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 December 2014 Severus Room, West Offices, York

1. Apologies / Attendance

		MAY	JUN	JUL	SEP	OCT	NOV	DEC
Chair & GP Prescribing Lead - VoYCCG	Dr Shaun O'Connell (SO'C)	✓	A	✓	✓	✓	✓	✓
Strategic Lead Pharmacist- CSU	Mrs Rachel Ainger (RA)	A	✓	✓	✓	✓	✓	✓
GP Prescribing Lead – S&RCCG	Dr Greg Black (GB)	✓	✓	✓	✓	✓	✓	A
Principal Pharmacist - Medicines Information	Mrs Jane Crewe (JEC)	✓	✓	✓	✓	✓	✓	✓
Consultant Anaesthetist	Dr Peter Hall (PH)	✓	✓	A	✓	✓	A	A
Deputy Chair & Consultant Physician	Dr David Humphriss (DH)	X	A	A	A	A	A	A
GP Vale of York CCG	Dr William Ovenden (WO)	✓	✓	A	A	✓	✓	✓
Senior Pharmacist - Clinical Effectiveness, CSU	Mrs Diane Tomlinson (DT)	✓	✓	✓	✓	✓	✓	✓
Consultant Physician	Dr Paul Jennings (PJ)	A	✓	✓	A	A	✓	✓
Deputy Chief Pharmacist	Mr Stuart Parkes (SP)	✓	✓	A	✓	✓	A	✓
Chief Pharmacist, Leeds and York Partnership, Mental Health	Ms Elaine Weston (EW)	✓	A	A	✓	A	✓	A
Deputy Chief Pharmacist Tees Esk and Wear Mental Health Trust (TEWV)	Mr Richard Morris (RM)		✓	A	✓	A	A	✓
Senior Pharmacist	Mr Alex Molyneux -Guest		✓	A	✓	A	✓	A
Consultant Urologist	Mr Richard Khafagy (RK)					✓	✓	A
Consultant Psychiatrist TEWV	Dr Raul Perez (RP)					✓	A	✓

Item		Action
1	**General business** **Apologies** Mrs Elaine Weston, Dr Greg Black, Dr David Humphriss, Mr Richard Khafagy, Dr Peter Hall Dr Shaun O'Connell chaired the meeting. Neither Dr Mark Quinn nor Mr David Pitkin is required to attend future meetings although Mr David Pitkin will continue to receive papers and minutes. **Declarations of Conflicts of Interest** With regards to item 7c (Targinact) Dr Peter Hall declared an interest with NAPP in that he had received honoraria for lectures to GPs, had attended sponsored lunches and accepted educational grants to attend European pain meetings.	
2	**Minutes of last meeting** EW advised that the correct numbers of patients referred to regarding Piportil injection at item 4 should read "has identified 20 patients currently receiving this medication". Otherwise, the minutes were accepted as an accurate record of the meeting.	

3	**Matters arising** a) Chairperson's actions to report – Nil to report, a new request had just been received and will be reported next month. b) Outcome of VoY SMT / SRCCG Business Committee All recommendations from last month's meeting had been accepted. Formularies and and commissioning positions have been updated to reflect this. c) Sucralfate enemas update No response to the meetings additional questions had been received from the applicant. A discussion ensued as to whether further discussions would be more appropriate if taken through York Hospitals NHSFT's D&T committee. However it was agreed that the evidence base was complete and that the only comment received was around an issue with supply that had proven unfounded. A submission to February MCC was requested, in the absence of an application, the treatment cannot be recommended (grey). d) Vesomni® treatment pathway – proposal not satisfactory The Vale of York CCG referral support service document for lower urinary tract symptoms in men was circulated at the meeting as evidence of place in therapy for Vesomni ® where "Consider offering an anticholinergic to men who still have storage symptoms after treatment successful treatment of voiding symptoms with an alpha blocker alone" was proposed to outline the place for Vesomni® in treatment. WO stated that as the first line treatment is tolterodine, it would be cheaper to use tolterodine with another anticholinergic drug, rather than use the combination product Vesomni ®. However if the patient was already taking solifenacin without the desired effect then moving to Vesomni ®appear appropriate. The question was asked where Vesomni ®would be used in secondary care, to which it was indicated, only where the two drugs had already been prescribed individually. SO'C stated that more detail was required from Dr Pickard and the applicant. Details were in RSS but had not been through the committee. DT was asked to obtain this from Dr Pickard and bring to the January meeting. e) Epilepsy formulary update – *for January meeting* f) Methotrexate decommissioning letter – project plan in development Formal project communication plan to be written by Y&HCS Medicines Management Team in conjunction with SP and brought to the January meeting. There had been no issues reported since the matter had been initially raised. However SP stated that the York pharmacy team would identify issues when carrying out normal medicines reconciliation on new admissions. g) Piportil depot injection – RM to report on TEWV position RM reported that TEWV would switch all patients once they had issued detailed guidance to all their prescribers. TEWV were unsure of the number of Scarborough area patients involved as prescribing was GP led in that area. RM agreed to share the new guidelines once formalised so that the Y&HCS MMT could pass it to CCG GPs	**JEC** **DT** **MMT / SP** **RM**

	working in that area. h) Aripiprazole injection – 6 monthly review RM stated that this was not prescribed by TEWV clinicians. RA informed the meeting that the LES meeting was not due to take place until the end of January but that she would ensure its discussion at that meeting. i) Lithium monitoring changes – shared care guidelines update TEWV planned to keep monitoring at 3 monthly intervals rather than move to the 6 month period suggested in the new guidelines. TEWV felt that this would prevent confusion around other drug monitoring time periods. SO'C asked that that Leeds and York Partnership Trust be contacted as to whether both trusts could agree a consistent approach to monitoring in the SCGs otherwise GPs will be asked to undertake different monitoring frequencies for this drug.	**RA** **DT**
4	**Mental Health medicines commissioning** • Leeds York Mental Health Partnership Nothing to report – verbal update on lithium shared care guidelines as being in progress was reported by DT. • Tees, Esk and Wear Valley Mental Health Trust • Reports have been received of promethazine being prescribed for anxiety. Any identified instances of this in primary care should be reported to TEWV. • TEWV are developing guidance for alcohol detoxification and it was noted there was a potential QUIP opportunity regarding ceasing the use of vitamin B compound strong. York Hospitals NHSFT discharge patients on thiamine not vitamin B Compound Strong. • Low dose olanzapine / quetiapine may be prescribed in secondary care (only) for eating disorders. Unlikely this will transfer into primary care but report to TEWV if any seen. • TEWV have no objections to galantamine MR being prescribed as a cost effective branded generic. SO'C requested this to be included as a potential QIPP opportunity. • 2 new depot drugs will shortly be available. A protocol is being developed for their use but the use will be in secondary care only.	**MMT** **MMT**
5	**North Yorkshire and Humber Treatment Advisory Group recommendations – notification of approved items from TAG – for agreement of recommendation by MCC:** None	
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 a) Nalmefene for reducing alcohol consumption in people with alcohol dependence. SO'C advised that NICE had not stated who should commission this drug but CCGs / County Councils / alcohol treatment services had to make it available. Currently substance misuse services, which local authorities have responsibility for, are not currently commissioned to provide this treatment and local authorities have no funds to commission it. It was noted that hepatologists may request it and therefore a York and Scarborough Trust position would be required.	

	SO'C though that it possible it could be recommended in general practice but only if a patient had specific structured support in place. The North Yorkshire County Council position would not be discussed by them until a meeting in February which was unfortunate given the need for the CCG to have a commissioning position published by the end of February. GP responses to being asked to prescribe it by patients should be no until the position clarified / ratified. It was indicated that a further reminder of the current position not to prescribe should be sent to general practice. b) Erythropoiesis‑stimulating agents (epoetin and darbepoetin) for treating anaemia in people with cancer having chemotherapy NICE indicate this is CCG responsibility, however, given this is linked to chemotherapy a response from NHS England was sought which indicated that the treatment was in tariff for this indication. However it is felt that this should be part of the chemotherapy support service, the Committee concluded that it is proposed that it will be RED (hospital only) and should be reported as a potential cost pressure at the hospital for now. c) Imatinib for the adjuvant treatment of gastrointestinal stromal tumours is NHS England commissioned. ***Action***: to acknowledge CCGs formal commissioning of approved TAs	MMT
7	**New submissions (includes new therapies and changes to existing policy positions) and appeals** a) **Alprostadil cream (Vitaros) for erectile dysfunction** Dr Hilmy and Dr Aaron Brown are currently working on a pathway however there needs to be further clarification as to place in therapy. Mr Hilmy would prefer to use it instead of MUSE while current sexual health guidance proposed either as an option. SO'C reminded the Committee that the concomitant use of PDE-5 inhibitors and vacuum pumps had been mentioned as part of the treatment pathway and therefore this should be included in the pathway if felt appropriate. This item to be brought tabled for February meeting however if the pathway and commissioning position for alprostadil cream is not addressed, the position remains as "do not commission" BLACK. b) **Dexamethasone intraocular implant (Ozurdex) for uveitis** Responses to questions posed at the November meeting were discussed where it was confirmed that dexamethasone implant is the commissioning responsibility of CCGs and Ozurdex will be indicated as an additional treatment to deal with flare ups associated with uveitis. The applicant had stated that no treatment pathway was possible as every patient is different. Current oral treatment involves large oral steroid doses started to deal with flare ups and then reduced. If not successful then oral methotrexate, mycophenolate or ciclophosphamide was tried. The last treatment option would be consideration of a biologic agent pending an IFR. It was noted that NTAG as part of their assessment of this treatment, has a treatment protocol with criteria for dexamethasone use that could be adapted for local use. Parameters to include would be vitreous haze score, BCVA and the requirement for an audit at six and at twelve months. SO'C asked that this protocol be adapted and submitted to the January meeting for	**MMT to liaise with Dr Brown & Dr Hilmy** **JEC** **JEC**

	potential approval. It was additionally agreed that ophthalmic inflammatory disease can be added to the SCG for ciclosporin. **c) Targinact® appeal** The application was discussed where it was noted that the historic PCT commissioning position was black (not commissioned), York Drug & Therapeutics Committee had approved Targinact® as a red (hospital only) treatment, however it had been noted that there was referral to primary care. Clinical studies had looked at non-malignant pain which represented the better evidence, more recently evidence was available for malignant pain but with criticism of the laxative regime (only permitting rescue bisacodyl). There were no comparisons available comparing Targinact® to other opiates with the addition of appropriate oral laxatives. It was noted from the evidence submission that patients receiving Targinact® reduced but did not eliminate the need for additional laxatives. Currently Targinact® is classed as a red drug in York but is being referred out to primary care as a recommendation. It was proposed to accept Targinact® for patients with intractable opioid induced constipation that had not responded to two full dose laxatives. Furthermore, they should also have tried at least two different opioids before being commenced on Targinact®. It was indicated that CCGs remind GPs of this and for GPs to be aware of the place of Targinact®. Initiation request may come from secondary care (as a clinic letter, not TAN form) with full direction which should be in line with CCG advice. Classify on the formulary as a "green" drug. **d)Epiduo appeal** Previously not commissioned and not supported by Scottish Medicines Committee, but more recently has been approved by Scotland when monotherapy has failed subject to as PAS. The application was discussed where this product was included in Primary Care Dermatology Society and European guidance as a 1st line option, though it was reported that other less costly options were available. It was noted that Vale of York CCG referral support service documentation was currently being reviewed by the CCG. It was proposed that all information be sent to Dr Alison Hunter and Dr Stainforth for consideration to formulate an acne formulary. They, along with the applicant should come back to the February meeting with an appropriate pathway for discussion / approval.	**DT** **MMT to liaise with Dr Hunter**
8	**Other medicines issues (local and/or national) including pathways/guidelines** a) Nortriptylline – The paper was discussed where it was agreed that amitriptyline should be used first line, nortriptyline would be reserved where amitriptyline results in excess sedation or has the individual has underlying cardiac problems as Maudsley reports nortriptylline has a preferable profile in these scenarios. b) Lidocaine medicated plaster (Versatis®) – formulary position specialist and non-specialist setting The current position is conflicting as hospital only (RED) on the joint formulary yet being prescribed in large volumes and the previous NICE clinical guideline for neuropathic pain (non specialist setting) permitted it as a 3rd line agent thus it was classified as green in primary care. It was noted that this product is only licenced indication is for post herpetic neuralgia yet there was considered to be a greater	**DT** **JEC/DT**

	proportion of use is off licence and the evidence base for this was questioned. A response from the local pain consultant was shared with the committee. A decision on this treatment was deferred pending submission of clearer indications of its usage with presentation of any associated clinical evidence. Until then, current position to be maintained for primary and secondary care. c) Ketamine for chronic pain – pathway and commissioning position GP guidance had been updated with a pathway but that comment was still awaited from palliative care and pain clinic. Bring back to February meeting. d) Medal ranking for drugs for erectile dysfunction The treatment choices were approved as presented within the document.	**JEC**
9	**Shared care guidelines** a) Outstanding shared care guidelines Updated list JEC informed the meeting of the following outstanding guidelines; 3 renal, mycophenolate, dornase alpha, and azathioprine. These had now been reviewed however comments were still awaited before they could come to the committee, also outstanding was dronadarone. It was requested that a table of SCG's with review dates are submitted to the January meeting. b) Azathioprine shared care guideline for renal patients See above c) Denosumab shared care guideline – safety update confirmation of changes. To be uploaded on to net formulary.	**JEC**
10	**Formulary items**	
11	**Monitoring / reporting - red / black drugs** The reports were noted and it was recognised some amendments to the data search were required.	
12	**Medicines safety –** MHRA Drug Safety update The latest update was discussed briefly, it was acknowledged that agomelatine (Valdoxan) has a risk of liver toxicity—reminder to test liver function before and during treatment Both Leeds and TEWV have as red hospital only prescribing so an updated commissioning position (currently black) is needed for the January meeting.	**DT**
13	**Horizon scanning, NICE Guidance and NICE Bites –** Nil	
14	**Patient and clinical communications –** a) LMWH pathway – joint communication to GPs Pathway approved in York Trust. Draft to be produced by VTE Committee and brought to next meeting for approval before communication to GPs.	**JEC**
15	**AOB** #VSL – Prescribing data proposed an upward trend in July /Aug /Sep. Reminder to be given to secondary care and GPs regarding the commissioning position when prescribed concomitantly with antimicrobials. (not for primary care prescribing). Individual practices to be contacted to confirm why prescribing	**RA**

	New syringe driver chart – York Trust to check how/if these are distributed to GP practices as a potential need for GPs to keep blank copies for completion. Anne Garry to put communication out to all users –check with CCG communications team.	**RA/JEC**
	Date of next meeting: Wednesday 21 January, 10-12noon, Craven Room, West Offices	