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 17 February 2016
Snow Room, West Offices, York

1. Apologies / Attendance

		FEB	MAR	APR	MAY	JUN	AUG	SEP	OCT	DEC	JAN	FEB
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	✓	✓	✓	✓	✓	A	✓	✓	✓
Principal Pharmacist - Medicines Information	Mrs Jane Crewe (JEC)	A	✓	✓	✓	✓	✓	✓	✓	✓	✓	A
Consultant Anaesthetist	Dr Peter Hall (PH)	✓	✓	✓	✓	A	A	✓	A	✓	✓	A
Consultant Physician	Dr Paul Jennings (PJ)	A	A	✓	✓	✓	✓	✓	✓	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	A	A	✓	✓	A	A
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 Monica Mason (MM)									✓	✓	✓

Item		Action
1	**General business** Apologies were received from Laura Angus, Jane Crew, Peter Hall, Richard Morris (and his deputy Chris Williams). Greg Black (GB) chaired the meeting. **Declarations of Conflicts of Interest** None declared as relevant to the meeting's agenda.	

2	**Minutes of last meeting** The minutes were accepted as an accurate representation of the January meeting.	
3	Matters arising **a) Chairperson's actions to report** VoY CCG received the following application: • Vitamin D injection for a patient where an oral prep was not suitable. Funding approved. Scarborough Ryedale CCG did not receive any applications. **b) Outcome of VoY SMT / SRCCG Business Committee** Items from the January meeting had been agreed in full by both VoY CCG Senior Management Committee and by Scarborough & Ryedale CCG Business Committee. **c) Tapentadol severe chronic pain treatment pathway** The pathway remains close to completion with the MMT to finish. **d) Biosimilar glargine** JEC circulated the decision, KE still to add to formulary. The acute trust is waiting demo pens to enable them to help familiarise patients with the new product. **e) Declaration of interests -** deferred to next meeting **f) Terms of reference - update -**deferred to next meeting **g) Melatonin for sleep disorders in young people with ADHD** Meeting yet to be arranged. RA to discuss with RM prior to arranging.	**RA** **MMT** **JEC/KE** **LA** **LA** **RA/LA**
4	**Mental Health medicines commissioning** • **Vorioxetine** - depression pathway algorithm update. The pathway was felt to be a very comprehensive document worth sharing with Primary Care Commissioning as a great example. It should have a link to it on the formulary. Both CCGs to remind prescribers (via newsletters) that the pathway clearly states that dosulepin is not a recommended treatment option. It was mentioned that sertraline is the first line treatment but is around a third more expensive than citalopram. It was suggested that sertraline may be the preferred option in some clinical cases. • Minutes from Dec 15 D&T TEWV updating their melatonin shared care document. The replacement of "children" with "patients" was noted. Given that the CCGs are currently reviewing melatonin RA agreed to ask RM for more information. • D&T feedback Jan 16- nil to report	**LA/JEC/RA** **RA**
5	**New medicine/product reviews (national or local)** 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: **New NICE guidance** **TA 375** Adalimumab, etanercept, infliximab, certolizumab pegol, golimumab, tocilizumab and abatacept, all in combination with methotrexate, are recommended as options for treating rheumatoid arthritis, and adalimumab, etanercept, certolizumab pegol or tocilizumab can be used as monotherapy for people who cannot take methotrexate because it is contraindicated or because of intolerance. This was APPROVED; the drugs adalimumab, etanercept, infliximab, certolizumab pegol, golimumab and abatacept are already RED – specialist prescribing only. Tocilizumab and biosimilar etanercept to be added to the RAG list as such. Treatment to start with the least expensive product. This will be biosimilar etanercept unless contraindicated.	**MMT**
	SP mentioned the very recent NICE TA *TNF-alpha inhibitors for ankylosing spondylitis and non-radiographic axial spondyloarthritis* that was not included in this agenda. This had not been published when the agenda was set but would come to next meeting along with any others produced by NICE in February/early March.	**MMT**
	NHS England – for information TA 376 Radium-223 dichloride for treating hormone-relapsed prostate cancer with bone metastases TA 377 Enzalutamide for treating metastatic hormone-relapsed prostate cancer before chemotherapy is indicated TA 378 Ramucirumab for treating advanced gastric cancer or gastro–oesophageal junction adenocarcinoma previously treated with chemotherapy – <u>NOT recommended</u> TA 379 Nintedanib for treating idiopathic pulmonary fibrosis TA 380 Panobinostat for treating multiple myeloma after at least 2 previous treatments TA 381 Olaparib for maintenance treatment of relapsed, platinum-sensitive, BRCA mutation-positive ovarian, fallopian tube and peritoneal cancer after response to second-line or subsequent platinum-based chemotherapy TA 382 Eltrombopag for treating severe aplastic anaemia refractory to immunosuppressive therapy <u>(terminated appraisal)</u> *It has been previously noted that in all cases of NHS England commissioned TAs whose approved drugs are provided locally, the Trust takes them to D&T and they are then added to the joint formulary as RED.*	

7	**New submissions (includes new therapies and changes to existing policy positions) and appeals** a) **Epiduo® appeal** – deferred to next meeting b) **Vitamin D for deficiency & insufficiency** The medal ranking document was approved for use by VoY CCG and the product choices approved by both CCGs – all GREEN. ProD3 - BLACK. This to be communicated to CCG prescribers. All to be reflected in OptimiseRx software as used by GP practices (by MMT) and to be changed on the formulary. Endocrinologists etc. to be made aware of this also. **c) Verteporfin PDT for CSCR** It was felt that the new trial that the ophthalmologists have submitted as evidence for its use in patients where laser photocoagulation is inappropriate, is not robust enough to warrant the committee to give its approval solely based on that: this was due to there being no control and no randomisation; and it was felt that 90% of cases would resolve with no treatment. MM advised that RDTC felt there was insufficient detail in the paper to make a recommendation. There was a Cochrane review in December 15 that concluded there was insufficient data to inform treatment decisions but mentions a further trial that is ongoing that may provide some more robust data. MM to complete a written paper to share before the next meeting for the committee to share with the ophthalmologists. It was also pointed out that other areas are not commissioning it as further evidence is felt required. **d) Ulipristal 5mg "Esmya" for of moderate to severe symptoms of uterine fibroids in adult women of reproductive age** It is already licensed for pre-op treatment although the CCGs did not approve it. The SMC have recently reviewed and approved it and it is on formulary in neighbouring Trusts where it is classed as Amber- specialist initiation. NICE guidance advises that a tablet should be a treatment option. It costs £114 for 28 days treatment and is usually prescribed in 3-4 monthly courses. It was felt that if the cohort of patients who would receive this were those who had been referred for surgery then there could be a cost saving. However if younger patients were treated with this then they might in later life also require surgery therefore this could simply be an additional cost. Submission to go back for further consideration by the gynaecologists. Is there more evidence that this is affordable i.e. evidence of the number of prevented operations with this treatment? If no evidence then the committee considers leuprorelin or goserelin to be a more cost effective option.	**LA** **RA/LA** **AM/JEC** **JEC** **MM** **SP**
8	**Other medicines issues (local and/or national) including pathways/guidelines** **a) York & Scarborough Drug & Therapeutics Committee minutes (latest approved)** None **b) Biosimilar etanercept** SP advised that Trust rheumatologists were committed to using it in new patients and to switch patients already being treated with the branded version. A letter has already been drafted and will shortly be going out to patients. The biosimilar would be offered in the pathway. If etanercept is not clinically appropriate then the patient will have a choice of another agent. Patients have not previously always received etanercept first line as there hasn't been a cost difference until now. How we gain share will be up to commissioners/finance. SP suggests that it is a change to the pathway to use the new	**JEC**

	drug although NICE state that the most cost effective treatment should be given. SOC questioned the 50% saving for new patients and stated that "the amount of work that the hospital incurs from changing to a biosimilar should be rewarded with a commensurate level of savings and not an excessive amount". While any savings made would benefit the local health economy in the present climate it was felt that the CCG should benefit more given the limited amount of work required by the Trust. SP argued that the Trust is committed to doing this quickly and he stated that it has taken a significant amount of work internally to get clinicians on board. The MCC endorses the move to biosimilar etanercept and it is now the responsibility of finance and contracting colleagues to decide on an appropriate share of savings. **c) Palliative care guidelines review –** deferred to next meeting The committee will review a list of drugs to be provided which are those included in the Scottish guidance that are non-formulary locally. **d) Omalizumab for chronic utricaria** NICE approved and NHSE recently moved it to be CCG commissioned. It is currently on the formulary as RED and the formulary requires slight alteration. Patients will be repatriated from care at Leeds and this is now in the hands of the contracting team. Item to come off the agenda now this has been clarified. **e) RAG classification – variation between CCGs** The two CCGs do not use AMBER consistently within the RAG classification lists. The amber definitions are the same but worded differently. The VoY RAG spreadsheet requires updating. The various definitions are listed at the top of the spreadsheets and RA will discuss this with AM prior to them being changed.	**JEC** **AM/RA**
9	**Shared care guidelines** **a) Standard text to letters regarding shared care** – deferred to next meeting **b) Triptorelin for precocious puberty** For consideration on receipt of an appropriate shared care guideline was produced. **c) Modafinil for narcolepsy** The main concern with this submission was around dose titration and what to do around lack of response. It was also felt that an initial follow up after one month should be with the specialist or the specialist nurse before referral out to practices. SP was asked to return it for amendment and resubmit it next month. **d) Epilepsy care plans** These had been developed following a meeting between the CCGs and the Trust. They were approved by the committee and will be added to the formulary with links.	**SP** **SP** **JEC**
10	**Formulary items** • Tadalafil / sildenafil for priapism No formal commissioning position exists. It was approved as RED. Use is usually short term. Use sildenafil first line.	

11	**Monitoring / reporting** **1) 12 month audit data MCC outcomes September 2014** The usefulness of these audit reports was questioned and it was suggested that future reports should perhaps only contain items of note. It was however considered that as the effort to produce these was minimal that they should continue in their current format and in summary the committee did find them of value. It was queried whether prasugrel was being stopped after 12 months: SCRCCG had undertaken a recent audit and it was suggested that a similar ticagrelol audit might be appropriate in VoY. **2) 12 month audit data MCC outcomes October 2014** Clonazepam use was much higher than expected and it was hoped that it was for historic, stable patients. The recommendation from epilepsy specialists for adult/children services that this is not used is to be reiterated to GPs via Clare Johnson. **3) 12 month audit data MCC outcomes November 2014** LMWH costs were much higher than expected and the data should be interrogated to identify if a reason can be found and reviewed accordingly. The spend on non-commissioned silk garments and Mirvaso gel was noted. **4) 12 month audit data MCC outcomes December 2014** Epoetin / darbepoetin – MMT to identify prescribing practices for them then to identify patients to allow SP to identify who is initiating these treatments. Nortriptyline – spend much higher than anticipated. MMT to identify if this is due to price increases or increased use. If increased use then MMT to identify high use practices and report at next meeting.	**RA** **MMT** **MMT/SP** **MMT**
12	**Medicines safety** a) MHRA Safety update It was noted that a recent change in safety advice around Mirabegron had been issued. BP to be monitored and that it should not be prescribed to hypertensive patients. It was suggested that audits might be useful in practices.	**MMT**
13	**Horizon scanning, NICE Guidance and NICE Bites** a) New products update RDTC would bring their monthly summary of newly prescribable drugs for future meetings. It was noted that a negative opinion regarding a human insulin biosimilar had been reported. The reference medicine was Humulin S®. b) NICE Update – these had been approved above already c) Ivermectin NICE evidence review This had been approved last month but not added to the recommendations to go to the business committees for final approval. It would be added this month. d) Biosimilar glargine NICE evidence review This had been approved last month and the NICE evidence review simply reported for information this month.	**MM/BR** **MMT**
14	**Patient and clinical communications** • GnRH agonists – supplementary information.	

	This information was now included on the clinic letter to patients. The committee expressed an interest in knowing what the patients are actually told in clinic regarding what action their GP will take. • Ondansetron for IBD – patient information leaflet. Deferred to next meeting SP to follow up these two points with JEC before the next meeting	**SP/JEC** **SP/JEC** **SP**
15	**AOB** a) BNF errors Correction material has yet to be sent out by the distributers. However the online version is correct and always up to date and therefore may be preferred. b) Regional medicines optimisation committees. NHSE has indicated that 4 regional committees will be set up to evaluate new medicines, or some new indications of existing medicines, which are not evaluated by the NICE TA programme. This should help eliminate unnecessary duplication of effort. It was suggested that such regional or national committees often found it difficult to obtain prescribers willing to attend and this might again be the case with this initiative. It was however hoped that improvement would be seen following this introduction.	
	Date of next meeting: Wednesday 16 March 9.30am-12am, Green Room (S015), West Offices, York	