NHS Vale of York Clinical Commissioning Group | NHS Scarborough and Ryedale Clinical Commissioning Group | York Teaching Hospital NHS NHS Foundation Trust

Minutes of Medicines Commissioning Committee Meeting
Wednesday 21 September 2016
Severus Room, West Offices, York

1. Apologies / Attendance

		OCT	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP
Strategic Lead Pharmacist- CSU	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	✓	✓	✓	✓	✓	✓	✓	✓	A	✓
Principal Pharmacist - Medicines Information	Mrs Jane Crewe (JEC)	✓	✓	✓	A	✓	✓	✓	✓	✓	A	✓
Consultant Anaesthetist	Dr Peter Hall (PH)	A	✓	✓	A	✓	A	✓	✓	A	A	✓
Consultant Physician	Dr Paul Jennings (PJ)	✓	A	✓	✓	✓	✓	✓	✓	✓	✓	✓
Consultant Urologist	Mr Richard Khafagy (RK)	A	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	CW	✓
GP Vale of York CCG	Dr William Ovenden (WO)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
GP Prescribing Lead - VoYCCG	Dr Shaun O'Connell	✓	✓	✓	✓	✓	✓	✓	✓	A	✓	A
Deputy Chief Pharmacist	Mr Stuart Parkes (SP)	A	A	✓	✓	✓	✓	✓	✓	A	✓	✓
Consultant Psychiatrist (TEWV)	Dr Raul Perez	A	A	A	A	✓	A	A				
Regional Drug & Therapeutics Centre, Newcastle (BR & MM alternate attending)	Ms Bhavana Reddy (BR)		✓	✓	✓	✓	✓	✓	✓	MM BR	✓	✓
Senior Pharmacy Technician – note taker	Stuart Kerr	✓	✓	✓	✓	A	✓	✓	✓	✓	✓	
Consultant Psychiatrist (TEWV)	Dr Shona McIlrae											✓

Item		Action
1	**General business** Laura Angus (LA) chaired the meeting	

	Apologies were received from Dr Shaun O'Connell, Mr R Khafagy **Declarations of Conflicts of Interest** Nothing declared MCC members who have not yet returned their declaration of interest statements were asked to do so as soon as possible. MM to forward this paperwork to the two psychiatrists from TEWV who will be attending MCC.	All
2	**Minutes of last meeting** The minutes were accepted as an accurate representation of the August meeting.	
3	**Matters arising** **a) Chairperson's actions to report** VoY CCG received the following application: Colesevelam (from GI dept.) for diarrhoea associated biliary complications. A couple of applications were received; however they each had slightly differing indications. **Action:** RA to forward details to SP to follow up. Scarborough Ryedale CCG received no applications this month **b) Outcome of VoY SMT / SRCCG Business Committee** Items from the August meeting had been agreed in full by VoY CCG Senior Management Committee and by the Scarborough and Ryedale CCG Business Committee. **c) Outstanding actions:** **Ulipristal feedback** – A meeting between the Trust gynaecologists and CCG has been arranged for the October 13th, and will be reported into the October MCC meeting. **Net formulary to be altered to make it clear that the specialist in SI or SR drugs meant the team and not just the consultant's initiation or recommendation –** JEC explained that the definition had been slightly altered to define specialists within each team. **Harmonisation of formularies / RAG status –** JEC explained that no further work had been undertaken since the decisions made at the August meeting, but would be meeting with LA to progress this work, with an aim to bring it to the October MCC. In particular work will be undertaken on dietary products and wound dressings. **Action:** JEC/LA to prepare paper for Oct MCC **Lidocaine patch pathway –** No progress has been made with this work to date, however it was agreed that GB, PH and WO would meet outside of this meeting to initiate this work. **Action:** GB, PH and WO to meet to prepare draft pathway prior to Oct MCC **Regional Medicines Optimisation Committees –** RA thanked group members for their comments which had been submitted for consultation, and explained to the group that a report was expected back in October. Group members enquired as to N-TAG's response, MM explained that N-TAG had also contributed to the RMOC consultation, amongst their comments they were likely to raise concern as to the benefit of the RMOC over the current operation of NTAG which has a mandate to make decisions on behalf of CCGs, and whether this will be hindered by the introduction of the RMOCs. **Action:** RA to forward the submission to MCC members for information. **MCC terms of reference –** the group were in the process of updating their terms of reference (ToR), MM offered to support this work as part of the role of professional	**Specified against action**

	secretary. LA to forward the draft ToR to MM, with an aim to return them to the October MCC meeting. **Action:** MM to update draft ToR and return them to MCC in Oct or Nov	
4	**Formulary and Managed Entry of New Drugs** **4.1 – New medicine reviews** Nothing to review **4.2 – Formulary applications** The group considered an application for dulaglutide, a weekly GLP-1 receptor agonist. The group evaluated the safety and efficacy of dulaglutide utilising evidence from the SMC assessment (published January 2016), NICE ESM59 and in line with NICE NG28 and noted that: • Dulaglutide has broader licensed indications than exenatide ER, to include use in combination with insulin and as monotherapy • unlike exenatide ER dulaglutide is licensed for use without dose adjustments in patients with moderate renal impairment • Dulaglutide is available via an automated pen device, which the group noted could ease the burden on carers/nursing staff and enable needle phobic patients The group noted the lack of head-to-head trials between the weekly products, but that dulaglutide was the same price as liraglutide once daily and exenatide weekly but that clinical data show dulaglutide is superior to exenatide twice daily but not inferior to liraglutide, but is a weekly preparation. It was agreed that dulaglutide would be added to the formulary as the first choice weekly GLP-1 agonist, with a green RAG status however exenatide weekly would remain on formulary as an alternative option. The group then discussed the development of a diabetes pathway by VoY, representatives for S&R expressed an interest in being involved with this work, and it was agreed that further discussions would take place outside of this meeting. **Action:** Dulaglutide to be added as first choice weekly GLP-1 agent to the formulary following CCG approval. **4.3 – Formulary amendments** Issue was raised regarding the RAG status across S&R for tadalafil once daily for the treatment of erectile dysfunction, which is listed as Grey rather than black, as it is by VoY. It was agreed that this would be amended from Grey to Black to bring this agent in line with the Y&S formulary, on the basis of the previous Y&S MCC decision. **Action:** See CCG approval then amend	**JEC/MMT**
5	**National and Regional Guidance** The group considered NICE TAs and MHRA drug safety update information published in August/September. It was agreed that the formulary be updated to reflect NICE TA401, TA402 and TA405, all of these agents are NHSE commissioned. MCC requested costing information for TA404 (Degarelix for treating advanced hormone-dependent prostate cancer) be brought to the October MCC meeting, TA403 will not be added to the formulary as it was a "not recommended" agent. The September MHRA DSU had not been available to send with the papers however MM gave a verbal update, JEC confirmed that the formulary would reflect these warnings with links to the MHRA advice added alongside levonorgesterol, posoconazole and idelalsisib as appropriate. The group also considered a safety summary produced by the RDTC in response to the FDA safety review *(type 2 diabetes medicines containing saxagliptin and alogliptin may increase the risk of heart failure, particularly in patient who already have heart or kidney disease)*. The	**JEC/MMT**

	summary concluded that at this time this information would not warrant changing alogliptin as the first line option on the formulary, as it is still the most cost effective treatment option and it is likely that the safety signal around heart failure applies to all gliptins. However it was suggested that this caution should be linked to the formulary. With regards switching patients to alogliptin, it was suggested and MCC agreed that this should be approached with caution and shouldn't be considered unless the patients are not stable on their current treatment option. JEC to communicate this information to the Trust clinicians. MM updated the group on new products recently launched or likely to launch in the near future, namely Loxapine, generic levofloxacin eye drops, bazedoxifene/conjugated oestrogen MR tablets, a licensed acetylcysteine tablet and a licensed glycopyrronium solution. The group were also reminded of the discontinuation of production of co-danthramer and co-danthrusate. Whilst the formulary currently highlights the impending discontinuation of these products it was noted that Y&S primary care prescribing Q1-Q4 2015 stands at 192 items (£12,729). It was agreed that a reminder would be issued on prescribing systems. **Action:** JEC to update the formulary as above and communicate alogliptin information to Trust as appropriate, MMT to issue reminder on co-danthrusate.	
6	**Mental Health Medicines Commissioning** 6.1 – TEWV minutes – no minutes this month as this group meets bi-monthly 6.2 – Safe Transfer of Prescribing Guidance The TEWV transfer of prescribing guidance was due for review in January 2016. RM updated MCC on the progress of this guideline update which included amendments to reflect recent formulary decisions including new drugs, shared care arrangements and national guidance. Most of the drug status changes had already been considered through D&T / MCC and as such the financial impact of these decisions had already been considered, it was noted that the implementation of NICE guidance in relation to antipsychotic prescribing will have a significant impact upon TEWV. There was further discussion around the direction from NICE for specialist MH services to retain physical monitoring of the patient (although not prescribing) for the first 12 months, and that it was agreed that the MH Trust would transfer the prescribing responsibility to primary care when the patient was stable, likely between 3 and 12 months. However the MHT would call the patient back in for monitoring at 12 months. There was a query about pre-treatment monitoring and RM confirmed that the MHT would carry out baseline and 12 month monitoring. The MHT had recognised that due to the geography of the area there may be instances where monitoring e.g. ECGs may be difficult and they hoped that on these few occasions that primary care may be able to assist in these situations. However the MHT stressed that they expected these occurrences to be limited. There was some discussion around paroxetine as it is no longer on the Trust formulary and it was agreed that MCC will relook at the positioning of paroxetine within the Y&S formulary in the near future. RM highlighted differences in the RAG coding between Y&S and TEWV, but it was agreed that it would not be possible to change this as it would affect other CCGs also, and as long as it was clearly referred to within the guidance it should not cause a problem. The MCC also asked that MHT check whether there is any monitoring required for venlafaxine. The MCC supports the proposed changes to the Safe Transfer of Prescribing Guidance, it was noted that an updated version will be submitted to TEWV D&T and a final version will be submitted to the MCC October meeting. **Action:** RM to update the final draft as per MCC discussions prior to submission to TEWV D&T, and then bring the final draft back to the October MCC meeting	**RM**
7	**Interface: Shared Care Guidelines (SCGs) and Pathways** **7.1 Alirocumab and evolucumab pathway** SP presented a draft version of the PCSK9 inhibitors pathway which had been developed by Dr Chandrajay (Trust lipidologist) and thanked MCC members for their comments which had shaped this pathway, which essentially reflects current NICE guidance. A number of points were covered	

	i.e. the flowchart within the pathway should aid the identification of patients who are suitable for treatment, PCSK9 inhibitors would only be available as RED drugs via Homecare arrangements and that the majority of patients would self-administer these agents, but that for the few who were unable to a medical day case option would be made available and this would incur a tariff cost. It had been proposed by the Trust that these agents would be delivered by cardiologists in combination with the lipidologist via a joint clinic, primary care members of the group re-iterated their concern with regards the cost impact of these agents and requested that a more consistent route be incorporated into the pathway by making ensuring PCSK9inhibitors are listed as RED "lipidologist" only drugs, thus ensuring the appropriateness of prescribing of these agents. There was discussion concerning the agent of choice in terms of Homecare arrangements, although it was noted that both agents have positive NICE TAs and will be listed on the formulary. The group raised a query as to the place in therapy of fibrates, which SP agreed to confirm. *Post meeting note: RA will enquire as to Hull's provision of these new drugs as they will need to work within ScR CCG commissioned arrangements.* **Action:** SP to feed comments back to pathway development group at meeting on 14th October 2016 **7.2 Growth Hormone paper** MCC members considered a proposal currently being considered by Leeds FT concerning the choice of growth hormone preparation. It was agreed that the MMT would look at this further with regards primary care data and that PJ and SP would seek feedback from secondary care colleagues. **Action:** MMT, PJ and SP to action as above	**SP** **MMT/ PJ/SP**
8	**Monitoring/reporting** **8.1 - Twelve month audit data June MCC outcomes** The group reviewed this data, the increased spend on vitamin B co-strong was noted **8.2 - VoY Red drugs data (April to June 2016)** VoY CCG have written to practices to requesting a review of red drug prescribing The group noted the high levels of lidocaine patch prescribing and reiterated the need for development of this pathway. **8.3 - ScR Red drugs data (Apr to June 2016)** RA had left the meeting at this point to attend a local antimicrobial event, but the group noted the data	
9	**Patient and clinical communications** Nothing to report	
10	**Items from other groups** **10.1 - Hull and East Riding Prescribing Committee (HERPC) minutes July 16** – were not available for the Sept MCC and will be brought to the Oct MCC **10.2 – Antimicrobial stewardship subgroup update** No update as meeting due that day **10.3 – York and Scarborough Drug and Therapeutics Committee minutes** Not received	

11	**Any urgent business** The group considered a briefing on the proposed choice of branded generic buprenorphine 7 day patch for the treatment of non-malignant pain of moderate intensity when an opioid is necessary for obtaining adequate analgesia. Butec® was the agreed choice of branded generic for use across Y&S, as it was considered to be similar to Butrans® whilst realising but it represents a cost saving	**MMT**
	Date of next meeting: Wednesday 19 October 9.30am-12am, Severus Room (F032), West Offices, York	