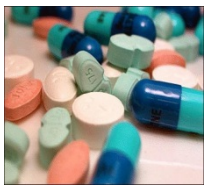
GMMMG Greater Manchester Medicines Management Group NHS

FORMULARY AND MANAGED ENTRY SUBGROUP



Minutes of the meeting held on
26th June 2018
1 - 3 pm
Pharmacy Dept. CMFT

Present:

Name	Title	Organisation	Jan	Mar	May	Jun	July	Sept	Nov
Elizabeth Arkell (EA)	Medicines Management Lead	UHSM	✓	LA		✓			
Liz Bailey (LB)	Medicines Optimisation Lead	Stockport CCG	✓	✓		✓			
Dr Pete Budden (PB)	GP Prescribing Lead	Salford CCG *(Chair)*	A	✓		✓			
Sarah Boulger (SB)	Senior Medicines Information Pharmacist	The Pennine Acute Hospitals NHS Trust	✓	✓		A			
Lorna Hand	Medicines Management and Medicines Information Pharmacist	CMFT	✓	✓		A			
Claire Foster (CF)	Senior Medicines Optimisation Advisor	MHCC	✓	✓		✓			
Leigh Lord (LL)	Locality Lead Pharmacist	Trafford CCG	✓	A		✓			
Rachel Macdonald (RM)	Pharmacist	LPC	A	A		✓			
Keith Pearson (KP)	Head of Medicines Management	Heywood Middleton and Rochdale CCG	✓	✓		A			
Prof Peter Selby (PS)	Consultant Physician	CMFT	✓	A		A			
Suzanne Schneider (SS)	MI Pharmacist	Bolton FT.	A	✓		A			
Dr Hina Siddiqi (HS)	GP	Trafford CCG				✓			
Lindsay Harper (LH)	Director of	SRFT	✓	A		A			

	Pharmacy								
Jonathan Peacock (JP)	Deputy Chief Pharmacist	WWL	✓	✓		✓			
Zoe Trumper (ZT)	Medicines Management	Pharmacist Wigan Borough CCG	✓	✓		A			
Andrew Martin (AM)	Strategic Medicines Optimisation Pharmacist	GM Shared Service.	✓	✓		✓			
Monica Mason (MM)	Principal Pharmacist Medicines Management	RDTC *(Professional Secretary)*	✓	✓		A			

OTC/Self Care meeting

1. **Apologies**
   Apologies had been received in advance as noted above. Faduma Abukar (FA) from Manchester Health and Care Commissioning was also in attendance.
   Kathryn Griffiths, Strategic Medicines Optimisation Pharmacist, GMSS was in attendance to record the minutes.

2. **Declarations of Interest:**
   No declarations of interest were received in advance. At the meeting RM noted that she works for a community pharmacy chain.

3. **Background**

   AM described the recently issued guidance: On 29th March 2018, NHSE issued guidance to CCGs describing 2 drugs of limited clinical value and 35 conditions which may be self-limiting and therefore suitable for patient self-care. Key aspects are encouraging self-care, stopping prescribing of drugs of limited clinical effectiveness and, where drugs are available over the counter for the treatment of minor conditions, these should not routinely be prescribed. Note also that the guidance is condition–based.

4. **GM spend**

   AM shared some finance and prescribing information. He highlighted that many of these conditions are experienced on a spectrum from 'appropriate for self-care' as they are self-limiting to 'significant impact' and that work on this subject would not realise all savings in the area as some prescribing would continue, and also may be for other indications.

5. **CCGs approaches**

   5.1. **Bury CCG**

   The data from Bury showed the impact of their work as they are the lowest prescribers of these drugs in GM. FA highlighted that Bury did not do an impact assessment prior to carrying out but NHSE advise doing this. Much cross over was noted between the Bury work and NHSE. Bury rolled out the work in around 18m. It was agreed as a collective across Bury to do this and that worked well.
   JP questioned what the impact on A&E was for Bury? PB asked if there was information from Bury on reducing appointments at GP? Had profile of indications changed?

   Action: AM to ask for information from Bury CCG regarding impact on A&Es and GP appointments/profile

5.2. Trafford CCG

LL gave an update on progress at Trafford – they have clinical buy in from clinicians. Some concerns have been expressed about where patients may otherwise go so seeking A&E, WIC and OOH buy-in, and LPC so pharmacies support the message. Trafford plan to use Midlands and Lancs CSU to do implementation support, who have had experience in other areas and are to send on PILs etc used elsewhere to LL. Trafford are also reviewing their MAS.

Action : LL to share PILs etc with AM when received

6. Resources from other areas

AM described the resources from other areas: including PrescQIPP, Derbyshire, NHSEngland and North East and North Cumbria region. The group agreed that Derbyshire policy was very comprehensive.

7. Issues raised

The group felt strongly that there needed to be a GM wide approach and public consultation, with local implementation. Implementation tools would be required as little has been forthcoming from NHSE. PresQIPP have developed a suite of Scriptswitch messages to add to systems. Concern was expressed that the document implies that each CCG must carry out their own consultation process which then could lead to problems if some accept and some reject. Could this be worked around under devolution?

It was noted that there would be quick wins and some more contentious issues. The group agreed that splitting the list into cohorts and tackling the quick wins as cohort 1, and leaving more contentious matters until later might be a good approach. It was suggested that the existing DNP list be cohort 1.

The group discussed outcomes, is there a way to tell if the profile of GP visits changes?

A review of the GM Minor Ailments Scheme (MAS) is pending but awaiting decisions from this meeting.

Concerns were expressed regarding the impact on community pharmacies in extra consultation work and reduced dispensing items. RM commented that the guidance was clear and community pharmacists wished to ensure that patients had options they were able to access and were not caught in middle.

RM commented that the LPC can offer support to pharmacists to ensure they recognise red flags and can redirect appropriate patients to their GP. There is a need to ensure standards across community pharmacists are even and adequate. The LPC has a training academy which can support. It was suggested that GP input to training could be helpful.

In terms of time frame, members commented that CCGs want this delivered urgently, but that in reality the re-education required of the population will take a long time to enact. Need to deliver some quick wins and a clear 'working towards' for other aspects.
Bury CCG took some time to roll out locally as they found problems with licensing of some medicines during the roll out phase and had to pause and revise their approach.

Concern was expressed by GPs attending as to how complaints might be managed. There is a mis-match between GP terms of service and the aspirations of document which could put GPs in front of GMC, and concern the GP would become the subject of a complaint for breach of contract rather than clinical negligence as a GP's Terms of Service state that if a patient requests treatment for an appropriate condition then you are obliged to prescribe.
PB felt that a statement was needed as to what this means for a GP, and GMMMG support for any GP in that situation. It was suggested that CSB write to NHSE regarding their expectations

that their guidance once enacted will not be used to criticise GPs. It was noted that CCGs must work to ensure GP engagement across the board, and ensure unity prior to roll out so all clinicians and pharmacies, WiC etc were on board with the same message. It would be essential to work with LMC partners. A useful piece of work to explore what GPs objected to who rejected the guidance? How can that be addressed and what exceptionality is incorporated?

A discussion was held as to whether this was guidance or policy? AM commented that whilst labelled as guidance it does say CCGs will be monitored on it.

Actions: AM to explore whether consultation can be done GM wide as a devolved GM?

AM to contact GM communications lead to seek GMHSCP support

AM to explore different outcome measures

MM draft letter for CSB to send to NHSE requesting support for GPs

8. Next steps for GM CCGs

The group felt that an initial generic policy was required that can be taken back to each CCG for local agreement, describing:

- The principle as to why doing it
- The steps the CCG needs to take to implement
    - Suggested phased approach
    - Consultation

CCGs would be asked to adopt this as a commissioning policy and work with their providers to adopt as policy.

Action: AM to adapt Derbyshire document and send round for comments prior to July subgroup meeting

9. Messages for secondary care

The consistency of message is key. A campaign should be carried out incorporating A&E, Minor injuries centres, WiC etc.
EA has a secondary care representative (acute medicine) at MFT-South that may join any working group.

Action: EA to pass contact details of representative to AM

10. Timescales for reporting back to CCGs

CSB would require: the policy; expectation of CCGs to explore implementation of that policy; proposal of phases of implementation; and timescales, (consultation Oct, results analysis Nov, policy December)
It was agreed to bring this paper back to the July meeting with the aim to deliver it to August CSB.

The next meeting will be held on 24th July 2018 12.00-2.00pm, MFT (standard FMESG meeting)