Co-chairs: Robert Hallworth & Dr Peter Budden
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GMMMG Medicines and Guidelines Subgroup
October 26th 2020, 12:00-14:00
via Teams

Minutes

Present:

Name	Title	Organisation	Aug	Sep	Oct	Nov-Mar	Apr
Robert Hallworth	Specialist Cancer Pharmacist	NHSE	✓	A	✓		
Dr Pete Budden	GP Prescribing lead	Salford CCG	✓	✓	✓		
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)		
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	✓		
Rebecca Demaine	Associate Director Commissioning	NHS Trafford Clinical Commissioning Group					
Andrew Martin	Strategic MO Pharmacist	GM Joint Commissioning team	✓	✓	✓		
Carol Dolderson	Lead Pharmacist – Medicines Management	RDTC	✓	A	✓		
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 September meeting** The minutes were approved pending the removal of a consultation period being required for sucralfate suspension, which has already been subject to a 6 week GM-wide consultation.
1.3	**Action log review** See action log document. MGSG were keen for GMMMG to provide guidance regarding the mechanism for collation and monitoring of patient safety reports that this group has been tasked with.
1.4	**MGSG Work plan 2020-21** The work plan was discussed and acknowledged to be a "live" document. The addition for the October meeting is a request from GMMMG to support the Indigo Gender Service with the development and governance of a series of shared care protocols for transferring of hormone therapy to primary care. DN has been working with their lead Prescriber (Dr Wookey) to ensure that the documents are fit for purpose, however since GMMMG on 8th October, at which it was agreed transfer of prescribing would be under SCPs, the service have asked for these drugs to have a green status to enable easier transfer of prescribing to GPs. MGSG discussed if this was appropriate and highlighted some other examples where prescribing mechanisms for new services have been overlooked by commissioners, in which the service provider has been expected to accept these costs. It was pointed out GPs are not specialists in this area and in general will not accept prescribing except under a well written SCP, they will also expect initiation to be undertaken by a specialist and only accept when the patient is stable. This has consequences for the commissioning of services and the group found it unacceptable for NHSE in this case to assume that GPs will automatically take on specialist prescribing, this information should be fed back to the service commissioners. MGSG was unanimous that GPs in GM should not be asked to take on prescribing of hormone therapy for gender services before the patient has been established on treatment, and that transfer of prescribing should take place under a shared care protocol. **Action: DN to feed back to Indigo and continue to support development of robust SCPs**
2. Review of GMMMG specialist initiation drugs	
2.1	**Review of Green specialist initiation RAG status post-consultation**

	A list of 9 drugs which the clinical reference group wished to change from green specialist initiation to support treating patients within the community was considered. MGSG agreed with the recommendations made but wished some wording to be altered for the prednisolone enema and budesonide MR capsules preparations. The group were not comfortable with the recommendation that the responsibility for patient counselling of these lies with primary care. If they are to be recommended by secondary care then the patient will be under a specialist IBD team who would be better placed to inform the patient of risks and benefits of treatment.
3.0 Reduce variation in access to shared care across GM	
3.1	**Progress update from IG** CD provided a verbal update of the current work in progress and when this is likely to come to MGSG. A number of consultations are now open, including transfer of prescribing responsibilities to primary care, a new version of the GM shared care protocol template and a review of the RAG criteria. MGSG members were invited to comment during this process.
4.0 FMESG / PaGDSG BAU	
4.1	**Horizon scanning document (October)** MGSG reviewed the horizon scanning report for October and picked out the pending NICE TA for bempedoic acid with/without ezetimibe. The date of publication for which is not available. It was felt this is likely to be specialist initiation and low uptake if supported by the available evidence, however a statement in GM may be needed if the TA is a long way from being published. DN will contact NICE for further information. A new licensed melatonin product is available which requires a review of the current prescribing options. It was noted that esketamine nasal spray has been approved for use by SMC but not NICE
4.2	**Withdrawal of Priadel tablets – update and options** Following the discussion at GMMMG, MGSG were asked to review the current GM position and suggest a way forward to reduce the risks should essential Pharma wish to reinstate the withdrawal of Priadel. The group heard from JW representing GM mental health who has recently discussed this issue because the trusts had begun to initiate new patients on Camcolit. All MH trusts have independently now decided to return to Priadel for new patients. This is due to a high degree of confidence that the CMA investigation will ensure that Priadel remains available in the UK long-term, but which may be at a higher price than currently paid. However once the cost of switching patients and the high price of Camcolit has been taken into account, as well as the benefits of the avoidance of potential patient safety incidents, this is likely to be good value. In addition there is a significant amount of work ongoing to identify all the patients taking lithium in GM and where their prescribing and monitoring is being done. This puts the MH services in a better position to make switches to Camcolit should it be required. MGSG members felt none of the options presented were adequate and that they wished to adopt a watching brief position, whilst continuing to ensure lists of lithium patients are accurate, ensuring a robust response if required.

	DN to feed back to GMMMG

5.0 AOB

None raised

Date of next meeting: 23rd November 12:00-14:00 via Teams