York and Scarborough
Medicines Commissioning Committee

Minutes of Medicines Commissioning Committee Meeting
Wednesday 19th October 2016
9.30-12pm, King John Room, West Offices, York

1. Apologies / Attendance

		DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT
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	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
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 (SO'C)	✓	✓	✓	✓	✓	✓	✓	A	✓	A	✓
Deputy Chief Pharmacist	Mr Stuart Parkes (SP)	A	✓	✓	✓	✓	✓	✓	A	✓	✓	A
Consultant Psychiatrist (TEWV)	Dr Michelle Beaumont (MB)											A
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
Consultant Psychiatrist (TEWV)	Dr Shona McIlrae (SM)										✓	A

Item		Action
1	**General business** Laura Angus (LA) chaired the meeting Dr Michelle Beaumont or Dr Shona McIlrae may attend from TEWV (would take it in turns) However apologies were received from both Dr Shona McIlrae and Dr Michelle Beaumont for the meeting today. It was also noted that Richard Khafagy has retired from the committee. **Declarations of conflicts of interest relating to the agenda** GB reaffirmed that he is a partner in a dispensing practice. It was noted that should the practice have any deals or rebates in place for specific drugs that may be considered by	**ALL**

	MCC then these would need to be declared in the usual way.	
2	**Governance**	
2.1	**Declarations of Interest Policy** The group were made aware of the updated VoY conflicts of interest policy which the MCC would adopt. There was also a table outlining the actions that should be taken during the meeting should a conflict be declared.	
2.2	**Revised terms of reference** The group discussed the updated terms of reference which had been drafted by the RDTC in line with national guidance but based on the previous MCC terms of reference. Comments were made on the proposed membership. It was felt that a lay person attendee was probably not required as patient opinion was canvased prior to items coming to MCC and there was also patient representation within the CCGs. It was noted that other members had been included (e.g. Public health doctor, Nurse and allied professional representation) BR stated that these members were often included in other groups and they had been included for discussion and agreement. It was felt that unfortunately public health would not have the capacity to send a member to the meeting; however they would be consulted outside of the meetings if required. Similarly nurses and other allied health professionals would be consulted when required. As the committee doesn't discuss non-medical prescribing issues routinely it was felt that they could also be consulted on an ad hoc basis as required. A few points were made around quoracy; it was felt that CCG clinicians should be changed to CCG GPs and two should be present. Similarly two CCG medicines management pharmacists should be present and one provider trust clinician and one provider trust pharmacist. It was agreed that a mental health representative needed to be in attendance for any mental health agenda items. The group approved the revised terms of reference following the above changes and corrections to the membership list (in line with the membership changes reported today). **ACTION:** BR agreed to make the above changes and forward to the final document to LA and RA.	**BR**
3	**Minutes of last meeting** The minutes were accepted as an accurate representation of the September meeting following a minor typo correction.	
4	**Matters arising** **a) Chairperson's actions to report** There were no actions to report **b) Outcome of VoY SMT / SRCCG Business Committee** Items from the September meeting had been agreed in full by VoY CCG Clinical Executive Committee and by the Scarborough and Ryedale CCG Business Committee. **c) Outstanding actions:** • **Chairs action on Colesevelam from GI department** *for diarrhoea associated biliary complications***:** LA fed back that she had forwarded the details of the various applications (for slightly different indications) onto SP to investigate further but she had heard nothing back. This would remain on the action log until further information was available. • **Ulipristal feedback –** RA and JEC fed back on the meeting that had taken place on October 13th. It had been noted that since the meeting had been arranged a NICE clinical guideline on heavy menstruation had been issued and this guideline outlined a place for Ulipristal both pre surgical and for fibroids. The pathway had therefore been revised in light of this,	

	however there were still queries around use in younger patients and pre-surgical use which hadn't been approved by MCC to date. **ACTION:** JEC to bring the revised pathway to the November meeting, until then ulipristal remained black. • **Harmonisation of formularies / RAG status** JEC explained that no further work had been undertaken since the decisions made at the August meeting. • **Lidocaine patch pathway** –this item is on the main agenda and will be discussed then. • **ADHD treatment algorithm** – this item is on the main agenda and will be discussed then. • **Lisdexamfetamine and guanfacine SCGs** – RM fed back that the SCGs were currently in development and would be brought back to MCC once they had been approved by the TEWV D&T. This was likely to be in Dec/Jan. **ACTION:** RW to forward SCGs once available. • **Dulaglutide** – this action has been completed and will be removed from the action log. • **Tadalafil formulary amendment** – this action has been completed and will be removed from the action log. • **NICE August updates** – this action has been completed and will be removed from the action log. • **Safe Transfer of prescribing guidance –** this item is on the main agenda and will be discussed then. • **Alirocumab and Evolocumab** – this item will be discussed under AOB. • **Growth Hormone paper** – no further work had been undertaken on this. **Action:** RA agreed to send the primary care data on this to secondary care and SP and PJ would seek further feedback. • **Branded generic buprenorphine 7 day patch choice** – this item has been completed and will be removed from the action log. **d) Degarelix –** The group discussed how degarelix would be used locally based on the protocol that had been supplied by the Trust. The updated NICE TA 404 now recommending use was noted at the meeting in September however further information was required prior to a RAG status being agreed. The alternative agents are all amber specialist initiation (no SCG). The NICE TA states that no resource impact is anticipated for this TA as degaralix is another treatment option for advanced hormone dependent prostate cancer in people with spinal metastases. The patient population who may fit the criteria for use are expected to be small. The benefit of degarelix is that there is no testosterone flare at the start of treatment this avoids the cost of using an ant-androgen treatment to prevent flares. As per the NICE TA degarelix is only available for use only if the commissioner can achieve at least the same discounted drug cost as that available to the NHS in June 2016. The group approved the protocol and approved degarelix as an amber specialist medicine. **ACTION**: JEC to add to formulary as above.	**Specified against action**
5 **5.1**	**Mental Health Medicines Commissioning** **TEWV minutes** – the group noted the minutes of the July meeting.	
5.2	**D&T feedback** The group noted that a 3 monthly Paliperidone injection was available and as this was the same cost as the current one monthly preparation. TEWV would consider using this for stable patients (who have been on the 1 monthly preparation for a minimum of 4 months) The North of England guidelines on long acting injections would be updated accordingly.	
5.3	**Safe Transfer of Prescribing Guidance** The TEWV has been updated and is presented for approval. Most of the drug status	

	changes had already been considered through MCC and as such the financial impact of these decisions had already been considered. The group approved the final version of the guidance and asked that all RAG status decisions are reflected on net formulary. It was noted that due to the lack of a SCG for lisdexamfetamine and guanfacine these drugs are listed as red, however a SCG for each drug is in development and these would be changed to Amber (SCG) once there had been approved. **ACTION:** JEC to update formulary as above.	**JEC**
5.4	**ADHD prescribing Algorithm** In May 2016 TEWV D&T approved guanfacine a new treatment for ADHD. This position had been supported by MCC, however it was agreed that a prescribing algorithm should be developed to define the place in therapy of guanfacine in line with its licensed indication and in relation to other treatment options. RM fed back that this algorithm is now presented for approval by MCC. As noted earlier SCGs for guanfacine and lisdexamfetamine are in development to support the safe transfer of prescribing to primary care. MCC asked that guanfacine be added as red to the formulary currently as no RAG status had been agreed previously. This would be changed to amber SCG once an SCG was available. The group asked that a link to ADHD algorithm be included in the formulary. RW fed back that this would be on the TEWV intranet shortly. **ACTION**: JEC to add to formulary as above.	
6	**National and Regional Guidance** • **Medicines Safety (MHRA drug update – October 2016)** This had only been published the day before the meeting so wasn't attached to the papers however BR gave a verbal update to members as below: - **Etoricoxib:** prescribing information now contains revised dose recommendations for rheumatoid arthritis and ankylosing spondylitis. The lowest possible dose was encouraged with a lower recommended dose of 60mg; this is due to the potential cardiovascular and other risks of using a coxib. The group noted that Etoricoxib is not in the formulary. - **Withdrawal of Retigabine.** BR noted that this had already been updated in the formulary. A letter had been sent to all healthcare professionals regarding withdrawal of retigabine – an antiepileptic drug from the market in June next year. It was being withdrawn due to limited and declining use. The letter outlines advice for healthcare professionals on alternative treatments and how to withdraw use from existing patients taking this drug. • **Monthly NICE update** **NHS England Commissioned NICE TAs** It was agreed that the formulary be updated to reflect NICE TA406, TA408, TA410, and TA412, all of these agents are NHSE commissioned. TA411will not be added to the formulary as it is a *'not recommended'* drug. **ACTION:** JEC to update formulary. **CCG Commissioned NICE TAs** <u>TA407:</u> secukinumab for active ankylosing spondylitis is a CCG commissioned agent and therefore further information around place in therapy and cost impact from specialists was requested. BR reported that it would likely be cost neutral as it would be used in place of anti-TNFs and likely after other treatment options had been tried. **ACTION:** JEC to check place in therapy with specialists and BR to add to recommendations list for CCG boards. *Post meeting note: Specialists fed back that other options would be tried first and secukinumab would only be used if these had failed. It is likely that secukinumab would be cost neutral or cost saving.* <u>TA409:</u> aflibercept for treating visual impairment caused by macular oedema after branch retinal vein inclusion. JEC fed back that she had discussed this with the specialist and that there would be no cost impact as it was an option for treatment alongside similarly priced options. It would also be used after laser treatment. **ACTION:** BR to add to recommendations list for CCG board.	**JEC** **BR**

	NICE Clinical Guidelines: The group noted the following NICE clinical guidelines and agreed to add in links to the guidance within the formulary: CG42: dementia, CG141 acute GI bleeding and CG126 Stable angina management. **ACTION:** JEC to add links to appropriate chapters as agreed. **Regional Guidance - NTAG recommendations:** BR gave the group a brief update on the most recent three NTAG recommendations. The group agreed that it would be useful to look at these in more depth to agree a Y&S MCC position. BR therefore agreed to add these to the agenda for the December meeting. **Horizon Scanning - New products:** The group noted the new medicines launched. It was noted that the new branded generic for quetiapine may be worth considering once it had been launched, as it had a better spread of strengths than the currently recommended Y&S branded generic quetiapine. BR suggested that specialist feedback or an application for use of the first in class agent – pitolisant (Wakix®) indicated for narcolepsy with or without cataplexy should be sought as current treatment options are limited. JEC and PJ indicated it was likely that specialists would be interested in this. **ACTION:** JEC agreed to check with neurologists if this was something they would like MCC to consider.	**JEC** **BR** **JEC**
7 **7.1** **7.2** **7.3**	**Formulary and Managed Entry of New Drugs** **New medicine reviews** Lesinurad for the treatment of gout: BR fed back that this was currently undergoing a NICE TA and that the draft ACD had been published that didn't recommend use. **Formulary applications** An application had been received for the Acapella® device; this was currently undergoing scoping and would be brought back to the November meeting. **Formulary amendments** There were no new formulary amendments for discussion.	
8 **8.1**	**Interface: Shared Care Guidelines (SCGs) and Pathways** **Lidocaine plasters** WO and PH updated MCC on the likely place of lidocaine plasters. It was proposed that new patients should only be given lidocaine plasters if they have allodynic pain (burning sensation) when lidocaine does work well, however this niche use has limited evidence base and is unlicensed therefore it is unclear as to whether it would pass the traditional thresholds for clinical cost effectiveness. It was noted that the NICE clinical guideline on neuropathic pain could not recommend lidocaine because the evidence base isn't available and not necessarily because the evidence base shows that it doesn't work. Members felt that if lidocaine was prescribed appropriately it may well be cost effective however recent audit work showed that it is being used for a wider use than is indicated. Discussion took place around whether lidocaine should remain for pain clinic use only however this was felt to be a problem due to capacity issues within the pain clinic and the fact that secondary care isn't set up to issue long term prescriptions, however specialist initiation with prescribing moving to primary care once an efficacy trial has taken place could be an option. PH also indicated that those that have been taking lidocaine patches for many years should have a treatment holiday once every 6 months or annually to evaluate whether the patches are still working and if they are still appropriate. MCC agreed that some advice for GPs on this would be helpful. It was agreed that there were two separate issues that MCC needed to address with regards lidocaine plasters – one was for existing patients and reviewing appropriateness of use and the other was outlining a place in therapy within the pain pathway (including palliative care use) and reviewing the current RAG status for new patients. It was noted that lidocaine plasters were in the formulary as a hospital only treatment and for Chronic Pain Consultant initiation only for allodynic pain with focal origin (unlicensed indication). **ACTION**: It was agreed that RA should share the audit data from Scarborough with MCC so that current use and appropriateness could be reviewed and that WO/PJ should put in an application and pathway to consider use as above.	**RA/WO/ PH**

8.2	**Toothpaste prescribing in maxillofacial patients** The group was asked to re-consider toothpastes and mouthwashes when recommended by maxillofacial departments. The group noted that the current position in the formulary is black as GPs shouldn't accept requests for items that dentists can prescribe themselves as they are not responsible for their dental care. It was noted that duraphat toothpaste can also be bought from dentists. The group agreed to leave the status as black.	
8.3	**Hypertonic sodium chloride 7% RAG status** The group reviewed the current SCG for the above drug and agreed that a SCG was not required as there were limited monitoring requirements. The group therefore agreed to amend the RAG status to Amber specialist initiation. **ACTION:** JEC to amend RAG status in formulary.	**JEC**
8.4	**Triptorelin for precocious puberty** This had been brought to the meeting as Leeds have decided not to update this particular shared care guideline as it was felt to be unnecessary. The drug would be initiated by specialists and the patient would remain under secondary care however as there are no monitoring requirements it was felt that the status could be amended to be amber specialist initiation. The group approved this update however they requested that a note go in the formulary to state that the patient would remain under secondary care for ongoing review. **ACTION:** JEC to update the formulary with the new RAG status.	
8.5	**Vaginal Candidiasis medal ranking** The group discussed the document presented. Whilst the group agreed that the most cost effective options should be first choice in the formulary, It wasn't clear whether the medal ranking was needed in this area; it was proposed that a few first line choices could be highlighted instead. There was also a query around fenticonazole which had been recommended as a silver option however this wasn't in the current antibiotic guidance. A query was also raised around the license for Nizoral® cream. It was therefore felt that further work was needed on this before it could be approved. **ACTION:** LA agreed to discuss with AM and bring back to a future meeting.	
8.6	**Amendment to vitamin D guidance** RA requested an update to vitamin D guidance based on a recent CCG decision around stopping prescribing of maintenance vitamin D therapy. This could be easily be bought by the patient at a much cheaper price than would be paid by the NHS if it were to be prescribed. It was noted that other regions have already taken this approach. In light of this the group agreed that the final column in guidance within the table entitled 'prescriber' should be deleted. **ACTION:** RA to update document. LA and SOC to discuss 'maintenance therapy prescriptions' on behalf of VoY CCG.	
9	**Monitoring/reporting**	
9.1	**Twelve month audit data July MCC outcomes** No data was available as there wasn't a meeting in July of last year.	
9.2	**VoY Red drugs data (April to June 2016)** No data available as this is reviewed quarterly.	
9.3	**ScR Red drugs data (Apr to June 2016)** No data available as this is reviewed quarterly.	
10	**Patient and clinical communications** Nothing to report	
11	**Items from other groups** The group discussed whether MCC should receive the minutes from Harrogate as members were aware that there had been discussions regarding T3 however this hadn't been brought to the MCC. It was noted however that T3 would be brought to the November meeting so it was felt that the minutes weren't necessary but may be useful.	
11.1	**Hull and East Riding Prescribing Committee (HERPC) minutes July 16** The minutes from HERC were noted.	
11.2	**Antimicrobial stewardship subgroup update**	

11.3	No update had been provided. **York and Scarborough Drug and Therapeutics Committee minutes** The June minutes had been shared and were noted by the group.	
11	**Any urgent business** **PCSK9 pathway** The group noted that this pathway had not yet been updated in light of the previous comments made. It was agreed that the use of fibrates for statin intolerant patients should be considered and agreed. It was also suggested that rosuvastatin should be tried prior to moving onto adding in ezetimibe. The group asked that the updated pathway be brought back to the November MCC meeting; however the NICE TAs would need to go to the CCG boards this month as they hadn't yet been added to the recommendations. The formulary had already been updated and links to the TAs had been included however there hasn't been any prescribing as the lipid specialists are awaiting approval of the pathway by MCC. It was noted that both drugs are to be RED and lipidologist use only. **ACTION:** JEC to check with SP as to the discussions around fibrates and rosuvastatin. Updated pathway to be brought back to November meeting. **VTE pathways** LA also raised the issue of that the updated VTE guidance looks significantly different to the version that had been approved by MCC. It was therefore agreed that this should be looked at further and the guidance within the formulary be removed from website until this has been clarified. **ACTION:** JEC agreed to review the versions available and remove the current guidance from the formulary until it had been agreed by MCC.	**JEC/SP**
12	**Date of next meeting:** Wednesday 16th November 9.30am-12am, Severus Room (F032), West Offices, York	