York and Scarborough
Medicines Commissioning Committee

Minutes of Medicines Commissioning Committee Meeting
Wednesday 15th February 2017
9.30-12pm, West Offices, York

1. Apologies / Attendance

		MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB
Strategic Lead Pharmacist- MMT	Mrs Rachel Ainger (RA)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
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)	✓	✓	✓	✓	✓	A	✓	✓	✓	✓	✓	✓
Consultant Anaesthetist	Dr Peter Hall (PH)	✓	A	✓	✓	A	A	✓	✓	✓	✓	✓	✓
Consultant Physician	Dr Paul Jennings (PJ)	✓	✓	✓	✓	✓	✓	✓	✓	A	✓	✓	✓
Deputy Chief Pharmacist Tees Esk and Wear Mental Health Trust (TEWV)	Mr Richard Morris (RM)	A	✓	✓	CW	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
Deputy Chief Pharmacist	Mr Stuart Parkes (SP)	✓	✓	✓	✓	A	✓	✓	A	✓	A	A	✓
Consultant Psychiatrist (TEWV)	Dr Michelle Beaumont (MB)												✓
Regional Drug & Therapeutics Centre, Newcastle – Professional Secretary (BR & MM alternate)	Ms Bhavana Reddy (BR)/ Mrs Monica Mason (MM)	✓ MM	✓ BR	✓ MM	✓ BR	MM + BR	✓ BR	✓ MM	✓ BR	✓ MM	✓ MM	✓ MM	✓ MM
Consultant Psychiatrist (TEWV)	Dr Shona McIlrae (SM)							✓	A	A	A	A	A

Item	
1	**General business** Laura Angus (LA) chaired the meeting Apologies were received from Dr Shona McIlrae, Dr Shaun O'Connell and Richard Morris for the meeting today. LA explained that SO'C had taken up the post as medical director, and requested that the meeting time for MCC be changed to accommodate his attendance. It was agreed that from April the group would meet on the second Wednesday of the month rather than the third.

	LA agreed to contact the consultant invited to join the group to check when he was available to start. **Action:** LA to contact consultant regarding MCC start date, MM to email out revised MCC dates to MCC members **Declarations of conflicts of interest relating to the agenda** GB declared a potential conflict of interest relating to Fostair® inhalers, however as the COPD and asthma pathways had not been submitted for approval this was not considered an issue for this meeting.
2	**Matters arising**
2.1	**Chairs actions to report** **Outcome of VoY SMT/SRCCG Business Committee** Items from the January meeting had been agreed in full by VoY CCG Senior Management Committee and by the Scarborough and Ryedale CCG Business Committee. **Draft minutes and matters arising from last meeting** The minutes were agreed following a couple of amendments **Action log/long-term matters arising** **Ulipristal pathway** – RA explained that she had recently received comments back from the specialists, and would bring the revised pathway to the March MCC meeting for approval. **Action:** RA to submit pathway to the March MCC meeting **RAG status of drugs with no formulary status –** this work was being undertaken outside of MCC and could be removed from the agenda. **Development of lidocaine patch pathway –** see agenda item 7.4 **Treatment of ADHD algorithm** – A link to this algorithm has been added to the formulary, this item was removed from the action log. **Growth hormone paper** – This item is on the primary care work-plan, it will be submitted to MCC in due course but can be removed from the MCC action log. **Vaginal candidiasis medal ranking** – LA had fed back the changes required to AM and will bring this report back to MCC once complete. **Action:** LA to submit report to MCC when available **T3 prescribing in Y&S** – Primary care are undertaking an audit of T3 prescribing in primary care and will submit this to MCC in due course. **Action**: MMT to submit T3 audit results to MCC March meeting **National and regional guidance/formulary amendments** – it was agreed that the botulinum formulary decision aid, and information regarding the stopping of bisphosphonates, will come to the March meeting. **Action:** MM and LA to submit relevant paper to March MCC **Joint NICE and NHSE consultation on changes to TA and HST programmes** – MM explained that she had submitted the comments received, no further action required. **COPD guidance** – MM is working to merge the individual pathways into one Y&S pathway. **Action:** MM to return this work to the March MCC

	OAB pathway – Minor changes are being made to this pathway, with ongoing discussions between RA and SP, it is hoped it will be ready for approval at the March meeting. **Action:** RA to submit for MCC approval at the March meeting. **LTHT medicines update – referrals from non-Leeds CCGs –** see agenda item 3.1 **Lithium monitoring SBARD from TEWV** – This had been shared with primary care by MMTs and can be removed from the action log **Lisdexamfetamine SCG for treatment by the Tuke Centre** - the minutes had recorded this action to JEC, however as a primary care action it was moved to the MMT, AM communicating the comments from the Jan MCC to the SCG authors **Action:** MM to amend the Jan minutes and MMT to communicate with SCG author **Formulary amendments approved at the Jan MCC –** JEC had updated the formulary accordingly **Safinamide application** – Post meeting note: Following the Jan MCC JEC had fed the comments back to the applicant who amended the application in line with the recommendation from MCC that this agent would be used after rasagiline , as an additional step before moving to more expensive options such as apomorphine infusion, rather than as an alternative to rasagaline as previously stated. As this application was now in line with use as approved by MCC at the January meeting, the agent was approved for formulary addition with an amber specialist initiation status, to "be reserved for use in those patients who fail on more established therapies". **Action:** JEC to add safinamide to the formulary as detailed following CCG approval **Peptac® application** – the formulary was updated accordingly. Action complete **Naltrexone for alcohol withdrawal** – the formulary was updated accordingly. Action complete **Applications for three Respimat® devices** – see item 6.1 **Methotrexate SCG** – see item 7.1 **Glaucoma pathway** – see item 7.3
3 **3.1**	**Governance** **LTHT Medicines Update – referrals from non-Leeds CCGs** MM explained that the RDTC had cross-referenced the RAG lists available for Leeds versus those available for York and Scarborough. It was noted that there are many agents listed on the Leeds lists that do not appear on the York and Scarborough lists, it appeared that in the main these were agents that would be expected to come through a tertiary centre and were NHSE commissioned. MM referred to a few discrepancies between both the Leeds lists and the York and Scarborough lists that may warrant further attention and it was agreed that this work could take place outside of MCC. Any required amendments would be submitted to MCC in due course, however although difficult to quantify it was not expected that the proposal to adopt Leeds RAG status for individual cases would be problematic. **Action:** MM and JEC to consider the RAG status of identified items and communicate any required amendments to MCC in due course

3.2	**RAG criteria for Y&S MCC** The group considered a proposed process for formulary assessment and RAG criteria, which was developed by the RDTC to support robust decision making within the MCC. The current positioning of non-formulary agents was discussed, it was recognised that classifying agents as non-formulary without a clear rationale was sometimes problematic; the group agreed that the role of the formulary was to ensure the most cost-effective agents were available for prescribing, and to reduce variations in prescribing across York and Scarborough. It was agreed that future applications would be assessed for formulary inclusion using the agreed criteria currently being trialled by the group. Those agents that were deemed unsuitable for formulary inclusion would be assessed for Black list inclusion i.e. not recommended for prescribing, any agent deemed unsuitable for black status would simply not be a formulary option; however in individual circumstances prescribing may be appropriate, this would be decided at a local level, a frequent number of off-formulary prescribing requests as noted by MMTs should be highlighted to MCC, as this may prompt a change in formulary choice, but it was recognised that the formulary was not expected to cover all prescribing in all patients and that an allowance needed to be made for some non-formulary prescribing, although efforts should be made to keep this to a minimum. Some minor amendments were suggested to the RAG criteria and it was agreed that the items currently listed as grey would be assessed in the near future. **Action:** MM to amend criteria for trial with future applications, and identify grey items for assessment.
3.3	**Updates to MCC forms** – MCC noted that minor updates e.g. contact details had been made to MCC forms and that these would replace those previously used. **Action:** JEC to add links to the new forms e.g. applications forms to the formulary website
3.4	**Y&S medicines efficiency sub-committee** – SP gave an overview of a subgroup to MCC that had been proposed. The aim of the group were highlighted i.e. and sought permission from MCC for this group to meet.
4.1	**Mental Health Medicines Commissioning** Tees, Esk and Wear Valley Mental Health Trust 1. D&T committee – summary report of January meeting (for information and discussion) 2. November D&T confirmed minutes 3. Psychotropic drug monitoring guidance – as stated in D&T summary, this has been approved for internal use, now for consultation with primary care. The intention is for it to be an electronically accessible resource (on TEWV intra and internet sites) and therefore easily updated, but a printable form will be added as an additional tab.
5	**National and Regional Guidance** • **Medicines Safety (MHRA drug update – February 2017)** • **Monthly NICE update** • **RDTC monthly horizon scanning** • **Apremilast pathway** • It was agreed that the formulary be updated to reflect NICE TA420 to TA431. The group reviewed information from the Trust specialists regarding their intention to use ticagrelor in line with TA420, the proposals were accepted by the group however they queried what steps would be undertaken to ensure that the GP knows when to transfer the patient to the 60mg BD dose. It was agreed that the specialist would need to be specific regarding these details on the discharge plan, and that JEC/SP would communicate these details to the specialists. It was agreed that primary care should review all those patients who have been receiving long-term ticagrelor with a view to stopping their prescription where appropriate. It was agreed that ticagrelor would be added to the formulary with an amber "specialist recommendation" status only to be recommended by a consultant cardiologist

	for use as outlined in TA420. The group considered a pathway to enable the use of apremilast for plaque psoriasis as per TA419, and noted that the pathway positioned apremilast in preference to a biologic in some patients namely those with a contraindication to biologics, but also those who did not want an injection. The group were concerned that this may result in an unintended increase in those patients receiving apremilast rather than a biologic first. The group queried whether the cost impact of apremilast within this approach had taken into account the future availability of biosimilars, which would reduce the costs of biologics. JEC and SP explained that they understood it was the intention of the specialists to offer biosimilars before apremilast wherever possible. MCC agreed the use of apremilast as per TA419, but as an option after biologics wherever possible, a red RAG status was issued. The group also asked JEC to confirm with specialists that the recently published MHRA warning concerning the use of apremilast and the risk of suicidal thoughts and behaviour in those with or without a history of depression had been considered. The need to carefully assess the benefits and risks of starting or continuing treatment, and the need to stop treatment if patients experience new psychiatric symptoms or existing symptoms worsen, and that patients need to know to inform a HCP if they notice changes in their mood. The group reviewed the MHRA DSUs for January, paying particular attention to the apremilast warning as detailed above, the formulary will reflect the warning issued by the MHRA. **ACTION:** JEC to update formulary as appropriate and MCC comments to Trust specialists. **Regional Guidance - NTAG recommendations:** There were no N-TAG recommendations to consider. **Horizon Scanning - New products:** The group noted the RDTC monthly horizon scanning information, in particular the hybrid version of tiotropium (similar to the handihaler device). **ACTION:** No action required
6.1	**Formulary and Managed Entry of New Drugs** **Formulary applications** **Applications for three Respimat® devices (olodaterol, tiotropium and olodaterol+tiotropium)** The group revisited this application which had been submitted last month but with the support of the formulary decision aid. The group noted that the applicant wished the agents to be assessed for use in bronchiectasis and cystic fibrosis in addition to COPD. The group noted that whilst the unlicensed use of beta2-agonists for bronchiectasis was supported somewhat via the British Thoracic society guidelines, there was a lack of evidence to support this unlicensed use in cystic fibrosis. It was also noted that whilst the applicant refers to the Leeds Cystic fibrosis guidance, the formulary listings for these agents do not reflect this. The group agreed that these agents be added to the formulary with an amber specialist initiated status, and that those indications which are unlicensed are clearly annotated on the formulary. **Action:** JEC to update the formulary as above

6.2	**Fulvestrant application –** this application is a resubmission of the 2015 application to use fulvestrant for the treatment of oestrogen-receptor positive metastatic or locally advanced breast cancer in postmenopausal women in whom disease progresses or relapses while on, or after, other anti-oestrogen therapy. The applicant had revised the application for the agent to be used as a second line treatment option after aromatase inhibitors. The previous submission (which was rejected) was as a 4th line endocrine therapy, where patients have progressed following treatment with tamoxifen, anastrozole / letrozole and exemestane. It was proposed that fulvestrant be used as an additional treatment while the tumour remains hormonally sensitive but before chemotherapy. The group noted that the position had been revised for 2 reasons: 1. The emergence of the Falcon Study, demonstrating n treatment naïve patients similar benefit and longer progression free survival than anastrozole. 2. The possibility that in the coming year selective cyclin dependant kinase inhibitors will be reviewed by NICE and these can be used with fulvestrant, thus the desire to make ensure fulvestrant is available should this happen. The group noted that the NICE position was due in the autumn and agreed that it would seem sensible to await their decision, however in the meantime they agreed to critically appraise the Falcon Study and this appraisal would return to MCC for the April meeting. **Action:** RDTC to appraise trial for the April MCC
6.3	**VoY wound care formulary** – the group were made aware of a wound dressings list which has been complied by Vale of York CCG, and a brief of the ONPOS ordering system was delivered. It was agreed that it would be advantageous for this list to be developed into a wound care formulary to cover York and Scarborough. **Action:** MM to forward the list to RA and GB in order that they can seek comment on its content.
7	**Interface: Shared Care Guidelines (SCGs) and Pathways**
7.1	**Methotrexate SCG –** at the January meeting MCC asked JEC to seek clarification from the SCG authors on a few points. JEC returned a revised version of the SCG to MCC and the group noted that: - a line had been added to explain when a SC route of administration would be appropriate. - Zlatal® brand had been added, although it was recognised that some wholesalers did not stock this brand - the wording around the dosing of folic acid was amended, to include a statement that specific advice would be issued to the prescriber - the statement regarding initiation of the prescription was reworded to include an 8 week minimum initiation period by the specialist team The group asked that it be made clear that whenever there was a change in dose that the patient would return to the care of the specialist as per initiation arrangements and that the evidence to support the statement regarding the five yearly pneumococcal vaccinations be substantiated. It was agreed that once these changes had been circulated to the group approval could be agreed by email. **Action: JEC to respond to the queries raised by MCC and circulate responses and a final draft of the SCG by email for approval.**
7.2	**Stopping bisphosphonate guidance –** this item was deferred to March MCC

7.3	**Glaucoma pathway** – A review of products used in the treatment of glaucoma as listed in the formulary and corresponding pathway were submitted by YFT by consideration by MCC. It was proposed that in order to ensure the use of the most cost effective agents there was a change in the order of use so that dorzolamide was moved from second line to first line, and brinzolamide was moved from first line to second line. Additional preservative free preparations were proposed for addition so that there was a preservative free option for each current product. It was agreed that currently no products would be removed from the formulary, but that this would be reviewed in due course. The group expressed concern that this pathway had not been submitted as a joint application from both York and Scarborough Trust and asked that it be forwarded to Scarborough Trust for their comments, after which it could seek MCC approval. **Action:** JEC to forward pathway to Scarborough Trust for comment following which approval can be sought from MCC.
7.4	**Lidocaine patch pathway** – The group considered the analgesic therapy flow cart for neuropathic pain which had been developed by YFT pain specialists in consultation with Scarborough Trust specialists and GPs. The group agreed it would be appropriate that with this pathway in place that lidocaine patches were changed from a Red status to an amber specialist initiation, patients would be initiated on treatment at the pain clinic with their GP continuing their treatment after a month. **Action:** JEC to update RAG status of lidocaine 5% patch and add a link to this pathway.
7.5	**VoY asthma pathway** – VoY representatives explained that work had been undertaken to update the asthma pathway to bring it in line with BTS guidance. The group agreed that this guidance be sent to Scarborough representatives for consultation after which it could be submitted as a joint application to MCC. **Action:** LA to forward updated pathway to Scarborough organisations for comments, after which MCC approval may be sought.
8 **8.1** **8.2** **8.3**	**Monitoring/reporting** **Twelve month audit data Sept and Oct MCC outcomes** The audit report was considered; the group noted that there had been an increase in prescribing of insulin degludec, but that no significant cost increase had been reported, presumably because the it was being prescribed as an alternative to other agents. The group commented that it would be useful to know more detail as to which agents it was replacing. **Action:** MMT to communicate this back to the report author **VoY Red drugs data (July to Sept 2016)** **ScR Red drugs data (July to Sept 2016)** The group asked what actions were being undertaken in response to red drug prescribing in primary care, primary care representatives explained that this prescribing was challenged at a local level. The group noted the level of lidocaine patch prescribing, and that this should cease to show in these reports following its move to an amber status.
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** – not received **Antimicrobial stewardship subgroup update** - nothing to update **York and Scarborough Drug and Therapeutics Committee minutes** – (October and December 2016) Comment was raised as to the lack of primary care attendance at the Trust D&T, primary care members responded that they felt the Trust D&T meetings were an opportunity for discussion of items concerning secondary care, and that MCC was the forum for interface issues i.e. those affecting primary and secondary care. It was agreed that if necessary the medical directors could continue this discussion.
11	**Any urgent business** Nothing raised

	Date and time of next meeting: **Wednesday 15th March 2017, 9.30 am, West Offices, York.**