WRITTEN QUESTION TO THE MINISTER FOR HEALTH AND SOCIAL SERVICES
BY DEPUTY G.P. SOUTHERN OF ST. HELIER CENTRAL
QUESTION SUBMITTED ON MONDAY 19TH FEBRUARY 2024
ANSWER TO BE TABLED ON MONDAY 26TH FEBRUARY 2024

Question

"Regarding the Medicines Optimisation Committee (MOC), will the Minister –

(a) detail how the MOC is constituted;
(b) explain the criteria used by the MOC when making a decision, and advise whether those decisions are made solely on medical grounds or if other factors, for example, social circumstances, are considered;
(c) state whether a decision of the MOC can be appealed and, if so, provide details of the procedure;
(d) advise to what extent, if any, a cost benefit analysis is performed on decisions made by the MOC; and
(e) advise whether the Minutes of the meeting held on 13th December 2023 are available, and if they are, provide a copy?"

Answer

(a) Medicines optimisation is a person-centred approach to safe, effective, and sustainable medicines use, to ensure people obtain the best possible outcomes from their medicines within available resources.

The Medicines Governance Committee (MGC) was established in 2005. The Medicines

Optimisation Committee has been developed to continue the work of the Medicines Governance Committee and to also include items that have been looked at by the Drugs and Therapeutics Committee such as the introduction of new medicines, and review of clinical policies involving medicines.

HCS established a Medicines Optimisation Committee in September 2023, which was developed to provide assurance of the safe, effective, and cost-effective use of medicines across HCS and is supported by a specialist pharmacist. Introduction of new medicines, review of clinical policies involving medicines and the management of medical gases are also supported by this committee.

The Committee is chaired by the Chief Pharmacist. Members of the committee also include senior medical, nursing, pharmacy and quality and safety staff. Mental health is also represented.

(b) Wherever possible members of the Committee will seek to make decisions and recommendations based on consensus. For any decision to be made, the Committee must be quorate (5 members).

In order for an application for a new medicine to be considered the applicant (or nominee) may attend the meeting to present the application and answer questions. The applicant must be a consultant who is currently providing care for the patient.

HCS have a standardised approach for dealing with requests for a new medicine. This is

complex and dependent on several factors. These factors include:

- Whether the medicine has a positive NICE Technology Appraisal in place
- Whether the medicine is for use in primary care as well, or just for use in secondary care
- Whether it is to be used for multiple patients, or for an individual patient

Depending on the answers to these questions, it will depend on the type of application which is required.

Factors considered will be evidence-based and include:

- Evidence of clinical effectiveness *(such as from clinical trials, reviews, peer-support evidence, national policy and guidance)*
- Anticipated health outcomes
- Comparisons with standard care which are currently available
- Cost-effectiveness
- Safety
- For individual patient requests – the specific patient details are considered such as why the patient would not be suitable for following the usual pathway of treatment or where any alternative options are not considered appropriate.

Individual patient funding requests are for treatment as an exception to existing policy. Therefore, specific patient details will be considered as to why the patient should be treated as an exception.

(c) Further evidence can be brought back to the Committee by the applying consultant for consideration, in line with the application process.

For Individual Patient Funding Requests, a separate panel can be arranged for the applying consultant to present the case.

(d) As explained, there is a standardised approach for dealing with requests for new medicines. Specifically, in relation to cost analysis:

- Where the National Institute of Clinical Excellence (NICE) have reviewed a medicine for a particular condition and determined that the medicine represents a cost-effective use of resources, HCS will automatically adopt this clinical and cost-effective opinion. The medicine can be used routinely for the indication covered by the NICE Technology Appraisal and in strict accordance with any conditions specified.

  NICE undertake economic evaluation in the form of a cost-effectiveness analysis, with the health effects being measured using an appropriate non-monetary outcome indicator. Specific guidance on methods used can be found in NICE's Technology Appraisal Guidance website.

- For medicines which have not been appraised by NICE for a particular indication or where NICE have reviewed a medicine and issued guidance such that the medicine does not represent a cost-effective use of resources – a consultant can make an Individual Patient Funding Request. These applications must include the likely financial implications of making the medicine available. An economic assessment will be performed which considers the true cost of the treatment to HCS. This will include the overall expected cost over the planned course of treatment as well as any offset costs that may be saved e.g. not having an alternative intervention or preventing the need for further treatment.

In assessing whether an intervention is 'value for money' the Incremental Cost Effectiveness Ratio (ICER) is used by NICE comparing Quality Adjusted Life Year (QALY) values with the alternative treatment. For IPFRs, relevant cost effectiveness data should be provided – the IPFR panel will use a description of the expected clinical benefit to assess value for money.

(e) See attached redacted minutes

Health and Community Services

Meeting:	**Medicines Optimisation Committee**
Venue:	Anaesthetic Seminar room / MS Teams
Date:	Wednesday 13th December 2023
Time:	9am-11am

Present:

Debbie O'Driscoll, Chief Pharmacist (acting) -Chair	DOD
, Lead Pharmacist Medicines Governance & Safety	
Patrick Armstrong, Medical Director	PA
, Lead Quality and Safety Manager	
, Policy Manager Quality & Safety	
Elizabet Gomes dos Santos, Consultant Oncology	EGdosS
, Acting Head of Quality and Safety	
Dr Sudheeram Alapati, Respiratory Consultant	SA
, Consultant Pharmacist, Mental Health	
, Lead Pharmacist Medicines Information	
, Pharmacy Services Manager	
Adrian Noon, Chief of Medicine	AN

1	**Apologies –** , Jessie Marshall, Dr Kumar, , , Simon West, , , , Zainab Kadhim ACTION: raise at SLT mental health representative needed at future meetings
2	**Previous minutes – DOD** It is felt the minutes are an accurate representation of the last meeting • asked for more of an update around patients bringing medicinal cannabis into hospital and how to deal with this. writing a paper which will be brought to the next meeting. There was discussion about the need for guidance around illicit drugs as well. ACTION: / to produce SOP "how illicit substances should be handled within the organisation". ACTION: to bring paper on options for inpatient use of medicinal cannabis to next meeting
3	**Matters arising from previous minutes – DOD** • Audit findings around medication storage/security on Wards. No further update. • , application form completed to adopt the Renal Association guidelines for management of acute hyperkalaemia, sent to AN & for sign off. ACTION: AN to confirm the Medical Care Group supports adoption of these guidelines. • confirmed guidance has been produced in relation to GLP1- receptor agonists, following meetings held with David Hopkins, , & • & working on Flow-chart for the new medicines process, once completed will be uploaded to the intranet. DOD forms that were ratified last time can be uploaded & communicated asked the committee if they prefer an online form or an MS Word document that is downloaded and typed into for the new medicines application form and IFR form. It is felt online form is the way forward.

	ACTION: distribute final version to care-groups ACTION: AN and to highlight at INSET days asked what inbox do these forms need to go to? DOD confirmed medicines governance inbox. DOD concerned about consultants, are they aware of process of the managed introductions of medicines to the organisation – PA confirmed No. ACTION: PA to inform consultants once final version of the application process is available. • has given feedback on metaraminol. No in stock on ED & ICU • has given feedback on tachocil, struggling to procure at the moment • Dr Thompson applied for remimazolam, this was rejected at the last committee meeting due to cost effectiveness. Suggested that Dr Thompson come back with more detail around how medication would be used/ evidence how it may be beneficial. ACTION: invite Dr Thompson to next meeting if new application submitted • has given feedback to Dr Muscat re: dalbavancin • has given feedback to Dr Chandler on cisatracurium however, ongoing supply issues with this at the moment • has given feedback to haematologist re: LK IVIG • CF drugs, agenda item for later in this meeting
4	**<u>Sub-Group updates –</u>** • No new PGD's considered, PGD's reauthorised as stated. • Discussion had in the PGD group about changes in the legislation re: PGD use by ambulance/public health • 3 members have left HCS so looking to recruit new people to the group
5	**<u>Medication Incident report –</u>** Report looks at Q3 incidents reported Group discussion/ report • confirmed lots of work being done with colleagues around Clozapine. Group discussion about Clozapine. highlighted that several of the incidents reported were nothing to do with clozapine per se and did not denote errors or issues with its use, but were being reported because clozapine is a critical medicine with specific monitoring and supply requirements associated with it. • suggested bespoke learning event to update care-groups on the policy, guidelines & expectations of bloods. ACTION: ensure this is mentioned at the governance review meeting. ACTION: For Care groups. Now Clozapine guidelines apply to all areas, not just to MH, they need to assess and be able to provide assurance to MOC that the guideline has been implemented in their areas. ACTION: review incidents related to opiates, care-group related for next meeting ACTION: to add wording to the report regarding no patient harm caused to future reports ACTION: to add to future reports about it being a good thing for organisations to have a good reporting culture.
6	**<u>Safety Alerts –</u>**

	• Shortage of methylphenidate prolonged-release capsules and tablets, lisdexamfetamine capsules, and guanfacine prolonged-release tablets. Memo has been sent out advising that there is still a shortage of this medication, managing current stock & have not had to refuse any existing patient treatments. Struggling with clinicians starting new patients on medication despite the action in the alert stating no new patients should start treatment. Also receiving requests from clinicians for exceptions to this national guidance. To help manage this situation we may introduce alternative brands if this situation continues. • Shortage of verteporfin 15mg powder for solution for injection HCS does not stock or use this medicine • Valproate: organisations to prepare for new regulatory measures for oversight of prescribing to new patients and existing female patients New regulatory measures; ○ Valproate must not be started in new patients (male or female) younger than 55 years, unless two specialists independently consider and document that there is no other effective or tolerated treatment, or there are compelling reasons that the reproductive risks do not apply. ○ At their next annual specialist review, women of childbearing potential and girls should be reviewed using a revised valproate Risk Acknowledgement Form, which will include the need for a second specialist signature if the patient is to continue with valproate and subsequent annual reviews with one specialist unless the patient's situation changes This has been cascaded to all consultants via email and all staff via HCS weekly message. has reviewed the patients we have issued valproate to from the Hospital Pharmacy recently and estimates we have female patients that need to be on the (Pregnancy Prevention Programme (PPP). has contacted the clinical leads for mental health and Dr Gibson (Neurology) to request sight of current Risk Acknowledgement forms completed as part of the annual review. If these have not been done then it needs to be completed by end January 2024. ACTION: PA to discuss with about leading on a working group ACTION: to add valproate to the organisational risk register ACTION: to update valproate policy ACTION: ensure alert has been cascaded to Learning disability service ACTION: to check this has been received and distributed by Primary Care Governance
7	**<u>Guidelines/Policies/Procedures –</u>** • Proposal from primary care to review/develop shared care arrangements in Jersey. is the lead. (information) Group discussion - Committee agrees that the work on shared care arrangements in Jersey should go ahead. offered her support with any Mental Health medicines. ACTION: to contact Medicines policy- This was completely reworked approx. 5 years ago and whilst amendments have been made in this time a full review is now required. Is there anyone that would like to work on the update? was involved in the review process last time but he no longer works for HCS. is now covering some of his role. ACTION: to approach about doing an initial review

	• NMP policy update – this policy is now due for renewal. Group discussion about whether this needs to be a standalone policy or not. On balance the committee felt a separate guidance/policy document was still required whilst some sections could be included in the update to the HCS medicines policy. • Medicines policy – amendment Amendment agreed • NMS Guideline It was acknowledged that this was introduced quickly in the wake of an SI so was not necessarily perfect, hence why it was only ratified for a year. has contacted offering to help review it and will initiate that process prior to expiry however as a medical emergency the guideline itself does not sit with Mental Health. noted that there were recommendations made regarding medicines however there was no associated detail regarding e.g. doses, which would make it tricky for clinical teams unfamiliar with this rare medical emergency. It was acknowledged that there is not necessarily clear evidence for what medicines and doses should be used to treat. The stock locations of the medicines in the guideline also needs to be sense checked. ACTION: to discuss with AN about getting someone to look at updating this guideline to include specific dosing recommendations ACTION: will identify stock locations of medicines mentioned in the guideline and feedback to /AN
8	**<u>New Medicine Applications –</u>** • CF drugs – NHS England commissioning criteria HCS follows the criteria for use set out in the NHS England commissioning statement for all CF drugs. • IPFRs IPFRs have been submitted by SA and Dr Luck for patients who have the same gene mutation. This is not included in the NHS England document (or on the expanded list of FDA approved mutations). SA was present to talk about the application for the eldest patient who is under his care. DOD asked is there any indication that suggests patients individually would respond positively to this treatment? The group considered the evidence supplied and balanced this against wider evidence including Product licensing and NHS commissioning criteria for these medicines. Committee decision- applications not approved. **<u>Formulary updates:</u>** Guselkumab – Approved (for information only) Patiromer & sodium zirconium cyclosilicate – will be adopted on to formulary, both NICE approved Application for uromune – number of individual patient applications for this treatment has increased so a formulary application has now been submitted. It is recommended in EAU guidelines on urological infections. NICE have not yet considered its use. Committee discussed & agreed this should be adopted on to formulary for use in accordance with the application.

9	**Items not discussed** • Drug safety update -defer to next meeting • Medication e-Learning -defer to next meeting • ICU drug chart -information only as approved by committee via email
10	**Dates of next meetings 2024** 21 February 12 June 11 September 4 December