York and Scarborough
Medicines Commissioning Committee

Minutes of Medicines Commissioning Committee Meeting
Wednesday 16th November 2016
9.30-12pm, West Offices, York

1. Apologies / Attendance

		DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV
Strategic Lead Pharmacist-MMT	Mrs Rachel Ainger (RA)	A	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Chair & Vale of York CCG Pharmacist	Mrs Laura Angus (LA)	✓	✓	A	✓	✓	✓	✓	✓	✓	✓	✓	✓
GP Prescribing Lead – S&RCCG	Dr Greg Black (GB)	✓	✓	✓	✓	✓	✓	✓	✓	A	✓	✓	✓
Principal Pharmacist Formulary, Interface and Palliative Care	Mrs Jane Crewe (JEC)	✓	✓	A	✓	✓	✓	✓	✓	A	✓	✓	✓
Consultant Anaesthetist	Dr Peter Hall (PH)	✓	✓	A	✓	A	✓	✓	A	A	✓	✓	✓
Consultant Physician	Dr Paul Jennings (PJ)	A	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	A
Deputy Chief Pharmacist Tees Esk and Wear Mental Health Trust (TEWV)	Mr Richard Morris (RM)	✓	A	A	A	✓	✓	CW	A	CW	✓	✓	A
GP Vale of York CCG	Dr William Ovenden (WO)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	A
GP Prescribing Lead - VoYCCG	Dr Shaun O'Connell (SO'C)	✓	✓	✓	✓	✓	✓	✓	A	✓	A	✓	✓
Deputy Chief Pharmacist	Mr Stuart Parkes (SP)	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	✓ MM	✓ BR	✓ MM	✓ BR	MM + BR	✓ BR	✓ MM	✓ BR	✓ MM
Consultant Psychiatrist (TEWV)	Dr Shona McIlrae (SM)										✓	A	A

Item	
1	**General business** Laura Angus (LA) chaired the meeting Apologies were received from Dr William Ovenden Dr Shona McIlrae, Dr Michelle Beaumont and Richard Morris for the meeting today, Dr Michelle Beaumont will attend from February but will continue to receive papers in the interim. SO'C will send out an invitation in order to find a consultant to replace RK. **Declarations of conflicts of interest relating to the agenda** Nothing declared

2	**Matters arising**
2.1	**Chairs actions to report** A request was approved by VoY CCG for the use of brimonidine eye drops for a patient unable to tolerate preservatives, also for a tiotropium respimat device for an asthmatic patient as per SIGN guidance. There was nothing to report from S&R CCG. **Outcome of VoY SMT/SRCCG Business Committee** Items from the October meeting had been agreed in full by VoY CCG Senior Management Committee and by the Scarborough and Ryedale CCG Business Committee. SO'C asked that an annual cost impact be included on the recommendations as previous. **Draft minutes and matters arising from last meeting** The minutes were agreed as accurate following a couple of minor amendments. **Action log/long-term matters arising** **Colesevelam –** the group were updated on this issue, discussions with the specialist indicated that an application would be coming to MCC in due course. **Action:** remove from action log and await application **Ulipristal pathway** – RA explained that she had updated the pathway documents; they were with the specialists for comment and would return to the December MCC meeting. **Action:** RA to submit pathway to the Dec meeting **RAG status of drugs with no formulary status** – there was no further progress to report on this matter **Development of lidocaine patch pathway** – see agenda item 7.1 **Treatment of ADHD algorithm** – JEC is awaiting TEWV (not present at meeting) to add a link to this algorithm to the website so that the formulary can also include this link. **Action:** JEC to add link to formulary when available **Lisdexamfetamine and guanfacine SCGs** – due at the Dec meeting. **Action:** RM to submit SCGs to the Dec meeting **PCSK9 pathway** – see agenda item 7.4 **Growth hormone paper** – RA explained that this pathway is with the specialist team for feedback, it was noted that the Leeds pathway would affect this paper and guidance on how to take this forward was being sought. **Action:** RA to update MCC once feedback received. **Pitolisant** – the group noted that this agent would only be available through a tertiary centre, and so there was no need for the MCC to consider it. **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 **VTE pathways** – see agenda item 7.2 **MCC Terms of reference –** this action is complete and can be removed from the agenda. Additional actions: **Triptorelin for precocious puberty –** JEC to update the formulary with the new RAG

	status (amber specialist recommendation). JEC confirmed that this action had been completed and it could be removed from the agenda. MM to submit it with the November recommendations. **T3 prescribing in Y&S** – it was agreed that RA would bring a paper to the December meeting. MM offered to provide some supporting information to RA. **Action:** RA to submit paper to Dec MCC **Toothpaste prescribing in maxillofacial patients** – JEC explained that the issue was not actually maxillofacial patients, but restorative dentistry in patients without a dentist. It was requested that a GP prescribe this toothpaste to this group of patients to alleviate this supply issue. However the MCC did not feel this was an appropriate arrangement, and that alternative arrangements should be made for dentists to undertake this supply. MM explained that a similar situation had arisen in GM and that a similar position had been taken, as can be seen from the GMMMG DNP list and minutes available on the website. **Action:** JEC to communicate MCC position to specialists
3	**Governance** Draft formulary assessment tool for approval – MM presented a draft formulary assessment tool, which could be used by the MCC to facilitate robust decision making when considering an agent for addition or removal to the formulary. The tool would be populated by the RDTC upon receipt of an application ensuring the evidence used was appropriate and of good quality. The group considered the merits of using the tool, and agreed that following some suggested amendments the group would trial its use over the next few months, making further amendments where necessary to ensure the tool was relevant to the functions of the group. **Action:** MM to make suggested amendments to tool, to return to MCC when required.
4 **4.1** **4.2**	**Mental Health Medicines Commissioning** **TEWV minutes** –. No meeting held **D&T feedback –** No meeting held
5	**National and Regional Guidance** • **Medicines Safety (MHRA drug update – November 2016)** • **Monthly NICE update** • **NHS England Commissioned NICE TAs** It was agreed that the formulary be updated to reflect NICE TA413, TA415 and TA416, the group noted that TA414 was a “not recommended” recommendation, but that as the agent was not listed in formulary there was no need to include it. The group noted recent NICE guidelines that had been published and asked that RM be contacted as to whether there was any action required by MCC as a result of the update to CG155 (Psychosis and schizophrenia in children and young people). The group noted CG181 and the clarification of high intensity statin treatment and asked that this be communicated to SP (who had left the meeting). The group discussed NG56 (Multimorbidity: clinical assessment and management) and the work that is currently underway to assess when it is appropriate to stop bisphosphonates. This information will be brought to the December meeting. The group reviewed the MHRA DSU for November and agreed to add a link to the MHRA warning for the risk of exacerbation of rosacea with brimonidine gel, which has a black rating in the formulary. **ACTION:** JEC to update formulary, MM to populate the formulary assessment tool for botulinum, LA to bring information on stopping bisphosphonates to the Dec meeting. **Regional Guidance - NTAG recommendations:** There were no further updates from NTAG this month

	Horizon Scanning - New products: The group noted the RDTC monthly horizon scanning information, in particular deferasirox which will be available as a film-coated tablet. A new preparation of botulinum toxin type a (Boucouture® is being launched, for the temporary improvement in facial lines in those over 65 years where their severity has an important psychological impact on the patient. This agent will be considered by MCC in December using the formulary assessment tool. **ACTION:** MM to complete formulary assessment tool for Dec meeting
6 **6.1** **6.2** **6.3**	**Formulary and Managed Entry of New Drugs** **New medicine reviews –** the group discussed the Joint NICE and NHSE consultation on changes to TA and HST programmes. It was agreed that MM would coordinate a response from the MCC based on any comments received by email. **Action:** All members to submit comments by email to MM **Formulary applications –** the group considered an application for formulary for the Acapella® Choice Vibratory PEP system and considered the formulary assessment tool populated by the RDTC which was being trialled. The group noted the East of England Priorities Advisory Committee statement (June 2015) on medical devices that stated that although evidence is weak, feedback from the East of England clinicians has indicated that that there is a place for using OPEP devices for cystic fibrosis patients where PEP alone has proved ineffective. There is limited evidence of benefit for patients with non-CF related bronchiectasis. However, the group noted that the Flutter® device is already listed on the formulary, as an amber agent, only for initiation by a specialist physiotherapist. The group noted that Acapella® does provide an additional advantage over Flutter® in that it is not gravity dependent and may be easier for some patients, particularly at low expiratory flows. The group asked what the likely cost impact of this new agent would be, as primary care would be expected to replace the agent and the lifespan of these agents is unclear. Whilst primary care prescribing data showed low levels of prescribing currently, the group recognised that it may simply be too early for these agents to be picked up yet. The group acknowledged the application expected 30 devices a year may be required by year 4 to 5 onwards, (in addition to the same number for Flutter®), resulting in an additional cost to the CCGs of £1,215 a year for the Acapella® device. Noting the uncertainty of the lifespan of Acapella® versus Flutter® MCC agreed that Acapella® be added to formulary as per the Flutter® device, but that it be reserved for use in those patients unable to use Flutter®. **Action:** JEC to update the formulary accordingly. **Formulary amendments –** nothing submitted
7 **7.1**	**Interface: Shared Care Guidelines (SCGs) and Pathways** **Lidocaine patch pathway –** PH explained that a pathway had been drafted and that it would come to the December MCC meeting for MCC comment/approval. The pain score questionnaire had been proposed as a useful outcome measure. RA queried asked whether the pathway would provide information on how to manage patients who had previously been on lidocaine patches, but had stopped and now wished to be restarted, as this was an issue in primary care, as to whether or not these patients would be referred back to the specialist for review first. RA agreed to share the Scarborough audit data with PH, there is some concern that GPs are initiating lidocaine patches rather than the specialists, it is hoped that a pathway may help to improve this situation. There was also discussion as to whether the palliative care teams would work to this pathway, JEC agreed to share it with them and bring feedback to the December meeting. **Actions:** PH to share draft pathway with JEC prior to the December meeting. RA to share Scarborough audit data with PH.

7.2	**VTE Pathways** The group noted that the pathways has been updated to amend "NOAC" to "DOAC" and to state that "if a patient has already had a dose of LMWH to wait 22-24 hours before first dose of DOAC is given", MCC approved these changes; additional future changes were discussed but will not be implemented at this stage. **Action:** no action for MCC
7.3	**COPD Guidance** This paper has been deferred to the December meeting **Action:** RA to submit paper to the December meeting
7.4	**PCSK9 pathway -** The final version of the PCSK9 pathway was presented which now includes rosuvastatin. This pathway was approved by MCC; although query was raised as to the threshold reduction in cholesterol which would warrant treatment to continue or stop, and how this will be monitored. Primary care has been asked to communicate to SP the sort of outcome data they wish the clinic to collect. **Action:** Primary care members to communicate to SP regarding outcome data required to be collected by the clinic
7.5	**Warfarin to DOAC switch** The Trust informed MCC that this document had been updated to include edoxaban information, and information regarding voriconazole/posaconazole interactions. MCC noted that this provided a useful reference for GPs **Action:** no action from MCC
7.6	**OAB pathway** SP updated MCC on his discussion with the Care of the Elderly consultants and their concerns over hospital admissions of those with a high anticholinergic score, including those agents used for OAB. It was felt that the current OAB pathway contained too many options, and that this could be further rationalised as presented in a draft revision. The group viewed the revised draft but made the following points: Why was tolterodine the only first line agent? Whilst oxybutynin (IR) should not be used in frail older women, it was still the most cost effective option for other patients. Why was fesoterodine the next step up from tolterodine? As a pro-drug of tolterodine (which is metabolised to tolterodine) with a similar side effect profile and an efficacy not dissimilar to other antimuscarinics but at a higher procurement cost (and a patent in place until 2022) this did not provide a logical next step to tolterodine. Mirabegron is included in the current pathway as per TA290, and so is available for those patients for whom antimuscarinic drugs are contraindicated or clinically ineffective or have unacceptable side effects. The group agreed that rather than amending the current OAB pathway completely, it would be more sensible to address the issue of assessing the anticholinergic risk of the patient in general practice. It was agreed that the pathway should be updated to include additional information regarding assessment of the patient's antimuscarinic score, and that consideration should be given to the place of trospium in the pathway. The CCGs were keen to look at "stop-start" work in this area and would appreciate support from the specialists. **Action**: SP to communicate this information to the specialists, MMT to review the pathway as per the points above
8	**Monitoring/reporting**
8.1	**Twelve month audit data August MCC outcomes** The group viewed this report for information
8.2	**VoY Red drugs data** No data available as this is reviewed quarterly.
8.3	**ScR Red drugs data** No data available as this is reviewed quarterly.
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** – not received
11	**Any urgent business** Nothing raised
	Date and time of next meeting: **Wednesday 21st December, 9.30 am, Severus Room (F032)**