Co-chairs: Robert Hallworth & Dr Peter Budden
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GMMMG Medicines and Guidelines Subgroup
November 22nd 2021, 12:00-14:00
via Teams
Minutes

Present:

Name	Title	Organisation	May	Jun	July	Aug	Sep	Oct	Nov
Robert Hallworth	Specialist Cancer Pharmacist	NHSE	✓	✓	✓	✓	✓	✓	✓
Dr Pete Budden	GP Prescribing lead	Salford CCG	A	✓	A	A	✓	✓	✓
Petra Brown	Chief Pharmacist	Pennine care NHS FT	✓	✓	A	✓	✓	A	✓
Nigel Dunkerley	Locality Medicines Optimisation Lead	Oldham CCG	✓ (+FT)	✓ (+FT)	✓ (+FT)	✓	✓ (+FT)	FT	✓ (+FT)
Claire Foster/ Lara Shah	Senior Medicines Optimisation Advisor/Deputy MO Lead	MHCC	✓	✓	A (AH)	A (AH)	✓ LS	✓ LS	✓ LS
Jonathan Peacock	Chief Pharmacist	Tameside & Glossop NHS FT	✓	✓	✓	✓	A	✓	A
Prof. Peter Selby	Consultant Physician	Manchester FT				A	A	A	A
Anna Swift	Associate Director Medicines Management	Wigan Borough CCG	✓	A	A	✓	A	A	✓
Amanda Fox	Assistant Chief Finance Officer	Oldham CCG	✓	✓	✓	A (KR)	✓	✓	✓
Rebecca Demaine	Associate Director Commissioning	Trafford CCG	✓	A	✓	✓	✓	A	✓
Claire Vaughan	Head of Medicines Optimisation	Salford CCG		✓	A	A	A	(TSM)	A
Paul Buckley	Chief Pharmacist	Stockport FT			✓	✓	A	A	A
Darren Staniforth	HCD Pharmacist	Manchester FT			✓	A (CO)	✓	✓	✓
Hafsa Sattar	HCD Pharmacist	PANHT			✓	A	SE	SE	✓
Juliet Bell	Senior Clinical Pharmacist	Bury GP Federation				✓	A	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	AP	✓
Monica Mason	Head of Prescribing Support	RDTC	✓	✓	✓	A	✓	A	A
Dan Newsome	Principal pharmacist	RDTC	✓	✓	✓	✓	✓	✓	✓

1. General Business	
	Welcome and apologies (see register above). Dr Pete Budden chaired the meeting
1.1	**Declarations of interest** None declared
1.2	**Minutes of the MGSG October meeting** The minutes were approved as an accurate record of the meeting held on 25th October 2021
1.3	**Action log review** An update was received on all the actions on the log. Action 102102 was closed for the time being due to the proposed review of GM HCDs assurance data which would incorporate this action.
1.4	**Update from November GMMMG and CRG** AW provided an update on CRG recommendations. **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. A paper was considered at the November meeting of GMMMG, which reflected the views of this group. The objective of the paper was to seek GMMMG input in order to take to the GM Primary Care Clinical Cell group for a mandate to progress the work. The chair of the Primary Care Clinical Cell was at GMMMG and asked that the paper be returned as a proposal paper, prior to submission to primary care cell. In order to retain the views of MGSG, it was proposed that a smaller group of members support AW to ensure that the proposal paper captures the recommendations made by this group. There appears to be little national appetite to resolve this situation so any solution will need to come from a GM or wider North West regional level.

	It was also noted that there is the outstanding response to the Coroner in regard to the shared care of lithium. **Action: AW, RD, LS and DN agreed to meet outside the meeting and further define the recommendations that MGSG believe are required in order to make shared care safe across GM.**
2.2	**GMMMG Melatonin SCP for children and adolescents** This item involves a SCP that was nearly fully developed when MGSG recommended a pause on all SCP development and to wait for RMOC. The SCP on the GMMMG website is out of date and it appears unlikely that RMOC will undertake the development of a national SCP for melatonin, however it is acknowledged that it is not clear when it is coming or what will be included in the next phase of this work. MGSG recognised the commissioning gap flagged by CRG at their November meeting, namely the lack of an adult service for adolescents to transition into. Currently once discharged they are under the care of their GP who is unlikely to have the knowledge and experience to discontinue or make a positive recommendation about length of treatment of this drug. Noting this issue, MGSG agreed that there needs to be more information in the document and for initiating clinicians to state the anticipated length of treatment, advise how to appropriately manage trial drug holidays and when and how to withdraw treatment. MGSG did not approve this SCP for publication and asked for the above issues to be reconsidered by CRG. **Action: RDTC to return the SCP to CRG for further development.**
3.0 Medicines and Guidance	
3.1	**EUR review and implications for the GMMMG HCDs pathways** This item was discussed between items 1.2 and 1.3 to enable Anna Pracz to be present. AP presented a report of the drug IFRs submitted within GM. It was explained that it is difficult to identify any themes due to the relatively low numbers (78), a significant proportion of IFRs are for patients who reach the end of the commissioned HCD pathway. MGSG heard that only a small minority of all the IFRs submitted were able to demonstrate true exceptionality, which is typically defined as: the patient being significantly different to the general population of patients with the condition in question and they are likely to gain significantly more benefit from the intervention than might normally be expected for patients with that condition. MGSG also heard that the proposed changes to the IFR process are likely to result in a single IFR panel being formed for the GM commissioners which will only consider requests where exceptionality has been demonstrated. This will be the case for all devices and procedures as well as medicines. The group welcomed the aims of the review which are to provide standardisation of IFR decisions for truly exceptional patients, but were concerned that the changes could introduce more inequity. This was raised in the context of patients who do not meet the exceptionality criteria but still need treatment. Under current rules these patients may receive this treatment at the provider trust at the trust's expense, but that this practice is variable and may depend on the size and financial situation of the provider, introducing further variation across GM.

	It was recognised that the clinical triage and IFR panels in operation in GM currently provide a valuable service that would be difficult to replicate within trusts, it was thought this could be necessary if a large proportion of requests are no longer being processed by the GM-wide route. MGSG went on to discuss how outcomes from IFR decisions will be monitored, the current system aspires to collect this data but there is no structure or process to do so. A replacement system should look to build this into the service. Should the review be implemented as planned there is potentially a very significant amount of work required from GMMMG to write and to update commissioning statements to cover a GM position on numerous cohorts of patients who would previously have been managed via the prior approval/IFR system. These would need to be produced rapidly after the process goes live. MGSG accepted the current system was not perfect but that it does work, albeit with some potential for inequity that results from a number of panels making the decisions. They asked that a new system should build on the successes of the current one and seek to address how patients can be fairly managed, should they not be deemed exceptional or the request for treatment is rejected. **Action: Comments and feedback on the proposals should be provided to AW**
3.2	**GMMMG HCDs pathway for rheumatoid arthritis** This update to the existing rheumatoid arthritis (RA) HCDs pathway includes a number of new TAs as well as provision for moderate RA. The pathway incorporates the proposed changes discussed in the above agenda item such as removal of IFR recommendation at the end of pathway which is replaced by MDT. It is accepted these are in the consultation stage but also that a change is required to HCD pathways to provide equity across GM. The pathway also recommends the use of a number of products outside product license and/or their NICE TA, these are: • The addition of using abatacept and rituximab as monotherapy (i.e. on its own or with a DMARD that is not MTX) which is off label & outside NICE guidance • The addition of the use of 40mg once weekly adalimumab which is licensed in monotherapy (defined by manufacturer as adalimumab without methotrexate) but now recommends weekly use with MTX and or other DMARDs. These are likely to be cost-neutral or possibly cost-saving in the case of adalimumab because the numbers of patients in these groups are small and without these treatment options, would otherwise use a similarly priced (or, in the case of adalimumab, more expensive) treatment option. MGSG approved the pathway to open for consultation **Action: Open for 6 week GM-wide consultation**
3.3	**GM COPD Management plan – update to include Trimbow NEXThaler DPI** AM proposed an update to the recently approved COPD management plan. Since the publication of the guideline in September 2021, Trimbow NEXThaler has received a marketing authorisation, which offers a triple therapy MDI option, is lower cost and lower carbon impact than the products it is recommended it replaces.

	MGSG agreed with the proposal and suggested this update be included without the need for further consultation. A further minor update to include the recommendation of a spacer being used with MDI devices was also approved. **Action: Updated COPD management plan to be published to the GMMMG website**
4.0 GMMMG Governance and BAU	
4.1	**CRG decisions for MGSG consideration and approval** Following some discussion about the merits of giving duloxetine 90mg and 120mg capsules a DNP vs Grey RAG status, the CRG recommendations were approved by MGSG, who agreed with a Grey status for duloxetine. **Action: RDTC to communicate these decisions to GMMMG and update formulary and RAG list as appropriate**
4.2	**Primary Care rebate Schemes** MGSG considered recommendations for 3 PCRS: • Pradaxa (dabigatran) – recommendation to reject because the scheme is only applicable to volumes of prescribing in excess of a baseline. MGSG agreed • Dacepton D-mine (apomorphine) pen – manufacturer has since withdrawn rebate scheme • Dacepton D-mine (apomorphine) pump – recommendation to reject due to terms of the scheme requiring the collection of patient data for processing by a 3rd party. MGSG agreed **Action: JCT to communicate decisions to manufacturers as appropriate**
4.3	**RDTC Monthly Horizon scanning: November** MGSG received the horizon scanning document from November and noted: • Icosapent ethyl – Wait for NICE TA, due March 2022 • Semaglutide injection (Wegovy) indicated for weight loss – also due for a NICE TA in March 2022. **Action: None required**
4.4	**MGSG work plan 2020-21** For information **Action: None required**
4.5	**National and regional updates** AW explained that the antimicrobial stewardship group are considering an update to the GM antimicrobial guidelines to incorporate the management of patients who are prescribed empirical antibiotics where a longer course or higher dose may be required. It was suggested that this could be in the form of an appendix to the document.

	Action: None required

5.0 AOB

None raised

Date of next meeting: 24th January 2022 12:00-14:00 via Teams