group members were keen that MCC should be more involved in issues relating to biosimilars. It was requested that SP should bring data on biosimilar prescribing trends for the next MCC meeting.
Action: SP to submit data on biosimilar prescribing trends for the October MCC meeting.

The group also noted the other recommendations by NTAG but agreed that no further actions were necessary expect to insert the link to the NTAG recommendation on sodium oxybate to the relevant section of the formulary.
Action: JEC to add link to sodium oxybate NTAG recommendation to formulary.

Medicines Safety (MHRA drug safety update – August 2017)

The group noted the drug safety updates for August. These had mostly been reflected in the relevant sections of the formulary but additional sections of the formulary had been identified where the warning regarding corticosteroids and the risk of central serous chorioretinopathy could also be added i.e. chapters 13&16.

Some issues were raised in relation to the adrenaline auto-injectors alert which recommends that 2 auto-injectors are prescribed and patients should carry them at all times - the age at which children can take responsibility for carrying their own pens, and whether the new advice could allow people to request 2 devices to hold at different addresses e.g. at school, at each parent's house, etc. However it was agreed that these points were outside of the remit of the committee.

	RDTC monthly horizon scanning (August 2017) The group noted the newly licensed first enoxaparin biosimilar (Inhixa®). SP informed the group that enoxaparin is mainly used in the Trust for patients with renal impairment but the Trust do not intend to use the biosimilar because it will be more costly for them than Clexane®; it is not expected that there is much use of Clexane in primary care. The group also noted a new levonorgestrel intrauterine device (Kyleena®), fluoxetine 10 mg tablets and patiromer powder for hyperkalaemia but no further action was necessary.
5.2	**Draft Y&S MCC response to NHSE consultation on proposed guidance for low priority for funding items** Group members were generally in agreement with the draft response which had been compiled based on the feedback received so far. It was agreed to include the comment stating that NHS England should issue clear national advice on how changes should be made, in the response for each item in section 4. Additional comments were that deprescribing could lead to significant increases in workload. Also, NHS England should look into eligibility for free prescriptions to ensure that the people who get it are those who really need it. They should also consider the introduction of a nominal fee for those who are eligible for free prescriptions. **Action:** EO to submit agreed response on behalf of Y&S MCC.
6 **6.1**	**Formulary and Managed Entry of New Drugs** **Formulary application: Resource ThickenUp Clear®** The group reviewed an application requesting the addition of Resource ThickenUp Clear® to the formulary as the first line thickening agent and to replace all existing thickening agents. Resource ThickenUp Clear® is a gum based thickener whereas currently used thickeners are starch based. The group noted the studies that showed Resource ThickenUp Clear® was associated with less incidence of aspiration compared with thin liquid, and similar efficacy to a starch based thickener in improving safe swallowing. However, gum based thickeners have a number of advantages over starch based thickeners: • Unlike starch based thickeners, gum based thickeners do not continue to thicken over time • Starch based thickeners become thinner upon mixing with saliva as they are broken down by amylase reducing the effectiveness of the thickened food or fluid whereas gum based thickeners are unaffected by amylase. • Gum thickeners have a smoother texture; they are less grainy and tend to be preferred by patients as they are more palatable which improves adherence and hydration. The group also noted that Resource ThickenUp Clear® was comparable in price to starch based thickeners for liquids thickened to stage 1 (syrup) consistency. For stage 2 (custard) and stage 3 (pudding) thickened liquids, Resource ThickenUp® was either similarly priced or more expensive. However SP noted that the application suggests most patients will be on stage 1 liquids as their costings were based on this consistency. The group agreed to the addition of Resource ThickenUp Clear® to the formulary as the first line thickening agent, as a green dug. It was highlighted that training/counselling on appropriate use would be necessary due to differences in the preparation instructions for Resource ThickenUp Clear® and starch based thickeners. LA noted that the CCG nursing team can liaise with the SALT team to arrange training. Another consideration was that Leeds hospital has retained Thick and Easy® on the formulary for the Children's hospital and patients with significant renal impairment. Therefore SP agreed to check with the SALT team what they usually do for these patient groups. **Action**: JEC to update formulary; SP to check with SALT team regarding paediatric patients and patients with renal impairment.
6.2	**Formulary application: New indications for ondansetron & granisetron** The group reviewed an application for additional indications for ondansetron and granisetron i.e.

	• PO ondansetron: for chronic nausea and vomiting when other antiemetics are contraindicated or unsuitable • SC ondansetron: for short term use in palliative care when other antiemetics are contraindicated or unsuitable. This would include patients with refractory nausea and vomiting, Parkinson's disease, and occasionally, bowel obstruction. • SC granisetron: second line to SC ondansetron for use in palliative care when use of a syringe driver is not suitable as granisetron can be given as a bolus SC injection. Use of these agents for the above indications is already taking place in practice. The Trust have identified patients being prescribed long-term ondansetron although it is not certain where this treatment is being initiated. Also, these agents are already used in palliative care as above. The palliative care team are seeking to reflect this in the Syringe Driver chart which is being reviewed. The group noted that there was lack of evidence to support use of either ondansetron or granisetron for these unlicensed indications. It was noted however that for patients with chronic nausea and vomiting, there are limited options as restrictions are in place by the MHRA for antiemetics such as domperidone and metoclopramide limiting their duration of use to 5 or 7 days due to safety concerns. Whilst ondansetron and granisetron have both been associated with QT prolongation, they have no restrictions on treatment duration. Clinical trials of long-term use (4-12 weeks) of serotonin antagonists in other indications did not suggest any serious adverse effects. It was also noted that the Palliative Care Formulary supports the use of these agents in certain circumstances. The group approved the use of ondansetron and granisetron for the proposed indications with a green status. The formulary will be clearly annotated to specify when they can be used, and that the indications are unlicensed. **Action**: JEC to update formulary.
6.3	**Formulary application: Ferric maltol** The group reviewed an application requesting the addition of ferric maltol to the formulary for its licensed indication i.e. treatment of mild to moderate iron deficiency anaemia (Hb >9.5g/dL) in patients with inflammatory bowel disease (IBD). The intended place in therapy is following failure of current formulary choices of oral iron salts prior to moving on to IV iron, potentially avoiding IV iron in some patients and the associated costs of administration. JEC explained that there were differences of opinion within the gastroenterology directorate with some specialists supporting the continued use of IV iron after current formulary oral iron salts. The group noted the clinical trial data which showed that ferric maltol was superior to placebo in improving Hb in patients who had failed previous treatment with other oral ferrous products. There are currently no data comparing ferric maltol with other oral iron salts or IV iron (an ongoing study comparing ferric maltol with Ferinject® is due to complete in Oct 18). However, the available data suggest that ferric maltol may be well tolerated in many patients with previous intolerance to oral ferrous salts. It was also noted that whilst ferric maltol is substantially more expensive than other oral ferrous salts, it is significantly cheaper than IV iron due to the associated administration costs (£404 per attendance at the Medical Elective Suite). There were some reservations as to whether ferric maltol would indeed be better tolerated than other ferrous salts and the possibility that many patients might end up on IV iron anyway. There was also some concern that if approved, ferric maltol may be used outside of its approved patient population e.g. in non-IBD patients. It was suggested that use could be audited in primary care to assess whether it is being used appropriately and what proportion of patients go on to receive IV iron. This could be done following a period of about 6 months if prescribing data indicates significant use. The group approved the use of ferric maltol for treating mild to moderate iron deficiency anaemia (Hb >9.5g/dL) in adults with IBD following recommendation by a gastroenterology specialist, and following adequate trial of at least 2 other oral ferrous salts on the formulary. **Action**: JEC to update formulary.

6.4	**Formulary application: Glucodrate** The group received an application to add Glucodrate to the formulary to replace St Mark's powder used in the treatment of high output stoma/short bowel syndrome. Glucodrate is a tropical flavoured, powdered blend of carbohydrate which is high in sodium but low in other electrolytes, developed in conjunction with St Mark's hospital. It is ACBS approved for patients with short-bowel-associated intestinal failure and intestinal insufficiency. The current first line option for these patients is double strength Diarolyte (10 sachets per day in 1L water). If hyperkalaemia occurs, the second line option is St Mark's electrolyte mix. A recipe of the St Mark's mix can be provided to patients to make their own, however patients who are unable to make their own are prescribed St Mark's powder which is an unlicensed product. It is proposed to use Glucodrate instead of St Mark's powder for these patients. Glucodrate is cheaper than St Mark's powder (£2.61 vs £12.24 per day) and is reportedly more palatable due to its tropical flavouring. It was noted that expected patient numbers are very small as only 4 patients have been prescribed St Mark's across York and Scarborough in the last 12 months. The group approved the addition of Glucodrate to the formulary as amber specialist initiation only for those patients who would be prescribed St Mark's solution and clearly unable to make their own. **Action**: JEC to update formulary.
6.5	**RAG status confirmation: Tiotropium Respimat for asthma** The group was asked to confirm the RAG status of Spiriva Respimat for asthma. Following its inclusion in the asthma pathway, it was added to the formulary as a green drug but the original application proposed a RAG status of amber specialist recommendation. The group agreed that a green status was appropriate as the use of tiotropium in primary care is well established (for COPD). Other areas have also assigned a green status for asthma e.g. Leeds and GMMMG. **Action**: JEC to update formulary with green status for tiotropium respimat for asthma.
6.6	**Formulary status review: Topical diltiazem** The group were asked to revisit the formulary choices for topical diltiazem following the recent approval of a change from cream to ointment due to lower cost in primary care (£61.98 vs £32.49). The Trust struggled to source a supplier for the ointment but have managed to find a supplier for the cream at around half the cost of the ointment (£15.36 vs £32.49). It was therefore proposed that both formulations should be added to the formulary with the cream used in secondary care and the ointment used in primary care. However, it was questioned whether there is much prescribing of topical diltiazem in secondary care as it is mostly prescribed for outpatients and by GPs so the formulary should include the item that is cheapest in primary care. JEC agreed to check levels of prescribing and feedback to the group. **Action**: JEC to check prescribing levels of topical diltiazem in secondary care.
6.7	**RAG status review: Sucroferric** The group reviewed a proposal to change the RAG status of sucroferric oxyhydroxide from red to amber shared care. Sucroferric is indicated for the management of hyperphosphataemia in adult chronic kidney disease (CKD) patients on haemodialysis or peritoneal dialysis. It was recently discovered that Leeds have this drug on their formulary as amber shared care while it is currently red on the York & Scarborough formulary. The drug is commissioned by NHS England who consider it suitable for shared care with primary care providing this is supported by the local prescribing committee. It was noted that the Trust recently approved sucroferric as a 4th line phosphate binding agent. The other NHS England commissioned phosphate binders on the formulary (sevelamer and lanthanum) did not have a RAG status assigned on the formulary but JEC indicated that these were meant to be red. Therefore it would be inappropriate for sucroferric as a 4th line agent to be amber while earlier choices are red. It was agreed that the red status would remain for sucroferric. SP noted that patients from Leeds would usually be transferred to the care of YFT specialists.

	Action: No action required for sucroferric. JEC to update formulary to indicate a red status for sevelamer and lanthanum.
7	**Interface: Shared Care Guidelines (SCGs) and Pathways**
7.1	**NHS England repatriation of post-transplant immunosuppressants to specialist centres – delay in Leeds Teaching Hospitals.** SP informed the group that this document is not relevant to York and Scarborough as it affects devolved CCGs in the North West in relation to liver transplants. No further action was required.
7.2	**Mycophenolate SCG for renal and rheumatology indications** The committee had been asked to address the lack of a mycophenolate shared care guideline for renal and rheumatology indications. The issue came to light as GPs in VoY have been asked to prescribe mycophenolate without a hospital shared care guideline despite the formulary stating that it is a shared care drug. When queried about a SCG, the rheumatology department referred to the Yorkshire regional rheumatology guidelines for the monitoring of adults on DMARDS from 2014. JEC explained that the renal team had started to develop a SCG but this has never been completed. The group agreed that there should be separate SCGs for transplant indications (until repatriation fully implemented) and non-transplant indications. However, it was noted that mycophenolate is only licensed for use post-transplant; its use for other indications (e.g. rheumatology) is unlicensed and not formally approved by Y&S MCC. Hence there was some concern around developing a SCG for unlicensed indications that are not formally commissioned without looking into the supporting evidence base, though some felt that a full evidence review for all unlicensed indications was not necessary. JEC kindly agreed to take on the SCG for the transplant indications building on the one that is already in development; this is to be brought back to the next meeting. SP offered to compile a defined list of non-transplant indications where mycophenolate is used to enable evidence reviews to be carried out before the production of the non-transplant indications SCG. **Action**: JEC to submit first draft of mycophenolate SCG for transplant indications for the October MCC meeting; SP to compile list of non-transplant indications for mycophenolate.
7.3	**OAB pathway** SP presented the updated pathway which had been written by Miss Verma in consultation with other YFT specialists. Some major changes included additional information on anticholinergic burden, more flexible dosing of tolterodine, referral to secondary care after inadequate response to two anticholinergics and removal of mirabegron as a 3rd line option. The pathway will also be amended to include information on the use of desmopressin for nocturia. The group welcomed the pathway and thanked SP for the work he had done on it. Some comments were raised including: • Oxybutynin had not been included among the first line choices but is considered by NICE as the most cost-effective OAB drug. The reason suggested for this was that oxybutynin is no longer used often due to side effects. • What was the rationale behind choosing solifenacin as a second line option? Although the patent is due to expire in 2018, solifenacin 10mg daily is currently more expensive than all other OAB drug options. SP noted that solifenacin was commonly prescribed by secondary care clinicians. • It would be useful to have first and second choices and then mirabegron as a third choice, rather than having mirabegron as a second choice for some patients only and no third line options. This would be in line with the TA for mirabegron. • The pathway states that mirabegron should be used for patients >65 years. This was different to the previous version which proposed use of mirabegron in >75 year olds. SP suggested that the age could be removed. The pathway will now be taken over by the MMT who will incorporate the comments and build on it, and resubmit to MCC once completed. **Action**: MMT to resubmit pathway with comments incorporated once completed.

7.4	**Outpatient prescribing guidelines (update)** This document had been updated, the only amendment being a change in the name of the new outpatient pharmacy contractor to Lloyds Pharmacy. Some suggestions were made about the Treatment Advice Note – to include information on whether or not a generic could be prescribed, and who to contact if any details cannot be understood. These will be considered when the document is due for printing. The document was approved.
8 **8.1** **8.2**	**Monitoring/reporting** **Twelve month audit data MCC outcomes for recommendations from** **ScR Red drugs data (Apr to Jun 17)** The reports were noted by the group.
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)** – Nil **Antimicrobial stewardship subgroup update** - No updates **York and Scarborough Drug and Therapeutics Committee minutes (June and July 2017)** The minutes were noted.
11 **11.1** **11.2**	**Any urgent business** **Pigmanorm** 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. It was requested that JEC feedback to the dermatology department that this item is not for prescribing in primary care. **Action**: JEC to feedback to dermatologists. **Adrenaline auto-injector** GB noted that a message was now flashing up on Optimise Rx that the dose of adrenaline auto-injector for adults is 500 microgram rather than 300 microgram. However, there is only one brand of 500 microgram auto-injector (Emerade®) which is currently out of stock.
	Date and time of next meeting: Wednesday 11th October 2017, 9:30am, Cerialis SO27, West Offices, York.