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 19 November 2014 Severus Room, West Offices, York

1. Apologies / Attendance

		MAR	MAY	JUN	JUL	SEP	OCT	NOV
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)	✓	✓	✓	✓	✓	✓	✓
Principal Pharmacist - Medicines Information	Mrs Jane Crewe (JEC)	✓	✓	✓	✓	✓	✓	✓
Consultant Anaesthetist	Dr Peter Hall (PH)	✓	✓	✓	A	✓	✓	A
Deputy Chair & Consultant Physician	Dr David Humphriss (DH)	A	X	A	A	A	A	A
Chief Pharmacist	Mr David Pitkin (DP)	A	X	A	A	A	A	A
GP Vale of York CCG	Dr William Ovenden		✓	✓	A	A	✓	✓
Senior Pharmacist - Clinical Effectiveness, CSU	Mrs Diane Tomlinson (DT)	✓	✓	✓	✓	✓	✓	✓
Consultant Physician	Dr Paul Jennings (PJ)	A	A	✓	✓	A	A	✓
Deputy Chief Pharmacist	Mr Stuart Parkes (SP)	✓	✓	✓	A	✓	✓	A
Consultant Rheumatologist	Dr Mark Quinn (MAQ)	A	X	A	A	A	A	A
Chief Pharmacist, Leeds and York Partnership, Mental Health	Ms Elaine Weston		✓	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	✓
Consultant Urologist	Mr Richard Khafagy						✓	✓
Consultant Psychiatrist TEWV	Dr Raul Perez						✓	A

Item		Action
1	**General business** **Apologies** Richard Morris; Stuart Parkes; Peter Hall Dr Greg Black chaired the meeting. **Declarations of Conflicts of Interest** Nil	
2	**Minutes of last meeting** The draft minutes from October meeting to be corrected at the end of item 7 where "approved" is to be replaced with "recommended". Otherwise, the minutes were accepted as an accurate record of the meeting.	**SK** Actioned

3	**Matters arising** a) Chairpersons actions to report Sucralfate enema – Mr S Stojkovic (Oct 14 request). A request was submitted to RA for one patient. The CCG agreed to fund for up to 56 days treatment expecting an MCC drug application form to be received within that timeframe. The CCG expects that the patient would be reviewed clinically every 28 days and that consideration is given to a trial without the drug. JEC stated that no further supplies had been made to the patient by the hospital. RA stated that the GP had been contacted and requested not to prescribe the treatment, and that the MCC would need to consider the evidence, who would oversee the patient and who would be responsible for monitoring the patient as part of a new product request, going forward. JEC stated that further input was required from the consultant who submitted the request form. PEJ sought clarification as to how sucralfate was sourced in the hospital given that it was non formulary and no Chairman's action had been submitted to request its use on this occasion. It was suggested that the process needs further investigation and consideration at the next D&T meeting. b) Outcome of VoY SMT / SRCCG Business Committee A summary of outcomes from the October meeting has been submitted to CCGs for formal agreement. NHS Vale of York CCG had approved the recommendations. c) Vesomni pathway – **to come to December meeting** JEC had given feedback to the specialists but had received no responses. **JEC to ask for item to be added to agenda of next meeting once she has received responses** d) LMWH pathway Use of LMWHs in lower limb immobility: WO reported that this looked to be a reasonable recommendation. It is vital that GPs are told when to prescribe the LMWH i.e. whether to continue it or not. Patients are reviewed within 2 weeks so communication needs to go out to GPs quickly. **Pathway agreed and SO'C asked that a letter to all GPs be sent out informing them of this pathway**. Requires joint communication, JEC to liaise with Lynn Ridley. e) Epilepsy formulary update Minor changes made to formulary and revised recommendations to this chapter sent to CCGs for ratification. Kirsten Evans to develop the care plans where this was agreed with the epilepsy specialists for December. Prescribing data has been captured in respect of MHRA drugs approved for generic prescribing – this is currently being reviewed. **GB, SO'C and Medicines Management Team to meet.**	**JEC** to obtain further info from requesting consultant Item to be added to agenda of next MCC meeting **SK** **SK** Recommendation documents to be circulated – standing item **SO'C with Dr Mark Pickard and Dr Hilmy** **JEC** **MM team**

4	**Mental Health medicines commissioning** • Leeds York Mental Health Partnership • Bipolar Disorder – NICE news Sept 2014 changes to guidance Lithium monitored 3 monthly for first year then 6 monthly thereafter if no complications (e.g. poor renal function) or interacting medicines **Shared care guidelines will need updating** • Monitor LFTS/U&Es at least annually for lamotrigine and valproate (reminder valproate should not be used in women of child bearing age) • Aripiprazole injection – 6 monthly review 50% of patients had been discontinued on the drug. Out of 18 patients started, 9 stopped. Reasons: 6/9 – inefficacy/deterioration in mental state. 3/9 – side effects (*all* due to severe akathasia). Average 1.6 doses given before stopping. • Pipotiazine (Piportil) depot injection EW reminded the meeting of the pending discontinuation of this drug. Leeds Trust has only 5 hospital based patients currently receiving this medication. CCGs have already been asked to identify their patients so a supervised switch can be done by the Trust (preferably with another "typical" depot antipsychotic. VoY CCG has identified 20 patients receiving this medication. GB asked if TEWV doing the same as Leeds. **DT to follow up request this information from RM** • Tees, Esk and Wear Valley Mental Health Trust No report	**Leeds/York mental health to revise** **Any local LES impact to be considered - RA**
5	**North Yorkshire and Humber Treatment Advisory Group recommendations – notification of approved items from TAG – for agreement of recommendation by MCC:** **a)** Ketamine for chronic pain – final recommendation Evidence base to support its use is weak. Also serious concern regarding potential for misuse. SO suggested it be a red drug, JEC advised that palliative care service happy with it being classified as red. Concern expressed about potential cost to CCGs. PEJ suggested it be made black not red given the quality of evidence presented compared to other drugs which are not commissioned. **SO stated that an algorithm/pathway be developed for palliative care service and pain clinic use for new/existing patients. SO asked that approximate future costs be communicated to the meeting by the Trust.** **b)** Brimonidine gel for facial erythema of rosacea – final recommendation Comments received from York and Scarborough Trust – may be useful as an option but no clear position as to which patients would be treated. Little evidence to support it and an expensive treatment therefore on the basis of cost-effectiveness **recommended not commissioned – BLACK.** **c)** Fostair combination inhaler for COPD – draft recommendation from TAG as drug is part of a wider consultation. **VoY CCG needs to review its COPD pathway; they are also looking at the asthma pathway.** MCC recommendation to approve the use of Fostair as proposed in the TAG summary, GB asked for the new Fostair dry powder device also to be approved. **d)** Molludab for molluscum contagiosum. Draft TAG recommendation circulated for comment. Noted that this is a self-limiting condition and the product is available over the counter. MCC recommendation not to commission – **BLACK.** **e)** Prostaglandin analogue eye drops – draft TAG recommendation reports on the preservative and preservative free products with sequence of therapies recommended as generic latanaprost 1st line, then bimatoprost or travaprost. Any patient requiring	Decision deferred pending algorithm JEC – pain algorithm for Dec meeting **DT** **DT** **DT**

	preservative free, 1st line is Monoprost formulation. **Table in the TAG summary to be amended to show preservative free preparations separately.** **Ophthalmologists asked to report / prescribe the topical eye drops generically rather than as a brand name, it was suggested medical secretaries could utilise an autocorrect function to resolve this.** **f)** Silk garments - TAG recommendation not to commission, additional comments received from York and Scarborough Trust consultants. Lack of evidence makes it difficult to justify use. MCC recommendation not to commission for **new** patients and cease prescribing for existing patients - **BLACK**	**DT**
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 Dabrafenib for treating unresectable or metastatic BRAF V600 mutation-positive melanoma commissioned by NHS England	
7	**New submissions (includes new therapies and changes to existing policy positions) and appeals** a) **Alprostadil cream (Vitaros) for erectile dysfunction** Alternative to injection so no scarring or priapism. Potentially for 30% of patients who fail to respond to PDE-5 inhibitor tablets e.g. sildenafil. No need for attendance at clinic or requirement to train patients in its use which is required with other. Suggested pathway – PDE-5 inhibitor, PDE-5 inhibitor +vacuum pump, Muse (due to evidence base), Vitaros, then alprostadil injection GPs could use it prior to referral for PDE-5 inhibitor +vacuum pump or Muse. There was a brief discussion about once daily tadalafil where JEC indicated the decision not to commission this formulation probably would be challenged. **SO'C stated that pathway needs to be clear before approval given.** **CCGs should consider lifestyle factors which were discussed, smoking / weight loss as part of existing primary care pathway. To be added to next meeting agenda.** **SO'C to ask Dr Pickard and Dr Brown to work with RK (and liaise with Dr Hilmy) on the treatment pathway** b) **Dexamethasone intraocular implant (Ozurdex) for uveitis** Reported as £6000 per patient per year if both eyes treated every 6 months. JEC had discussed with applicant where it was indicated that the majority of patients will continue on systemic steroids. Envisaged this product will only as used as "rescue therapy" for patients already on systemic steroids. Patient numbers proposed as 7 to 8 in Vale of York and 2 in Scarborough Ryedale based on evidence from Calderdale use. Patients will require one or maybe 2 injections. Alternative is intraocular Kenalog which is unlicensed (and contra-indicated) for this route of administration. There was discussion about current product choice and licensed versus unlicensed product use. PEJ indicated licensed preparation is therefore preferred. This appears not to be a drug that would produce savings, rather an expensive add on treatment. No decision was made. **Further information is required:-**	**SO'C/RK** **JEC to ask questions and report back answers**

	Will systemic corticosteroids continue? Is Kenalog being used now and if so, how is it being made up? Does any national audit take place to determine effectiveness? Confirmation that this is CCG commissioned as NHS England manual includes severe uveitis **Page numbers to be added to the application forms.**	
8	**Other medicines issues (local and/or national) including pathways/guidelines** a) Nortriptylline – **for December meeting** b) Update - Anticoagulation choices in non-valvular AF Completed and sent to Jane Knights. **Ratified** c) Heparin prescribing during infertility treatment / management of recurring miscarriage – **for December meeting**	**SK** **DT** **SK**
9	**Shared care guidelines** a) Outstanding shared care guidelines Ciclosporin – **once agreed updates made then ok to approve** **Committee requires a list of what else outstanding**. It was suggested that this list would include melatonin and two immunosuppressants for renal patients (mycophenalate plus one other). **Ophthalmologists to be asked about any shared care guidelines they required for immunosuppressants. Uveitis can be added to ciclosporin SCG.** b) Azathioprine shared care guideline **SO'C indicated need guideline for renal patients despite the drug being red** c) Denosumab shared care guideline – safety update Monitoring requirements had been updated to reflect MHRA revisions. A discussion took place regarding which wording was most appropriate regarding who had responsibility for checking calcium levels 2 weeks after initiation of treatment. SO'C and GB concluded GPs couldn't undertake the 2 week calcium review at initiation. Agreed that the specialist to complete blood test request form when FIRST injection is given in clinic. This is to ensure that initial calcium check is done and reviewed. Then GP takes responsibility for future calcium checks. **Wording to be revised in SCG to reflect this.**	**JEC** **JEC** **JEC** **JEC** **JEC**
10	**Formulary items** Epilepsy chapter -reported earlier on the agenda.	
11	**Monitoring / reporting** CCG Red and Black drugs April to August 2014 data **AM to inform all GPs (Vale of York) of names of all red and black drugs** The lists of these are already on VoY website. **AM to ask Simon Lockley to put on SRCCG website if not already done.** CCGs to tackle any GP prescribing firmly	**AM**
12	**Medicines safety –** MHRA Drug Safety update Dexamethasone 4mg/ml injection is discontinued. York and Scarborough Trust now use the 3.3mg strength. GPs should do the same to avoid potential for confusion. **This to be communicated to all GPs**	**JEC to share communications**

13	**Horizon scanning, NICE Guidance and NICE Bites –** Nil of note	
14	**Patient and clinical communications –** Nil	
15	**AOB** Nil	
	Date of next meeting: Wednesday 17 December, 10-12noon, Severus Room, West Offices	