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GMMMG Medicines and Guidelines Subgroup
June 28th 2021, 12:00-14:00
via Teams

Minutes

Present:

Name	Title	Organisation	Sep	Oct	Nov-Mar	Apr	May	Jun
Robert Hallworth	Specialist Cancer Pharmacist	NHSE	A	✓		A	✓	✓
Dr Pete Budden	GP Prescribing lead	Salford CCG	✓	✓		✓	A	✓
Petra Brown	Chief Pharmacist	Pennine care NHS FT	✓	A (JW)		✓	✓	✓
Nigel Dunkerley	Locality Medicines Optimisation Lead	Oldham CCG	✓ (+FT)	A (FT)		A (FT)	✓ (+FT)	✓ (+FT)
Claire Foster	Senior Medicines Optimisation Advisor	MHCC	✓	✓		✓	✓	✓
Jonathan Peacock	Chief Pharmacist	Tameside & Glossop NHS FT	✓	A		✓	✓	✓
Prof. Peter Selby	Consultant Physician	Manchester FT	✓	A				
Anna Swift	Associate Director Medicines Management	Wigan Borough CCG	✓	A			✓	A
Amanda Fox	Assistant Chief Finance Officer	Oldham CCG	A	✓		A	✓	✓
Rebecca Demaine	Associate Director Commissioning	Trafford CCG				✓	✓	A
Claire Vaughan	Head of Medicines Optimisation	Salford CCG						✓
Andrew Martin	Strategic MO Pharmacist	GM Joint Commissioning team	✓	✓		✓	✓	✓
Andrew White	Head of Medicines Optimisation	GM Joint Commissioning team					✓	✓
Monica Mason	Head of Prescribing Support	RDTC				✓	✓	✓
Dan Newsome	Principal pharmacist	RDTC	✓	✓		✓	✓	✓

1. General Business	
	Welcome and apologies (See register above). Dr Pete Budden chaired the meeting Anna Pracz (AP) and Elaine Radcliffe (ER) of GM JCT were in attendance
1.1	**Declarations of interest** None declared
1.2	**Minutes of the MGSG May meeting** The minutes were approved an accurate record of the meeting held on 24.05.21 with the clarification regarding the initials "PB" against a number of actions. PB will remain as Dr Pete Budden and PeB will be used denote Petra Brown as is done for GMMMG meetings. It was agreed to remove those MGSG members from distribution lists who have not attended the last 6 meetings.
1.3	**Action log review** DN gave an update on action 042103 and AW provided further information on items 052101 & 052102.
1.4	**Update from June GMMMG and CRG** MM provided a verbal update from June GMMMG to state that GMMMG have been made aware of a medicines prioritisation matrix that is in use by GM Directors of Commissioning (DoCs) which may influence the pieces of work that GMMMG is instructed to undertake. The documents considered by MGSG in May regarding aducanumab and the NICE NG196 DOAC guidance have been escalated to DoCs to discuss alongside the aforementioned prioritisation matrix. Members of the HCDSG will be invited to join either MGSG or CRG depending on role and geography so that this experience is retained for GMMMG decision-making. AM provided an update on the smoking cessation work which has been considered by all the local authority commissioners and approval is being sought. After which it will return to GMMMG for sign-off Initial conversations have begun to start the process of including filgotinib and other agents for the treatment of mild-moderate rheumatoid arthritis into the RA pathway. **Action: DN to invite HCDSG members to CRG and MGSG from July**
2.0 Reduce variation in access to shared care across GM	
2.1	**Alignment of GM SCP Commissioning Arrangements – Update** This verbal update was provided by AW who explained that the joint paper to be discussed at GM DoCs is being finalised by Fiona Meadowcroft and himself. It is taking considerable time

	and care in order to ensure that this proposal is well received against a background of variations in commissioning of shared care and the differential impact that the recommendations will have on commissioners. It is anticipated that this will be ready for consideration by GMMMG at their July 2021 meeting. **Action:** None required from MGSG
3.0 Medicines and Guidance	
3.1	**Gabapentinoids Prescribing in Pain: Resource Pack** MGSG considered a document that was first approved by the Pathways and Guidelines Subgroup in January 2021. The document was welcomed and was not thought to have any significant commissioning and finance implications and was approved by MGSG. A number of recommendations were made by the paper's author on behalf of the working group which included a review of the GMMMG neuropathic pain in adults guideline, which is underway, a request to consider if some drugs now need to be considered for a DNP or Grey RAG status, which will be done via CRG. It was accepted that the GM tableau platform would be the right place to report on any outcomes associated with the implementation of the resource. This could be supported by the development of data entry templates for use at practice level. **Action: AP to communicate the recommended changes in formulary RAG to CRG and liaise with the relevant GM BI team to develop the reports on Tableau**
3.2 & 3.3	**Updated GMMMG COPD Management Plan** AM presented the updated COPD management plan which has been developed in conjunction with the respiratory clinical working group. It has been heavily influenced by the sustainability agenda led by the Mayor of GM, GMCA and GMHSP to move from routine prescribing of pMDI devices to low carbon DPIs. MGSG heard that the prescribing of inhalers equates to 3% of all NHS carbon emissions and for 15% of the primary care carbon footprint. Hence why this work is seen as a priority for GM. AW explained that the pathway has been amended since receiving clinical approval from the CRG and indicators have been added to denote which devices require the most inspiratory effort (as measured using an In-Check device) and which have the highest carbon footprint. The environmental impact of which has been illustrated by showing the distance one would need to travel in an average fossil fuel car to have an equivalent carbon emission. This has also been RAG rated and is based on 13 inhalers per year for regular use inhalers and 2 doses per day if used on a prn basis. **Carbon and financial impact assessment of updated GM COPD management plan** The carbon and financial impact of the pathway has been modelled by the RDTC, and contains a number of assumptions and caveats based on the data available and the development stage of the tool. Firstly it is not possible to separate primary care prescribing for asthma and COPD as the tool utilises ePACT2 data, and is therefore primary care prescribing only. Secondly it has not yet been developed to include the impact of switching combination inhalers, nor the impact of switching from individual inhalers to a combination inhaler (RDTC analysis suggests this would be a limited number of patients). The current carbon footprint of all inhalers in Greater Manchester HSC Partnership is 48,354,814 KgCO2e (Dec 19 - Nov 20). The SABA share of

	these emissions is 28,245,440 KgCO2e which makes up 58.4% of the CCG's current inhaler carbon footprint and is therefore a good group of inhalers for the initial focus of this work. DN asked if MGSG were willing to accept the indicative financial cost of the medicines in order to reduce the system's carbon emissions, accepting that the presented impact assessment by no means captures the work required by the individuals working to make the changes and the education and training required to do so. Unfortunately AF, as the GM finance representative, was unavailable during this section of the meeting but has provided the following comments via email following the meeting. *"From a finance perspective the wider economic benefits to cutting GM's carbon footprint are more than justified, however any tangible increases to costs need to be mitigated given the NHS's budgetary pressures.* *Given that the lower cost impact of using Salbutamol Easyhaler DPI would produce a greater reduction in carbon footprint, it is felt that this would be the preferred option where clinically safe to do so, however work should continue with the Medicines Value workstream to identify savings proposals to mitigate these additional costs"* It was pointed out that there is a cultural change required from patients and prescribers to reduce the overprescribing of SABA devices, which traditionally patients have had multiples of and received on repeat prescription, meaning large volumes of prescribing to a patient does not necessarily indicate poor disease control. An appropriate first step may be to address this area of prescribing. The costs associated with this work look very large but the capacity in an already over-stretched system to take on any extra work, however valuable, is non-existent. Therefore it would be reasonable to expect this work to take up to three years to implement which would make the related costs figures easier to manage. The publication of the asthma pathway and new recommendations on low-carbon devices for this condition is likely to follow the COPD pathway soon. The group heard that the work to switch asthma patients would likely be even more challenging given the greater number of patients involved, however they accepted that the review of COPD patients may be clinically more important and wished to strike a balance between these competing priorities. Members went on to suggest that a strategy for implementation, supported by a suite of tools and guidance would be welcome, and recognised that these changes would need to be driven at a local or PCN level rather than by the ICS. PCNs did have target for reducing the prescribing rates of pMDIs but MGSG heard this is no longer in the objectives for primary care for 2021-22. MM then pointed out that this work is also happening at a national and regional level and GM would risk duplication by embarking on a project to develop these resources. A pragmatic approach may be to wait and use the resources which were expected to come from this national work. MGSG agreed to monitor national developments for the time being. AW is linked in to the GM sustainability board and can provide guidance on this as things progress. Attention turned to how patients may be engaged to help drive the changes and it was acknowledged that some individuals may ask for a change to be made so they can "do their bit" by switching to a low carbon alternative device. MGSG agreed that the pathway was clinically sound and wished to approve for use. However a plan on how it should be implemented is lacking and the decision was to monitor the national and regional work for a steer. **Action: GMMMG to receive the pathway with the carbon and financial impact assessment once finance input has been included.**

	Action: AW to feedback what national work is planned/proposed to aid implementation of these changes.
3.4	**GM Antimicrobial Guideline update from v8.0 to v9.0** The proposed changes to this guideline were approved by MGSG. **Action: GMMMG to receive v9.0 of guidance**
3.5	**Coroner's Regulation 28 letter response – Problematic polypharmacy** AW presented an anonymised version of a Coroner's letter detailing the case of a GM patient who had been in receipt of co-codamol from their GP and had also bought OTC paracetamol, resulting in death from liver failure. In their investigation the coroner pointed to the failure to conduct an adequate medication review, in which the patient should be asked about their use of OTC products. The clinicians and primary care pharmacists on MGSG acknowledged that co-prescribing of these and similar products does happen, is fortunately not common and is recognised to be poor prescribing. OTC purchasing is unlikely to be effectively monitored and since paracetamol can be sold as a general sales list (GSL) product from the supermarket, the patient is unlikely to be asked about the use of other medicines. The group discussed how the current prescribing systems and stretched primary care teams lend themselves towards churning out prescriptions as efficiently as possible, leaving little time for effective review. There is GM guidance in the form of a polypharmacy resource pack published in February 2021, which if followed could be used to address this issue. However MGSG did not feel able to provide any assurance that this is widely used and is being adhered to. The issue may be better addressed by the GM medicines safety work stream and MGSG requested that it is considered for development by the group. **Action: AW to draft response to coroner's letter within requested timescales.**
4.0 GMMMG Governance and BAU	
4.1	**CRG decisions for MGSG consideration and approval** All CRG recommendations were approved. **Action: GMMMG to receive decisions with significant commissioning and finance implications**
4.2	**Guidelines on defining RAG, DNP and Grey** MGSG approved this document on the basis that an update may be required pending the ongoing national work to develop shared care protocols. **Action: GMMMG to receive**
4.3	**IPMO priorities for Medicines Optimisation & Safety workstream** An update was provided by CV regarding the work planned to take place under the MO and safety workstream. This group has not yet met in full but when they do so, plan to test 2 different approaches to delivering the planned outcomes; either a system-wide integrated approach or co-ordinate the outcomes from each sector through separate workstreams.

	The governance and terms of reference and currently being developed and as yet it is not clear what the request of MGSG is to support the delivery of these outcomes. The group heard there is no spare resource from the GM support services to assist. **Action: None required from MGSG**
4.4	**RDTC Monthly Horizon scanning: June** MGSG considered the June horizon scanning document, noting that CRG have already received this and will make any recommendations for amendment to the formulary. PB pointed out a further approval for empagliflozin for the heart failure indication and AM asked the group to note the EMA's approval of setmelanotide, which although currently only indicated for a rare indication, could in future be used to treat other causes of obesity. **Action: None required**
4.5	**MGSG work plan 2020-21** Provided for information and to show the comments from last month have been incorporated. It is a working document and will be updated on an ongoing basis **Action: None required**
4.5	**GMMMG website guidance review** A list of all the current resources on the GMMMG website was presented by AW who asked for the group's input into retiring obsolete and superseded documents. MGSG agreed that RDTC and GM JCT will continue to manage the resource library within existing resource, and to the timescales in the paper as far as is practicable. **Action: RDTC and GM JCT to continue with review**
4.6	**National and regional updates** **Action:** None required
5.0 AOB None raised	
Date of next meeting: 26th July 2021 12:00-14:00 via Teams	