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

Wednesday 23rd may 2018, 10am until 12 noon
St James House, Salford.

Draft Minutes

1. General Business	
1.1	Welcome and apologies (See register in appendix 1) Apologies as per register were noted.
1.2	**Conflicts of Interest** Nil
1.3	**1. Minutes** The draft minutes were agreed as accurate and will be published to the GMMMG website. **Action: Publish on GMMMG website following CSB**
1.4	**Actions and Matters arising** The outstanding actions not included on this agenda were noted by the group. • The draft recommendation for duplimumab for dermatitis is being shared with SRFT to assess the patients currently receiving dupilumab via EAMS against the proposed criteria. The commissioning implications from Salford CCG will be shared with HCDSG to support the managed entry of this HCD should NICE issue a positive TA.
2. Medicines Optimisation	
2.1	**Progress report (May 2018): Adalimumab biosimilar implementation plan** GMSS provided the group with an update on the progress made by the adalimumab biosimilar working group. Of note was the move to monthly meetings, the extended membership to include additional clinicians and commissioners, an update on the meetings with individual Trusts, and details of the engagement undertaken with specialities and patient groups. A baseline report was presented following scoping undertaken to assess the needs of this project. The report provided a summary of the current usage of each of the

	biologics, and their corresponding biosimilar products across GM. It provides data on patient numbers and spend, in addition to Homecare providers and available Trust resources. It was agreed that a disclaimer would be added to this report in relation to rituximab, acknowledging its use for lupus and that Trusts are likely submitting combined CCG and NHSE commissioned data. There was some discussion amongst the group as to how this information would be utilised to develop business cases, and that commissioners and finance teams would need to know in good time of any additional resource required to implement biosimilar adalimumab. It was confirmed that this would be discussed at the next Chief Pharmacists meeting, with the need to highlight any resource requirements to their organisations in sufficient time. Project assurance had been agreed at the CSB and it was agreed that a bi-monthly report would be submitted to each CSB meeting. In addition a HCD commissioner assurance group was to be established. The HCDSG Chair queried the need for this stating that HCDSG could provide this assurance. It was confirmed that the HCD commissioner assurance group will meet once or twice to agree assurance principles and processes for all tariff excluded HCDs and will communicate these to HCDSG to take forward, but that HCDSG will continue to provide assurances to CSB, and in turn the AGG and MSB. It was noted that the working group would meet with Abbvie in the coming weeks, the group raised some queries that they would like raised in this meeting. The working group will bring the responses to the June HCDSG meeting. HCDSG recognised the efforts of the working group and thanked them for the progress made to date. An update from the regional procurement pharmacist on the national tendering strategy was delivered, it was noted that plans had not yet been finalised but an update would be given as soon as possible. It was stressed that this information should be communicated to CSB, and it was noted that it is contained within the risk register and would be included in the progress report that is submitted to CSB. The following actions were agreed: • **A monthly progress report would return to HCDSG which would in turn be shared with CSB (and in turn DoCs, DFCOs and AGG) and GM Chief Pharmacists.** • **The May progress report would be shared with the rheumatology network, specialist pharmacists and HCD pharmacists.** • **DT agreed to support AP in strengthening communication with MFT clinicians** • **CS would remind Chief Pharmacists to complete the adalimumab biosimilar resource scoping template and return this as appropriate to commissioner/finance within Trust** • **AP to update progress paper with risks discussed (as per risk register)**

	and submit to CSB
2.2	**Biosimilar Assurance Report** GMSS presented a report to HCDSG taking information from the BI tool dashboard. In summary. The report highlighted the slow uptake of biosimilars across the NW, which has represented a significant lost financial opportunity. With regards to the data available relevant to GM, data is now available from 7 out of 8 GM Trusts as to their use of originator and biosimilar versions for 3 CCG-commissioned biologic drugs which are now patent expired – etanercept, infliximab and rituximab – and for which biosimilar versions are available. Appendix 1 of the report shows the rate of uptake for each of the 3 drugs listed above at the latest month for which data is available, a line graph showing progress over time, a split of originator and biosimilar items by Provider and a pictorial representation of product mix. It reported that biosimilar uptake for the three drugs, etanercept, infliximab and rituximab stands as 48%, 86% and 75% respectively. The group noted that for NHSE-commissioned Specialised services, there is a stated ambition of 90% of new patients being on the best value biological medicine within 3 months of product launch and 80% of existing patients within 12 months, or sooner if possible. NHSE recommends that this should be mirrored for CCG commissioned services. Appendix 2 of the report quantified the lost financial opportunity of this report but is dependent on the particular biosimilar used for both infliximab and rituximab. The total for Greater Manchester for February 2018 is in the range £38k-£62k. Data was also presented in appendix 2 to show that the actual opportunity lost is now fairly low for etanercept as the originator price is close to that of the biosimilars. The greatest biosimilar savings are available early i.e. immediately after they become available. It appears that originator prices then drift down towards that of the biosimilars. The group accepted that the potential lost opportunity of around £50k for the month of February across GM is difficult to calculate accurately due to various factors at play e.g.biosimilar product mix, Trust service fees, existing homecare arrangements, gainshare agreements. They also noted that it is not yet possible to split the lost opportunity by Provider, but that GMSS hoped to present this in next month's report. It was agreed that Trusts should be challenged where biosimilar switches appeared to be lagging, and that Chief Pharmacists and Commissioners would be contacted to explain why some biosimilar switches i.e. those with a red status have not happened, this information will be returned to the June HCDSG meeting. **Action:** AM to submit this report to CSB to request approval for sharing with AGG. Biosimilar challenge information to return to the June HCDSG meeting
2.3	**HCD Reporting** The group briefly discussed the need for this reporting, to highlight variation in high

	cost drug spend (additional to biologics/biosimilars) across GM, in response to a call for this information from the HSCP. It was agreed that this would be undertaken by the GMMMG Data task and finish group, but that the membership of this group would be refreshed to include members of the HCDSG already undertaking this work with GMSS. **Action:** MM to renew the membership of this T&F group, with a report to return to the July meeting.
2.4	**GM biologics pathway for psoriasis** A review of the GM biologics pathway for psoriasis is being undertaken; the aim is to update the pathway to be product selective where NICE TAs positions all agents similarly. It was agreed that this piece of work should be taken through the GM dermatology group to ensure good clinician engagement. The RDTC will support any evaluation of trials as required, and ensure that this pathway development follows the GMMMG approved process. It was agreed that the pathway should make clear the provider route, particularly of tier 3 therapies, and the impact of satellite services should be considered. The group will also request audit data to monitor the application of and adherence to the current pathway to assess the sequential use of biologics across GM. As an interim measure the pathway will be updated to reflect the most recent NICE TA for brodalumab. **Action:** SJ to take this pathway to the GM dermatology group for development as discussed.
2.5	**National Pharmaceutical Supply Group Position Statement (Dec 2017): Signing of non-disclosure agreements by hospital trust chief pharmacists** The group acknowledged the statement issued by the National Pharmaceutical Supply Group Position Statement (Dec 2017) regarding the signing of non-disclosure agreements by Hospital Chef Pharmacists was noted by the HCDSG, it was agreed that this statement be communicated as appropriate across GM, and that NHSE and some GM organisations include this within their contracts. **Action:** CS to communicate this to chief pharmacists
2.6	**Blueteq use across GM** The variation in the use of Blueteq across GM was discussed. A meeting between DS, SMcK and a representative from Blueteq® highlighted improvements which could be made to optimise the functionality of Blueteq e.g. form design amendments to enable measurement of pathway outcomes. It was agreed that the GMMMG data task and finish group would be asked to develop a measurement strategy for all GMMMG groups. Thereafter discussion would be undertaken as to the tools/data products that may support this monitoring e.g. Blueteq **Action:** MM to communicate this request to the data T&F group following revision of

	the membership

3. Horizon scanning and work planning

3.1	**RDTC MHSD (includes MHRA DSU links) (Apr and May 2018) and work plan** It was agreed that the group plan for the managed entry of the monoclonal antibodies for migraine, as these products are likely to present a significant financial impact to the GM health economy.

4. Communication from other groups

	• GM HCD optimisation network • Medicines Optimisation Clinical Reference Group • HIM • Chief Pharmacists • RMOC **Updates on work being undertaken by those listed above were communicated to the group. It was noted that the Free of Charge policy is yet to be approved for publication by RMOC.**

5. AOB

	Nil

Date of next meeting: Wednesday 27th June 2018 – Community room 1, Pendleton Gateway, Salford

Attendee	F	M	A	M	J	J	A	S	O	N	J
Charlotte Skitterall Chief Pharmacist MFT		✓	✓	✓							
Danielle Timoney Deputy Director of HCD Pharmacist MFT		A	✓	✓							
Steve Simpson Chief Pharmacist Bolton Trust		✓	✓	A							
Paul Buckley Chief Pharmacist Stockport Trust		A	A	A							
Darren Staniforth HCD Pharmacist MFT		A	✓	✓							
Selwa Elrouby or Andrea Marrosu HCD pharmacist or MI pharmacist SRFT		✓ SE	✓ AM	✓ AM							
Robert Elsey Specialist Pharmacist PAT		✓	✓	✓							
Claire Vaughan Head of MO Salford CCG		✓	✓	✓							
Jeanette Tilstone Head of MO Bury CCG		A	✓	✓							
Susan McKernan Senior MO Adviser North Manchester CCG		A ✓ KL	✓	✓							
Jole Hannan CCG Interface Pharmacist Bolton CCG		A	A	✓							
David Dolman Deputy Chief Finance Officer Stockport CCGs		A	A	A							
Glenn Harley NW Procurement lead NW		✓	A	✓							
Connie Chen GP Manchester CCG		A	✓	A							
Consultant rheumatologist (Therese Brammah, Sahena Haque, Louise Mercer, Surabhi Wig (Bolton)or Charlie Filer)		✓ SH	✓ SW	✓ CF							
Sarah Jacobs Strategic medicines optimisation pharmacist GM Shared Service		✓	✓	✓							

Andrew Martin Strategic Medicines Optimisation Pharmacist GM Shared Service		✓	✓	✓							
Anna Pracz Medicines optimisation pharmacist GM Shared Service		✓	✓	✓							
Brian Galea Systems Administrator GM Shared Service		A	A	A							
Monica Mason Principal pharmacist RDTC		✓	✓	✓							