Chair: Charlotte Skitterall, Chief Pharmacist, MFT
Vice Chair: Claire Vaughan, Head of Medicines Optimisation, Salford CCG
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HIGH COST DRUGS SUBGROUP

Wednesday 27th March 2019, 10a.m. - 12noon, St James's House, Pendleton Way, Salford. M6 5FW

Minutes

1. General Business	
1.1	Welcome and apologies (See register in appendix 1) Chris Astbury (HCD Pharmacist Pennine Acute Hospital NHS Trust) was welcomed to the group to replace Rob Elsey.
1.2	**Conflicts of Interest** Nothing in relation to agenda.
1.3	**1. Minutes** The draft minutes from the February telecom were agreed as accurate **Action:** Publish on GMMMG website following CSB
1.4	**Actions and Matters arising** The group noted and agreed the actions from February as follows: • Adalimumab biosimilar implementation plan – this item has been closed and moved to assurance reporting • Managed entry of monoclonal antibodies for migraine across GM – the NICE TA publication date has been delayed, the group asked that data be reported back into the next HCDSG meeting to assure the group of GM prescribing to date **Action:** AM to return requested data to the April HCDSG meeting • Treatment options for AMD across GM – HCDSG acknowledged that CSB have supported the authors request for an extended timescale for submission of a GM proposal paper **Action:** to update work plan to accommodate revised submission date
2. Medicines Optimisation	
2.1	**Blueteq use across GM** Part of this item was deferred to the next meeting in BG's absence; however DS presented a poster which is in development to highlight the benefits of using Blueteq to commissioners, providers and clinicians. It was agreed that the poster be further

	developed with an aim that it be submitted to CSB to demonstrate the value of good quality data and the benefits to the implementation of Blueteq across GM. **Action:** DS to further develop poster as discussed, second draft to return to HCDSG prior to CSB submission. BS to present at April meeting as unable to attend today.
2.2	**HCD Pathways** There was further discussion on the progress of the HCD pathways reviews, and the need to prioritise this work within HCDSG. The group discussed at length what is happening to patients who reach the end of the treatment pathway, the importance of ensuring dose optimisation, sequential use of biologics and clarity on what constitutes treatment failure, cost and effectiveness of alternative interventions and the need for all these elements to be incorporated into the pathway reviews as well as scoping and understanding patient cohorts and numbers, service design, etc. It was acknowledged that currently the pathways are focused on evidence-based clinical interventions with elements of commissioning guidance, e.g. number of treatments allowed within individual pathway. It is expected that these pathways are transformed into commissioning pathways which would include clearer guidance on abovementioned elements. This discussion led into item 2.3 below. **Action:** Lead reviewers of pathways to return scoping documents to April meeting for full discussion and prioritisation.
2.3	**IFR drug requests report** The group considered a summary report detailing individual funding requests (IFRs) for tariff excluded high cost drugs. The presented paper provided detailed information on IFR decision outcomes, highlighted variation in submission levels at various angles (by provider, commissioner, therapy area, etc.) It was acknowledged that although individual cases may be followed up for clinical outcomes by clinicians, these are not assessed by commissioners nor form a GM perspective. It was understood that there is no GM IFR panel, and that funding approval is granted at local CCG panels. The number of IFR requests received in the previous 12 months was considered, this was presented by Provider and Commissioner, more detail was also provided on the specific treatments requested, in particular the sequential use of biologics, and on the outcome of IFR requests. It was noted that this may not reflect the GM situation properly as it is acknowledged that a degree of HCD use does likely not follow IFR route as appropriate. The group discussed the reasons for any variation in the data provided i.e. the influence of tertiary centres, the handling of IFR applications prior to their submission to the IFR panel. The group recognised that the usefulness of the data presented was limited, but agreed that it supported an introduction to this discussion. A communication received regarding guidance on treatment when the patient reaches the end of the commissioned pathway was discussed, the group recognised the need for more robust guidance. Full reviews of the GMMMG pathways for HCD use in

	rheumatoid arthritis, psoriatic arthritis, rheumatoid arthritis and psoriasis are scheduled and as discussed above the group recognised the need to escalate this work and to ensure that it was fully scoped to ensure all the requirements of this review are captured. **Action:** MO Hub to return a paper to CSB in May looking at follow-up of IFR requests and development of reporting on clinical outcomes.
2.4	**Dibotermin alfa (InductOs) for acute tibial factures: draft position statement** A draft position statement for the managed entry of Dibotermin alfa for the treatment of acute tibia fractures in adults, as an adjunct to standard care using open fracture reduction and intramedullary unreamed nail fixation. (CCG commissioned) was presented to the group. There was query as to whether it was necessary for such a statement to be issued as there did not appear to be a GM wide appetite for use of this agent; SRFT anticipated use in around 15 patients and MFT in around 10 patients. It was agreed that the draft statement be put out for GM wide consultation with the comments return to HCDSG for consideration. **Action:** MM to upload draft statement to the GMMMG website for consultation.
3. Monitoring and Assurance Reporting	
3.1	**GM Biosimilar Uptake Assurance Paper** The GM biosimilar uptake assurance report for March was presented to the group, who noted that the delay in rapid implementation of biosimilar adalimumab continues and the issues remain unresolved in a couple of localities regardless of recent escalation to CSB and GM heads of commissioning and finance. There was suggestion that the areas within GM that had achieved more rapid uptake were those which had been adequately resourced to enable switching to occur. Those areas where uptake was disappointing explained that this was likely due to protracted discussions (internal and external) between finance teams to secure the necessary resource. In some areas delays have be due to securing workforce. Disappointment was expressed that given the significant amount of preparatory work undertaken by HCDSG to support this project, GM was lagging behind other areas. It was acknowledged that the bulk of this work had been directed to supporting clinician engagement and coordination of communication and actions in GM, which was achieved. There was comment that the change in the procurement framework which saw the direction by NHSE of a specified product for the region had some impact on this project, and meant that a large amount of the initial work undertaken by HCDSG was considered unnecessary. Additionally the proposed reference price which was applied from 1st April 2019, has shifted the driver from commissioners to provider Trusts, although HCDSG re-emphasised the need for the saving to the GM economy as a whole to be the focus. It was also noted that the change in originator price has made an impact on the implementation of biosimilar adalimumab. DD representing finance at this meeting agreed to raise the issue of the slow rate of switching to the adalimumab biosimilar with GM finance teams, and to ask that each

	CCG be supportive and work with their local trust to resolve any outstanding issues. It was agreed that monthly assurance reporting for adalimumab should remain in place as part of this assurance report. **Action:** MM to submit this biosimilar assurance paper to the next CSB meeting and request that CSB to note the uptake rate of adalimumab biosimilar across GM. DD to communicate any update from finance conversations to MM and CS, to be relayed to CSB as appropriate.
3.2	**High Cost Drug reporting** This item was deferred to the next meeting in BG's absence
4. Scoping and work planning	
4.1	**Proposed HCDSG work plan 2019/20: Update from CSB** The work plan is awaiting Chairs comments and will be shared in due course.
4.2	**Monthly horizon scanning (March 2019)** Noted for information and to be included within workplan as appropriate – in particular Risankizumab for severe plaque psoriasis which is expected to be assessed by NICE (TA) in August.
4.3	**Interferon/PEG-interferon for essential thrombocythaemia** HCDSG was asked to consider whether a commisisoning policy for for Interferon / PEG-interferon for essential thrombocythaemia / polycythaemia. It was noted that there have been one IFR request in 2013, one in 2014 and two in 2016, none in 2017 or 2018 then two recently. The group agreed that this did not exceed the numbers to be considered a cohort, and asked that if an item it to be considered the necessary scoping should be undertaken. **Action:** AM to submit scoping of this item to a future HCDSG if and when patient numbers exceed that of an IFR consideration.
5	**Communication from other groups** • GM HCD optimisation network • Medicines Optimisation Clinical Reference Group • Health Innovation Manchester • Chief Pharmacists • RMOC A brief update of the outputs of these groups was noted, in particular a revision of the terms of reference of the MO CRG
6. AOB	

	Jeanette Tilstone announced that due to her upcoming retirement this would be her last meeting. The group thanked her for her commitment and hard work and wished her a pleasant retirement. CCG MO leads were asked to identify another lead to take Jeanette's seat, as commissioner representation on this group is important.
Date of next meeting: 24th April 2018, 10-12 noon at St James House, Salford (Broughton suite).	

Attendee	A	M	J	J	A	S	O	N	J	F	M
Charlotte Skitterall Chief Pharmacist, MFT	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓
Carolanne O'Sullivan HCD pharmacist, MFT								✓	✓	✓	A
Steve Simpson Chief Pharmacist, Bolton Trust	✓	A	✓		✓	A	✓	✓	✓	✓	✓
Paul Buckley Chief Pharmacist, Stockport Trust	A	A	✓		✓	A	A	✓	A	✓	A
Darren Staniforth HCD Pharmacist, MFT	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓
Andrea Marrosu HCD pharmacist, SRFT	✓	✓	✓		A	✓	✓	✓	A	✓	✓
Robert Elsey Specialist Pharmacist, PAT	✓	✓	✓		✓	✓	✓	✓	A	✓ CA	
Chris Astbury HCD Pharmacist, Pennine Acute Trust											✓
Claire Vaughan Head of MO, Salford CCG	✓	✓	✓		✓	✓	✓	✓	A	A	A
Jeanette Tilstone Head of MO, Bury CCG	✓	✓	✓		✓	A	✓	✓	✓	A	✓
Susan McKernan Senior MO Adviser, North Manchester CCG	✓	✓	✓		✓	✓	A	✓	✓	A	✓
Jole Hannan CCG Interface Pharmacist, Bolton CCG	A	✓	A		✓	A	A	A	✓	✓	✓
David Dolman Deputy Chief Finance Officer, Stockport CCG	A	A	✓		A	✓	A	A	✓	✓	✓
Glenn Harley NW Procurement lead	A	✓	✓		A	✓	A	✓	A	A	✓
Connie Chen GP, MHCC	✓	A	A		✓	A	✓	✓	✓	✓	✓
Consultant rheumatologist (Therese Brammah, Sahena Haque, Louise Mercer, Surabhi Wig, Audrey Lowe or Charlie Filer)	✓ SW	✓ CF	✓ CF		A			✓ LM			✓ AL
Sarah Jacobs Head of MO, GM Shared Service	✓	✓	✓		✓	✓	✓	A			
Andrew Martin Strategic MO Pharmacist, MO Hub	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓
Anna Pracz MO pharmacist, MO Hub	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓
Elaine Radcliffe Mo Pharmacist, MO Hub										✓	A
Brian Galea Systems Administrator, MO Hub	A	A	A		✓	A	✓	A	A	A	A
Monica Mason Head of Prescribing Support, RDTC	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓