Minutes of the GMMMG Clinical Reference Group Meeting
Tuesday November 9th 2021, 12:00-14:00
via MS Teams

Name	Title	Organisation	Jun	Jul	Aug	Sep	Oct	Nov
Dr Connie Chen (CC)	GP Lead Medicines Optimisation	Manchester Health and Care Commissioning	✓	✓	✓	✓	✓	✓
Dr Hina Siddiqi (HS)	GP		A	A	A	A	A	A
Dr Jonathan Schofield(JS)	Consultant physician acute medicine & diabetes	Manchester FT	✓	A	A	✓	✓	✓
Sarah Boulger SB)	Medicines Information Pharmacist	Pennine Acute	A	✓	A	✓	A	✓
Suzanne Schneider (SS)	Medicines Information Pharmacist	Bolton FT	✓	✓	✓	✓	A	✓
Gary Masterman (GM)	Associate Director of Pharmacy	Wrightington, Wigan and Leigh FT	✓	A	✓	A	✓	✓
Andrea Marrosu (AM)	High cost medicines and home care pharmacist	Salford Royal FT	A	✓	A	✓	✓	A
Peter Marks (PM)	LPC Board Member	GM LPC	A	A	A	A	A	A
Keith Pearson (KP)	Head of Medicines Optimisation	Heywood, Middleton & Rochdale CCG	✓	✓	A	A	✓	✓
Lucy Tetler (LT)	Medicines Optimisation Pharmacist	Bury CCG	✓	✓	✓	A	✓	✓
Helen Isherwood (HI)	Medicines Optimisation Pharmacist	Manchester FT	✓	✓	✓	✓	✓	A
Steven Buckley (SB)	Director of pharmacy	GM Mental Health FT	✓ (SB)	A	✓	A	A	✓
Faduma Abukar (FA)	Head of medicines management	Stockport CCG	✓	A	✓	A	✓	✓
Zoe Trumper (ZT)	Assistant director of medicines management	Wigan Borough CCG	✓	✓	A	✓	A	A
Faisal Bokhari (FB)	Deputy Head of Medicines Optimisation	Tameside & Glossop CCG	✓	✓	✓	✓	✓	✓
Jennifer Bartlett (JB)	Team Leader Neighborhood Integrated Practice Pharmacists	Salford Royal FT	✓	✓	✓	✓	A	✓
Claire Foster (CF)	Senior Medicines Optimisation Adviser	Manchester Health and Care Commissioning	✓	✓ AH	A	✓ AH	A	✓
Jole Hannan (JH)	CCG Interface Pharmacist	Bolton CCG		✓	✓	✓	✓	✓
Consultant Rheumatologist Audrey Low Ben Parker Charlie Flier Dipak Roy Louise Mercer Meghna Jani Sahena Haque Anindita Paul		SRFT MFT Stockport TGH Stockport SRFT UHSM Bolton			✓ AL	A	✓ AP	✓ LM

Lizzie Okpara (LO)	Lead Pharmacist Medicines Management	RDTC	✓	✓	✓	A	A	A
Dan Newsome (DN)	Principal Pharmacist	RDTC	A	✓	✓	✓	✓	✓
Nancy Kane (NK)	Senior medical information scientist	RDTC						✓
Conor McCahill (CM)	Senior Pharmacist	RDTC				✓	A	A
Andrew White (AW)	Head of Medicines Optimisation	JCT	✓	✓	✓	✓	A	✓
Andrew Martin (AMart)	Strategic Medicines Optimisation Pharmacist	JCT	A	✓	✓	✓	✓	✓
Karina Osowska (KO)	Medicines Optimisation Pharmacist	JCT	✓	A	✓	✓	A	✓

1. General Business	
1.1	**Welcome and apologies** The chair welcomed the group and noted apologies as above. Dr Mars Skae, consultant paediatric endocrinologist at Royal Manchester Children's Hospital, joined the meeting for item 3.3 only, which was discussed at the start of the meeting.
1.2	**Declarations of interest** No new interests were declared
1.3	**Minutes of the last meeting** The minutes of the October 2021 meeting were agreed as a true record.
1.4	**Action log review** See action log
1.5	**Update from October MGSG meeting** DN updated the group that the inflammatory bowel disease high cost drugs pathway was approved to open for GM-wide consultation. An evidence review of dose escalation for ustekinumab in Crohn's disease did not identify any new evidence, so this will not be routinely commissioned but the implications of which will be considered alongside a EUR review which is being discussed by GMMMG later this week. There may be a number of commissioning statements that require discussion and approval by CRG following this EUR review. MGSG agreed that the narcolepsy pathway is a priority piece of work but that current resource availability dictates it should be picked up after one of the HCD pathways currently in process is completed. An update to the GM antimicrobial guidelines was approved and is live on the website. An update was given on inclisiran. There is a clear view from NHSE/I that inclisiran should be a green drug on formularies and delivered in primary care. The cost to hospitals is not clear at present; if ordered by usual channels the costs appear higher than the commercial access agreement available only to primary care at present, but other mechanisms may exist. Health Innovation Manchester expect to have a case finding tool live on GP clinical systems by end of November, though it is currently not clear if this will apply to all GP systems in use in GM. Inclisiran may disrupt pathways, and raises questions on the place for PCSK9 inhibitors. This will

	be discussed further at GMMMG later this week, and an accelerated access collaborative lipid pathway is expected in November. HinM also implied that other treatments are also likely to come via this AAC route in future.
2.0 Matters arising	

2.1	**Consultation feedback on September 21 actions**
	No comments were received on the following recommendations:
	• Insulin degludec for type 1 and type 2 diabetes: GREEN following specialist initiation and GREY (criterion 3), only for use:
	  ○ If there is particular concern about nocturnal hypoglycaemia despite optimisation of medication regimen
	  ○ For patients with an unpredictable lifestyle (e.g. shift workers)
	  ○ For patients who need help from a carer or healthcare professional to administer injections [NEW from NG17]
	• Dapsone 50mg & 100mg tablets as second line option for *Pneumocystis carinii* pneumonia (PCP) prophylaxis, and isoniazid 100mg tablets for TB prophylaxis in renal patients considered to be at high risk of developing TB: GREEN following specialist initiation
	
	One comment was submitted on the proposal to assign duloxetine 90 mg & 120 mg capsules GREEN & Grey (criterion 2) status, only for use where the prescriber believes that patient's pill burden is high enough to justify the extra cost associated with the use of these formulations. The commenter felt the grey criterion was subjective, but CRG agreed that what constitutes an excessive pill burden will vary with the individual. It was agreed to enact this recommendation as per the consultation.
	
	Action: RDTC to submit these actions to MGSG for information and enact on the GMMMG website.

3.0 Formulary and RAG	
3.1	**Formulary Amendments October 2021** CRG approved the formulary amendments to open for consultation. **Action:** RDTC to open these decisions for GMMMG consultation as appropriate
3.2	**Haloperidol 500 microgram tablets – DNP assessment** The group reviewed a Do Not Prescribe (DNP) assessment, and agreed that, since licensed liquids are available and are significantly more cost-effective, haloperidol 500 microgram tablets should be assigned a DNP status under criterion 2 (Drug is clinically effective but more cost-effective products are available). The group heard that work has already begun in some areas to reduce use of the tablets, and that via communication with the manufacturers of the liquid assurance has been provided, that there is adequate supply to support a switch if this was to be recommended. CRG heard there is no clinical concern with switching from tablets to liquid in terms of characteristics or acceptability.

	Action: RDTC to open this decision for GM-wide consultation.
3.3	**Testosterone for delayed puberty – RAG change request** Dr Mars Skae presented this item. She explained that a number of boys attend clinic for this indication, and endocrinologists usually liaise with GPs to coordinate starting testosterone in secondary care and increasing the dose over several months. Secondary care retains responsibility for reviewing the patient regularly, advising on appropriate doses, and carrying out any monitoring that is clinically indicated. Monthly IM injection is the preferred route in order to support adherence. This is usually not problematic, although the pandemic has presented barriers. The ask is for this practice to resume, in line with the current GMMMG RAG of Green specialist initiation, but there has been some pushback from primary care. This results in patients having to attend clinic, which presents service pressures, hence the request for primary care to take on initiation and amend the RAG to Green specialist *advice.* The only safety issue identified was that Sustanon contains peanut oil, so must be avoided in patients with anaphylaxis. Other preparations can be used in this population and no anaphylaxis has ever been encountered in this setting. The group heard that it is challenging to start this treatment in clinic, since appointments are short and the time is required to explain the treatment to the patient and parents and/or carers. Additionally, there is no nurse available in clinic to pick up the administration. Administering at a later appointment allows patients and parents time to digest the information given, and ask follow-up questions prior to starting treatment. However primary care representatives reported that the information shared with patients prior to first administration is not always adequate, and some attend primary care appointments with little or no understanding that they are due to start an injected treatment. Giving first injection in a setting where neither patient nor person administering the injection is familiar with the drug can be extremely challenging and could undermine patient and carer confidence in the treatment There are also capacity pressures in general practice, in that not all practices have nursing staff available to administer. It was acknowledged however that administering the treatment in primary care is likely to be less disruptive for patients and result in fewer missed hours at school. There was a query around why the regular monitoring outlined in the product summary of characteristics is not recommended in this patient population. Dr Skae explained that monitoring of haematocrit is traditionally done in the adult settings, particularly in people with prostate issues or cancers. The BSPED guideline on testosterone in infancy and adolescence is used by most endocrinologists, and does not recommend routine monitoring. Regular bloods therefore aren't recommended in GM, and the service is not aware of any clinical or safety issues that have arisen as a result of this practice. Secondary care services do regularly review patients, and would undertake any monitoring that was clinically indicated. There followed a discussion around what RAG status is most appropriate, AMBER shared care was considered due to the potential for separation of the prescribing and monitoring, but the group consensus was to continue with the current status of GREEN (following specialist initiation), together with an information leaflet for prescribers. It was agreed that ongoing communication between specialist and primary care is a key issue that needs to be consistent. **Action:** Dr Skae & LK to discuss outside the meeting to develop an information leaflet, and bring back to a future CRG meeting.
3.4	**Trurapi (biosimilar insulin aspart) – formulary application**

	An application was received for Trurapi, a biosimilar of insulin aspart (NovoRapid), which has high use in Greater Manchester in both T1DM and T2DM. An evidence review suggested that the efficacy and safety profiles of the two products is very similar. Trurapi is supplied in a pen which is already in clinical use, and which closely resembles the NovoRapid products in its colour and design. From a patient perspective this was felt to be helpful in aiding its use, but group considered whether there is potential for confusion, particularly when dispensing, given this similarity, but it was felt that the difference in names mitigate this risk. It was also noted that cartridges and reusable pens are available for Trurapi. No information was available on relative carbon impact of these presentations, but it was felt that reducing single-use plastics was desirable. The group's preference was that Trurapi should be the first-line formulary choice for new starters of fast-acting bolus insulins. Switch programs for existing patients present logistical issues and would need local assessment and implementation. For example, guidelines in use at MFT recommend NovoRapid for short-term peri-operative use, which may be similar in other trusts. DN highlighted that NovoRapid is currently a second choice option on formulary, but has much higher use in GM than the current first-line choices. NICE guidance currently recommends that where a biosimilar becomes available, a conversation should happen between prescriber and patient to assess whether a switch is appropriate. There is a substantial cost difference; the list price of Trurapi is 30% lower than NovoRapid, and savings of over £1 million per year may be possible in GM if patients were to switch. There is a GM statement that biosimilars of high cost drugs should be adopted, as best value options. The group discussed that this could be amended to encompass all biosimilars that are clinically equivalent to the originator product, but noted that the assurance that use is appropriate comes from discussions at CRG. It was agreed that these should still occur for each new product to provide this assurance and to assess formulary placement, therefore an update to the GMMMG biosimilars statement was not thought necessary at this time. The group also agreed that the formulary should be reviewed and updated to reflect the in practice first-line choices of insulin and to ensure that each included insulin is identified by both brand and insulin type. **Action**: RDTC to open GM-wide consultation; Trurapi to be added to formulary as the first line fast-acting insulin, ahead of NovoRapid, and with a preference for refills rather than new pens to reduce single use plastics. **Action**: carbon impact of insulin devices to be flagged to the GM sustainability group for assessment
4.0 Pathways and Clinical Guidelines	
4.1	**GM Neuropathic Pain Guideline** A review of this existing GMMMG guidance was requested by MGSG in June. A technical review was conducted, so no working group was needed. The review identified that the recommendations on amitriptyline titration and duloxetine couldn't be supported by the available evidence, so advice was sought from clinicians at MFT & SRFT. These recommendations have therefore been updated to reflect the BNF & SPC recommendations for these drugs. Amitriptyline remains first line, gabapentinoids second line, and duloxetine third line. CRG are asked to approve this guideline for publication. The group had some minor comments and requests:

	• The recommendation on drugs not to be prescribed to be made clearer/more bold • Statement to be added around avoiding use of multiple serotonergic drugs (e.g. for neuropathic pain and depression) where possible, and to assess patients holistically to minimise the number of medicines prescribed where possible, as well as providing a link to a useful SPS resource. • Recommendations on assessing anticholinergic burden prior to medicine initiation to be added. • There is a tendency for users to go straight to the algorithm, so could this be expanded to include more of the explanatory notes. • Given the discussion above regarding duloxetine 90mg and 120mg, could the wording in this guidance be clarified to specify 60mg tablets once or twice daily. • Current wording on tramadol is vague; can this be reviewed to define the terms short term and long term in this context. • Statement on nortriptyline to be added. The group queried whether gabapentin was intended to be placed ahead of pregabalin, since pregabalin is now the more cost-effective option. It was acknowledged that this recommendation likely dates from when gabapentin was the lower cost option, and should be reviewed. Once amendments are made, a judgement will be made on whether the updated version differs sufficiently from the existing guidance to require GM-wide consultation. If consultation is not required, the guidance will be submitted to MGSG for information and published on the web. **Action:** JCT to make suggested amendments, with input from SB, SS, and JH.
4.2	**Acne Guidance review – Project scoping tool** The GM acne pathway was developed by a dermatology working group in 2015 as part of a suite of primary care pathways. NICE guidance has now been published, so the pathway and formulary need to be reviewed to align. Proposed changes include: • Alignment with NICE NG198 & GMMMG antimicrobial guidance. • Acne severity grading • Changes to oral & topical treatment choice In line with GMMMG process, a working group is required to update this guidance. A dermatology clinician from SRFT has already been identified but further members are needed, ideally a GPwSI and primary care nurses if possible. Timescale for update will depend on when the working group is able to form, but it is hoped that a draft can be returned to CRG for the January or February meeting. **Action**: CRG members to nominate working group members to ensure GM-wide representation from both primary and secondary care and communicate these to KO.
5.0 Shared care	
5.1	**Melatonin shared care protocol** At last meeting there was discussion around melatonin liquid and the melatonin shared care protocol for children which was first updated in 2019 to add Slenyto. The SCP has been for GM-

	wide consultation but was delayed by the pandemic, and then by the ongoing discussions around shared care in GM. The draft discussed today had one amendment, which attempts to give examples of exceptional circumstances which may warrant use of a melatonin liquid. The group agreed this amendment, and made request for two further minor amendments: • Wording to clarify that the concern around use of the licensed Colonis liquid in children is to do with excipients, and not any intrinsic safety problem with melatonin itself. • Wording to clarify that crushing tablets or otherwise changing the formulation of a licensed medicine will render its use off-label. The current draft recommends that informed consent for off-label use is obtained "where applicable", but doesn't acknowledge that any crushing of tablets under this SCP will be off-label. The group discussed the issues around patients who turn 18 and graduate from paediatric services. A SCP for melatonin in adults was developed and was subsequently withdrawn because there are no adult services in GM. It would therefore be useful to give clear advice on how to manage care for these patients who are no longer under a specialist. A blanket recommendation to stop at 18 is not appropriate, but if there is no service for adults, the alternative is for the GP to review and decide on continuing prescribing. It was agreed that this should be flagged to MGSG as a commissioning gap. The group agreed that shared care is not the ideal mechanism to manage melatonin prescribing, but may be the best mechanism currently available. **Action**: DN to submit to MGSG for approval following amendments as agreed, with request to assess the commissioning issues at the boundary between paediatric and adult services.
6.0 Work plan and horizon scanning	
6.1	**Horizon scanning October 2021** There were several items of note. • New Trimbow DPI, which will be assessed for inclusion in COPD pathway. • Ryeqo for uterine fibroids, which is on the NICE agenda. A technology appraisal is expected in June 2022. Advice will be sought from primary care on whether a GM position is needed in advance of this. • Tirbanibulin for actinic keratosis, which is in scope of GM primary care pathways on AK. **Action:** CRG members to feedback on whether there is appetite from their organisations to use these products ahead of NICE guidance/formulary applications.
6.2	**MGSG work plan** Received for information.
7.0 AOB SB raised that there is a mechanism in secondary care whereby prescribers are notified of lithium levels above a certain threshold by phone. There is an ask from certain labs measuring lithium levels to increase the threshold at which this happens, possibly due to capacity issues, which presents a potential safety risk. The group agreed that this change would not be considered safe and could be contrary to internal lithium monitoring procedures and guidance. Representatives from the acute trusts and mental health agreed to further explore within their own organisations and communicate their findings with SB who will write a paper.	

Action: SB prepare a paper for submission to MGSG, stressing the safety implications
Date of next meeting: Tuesday 14th December 12:00-14:00 via Teams