Co-chairs: Robert Hallworth & Dr Peter Budden
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GMMMG Medicines and Guidelines Subgroup
May 24th 2021, 12:00-14:00
via Teams

Minutes

Present:

Name	Title	Organisation	Aug	Sep	Oct	Nov-Mar	Apr	May
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	✓	A (JW)		✓	✓
Dr Richard Darling	GP Prescribing Lead	Heywood, Middleton and Rochdale CCG						
Nigel Dunkerley	Locality Medicines Optimisation Lead	Oldham CCG	✓ (+FT)	✓ (+FT)	A (FT)		A (FT)	✓ (+FT)
Claire Foster	Senior Medicines Optimisation Advisor	MHCC	A (AH)	✓	✓		✓	✓
Lindsay Harper	Chief Pharmacist	Salford Royal NHS FT						
Jonathan Peacock	Chief Pharmacist	Tameside & Glossop NHS FT	✓	✓	A		✓	✓
Gavin Ronaldson	Pharmacy Lead for Medicine	Manchester FT						
Prof. Peter Selby	Consultant Physician	Manchester FT	✓	✓	A			
Anna Swift	Associate Director Medicines Management	Wigan Borough CCG	✓	✓	A			✓
Amanda Fox	Assistant Chief Finance Officer	Oldham CCG		A	✓		A	✓
Rebecca Demaine	Associate Director Commissioning	Trafford 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). Robert Hallworth chaired the meeting
1.1	**Declarations of interest** None declared
1.2	**Minutes of the MGSG April meeting** The minutes were approved an accurate record of the meeting held on 26.04.21
1.3	**Action log review** MM and AW provided an update from GMMMG on actions 042101 and 042102 – see agenda items 1.4 & 2.1 042104 was discussed under agenda item 2.2 DN gave an update on action 042103
1.4	**Update from May GMMMG and CRG on recent MGSG decisions** MM provided a verbal update from GMMMG which included the actions on the azathioprine shared care protocol (SCP) approved by this group in April. GMMMG accepted that the SCP was clinically sound but also that there is variation in how thoroughly these SCPs are commissioned by each area in GM. It was noted that there must be a balance struck between patient safety by publishing a document which all GM areas will adhere to and the commissioning responsibility of each locality. GMMMG agreed to submit the recommendation to GM Directors of Commissioning and ensure that the SCP document is annotated to show which areas have agreed to commission the service. MGSG have not yet been granted delegated decision-making by GMMMG, it is anticipated this will happen soon as GMMMG transitions to a new role as the ICS MO board. A discussion took place on how to improve communication between each of the groups and ensure work is not duplicated. MGSG were reminded that the groups consider different aspects of work; the role of MGSG remains to consider the commissioning and finance implications before which CRG will have made any clinical recommendations on the introduction of new drugs and guidance. There was a request for sharing of work across the region, some of which may not need to be approved via GMMMG routes but will need to have undergone some local governance process. MGSG are happy to consider work will benefit all areas and reduce duplication. **Action:** None required

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 following initial discussions the target for having a single shared care commissioning policy of April 2022 looks ambitious. The success of the work relies on coordinating of all those involved in the plans. The variation in commissioning above is mirrored in the value of the primary care quality schemes, under which GPs are funded to monitor drugs for shared care arrangements. It is believed there is a 3-fold variation in funding which needs to be addressed, therefore CFOs have been requested to share their current schemes to validate these differences. These schemes run for up to 3 years and may be difficult to terminate early in order to introduce a new GM-wide scheme. AW confirmed he was taking on this work in the absence of Katherine Griffiths who is leaving her post with JCT. **Action:** None required from MGSG
2.2	**Pathways update on scoping:** • **Headache** – This is being led by Sarah Jacobs, a scoping document is being developed • **Ophthalmology** – AM attends the GM elective care reform board meetings who are considering the full pathway of ophthalmology services and not just the drugs element. A request has gone to GM MO leads to confirm if this work remains a priority for 2021 and feedback is awaited. • **Moderate RA** – AM will begin work on this soon. It was noted that the block contract finance arrangements currently in place are causing issues HCDs when homecare services are not funded but are essential to the safe management of many drug therapies. **Action: JCT to finalise scoping documents to return to MGSG in June**
3.0 Medicines and Guidance	
3.1	**CRG decisions for MGSG consideration and approval** None for approval
3.2	**NICE NG196: AF diagnosis and management: cost and commissioning impact** Following a discussion at May's meeting of the CRG, MGSG were asked to consider the potential impact of the implementation of this NICE guidance, published in April 2021. The paper outlined 3 issues that the guidance has created; • The use of a new bleeding risk assessment tool, ORBIT, in place of the established HAS-BLED. It will take some time to integrate this into clinical systems, a limitation which NICE have recognised • There is a new recommendation that direct oral anticoagulants (DOACs) will be first choice for stroke prevention in AF unless contraindicated. This will likely mean a continuation of a shift that began before but has been accelerated by the COVID pandemic, from vitamin K anticoagulants to DOACs. Patients not yet taking a DOAC should also be offered the opportunity to switch at their next routine appointment, thereby avoiding issues with capacity. These recommendations have an estimated GM cost impact of £7.5m on drug expenditure over the next 5 years.

	• The third issue is regarding the commissioning of anticoagulant monitoring clinics which NICE have suggested will be gradually decommissioned, potentially *saving* £3.4m over the same 5 year period in GM. Prior to the meeting PB had fed in comments to suggest that the risks of DOACs may not be fully considered by the NICE guidance. It was felt that the group are not well placed to examine the clinical detail of the NICE guidance and should focus on the commissioning and finance implications of the document. MGSG went on to discuss the NICE cost estimate figures and proposed that they were not credible as it is not easy to take costs out of the system simply by decommissioning a service, especially when anticoagulant clinic services are on a block contract rather than a volume driven payment system, and suggested that the real net impact may be somewhere in the range of £4-7m over 5 years. There are many patients for whom a DOAC will not be a suitable treatment for AF, as well as patients who must continue to take Vit K anticoagulants for other indications such as mechanical valves. If a planned programme of decommissioning were to take place this should result in a patient-centric service, that doesn't require patients to travel to have their INR tested. The group discussed what this could look like and suggested that the NICE guidance provides an opportunity for GM to reconsider the anticoagulant model that is in place and design a new GM-wide anticoagulant service. **Action: RDTC to flag to GMMMG with the recommendations made by MGSG**
3.3	**Horizon scanning document (May 2021)** DN picked out the relevant items from the RDTC's monthly horizon scanning • Levofloxacin eye drops – flag to GM antimicrobial working group • Bempedoic acid – discussed by CRG who were unable to place due to lack of clarity on the availability of a PAS price for any primary care prescribing. Recent communication from NHSE confirms this will be available to primary care but that any rebate has been included in the 2021-22 uplift to CCG allocations. **Action: Ensure GM antimicrobial working group aware of levofloxacin eye drop preparation**
3.4	**Aducanumab for dementia – potential impact** The paper presented to MGSG outlines some of the potential issues that may arise should NICE approve aducanumab for mild dementia in Alzheimer's Disease. This is a very common condition ensuring demand will be high and around which there is likely to be a great deal of publicity and political lobbying, so it is important for initial discussions regarding patient access to begin as soon as possible. The NICE TA is scheduled to publish in May 2022, around which time the drug may receive its UK license. An initial assessment of potential costs to GM have been shown to be a significant underestimate of the anticipated list price which will be around £26k per patient per year making the cost to GM in year 1 closer to £8m (it is likely that a discount in the form of a PAS will be negotiated). The group also heard that this does not take into account the costs associated with diagnosis which may require a lumbar puncture or amyloid PET scan as part of the drug's licensing, which is aimed at early AD, the detection of which will likely be done by primary care. Currently GM's mental health services do not appear to have the infrastructure to manage the diagnosis and administration of the drug which may require a day-case setting for IV infusion. If there is a large service redesign required in order to provide access, it was suggested that GM approach Health Innovation Manchester to ask for support. Many MGSG members remember the business case that was required to fund

	Herceptin when it first reach the UK market, and that the circumstances surrounding access to aducanumab have some similarities which could be applied to the current discussions The current opinion is that the drug will be CCG-commissioned, probably via old age psychiatry services. Mental health services, however, have never had to provide a tariff-excluded drug to patients before and therefore do not, at present, have the mechanisms in place to manage this service. It was suggested that the Salford neurology unit may have an interest in prescribing the drug It was pointed out that by May 2022, CCGs will no longer exist, and therefore MGSG felt that this is something that needs to be considered by the ICS board for system-wide implementation. The group agreed that providing access to the drug goes well beyond drug costs and administration and the key to smooth access will be through the development of a GM pathway by linking with the ICS and commissioning and finance colleagues. It was felt to be a good example of why medicines cannot be considered in isolation to the rest of the system and why MO should be engaging as much as possible with the ICS. AF then informed the group that Ben Galbraith has now been named in post as the GM ICS Finance Programme Director. **Action: RDTC to flag the potential financial and commissioning risk to GMMMG**
3.5	**MGSG work plan 2020-21** MGSG discussed the current workplan which is a working document and aims to capture the key priorities for MGSG and CRG as well as the business as usual work that runs in the background. MGSG agreed to remove the cardiometabolic pathway from the list, because this is being done by NICE. It was suggested that the completed pieces of work, displayed in grey, could be moved to the bottom of the document to enable it to be read more easily. The group then discussed the progress to date with the asthma and COPD pathways which are likely to be a system-wide priority in the context of carbon emission savings, driven by the political importance of making these changes. The green inhaler group on which AW sits is looking to accelerate the work which to date has been delayed due to lack of clinical agreement and demonstrating the ICS-level carbon savings. AW stated that ideally GM should look to move towards the lowest carbon inhalers available, but that this would come with significant cost implications, however it should be considered too important to ignore. The group went on to discuss a realistic timescale for implementation of any inhaler switching work, which will almost certainly be limited by the available resource, much of which is focussed on COVID recovery. CF explained that MHCC have included carbon inhaler switches in their PCN DES for 2021 and that the work is being done by PCN pharmacists. The initial data from which should help set a realistic timescale for the work to be completed at an ICS level and allow monitoring implementation against this. **Action: CF to feedback MHCC data on inhaler switches to MGSG when available**
3.6	**National and regional updates** The group were updated on the work being undertaken through the “Enhancing our approach to medicines optimisation and pharmacy” programme, and the roles of RMOC and GMMMG as part of this. The group were reminded that there are consultations running regarding the revised RMOC terms of reference and the first set of draft RMOC national shared care protocols. **Action:** None required

4.0 AOB

None raised

Date of next meeting: 28th June 2021 12:00-14:00 via Teams