Co-chairs: Robert Hallworth & Dr Peter Budden
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GMMMG Medicines and Guidelines Subgroup
September 20th 2021, 12:00-14:00
via Teams
Minutes

Present:

Name	Title	Organisation	Nov-Mar	Apr	May	Jun	July	Aug	Sep
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	✓	✓
Nigel Dunkerley	Locality Medicines Optimisation Lead	Oldham CCG		A (FT)	✓ (+FT)	✓ (+FT)	✓ (+FT)	✓	✓ (+FT)
Claire Foster/ Lara Shah	Senior Medicines Optimisation Advisor/Deputy MO Lead	MHCC		✓	✓	✓	A (AH)	A (AH)	✓ LS
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	A
Paul Buckley	Chief Pharmacist	Stockport FT					✓	✓	A
Darren Staniforth	HCD Pharmacist	Manchester FT					✓	A (CO)	✓
Hafsa Sattar	HCD Pharmacist	PANHT					✓	A	SE
Juliet Bell	Senior Clinical Pharmacist	Bury GP Federation						✓	A
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					✓	✓	AP
Monica Mason	Head of Prescribing Support	RDTC		✓	✓	✓	✓	A	✓
Dan Newsome	Principal pharmacist	RDTC		✓	✓	✓	✓	✓	✓

1. General Business	
	Welcome and apologies (See register above). Dr Pete Budden chaired the meeting The group welcomed Sian Ellis, deputising for HS. Dr Murugesan Raja who was in attendance for item 3.3
1.1	**Declarations of interest** None declared
1.2	**Minutes of the MGSG August meeting** The minutes were approved an accurate record of the meeting held on 23rd August 2021
1.3	**Action log review** AW provided an update on action 082101. DN provided feedback on items 042103 and RH on 082102
1.4	**Update from September GMMMG and CRG** DN acknowledged that GMMMG meeting for August had been stood down and that the CRG update had been provided as part of the action log review **Action: none required**
2.0 Reduce variation in access to shared care across GM	
2.1	**Update on GM Governance regarding SCP commissioning** This is now a standing agenda item to which AW provided a verbal update. At the August MGSG meeting there was a great deal of disappointment, even anger, that the GM Directors of Commissioning (DoCs)and Directors of Finance (DoFs) appeared to be prioritising savings over safety when the GM single commissioning position for shared care proposal was turned down. A paper drafted to highlight these concerns was due to be discussed by GMMMG at their September meeting, which was unfortunately stood down. However a further attendance by AW at GM DoCs, where the issue was once again discussed, has now caused a rethink and a meeting is set to be arranged between the

	Tameside and Glossop CCG Director of Commissioning, GMMMG finance and commissioning representatives, and GM support services. AW asked for clinician involvement to further demonstrate this is a real issue for those working with the shared care system. MGSG agreed with the next steps and were keen for the group's position to be represented in the planned discussions.
3.0 Medicines and Guidance	
3.1	**GMMMG High Cost drugs assurance frameworks** A paper drafted to highlight some of the problems with the proposed (and one already published) high cost drugs (HCDs) assurance frameworks was discussed. MGSG heard that there are 4 HCD pathways which were drafted by working groups and clinically approved but have not been published because GMMMG had asked for an agreed assurance framework to accompany the pathway This has resulted in out of date pathways in GM, providing opportunity for inequalities in access to and outcome from treatment and a large number of individual funding request (IFR) submissions. There is only one HCD assurance framework in existence in GM, for the psoriasis HCDs pathway. This was developed by the lead commissioner with a single department but has not been implemented. A review of data provided from a shadow assurance framework, conducted in December 2020, concluded that it could not provide the necessary assurance regarding spend and outcomes. MGSG heard it is not possible to collect HCD use data consistently using Blueteq because it has not been rolled out in all GM providers. Comments from CV submitted prior to the meeting suggested that as the ICS matures the system needs to consider a collaborative approach to monitor spend and outcomes of high cost drugs and provide the required assurance. MGSG agreed with this yet also recognised the need for up to date clinical pathways. MGSG agreed with the proposal to separate the clinical pathways from the assurance frameworks at this time, so that safe equitable care can be provided. However caveat is that this assurance is essential and that MGSG will oversee work to implement a workable method of collating it. Discussion then turned to what this assurance system could look like. Blueteq is mandated by NHSE specialised commissioning and is also in use for CCG/ICS commissioned drugs in most GM trusts. It therefore appeared reasonable to explore if this could be implemented in all GM trusts as a starting point. MGSG accepted that it is not an ideal system but could provide useable data if applied correctly. An options appraisal to articulate the alternatives was requested to return to MGSG **Action: HCDs working groups to continue to progress HCDs pathways and return to MGSG prior to consultation** **Action: MGSG to develop options appraisal for HCDs assurance data collection**
3.2	**IBD HCD pathway scoping template** A document was presented to MGSG to ask particular questions about the intended scope of the IBD pathway review which is already underway. The working group have expressed an interest to include some off-label usage of ustekinumab and use of infliximab out with the NICE TAs in the clinical pathway.

	The group heard that a large number of IFRs are being submitted for use of ustekinumab despite there being a commissioning statement advising that the escalated dosage regimen is not deemed suitable for routine commissioning due to limited evidence base for clinical and cost-effectiveness. It was questioned whether the negative commissioning statement is actually useful. One trust representative stated that they screen IFRs before they are submitted to commissioners, and a significant number are turned down internally. It is unclear whether this is consistent approach across GM, but this is rather unlikely. The use of infliximab appears to be accepted practice, is less expensive due to biosimilars being available and is already routinely used in some gastroenterology departments. Further scoping for use in GM is underway. It was agreed that these regimens would be suitable to be included in the pathway as routinely commissioned. MGSG agreed that the pathways should reflect current practice where evidence based and cost-effective. Where a commissioning statement has been produced, the responsibility to produce further evidence to amend this rests with the clinicians making the request. It was acknowledged that there is no established process nor infrastructure in place in GM for monitoring outcomes of drugs approved via IFR route A review of GMEUR service is underway and targeted at removing the function of processing 'not-true IFRs (i.e. not based on grounds of clinical exceptionality but being outside of pathway) meaning these will likely need to be considered elsewhere. Due to the change in funding streams for erstwhile tariff excluded drugs, provider finance teams will now need to have sight of these pathways, which may change the approval routes for the documents. **Action**: None required from MGSG, IBD pathway progress to continue
3.3	**GM Asthma management plan** This item was discussed ahead of item 1.3 to enable Dr Raja (MHCC Clinical Lead for respiratory medicine, and GM&EC SCN GP Clinical Lead for respiratory medicine, who was in attendance, to return to clinical work. MGSG considered the draft asthma management plan and were happy with the clinical content as developed by the asthma working group. The trend for increased use of MART/SMART regimens was noted and that this requires careful monitoring from GP practices to prevent inappropriate use and excess costs. The financial cost of the pathway was noted by AF, who also acknowledged the carbon-reduction benefits. Finance teams will need to accept the primary care budget pressures associated with the work and recognise that sustainable inhaler use will add cost. The carbon footprint savings are not available at this time due to the fact this will vary depending on the uptake of SMART/MART regimes but progress will be tracked across the region and reported on going forward as part of the sustainability agenda. MGSG agreed that this can be opened for 6-week GM-wide consultation after which it will return to MGSG. DN raised the recent news article regarding the purchase of Vectura by the Tobacco giant, Philip Morris International. MGSG believed that there is little that can be done and it is not reasonable to question the ethics of this pharmaceutical company takeover and not others. **Action: RDTC to open for consultation. AM to provide DOIs for working group to RDTC and chairs**

3.4	**Polypharmacy resource pack** This technical update, scheduled to be done every six months was approved. Positive feedback on the document has been received as well as a suggestion that it would be more accessible in a digital format. **Action: RDTC to upload updated document to GMMMG website**
4.0 GMMMG Governance and BAU	
4.1	**CRG decisions for MGSG consideration and approval** All decisions were approved. A discussion was had on the out of date shared care protocols (SCPs) on the GMMMG website. Despite an explanation that these are still valid it appears a number of GPs have declined to accept shared care because the document is past its review date. MGSG should consider writing to GP practices to explain the situation.
4.2	**GMMMG primary care rebate scheme (PCRS) review – Pipexus** MGSG heard that at their August meeting GMMMG approved changes to the ethical framework for primary care rebates. This removed the clause preventing drugs in category A of the drug tariff being considered for rebate schemes. Traditionally GMMMG has been against branded generic prescribing but recent financial pressures have removed this reluctance to accept these rebates. MGSG accepted that PCRS for branded generics are not ideal given the potential for impact on community pharmacy and conflict with secondary care purchasing contracts, but believed the opportunity for significant savings cannot be overlooked. MGSG approved the rebate scheme for Pipexus on the condition that an updated ethical framework is to be produced. **Action: None for MGSG**
4.3	**Blueteq forms – Erenumab for migraine** MGSG accepted the forms for immediate use
4.3	**RDTC Monthly Horizon scanning: September** MGSG received the horizon scanning document from September and noted: • A new liothyronine product • The SMC have taken a different position on inclisiran use to NICE and are recommending it for specialist use only. A paper on lipid pathways at the October meeting is expected to discuss this in more detail. **Action: None**
4.4	**MGSG work plan 2020-21** For information **Action: None required**

4.5	**National and regional updates** None received **Action:** None required

5.0 AOB

DS shared the recently published AAC lipid pathway documents for consideration. These will be discussed in more detail at the October meeting with a paper on GM lipid pathways

Date of next meeting: 25th October 2021 12:00-14:00 via Teams