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 15 June 2016
Auden Room, West Offices, York

1. Apologies / Attendance

		JUN	AUG	SEP	OCT	DEC	JAN	FEB	MAR	APR	MAY	JUN
Strategic Lead Pharmacist- CSU	Mrs Rachel Ainger (RA)	✓	A	✓	✓	A	✓	✓	✓	✓	✓	✓
Chair & Vale of York CCG Pharmacist	Mrs Laura Angus (LA)	✓	✓	✓	✓	✓	✓	A	✓	✓	✓	✓
GP Prescribing Lead – S&RCCG	Dr Greg Black (GB)	✓	✓	✓	A	✓	✓	✓	✓	✓	✓	✓
Principal Pharmacist - Medicines Information	Mrs Jane Crewe (JEC)	✓	✓	✓	✓	✓	✓	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
Deputy Chief Pharmacist Tees Esk and Wear Mental Health Trust (TEWV)	Mr Richard Morris (RM)	A	A	A	✓	✓	A	A	A	✓	✓	CW
GP Vale of York CCG	Dr William Ovenden (WO)	✓	✓	A	✓	✓	✓	✓	✓	✓	✓	✓
GP Prescribing Lead - VoYCCG	Dr Shaun O'Connell	A	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Deputy Chief Pharmacist	Mr Stuart Parkes (SP)	A	✓	✓	A	A	✓	✓	✓	✓	✓	✓
Consultant Psychiatrist (TEWV)	Dr Raul Perez	A	A	A	A	A	A	A	✓	A	A	
Regional Drug & Therapeutics Centre, Newcastle (BR & MM alternate attending)	Ms Bhavana Reddy (BR)					✓	✓	✓	✓	✓	✓	✓
Senior Pharmacy Technician – note taker	Stuart Kerr	✓	✓	✓	✓	✓	✓	✓	A	✓	✓	✓

Item		Action
1	**General business** Laura Angus (LA) chaired the meeting. Apologies were received from Mr Richard Khafagy and Mr Richard Morris. Mr Chris Williams (CW) attended in place of RM. **Declarations of Conflicts of Interest** None relevant to today's agenda	

2	**Minutes of last meeting** With the following amendments, the minutes were accepted as an accurate representation of the April meeting: Item 3g– MM has asked that the following wording should be removed as they were inaccurate - "MM advised that the GMMMG pathway was very similar with a cap on the number of treatments to a maximum of four on the NHS; if more were required then these would have to be done privately". MM had commented that it was likely that GMMMG might recommend use as per the licensed indication in women of reproductive age, for up to four treatment courses and that this is similar to the draft York pathway; however she did not mention private treatment. Item 3k – Correct spelling of surname is Newsome not Newsane Item 4 – Correct surname is Williams not Williamson Item 7 – Minute entry is correct although SO'C asked if edoxaban was to be added to the AF patient leaflet. SP advised that Jane Knight would include it.	**SP**
3	Matters arising **a) Chairperson's actions to report** VoY CCG received the following applications • Coagucheck test strips – approved • Tiotropium Respimat for bronchiectasis – approved. LA advised that this was the 3rd or 4th request for this medication via this route and perhaps the Trust should submit a formal request. Scarborough Ryedale CCG received the following applications • Colomycin nebules for bronchiectasis from Dr Ford – Not approved as this is a RED drug. GB advised that this was not the first submission for this medication and perhaps the Trust should submit a formal request. • Vancomycin for C.Diff. It was suggested that perhaps vancomycin for C.Diff should be Amber SR if approved by microbiology rather than RED. SP to ask the consultant microbiologist for his view first. **b) Outcome of VoY SMT / SRCCG Business Committee** Items from the May meeting had been agreed in full by VoY CCG Senior Management Committee and by the Scarborough & Ryedale CCG Business Committee. **c) Oral contraceptive pill formulary wording review around Rivegedon 1st line, Gederal 2nd line requiring review. –** Deferred until LA and JEC can discuss **d) Melatonin for sleep disorders in young people with ADHD** RA advised that the MMT had not been able to identify capacity to help find patients on expensive preparations. The shared care guideline still had to be finalised. It was hoped that GPs could review patients opportunistically and either switch the patient themselves or refer them to their consultant for switching at their next review. It was suggested that perhaps a phone call between GP and consultant regarding individual patients might speed any switching along. WO commented that he thought he was seeing patients on increasingly large doses and proposed to audit this and report back to the next meeting. **e) Ulipristal feedback** – the proposed multidisciplinary meeting has still to be arranged to	**SP** **LA/JEC** **RA** **WO** **RA**

	discuss the issue further. **f) Link required to TEWV magnesium levels in patients taking citalopram/escitalopram document** – confirmation of permission to use a link to the whole document has still to be obtained **g) Shared care plan and pathway for lisdexamfetamine -** RA advised that she would discuss progress with RM and John Hampton outside the meeting. There is no pathway currently. CW advised that TEWV hoped to take something to their D&T in July and then bring to this committee in August. The topic will therefore be deferred until then. **h) RAG status approval from Gastroenterology consultants re MCC proposed RAG status from previous month's meeting** Dr Robins agreed with MCC recommendations for all except the following two drugs listed below. JEC to bring these back to the committee for further debate next month: • Hydrocortisone rectal – AMBER (specialist recommendation) • Prednisolone rectal – AMBER (specialist recommendation) **i) Sacubitril/Valsartan (Entresto)** - update A recent MTRAC review document had been shared with the committee for further information. LA had worked through the NICE costings algorithm (for VoY) and the potential costs were lower (for both CCGs) than the original estimates that had already been approved by both CCG business committees. The commissioning position was clarified as **AMBER Specialist Initiation.** The issue around initial titration was discussed and it was felt that if necessary (i.e. there were no specialist nurses in that area) this could be done by GPs. A communication for primary care prescribers was to be developed: the acute trust is preparing a document for community pharmacists. This would reflect that the first prescription would be initiated by cardiologist or prescribing specialist nurse. The specialist nurses would also be responsible for most of the monitoring. However in areas not covered by specialist nurses it was asked whether the cardiologist could refer patients to district nurses for blood pressure checks etc. SP to find out and include in the communication if appropriate and then update SO'C, LA and RA. **j) Link pathway to be shared with GB to clarify use of a LABA alone. Appropriate recommendations for asthma patients to be added to Vale of York's Optimise RX** LA still to action k) **Link to MHRA Safety alerts for BCR-ABL tyrosine kinase inhibitors and also for Idelalisib for chronic lymphocytic leukaemia and follicular lymphoma to be added to formulary** JEC still to action **l) Requested minor alterations made to ondansetron IBD PIL** - Actioned In light of the many actions arising after each meeting it was agreed that a draft action list would now be sent out to all concerned as soon as possible after every meeting.	**JEC** **RA** **JEC** **SP** **LA** **JEC** **SK**
4	**Mental Health medicines commissioning** a) Tees, Esk and Wear Valley Mental Health Trust • D&T feedback May 16 CW advised the committee that a shared care protocol is being developed for lisdexamfetamine (currently a red drug) and an algorithm is being developed for the treatment of ADHD which will include guanfacine. It is hoped to bring this to the committee in August/September.	**RM**

	Following an incident where a patient's INR rose rapidly during memantine titration, the following advice has been issued– patients taking warfarin AND memantine, should have INR checked weekly for the whole of the memantine titration period (once stabilised the period can revert to the usual frequency if INR is stable). The North East & Cumbria antimicrobial prescribing guideline (adopted by TEWV) has been updated. A more localised version of that guideline exists for the North Yorkshire and York & Selby localities. It is likely that TEWV will adopt both versions at the July D&T with an overarching guideline highlighting some key issues and signposting localities to the most appropriate guidelines. Harmonisation of formularies / RAG status – to be discussed with Peter Billingsley and Louise Barker TEWV Consultant representative at this committee – Dr Raul Perez will no longer attend. TEWV are looking for a more locally situated consultant to attend but no one identified as yet. SO'C raised the matter of antipsychotic depot prescribing. CW advised that in most areas there were no issues with primary care administering these. GB stated that primary care prescribing of depots occurs in Ryedale. CW advised that a new 3-monthly depot was in the pipeline and would need to be considered as a treatment option. It was no more expensive than other options and will reduce the frequency of treatment attendances. It was agreed that communication between patients and healthcare professionals was key in the successful treatment of this client group: arrangements needed to be in place to ensure feedback and review of patients that failed to attend for their depot. • Adoption of TEWV Shared Care– where RAG status might conflict RA and RM to meet in the next month or so.	**RM/RA** **RM/RA**
5	**New medicine/product reviews (national or local)** a) Nil	
6	NICE Technology Appraisals (TAs) New TAs from NICE since last meeting to note formal commissioning requirements to be formally ratified at SMT/Business Committee were as follows: CCG: TA390: Canagliflozin, dapagliflozin and empagliflozin as monotherapies for treating type 2 diabetes. NICE suggests this will be cost neutral. BR indicated that a GMMMG diabetes guideline remains under development. Approved as GREEN **NHS England – for information** TA391: Cabazitaxel for hormone-relapsed metastatic prostate cancer treated with docetaxel Approved as RED	
7	**New submissions (includes new therapies and changes to existing policy positions) and appeals** a) **Nil**	

8	**Other medicines issues (local and/or national) including pathways/guidelines** **a) Antimicrobial stewardship – new standing item** RA met with Neil Todd (Consultant Microbiologist) and the suggestion was that a primary care antimicrobial stewardship group be set up, as a subcommittee of the MCC. RA advised that this would fit with NICE guidance and that the acute trust TOR for their antimicrobial stewardship committee could easily be adapted for use. The formation of such a sub group was approved and WO volunteered to represent VoY CCG on it. RA suggested that representation from HaRD CCG be invited. The group would report to this committee on matters relating to antimicrobial stewardship, including the antibiotic Quality Premium, antibiotic prescribing education and review of data. **b) Methylphenidate recommendation from The Retreat, York** – Deferred to next meeting **c) RAG status of drugs with no formulary status** None **d) Lidocaine Patch Pathway** Lidocaine patches have been categorised as RED, based on the limited licence and weak evidence for use in unlicensed areas. There was debate regarding the value of a pathway to help manage patients currently receiving it and help signpost others who may benefit from it. PH advised that lidocaine patches have the advantage of having no side effects other than minor issues with the adhesive for some patients. His view therefore was that lidocaine patches are a very good choice for treating localised pain associated with post-surgical pain and neuralgia in patients who had already tried relatively cheap oral treatments, or in elderly patients who could not tolerate the side effects of the oral treatments. The Trust would prescribe it for an initial 6-8 week trial. If of no benefit then it would be stopped, if successful it would continue. It was felt that prescribing in primary care did not follow that initial trial period and patients were often left on it, also without appropriate treatment holidays to identify if the condition had cleared up. PH agreed to review the current pathway to include lidocaine patches but with the above mentioned caveats. This was to be submitted to the committee to allow it to consider a formulary change from RED to amber specialist initiation. Both GB and WO agreed to take part in the pathway review. PH advised the committee that he feared that there were many such pain treatments, especially opiates, that prescribers did not encourage patients to take drug holidays from. The concern being that many patients may continue to take opiates when there was no longer any need for such a dose, or at all. **e) Ocular lubricants** – Change of amber status of all from amber SI to amber SR; Addition of amber SR oral doxycycline or oral azithromycin; Request clarification of status for all preparations not listed. On reflection the ophthalmologists who consulted in the production of the original paper now feel that the AMBER classifications approved should be instead AMBER specialist <u>recommendation</u> and not initiation. This was agreed for: Sodium hyaluronate 0.2% HYLO-FORTE	**RA** **LA** **PH/JEC** **GB/WO**

	Sodium hyaluronate 0.4% CLINITAS Carmellose 0.5%, glycerol 1% & castor oil 0.25% OPTIVE PLUS Propylene glycol, hydroxypropyl guar, mineral oil, etc. SYSTANE BALANCE It was also agreed for : Acetylcysteine 5% ILUBE Sodium chloride 5% with sodium hyaluronate 0.15% ODM5 But not for: Ciclosporin 0.1% IKERVIS 30 units dose. This would remain AMBER specialist <u>initiation.</u> The last three drugs mentioned above, not being used to treat Dry Eye, should be removed from the final version of the Dry Eye and Corneal Damage/Erosion/Dystrophy guidance document. Autologous serum should also be removed. JEC to check that this use of oral doxycycline and azithromycin fits with the antibiotic guidance. If they do then these are approved as GREEN for posterior blepharitis but these should NOT be included in the guidance document. **f) York & Scarborough Drug & Therapeutics Committee minutes (latest approved)** None to report	**AM** **JEC** **AM**
9	**Shared care guidelines** **a) Melatonin shared care guidelines** This had been produced by Dr Abbey at York and shared with her Scarborough based consultant colleagues. GB and RA have suggested that some alterations be made. Further discussion is required regarding what happens to a patient's treatment when they become 18 years of age. It was agreed that the guideline was approved and would be adopted and sent out once the requested alterations were actioned.	**JEC/RA**
10	**Formulary items** a) Nil	
11	**Monitoring / reporting** **1) 12 month audit data MCC outcomes – March 2015** The data was discussed. It was considered that the spend on strontium was high and practice use should be identified and reviewed. **2) CCG RED drugs prescribed Q4 15-16** It was noted that much of the VoY RED drug spend is due to some of the drugs included having dual classification (e.g. as amber and red) depending on the condition treated. SO'C asked that those drugs be removed prior to all future (quarterly) lists coming to MCC. It was questioned as to whether eplerenone should be on the RED drug list – it is red for the treatment of chronic central serous chorioretinopathy by ophthalmology hence why it had been included.	**SK/MMT** **SK**
12	**Medicines safety** a) MHRA Safety update - This had not been published in time to be considered.	
13	**Horizon scanning, NICE Guidance and NICE Bites** The RDTC monthly horizon scanning document had previously been distributed to those attending. BR briefly mentioned the following: a) Adalimumab injection – a change in formulation to reduce the volume administered of	

	an existing drug. Cost remains the same. b) Safinamide - for the treatment of adult patients with idiopathic Parkinson's disease as add-on therapy to a stable dose of Levodopa (L-dopa) alone or in combination with other PD medicinal products in mid-to late-stage fluctuating patients. RDTC have already carried out a review and BR to share with SP and bring to next meeting. c) The positive opinion given to saxagliptin/dapagliflozin 5 mg and 10 mg tablets. d) The forthcoming NICE guidance due on: Hypercholesterolaemia (primary), dyslipidaemia (mixed) - evolocumab [ID765] Hypercholesterolaemia (primary), dyslipidaemia (mixed) - alirocumab [ID779] BR advised that a lipid specialist might want to define which particular sets of patients might be suitable for access to these drugs: a pathway will need to be agreed once these sets of guidance are published.	**BR**
14	**Patient and clinical communications** Nil	
15	**AOB -** a) The date for the introduction of the four proposed regional medicines committees is still awaited but thought to be October 2016. It is believed that they will co-ordinate what drugs they review to ensure no overlap occurs. b) Gender dysphoria – NHSE have advised that GPs should prescribe for this group of patients; however the BMA has indicated that it will not insist that GPs prescribe out with their competence. Neither Scarborough nor VoY CCG currently has a formal position for treating this condition.	
	Date of next meeting: Wednesday 20 July 9.30am-12am, Snow Room (G035), West Offices, York	