Co-chairs: Robert Hallworth & Dr Peter Budden
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GMMMG Medicines and Guidelines Subgroup
August 23rd 2021, 12:00-14:00
via Teams
Minutes

Present:

Name	Title	Organisation	Oct	Nov-Mar	Apr	May	Jun	July	Aug
Robert Hallworth	Specialist Cancer Pharmacist	NHSE	✓		A	✓	✓	✓	✓
Dr Pete Budden	GP Prescribing lead	Salford CCG	✓		✓	A	✓	A	A
Petra Brown	Chief Pharmacist	Pennine care NHS FT	A (JW)		✓	✓	✓	A	✓
Nigel Dunkerley	Locality Medicines Optimisation Lead	Oldham CCG	A (FT)		A (FT)	✓ (+FT)	✓ (+FT)	✓ (+FT)	✓
Claire Foster	Senior Medicines Optimisation Advisor	MHCC	✓		✓	✓	✓	A (AH)	A (AH)
Jonathan Peacock	Chief Pharmacist	Tameside & Glossop NHS FT	A		✓	✓	✓	✓	✓
Prof. Peter Selby	Consultant Physician	Manchester FT	A						A
Anna Swift	Associate Director Medicines Management	Wigan Borough CCG	A			✓	A	A	✓
Amanda Fox	Assistant Chief Finance Officer	Oldham CCG	✓		A	✓	✓	✓	A (KR)
Rebecca Demaine	Associate Director Commissioning	Trafford CCG			✓	✓	A	✓	✓
Claire Vaughan	Head of Medicines Optimisation	Salford CCG					✓	A	A
Paul Buckley	Chief Pharmacist	Stockport FT						✓	✓

Darren Staniforth	HCD Pharmacist	Manchester FT						✓	A (CO)
Hafsa Sattar	HCD Pharmacist	PANHT						✓	A
Juliet Bell	Senior Clinical Pharmacist	Bury GP Federation							
Andrew Martin	Strategic MO Pharmacist	GM Joint Commissioning team	✓		✓	✓	✓	A	✓
Andrew White	Head of Medicines Optimisation	GM Joint Commissioning team				✓	✓	✓	✓
Sarah Jacobs	Strategic MO Pharmacist	GM Joint Commissioning team						✓	✓
Monica Mason	Head of Prescribing Support	RDTC			✓	✓	✓	✓	A
Dan Newsome	Principal pharmacist	RDTC	✓		✓	✓	✓	✓	✓

1. General Business	
	Welcome and apologies (See register above). Robert Hallworth chaired the meeting The group welcomed Helen Burgess and Ann Harrison as GP representatives, as well as Carolanne O'Sullivan and Karen Ratzeburg deputising for DS and AF respectively.
1.1	**Declarations of interest** DN declared an interest related to item 2.2: The RDTC also provide professional secretariat support for RMOC North.
1.2	**Minutes of the MGSG July meeting** The minutes were approved an accurate record of the meeting held on 26th July 2021
1.3	**Action log review** AW provided an update on action 042101 and 042102. DN provided feedback on items 042103, 052103 and 072104.
1.4	**Update from August GMMMG and CRG** AW provided a verbal update from the August GMMMG which considered the updated integrated pharmacy and medicines optimisation (IPMO) plan. This will now be finalised by the GMMMG chairs and circulated. It was noted that there was a missed opportunity of around £2.3m savings on biosimilars across GM during the last 12 months. The COPD pathway was approved and a timescale for implementation of 3 years agreed in principle, however a more ambitious plan of 1 year was also thought to be achievable.

	GMMMG also agreed to delegate authority for medicines decision-making to MGSG and that it should be renamed as the “medicines optimisation sub-committee” or similar. This delegated authority will be for the same values as GMMMG previously held of £200k in any of years 1-5 of implementation. More details will be contained in the terms of reference when they are finalised which will form part of the September agenda of MGSG. For the purposes of this meeting the decision-making on rebates was passed over immediately. **Action: none required**
2.0 Reduce variation in access to shared care across GM	
2.1	**Update on GM Governance regarding SCP commissioning** The paper developed by AW and RD requesting a single Greater Manchester commissioning position on shared care was presented to a joint GM Chief Finance Officers and Directors of Commissioning meeting. It was confirmed that CFOs and DoCs are not supportive of this work stream at this time due to the resource required to implement it. A saving of 3% on the primary care medicines budget was requested, which is in the region of £75m-85m during the second half of 2021-22. GMMMG have been tasked with developing a plan to deliver this which was discussed at their August meeting. AW communicated that GMMMG members expressed their disappointment that prescribing budgets are being targeted for what were considered to be unrealistic savings. The GM DoCs / DoFs were informed of the safety aspects of this work and that following the Coroner’s letter GMMMG may have to report that there has been little progress towards developing a safer shared care system. MGSG members noted that the ICS is an organisation in development and as a single commissioning process forms under a Greater Manchester Integrated Care Board it is anticipated there may be further opportunities to re-present this proposal. Further development was suggested, with additional information on the real cost of shared care incidents to include patient and system costs, both financial and non-financial. This is because MGSG believed that the decisions taken do not accurately reflect the costs associated with preventing and dealing with serious incidents. MGSG agreed that to continue to develop the proposal is unlikely to succeed until a new governance structure is in place, therefore work should refocus on making the current system safer. MGSG then heard that further incidents, like the one that prompted the GM review, are possible if the shared care process is not made safer and more transparent. It was suggested that the process of clearly identifying which organisations have commissioned against each shared care protocol at the top of each document should be implemented as soon as possible. Whilst MGSG agreed that this was a reasonable interim measure, they heard it was also unlikely that this information could actually be made available by commissioning teams because they are unaware of how to obtain it, and given JCT have been unable to get accurate information during their scoping exercise it was unclear if this course of action was realistic. The members present were asked what could therefore reasonably be done, at this point in time, to make GM shared care safer. It was suggested that this needs to be added to relevant risk registers. **Action: RDTC and JCT to escalate to GMMMG as a patient safety risk. The potential for further shared care incidents should be included on relevant risk registers** During this conversation a tangential issue of the repatriation of transplant shared care prescribing to Leeds Hospitals was raised. AS believed that this process should now have

	been completed however there is still prescribing going on in GM and could GMMMG as an organisation request further information. **Action: RH to contact Paul McManus to ask about the repatriation of transplant medicine prescribing to Leeds Hospitals.**
2.2	**GMMMG and RMOC shared care protocol development** MGSG heard that due to the issues discussed in the previous agenda item it is proposed that GM work on shared care is paused to wait for RMOC to catch up, at which point these SCPs will be implemented in GM, accepting that there is currently no single commissioning process to do so. Where GM utilise shared care for drugs not yet considered by RMOC, these will be reconsidered by the GM Clinical Reference Group (CRG) and if still deemed suitable for shared care, submitted to RMOC for inclusion in a future series of SCPs. MGSG, however, did not agree with the proposal to work towards removing shared care for any medicines that the RMOC did not think were appropriate. It was felt that the list of SCPs that GM use is the result of variable commissioning of secondary and primary care services and that a degree of flexibility within each ICS is required to develop shared care to maintain patient safety. **Action: CRG to review GM list of SCPs. Following which it will be submitted to RMOC for consideration.**
2.3	**GMMMG SCP updates: Mycophenolate for ILD & Oral methotrexate for pulmonary sarcoid** These two updated SCPs were given approval to be implemented in GM as far as the current commissioning arrangements permit. **Action: Publish once ratified by GMMMG**
2.4	**GMMMG shared care information leaflet** MGSG recognised that this resource could prove to be a useful tool when discussing the process of shared care with their patients. A good deal of credit was given for the document to the rheumatology team at MFT on which the version tabled was based, as well as thanks to the communications team at MHCC who reviewed the document to optimise the plain language and readability of the content. A number of comments were received including; if it could also reflect the different models of shared care in existence in GM as well as going further in highlighting that where patients do not attend for routine monitoring, their medicine may be stopped. MGSG believed that this document would be a useful addition to the RMOC process and asked that it be shared. If the comments could be addressed without significant alterations to the tone and content of the document, MGSG were happy to approve for publication following chair's action. Otherwise this would need to return to a future meeting for approval. **Action: RDTC to review submitted comments and make necessary changes. Following which discuss with chair for action / return.** **RDTC to share with RMOC for consideration of adoption / adaptation**

3.0 Medicines and Guidance	
3.1	**GMMMG wet age-related macular degeneration (wAMD) High Cost drugs pathways scoping** MGSG approved the formation of a GM-wide working group to develop a wAMD treatment pathway to look at cost-effective options for the condition including biosimilars. This is a high spend area with no existing pathway and a wide range of commissioning arrangements. It was agreed that this work should be overseen by MGSG who would provide the approval to open for GM-wide consultation to ensure that the commissioning and financial implications are explored in advance and on which comments can be sought. **Action: None required from MGSG**
4.0 GMMMG Governance and BAU	
4.1	**CRG decisions for MGSG consideration and approval** Given that MGSG will soon receive delegated financial decision-making authority for medicines up to the value of £200k (in any of years 1-5 of a new treatment), they discussed the high cost items and those with a significant commissioning impact in some detail, in particular andexanet alfa. It was raised that the potential financial impact may not be affordable within the current financial envelope for a number of trusts, despite this being a NICE TA recommendation. This means organisations may not be currently providing access in line with NICE and must be flagged to GMMMG. All CRG recommendations were accepted, those with a significant commissioning and / or financial impact will still require GMMMG sign-off until the delegated authority has been transferred. **Action: GMMMG to receive decisions with significant commissioning and finance implications in particular the financial impact of andexanet alfa**
4.2	**GMMMG rebate scheme review – FreeStyle Libre and FreeStyle Libre 2** The recommendation to decline the primary care rebate scheme (PCRS) was approved by MGSG. The GMMMG ethical framework for PCRS is clear that schemes not based on a straight discount will not be accepted, particularly those where payments are dependent on prescribing volumes or growth, which could be viewed as an incentive to prescribe. The actual value of the scheme is not known because the savings require a complex calculation that was not undertaken due to the decision to reject it as unsuitable being evident. MGSG recognised the need to provide justification when rejecting PCRS, in light of the savings plan that GMMMG have been requested to produce, however this PCRS is clearly against the principles drawn up by GMMMG **Action: None for MGSG**

4.3	**RDTC Monthly Horizon scanning: August** MGSG received the horizon scanning document from August and noted: • A potential third biologic agent, tralokinumab, for the treatment of atopic dermatitis. More information is required before a decision can be made on the need for a pathway but it was agreed this should be monitored. • TA175 for moderate rheumatoid arthritis. A GM pathway is in development but concern exists around the existing rheumatology service and homecare capacity. MFT estimate that an extra 200 patients may require homecare which is not manageable. • New duloxetine products which are unlikely to be cost effective and may warrant being added to the DNP list. **Action: refer duloxetine products to CRG for assessment**
4.4	**MGSG work plan 2020-21** Not discussed **Action: None required**
4.5	**National and regional updates** None received **Action:** None required
5.0 AOB MGSG agreed to move the date of September meeting to 20th September 2021.	
Date of next meeting: 20th September 2021 12:00-14:00 via Teams	