Minutes of the GMMMG Clinical Reference Group Meeting
Tuesday May 10th 2022, 12:00-14:00
via MS Teams

Name	Title	Organisation	Nov	Dec	Feb	Mar	Apr	May
Dr Peter Budden (PB)	GP	St Andrews Medical Practice					✓	✓
Dr Helen Burgess (HB)	GP	Manchester Health and Care Commissioning					✓	A
Dr Jonathan Schofield(JS)	Consultant physician acute medicine & diabetes	Manchester FT	✓	✓	✓	✓	✓	✓
Sarah Boulger (SBo)	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	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	✓	✓	✓	✓	SM	✓
Steven Buckley (SB)	Director of pharmacy	GM Mental Health FT	✓	A	✓	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	✓	✓	A	✓	✓	A
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)
Jole Hannan (JH)	CCG Interface Pharmacist	Bolton CCG	✓	✓	✓	✓	✓	✓
Jacqueline Coleman (JC)	Medicines Optimisation, Interface Pharmacist	Stockport CCG				✓	A	
Consultant Rheumatologist Audrey Low Ben Parker Charlie Flier		SRFT MFT Stockport	✓ LM	✓ DR	A	✓ AL	✓ AP	A

Dipak Roy Louise Mercer Meghna Jani Sahena Haque Anindita Paul		TGH Stockport SRFT UHSM Bolton						
Dan Newsome (DN)	Principal Pharmacist	RDTC	✓	✓	✓	A	✓	✓
Nancy Kane (NK)	Senior medical information scientist	RDTC	✓	A	A	A	✓	✓
Conor McCahill (CM)	Senior Pharmacist	RDTC	A	✓	✓	✓	✓	✓
Andrew White (AW)	Head of Medicines Optimisation	JCT	✓	✓	✓	✓	✓	✓
Andrew Martin (AMart)	Strategic Medicines Optimisation Pharmacist	JCT	✓	✓	✓	✓	✓	✓
Karina Osowska (KO)	Medicines Optimisation Pharmacist	JCT	✓	A	✓	A	A	A

1. General Business	
1.1	**Welcome and apologies** The chair welcomed the group and noted apologies as above. Anna Pracz and Elaine Radcliffe from the GM JCT were in attendance.
1.2	**Declarations of interest** Previously declared where relevant. No new declarations of interest were submitted.
1.3	**Draft April 2022 CRG Minutes** The April 2022 CRG Minutes were accepted. The date on the header was incorrect (showed March instead of April) and will be amended.
1.4	**Action log review** Most items had no updates, the action owners will be approached for updates. **05212.1—NG196 – Availability of ORBIT bleeding risk tool** Suggested that as no significant updates, this item is closed. ORBIT will be rolled out when ready, and NICE have other tools until this is available. **08215.5—SCP for melatonin in children and adolescents** CAMHS team comments have been returned. RDTC will update in line with these, send back via CAMHS, then to CRG to progress this item.
1.5	**Update from GMMMG** Update given to CRG by AW.
2.0 Matters arising	
2.1	**CRG Consultation March 2022** No comments were received on March actions.

	It was clarified to CRG that moxonidine came with no expected cost or commissioning impact with current plan for green with specialist initiation in RAG list. **Action**: RDTC to submit actions to GMMMG for approval.
2.2	**CRG terms of reference** It was explained to the group that the restructuring of GMMMG, and the move towards an ICS, means that the terms of reference for all subgroups are being reviewed. This is in part to ensure that all functions that are required are accounted for and are split between the subgroups in an efficient way.
3.0 Formulary and RAG	
3.1	**Formulary Amendments April 2022** CRG approved the formulary amendments to open for consultation and noted the following: **1.** Inadvertent oral administration of potassium permanganate The NPSA alert for the inadvertent oral administration of potassium permanganate was discussed, specifically with regards to CRG"s role in actioning these alerts. It was noted that CRG does not have access to primary care functions in the same way that local APCs would, and that it should be reviewed at trust area committee level. It was noted that other NPSA alerts are not put out for consultation and feedback on implementation. It was asked if to the GMMMG IPMO group could be asked to look at actioning and providing assurance into these and similar alerts, and although this was felt to be reasonable in principle, it was noted that with current workplan capacity it may not be feasible to consider at this point. It was also noted that IPMO priorities already agreed, and similar items previously rejected as the intention is strategic perspective rather than individual item consideration and prioritisation. The action is for providers to look at this as per NPSA alert and recommend to GMMMG for formulary change if required. (CRG not actively looking at this.) **Action:** RDTC to open formulary amendments for GMMMG consultation
3.2	**DPP4 Inhibitors – Formulary Review** It was explained that sitagliptin comes off patent in September and that there will be significant savings to be made even if no action is taken. The likely generic price is currently unknown but is estimated to be at least a 40-80% reduction from current brand price. The current document is a comparison document, though there is a longer one that can be provided to CRG if requested. The current first-line choice in GM is alogliptin (on a cost basis) and it has the highest prescribing rate amongst DPP4 inhibitors. Other DPP4 inhibitors were kept due to significant prescribing rates and/or clinical advantages on the last occasion that this formulary section was reviewed The current proposal is to remove alogliptin as the first line DPP4 inhibitor and leave as an alternative option, promoting sitagliptin to first-line based on cost. It was noted there is precedence for this, and this is what happened when alogliptin was placed as the first-line option.

	It was noted that there is a recent FDA warning regarding alogliptin and saxagliptin with regards to heart failure, though it was questioned whether it would be appropriate to add this information as it hasn't come from the MHRA or EMA, and whether appropriate to pre-empt regulator. Concerns were raised around swapping programme when patients were swapped recently (a few years ago) to alogliptin for cost savings. May have pushback from CCGs due to volume of patients and expected complaints. It was noted that the way this is presented will have to be careful, in that it needs to be realistic – if savings are suggested based on significant numbers of conversions, it puts more pressure onto local teams to meet those targets. CRG acknowledged their role in making the strategic decisions but that the degree and method of implementation should be determined by locality. Vildagliptin was mentioned as another DPP4 inhibitor coming off patent shortly, though it was noted that there is a very low volume of prescribing compared to other DPP4 inhibitors and it may be easier to keep formulary simpler. Saxagliptin is the next DPP4 inhibitor off patent, so it was decided to leave as-is (as an alternative option) to avoid converting too many patients off of it. . **Decision**: CRG happy to reposition DPP4 inhibitors to move sitagliptin to first-choice, with others (including alogliptin) as alternatives.
3.3	**Dulaglutide formulary position amendment request** This request is to move dulaglutide to equal first-line position alongside semaglutide (current first-line option). It was noted that this was reviewed in October 2019, and there was some desire from CRG to remove dulaglutide on basis of lack of CVD outcome data, however there is now more published data to support dulaglutide use in patients at high risk of CVD. The NICE meta-analyses suggest semaglutide dominates all other options at any other point in the care pathway for all patient groups. Current prescribing ratio is 42% for dulaglutide and 58% for semaglutide, in Greater Manchester, showing that the current formulary position is not limiting access. It was noted that liraglutide patent expires in February 2023, whereas dulaglutide expires in 2029. It was also noted that NICE suggest more cost effective is semaglutide, and so there is little justification to move dulaglutide to (equal) first-line choice, especially as semaglutide dominates in most situations. This is despite some clinicians preferring dulaglutide as it has an easier device for use. **Decision:** No change to the formulary
3.4	**Anti-reflux milks DNP request** This item has arisen as concern raised by primary care pharmacist regarding usage of anti-reflux baby milk formula, to enquiry if GM position to be taken, here. It was noted that this may not meet the threshold for CRG (as £33,000 per year total cost), and that some comments received suggest this may pose a potential inequality issue if those that need these products are unable to purchase them. It was noted that an example group is parents of premature babies who already see significant costs for other aspects of care. It was noted that these products can be obtained via the Healthy Start scheme. It was suggested that although the cost is low, if it meets criteria for DNP, we can put this to consultation, and cost-of-living concerns are likely going to be raised in response to this. AW raised the issue of finance teams applying pressure to areas of prescribing such as gluten-free and that

	turning down an opportunity to make this DNP would have to be justifiable as doing so might be seen in a negative light. The notion of "setting a precedent" was raised, and whether by doing this for a low-spend item means that practice pharmacists may use this route to aid in declining requests for prescriptions, even when it isn't high-priority for CRG. Concern was noted that this may lead to an increase in DNP submissions even if the overall regional spend is low. One possible solution was to consider prescribing trends, and if remains low cost long-term we can deprioritise items such as this. There was broad agreement for DNP status, on the basis of criterion 3, in consideration of availability via the Healthy Start scheme. **Action:** Agreed to go for consultation as DNP (criterion 3)
3.5	**Hypersalivation RAG** This item was discussed during the April 2022 CRG meeting, and concerns were raised at the time with the treatment order (due to concerns around order of costs). The team has replied to these concerns. It was also noted that some of the comments from April 2022 CRG meeting seem to be highlighting the differences in availability between primary and secondary care, and concerns around clinical oversight. It was suggested that if the order of products in terms of cost-efficacy was agreeable with CRG, that the local pathway could also be reviewed with consideration to making it a GM pathway. It was agreed to discuss with the authors with the aim of returning to the June 2022 CRG meeting with the final pathway version and final RAG statuses for medicines for review. **Action:** To review pathway and RAG statuses at June 2022 CRG meeting (to possibly accept both, to go for consultation).
4.0 Pathways and Clinical Guidelines	
4.1	**DOAC choice for AF – prescriber's guide** Two documents were presented; the first a DOAC comparison table is an RDTC document and is published on the RDTC website and members were encouraged to share across their networks. The second is a draft decision aid, adapted with permission from one produced by Cheshire and Merseyside Partnership and includes a proposed GM position statement for the use of edoxaban. The decision aid was discussed in detail, and it was noted that there are some sections where the information within the prose differed from information within the table. For example, the major GI symptoms sections do not appear to align, and it may be easier to use if the second section is not there. Questions were raised regarding the appearance of direct comparisons between DOACs in the comparison table, when it is acknowledged that there are no head-to-head studies published. It was clarified that this is not the case. The group acknowledged that population level cost-effectiveness does not always translate to and be useful in discussing risks and benefits at an individual patient level. The importance of a GM-wide approach to having consistency with new initiations of DOACs was noted, and that this may take some time to produce ensuring there is adequate engagement. It was suggested that some regions in GM may be less happy with waiting due to potential cost-savings with switching. The need for cardiology input in order to ensure an alignment between primary and secondary care was recognised, though it was discussed that this may delay things further. It was

	also noted that this has been raised locally with the Salford Thrombosis Committee, though this will be wider than treatment for AF. Some secondary care representatives would not provide an update on internal discussions regarding their position on this issue. CRG were happy with a recommendation that new initiations where suitable for edoxaban should receive the lowest cost medicine but found it much more difficult to reach a consensus on switching. This was not helped by the problems raised with the supporting documentation and decision could not be reached to even agree what process this work should go through to optimise GM-wide consensus. It was therefore agreed that PB and DN would discuss further outside the meeting. It was expressed that the RDTC comparison table is useful for conditions on the whole, and the decision aid is useful for first-choice preference. Provided the information and purpose of each is clear, they could sit alongside each other. <u>Decision:</u> Discussion to continue outside of meeting between PB and DN on what process should be followed to obtain GM consensus
4.2	**GMMMG Headache Pathway** AP explained that this pathway has previously come via CRG and has been consulted on. The feedback from this process has been incorporated (where appropriate) into the latest update, including the removal of oral diclofenac, and including 'do not do' recommendations from NICE CG150. It was clarified that information regarding candesartan use as a prophylactic agent come from BASH and SIGN guidance, and links to external resources have been included. The updated RAG statuses of items have been made clear on formulary. No comments were received from CRG, and there was broad agreement to go to GMMMG for approval. **<u>Action:</u>** Approved. To be submitted to GMMMG for ratification as part of the subgroup decision table
4.3	**Antibiotic guidelines for patients with antibody deficiency** Elaine Radcliff (ER) introduced this topic. The introduction of Otigo ear drops, and a recommendation to use them prior to antibiotics, was highlighted. It was noted that the comments have gone via the antibiotic formulary steering group, and that the group decided to include Otigo in line with NICE recommendations. The cost was highlighted, noting that the Otigo ear drops cost more than a standard antibiotic course, though the total cost within Greater Manchester is estimated as £35-40,000, and the cost should be off-set by reductions in antibiotic resistance and overuse. **<u>Action:</u>** Antimicrobial guideline update was approved and GMMMG website to host NCA guidance for primary care reference
4.4	**NICE NG17: Type 1 diabetes in adults: diagnosis and management – Implications for provision of real-time (rtCGM) & intermittently scanned/flash continuous glucose monitoring (isCGM)** Following the publication of NG17 on 31st March 22 where it is recommended that all T1DM patients are offered either rtCGM or isCGM It was highlighted that this is going to cause a large cost pressure to both primary and secondary care, and it needs to be considered how GMMMG will support this. Currently there is a process ongoing within EUR team regarding this as the policy for initiating CGM is managed by that team. It was discussed that although this is from NICE guidance rather than from a NICE TA, there is not the mandatory time pressure there normally would be in

	terms of commissioning, however the pressure is coming from patients and patient groups to have these available as soon as possible, as well as the national diabetes clinical advisor. It was noted one possible barrier is whether primary care teams have the experience/knowledge to initiate these, particularly with decision making regarding first-choice products. The decision-making process, and the risk of exacerbating existing health inequalities if initiation is based primarily on patient request, was noted. There was a desire to stick to the established governance process but an acknowledgement that the time delays may lead to some pushback. The discussion could not progress without commissioning and finance representation which CRG does not have within its terms of reference. It was therefore agreed that this issue should be escalated to GMMMG to seek a resolution. **Action** : Escalate to GMMMG as there are significant cost pressures and patient impact factors with decisions surrounding the change to glucose monitoring recommendations.
5.0 Shared care	
	No agenda item
6.0 Work plan and horizon scanning	
6.1	**Horizon scanning April 2022** CRG noted the contents of the document, and one item was discussed. **1. Somatrogon 24mg, 60mg solution for injection in pre-filled pen** This product was highlighted as the novel formulation allows for weekly (instead of daily) administration. It was noted this is nominally commissioned by NHS England, however there is a history within the GM area of GPs prescribing these items under shared care arrangements. There is a current spend of approximately £3m on somatropin regionally, and if this new product is more expensive, we might see an increase in regional spending as it appears it may be more tolerable for patients. It was suggested that this item is bought back in future, perhaps when cost information is available.
6.2	**GMMMG (JCT) work plan** Received for information.
7.0 AOB **1. HRT Provision – What is needed in GM?** Due to time constraints, this item was not discussed fully, but there was agreement to begin discussions over email with an intention of bringing to the June 2022 CRG meeting. **2. Cardiorenal pathway** It was noted a final copy of this pathway has been made available, and will be shared with DN. The launch meeting for this pathway (it has not come via GMMMG) is 12th May 2022. DN confirmed further discussion is likely to happen regarding this pathway and the potential impact it will have within the area	
Date of next meeting: Tuesday 14th June 2022 12:00-14:00 via Teams	